HOMELESSNESS STIGMA AS A FUNCTION OF MILITARY AND TRAUMA STATUS: AN EXPERIMENTAL STUDY

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ABSTRACT

HOMELESSNESS STIGMA AS A FUNCTION OF MILITARY AND TRAUMA STATUS: AN EXPERIMENTAL STUDY

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The present study assessed the stigma-related reactions among participants who read one of three vignettes concerning a homeless man with mental illness as a result of (a) unknown reasons; (b) sexual abuse; or (c) combat trauma. We asked 112 undergraduate students at a midsized, private university who were currently enrolled in upper-level psychology courses to complete five questionnaires in response to the vignette to which they were randomly assigned.

Overall, the results were non-significant and did not support the hypotheses. This is surprising given what we know about stigma-related research. Typically, negative reactions are less severe when an evaluator attributes a person’s situation as out of his/her control (Weiner, 1980). Thus, we hypothesized that there would be less severe negative reactions for participants who read about a hypothetical homeless man with mental illness as a result of sexual abuse or combat trauma because these may be considered as out of a person’s control. More specifically, we also expected to find that stigma-related reactions would be less severe towards the hypothetical homeless man with mental illness
as a result of combat trauma compared to sexual abuse because there seems to be
compassion felt towards veterans, although it is still a stigmatizing condition (Hoge et al.,
2004; Rosenheck et al., 2010).

The results from our qualitative questionnaires provided insight in attempting to understand our non-significant results. For example, we found that most participants across conditions (even in the homelessness vignette condition that did not mention trauma) believe that trauma is highly associated with homelessness. Consequently, we may have had a weak experimental manipulation (i.e., reading a vignette about a homeless person with a history of trauma vs. reading a vignette about a homeless person without any mention of past trauma) because participants may have assumed there was a trauma history when reading about their vignette character, even when the vignette did not even mention trauma. Another factor is that the participants were mostly social science majors in their third or fourth year of their undergraduate education. As a result, they may have been more knowledgeable about the issues related to homelessness or social stigma in general. Other limitations in the study are noted (e.g., lack of a diversity in the sample) and recommendations for research (e.g., using community samples) are provided.
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INTRODUCTION

The consequences of being stigmatized can be deleterious because groups that are stigmatized are often victims of prejudice, thus leading to discrimination (Corrigan & O’Shaughnessy, 2007). Groups that are stigmatized (e.g., people who are homeless or have mental illness) react negatively to stigma, which may inhibit them from seeking the resources that they need to receive help (Hinshaw & Steir, 2008). This rejection exacerbates their social alienation and lack of social support, thus feeding into a vicious cycle (Nooe & Patterson, 2010). To change stigmatizing attitudes toward the homeless, researchers must identify specific factors that influence (augment or reduce) stigma reactions, such as the co-occurrence of mental illness (Snow & Reeb, in press). Results of this study will have important implications for anti-stigma strategies, such as group protests, education, and contact strategies (Corrigan & O’Shaughnessy, 2007).

Most stigma-related research has focused on mental illness and, with few exceptions (Snow & Reeb, 2013), studies have not examined stigma associated with the co-occurrence of homelessness and mental illness, nor have studies determined if stigma is less severe when a homeless person with mental illness has a documented history of trauma. In a literature review, Snow & Reeb (in press) recommended research to examine whether “stigma-related reactions are less severe if the homeless person is a military veteran or has a trauma history” (p. 24). The purpose of the present study is to examine the ways in which stigma towards a homeless man with a mental illness varies
as a function of military and trauma backgrounds. This thesis is organized into a number of sections. The first section defines the concept of social stigma and its specific components (i.e., stereotypes, prejudice, discrimination, attribution). Given the purpose of the present study, this section also provides an overview of research on stigma against mental illness and homelessness. The second section discusses the link between homelessness and background trauma and provides an overview of research suggesting that social stigma against homeless individuals may vary as a function of presence/absence (or type) of background trauma. The third section describes the background for the present study and delineates the study’s hypotheses. The fourth section describes the methods and procedures of the present study, and the final section presents the findings and their implications.

**The Concept of Social Stigma: Relevance to Mental Illness and Homelessness**

**Social Stigma**

Goffman (1963) first defined stigma as an “attribute that is deeply discrediting” and diminishes the holder “from a whole and usual person to a tainted, discounted one” (p. 3). According to Corrigan and colleagues (2003), stigma includes three main components: stereotypes, prejudice, and discrimination. Stereotypes are “collectively held beliefs about members of social groups” (Corrigan, et al., 2003, p. 163). Although stereotyping is an efficient way of categorizing people and forming expectations for a person in a particular group, stereotypes often incorporate a prejudicial attitude, which involves “an evaluative (generally negative) component….which leads to discrimination – the behavioral reaction” (Corrigan & O’Shaughnessy, 2007, p. 91). Typically, discriminatory behaviors include hostile behaviors, rejection, avoidance, segregation,
coercion, and withholding help (Hinshaw & Stier, 2008). One result of stigma (and associated discrimination) for those being stigmatized is self-stigma. Self-stigma (i.e., the internalization of public stigma) leads to a loss of self-esteem and self-efficacy, a tendency to fully blame oneself for a problem or condition, and a general feeling of shame (Corrigan & Watson, 2002; Corrigan, 2000).

To explain the association between stigma and discrimination, Weiner (1980) applied attribution theory. Weiner speculates that there are three causal attributions of a situation: locus, stability, and control. Locus can include internal or external appraisals (Houston, 1972). For internal locus, a person believes that the consequences of one’s behavior are dependent upon his or her actions. For external locus, a person believes that the consequences of one’s behavior are not dependent upon his or her actions. Stability of causality is concerned with whether the cause is permanent or can be altered. Control of causality is the degree to which a person has control over the situation. The type of attribution used (locus, stability, or control) guides the emotional reaction, which leads to the behavior a person exhibits toward the person being evaluated. If a negative situation is believed to be under the person’s control, the evaluator may respond with feelings of disgust or anger (e.g., a bystander is disgusted with a homeless man who is perceived as becoming homeless due to irresponsible behavior, such as substance abuse). On the other hand, if the evaluator believes the situation is outside of the person’s control, she or he may respond with feelings of pity and sympathy (e.g., a bystander pities the homeless man who is believed to be homeless due to problems associated with military trauma). In the former situation, the evaluator may avoid the person under suspicion; in the latter
situation, the evaluator may be more likely to help. Weiner’s research has shown that locus and controllability are the best predictors of emotional reactions.

**Stigma Against Mental Illness and Homelessness**

While there is not as much research about the stigma of homelessness as there is about the stigma of mental illness, there is a growing body of research. For example, Phelan, Link, Moore, & Stueve (1997) using vignettes found that participants rate a hypothetical homeless man more negatively than a man who is described as poor but domiciled. That is, there are higher rates of social distance and blame and lower rates of compassion for the former individual. Thus, their research supports the idea that homeless people would experience greater degrees of stigma compared to domiciled poor people (Phelan et al., 1997). Stigma appears to be a chief trepidation of the homeless population (Bhui, Shanahan, & Harding, 2006). In fact, some homeless individuals have described being spat on or denied treatment because agency employees assumed they were only trying to obtain warmth (Bhui, Shanahan, & Harding, 2006). In a recent study, Snow & Reeb (2013) discovered that participants believed a hypothetical homeless person with no mental illness was more responsible for his/her condition and had less feelings of pity toward the homeless person compared to a hypothetical homeless person with a mental illness. Kidd (2007) found that panhandling, a behavior commonly associated with homelessness, was very much related to perception of social stigma especially because it is a public display of people’s homelessness. Kidd (2007) also found that perceived stigma was significantly related to low self-esteem, loneliness, suicidal ideation, and feeling trapped. So, it seems as though being homeless and experiencing stigma is also related to a number of mental health problems.
People with mental illness represent one of the most stigmatized groups in our society (Corrigan et al., 2000; Hinshaw & Steir, 2008). Individuals with mental illness are labeled, stereotyped, and unfairly linked with negative attributes; as a consequence, they experience severe discrimination. The public often stereotypes those with mental illness as dangerous or unpredictable and frequently blames them for their condition, leading to fear, rejection, and coercive behavior (Corrigan & Wassel, 2008).

Because homelessness and mental illness are so closely associated in the minds of many people, it would be difficult (or meaningless) to examine stigma toward homelessness without taking this fact into account. Given the high degree of social stigma against mental illness it has been suggested that the close link in people’s mind between homelessness and mental illness actually contributes to the public social stigma regarding homelessness. In a literature review, Snow and Reeb (in press) draw a number of conclusions from research on the relationship between homelessness and mental illness. First, the majority of the homeless population does not have a mental illness (U.S. Department of Housing and Urban Development, 2010). Research has found approximately 15-26% of the homeless population has a mental disorder (U.S. Department of Housing and Urban Development, 2010; University of California – San Diego School of Medicine, 2005; National Resource and Training Center on Homelessness and Mental Illness, 2003; Snow, Baker, & Anderson, 1986). However, although the majority of homeless individuals do not have a diagnosable mental illness, it appears that many of them have vulnerabilities that detract from their adjustment (Koegel, 2007). For example, homeless individuals tend to have an array of problems such as poverty, housing instability, history of physical or sexual abuse in previous
homes, job loss, and alcohol or drug use (Koegel, 2007). These vulnerabilities usually occur in combination and can often lead to feelings of social alienation (Koegel, 2007; Wallace, 1968).

Second, at times, the media reports hyperbolic estimates of the relationship between homelessness and mental illness (Buck & Toro, 2007). As one extreme example, Powell (2011) wrote in a New York Times piece, “Every study of homeless single adults has found that a decided majority suffer from mental illness and the addictions that are its handmaidens.” These media examples lead the public to have a misconstrued idea of mental illness and homelessness.

Third, perhaps due to the point made above, the public also overestimates the relationship between homelessness and mental illness. For example, in a study examining the views of urban habitants towards the homeless, 66% responded that mental illness almost always or frequently come to mind. (Arumi et al., 2007). In another study, Lee, Jones, and Lewis (1990) found that over half (53%) of participants believed that most homeless individuals had a mental illness.

Fourth, the public’s exaggeration of the link between homelessness and mental illness appears to contribute to stigmatization of the homeless population (Snow & Reeb, in press). The stigma that homeless individuals face is associated with social distance, mistrust, discrimination in housing, and perceptions of worthlessness, dangerousness, dirtiness, and lack of intelligence (Phelan et al., 1997). Furthermore, Hinshaw and Steir (2008) reported, “Mental illness stigma is highly related to public perceptions – often fueled by biased and misleading media portrayals – that mental disorders are strongly linked to danger and violence” (p. 387); in fact, individuals with mental illness are only at
a slightly increased risk for violence, and the link is limited to certain types of mental illness. For example, in a recent study, Snow & Reeb (2013) found that participants had stronger beliefs of dangerousness, fear, and support for segregation towards a hypothetical vignette character when the character was portrayed as having a mental illness.

Fifth, trauma is linked to homelessness. Homelessness is traumatic for most individuals, (Billy & Sharpe, 2008) and homelessness itself represents a set of stressors (e.g., sudden loss of home, exposure to unsafe living conditions and/or trauma) that may precipitate or exacerbate mental illness (Snow & Reeb, in press). Because the relationship between trauma and homelessness is central to this project, the topic is explored in more detail in the next section.

**Trauma and Homelessness**

For the purpose of this study, this review will focus on two types of trauma (military related trauma, sexual abuse trauma) that have been found to be related to homelessness. Often, it is the case that homeless individuals experienced trauma before becoming homeless. Research suggests that 61% of homeless men had experienced trauma at one point in their lives (Buhrich et al., 2000), and over 73% of homeless adults had experienced abuse (Clarke et al., 1995). For example, trauma in homeless men could be from military experience because 40% of homeless men are veterans (Kim & Ford, 2006; Nooe & Patterson, 2010), or sexual abuse, which is seen in 10-19% of homeless men (Buhrich et al., 2000; Nooe & Patterson, 2010). Given the history of trauma in homeless men, it is not surprising that the homeless population is at an increased risk for developing post-traumatic stress disorder (Kim & Ford, 2006). In fact, according to a
study conducted on homeless adults in St. Louis, 20% of homeless men had post-traumatic stress disorder (Piening & Bassuke, 2007). Studies investigating the percentage of homeless male veterans with post-traumatic stress disorder are scarce. However, some studies have concluded that there are no differences in rates of post-traumatic stress disorder among homeless Vietnam veterans and nonhomeless low-income veterans, although the rates are still high (Rosenheck, Kasprow, & Seibyl, 2007). Some researchers conclude that factors such as poverty, social isolation, and substance abuse better predict homelessness. According to the National Coalition for Homeless Veterans, the majority of veterans suffer from mental illness, alcohol and/or substance abuse, or co-occurring disorders (National Coalition for Homeless Veterans, 2013). The Coalition also reports that a substantial number of homeless veterans are living with persistent effects of post-traumatic stress disorder and substance abuse, which are exacerbated by veterans’ lack of social support.

In a study of homeless men, Kim, Ford, Howard and Bradford, (2010) found that 55.6% of their sample had a history of childhood sexual abuse, and 53.1% of their sample had a history of adult sexual abuse. Furthermore, both of these abuse experiences were significantly related to mental health problems. Researchers have found that a history of military experience or a history of childhood trauma (e.g., sexual abuse) are risk factors for homelessness (Gamache et al., 2001; Nooe & Patterson, 2010; Rosenheck et al., 1994). In fact, 16% of homeless veterans reported that their history of military experience contributed to being homeless “very much” (Rosenheck, et al., 2007). Moreover, childhood sexual abuse that was prolonged and severe was related to chronic homelessness (Morrell-Bellai et al., 2000). Although it is clear that a history of trauma is
common in the homeless population, researchers have not determined if there are fewer negative reactions (e.g., stigma) toward homeless individuals when their trauma histories are known.

**Stigma and Trauma**

**Background of Combat Trauma and Subsequent Homelessness**

Those in the military have a significant likelihood of experiencing trauma. Nearly *all* soldiers and marines recently deployed to Iraq and Afghanistan report being shot at (93%) or seeing dead bodies/human remains (95%) (Hoge et al., 2004). Exposure to trauma in the military frequently leads to the development of post-traumatic stress disorder as well as other mental health problems (Nash, Silva, & Litz, 2009), which increase the risk of subsequent homelessness (Tessler, Rosenheck, & Gamache, 2001). Some research (Dickstein et al., 2010; Hoge et al., 2004; Stecker et al., 2007) suggests that, due to the social norms within the military, many survivors of trauma hesitate to seek mental health services because doing so could potentially harm their careers. Researchers (Dickstein et al., 2010; Hoge et al., 2004; Stecker et al., 2007) have identified specific reasons for this hesitancy, including: a wish to avoid the “mental illness” label, a fear of being excluded, a fear of being blamed for their problems, and a concern that others would lose confidence in them or view them as unreliable or weak.

Within the military culture, stigma toward trauma-related mental health problems seems to be greater than what is found within the general population. This may have to do with the “inner strength” that is emphasized within the military culture (Dickstein et al., 2010; Nash, Silva, & Litz, 2009). For example, the “Battlemind” program aimed to teach resiliency has been said that it “enables soldiers to courageously face
adversity…and will empower them to overcome the readjustment difficulties and stress symptoms they experience after deployment” (Nash, Silva, & Litz, 2009, p. 792). Dave Grossman, a popular speaker on the topic of combat stress in the military and law enforcement, was quoted as saying “having PTSD is more like being fat than like having diabetes – you can choose not to be fat” at the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury Warrior Resilience Conference (Grossman, 2008 as cited in Nash, Silver, & Litz, 2009, p. 792).

However, it seems that the public has compassion toward veterans due to their many sacrifices (Rosenheck et al., 2007), as evidenced by the public’s endorsement of services for veterans (e.g. Wounded Warrior Project, Veterans Affairs Mental Health Services). The Department of Defense (DOD) reported, “In the history of warfare, no other nation or its leadership has invested such an intensive or sophisticated effort across all echelons to support the psychological health of its military service members…as the [DOD] has invested during the Global War on Terrorism” (p. 5). Furthermore, “Early and non-stigmatizing psychological health assessments and referrals to services will be routine and expected” (p. 6) (Department of Defense Task Force on Mental Health, 2007). Therefore, it is reasonable to hypothesize that, relative to the level of stigma toward a homeless person with a mental illness that developed for unknown reasons, the degree of stigma would be less for a homeless person with mental illness that developed due to military combat trauma.

Background of Sexual Abuse and Subsequent Homelessness

As noted earlier, research shows that a history of abuse (including sexual abuse) is common in the background of homeless men. In general, victims of sexual abuse often
have feelings of shame and stigma (Finkelhor & Browne, 1985). It appears that social stigma is greater in victims of sexual abuse compared to victims of emotional or physical abuse, especially if (a) the victim knew the perpetrator well and (b) the victim is a male (Foynes et al., 2009; Saewyc et al., 2006). Foynes and colleagues found that victims of sexual abuse were less likely to report the abuse when the victim-perpetrator relationship was “very close.” The researchers believed that this was the case because the stigma tends to be even higher when the sexual abuse is characterized by “very close” victim-perpetrator relationships or incest compared to “not very close” victim-perpetrator relationships. “Very close” was defined as sexual abuse committed by parents, stepparents, siblings, or boyfriends/girlfriends. Whereas, “not very close” was defined as sexual abuse committed by individuals other than those previously listed such as other relatives, teacher/babysitter/coach, stranger, or acquaintance. Other research (Saewyc et al., 2006; Holmes & Slap, 1998; Romano & Luca, 2001) has pointed out that stigma is greater when the victim is a male because admitting to being sexually abused is also perceived as admitting to being homosexual.

Approximately 3-16% of males have been victims of child sexual abuse (Kisanga et al., 2011). Boys who are sexually abused are hesitant to report their abuse because they worry about being punished, want to feel that they can handle it on their own, and fear being labeled as a “homosexual” and stigmatized as a consequence (Holmes & Slap, 1998). Kisanga and colleagues (2011) found that sexually abused children did not disclose their experience because they feared they would be stigmatized, excluded, or re-victimized by their offender.
Given these findings, and the findings noted in the earlier section, there is reason to expect that a homeless person with a history of mental illness caused by sexual abuse would be stigmatized to a greater degree than a homeless veteran with a history of mental illness caused by combat trauma. However, the homeless person with mental illness caused by sexual abuse, when compared to a homeless person with mental illness due to unknown causes, may be stigmatized less. This is because, when the cause of mental illness is unknown, it is commonly assumed that the mental disorder was due to irresponsible decisions or behavior (Feldman & Crandall, 2007). In recent research, Feldman and Crandall (2007) found three traits that best predicted mental illness stigma: responsibility, dangerousness, and rarity. This means the stigma-related attitudes (e.g. avoidance, punishment, rejection) were highest when mental illnesses were perceived as the individual’s fault, dangerous, and rare.

**The Present Study**

**Background**

There is a dearth of research examining the relationship between stigma and the mentally ill population with a history of trauma exposure. Researchers are unsure as to whether trauma history will decrease the degree of stigma towards the homeless. The present study plans to address this question by using a sample of college student participants. Using past studies assessing stigma-related attitudes as a guide (Corrigan et al., 2003), we will investigate the relationship between causal attributions, dangerousness, emotional responses and behavioral responses through the use of hypothetical vignettes. We will determine the extent to which social stigma against a homeless man with mental illness is less severe depending on the following: (a) whether
the hypothetical vignette character has a history of trauma; and (b) if there is a history of trauma, are there differences between military-related combat trauma and sexual abuse.

A strength of the current study is that it will statistically control for the social desirability bias. Social desirability may become an issue when measuring a construct that participants may answer to make them appear socially acceptable and positive. This is especially true when the measure is face valid and participants are able to alter their responses to fit with social allure. To alleviate the issue of social desirability, the Balanced Inventory for Desirable Responding will be administered (Paulhus, 1991). Few studies (Kingree & Daves, 1997; Alexander & Link, 2003; Snow & Reeb, 2013) have actually controlled for social desirability in the social stigma research, but when socially desirability is controlled, results remain significant.

**Hypotheses**

There tends to be fewer stigma-related attitudes when the cause of the stigmatizing condition is outside of the person’s control (e.g. trauma), as opposed to when the cause is unknown (Hinshaw & Steir, 2008). Thus, Hypothesis 1 is as follows: *After controlling for social desirability, participants will have significantly greater negative reactions when the vignette describes a man who became homeless following the onset of mental illness that developed for unknown reasons, compared to when the vignette describes a man who became homeless following the onset of mental illness that developed as a result of combat trauma or sexual abuse. In other words, when the vignette portrays a homeless man with mental illness and no history of trauma, participants will: (a) display higher scores on Personal Responsibility (Blame), Anger, Dangerousness, Fear, Avoidance, Segregation, and Coercion subscales of the Attribution...*
Questionnaire; and (b) display lower scores on Pity and Willingness to Help subscales of this psychometric measure. Stigma-related attitudes should be most severe when there is not a history of trauma because it is common for participants to attribute the cause of mental illness as within the person’s control, thus worsening the degree of stigma (Hinshaw & Steir, 2008).

Hypothesis 2 is as follows: Relative to participants who read the vignette portraying a homeless man with no history of trauma or a history of sexual abuse, participants who read the vignette portraying a homeless man with mental illness and a history of combat trauma, will (a) display lower scores on Personal Responsibility (Blame), Anger, Dangerousness, Fear, Avoidance, Segregation, and Coercion subscales of the Attribution Questionnaire; and (b) display higher scores on Pity and Willingness to Help subscales of this psychometric measure even after controlling for social desirability. These results are expected because our society seems to be more compassionate towards veterans as evidenced by programs aimed towards providing care for veterans (e.g. Veterans Affairs Mental Health Services) and the recent DOD Task Force publication (Department of Defense Task Force on Mental Health, 2007) stating the need of providing psychological health to our veterans.

Clinical Significance

Social stigma can inhibit homeless people’s attempts to obtain housing and employment, and it can result in self-stigma, causing negative self-evaluation and feelings of incompetence (Snow & Reeb, in press). If stigma is less severe when a history of trauma and/or military service is documented, then this is significant finding because over 40% of homeless men are veterans (Kim & Ford, 2006) and over 60% of
homeless men are trauma survivors (Buhrich et al., 2000). Results of this study can be applied to anti-stigma strategies, such as those discussed by Corrigan and O’Shaughnessy (2007). As explained earlier, Corrigan and O’Shaughnessy (2007) describe three strategies for reducing stigma: protests, education, and contact. Although protests are aimed in reducing the public’s stigma, it can actually have the opposite effect and cause *attitude rebound* (i.e. more severe negative reactions). This is because protests attempt to decrease negative attitudes while not advocating for positive ones (Snow & Reeb, in press). Research has shown that, “a strategy that combines contact and education component may be best” (Snow & Reeb, in press, p. 23). The results of this study will have implications for various types of anti-stigma projects.

If the hypotheses of the present study are supported, these data can guide educational interventions in an effort to reduce stigma. The public would be educated about the high percentage of homeless men who are veterans and/or suffered through a trauma in the past. The current study is also applicable to the element of contact. Perhaps once individuals become more knowledgeable of the relationship between homelessness and trauma, they will be more compassionate toward the homeless population and may be more likely to volunteer at local homeless shelters. Once they are working at the shelters, volunteers are interacting with homeless individuals more frequently than if they were to simply pass these people on the streets. Moreover, contact with a stigmatized group results in perennial attitude changes (Corrigan et al., 2003), and contact may be a byproduct of educating the public (Snow and Reeb, in press). The present study aims to contribute to the understanding of the role of trauma in stigma
towards the homeless population, and thus help to reduce some of the negative attitudes associated with homelessness.
METHOD

Participants

Participants included 112 college students (66 female, 46 male) from the University of Dayton, a midsized, private university in the Midwest. These participants were recruited from undergraduate psychology courses and were rewarded extra credit for their participation in this study. Each participant was randomly assigned to a condition. There were 38 students in condition 1 (no trauma), 36 students in condition 2 (sexual abuse), and 38 students in condition 3 (combat trauma). Among the participants, 89.3% identified as White, 5.4% identified as African American, 1.8% identified as Asian American/Pacific Islander, 1.8% identified as Latino/a, and 0.9% did not identify an ethnicity. Participants ranged in age from 18 to 23 ($M = 20.80$, $SD = 1.06$). Among the participants, 7.1% were first-years, 17.9% were sophomores, 33.0% were juniors, and 42.0% were seniors. When participants were asked about the highest level of education completed by his or her mother, 5.4% reported high school diploma, 11.6% reported some college, 10.7% reported Associate’s degree, 47.3% reported Bachelor’s degree, and 25.0% reported graduate/professional training. When participants were asked about the highest level of education completed by his or her father, 0.9% reported some high school, 6.3% reported high school diploma, 8.9% reported some college, 6.3% reported Associate’s degree, 40.2% reported Bachelor’s degree, and 37.5% reported graduate/professional training. Participants were also asked about their political
affiliation. Approximately 36% identified as republican, 17.0% identified as democrat, 10.7% identified as independent, 3.6% identified as libertarian, 0.9% identified as moderate, and 29.5% reported no political affiliation. Additionally, 2.7% did not answer. Finally, participants were asked about where he or she grew up, and 74.1% reported that he or she grew up in the suburbs, 14.3% reported growing up in a small town (population under 50,000), 8.0% in a city, 1.8% in a rural area outside a metropolitan, and 1.8% of respondents did not answer.

Measures

Demographic Questionnaire. The demographic questionnaire asked participants about their age; sex; ethnicity; year in school; parent’s education background, type of area they grew up in, political affiliation, military history, and sexual abuse history. The information was collected to determine if these data influence their responses to other questionnaires. The demographic questionnaire is presented in Appendix B.

Attribution Questionnaire. The Attribution Questionnaire is a 27-item instrument based on the measure developed by Corrigan et al. (2003) to assess the following constructs: Personal Responsibility Beliefs (Blame), Pity, Anger, Fear, Help, Dangerousness, Avoidance, Segregation, and Coercion. Participants will respond to the items using a 9-point Likert Scale; e.g. It is Billy’s own fault he is in the present condition (9 = yes, absolutely so), with higher scores indication more identification with those items. Subscales were obtained for the previous constructs by summing participants’ scores to each item in that subscale. Corrigan and colleagues reported that each subscale has high reliability (alpha coefficients: Personal Responsibility = .70; Pity = .74; Anger = .89; Fear = .96; Helping = .88; and Coercion/Segregation = .89). There is
evidence for a six-factor solution: Fear/Dangerousness ($\alpha = .93$), Help/Avoidance ($\alpha = .82$), Responsibility Beliefs ($\alpha = .60$), Coercion/Segregation ($\alpha = .79$), Pity ($\alpha = .77$), Anger ($\alpha = .81$). The Attribution Questionnaire is presented in Appendix C.

*Balanced Inventory of Desirable Responding* (BIDR; Paulhus, 1991). The BIDR is a 40-item measure to assess two forms of social desirability: Self-deceptive enhancement (SDE) and impression management (IM). Self-deceptive enhancement is defined as “the tendency to give self-reports that are honest but positively biased” (Paulhus, 1991, p. 31). Impression management is defined as “explicit self-presentation toward an audience” (Paulhus, 1991, p. 37). As outlined above and fully discussed in the following section, the present study controlled for social desirability. A social desirable responding (SDR) score is calculated by summing the scores on all items of the questionnaire. The first 20 items on the measure can be summed to provide a SDE subscale score, and the last 20 items can be summed to provide an IM score. Participants will respond to the items on a 7-point Likert scale (1 = not true; 7 = very true). The BIDR has been shown to have good reliability in the overall scale and the subscales. The alpha coefficient for internal reliability was .83 (Paulhus, 1991). The alpha coefficients for the SDE subscale ranged from .68 to .80 and .75 to .86 for the IM subscale (Paulhus, 1991). There is evidence for concurrent validity such that the SDR is correlated with the Marlowe-Crowne Scale ($r = .71$) and the Multidimensional Social Desirability Inventory ($r = .80$). The BIDR is presented in Appendix D.

*Supplemental measures.* Two measures were created for the present study to provide additional information about participants’ beliefs about homelessness (Appendix E) and their exposure to the homeless population (Appendix F). The measure
concerning participants’ beliefs about homelessness assessed their views about how one becomes homeless and the relationship between homelessness and trauma. Additionally, it specifically asked if they believed if a traumatic experience could cause homelessness. The exposure to homelessness scale assessed how frequently participants observed or encountered the homeless population before attending the University of Dayton and since attending the university. Participants also answered whether or not they had participated in community service activities involving the homeless population.

**Procedure**

After approval of the University of Dayton’s Department of Psychology Research Review and Ethics Committee, approximately 112 students were recruited from undergraduate psychology courses. Participants received extra credit upon completion of the study. The researcher obtained informed consent from all participants (see Appendix G for the informed consent). Each participant completed the following measures (in order): a vignette, an Attribution Questionnaire (Corrigan et al., 2003), the BIDR (Paulhus, 1991), a qualitative measure assessing respondents’ beliefs about homelessness, an exposure to homelessness scale, and the demographics questionnaire. Participants were randomly assigned to one of the three vignettes. Besides the different vignettes, all other information remained consistent across groups. After completion, participants were debriefed and thanked for their contribution (see Appendix H for the debriefing form).

Three vignettes were written for the current study, each describing “Billy who is homeless.” The information provided in the three vignettes was designed to manipulate the independent variable of a history of trauma. All other information provided in the vignettes was consistent across groups. Each participant was randomly assigned to one
of the following vignettes concerning Billy’s trauma history: 1) Billy has no history of trauma; 2) Billy has a history of combat trauma; or 3) Billy has a history of sexual abuse. The vignettes are presented in Appendix A.
RESULTS

Preliminary Analysis

A correlation matrix was created in order to determine if the specific subscales of the Attribution Questionnaire, which is the dependent variable, are interrelated. As seen in Table 1, the subscales are correlated, which implies that the subscales are variations of the same broad construct and justifies the use of a MANCOVA. Thus, the subscales will serve “jointly” as a dependent variable. The correlation matrix illustrated that the subscales of the Attribution Questionnaire subscales tended to covary, as 23 out of the 36 correlations are significant. Significant correlations ranged in magnitude from .19 to .84. These results are similar to another study that utilized the Attribution Questionnaire (Snow, 2013).

As seen in Table 1, the covariate (social desirability bias) was also correlated with the subscales of the Attribution questionnaire. The overall social desirability score was significantly correlated to the likelihood to help subscale of the Attribution Questionnaire (r = .24, p = .011). Additionally, the BIDR subscales (impression management and self-deceptive enhancement) were correlated with the Attribution Questionnaire subscales. The impression management subscale was significantly correlated to the likelihood to help subscale (r = .28, p = .016), and the avoidance subscale (r = -.19, p = .05). The self-deceptive enhancement subscale was significantly correlated to the pity subscale (r = -.19, p = .044). Thus, the overall social desirability score correlated with one out of the
Table 1.
*Intercorrelations of Attribution Questionnaire Subscales and BIDR Total Score and Subscales of Overall Sample*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pity</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Help</td>
<td>.25**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Segregation</td>
<td>.03</td>
<td>-.35**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Coercion</td>
<td>.18</td>
<td>-.10</td>
<td>.45**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Fear</td>
<td>.05</td>
<td>-.30**</td>
<td>.51**</td>
<td>.26**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Danger</td>
<td>.04</td>
<td>-.26**</td>
<td>.54**</td>
<td>.34**</td>
<td>.84**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Anger</td>
<td>-.12</td>
<td>-.12</td>
<td>.30**</td>
<td>.10</td>
<td>.40**</td>
<td>.40**</td>
<td>-----</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Avoidance</td>
<td>-.16</td>
<td>-.58**</td>
<td>.44**</td>
<td>.28**</td>
<td>.22*</td>
<td>.26**</td>
<td>.01</td>
<td>-----</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Blame</td>
<td>-.32**</td>
<td>-.19**</td>
<td>.19*</td>
<td>.12</td>
<td>.26**</td>
<td>.20*</td>
<td>.42**</td>
<td>.18</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>10. BIDR (Total)</td>
<td>-.13</td>
<td>.24*</td>
<td>-.06</td>
<td>-.07</td>
<td>-.09</td>
<td>-.07</td>
<td>.03</td>
<td>-.14</td>
<td>.05</td>
<td>-----</td>
</tr>
<tr>
<td>11. BIDR (Self-Deceptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancement Subscale)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. BIDR (Impression Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subscale)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. *p ≤ .05. **p ≤ .01
nine attribution questionnaire subscales; the impression management subscale correlated with two out of the nine attribution questionnaire subscales, and the self-deceptive enhancement subscale was correlated with one out of the nine attribution questionnaire subscales. Because there was some level of correspondence between the BIDR and the Attribution Questionnaire subscales, we made the decision to use the BIDR as a covariate in the subsequent analyses.

Because the subscales of the Attribution Questionnaire were found to be interrelated, a MANCOVA was utilized, with Vignette Condition as the independent variable, social desirability as the covariate, and the subscales of the Attribution Questionnaire serving as the “joint” dependent variable. The three levels of the independent variable (Vignette Condition) included: homeless male with mental illness and no trauma history; homeless male with mental illness and a sexual abuse history; and homeless male with mental illness with combat trauma history.

**Examination of Hypotheses**

A one-way MANCOVA revealed a non-significant main effect for condition, $F(18, 200) = 1.39, p = .14$. Table 2 contains the means and standard deviations on the dependent variables for the three groups. Although the overall MANCOVA yielded a non-significant result, a separate ANCOVA was conducted for each subscale of the Attribution Questionnaire in an attempt to (a) better understand the findings and (b) set the stage for comparing the results of this study to the results of past research.

In partial support of Hypothesis 2, a one-way ANCOVA revealed that avoidance, $F(2,108) = 3.87, p = .024$, varied as a function of condition. However, these results should be interpreted with extreme caution for two reasons. First, the assumption of
homogeneity of variance was violated, \( F(2,109) = 4.67, p = .01 \). Second, this was the only significant ANCOVA finding out of the nine tests that were assessed. Thus, there is an increased chance that these findings were significant due to alpha error. Follow-up tests were conducted to evaluate the pairwise differences among the means. There was a significant difference in the means between the group that was assigned to the vignette describing a homeless man with a history of sexual abuse and the group that was assigned to the vignette describing a homeless man with a history of combat trauma, \( F(1, 109) = 6.52, p = .012 \). The group assigned to the vignette describing a homeless man with a

<table>
<thead>
<tr>
<th>Attribution Questionnaire Subscale</th>
<th>(1) Mental Illness with No Trauma History ((n = 38))</th>
<th>(2) Mental Illness with Sexual Abuse History ((n = 36))</th>
<th>(3) Mental Illness with Combat Trauma History ((n = 38))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>( SD )</td>
<td>( M )</td>
</tr>
<tr>
<td>Blame</td>
<td>12.08</td>
<td>3.59</td>
<td>11.33</td>
</tr>
<tr>
<td>Anger</td>
<td>7.50</td>
<td>4.11</td>
<td>7.86</td>
</tr>
<tr>
<td>Pity</td>
<td>19.21</td>
<td>4.14</td>
<td>21.28</td>
</tr>
<tr>
<td>Help</td>
<td>18.05</td>
<td>4.04</td>
<td>17.03</td>
</tr>
<tr>
<td>Danger</td>
<td>10.68</td>
<td>3.86</td>
<td>11.81</td>
</tr>
<tr>
<td>Fear</td>
<td>9.05</td>
<td>3.86</td>
<td>9.50</td>
</tr>
<tr>
<td>Avoidance</td>
<td>17.32</td>
<td>4.05</td>
<td>19.08</td>
</tr>
<tr>
<td>Segregation</td>
<td>8.97</td>
<td>4.23</td>
<td>10.33</td>
</tr>
<tr>
<td>Coercion</td>
<td>15.95</td>
<td>4.48</td>
<td>16.64</td>
</tr>
<tr>
<td>Total</td>
<td>118.82</td>
<td>18.37</td>
<td>124.86</td>
</tr>
</tbody>
</table>
history of sexual abuse had higher rates ($M = 19.08, SD = 4.53$) of avoidance compared to the participants assigned to the vignette describing a homeless man with a history of combat trauma ($M = 16.18, SD = 5.86$). This partially supports Hypothesis 2, which stated that compared to participants who read a vignette describing a homeless man with mental illness as a result of sexual abuse, participants who read a vignette describing a homeless man with mental illness as a result of combat trauma would show *lower* scores on the avoidance subscales of the attribution questionnaire. Nevertheless, due to the reasons cited above, the finding must be viewed with extreme caution.

Contrary to Hypothesis 1 and 2, one-way ANCOVAs indicated non-significant differences among conditions for the vast majority of Attribution Questionnaire subscales, including: feelings of pity towards the vignette character, $F(2,108) = 2.63, p = .08$; fear towards the vignette character, $F(2,108) = .99, p = .38$; anger towards the vignette character, $F(2,108) = .46, p = .63$; desire to segregate the vignette character $F(2,108) = 1.03, p = .36$; coerce the character into treatment, $F(2,108) = .18, p = .83$; perceived dangerousness of the character, $F(2,108) = 1.11, p = .34$; placing blame on the vignette character, $F(2,108) = 1.83, p = .17$; and willingness to help, $F(2,108) = .69, p = .51$. In other words, regardless of whether the participants read about a homeless man with mental illness as a result of unknown reasons, sexual abuse, or combat trauma, their stigma-related reactions did not differ significantly from each other on these subscales.

**Supplemental Qualitative Analyses**

As noted earlier, participants also completed a supplemental qualitative measure to assess their beliefs about homelessness. Participants were asked the following questions: (1) *In your opinion, how does a person become homeless?*; (2) *Please provide*
your beliefs on the relationship between homelessness and trauma; (3) When an individual who is homeless also has a trauma history, do you believe that it is the case the traumatic experience caused the homelessness? Please elaborate. In this section, themes identified in participants’ responses are delineated, and the extent to which each theme was found in participants across the different conditions is explored. As different themes are considered, I will proceed in the following order: (a) those commonly identified in the sample across conditions; (b) those commonly identified in the sample but somewhat inconsistently so across conditions; (c) those mostly identified (or much more commonly identified) in participants in some conditions than in others; and (d) those uncommonly identified. To assist the reader in considering the subsequent text, please note that:

- Condition 1 involved participants reading about a hypothetical homeless man with mental illness as a result of unknown reasons (i.e., no trauma condition);
- Condition 2 involved participants reading about a hypothetical homeless man with mental illness as result of sexual abuse.
- Condition 3 involved participants reading about a hypothetical homeless man with mental illness as a result of combat trauma.

**How does a person become homeless?** Across the different experimental conditions, participants also believed that laziness/lack of responsibility/no motivation were a contributing factor to homelessness with 22.0% of the participants noting this as a factor. Nearly 19% (18.9) in condition 1, 25.7% in condition 2, and 21.6% in condition 3 noted this theme. There was also a tendency for participants’ comments to support the theme of family background/poor upbringing with 17.4% of the participants doing so.
across conditions. Endorsement of this theme was fairly consistent across conditions, with 18.9% in condition 1, 17.1% in condition 2, and 16.2% in condition 3 believed that family background/poor upbringing contributed to homelessness. Another theme was that of bad luck with 15.6% of participants endorsing this theme and 13.5% in condition 1, 17.1% in condition 2, and 16.2% in condition 3 doing so. The final theme that was seen across all conditions was the idea of lack of resources with 7.3% of participants endorsing the theme. When broken down by condition, 8.1% in condition 1, 5.7% in condition 2, and 8.1% in condition 3 believed this was a contributing factor.

Certain themes were seen in two conditions more commonly than a third condition. For example, substance abuse was listed as a contributing factor in 24.3% of the participants in conditions 1 and 3 but increased to 34.3% in condition 2. When looking at it across all the conditions, we found that it was endorsed by 27.5% of the participants. Nearly 14% (13.8) of the participants across conditions stated that poor decisions were a contributing factor to becoming homeless. This was seen in 21.6% in condition 1, 17.1% in condition 2, but only 2.7% in condition 3. Finally, 8.3% of participants endorsed the theme of physical illness as a contributing factor to becoming homeless, with 10.8% in condition 1, only 5.7% in condition 2, and 8.1% in condition 3 noting this as a factor. Trauma (including natural disasters and accidents) was endorsed by 7.3% across conditions, with 8.1% in condition 1 endorsing this theme, 11.4% in condition 2 but only 2.7% in condition 3.

Other themes did not seem to be equally represented in all conditions. Mental illness was noted in 31.2% of the participants’ responses across conditions. However, when assessing each condition, 37.8% endorsed this theme in condition 1, 31.4% in
Table 3.
Percentages of Themes for Each Condition and Overall Sample

<table>
<thead>
<tr>
<th>Themes</th>
<th>Condition 1</th>
<th>Condition 2</th>
<th>Condition 3</th>
<th>Overall Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad Luck</td>
<td>13.5%</td>
<td>17.1%</td>
<td>16.2%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Criminal Background</td>
<td>2.7%</td>
<td>2.9%</td>
<td>5.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Family Background/Poor Upbringing</td>
<td>18.9%</td>
<td>17.1%</td>
<td>16.2%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Inability to Overcome/Giving Up</td>
<td>8.1%</td>
<td>2.9%</td>
<td>5.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Job Loss</td>
<td>29.7%</td>
<td>22.9%</td>
<td>37.8%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Lack of Education/Bad Education</td>
<td>5.4%</td>
<td>8.6%</td>
<td>16.2%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Lack of Resources</td>
<td>8.7%</td>
<td>5.7%</td>
<td>8.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Laziness/Lack of Responsibility/No Motivation</td>
<td>18.9%</td>
<td>25.7%</td>
<td>21.6%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>37.8%</td>
<td>31.4%</td>
<td>24.3%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Other</td>
<td>5.4%</td>
<td>2.9%</td>
<td>0.0%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Physical Illness</td>
<td>10.8%</td>
<td>5.7%</td>
<td>8.1%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Poor Decisions</td>
<td>21.6%</td>
<td>17.1%</td>
<td>2.7%</td>
<td>13.8%</td>
</tr>
<tr>
<td>Poverty/Financial Difficulties</td>
<td>13.5%</td>
<td>22.9%</td>
<td>27.0%</td>
<td>21.1%</td>
</tr>
<tr>
<td>Social Situation/Lack of Social Support</td>
<td>21.6%</td>
<td>34.3%</td>
<td>10.8%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>24.3%</td>
<td>34.3%</td>
<td>24.3%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Trauma</td>
<td>8.1%</td>
<td>11.4%</td>
<td>2.7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Veteran Status</td>
<td>2.7%</td>
<td>0.0%</td>
<td>5.4%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>
condition 2, and 24.3% in condition 3. Another identified theme was job loss as seen in 30.3% of the participants’ responses across condition, with 29.7% endorsing this theme in condition 1, 22.9% in condition 2, and 37.8% in condition 3. The theme of *social situation/lack of social support* was seen in 22.0% of the participants’ responses but also had a fairly large discrepancy among the different experimental conditions. For instance, 21.6% of participants in condition 1, 34.3% in condition 2, and 10.8% in condition 3 believed that this was a contributing factor to becoming homeless. Social situation/lack of social support was followed by *poverty/financial conditions* with 21.1% of the total sample stating that they believed this was a contributing factor to becoming homeless. Specifically, 13.5% endorsed the theme of poverty/financial conditions in condition 1, 22.9% in condition 2, and 27.0% in condition 3. Approximately eight percent (8.3) of the participants believed that *lack of education/bad education* was a contributing factor for homelessness with 5.4% in condition 1 endorsing this theme, 8.6% in condition 2, and 16.2% in condition 3.

Less commonly, 5.5% of participants across conditions noted that the *inability to overcome difficulties/giving up* were related to becoming homeless with 8.1% in condition 1, 2.9% in condition 2, and 5.4% in condition 3 endorsing this theme. Less than four percent of participants noted a *criminal background* as being a contributing factor for homelessness with 2.7% in condition 1, 2.9% in condition 2, and 5.4% in condition 3 endorsing this theme. Finally, *veteran status* was an identified theme in 2.8% of the sample. It was seen in 2.7% of the participants in condition 1 and 5.4% in condition 3; however, no participants noted veteran status in condition 2.
Less than three percent of participants wrote reasons that did not fit into any of the previous categories. Two people (one in condition 1, one in condition 2) wrote that losing one’s home was a contributing factor to homelessness. Interestingly, one person wrote that disobedience to God was a contributing factor. When broken down by condition, 5.4% in condition 1, 2.7% in condition 2, and no participants in condition 3 wrote reasons other than those that fit into previous categories.

In summary, participants commonly noted that mental illness (24-38%) and substance abuse (24-34%) were risk factors for homelessness. Participants also believed that job loss (23-38%); poverty/financial difficulties (14-27%); and laziness/lack of responsibility/no motivation (19-26%) were contributing factors for becoming homeless. Even though there were some discrepancies as to how common these themes were seen across all conditions, they were still the most commonly reported belief as to why someone may become homeless. All of the previously listed information is also available in Table 3.

**The relationship between homelessness and trauma.** The second question, which assessed the participants’ beliefs about the relationship between homelessness and trauma, had the lowest response rate; 98 people responded. Our hopes for creating this question was to determine if participants understand that there was a reciprocal relationship between homelessness and trauma. Also, there were no themes that were evenly distributed across all conditions, which are further outlined below. Out of those who responded, 29.6% stated that trauma leads to homelessness, but it seemed to be more common in condition 2 and 3 compared to condition 1. Only 23.5% of the participants in condition 1 endorsed the idea that trauma leads to homelessness with
34.4% endorsing this in condition 2, and 31.3% in condition 3. This was followed by 21.4% of respondents noting that it was related, although they did not state how they were related. This particular idea tended to be represented more in the comments of participants in condition 1 (26.5%) and condition 2 (25.0%) compared to condition 3 (12.5%). Others (18.4%) reported that there was an indirect relationship such that trauma would lead to mental illness, job loss, substance abuse, or issues in general, which would then lead to homelessness. This was most commonly seen in condition 1 (29.4%), followed by condition 3 (15.6%), then condition 2 (9.4%). Additionally, 13.3% reported that homelessness was traumatic. This particular theme tended to be represented in the comments of participants in condition 1, with 14.7% endorsing it and condition 3, with 18.8% endorsing it. However, only 6.3% of participants in condition 2 noted that they believed homelessness was traumatic. Less commonly, only 5.1% of the sample believed that there was no relationship or the relationship was not strong between homelessness and trauma. When broken down by condition, 2.9% in condition 1, 6.3% in condition 2, and 6.3% in condition 3 believed there was no relationship or that the relationship was not strong. Importantly, the only participants who noted that there was a relationship between childhood trauma and homelessness were those that were assigned to read the vignette describing the homeless man with mental illness as result of sexual abuse with 6.3% of them endorsing this theme. The relationship between veteran status specifically and homelessness was endorsed by 2.9% of the participants in the first condition and 3.1% in the third condition. This theme was not represented in the second condition at all.
In conclusion, when looking across conditions, most participants believed that trauma leads to homelessness (23-34%), which was counter to what we were expecting to find (i.e., that participants would discuss the bidirectional relationship between homelessness and trauma). However, participants also commonly mentioned that trauma and homelessness were related (12-27%), and thus it is possible that, by broadly stating that they are related, they may believe trauma and homelessness are bidirectional but failed to mention it specifically.

*Does the traumatic experience cause homelessness?* Only three people did not complete the third question assessing whether a traumatic experience causes homelessness leaving 109 responses. Across the different experimental conditions, there was a tendency to give comments that supported the idea that trauma was a *contributing factor*, with 73.4% of participants doing so. It is very important to note that this finding was identified as very common across all three conditions. When assessing each condition separately, we found that 70.3% in condition 1, 77.1% in condition 2, and 73.0% in condition 3 believed trauma was a *contributing factor*. Approximately 20% (20.2) stated that *trauma caused homelessness*, but 17.4% of those respondents believed that it was *not always* the case that trauma caused homelessness. Almost a quarter (24.3%) of the participants in condition 1 endorsed the idea that *trauma caused homelessness* followed by 18.9% in condition 3, and 17.1% in condition 2. However, 18.9%, 11.4%, and 21.6% in condition 1, 2, and 3 respectively believed that it was *not always* the case that trauma caused homelessness. Finally, less than three percent (2.8) responded that trauma *did not cause* homelessness with 2.7% in condition 1, 2.9% in condition 2, and 2.7% in condition 3 endorsing it.
To summarize, the majority (e.g., 70-77%) of participants believed that trauma was a *contributing factor* for homelessness. This means that trauma could lead to other issues (e.g., mental illness, job loss, substance abuse) that were noted in the first qualitative question concerning the participants’ beliefs about causes of homelessness, which would then lead to subsequent homelessness. In some cases, participants did believe that trauma could *cause* homelessness (17-24%) and few participants believed that trauma *did not cause* homelessness (less than 3%).
DISCUSSION

The discussion will be organized into two main sections. In the first section, I will reiterate quantitative findings in my study, discuss how those findings support or do not support hypotheses, and relate the findings to past research. In this interpretation of the findings, I will also consider the relevance of supplemental qualitative data collected from the present study in attempting to understand and explain quantitative findings. In the second section, I will discuss the limitations and future research directions.

Interpretation of Findings

Hypothesis 1 stated that participants will have significantly greater negative reactions towards a homeless man with mental illness as a result of unknown reasons compared to a homeless man with mental illness as a result of sexual abuse or combat trauma. In other words, for vignettes that portray a homeless man with mental illness and no trauma history, participants will: (a) exhibit higher scores on Personal Responsibility (Blame), Anger, Dangerousness, Fear, Avoidance, Segregation, and Coercion subscale of the Attribution Questionnaire; and (b) exhibit lower scores on Pity and Willingness to Help subscales of this psychometric measure compared to participants who read a vignette describing a homeless man with mental illness as a result of sexual abuse or combat trauma. Following from this, Hypothesis 2 stated that participants will have significantly greater negative reactions towards a homeless man with mental illness as a result of sexual abuse compared to a homeless man with mental illness as a result of...
combat trauma. In general, the ANCOVAs used to examine these hypothesis yielded non-significant results. However, results from the data analysis found partial support for Hypothesis 2. Specifically, we found that participants who read the vignette describing a homeless man with a history of sexual abuse had higher rates of avoidance compared to the participants assigned to the vignette describing a homeless man with a history of combat trauma. However, these findings should be interpreted with caution because the Levene’s test for homogeneity of variance was also significant, and our alpha error risk was also increased due to the fact we ran numerous ANCOVAs. Kisanga and colleagues (2011) found that sexually abused boys did not want to discuss their experiences of sexual abuse because they felt they would be excluded. The interpretation of the present study’s findings would support this belief though, again, our one significant finding must be interpreted with caution due to the reasons noted above. Perhaps society would be more inclined to avoid and thus exclude those who have been survivors of sexual abuse compared to individuals who have survived combat, but additional research is needed to examine this hypothesis.

A brief discussion is needed in order to (a) remind the reader regarding the rationale for our hypotheses and (b) explain why our findings are surprising. The purpose of this study was to determine if participants’ stigma-related reactions differed depending on whether they read a vignette describing a homeless man with mental illness as a result of (a) unknown reasons; (b) sexual abuse; or (c) combat trauma. Past research (Snow & Reeb, 2013) has specifically questioned if stigma-related reactions would be less severe towards a homeless man with mental illness who was a veteran compared to someone who did not have military experience. This has to do with the controllability of
the event that is related to the mental illness. In the case of sexual abuse and combat trauma, the survivor of sexual abuse or combat trauma is presumed to have had less control over the situation in which they were placed. In other words, there may be less blame placed on a homeless individual with these trauma histories compared to a homeless individual who was abusing alcohol and drugs. The logic behind these assumptions is closely linked to Weiner’s (1980) attribution theory. In this theory, there are three causal attributions of a situation: locus, stability, and control. When someone’s behavior is dependent on a person’s actions, we label this as “internal locus.” On the other hand, if the behavior is not dependent on a person’s actions, we label it as “external locus.” Stability is simply whether or not a person’s situation is permanent or able to be changed. Control of causality is the degree to which a person has control over the situation. The nature of these attributions (locus, stability, control) will affect his/her emotional reactions, which then affect potential behaviors. In the case of the present study, we hoped to find that participants would attribute the homelessness with mental illness as out of the persons’ control in the case of the vignette character with a sexual abuse history or combat trauma history and thus have lesser degrees of stigma-related reactions compared to the vignette character with no trauma history noted. However, this was not the case.

We were also interested in assessing if stigma-related reactions would be less severe for someone with a combat trauma history because the percentage of veterans in the homeless male population is over 40% (Kim & Ford, 2006). Also, nearly 60% of homeless men are victims of trauma. Thus, these issues seem to be disproportionately prevalent in the homeless population compared to the general population. For instance,
only 24% of men are veterans in the general population compared to the 40% in the homeless population (Newport, 2012). In regards to sexual abuse, researchers have found that over half of their sample of homeless males had a history of childhood sexual abuse whereas the percentage of males who have been victims of child sexual abuse is 3-16% (Kim et al., 2010, Kisanga et al., 2011).

Individuals who have experienced combat trauma are hesitant to discuss their difficulties overcome it because of the military culture. Studies have found that military service members do not want to disclose mental health difficulties because they do not want to be blamed, excluded, or seen as weak (Dickstein et al., 2010; Hoge et al., 2004; Stecker et al., 2007). Similarly, men that have been sexually abused are hesitant to discuss their experiences because they do not want to be stigmatized or labeled as homosexual, and they also feel like they can handle it on their own (Holmes & Slap, 1998; Kisanga et al., 2011).

The substantial difference between men who have survived combat trauma and men who have survived sexual abuse is that, although stigmatizing attitudes are exceptionally high within the military culture, this is not the case in the general public. The public tends to feel compassionate towards our veterans due to their sacrifices and efforts overseas (Rosenheck et al., 2010) as well as the endorsement of programs such as the Wounded Warrior Project. There do not seem to be programs for male sexual abuse that are as notable as those to help veterans. Regardless of these facts, we did not find that there were differences in stigma-related reactions between participants who read about a vignette character with a history of sexual abuse compared to a vignette character with a history of combat trauma. As stated, because these issues are so prevalent and
highly stigmatized against, it was important to assess if stigma-related reactions were less severe towards these individuals in order to drive public awareness campaigns to reduce stigma. Unfortunately, we did have the data to support our hypotheses.

At this point, it is important to consider some factors that may help to explain our unexpected findings. The qualitative data in our present study allowed for a better understanding for why we did not find significant results. Although there were general themes for reasons that participants believed someone could become homeless, the rates at which these themes were identified in each group were different (see Table 3). For example, mental illness was the most commonly reported theme among the sample, but the percentages among the groups ranged from 24.3 to 37.8%. Also social situation/lack of social support was also a common theme as it was seen in 22.0% of the participants’ responses. However, these percentages ranged from 10.8% to 34.3% among each condition. Although this study utilized random assignment, it is possible that there were still significant differences among the groups. Specifically, it seems like the core beliefs for why a person could become homeless (e.g., mental illness, poverty, trauma, job loss) were significantly different among the groups. As a result, the groups could have been different prior to the start of the experiment and, if it is the case that the participants in different groups began the study with different belief systems about homelessness despite random assignment, this may have precluded an adequate examination of our hypothesis. Additionally, we found that over 70% of participants across all conditions believed that trauma was a contributing factor for becoming homeless. Thus, it is possible that even though the vignette describing a homeless man with mental illness as a result of unknown reasons did not specifically state anything about trauma, many participants could have
been assuming that the homeless man had a trauma history. This issue will be addressed again in the following sections.

**Limitations and Future Directions**

Several limitations of the present study should be noted. The study utilized a sample of undergraduate students and consequently, it is unclear if these results would generalize to community populations. College students may differ in their attribution beliefs compared to individuals in the community. Further, the majority of the students sampled were upperclassmen (75% juniors and seniors) and 25% were psychology majors. Students were also sampled from two Abnormal Psychology classes and one Substance Abuse and Dependence class. Thus, perhaps because these participants were nearing the end of their undergraduate career and a substantial percentage were majoring in psychology (and thus would have completed more psychology courses compared to first-years or sophomores), their stigma-related beliefs may be different than those who are earlier in their undergraduate coursework or not majoring in a course of study closely related to the present experiment. To examine this hypothesis further, research could assess how stigma-related reactions change from first-year students to seniors as a function of college major or service-learning experiences related to homelessness.

In a similar study, Snow (2013) asked primarily first-year students to complete the Attribution Questionnaire after reading a vignette describing a homeless individual with or without mental illness. Snow (2013) found that participants rated the hypothetical vignette character as more dangerous and fear-provoking and wanted to segregate the person (i.e., hospitalization) and coerce the person (i.e., force medication). Because Snow (2013) utilized students who were not as advanced in their academic...
career, it is possible that they did not have fully developed beliefs about mental illness or homelessness that would have affected their responses if they did indeed have those strong beliefs.

Another limitation of the present study is the lack of diversity within the sample of participants. The majority of the participants were white, female students. Future studies should use community samples in order to diversify the sample, including age, race, and gender. It would be interesting to examine differences in stigma toward homeless individuals (with and without histories of trauma) in community members from different “walks of life” (e.g., vocations, different levels of socioeconomic status, race/ethnicity, sex, and so on). The measures used in the current study were self-report measures, which rely on participants to subjectively report their stigmatizing attitudes. In the future, researchers may benefit from using implicit tests and physiological measures to document stigma-related reactions and changes in behavior after reading about a homeless person with mental illness. It may also be advantageous for researchers to directly observe participants' behavior. For example, researchers could conduct observational research by seeing how people interact with homeless individuals in a shelter or on a street (e.g., avoiding eye contact, protecting valuables). Additionally, the vignettes in this study made no note of substance abuse. However, participants wrote that they often believed that substance abuse contributed to homelessness. Thus, it would be interesting for future studies to explore participants’ beliefs towards homeless individuals with identified substance abuse issues, as compared to their beliefs about homelessness individuals without substance abuse issues.
As discussed earlier, we expected participants to place less personal responsibility (blame) on the vignette character with a history of combat trauma because combat trauma could be perceived as out of the person’s control. However, it may have been the case that because we stated that the vignette character had multiple tours in Iraq, participants assumed he had reenlisted. Thus, future research could assess the role that reenlistment plays in regards to stigma-related reactions as this could be related to control (i.e., a person has control over how many times he/she chooses to reenlist). Further, researchers could include information on why the person is reenlisting (e.g., needs additional money, wants to increase rank in military) to determine if that affects the degree of stigma.

Researchers could also develop a within-subjects design. In this type of study, participants could read each vignette and then complete the Attribution Questionnaire to determine their stigma-related reactions. By doing this, it would increase the power of the study. However, two things would need to be considered. First, the researcher would need to be cautious of pre-test desensitization/reactivity to the measures. Additionally, the researcher would need to be cognizant of the added time it would take for participants to complete the questionnaire for all the vignette conditions. Perhaps it would be beneficial to shorten the Attribution Questionnaire or be mindful of the additional questionnaires the participants are asked to complete.

Another possible avenue for research would be to develop a psychometric instrument (e.g., The Beliefs About Causes of Homelessness Scale) that includes items reflecting the themes identified in qualitative data (i.e., the comments written by participants about their perceptions and beliefs regarding the cause of the problem) (see Table 3). With such a psychometric instrument, it would be possible to determine
differences in beliefs about the causes of homelessness as a function of a wide range of
demographic, psychosocial, and experiential backgrounds.
SUMMARY AND CONCLUSIONS

The present study explored whether a person’s stigma-related reactions differed depending on if the vignette they read portrayed a homeless man with mental illness as a result of: (a) unknown reasons; (b) sexual abuse; or (c) combat trauma. The present study recruited undergraduate students in upper-level psychology courses. Participants were predominately white and upperclassmen (juniors and seniors). Students were asked to complete the following questionnaires: (1) Demographic questionnaire; (2) Attribution questionnaire; (3) Balanced Inventory for Desirable Responding; (4) Supplemental qualitative questionnaire concerning their beliefs about homelessness and trauma; (5) Exposure to the homelessness population. Once the participants read the vignette and completed the questionnaires, they were debriefed and rewarded extra credit in their class.

Overall, the results were non-significant and did not support the hypotheses. These findings are surprising given what we know about the research concerning stigma, especially Weiner’s attribution theory (1980). Weiner (1980) stated that individuals tend to have less negative reactions to another person’s circumstance when the observer sees the situation as out of one’s control. Because exposure to a traumatic event (e.g., combat trauma, sexual abuse) can be perceived as out of a person’s control, I hypothesized that stigma-related reactions would be less severe for participants who read about a homeless man with mental illness a result of a trauma (e.g., combat trauma, sexual abuse). More specifically, there is a plethora of research (Saewyc et al., 2006; Holmes & Slap, 1998;
Romano & Luca, 2001) supporting the idea that men who are sexually abused are stigmatized due to fear of being labeled as homosexual or being revictimized. Additionally, military personnel often stigmatize combat veterans who experience mental illness. Military members often do not express mental health concerns because they fear it will hurt their career or others will seem them as weak (Dickstein et al., 2010; Hoge et al., 2004; Stecker et al., 2007). However, there also seem to be public campaigns that are more prominent within our culture (Wounded Warrior Project) that show compassion towards helping veterans receive mental health care whereas this does not seem to be the case with males survivors of sexual abuse.

A number of factors that may help to explain the findings are noted, including some findings from supplemental qualitative data that were collected. One such factor is that qualitative data suggested that most participants (across conditions) associated trauma with homelessness; therefore, participants who read vignettes not mentioning trauma may have still assumed that trauma was part of the individual’s history. Such a scenario would detract from the potency of the experimental manipulation (i.e., reading a vignette about a homeless person with a history of trauma vs. reading a vignette about a homeless person without any mention of past trauma). Another factor that may have detracted from the potency of the experimental manipulation is that many participants were social science majors and toward the end of their undergraduate education, and so perhaps many of them were at least somewhat familiar with issues related to homelessness. Some other studies that used highly similar methodologies to examine how stigma toward homelessness varies depending on background information provided (Snow, 2013) utilized participants who were early in their undergraduate education.
Other limitations in the study are noted, such as lack of diversity in the sample.

Recommendations for research are also provided, such as examining stigma toward homeless individuals (with or without trauma) in more diverse community samples, and examining how social stigma changes in undergraduates from freshman to senior year as a function college major and service experience during college.
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APPENDIX A

HOMELESSNESS VIGNETTES

**Homeless Without History of Trauma**

Billy is 30 years old and is currently homeless. He is not married and does not have any children. Billy has a long history of estranged family relationships. Billy has been living in shelters for homeless people and has been unemployed for over a year now. Billy developed a mental illness prior to becoming homeless.

**Homeless With a History of Sexual Abuse**

Billy is 30 years old and is currently homeless. He is not married and does not have any children. Billy has a long history of estranged family relationships. Billy has been living in shelters for homeless people and has been unemployed for over a year now. Prior to becoming homeless, Billy had been previously sexually abused and had developed a mental illness.

**Homeless with a History of Combat Trauma**

Billy is 30 years old and is currently homeless. He is not married and does not have any children. Billy has a long history of estranged family relationships. Billy has been living in shelters for homeless people and has been unemployed for over a year now. Prior to
becoming homeless, Billy had served in the military, had multiple tours in Iraq, was exposed to multiple military trauma-related events, and developed a mental illness.
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Please take a few moments to complete the following demographic information.

1. Age: __________________

2. Gender:   Male   Female

3. Ethnicity (check all those that apply):   Caucasian   African
   American Latino/a   Asian/Pacific Islander   Native
   American   Other: Please describe:
   ______________________________________________________________________

4. Year in School:   Freshman   Sophomore   Junior
   Senior

5. Major: ______________________________

6. Highest Level of Education Completed by Mother:
   High School Diploma   Some College   Associate’s Degree
   Bachelor’s degree   Graduate/Professional Training

7. Highest Level of Education Completed by Father:
   High School Diploma   Some College   Associate’s Degree
   Bachelor’s Degree   Graduate/Professional Training

8. Where did you grow up?
   City   Suburb   Small Town (population under 50,000)
Rural area outside a Metropolitan Region

9. What is your political affiliation?

Democrat       Republican       Independent       Libertarian

No Affiliation

Other (please specify): _________________________________

10. Have you or has anyone in your immediate family (e.g. parents, siblings) served in the military?

Yes       No

11. Have you or, as far as you know, has anyone in your family (e.g., siblings, cousins, etc.) or friends ever been sexually abused?

Yes       No
APPENDIX C
ATTRIBUTION QUESTIONNAIRE

Please read the following paragraph statement about Billy:

(A vignette from Appendix A will be inserted here)

Now answer each of the following questions about Billy. Circle the number of the best answer to each question.

**Blame**

10. I would think that it was Billy’s own fault that he is in the present condition.

1 2 3 4 5 6 7 8 9
no, not at all yes, absolutely so

11. How controllable, do you think, is the cause of Billy’s present condition?

1 2 3 4 5 6 7 8 9
not at all under completely under
personal control personal control
23. How responsible, do you think, is Billy for his present condition?

1 2 3 4 5 6 7 8 9
not at all very much
responsible responsible

Anger

1. I would feel aggravated by Billy.

1 2 3 4 5 6 7 8 9
not at all very much

4. How angry would you feel at Billy?

1 2 3 4 5 6 7 8 9
not at all very much

12. How irritated would you feel by Billy?

1 2 3 4 5 6 7 8 9
not at all very much

Pity

9. I would feel pity for Billy.

1 2 3 4 5 6 7 8 9
none at all  very much

22. How much sympathy would you feel for Billy?

   1  2  3  4  5  6  7  8  9

none at all  very much

27. How much concern would you feel for Billy?

   1  2  3  4  5  6  7  8  9

none at all  very much

Help

8. I would be willing to talk to Billy about his problems.

   1  2  3  4  5  6  7  8  9

not at all  very much

20. How likely is it that you would help Billy?

   1  2  3  4  5  6  7  8  9

definitely  definitely

would not help  would help

21. How certain would you feel that you would help Billy?

   1  2  3  4  5  6  7  8  9

not at all certain  absolutely certain

Dangerousness

2. I would feel unsafe around Billy.
13. How dangerous would you feel Billy is?

1 2 3 4 5 6 7 8 9
no, not at all  yes, very much

18. I would feel threatened by Billy.

1 2 3 4 5 6 7 8 9
not at all  very much

19. How scared of Billy would you feel?

1 2 3 4 5 6 7 8 9
not at all  very much

24. How frightened of Billy would you feel?

1 2 3 4 5 6 7 8 9
not at all  very much

Avoidance (reverse score all three questions)

7. If I were an employer, I would interview Billy for a job.
16. I would share a car pool with Billy every day.

1 2 3 4 5 6 7 8 9

not likely very likely

26. If I were a landlord, I probably would rent an apartment to Billy.

1 2 3 4 5 6 7 8 9

not likely very likely

**Segregation**

6. I think Billy poses a risk to his neighbors unless he is hospitalized.

1 2 3 4 5 6 7 8 9

none at all very much

15. I think it would be best for Billy’s community if he were put away in a psychiatric hospital.

1 2 3 4 5 6 7 8 9

not at all very much

17. How much do you think an asylum, where Billy can be kept away from his neighbors, is the best place for him?

1 2 3 4 5 6 7 8 9
Coercion

5. If I were in charge of Billy’s treatment, I would require him to take his medication.

123456789
not at all very much

14. How much do you agree that Billy should be forced into treatment with his doctor even if he does not want to?

123456789
not at all very much

25. If I were in charge of Billy’s treatment, I would force him to live in a group home.

123456789
not at all very much

Note: Items are organized according to subscale. The item number indicates the item’s actual placement in the questionnaire as completed by the participant.
APPENDIX D

BALANCED INVENTORY OF DESIRABLE RESPONDING

Using the scale below as a guide, indicate how much you agree with each statement.

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Not true | Somewhat true | Very true

**Self-Deceptive Enhancement Subscale:**

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1. My first impressions of people usually turn out to be right.
2. It would be hard for me to break any of my bad habits. (R)
3. I don’t care to know what other people really think of me.
4. I have not always been honest with myself. (R)
5. I always know why I like things.
6. When my emotions are aroused, it biases my thinking. (R)  

7. Once I’ve made up my mind, other people can seldom change my opinion.  

8. I am not a safe driver when I exceed the speed limit. (R)  

9. I am fully in control of my own fate.  

10. It’s hard for me to shut off a disturbing thought. (R)  

11. I never regret my decisions.  

12. I sometimes lose out on things because I can’t make up my mind soon enough. (R)  

13. The reason I vote is because my vote can make a difference.  

14. My parents were not always fair when they punished me. (R)  

15. I am a completely rational person.  

16. I rarely appreciate criticism. (R)  

17. I am very confident in my judgments.  

18. I have sometimes doubted my ability as a lover. (R)  

19. It’s all right with me if someone happens to dislike me.
20. I don’t always know the reasons why I do
the little things I do. (R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Impression Management Subscale:**

21. I sometimes tell lies if I have to. (R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

22. I never cover up my mistakes.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

23. There have been occasions when I have
taken advantage of someone. (R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

24. I never swear.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

25. I sometimes try to get even rather than
cover up my mistakes.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

26. I always obey laws, even if I’m unlikely to
cover up my mistakes.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

27. I have said something bad about a friend
behind his or her back. (R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

28. When I hear people talking privately, I
avoid listening.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

29. I have received too much change from a
salesperson without telling him or her. (R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

30. I always declare everything at customs.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

31. When I was young I sometimes stole things.
(R)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

66
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>32.</td>
<td>I have never dropped litter on the street.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33.</td>
<td>I sometimes drive faster than the speed limit. (R)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>34.</td>
<td>I never read sexy books or magazines.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35.</td>
<td>I have done things that I don’t tell other people about. (R)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36.</td>
<td>I never take things that don’t belong to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>37.</td>
<td>I have taken sick-leave from work or school even though I wasn’t really sick. (R)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>38.</td>
<td>I have never damaged a library book or store merchandise without reporting it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>39.</td>
<td>I have some pretty awful habits. (R)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>40.</td>
<td>I don’t gossip about other people’s business.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: Items are organized according to subscale. “R” = reverse score.
Here are a few questions that ask you to explain your opinion. Please provide about a paragraph for each question.

1. In your opinion, how does a person become homeless?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

2. Please provide your beliefs on the relationship between homelessness and trauma.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

____
3. When an individual who is homeless also has a trauma history, do you believe that it is the case the traumatic experience caused the homelessness? Please elaborate.

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
APPENDIX F

EXPOSURE TO HOMELESSNESS SCALE

1. Growing up, how frequently did you observe or encounter people who you believe to be homeless?

   1   2   3   4   5
   Never  Seldom Occasionally Often Always

2. Since coming to the University of Dayton, how frequently do you observe or encounter people who you believe to be homeless?

   1   2   3   4   5
   Never  Seldom Occasionally Often Always

3. Have you engaged in any community service activities where you interacted with the homeless?

   Yes___________  No___________
APPENDIX G

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Project Title: Homelessness Stigma as a Function of Military and Trauma Status: An Experimental Study

Investigator(s): Rebecca Kinsey, B.A.

Description of Study: Participants will complete self-report measures that collect basic demographic information and assess various opinions of an individual described in a vignette.

Adverse Effects and Risks: This study involves minimal risks. No adverse effects or significant risks should arise during the present study. In the event that you are in the need of counseling for any purpose, you can contact the Counseling Center. You are free to terminate your participation at anytime or skip questions you are not comfortable with answering.

Study Duration: The study will take approximately 45 minutes to complete.

Confidentiality of Data: Your name will be kept separate from the data. Both your name and the data will be kept in a locked filing cabinet. Only the investigators named above will have access to the locked filing cabinet. Your name will not be revealed in any document resulting from this study. You will be observed directly by the experimenter.

Contact Person: Participants may contact Rebecca Kinsey, kinseyrm@gmail.com or Roger Reeb, PhD, SJ 306, (937) 229-2395, rreeb1@udayton.edu. If you have questions about your rights as a research participant, you may contact the chair of the Research Review and Ethics Committee, Greg Elvers, PhD in SJ 312, (937) 229-2171, gelvers1@udayton.edu. If you would like to contact the Counseling Center, an appointment can be made by calling 229-3141. The Counseling Center is located on the first floor of Gosiger Hall.
I have voluntarily decided to participate in this study. The investigator named above has adequately answered any and all questions I have about this study, the procedures involved, and my participation. I understand that the experimenter will be available to answer any questions about research procedures throughout this study. I also understand that I may voluntarily terminate my participation in this study at any time and still receive full credit. I also understand that the investigator named above may terminate my participation in this study if s/he feels this to be in my best interest. In addition, I certify that I am 18 (eighteen) years of age or older.

______________________________________________________________

Signature of Student                  Student’s Name (printed)

Date

______________________________________________________________

Signature of Witness

Date
Information about the Homelessness Stigma as a Function of Military and Trauma Status: An Experimental Study

Objective:
Most stigma-related research has focused on mental illness and, with few exceptions (Snow & Reeb, 2013), studies have not examined stigma associated with the co-occurrence of homelessness and mental illness, nor have studies determined if stigma is less severe when a homeless person with mental illness has a documented history of trauma. In a literature review, Snow & Reeb (in press) recommended research to examine whether “stigma-related reactions are less severe if the homeless person is a military veteran or has a trauma history” (p. 24). The present study will examine the ways in which stigma towards a homeless man with a mental illness varies as a function of military and trauma backgrounds.

Hypothesis:
The first main objective is to examine the general hypothesis that social stigma is greater when a homeless person is portrayed as also having a history of trauma. The second objective is to determine the extent to which stigma varies depending on whether that trauma history is because of military combat or sexual abuse. The third objective is to verify that the observed results regarding public stigma towards a homeless male hold up after statistically controlling for social desirability bias, which is the tendency for respondents to answers questions in a manner that will be viewed favorably by others.

Your Contribution:
Your contribution will allow us to learn more about the social stigma of homelessness and its relation to trauma history.

Benefits:
Findings of this study will have both theoretical and practical implications. Theoretically, it is important to develop a conceptual model of this complex social problem, and this will require that we identify and understand the variety of factors contributing to the stigmatization of homelessness. From a practical standpoint, knowledge of these attitudes can help direct policymakers who are searching for public support for initiatives that concern the homeless population and this research could lead to the development of programs that reduce and prevent stigma.
Assurance of Privacy:
We are studying the effects of trauma history on the stigma of homelessness and are not evaluating you personally in any way. Your responses will be kept completely confidential and your responses will only be identified by a participant number in the data set with other participant numbers. Your name will not be revealed in any document resulting from this study.

Contact Information:
Students may contact Rebecca Kinsey, kinseyrm@gmail.com or Roger Reeb, PhD, SJ 306, (937) 229-2395, if you have questions or problems after the study. If you have questions about your rights as a research participant you may also contact the chair of the Research Review and Ethics Committee, Greg Elvers, PhD in SJ 312, (937) 229-2171, gelvers@udayton.edu. If you would like to contact the Counseling Center, an appointment can be made by calling 229-3141.

Thank you for your participation. I will update your research credit on the online system.

References:
