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An application of the reformulated theory of learned helplessness with sheltered homeless adults

Tobin, Jonna Jean, Ph.D.
The Ohio State University, 1992
AN APPLICATION OF THE REFORMULATED THEORY OF LEARNED HELPLESSNESS WITH SHELTERED HOMELESS ADULTS

Dissertation

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By

Jonna Jean Tobin, M. A., M. A.

* * * * *

The Ohio State University

1992

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Dedicated to my son
Jeremiah John Lord
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## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Review of the Literature</td>
<td>8</td>
</tr>
<tr>
<td>Demographic Information About the Homeless</td>
<td>10</td>
</tr>
<tr>
<td>Age Distribution of the Homeless Population</td>
<td>10</td>
</tr>
<tr>
<td>Representation of Families Among the Homeless</td>
<td>11</td>
</tr>
<tr>
<td>Disaffiliation and Marital Status</td>
<td>11</td>
</tr>
<tr>
<td>Health Problems Among the Homeless</td>
<td>12</td>
</tr>
<tr>
<td>Representation of Veterans Among the Homeless</td>
<td>12</td>
</tr>
<tr>
<td>Length of Time Homeless</td>
<td>13</td>
</tr>
<tr>
<td>Previous Episodes of Homelessness</td>
<td>13</td>
</tr>
<tr>
<td>Demographic Information for Ohio</td>
<td>14</td>
</tr>
<tr>
<td>Mental Illness Among the Homeless</td>
<td>15</td>
</tr>
<tr>
<td>Methodological Difficulties</td>
<td>15</td>
</tr>
<tr>
<td>Estimates of Mental Illness Among the Homeless</td>
<td>16</td>
</tr>
<tr>
<td>Substance Abuse Among the Homeless</td>
<td>19</td>
</tr>
<tr>
<td>Minority Representation and Differences</td>
<td>20</td>
</tr>
<tr>
<td>Gender Representation and Differences</td>
<td>22</td>
</tr>
<tr>
<td>Factors that may Precipitate/Contribute to Homelessness</td>
<td>23</td>
</tr>
<tr>
<td>The Impact of the Experience of Being Homeless</td>
<td>28</td>
</tr>
<tr>
<td>The Theory of Learned Helplessness (LH)</td>
<td>32</td>
</tr>
<tr>
<td>The Reformulated Theory of Learned Helplessness</td>
<td>36</td>
</tr>
<tr>
<td>Explanatory Style and Depression</td>
<td>37</td>
</tr>
<tr>
<td>Methodological Concerns with LH Research</td>
<td>40</td>
</tr>
<tr>
<td>LH, Explanatory Style, and Success and Achievement</td>
<td>43</td>
</tr>
<tr>
<td>LH, Explanatory Style, and Health</td>
<td>45</td>
</tr>
<tr>
<td>Clinical Applications of the Reformulated Theory of LH</td>
<td>49</td>
</tr>
</tbody>
</table>

II. Methods | 51 |
| Design and Participants | 51 |
| Procedure | 52 |
| Independent Variables | 54 |
| Length of Time Homeless | 54 |
| Gender | 55 |
III. Results ............................................................................................................................ 70

Descriptive Statistics ........................................................................................................... 70
  Demographic Characteristics ............................................................................................... 70
  Psychological Instability ...................................................................................................... 73
  Alcohol Abuse .................................................................................................................... 77
Internal Consistency ............................................................................................................. 78
  Expanded Attributional Style Questionnaire (EASQ) ......................................................... 78
  Fifteen Original Items of the EASQ .................................................................................... 78
  Nine New Items of the EASQ .............................................................................................. 79
Tests of Hypotheses ............................................................................................................. 79
  Preliminary Analyses .......................................................................................................... 81
  Hypothesis One .................................................................................................................... 82
  Hypothesis Two ................................................................................................................... 84
  Hypothesis Three ................................................................................................................. 84
  Hypothesis Four .................................................................................................................. 84
Psychological Instability Among the Homeless .................................................................. 85
Alcohol Abuse Among the Homeless ................................................................................... 86
Additional Post Hoc Analyses .............................................................................................. 88
Analysis of Written Responses ............................................................................................ 90

IV. Discussion .......................................................................................................................... 97

  Major findings and interpretations ...................................................................................... 98
  Methodological limitations ................................................................................................ 106
  Implications for practice. ................................................................................................... 109
  Recommendations for research ......................................................................................... 111
  Summary and conclusions ................................................................................................. 115

LIST OF REFERENCES .............................................................................................................. 117

APPENDICES. .......................................................................................................................... 134

A. Demographic Information Form ....................................................................................... 134
B. Request for Participation Form .......................................................................................... 138
C. Standardized Instructions for Administering the Questionnaire .................................... 140
D. Instructions and Sample Item from the EASQ ............................................................... 143
E. The Expanded Attributional Style Questionnaire ........................................................... 145
F. Replacement Items for the EASQ ..................................................................................... 147

vii
G. Sample Items from the Brief Symptom Inventory . . . . . . . . . . . . 149

H. Modified Michigan Alcoholism Screening Test . . . . . . . . . . . . 151
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographics of the Sheltered Homeless, Comparing the Entire Sample With Those Experiencing Their First Episode of Homelessness</td>
<td>71</td>
</tr>
<tr>
<td>2. Frequency Distributions for Participants Who Scored above T-score 63 on Nine Dimension Scales of the Brief Symptom Inventory</td>
<td>75</td>
</tr>
<tr>
<td>3. Internal Consistency of the Revised Version of the Expanded Attributional Style Questionnaire</td>
<td>78</td>
</tr>
<tr>
<td>4. Correlations Between Scales of the EASQ, Alcohol Abuse, Length of Time Homeless, and Dimensions of the BSI</td>
<td>81</td>
</tr>
<tr>
<td>5. Mean Scores on the EASQ by Length of Time Homeless</td>
<td>83</td>
</tr>
<tr>
<td>6. Mean Scores on the EASQ by Gender</td>
<td>83</td>
</tr>
<tr>
<td>7. Mean Scores on the Stable Scale of the EASQ by Length of Time Homeless</td>
<td>84</td>
</tr>
<tr>
<td>8. Mean Scores on Dimensions of Psychological Instability by Gender</td>
<td>86</td>
</tr>
<tr>
<td>9. Mean Scores on the Michigan Alcohol Screening Test by Gender</td>
<td>87</td>
</tr>
<tr>
<td>10. Correlations between Alcohol Abuse Scores and Scales of the EASQ</td>
<td>87</td>
</tr>
<tr>
<td>11. Correlations between Alcohol Abuse Scores and Dimensions of the Brief Symptom Inventory</td>
<td>88</td>
</tr>
<tr>
<td>12. Recurrent Themes in Written Responses</td>
<td>92</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

Statement of the Problem

The number of people who are without homes in the United States has been steadily increasing for the past decade. From results of a recent survey of 27 major cities, the United States Conference of Mayors (1989) estimated that between 1986 and 1987 the homeless population increased by 25%. Estimates of the total number of homeless people have ranged from 250,000 to 4 million nationally (General Accounting Office, 1985; Hombs & Snyder, 1982; Housing and Urban Development, 1984; U.S. Conference of Mayors, 1989). The National Alliance to End Homelessness estimates that there are 735,000 people homeless on any given night in the United States (in Levine and Rog, 1990).

Concerns about the homeless population are not limited to ones about the increasing numbers. Several researchers have begun to express concern about the changing make-up of the "new homeless" in comparison to the "old homeless" (First, Roth, & Arewa; Rossi, 1990; Sosin, Colson, & Grossman, 1988). These researchers note that the new homeless are no longer concentrated mainly in skid row areas of major cities, are no longer primarily older caucasian males with chronic alcoholism, and are no longer
a population that has some form of shelter accessible to them. The new homeless tend to be composed of a younger, poorer, more heterogeneous population that includes more minorities, women, and families than before. In addition, a large number of the homeless population are literally living on the streets with no available shelter, an indication of the severe housing deprivation that characterizes the new homeless (Rossi, 1990).

Research has provided a great deal of demographic information about the homeless population. Information has been compiled about the age, marital status, health concerns, and education level of the homeless population as well as gender and minority representation and estimates of mental illness and substance abuse among the homeless (Herman, McGorry, Bennett, van Riel, & Singh, 1989; Roth, Bean, Lust, & Saveanu, 1985; U.S. Conference of Mayors, 1989; Vernez, Burnam, McGlynn, Trude, & Mittman, 1988). In addition, researchers have provided evidence of factors that may precipitate or contribute to a person becoming homeless and recently have begun to examine the potential effects of homelessness (Arce & Vergare, 1984; Baxter & Hopper, 1984; Lamb, 1984; Sosin, Colson, & Grossman, 1988).

The information gathered about the potential effects of homelessness has led to the suggestion by some researchers that being homeless may cause a person to be at risk for prolonged homelessness (Goodman, Saxe, & Harvey, 1991; Merves, 1986; Milburn & D'Ercole, 1991: Snow & Anderson, 1991). For example, Snow and Anderson (1991) found that for some, homelessness led to
a feeling of hopelessness followed by despondency and a decrease in behaviors necessary to extricate one's self from street life. The hopelessness seemed to develop after the homeless people experienced a number of the unresolvable dilemmas and double-binds characteristic of homelessness (e.g., can't get a job without an address and can't get a place to live without a job). This pattern of responding to uncontrollable events with hopelessness and passivity is similar to what has been observed about learned helplessness.

In the current study, the theory of learned helplessness described by Seligman (1975) is suggested as a model for understanding why it may be difficult for some homeless people to get back on their feet. According to the theory of learned helplessness, people who are exposed to uncontrollable aversive events learn that responding is futile. It is suggested that this learning decreases the motivation to respond to future events and produces cognitive and emotional deficits that resemble symptoms of depression. The learned helplessness deficits that have been observed following exposure to an uncontrollable aversive event include depressed mood, blaming failures on lack of ability and worthlessness, losing interest in usual activities, decreased appetites, early-morning awakening, difficulty with new learning, concentration, psychomotor retardation, and decreased energy and passivity (see Seligman, 1990).
Seligman's original theory of learned helplessness was reformulated after researchers observed that some animals and humans exposed to uncontrollable aversive events did not seem to experience learned helplessness deficits (Abramson, Seligman, & Teasdale, 1978). The reformulated theory of learned helplessness emphasizes explanatory style. It states that the pattern of how a person explains events affects how long learned helplessness deficits will last, the extent to which deficits will be generalized to other situations, and the extent to which a loss of self-esteem is experienced following exposure to uncontrollable aversive events.

There are three dimensions of explanatory style included in the reformulated theory of learned helplessness. First, it is suggested that when negative events are habitually explained with stable causes (something that will persist over time) it is more likely that learned helplessness deficits will last longer following exposure to an uncontrollable aversive event than when negative events are habitually explained with unstable causes (something that will be relatively transient). Second, it is suggested that when negative events are habitually explained with global causes (something that will also affect other outcomes and events) it is more likely that learned helplessness deficits will generalize to other situations following exposure to an uncontrollable aversive event than when negative events are habitually explained with specific causes (something specific to the particular event). Third, it is suggested that when negative
events are habitually explained with internal causes (something due to the person) it is more likely that a loss of self-esteem will follow exposure to an uncontrollable aversive event than when negative events are habitually explained with external causes (something about the situation or due to others).

The reformulated theory of learned helplessness suggests that people with a pessimistic explanatory style will suffer more learned helplessness deficits following exposure to uncontrollable events than people with an optimistic explanatory style. According to the theory, a person with a pessimistic explanatory style habitually explains negative events with stable, global, and internal causes. In contrast, a person with an optimistic explanatory style habitually explains negative events with unstable, specific, and external causes.

Within the reformulated theory of learned helplessness there is no explanation for how a pessimistic explanatory style develops. The results of some research suggests that role modeling or early experiences of either mastery or helplessness may predispose one to an optimistic or pessimistic explanatory style (Nolen-Hoeksema, Girdus, & Seligman, 1986; Seligman & Visintainer, 1985). The theory does suggest that explanatory style is a relatively enduring trait, and results from several studies have supported this notion (Burns & Seligman, 1989; Peterson, Seligman & Vaillant, 1988).

Though the theory suggests that explanatory style is a relatively stable trait, there is research that has demonstrated
that explanatory style can be changed (Seligman, et al., 1988). Seligman, et al., demonstrated that explanatory style can be changed when the person's habitual explanations are challenged through cognitive therapy. If explanatory style can become more optimistic following cognitive therapy, is it possible that explanatory style can become more pessimistic following exposure to a series of varied uncontrollable aversive events.

Numerous research projects have documented that homeless people are exposed to a number of uncontrollable aversive life events both immediately before and after becoming homeless (see for example, Roth & Bean, 1986; Ryan, Goldstein, & Bartelt, 1989). The present study examined the relationship between learned helplessness, explanatory style, gender, and length of time homeless in a sheltered homeless population. Gender was included as an independent variable because there is research that suggests females may have a more pessimistic explanatory style than men (Dweck & Light, 1980).

The current study also examined prevalence estimates for alcohol abuse and psychological instability among the homeless. Though the results of research examining these variables has yielded inconsistent prevalence estimates, most researchers agree that alcohol abuse and psychological instability are a concern for a significant number of homeless people (Breakey & Fischer, 1991; Herrman, McGorry, Bennett, van Riel, & Singh, 1989; Fischer and Breakey, 1991; Roth, Bean, Lust, & Saveanu,
Alcohol abuse and psychological instability were examined in the current study for two reasons. First, these variables were measured and included in the analysis in order to control for changes in explanatory style that might be due to either alcohol abuse or psychological instability instead of exposure to the uncontrollable aversive events of homelessness. The second reason for examining alcohol abuse and psychological instability was to contribute to the body of research on the sheltered homeless population.

The current study is exploratory in nature. No research was found that used the reformulated theory of learned helplessness as a model for understanding the potential impact of homelessness. The purpose of the study is to both examine the relationship between learned helplessness, explanatory style, gender, and length of time homeless in a sheltered homeless population and to explore the potential benefit of future applications of the reformulated theory of learned helplessness to the homeless experience.

There are four hypotheses specified for the current study. The first hypothesis states that sheltered homeless people will indicate a more pessimistic explanatory style as the amount of time they have been homeless increases. The second hypothesis states that homeless women will indicate a more pessimistic explanatory style than homeless men. The third hypothesis states
that scores on the depression scale of the psychological instability measure will indicate a significant positive relationship with explanatory style. The final hypothesis predicts an increase in pessimistic explanatory style between the first (less than one month) and second (one month to six months) length of time homeless conditions, no significant difference between the second and third (six months to a year) conditions, and a decrease between the third and fourth (over one year) conditions. This hypothesis is included to test the possibility that, as Snow and Anderson's (1991) research suggests, homeless people's experience of helplessness may increase with time on the streets until they identify with the role of being homeless and then may decrease.

Review of the Literature

The review of the literature is divided into two major parts. The first part reviews the literature on homelessness and contains seven sections that describe various aspects of research on this topic. The second part of the literature review focuses on the research conducted with the theory of learned helplessness and the reformulated version of the theory. The portion of the literature review focusing on learned helplessness also contains seven separate sections.

Government agencies, academic researchers, and providers of services for the homeless have compiled a great deal of demographic information about the homeless population. Specifically, this information has been compiled on the age,
marital status, health concerns, armed services experiences, length of time homeless, and previous episodes of homelessness of the homeless population. The information about each of these areas is summarized and demographic information for the state of Ohio is presented in the first section of this review.

A growing concern among psychologists is the prevalence of mental illness and substance abuse among the homeless population. The second section reviews the literature that contains information about mental illness among the homeless and methodological difficulties in determining estimates of mental illness among the homeless. Estimates of substance abuse problems among the homeless are presented in the third section of this review.

In addition to providing demographic information about the homeless, researchers have investigated differences observed within the homeless population that appear to be due to gender and minority status. Information about minority and gender representation and differences among the homeless population are presented in the fourth and fifth sections of the literature review. The sixth and seventh sections of this review contain information about factors that may precipitate or contribute to homelessness and the potential impact of the experience of being homeless.

The first section of the portion of the literature review that focuses on learned helplessness describes the development and empirical support for the theory of learned helplessness.
The second section describes the development and empirical support for the reformulated theory of learned helplessness. In the third section, the research on explanatory style and depression is described. This section is followed by a discussion of some of the methodological concerns with research on learned helplessness presented in section four. The next two sections describe research that examined the relationship between learned helplessness, explanatory style, and success and achievement (section five) and health (section six). The final section describes some of the clinical applications of the reformulated theory of learned helplessness.

**Demographic Information About the Homeless**

*Age distribution of the homeless population.* Estimates of the age distribution of the homeless population range from a reported mean age of 30.5 years (Morse et al., 1985) with a range of between 17 to 62 years of age, to indications that 80% of the homeless population may be 45 years of age or younger (Vernez et al., 1988). Sosin, Colson, & Grossman (1988) found that 19% of their sample of homeless adults were 25 years of age or younger, 50% were between the ages of 26 and 40 years of age, 21% were between 41 and 51 years of age and 9.5% were between the ages of 56 to 70 years of age. Results of a survey of 5500 homeless adults in Pennsylvania indicated that 82% were between the ages of 18 and 45 (Ryan, Goldstein, & Bartlett, 1989). These studies seem to support the growing perception of the "new homeless" as a younger population.
Representation of families among the homeless. A characteristic of the current homeless population that seems to be of particular concern is the increasing representation of families among the homeless. The U.S. Conference of Mayors (1989) reported that 36% of the homeless population included in their survey of 27 cities were families. The majority of these families appear to be female single parent households. For example, results of an extensive survey (N = 5500) of the homeless in Pennsylvania indicated that 33.6% of the homeless sample was composed of single parents (Ryan, Goldstein, & Bartlett, 1989).

Disaffiliation and marital status. Another area of concern about the homeless population is their lack of affiliation and supportive relationships with others. One group of researchers found that 74% of the homeless reported having no family relationships, 73% reported having no friends, and 40% reported having no relationships with anyone. This disaffiliation also is apparent in results from research that has shown the homeless population to be predominantly unmarried (e.g., Roth, Bean, Lust & Saveanu, 1985). Estimates of the number of single, separated, divorced, and widowed among the homeless range from 87.6% (Ryan, Goldstein, & Bartlett, 1989) to 95.5% (Morse et al., 1985). In comparing the number of single person households among the homeless (66%) with the number of single person households among the very poor (27%) and the general population (31%) Sosin, Colson, and Grossman (1988) found the number of homeless people
included in this category to be disproportionate high. Whether the high levels of disaffiliation among the homeless is caused by their homelessness or a factor that contributes to their being homeless is not clear.

**Health problems among the homeless.** Health problems are also an important concern about the homeless population. Rossi (1990) reports that 25% of the homeless have serious physical disabilities, with 13% identifying poor physical health as the single most important factor contributing to their homeless status. In a sample of homeless men and women in a shelter in New York City, 75% had received medical services in the past year (Surber, Dwyer, Ryan, Goldfinger, & Kelly, 1988). These researchers also found an 8.5% rate of tuberculosis in the shelter, compared with the current .0123% rate in the United States. Another alarming estimate is the 5% rate of AIDS or HIV-related illness among the homeless reported by the U.S. Conference of Mayors (1989).

**Representation of veterans among the homeless.** A consistent but not well understood finding is the over-representation of veterans among the homeless. Researchers have consistently reported that 26% of the homeless population have been in the armed services (see for example Sosin, Colson, & Grossman, 1988; U.S. Conference of Mayors, 1989; Vernez, Burnam, McGlynn, Trude, & Mittman, 1988). Sosin, Colson, & Grossman (1988) compared a homeless sample to a very poor sample and found
that the very poor sample included 16% veterans and the homeless sample included 26% veterans.

**Length of time homeless.** Information about the amount and number of times a person has been homeless has led some researchers to develop ways to classify the homeless for the purposes of doing research. Though most researchers classify the homeless according to the amount of time they have been homeless during the current episode of homelessness (e.g., Morse et al., 1988; Ryan, Goldstein, & Bartlett, 1989; Sosin, Colson, & Grossman, 1988) some have incorporated previous episodes of homelessness into their schema (e.g., Koegel, Burnam, & Farr, 1988).

It has been estimated that the average length of time a person is homeless is around two years, with the median time homeless being 90 days, and with approximately two thirds of the homeless population being able to resolve their homelessness in less than a year (Sosin, Colson, & Grossman, 1988). One group of researchers found that 22% of the homeless in their sample had been homeless for less than one month, 38% had been homeless from between one to six months, 14% had been homeless between seven to 12 months, and 26% had been homeless for over one year (Ryan, Goldstein, & Bartlett, 1989). Morse et al. (1988) found a range for length of time homeless of one day to 14 years, with a mean of 14.5 months and a standard deviation of 27.7 months.

**Previous episodes of homelessness.** Researchers have found that many of the homeless were not experiencing homelessness for
the first time. Sosin, Colson, & Grossman (1988), for example, found that 50% of the homeless people in their sample had experienced homelessness before. Using a classification scheme that accounts for previous episodes of homelessness, Koegel, Burnam, & Farr (1988) found that the "newly homeless" (first episode of homelessness, homeless for less than one year) were less likely to suffer from schizophrenia and substance abuse problems than the "episodic" (multiple episodes, current episode less than one year) or "longterm" (current episode longer than one year) homeless. They also noted that depression was more elevated in the newly homeless group than in the other two. It seems that useful information might best be obtained when both length of time homeless and previous episodes of homelessness are accounted for in some way.

**Demographic information for Ohio.** Demographic information for the state of Ohio and for Franklin County has been compiled by an in-depth study funded by the National Institute of Mental Health (Roth, Bean, Lust, & Saveanu, 1985). According to the results of interviews with a random representative sample of 979 homeless people, 80% of the homeless population in Ohio are under 50 years of age, 33% are minorities, 81% are male, and 93% are single, separated, or divorced. In addition, 45% are high school graduates, 14.5% have attended or graduated from college, 32% are veterans (8.5% Vietnam veterans), 25% are employed, 87.3% have worked for pay at some point in their lives, and 31% experience health problems. The demographics reported for Franklin county
are similar to the ones for Ohio for age (80% under 50 years of age) and minority representation (30%). However, in Franklin county there is a lower percentage of homeless that are single, separated, or divorced (82%) and a slightly higher percentage of veterans (37.5%).

Mental Illness Among the Homeless

An area of growing concern for researchers of the homeless population, and in particular for psychologists, is the prevalence of mental illness among the homeless. The National Institute of Mental Health has defined the homeless mentally ill as "individuals age 18 years or older who have long-term severe mental illness and no fixed place of residence" and has defined long-term severe mental illness as "a severe and persistent mental or emotional disorder that disrupts functional capacities for such primary aspects of daily life as self-care, household management, interpersonal relationships, and work or school (p. 963, Levine & Rog, 1990). Most research that describes mental illness among the homeless, however, lists prevalence estimates rather than a classification according to severity level.

Methodological concerns with the measurement of mental illness among the homeless. There appear to be several methodological concerns with attempts to measure mental illness among the homeless. First, there is a lack of consistency across studies in the instruments that are used to determine mental illness, in the threshold that determines caseness, and in the temporal reporting frames used. Second, the standardized
instruments used have not been normalized for a homeless population and may not be applicable (Fischer & Breakey, 1991). Third, the information gained from standardized instruments may not be generalizable to other contexts (Koegel, Burnam, & Farr, 1988). Several researchers have noted that behaviors that may be adaptive, common, or a consequence of being homeless may pathologize results on tests that would rate these behaviors as bizarre (Bean, Stefl, & Howe, 1987; Koegel, Burnam, & Farr, 1988; Snow, Baker, & Anderson, 1986).

Estimates of mental illness among the homeless. Prevalence estimates of mental illness among the homeless seem to vary according to the methods used to measure mental illness. For example, a year-long field study with 164 homeless people in Austin, Texas found that 15% met the researcher's criteria for mental illness (Snow, Baker, & Anderson, 1986). In Snow, Baker, and Anderson's study a homeless person was considered mentally ill if two of three criteria were met: 1) if the person had a history of psychiatric hospitalization, 2) if the person was designated as mentally ill by other homeless people, and 3) if the person exhibited bizarre, situationally inappropriate behavior. In contrast to Snow, Baker, and Anderson's findings, results from a retrospective record review of 285 hospitalized psychiatric patients who listed either "streets", "transient", or "no local address" on admission forms found that 36% had been admitted with a diagnosis of schizophrenia, and 24% had been
admitted with a diagnosis of affective disorders (Surber, Dwyer, Ryan, Goldfinger, & Kelly, 1988).

In much of the research that is done to estimate the prevalence and type of mental illness among the homeless, standardized instruments are used to measure psychological disturbance. For example, Kahn, Hannah, Hinkin, Montgomery, & Pitz (1987) found that 36% of the homeless people in their sample scored above a T-score of 80 on scale 8 of the MMPI, 27% scored above a T-score of 80 on scale 6, 26% scored above a T-score of 80 on scales 4 and 9, and 22% scored above a T-score of 80 on scale 2. They concluded that 56% of the overall population were either severely mentally ill or had substance abuse problems or both.

A study using the Diagnostic Interview Schedule in face to face interviews with 379 homeless people in Los Angeles estimated that 26.2% of the population experienced chronic and severe mental illness (Koegel, Burnam, & Farr, 1988). They noted that the highest prevalence rates were for affective disorders and antisocial personality, and that when the homeless sample was compared with a non-homeless sample the rates were most disproportionately high for schizophrenia and mania.

Another instrument that has been used to measure mental illness among the homeless is the SCL-90 (Derogatis, 1977). Using this instrument, Depp and Ackiss (1983) found that homeless people obtained mean scores that were higher than those obtained by nonpatients, but not as high as those obtained by psychiatric
outpatients. Results from a study that used the SCL-90 with 248 homeless people residing in thirteen different shelters in St. Louis estimated that 50% of the population were experiencing psychiatric symptoms (Morse et al., 1985).

Though there is a great deal of variation in prevalence rates for mental illness among the homeless the generally accepted consensus seems to be that about one third of the homeless population has some form of mental illness. This consensus is supported by the results of several recent studies that have indicated prevalence estimates of mental illness among the homeless ranging from 25% to 33% (Herrman, McGorry, Bennett, van Riel, & Singh, 1989; Roth, Bean, Lust, & Saveanu, 1985; U.S. Conference of Mayors, 1989; Vernez, Burnam, McGlynn, Trude, & Mittman, 1988).

As with so many other characteristics observed in the homeless population it is difficult to determine if mental illness has caused some people to be homeless, has been a result of their homelessness, or both. In a recent special issue of the American Psychologist that focused on the issue of homelessness, Fischer and Breakey (1991) noted that results of research examining mental illness among the homeless have indicated that the homeless have exhibited symptoms of emotional distress two to eight times higher than the general population. They also pointed out that the most frequently occurring personality disorders observed among the homeless (paranoid, schizoid, and antisocial) are the ones that would be most likely to interfere
with their ability to form close, supportive relationships with others.

Substance Abuse Among the Homeless

It has been suggested that alcoholism is the most pervasive health problem of the homeless (Breakey & Fischer, 1991). When compared with rates expected in the general population (10% for men and 3-5% for women) it is estimated that prevalence rates among the homeless are as high as six to seven times greater among the homeless. In addition, when compared with a non-homeless alcohol-dependent group, homeless alcoholics appear to drink more drinks, for longer periods of time and with greater frequency. Homeless alcoholics also are reported to be more impaired in social and vocational functioning and exhibit a higher prevalence of psychiatric disorders than a non-homeless alcoholic control group (Fischer & Breakey, 1987; Koegel & Burnam, 1988).

As is the case with the research that examines prevalence rates of mental illness among the homeless, there is a great deal of variation in estimates of the rates of substance abuse among this population. For example, Priest (1976) estimates that 9% of the homeless population are definitely alcoholic and that 9% are probably alcoholic, and Vernez, Burnam, McGlynn, Trude, & Mittman (1988) estimate that between 54 and 93% of the homeless have a history of substance abuse or dependence. Most of the studies that provide estimates for substance abuse among the homeless range from around 20% (Arce, Tadlock, & Vergare, 1983; Herrman,
McGorry, Bennett, van Riel, & Singh, 1989; Lipton, Sabatini, & Katz, 1983; Roth, Bean, Lust, & Saveanu, 1985) to around 45% (Koegel, Burnam, & Farr, 1988; U.S. Conference of Mayors, 1989) with several studies indicating around 33.3% (Bassuk, 1983; Bassuk, Rubin, & Lauriat, 1984; Kahn, Hannah, Hinkin, Montgomery, & Pitz, 1987). Though the research does seem to support the notion that alcohol abuse may be a problem for a significant portion of the homeless population, the lack of consensus regarding prevalence rates and the reliance on cross-sectional research precludes making any firm conclusions regarding the extent and or causative nature of alcoholism among the homeless. 

Minority Representation and Differences Among the Homeless

Increasing proportions of racial minority representation among the homeless has been documented by four surveys that yielded percentages of minorities that range from 65 to 75 percent (Morse et al., 1985; Ryan, Goldstein, & Bartlett, 1989; Sosin, Colson, & Grossman, 1988; U.S. Conference of Mayors, 1989). In addition, of 42,539 homeless people in sixteen cities reported by the Robert Wood Johnson/Pew Memorial Trust, 51% were minorities (in First, Roth, & Arewa, 1988). Of these, 40% were African-Americans, and 11% were Hispanic and Asian-Americans. Using a random representative sampling procedure at thirteen different shelters in St. Louis, Morse et al. (1985) found that 66% of their sample was composed of racial minorities.

The increasing proportions of racial minorities documented among the homeless population are disproportionate to the
percentages of these minorities in the general population. For example, results of a study done in Ohio that used a random representative sampling procedure to select 979 homeless participants indicated that 29.8% of the participants were African-Americans. This is much higher than the percentage (11%) of African-Americans estimated for the state population (Roth, Bean, Lust, & Saveanu, 1985). Results from this study also suggested that African-American homeless people tend to be younger, tend to have a somewhat higher educational level, contain a slightly higher proportion of Vietnam veterans, tend to be homeless for shorter periods of time, and tend to have suffered greater unemployment than Caucasian homeless people. In addition, results indicated that African-American homeless people had not experienced as much psychiatric hospitalization, jail detention, alcohol problems, and physical health problems as their Caucasian counterparts (First, Roth, & Arewa, 1988).

In another study, Wright and Weber (1987) found disproportionate rates of alcohol abuse among homeless men and women of various racial backgrounds. They found that 60% of the Native American homeless men in their sample exhibited evidence of alcoholism, compared to 38% of the African-American, 35% of the Caucasian, 28% of the Latino, and 17% of the Asian-American homeless men. This effect also was observed for the homeless women in their sample with 36% of the Native Americans, 13% of the African-Americans, 12% of the Caucasians, and 4% of the Latino homeless women exhibiting evidence of alcoholism.
Gender Differences Among the Homeless

In addition to differences observed with racial minority groups among the homeless, some researchers have noted differences between homeless men and homeless women. Though more and more women are joining the ranks of the homeless, in general homeless people are more likely to be men (Vernez et al., 1988). For example, of the 5500 homeless people surveyed in Pennsylvania, 67% were men (Ryan, Goldstein, & Bartlett, 1989). Men also tend to be homeless longer and seem to experience a poorer quality of life with fewer, more limited services, and a poorer quality of care than homeless women (Morse et al., 1985).

Prevalence estimates of alcohol and drug abuse seem to be higher among homeless men compared to homeless women. In a recent review of research that examines alcohol and drug abuse among the homeless, the authors note that prevalence estimates for the number of homeless men with alcohol problems are as high as 80%, while the rates for homeless women are as high as 63%. A similar pattern was observed with prevalence estimates for drug problems, with rates for homeless men with drug problems being as high as 61% and rates for homeless women being as high as 26% (Fischer & Breakey, 1991).

Gender differences also have been noted in estimates of rates of mental illness among the homeless. Several researchers have observed higher rates of mental illness in homeless women as compared with homeless men (e.g., Crystal, 1984; Robertson, Ropers, & Boyer, 1985; Vernez et al., 1988). Fischer and Breakey
(1991) note that prevalence estimates of mental health problems have been as high as 71% for homeless women compared with estimates as high as 52% for homeless men.

A comparison of characteristics of homeless men and women based on information gleaned from assessments that were conducted in New York City shelters suggested additional differences between these groups (Crystal, 1984). Crystal concluded that homeless women were more likely to be previously or currently married, more likely to have a history of psychiatric hospitalization, less likely to have been involved with the criminal justice system, more likely to have grown up in difficult family circumstances and less likely to have been employed than homeless men.

Factors that may Precipitate or Contribute to Homelessness

Research with the homeless has examined demographic information, mental illness and substance abuse among the homeless, minority and gender representation and differences, and also has attempted to isolate the factors that have contributed to the increase in homelessness over the last decade. In addition, an attempt has been made to clarify specific events that have precipitated episodes of homelessness.

Deinstitutionalization has been cited frequently in the literature as a factor that has contributed to or caused a substantial increase in homelessness (Appleby & Desai, 1985; Hope & Young, 1985; Lamb, 1984). The deinstitutionalization movement that began in the 1960s attempted to increase the
quality and efficiency of mental health care for the chronically mentally ill by placing the responsibility for providing that care on local communities rather than the state or federal government. Many, however, believe that deinstitutionalization resulted in a dramatic increase among the homeless of people who had been previously cared for in institutions (American Psychiatric Association, 1984; Arce & Vergare, 1984; Baxter & Hopper, 1984; Lamb, 1984).

Other researchers believe that deinstitutionalization had a limited impact on increases in homelessness. Sosin, Colson, and Grossman (1988) noted that the belief that deinstitutionalization caused increases in homelessness has not been supported by historical information since deinstitutionalization occurred about ten years before increases in homelessness were noted. Taking a different approach, Snow, Baker, & Anderson (1986) compared the net changes in resident population of Texas State Hospitals with the number of local Salvation Army users between 1979 and 1984. They found that between 1979 and 1984 the state hospital populations decreased from 5,508 to 4,928 residents (a decrease of 10%). The number of Salvation Army users, however, had increased from 4,938 to 11,271, an increase of 126%.

The U.S. Conference of Mayors (1989), in a report that compiled information from 27 cities in the United States, provided a list of six factors that may have contributed to increases in homelessness. Each factor on the list is presented in order of its purported contribution to the increase and
maintenance of homelessness, with the first item on the list
having the greatest contribution. The contributing factors
identified by the U.S. Conference of Mayors include 1) the lack
of affordable housing, 2) high rates of unemployment, 3) lack of
income, 4) substance abuse and lack of needed services, 5)
inadequate benefit levels in public assistance, and 6) mental
illness and lack of needed services.

The list of contributing factors compiled by the U.S.
Conference of Mayors is similar to the five categories that
Roberts and Keefe (1986) gleaned from in-depth interviews with
thirty-seven homeless people. The categories they believe have
contributed to increases in homelessness include 1) substance
abuse, 2) chronic mental illness, 3) the de-industrialization of
the frost-belt cities and the new poor that have resulted, 4) low
income leading to evictions (with the low income elderly and the
chronically unemployed being the most vulnerable), and 5) single
parent women who are unable to meet their expenses.

The notion that the factors clarified by the U.S.
Conference of Mayors and Roberts and Keefe (1986) have
contributed to increases in homelessness is supported by
information about the events that have precipitated homelessness.
Overall, Ryan, Goldstein, and Bartelt (1989) found that of the
5500 homeless people surveyed, economic factors were listed as
events that precipitated homelessness at a far greater level than
characteristics of the individuals (e.g., substance abuse or
mental illness). In another study, 50% of the homeless listed
eviction from housing/can't pay bills, 21.3% listed domestic violence and abuse, 16.8% listed that their homes or apartments were either torn down, burned down or condemned, and 11.4% listed relocation as the events that precipitated their homelessness (Sosin, Colson, and Grossman, 1988).

Using results from a study of 238 homeless men and women in Los Angeles County, Robertson and Ropers (1985) categorized the events the homeless had listed as precipitating their homelessness into four separate categories. Fifty percent of the homeless in their sample listed a precipitating event that the researchers categorized as economic/political. This category included victims of welfare cuts, underemployed, unemployed, retired, immigrants, migrant workers, refugees, undocumented workers, political exiles, new poor, evictions, and foreclosures. Twenty-five percent listed an event that the researchers categorized as psychiatric. This category included the deinstitutionalized, the mentally ill, the chemically dependent, and the developmentally disabled. The third category, personal crises, included events such as divorce, a death in the family, illness or disability, domestic violence, and runaways. The responses of 20% of the homeless fell into this category. The final category, natural catastrophes, included events from the responses of 5% of the homeless population sampled. This category included events such as floods, fires, and earthquakes.

Another factor that may contribute to a person's becoming homeless is a history of institutional separation from family. A
study that used a random sample of 535 people who get their main meal at a soup kitchen or shelter in Chicago found that 14.5% of the homeless and 7.2% of the very poor non-homeless had been placed in foster care or group homes before the age of seventeen. This compares to the 2-3% estimate for the general population (Sosin, Colson, and Grossman, 1988). Susser, Struening, & Conover (1987) found that 23% of the homeless in their sample who were experiencing their first episode of homelessness had been placed in out of home care as a child. An even higher rate was noted in a sample of homeless adults in Minneapolis, where almost 40% had a history of placement as a child (Piliavin, Sosin, & Westerfelt, 1988).

There is also evidence that suggests that homeless women may have been disproportionately (as compared with other women) exposed to other types of trauma as well. For example, D'Ercole and Struening (1990) reported that 43% of their sample of homeless women with and without children in New York City had experienced rape by a family member or other adult, and 74% had been physically abused. In comparing homeless and housed mothers in Boston, Bassuk and Rosenberg (1988) found that 41% of the homeless and 5% of the housed mothers reported having been physically abused as a child and 41% of the homeless and 20% of the housed mothers reported having been battered in an adult relationship.

In another study comparing newly homeless and housed mothers in New York City, Shinn, Knickman, & Weitzman (1991)
found that 11.4% of the newly homeless and 6.5% of the housed mothers reported experiencing physical abuse as a child, 9.9% of the newly homeless and 4.2% of the housed mothers reported experiencing sexual abuse as a child and 27% of the newly homeless and 16.6% of the housed mothers reported having been abused or threatened as an adult. Susser, Struening, & Conover (1987) concluded that the combination of scarce family resources and conflictual family relationships may make a person more vulnerable to the experience of homelessness.

The Impact of the Experience of Being Homeless

In addition to clarifying the political, social, economic, and individual factors that may contribute to or precipitate a person becoming homeless, researchers are beginning to examine the impact that the experience of homelessness may have upon the homeless. Among the consequences that being homeless has had upon families, The U. S. Conference of Mayors (1989) noted emotional and mental health problems, depression, stress, difficulties with school attendance, developmental delays in children, decreases in school performance, loss of self-esteem, and a feeling of hopelessness. Other researchers have observed high rates of emotional distress and feelings of demoralization among the homeless (Morse & Calsyn, 1986) as well as high rates of depression (Kahn, Hannah, Hinkin, Montgomery, and Pitz, 1987).

Information from two field studies further helps to clarify the impact that being homeless may have on people. The first field study took place in Columbus, Ohio with homeless women
(Merves, 1986). Merves used key informant interviewing, participant observation (over a six month period), and life histories to obtain information about the experience of being homeless as seen mainly through the eyes of fifteen homeless women. She described the most pervasive experience shared by these women as one of a loss of freedom and dignity brought about by the pervasiveness of their impoverishment and a new world of rules, regulations, curfews, different types of people, noise, and lines. Feelings that were expressed by most of the homeless women included feeling like an outcast, feeling disappointed with life, and feeling uncertain about the meaning of life.

The second study that examined the impact that being homeless may have on people is the year long field study done by Snow and Anderson (1987) in Austin, Texas. They examined patterns of obtaining income, shelter, employment, and food, and other adaptive strategies (e.g., substance use, forming friendships) and how they changed as the formation of an identity as a homeless person occurred. They contend that as the length of time on the streets increases, the need for the homeless person to maintain dignity and self worth also increases. Over time this results in the homeless person forming an identity within the culture of homelessness that can afford them value and worth. Once a person has constructed an identity as a homeless person, getting off the streets can become increasingly difficult.

In their recent work, Snow and Anderson (1991) described four sets of factors that they believe influence a homeless
persons movement in and out of homelessness. The first set of factors are categorized as personal resource deficits and include disabilities (e.g., poor health, criminally inclined), lack of human capital (e.g., work experience, education), lack of material resources (e.g., tools, transportation) and lack of social margin (e.g., showing up late for work). The second set of factors that Snow and Anderson believe make it difficult to get off the streets are classified as institutional factors and include an emphasis on providing accommodative services, the bureaucratic nature of agencies, and the selectivity bias that frequently occurs with rehabilitative services. The third set of factors are classified as street-based group ties, and the final set of factors are designated cognitive factors.

The cognitive factors described by Snow and Anderson are the most relevant for the current study and will be described more fully. The first cognitive factor that may limit the ability of the homeless to get off the streets is their inability to formulate a concrete plan of action aimed at resolving their homelessness. Snow and Anderson believe that the homeless have difficulty coming up with a plan to get off the streets for two reasons. First, the experience of being homeless requires a present rather than future orientation regarding survival needs. After securing food, shelter, health care, and other necessities there may be little time and energy left to strategize for the future. Second, the experience of being homeless is filled with many unresolvable dilemmas and double-binds. Snow and Anderson
provide an example of a homeless man who could not gain admission to a halfway house without a job, and could not get a job without an address.

The second cognitive factor described by Snow and Anderson is the hopelessness that results from repeated failed attempts to secure steady employment, financial assistance, and/or other resources necessary for the homeless to work their way off the streets. Snow and Anderson observed that a common response to this sense of hopelessness was for the homeless to become despondent and unmotivated. As they learned that their actions had no desirable impact on their environment they seemed to quit trying, and slipped further into homelessness. With regard to the cognitive factors they described, Snow and Anderson stressed their belief that these are not symptoms of pathological thinking or bad habits, but result from the lived experience of being homeless. From the time they spent observing and conversing with the homeless they concluded that the state of being homeless creates problems that make it difficult to get back off the streets, and that the longer one is homeless the more difficult it will be to extricate from street life.

The hopelessness and despondency that Snow and Anderson observed in the homeless in response to their inability to have a desirable impact on their environment seems very similar to the concept of learned helplessness (Seligman, 1975). Learned helplessness theory suggests that when people are exposed to an
inescapable negative event they may learn their actions are to no avail and stop trying to better or escape their situation.  

The Theory of Learned Helplessness

Learned helplessness was first described after researchers (Overmier & Seligman, 1967; Seligman & Maier, 1967) observed that dogs exposed to inescapable shock failed to escape when subsequently exposed to escapable shock. To test the hypothesis that the dogs had learned to be helpless, a series of triadic experiments were conducted. These experiments used groups of three dogs, two of which were yoked together to insure that they received the same amount of shock. The first group of dogs received shock that they could escape by pushing a panel with their nose. The second group of dogs received the same amount of shock as the first group of dogs, but none of their responses had any effect. In the second group the shock would cease only when the "yoked" dog in the first group pushed its panel. The third group of dogs received no shock at all. After the dogs were exposed to the experimental conditions in the first part of the experiment, they were each placed in a shuttle box and given shocks that they could escape by jumping over a low barrier to the other side of the shuttle box. The experimenters found that all of the dogs in the first group quickly learned to jump over the barrier and escape the shock. Six of the eight dogs in the second group, however, sat down and made no attempt to escape. Thus it was suggested that through exposure to inescapable shock
the dogs had learned a helplessness that affected their behavior in subsequent similar situations.

This finding was disputed by behaviorists who believed the dogs in the second (inescapable shock) condition had been inadvertently reinforced for sitting down. Maier (1970) designed an experiment to test the hypothesis that the dogs who had received inescapable shock had received reinforcement for doing nothing. He used the same triadic design as the first group of experiments, but changed the response that would result in a termination of the shocks. The first group of dogs were reinforced by having the shock terminated every time they were still for five seconds. Again, each dog in the second group was yoked to a dog in the first group. They received the same amount of shock, but the termination of the shock was not contingent upon any response on their part. The third group of dogs received no shocks. Maier found that most of the dogs in the third group and those who had been reinforced for sitting still quickly learned to jump the barrier and escape shock when they were placed in the shuttlebox. The majority of dogs in the second group again did not try to escape the shock.

The deficits observed in the dogs following exposure to inescapable shock were interpreted in terms of learning theory (Maier, Seligman, & Solomon, 1969; Seligman, Maier, & Solomon, 1971; Seligman, 1975). These researchers proposed that the dogs learned that their responses to eliminate the shock were independent of the actual shock they were receiving. This
learning produced an expectation of future response-outcome independence that generalized to new situations to produce motivational, learning, and emotional deficits. Seligman defined helplessness as "the psychological state that frequently results when events are uncontrollable" (p. 9), and defined uncontrollable as what occurs when the outcome of an event is independent of voluntary responses initiated to have an impact upon it.

The laboratory experiments with learned helplessness in animals were followed by an experiment designed to examine learned helplessness in people. Hiroto (1974) used a triadic design in his experiments similar to the one used in the animal experiments. In the first condition people were exposed to loud noise that could be turned off by pressing the right combination of buttons on a panel before them. The people in the second group were yoked to the people in the first group. They experienced the same amount of loud noise no matter what combination of buttons were pushed. The third group did not experience any loud noise. After being exposed to the loud noise each person was taken to a hand shuttle box. In order to shut off annoying noise the person's hand had to be moved from one side of the shuttlebox to the other. Hiroto found that the majority of people who had been exposed to noise they could turn off, and those who had experienced no noise quickly learned to move their hands from one side of the shuttlebox to the other.
The majority of those who had been exposed to unstoppable noise sat passively and did not try to escape the annoying noise.

Following the laboratory observations of learned helplessness, Seligman (1975), noticing parallels between learned helplessness and emotional, motivational, and behavioral deficits observed with depression, proposed the theory of helplessness as a model for depression. Humans exposed to inescapable noise or unsolvable problems reported a depressed mood and blamed their failure to solve problems on their lack of ability and worthlessness. Animals exposed to inescapable shock lost interest in their usual activities, lost their appetites, and developed early-morning awakening. Both animals and humans had difficulty with new learning, concentration, and showed psychomotor retardation, and decreased energy following exposure to an uncontrollable aversive event. These animals and humans did not fight back when attacked, and made no attempt to escape shock, get food, or solve problems (see Seligman, 1990).

Though the theory seemed to offer a viable explanation for what occurs in depression, it was unable to account for all of what had been observed in the early helplessness experiments. First, there was no explanation within the theory for the fact that one third of the dogs and one third of the people in the inescapable shock or noise conditions never became helpless. Second, the theory was unable to account for the fact that some of the dogs recovered from their learned helplessness quickly and some never fully recovered. Third, the theory offered no
explanation for the observation that some of the dogs and people who became helpless were only helpless in similar situations and others seemed to experience helplessness in new situations as well. Fourth, the theory did not account for the fact that 10% of the dogs and people who were in the "no shock" or "no noise" control groups did not try to escape the shock or noise when placed in the shuttlebox. Finally, the theory did not explain why some people blamed themselves for failing to escape the noise and some blamed the experimenter for presenting them with unsolvable problems.

The Reformulated Theory of Learned Helplessness

To account for the differences observed in the development, generality, and chronicity of learned helplessness in humans and animals following exposure to inescapable aversive events, Abramson, Seligman, and Teasdale (1978) expanded the theory of helplessness to include explanations made about the cause of the original uncontrollable event. According to the reformulated learned helplessness theory, if people believe that uncontrollable aversive events were caused by something about themselves (internal) versus something about the situation or others (external), they are more likely to suffer a loss of self-esteem following such an event. If people believe that the cause of an uncontrollable aversive event is something that will persist over time (stable) versus something that will be relatively transient (unstable), depressive reactions following such an event are more likely to persist over time. If people
believe that the cause of an uncontrollable aversive event is something that will also affect other outcomes and events in their lives (global) versus something that is specific to the particular aversive event (specific) then helplessness or depressive reactions are more likely to generalize to other outcomes and events in their lives. Thus, the reformulated learned helplessness model for depression postulates that explaining an uncontrollable aversive event with internal, stable, and global causes will lead to lower self-esteem and more persistent and pervasive depression than a less pessimistic explanatory style. Explanatory style is defined as "the habitual pattern of explanations an individual makes for good and bad events (Schulman, Castellon, & Seligman, 1989, p. 505)."

**Explanatory Style and Depression**

In order to provide a means for examining the reformulated learned helplessness theory, Peterson et al. (1982) developed an instrument to measure individual differences in tendencies to explain positive and negative events with internal (versus external), global (versus specific), and stable (versus unstable) causes. The Attributional Style Questionnaire (ASQ; Peterson et al., 1982) has been used in a great deal of research that has provided support for the reformulated theory of learned helplessness (Tennen & Herzberger, 1985). The research designed to test the reformulated theory of learned helplessness has yielded results indicating that scores on the ASQ correlate with scores on the Beck Depression Inventory (BDI; Beck, 1967) in the
direction predicted by the theory (Eaves & Rush, 1984; Ganellen, 1988; Peterson, Bettes, & Seligman, 1985; Raps, Peterson, Jonas, & Seligman, 1982; Seligman, Abramson, Semmel, & von Baeyer, 1979). Specifically, these researchers found that as participants' scores for internal, global, and stable causes for hypothetical aversive events increased so did their scores on the BDI.

Further support for the reformulated theory of learned helplessness has been provided by research that used explanatory style to predict who was most likely to become depressed following an uncontrollable event, failure, or defeat (Hunsley, 1989; Metalsky et al., 1982). For example, Metalsky et al. (1982) used scores on the BDI and the Attributional Style Questionnaire to predict which students would become depressed after experiencing a failure. One week before taking a midterm students were asked what grade would constitute a failure for them. Following the midterm, students were informed of their grades and again completed the BDI. Results indicated that 30% of the students who received a failing grade (according to their own definitions) scored above the cutoff score for depression on the BDI. In addition, 30% of the students whose scores on the Attributional Style Questionnaire were indicative of a pessimistic explanatory style scored above the cutoff score for depression on the BDI. In contrast, 70% of the students whose scores on the Attributional Style Questionnaire were indicative
of a pessimistic explanatory style and who had received a failing grade scored above the cutoff score for depression on the BDI.

The reformulated theory of learned helplessness also was used to predict who would be most at risk for depression in a male prison population following incarceration (Peterson, Nutter, & Seligman, 1982). The ASQ was completed within a week of incarceration by 245 prisoners. Within a week of their release (ranged from 1 week to 1 year) the prisoners completed the BDI. The average of scores on the BDI (M = 17.7) were in the moderate to severely depressed range. The researchers also observed that explanations for negative events were positively correlated with scores on the BDI. Those who had a pessimistic explanatory style upon entering prison were the most severely depressed upon leaving prison.

Several longitudinal studies provide support for the reformulated theory of learned helplessness (Nolen-Hoeksema, 1983; O' Hara, Rehm, & Campbell, 1982; Seligman et al., 1984). For example, Nolen-Hoeksema (1983) found that a pessimistic explanatory style (internal, global, and stable explanations for aversive events) predicted depressive symptoms in children two months after they had been tested. This finding held even when initial level of depression was controlled for. Seligman et al. (1984) also found that scores on the ASQ predicted later symptoms of depression when initial level of depression was held constant. In another longitudinal study, O' Hara, Rehm, & Campbell (1982) found that scores on the ASQ predicted level of depression for
women three months after the birth of their first child. This finding was not, however, replicated in a similar study (Manly, McMahon, Bradley, & Davidson, 1982).

Methodological Concerns with Research on Learned Helplessness

There appear to be several methodological concerns with the research conducted to examine the reformulated theory of learned helplessness that preclude making firm conclusions about the efficacy of the theory. First, much of the research conducted to prove or disprove the theory has not tested the diathesis-stress aspect of the model (e.g., Burns & Seligman, 1989; Peterson & Seligman, 1984; Peterson, Seligman, & Vaillant, 1988). The theory suggests that explanatory style will predict depressive symptoms after exposure to an uncontrollable aversive event. However, much of the research has correlated explanatory style with depressive symptoms without exposure to an uncontrollable aversive event. In addition, studies that did include exposure to an uncontrollable aversive event typically have not assessed the extent to which the aversive event is aversive for each respondent (e.g., Hunsley, 1989; Metalsky et al., 1982). For example, it is not known if doing poorly on an exam would be comparably aversive across students.

Another methodological concern that relates to the diathesis-stress aspect of the model is the failure to obtain a record of ongoing life events. Results for longitudinal studies that focus on one event as the uncontrollable aversive event may be confounded by other positive and negative life events (e.g.,
Hunsley, 1989; Metalsky et al., 1982; Metalsky, Halberstadt, & Abramson, 1987; Peterson, Nutter, & Seligman, 1982). For example, it is not known if any of the students who became depressed after doing poorly on an exam also experienced the divorce of their parents, a break-up of a romantic relationship, or other stressors that may have contributed to their higher depression scores.

A third methodological concern with research conducted to examine the reformulated theory of learned helplessness is the reliance on non-representative or self-selected samples (e.g., Burns & Seligman, 1989; Hunsley, 1989; Peterson, Bettes, & Seligman, 1985; Peterson, Seligman, & Vaillant, 1988). The reformulated theory of learned helplessness is suggested as a model of depression, yet much of the research has used populations with only mild levels of depression (e.g., students, children). The small range of scores obtained by respondents in these studies may not be generalizable to people who become depressed following uncontrollable aversive events.

The use of correlational designs in some of the research conducted to examine the reformulated theory of learned helplessness is a fourth methodological concern that suggests a cautious acceptance of results that provide support for the theory (e.g., Alloy, Abramson, Peterson, & Seligman, 1984; Eaves & Rush, 1984; Ganellen, 1988; Peterson, Bettes, & Seligman, 1985; Raps, Peterson, Jonas, & Seligman, 1982; Seligman, Abramson, Semmel, & von Baeyer, 1979). With the correlational
studies there is no way to determine causality of the measured variables. For example, it is not known if a pessimistic explanatory style leads to depression or depression leads to a pessimistic explanatory style. In addition, responses obtained at the same time may be consistent because of a respondent-imposed consistency of responses rather than a characteristic way of explaining positive and negative events (Peterson, Bettes, & Seligman, 1985).

Several researchers have commented on additional concerns with research conducted to examine the reformulated theory of learned helplessness. For example, Carver, Ganellen, & Behar-Mitrani (1985) suggested that the complexity of the format and the diversity of the hypothetical events used to measure explanatory style may lead to measurement error. In addition, Power (1987) noted that the potential biases due to related cognitive dimensions are not typically measured or accounted for in the learned helplessness research. Finally, changes in depression level and explanatory style that might be due to spontaneous recovery instead of to cognitive therapy aimed at changing the way people explain the events that happen to them, have not been ruled out by the use of a non-treatment control group (Seligman, et al., 1988).

In addition to the methodological concerns noted above, a problem for proponents of the reformulated theory of learned helplessness has been the presence of disconfirming studies (e.g., Hammen & Cochran, 1981; Hammen & deMayo, 1982; Peterson
& Conn, 1982). These studies did not find the predicted correlation between explanatory style and depressive symptoms. However, Peterson and Raps (1983) reported that studies with disconfirming results tended to not distinguish between explanations and explanatory style. Disconfirming studies provided respondents with fewer events (\( M = 2.14 \) events) for which to offer explanations for than studies that confirmed the tenets of the theory (\( M = 6.25 \) events). In addition, in a review of 61 published tests of the reformulated theory of learned helplessness, Peterson, Villanova, & Raps (1985) found that studies that confirmed the predictions of the reformulated theory of learned helplessness tended to use hypothetical events, larger samples, and more events than studies that disconfirmed the predictions of the theory. Finally, in a meta-analysis of 104 studies involving 15,000 participants, Sweeney, Anderson, and Bailey (1986) found a highly reliable relation of moderate size between explanatory style and depressive symptoms.

**Learned Helplessness, Explanatory Style and Success and Achievement**

In addition to predicting depression, the reformulated theory of learned helplessness has been used to predict who is most likely to be successful at work (Seligman and Schulman, 1986). The ASQ was completed by 104 newly hired insurance agents. They found that insurance agents who scored in the less optimistic half of the ASQ were twice as likely to quit as those who scored in the more optimistic half. Insurance agents who
scored in the lower 25% on the ASQ were three times as likely to quit as those who scored in the upper 25%. In addition, they found that agents who scored in the more optimistic half of the ASQ sold 20 percent more insurance than those in the less optimistic half and those who scored in the upper 25% on the ASQ sold 50 percent more insurance than those who scored in the lower 25%. Scores on the ASQ predicted both those most likely to quit and those likely to be most productive.

In addition to predicting success at work, researchers have used the reformulated theory of learned helplessness to predict achievement at school. Preliminary results from a continuing longitudinal study that began with four hundred third-grade children, their parents, and their teachers have suggested a strong relationship between explanatory style, achievement in school, and depression (Nolen-Hoeksema, Gignus, & Seligman, 1986). Researchers found that children with a pessimistic explanatory style (as measured by a children's version of the ASQ) were more likely to get depressed and more likely to have poorer school achievement than children who saw negative events as external, specific, and unstable.

Another study that used the ASQ to predict achievement, examined the relationship between scores on the ASQ and the achievement of college students who did better or worse than their SAT scores, high-school grades, and achievement tests suggested they would (Peterson & Barrett, 1987). Results indicated that first year college students whose scores on the
ASQ were indicative of a pessimistic explanatory style tended to do worse than other predictors suggested they might. In comparison, those who entered college with a more optimistic explanatory style tended to do better than other predictors suggested they might.

**Learned Helplessness, Explanatory Style and Health**

In addition to predicting depression and success at work and school, a number of researchers have used the reformulated theory of learned helplessness to examine the relationship between helplessness, explanatory style, and health. The triadic design used in the early learned helplessness experiments was used with three groups of rats that had been implanted with potentially lethal cancer cells (Visintainer, Volpicelli, & Seligman, 1982). The cancer cells would be lethal if their growth was not stopped by the animal's immune system. The first group of rats were exposed to mild escapable shock, the second group were exposed to mild inescapable shock, and the third group were exposed to no shock at all. Researchers found that 50% of the rats that were exposed to no shock rejected the cancer cells, 70% of the rats that were exposed to escapable shock rejected the cancer cells, and 27% of the rats that were exposed to inescapable shock rejected the cancer cells.

The differences in cancer cell rejection rates also were observed when exposure to inescapable shock, escapable shock, or no shock occurred in childhood and cancer cell implantation occurred during adulthood (Seligman & Visintainer, 1985).
Researchers found that rats who were exposed to escapable shock in childhood had a higher cancer cell rejection rate following implantation of cancer cells in adulthood than rats exposed to no shock. This effect held even when the rats were exposed to inescapable shock following implantation. In contrast, rats exposed to inescapable shock in childhood had a lower cancer cell rejection rate following implantation of cancer cells in adulthood than rats exposed to no shock, even when exposed to escapable shock following implantation.

A number of researchers have examined the role of helplessness, explanatory style and health in humans as well. For example, Peterson (1988) examined the relationship between explanatory style and health and number of visits to a physician in 150 undergraduates. Students completed the Attributional Style Questionnaire (ASQ; Peterson et al., 1982) and reported health complaints and number of visits made to a physician in the recent past. The number of illnesses and visits to a physician experienced by the students were followed for one year. Results indicated that students with a more pessimistic explanatory style experienced twice as many infectious diseases and made twice as many visits to a physician than students with a more optimistic explanatory style did.

Researchers also have examined the role of explanatory style and health over longer time spans. In order to examine the relationship between explanatory style and health across a longer time span, several researchers developed a method for analyzing
written materials (e.g., diaries, interviews) to determine explanatory style (Peterson, Luborsky, & Seligman, 1983; Schulman, Castellon, & Seligman, 1989). The Content Analysis of Verbatim Explanations (CAVE) technique requires treatment of spoken or written statements about spontaneously occurring events and their explanations as questionnaire items and submitting them to a panel of judges to rate on a 1-7 scale for internality, stability, and globality. Scores on the ASQ were found to correlate 0.71 with scores derived using the CAVE method.

The first study that examined the relationship between explanatory style and health over a longer time span used questionnaires completed by 99 men who graduated from Harvard between 1942-1944 (Peterson, Seligman, & Vaillant, 1988). These men had been chosen to participate in the Study of Adult Development (Vaillant, 1977) on the basis of screening procedures that determined them to be the most academically successful, and most psychologically and physically healthy members of their class. Researchers used the CAVE technique to analyze open-ended questionnaires regarding difficult wartime experiences that were completed by the men in 1946. Negative events and their explanations, when offered by the men, were rated on 7-point scales by four independent judges who were blind to experimental conditions. Reliability ratings for judges ratings were .85 for stability, .77 for globality, and .90 for internality. Results indicated that men who attributed negative events to internal, stable, and global causes in their youth were less healthy.
particularly after age 45, than men judged to have a less pessimistic explanatory style.

An explanation for the observed relationship between explanatory style when young and healthiness as an adult was offered by researchers who observed that explanatory style for negative events appears to remain stable across a person's lifetime (Burns & Seligman, 1989). Burns & Seligman had judges blind to conditions use the CAVE technique to analyze the Life Style and Attitude Survey completed by 30 adults with an average age of 72 years and samples of writing (e.g., from diaries, letters) from when they were younger (M = 20.5 years). The Life Style and Attitude Survey contains three questions, to be answered with at least 250 words, about the circumstances of one's current life, e.g., interests, hobbies, friends, problems. In addition to completing the Life Style and Attitude Survey, respondents also completed the Beck Depression Inventory (BDI). Results indicated that the way respondents explained negative events when younger correlated with their current way of explaining negative events (r = .54, p < .002). There was, however, no significant correlation between younger and current ways of explaining positive events. Though scores on the BDI were correlated in the direction predicted by the reformulated theory of learned helplessness for explanations given for positive events, scores on the BDI were not correlated with explanations for negative events.
Clinical Applications of the Reformulated Theory of Learned Helplessness

In addition to being used to predict depression, success at work and school, and health, the reformulated theory of learned helplessness has been used as a model for understanding clinical populations and for providing principles to guide the development of treatment recommendations. For example, persuasion was used to change explanations for failures in reading performance (Chapin & Dyck, 1976; Fowler and Peterson, 1981) and arithmetic (Dweck, 1975) in children. Results indicated that changes in explanations for failure were associated with increased persistence (e.g., increase in the number of sentences read out loud) and performance (less decreases of correct math problems after failure). Changes in explanatory style for negative events (following cognitive therapy) also has been associated with changes in depressive symptoms in unipolar depressed patients.

The reformulated theory of learned helplessness also has been used as a framework to guide clinicians in conceptualization and treatment of various populations. For example, Mandel & Marcotte (1983) found that family practice residents exposed to seminars on the reformulated theory of learned helplessness developed more complete treatment plans and were more likely to ask battered women about alcohol and child abuse in the family than residents who did not attend the seminars. They suggested that the reformulated theory of learned helplessness be used to guide family therapists in the assessment and treatment of
battered women. In addition, the reformulated theory of learned helplessness has been used to explain some of what occurs in a family with an alcoholic member (Griffith, 1986) and more generally as a model for passive maladaptive responses to any form of victimization (Peterson & Seligman, 1983). Peterson and Seligman (1983) suggest that "when uncontrollable bad events precede helpless behavior, and when the helpless individual expects future responding to be futile, it may well be that learned helplessness is operative" (p. 107). In a review of research that used the ASQ to provide theoretical support for the reformulated theory of learned helplessness, Tennen and Herzberger (1985) conclude that, in addition to depression, the ASQ can be applied to research on achievement motivation, self-esteem, parental behavior, life changes, gender differences, and responses to aversive life events.
CHAPTER II

METHOD

Design and Participants

A 4 x 2 factorial design was conducted to examine the relationship between length of time homeless (less than one month, one to six months, six months to one year, and over one year), gender and explanatory style among a sheltered homeless population. In order to control for changes in the variance that might be due to alcohol abuse or psychological instability, these variables were measured and included as covariates in the data analysis. Estimates of alcohol abuse and psychological instability also were examined to determine if differential patterns emerged based on gender.

One hundred and sixty-eight homeless men and women received five dollars each for their voluntary participation. Participants were recruited at the Open Shelter, Friends of the Homeless, Holy Rosary, Salvation Army, and Faith Mission, five agencies that provide shelter for the homeless in Columbus, Ohio. Three of these agencies, The Open Shelter, Friends of the Homeless, and the Faith Mission are 24 hour emergency walk-in shelters. The Open Shelter has space for 95 males with a typical occupancy of 105. The Friends of the Homeless has space available for 80 males and 35 females, and
Faith Mission has space available for 110 males, 35 females, and 5 families. The Holy Rosary has space available for 35 women and their children. Access to services at Holy Rosary is secured through an interview screening and referral process. Finally, Salvation Army is a walk-in shelter with space available for twenty-two women and their children. The recruitment process was consistent for all the shelters. Participants included one hundred males and sixty-eight females, predominantly between the ages of twenty-one to fifty-one (90%), with a median age of thirty-four and a range from sixteen to sixty-six years of age (five participants did not specify age).

Procedure

Almost all data were collected by the experimenter, a 36 year old female doctoral candidate in counseling psychology, with assistance from a friend and a family member. The assistants were available to read the questionnaires and to write out responses for participants who were unable to do so. A staff member at each site assisted with scheduling, introductions and security. At one site, a shelter for women with children, a staff member collected the data for twelve homeless participants without the experimenter being present. This occurred only after the staff member had collected data with the experimenter and was familiar with the procedure. The experimenter and all staff and non-staff members who participated were given a copy of and asked to follow
instructions regarding the procedure for administering the questionnaire (See Appendix C for Standardized Instructions for Administering the Questionnaire form).

The recruitment process was consistent for all the shelters. Participants were informed that a graduate student and a professor at The Ohio State University were requesting their assistance in identifying some of the ways that being homeless might make it hard for homeless people to get back on their feet. In addition, they were informed that their participation was voluntary and that they could refuse to participate at any time (See Appendix B for Request for Participation form).

Confidentiality was maintained throughout the study. Anonymity was preserved by not requiring participants to put their names on the study questionnaire. Demographic information (age, gender, marital status, veteran status, education level, ethnicity) was used only to provide descriptive information about homeless people. At no time was an attempt made to identify the research participants. Participants were asked to provide the first six digits of their social security numbers and the first letter of their last name. This seven-digit code is the code that community service providers for the homeless use to keep track of utilization rates. If the results of the current study suggest a benefit in pursuing longitudinal research this code can be used to find where those homeless who agreed to be
contacted at a later date may be located. The code can only be used to obtain information about possible locations of participants and cannot identify them. Provision of the seven-digit code was completely voluntary.

Homeless participants completed a questionnaire that contained a request for demographic information (see Appendix A for demographic information form), a measure of explanatory style, a measure of psychological instability and a measure of alcohol abuse. The measures included in the questionnaire were a modified version of the Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988) the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), and the Michigan Alcoholism Screening Test (MAST; Selzer, 1971). The final page of the questionnaire presented the question "What is the most important thing that people who have not been homeless need to understand about the homeless?" (Ryan, Goldstein, & Bartlett, 1989, p. 32).

Independent Variables

Length of time homeless. Participants were placed in one of four length of time homeless conditions based on the amount of time they had experienced the current episode of homelessness. The four conditions of homelessness for the current study were less than one month, one month to six months, six months to one year, and over one year. These categories were suggested by results for the study done in Franklin county indicating that 30% of the sampled homeless
population had been homeless for 30 days or less, 43% had been homeless between 31 and 365 days, and 22% had been homeless for over a year (Roth, Bean, Lust, & Saveanu, 1985). In the current study sixty-four (38.1%) participants were in the less than one month condition, forty-two (25%) were in the one month to six months condition, twenty-five (15%) were in the six months to one year condition, and thirty-seven (22%) were in the over one year condition.

**Gender.** Results of research with the homeless has suggested that homeless females may experience a poorer quality of life than homeless men and that the severely mentally disordered among the homeless are more likely to be women (Morse et al., 1985; Vernez, Burnam, McGlynn, Trude and Mittman, 1988). In addition, some researchers have observed that females are more susceptible to experiencing learned helplessness than men (Dweck & Light, 1980; Seligman et al., 1984). The current study included one hundred male and sixty-eight female participants.

**Dependent Variables**

**Explanatory style.** Participants' explanatory style was measured using a modified version of the Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988). The EASQ is a revised version of the Attributional Style Questionnaire (ASQ; Peterson et al., 1982) that was developed to measure an explanatory style indicative of more persistent and pervasive learned
helplessness deficits following exposure to an uncontrollable aversive event. Explanatory style is defined as "the tendency to select certain causal explanations for good and bad events" (Tennen & Herzberger, 1985).

The ASQ is a self-report measure that requires respondents to imagine that they are experiencing each of the six good events and six bad events described. After reading each description the respondents are asked to write one major cause for the event and to rate the cause on three seven-point scales indicating whether they thought the cause was 1) due to something about them (internal) or something about other people or circumstances (external), 2) something that would always be present (stable) or never be present again (unstable), and 3) something that would influence just this situation (specific) or would also affect other areas of their life (global). Internal, stable, and global explanations receive higher scores whereas external, unstable, and specific scores receive lower scores. Higher scores are more indicative of a pessimistic explanatory style and lower scores are more indicative of an optimistic explanatory style. The central prediction of the reformulated learned helplessness model is that people with a pessimistic explanatory style will exhibit more persistent and pervasive learned helplessness deficits following uncontrollable, aversive events than people with a more optimistic explanatory style.
Since the learned helplessness deficits observed in humans and animals following exposure to an uncontrollable, aversive event seem to parallel symptoms of depression, correlations between a pessimistic explanatory style and depressive symptoms have been used to provide support for the Attributional Style Questionnaire. Validity for the ASQ has been reported by Peterson & Seligman's (1984) review of studies that measure the relationship between ASQ scores and depression ratings on the Beck Depression Inventory (BDI; Beck, 1967). In a college student population (N = 143) depressive symptoms as measured by the short form of the BDI (Beck & Beck, 1972) were correlated with internal (r = .41, p < .001), stable (r = .34, p < .001), and global (r = .35, p < .001) explanations for negative events (Seligman, Abramson, Semmel, & von Baeyer, 1979). In addition, they found that composite scores for negative events correlated with respondents' depressive symptoms (r = .48, p < .001). In a similar study Peterson, Bettes, and Seligman (1982) found that students' (N = 66) depressive symptoms were correlated with internal (r = .44, p < .001), stable (r = .42, p < .001), and global (r = .29, p < .02) explanations for negative events (composite r = .39, p < .001). Schulman, Castellon, & Seligman (1989) also reported correlations between depressive symptoms and internal (r = .36, p < .0001), stable (r = .35, p < .0001), and global (r = .37, p <
.0001) explanations for negative events (composite $r = .46$, $p < .0001$) among college students ($N = 160$).

Research supporting the validity of the ASQ also has examined the relationship between explanatory style and depressive symptoms in lower class and depressed populations. In a sample of forty-one females receiving welfare benefits, Navarra (1981) found that depressive symptoms correlated with internal ($r = .42$, $p < .01$), and global ($r = .50$, $p < .001$) explanations for negative events (composite $r = .50$, $p < .001$), but not with stable explanations ($r = .12$, ns). A similar finding was reported by Persons & Rao (1981) who found that depressive symptoms correlated .60 with internal and .53 with global explanations for negative events (composite $r = .50$, $p < .001$), but not with stable explanations. In a more recent study, Seligman, et al. (1988) found that composite scores for negative events correlated with severity of depression at cognitive therapy intake ($r = .56$, $p < .0002$), termination ($r = .57$, $p < .0008$) and one-year follow-up ($r = .64$, $p < .0005$). In addition, Raps, Peterson, Reinhard, Abramson, & Seligman (1982) found that depressed patients were more likely to attribute bad events to internal, global, and stable causes than were nondepressed or schizophrenic patients, $F (2, 103) = 10.69$, $p < .001$.

Validity for the ASQ also has been supported by research that examined the relationships between scores on the ASQ and
naturally occurring explanations for events. For example, composite scores for negative events on the ASQ have been shown to significantly correlate ($r = .30$, $p < .05$) with spontaneously given explanations for self-reported negative events (Peterson, Bettes, & Seligman, 1982). In addition, Castellon, Ollove, & Seligman (1982) found a correlation ($r = .38$, $p < .02$) between composite scores for negative events and composite scores from a blind content analysis of reasons psychiatric patients provided for why they sought treatment and for the origin of their symptoms.

In a review of research that has been done with the Attributional Style Questionnaire, Tennen and Herzberger (1985) conclude that the internal consistency of the ASQ has been modest. Peterson et al. (1982) reported internal consistency reliability coefficients for composite scores for bad events (18 items) of .72 and for composite scores for good events of .75. Internal consistency reliability coefficients reported for subscales (6 items each) were less satisfactory, ranging from .44 for the globality subscale for good events to .69 for the globality-bad events subscale. Test-retest reliability ($r = .64$, $p < .001$) has been demonstrated in undergraduate samples over a period of four to five weeks (Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman, 1982). Seligman, Castellon, Cacciola, Schulman et al. (1988) also found that explanatory style scores were stable ($r = .15$, $p < .0003$) over a one year
period from termination of cognitive therapy to follow-up with depressed patients.

It should be noted, however, that some studies have demonstrated that as depression scores decrease, scores on the ASQ also change and become less characteristic of a pessimistic explanatory style (Hamilton & Abramson, 1983; Persons & Rao, 1985). For example, Persons and Rao (1985) found that the change in explanatory style scores over the course of therapy (mainly anti-depressant medication) accounted for 49% of the total change in depression. In addition, Seligman et al. (1988) found a correlation \( r = .65, p < .0001 \) between explanatory style score change (mean change = 1.40) and depression score change (mean change = 9.8) from intake to conclusion of cognitive therapy with depressed patients.

The Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988) was developed to improve the reliabilities of the three subscales of the ASQ (Peterson, 1991). After increasing the number of bad hypothetical events from 6 to 24, Peterson and Villanova (1988) found that the internal consistency reliability coefficients were much more satisfactory. Using Cronbach's (1951) coefficient alpha, they found internal consistencies of .66 for internality, .85 for stability, and .88 for globality. Evidence for the validity of the EASQ was also reported by Peterson and Villanova (1988). They found significant
correlations between scores on the internal \( r = .32, p < .001 \), stable \( r = .18, p < .05 \) and global \( r = .36, p < .001 \) subscales of the EASQ and ratings of explanations for bad events, and also between scores on the internal \( r = .18, p < .05 \), stable \( r = .19, p < .05 \) and global \( r = .40, p < .001 \) subscales of the EASQ and ratings of depression.

A criticism of both the ASQ and the expanded version of the ASQ has been that the hypothetical good and bad events may not be relevant for certain groups of people (Tennen & Herzberger, 1985). For example, imagining being placed on academic probation seems to have little relevance for a woman preparing for childbirth (Cutrona, 1983), elderly people (Cochran & Hammen, 1985), or spouses of the chronically ill (Pagel, Becker, & Coppel, 1985). In response to this, Peterson (1991) suggests that first, researchers use items that are most germane for their population sample and second, that researchers use as many items as possible from the original EASQ to insure that the internal consistency of the subscales is upheld.

In the current study, fifteen of the twenty-four items on the EASQ were deemed relevant for a homeless population (see appendix D for instructions for and a sample item from the EASQ and appendix E for a listing of the twenty-four original items of the EASQ). The determination of the relevance of the items was based on a review of the literature on people without homes, as well as over three
years of experience working with the homeless population. Experience working with the homeless and a review of the literature also were used to construct nine items to replace those that were dropped from the EASQ (see Appendix F for a listing of replacement items).

**Psychological instability.** The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) was used to measure participants' level of psychological instability. The BSI is a shortened version of the SCL-90-R (Derogatis, 1977) which was developed to measure psychological symptom states and distress levels in adults. The BSI contains 53 items in a self-report symptom inventory format (see appendix G for a listing of sample items from the BSI). Each item is rated on a 5-point scale of distress (0-4) anchored with "not-at-all" (0) at one end and "extremely" at the other end.

Psychological instability is measured by using the nine primary symptom dimensions and the three global indices of distress level. The global indices include the General Severity Index (GSI; an indicator of current psychological distress level) the Positive Symptom Distress Index (PSDI; indicator of intensity of distress) and the Positive Symptom Total (PST; indicator of actual number of symptoms endorsed). The GSI is the average of all 53 items, the PST is the total number of non-zero responses, and the PSDI is the total of all the items divided by the PST. The nine primary symptom dimensions include somatization, obsessive-compulsive,
interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Scores are averaged within dimensions and compared with a t-score distribution based on one of the norms available for the BSI (e.g., psychiatric inpatients, psychiatric out-patients, non-patients). The norms for the non-patient group were used to interpret respondents' scores in the current study.

The BSI contains simple language and is said to be appropriate for use with individuals having a reading knowledge equivalent to the sixth grade. Derogatis & Melisaratos (1983) reported internal consistency reliability coefficients ranging from .71 for psychoticism to .85 for depression for the nine primary symptom dimensions of the BSI. Test-retest reliability for a period of two weeks has been reported at a level of .90 for the General Severity Index, and ranging from .68 (psychoticism) to .91 (phobic anxiety) for the symptom dimensions. Validity evidence for the BSI has been reported by Derogatis & Melisaratos' studies of the relationship between BSI symptom dimension scores and MMPI scale scores. For the current study, it is important to note that the BSI has been used in at least four major studies to provide information about the extent of mental illness among the homeless (Depp & Ackiss, 1983; Lane & Depp, 1986; Morse, Shields, Hanneke, Calsyn, & Burger, 1985; Mowbray & Solarz, 1986).
Alcohol abuse. Participants' level of alcohol abuse was measured using the Michigan Alcoholism Screening Test (MAST; Selzer, 1971; Selzer, Vinokur, & van Rooijen, 1975). The MAST is a 25-item self-report test that serves as a screening tool for alcoholism. Each item consists of a question about drinking that is answered with either a 'yes' or a 'no'. Total scores range from 0 to 53 with a score of 7 as a cutoff score for identifying alcoholics (Selzer, Vinokur, & van Rooijen, 1975). Selzer, Vinokur, & van Rooijen (1975) reported internal consistency reliability coefficients ranging from .83 to .95. Validity evidence for the MAST has been reported by Selzer, Vinokur, & van Rooijen's studies correlating total MAST scores and criterion group membership.

For the current study four of the test items were changed to increase the MAST's suitability for the homeless population (see Appendix H). Specifically, these four items contained references to family members or wives that were changed to more global words like "others" or "anyone". Research has shown that 95% of the homeless are single, divorced, or separated (Morse et al., 1985), and that 74% have no family relationships (Bassuk, Rubin, & Lauriat, 1984).

Data analysis

The first part of the data analysis consisted of an analysis of the internal consistency of the modified Expanded Attributional Style Questionnaire (EASQ; Peterson &
Villanova, 1988). Cronbach's (1951) alpha was used separately with the 15 items contained in the standard version of the EASQ and the 9 items that were developed by the current researcher for use with the homeless population. The internal consistency of all twenty-four items of the revised EASQ was also analyzed.

Two separate sets of analyses were used to test the hypotheses of the study. The first set analyzed the responses of the entire sample of participants. The second set of analyses examined only the responses of participants who were experiencing their first episode of homelessness. This was done to control for a potential confounding of the length of time homeless variable that might be caused by previous episodes of homelessness.

The main analysis consisted of a 4 x 2 Analysis of Covariance (ANCOVA) using the independent variables (length of homelessness, gender) to predict explanatory style. Scores on measures of psychological instability and alcohol abuse were included as covariates in order to control for changes in variance that might be due to these factors instead of the independent variables. The results of this analysis were predicted to be as follows: 1) sheltered homeless people will indicate a more pessimistic explanatory style in proportion to the amount of time they have been homeless, and 2) homeless women will indicate a more pessimistic explanatory style than homeless men.
Pearson correlations were calculated to insure that the results of the ANCOVA were not being confounded by correlations between the covariates and independent variables and between the covariates and the dependent variable. The correlations also were conducted to better understand the relationship between explanatory style, gender, length of time homeless, psychological instability and alcohol abuse among the homeless. Since the results of the correlational analysis suggested a possible confounding, an additional analysis was conducted to better test the hypotheses of the current study. The first two hypotheses were examined with an Analysis of Variance (ANOVA) using gender and length of time homeless to predict scores on the explanatory style measure.

Pearson correlations also were calculated to determine the relationship between scores on the depression scale of the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) and scores on the modified version of the Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988). The third hypothesis states that the results of this analysis would indicate a significant positive relationship between explanatory style and depressive symptoms.

To test the possibility that, as Snow and Anderson's (1991) research suggests, homeless people's experience of helplessness may increase with time on the streets until they
identify with the role of being homeless and then may decrease, a quadratic trend analysis was performed. The fourth hypothesis stated that results would indicate an increase in explanatory style scores (more indicative of a pessimistic explanatory style) between the first (less than one month) and second (one month to six months) length of time homeless conditions, no significant difference in explanatory style scores between the second and third (six months to a year) conditions, and a decrease in scores between the third and fourth (over one year) conditions.

In order to better understand the relationship between length of time homeless, gender, psychological instability, and alcohol abuse two additional analyses were conducted. First, a Multivariate Analysis of Variance (MANOVA) was completed using gender and length of time homeless to predict scores on the twelve subscales of the psychological instability measure. Second, an ANOVA was conducted using gender and length of time homeless to predict alcohol use.

The next part of the data analysis examined patterns indicated in responses given to the demographic information questions, the alcohol abuse measure, and on the individual scales of the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983). Frequency distributions were determined for demographic variables and for each subscale of the BSI. Frequency distributions also were determined for scores on the MAST that were above the cutoff point for indicating an
alcohol abuse problem. The frequency distributions for the subscales of the BSI and for scores on the MAST were sorted by gender.

The final page of the questionnaire presented the question "What do people who have never been homeless need to understand about the homeless?" Participants' answers to this question were submitted to a qualitative analysis (Lincoln & Guba, 1985) to provide information that could be used for two purposes. First, this information could be used to increase understanding of the sheltered homeless population. Second, the information gleaned from the written responses could provide a source of information to confirm or disconfirm two major assumptions of the study. These assumptions are 1) that homelessness is experienced as an uncontrollable aversive event, and 2) that experiencing homelessness may put people at greater risk for prolonged homelessness. Each written response was read and sorted in order to identify recurring themes (Lincoln & Guba, 1985). The assumption of this analysis is that recurring themes are indicative of shared perceptions of the homeless.

The final part of the data analysis included a post hoc analysis. This analysis used t-tests and chi square tests to compare participants with a more pessimistic explanatory style (those who scored at or above the midpoint on the internal, global, and stable and composite scales of the EASQ) with participants with a more optimistic explanatory
style (those who scored below midpoint on the scales of the EASQ). These groups were compared to determine if they differed on demographic variables, alcohol abuse, psychological instability, and length of time homeless. T-tests were used for comparisons between groups on continuous variables (psychological instability and alcohol abuse) and chi square tests were used for comparisons between groups on discrete variables (demographic variables and length of time homeless).
CHAPTER III
RESULTS

Descriptive Statistics

Demographic characteristics

Frequency distributions for demographic characteristics of the entire sample and those of participants experiencing their first episode of homelessness are presented in Table 1.

**Gender.** This sample included sixty-eight female and one hundred male participants. Males represented 59.5% of the sample and females represented 40.5%.

**Age.** Participants ranged in age from 16 to 66 years of age with 90% of the sample between 21 and 51 years of age and 50% between 30 and 45 years of age. The median age for participants was 34.

**Ethnicity.** Slightly over half (52%) of the sample were African Americans (n = 87). This compares to 37% Caucasian (n = 63), 4.8% Native American (n = 8) and .6% (n = 1) Hispanic American. Nine participants (5.4%) did not specify ethnicity.

**Veteran Status.** A little over one-fourth of the sample (26.8%) indicated that they had served in the armed forces (n=45), and of those, fifteen were Vietnam veterans (8.9% of the entire sample.)
Table 1
Demographics of the Sheltered Homeless, Comparing the Entire Sample With Those Experiencing Their First Episode of Homelessness

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Entire Sample</th>
<th>% of Total</th>
<th>First Episode</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>100</td>
<td>59.5%</td>
<td>58</td>
<td>62.4%</td>
</tr>
<tr>
<td>Female</td>
<td>68</td>
<td>40.5%</td>
<td>35</td>
<td>37.6%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>87</td>
<td>51.8%</td>
<td>50</td>
<td>63.8%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>63</td>
<td>37.5%</td>
<td>33</td>
<td>35.5%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>9</td>
<td>5.4%</td>
<td>5</td>
<td>5.4%</td>
</tr>
<tr>
<td>Native-American</td>
<td>8</td>
<td>4.8%</td>
<td>4</td>
<td>4.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>.6%</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never been married</td>
<td>76</td>
<td>45.2%</td>
<td>44</td>
<td>47.3%</td>
</tr>
<tr>
<td>Divorced</td>
<td>41</td>
<td>24.4%</td>
<td>27</td>
<td>29.0%</td>
</tr>
<tr>
<td>Separated</td>
<td>23</td>
<td>13.7%</td>
<td>9</td>
<td>9.7%</td>
</tr>
<tr>
<td>Married</td>
<td>18</td>
<td>10.7%</td>
<td>8</td>
<td>8.6%</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>3.0%</td>
<td>3</td>
<td>3.2%</td>
</tr>
<tr>
<td>Living together</td>
<td>5</td>
<td>3.0%</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>Veteran Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no</td>
<td>123</td>
<td>73.2%</td>
<td>68</td>
<td>73.1%</td>
</tr>
<tr>
<td>yes</td>
<td>45</td>
<td>26.8%</td>
<td>25</td>
<td>36.9%</td>
</tr>
<tr>
<td>Vietnam veteran</td>
<td>15</td>
<td>8.9%</td>
<td>6</td>
<td>6.5%</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Entire Sample</th>
<th></th>
<th>First Episode</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. % of Total</td>
<td>No. % of Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>83</td>
<td>50.3%</td>
<td>45</td>
<td>49.5%</td>
</tr>
<tr>
<td>2</td>
<td>32</td>
<td>19.4%</td>
<td>18</td>
<td>19.8%</td>
</tr>
<tr>
<td>1</td>
<td>22</td>
<td>13.3%</td>
<td>13</td>
<td>14.3%</td>
</tr>
<tr>
<td>5 or more</td>
<td>9</td>
<td>5.5%</td>
<td>6</td>
<td>6.6%</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>6.1%</td>
<td>5</td>
<td>5.5%</td>
</tr>
<tr>
<td>3</td>
<td>9</td>
<td>5.5%</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>56</td>
<td>33.0%</td>
<td>31</td>
<td>33.3%</td>
</tr>
<tr>
<td>9th-11th grade</td>
<td>52</td>
<td>31.0%</td>
<td>22</td>
<td>23.7%</td>
</tr>
<tr>
<td>High school</td>
<td>41</td>
<td>24.4%</td>
<td>26</td>
<td>26.9%</td>
</tr>
<tr>
<td>1st-8th grade</td>
<td>10</td>
<td>6.0%</td>
<td>8</td>
<td>8.6%</td>
</tr>
<tr>
<td>College graduate</td>
<td>8</td>
<td>4.8%</td>
<td>6</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

**Marital Status.** Most of the participants were either single, divorced, widowed, or separated (86.3%). Seventy-six (45.2%) of the participants had never been married, forty-one (24.4%) indicated that they were divorced and twenty-three (13.7%) indicated they were separated. Eighteen (10.7%) participants reported that they were married, five (3.0%) reported that they were living together, and five (3.0%) reported that they were widowed.

**Number of children under eighteen.** Almost half of the sample (49.7%) indicated that they had one or more children under eighteen years of age. Thirty-two (19.4%) reported
having two children, twenty-two (13.3%) reported having one child, ten (6.1%) reported having four children, nine participants (5.5%) reported having five or more children.

**Education.** One third (33%) of the sample indicated that they had received some college education (n=56), and eight participants were college graduates. Forty one (24.4%) were high school graduates and fifty two (31%) had completed between the ninth and eleventh grade. Only 6% (n=10) of the sample indicated that they had less than an eighth grade education, and only one person (.6%) completed no formal schooling.

**Episodes of homelessness.** Ninety-three (58.5%) participants were experiencing their first episode of homelessness. Twenty-five (15.7%) participants had been homeless once before and twelve participants had been homeless twice before. Five percent (n=8) of the sample had been homeless three times before and 13.3% (n=20) had experienced four or more previous episodes of homelessness.

**Psychological instability**

Psychological instability was determined from scores on the Brief Symptom Inventory by using a formula outlined by Derogatis and Melisaratos (1983). According to their formula, an indication of psychological instability is a Global Severity Index (GSI) score greater than or equal to T-score 63, or any two primary dimension scores greater than or equal to T-score 63. In the current study over two-thirds of
the sample (70.2%) received either a Global Severity Index (GSI) score equal to or greater than a T-score of 63 (using non-patient norms) or received a T-score equal to or greater than 63 on two or more primary dimensions (e.g., somatization, obsessive-compulsive). The GSI is the average of all 53 items on the Brief Symptom Inventory and is used as an indicator of current psychological distress level. Those scoring equal to or above a T-score of 63 on the GSI included 71% (n=71) of the males in the sample and 69% (n=47) of the females. See Table 2 for a comparison of homeless men and women who scored above a T-score of 63 on the nine primary dimension scales of the Brief Symptom Inventory.

**Paranoid ideation.** The paranoid ideation dimension focuses on characteristics indicative of a paranoid way of thinking, such as grandiosity, suspiciousness, hostility, fear of loss of control, and delusions. Three-fourths of the sample (75%) scored above a T-score of 63 on the paranoid ideation measure. The high scorers included 76% (n = 76) of the males and 73.5% (n = 50) of the females in the sample.

**Psychoticism.** The psychoticism dimension reflects characteristics indicative of a level of distress ranging from mild interpersonal alienation to psychosis. Almost three-fourths (73.8%) of the sample scored above a T-score of 63 on the psychoticism dimension. High scorers included 77% (n=77) of the male and 69% (n=47) of the female participants.
Table 2
Frequency Distributions for Participants Who Scored above T-score 63 on Nine Dimension Scales of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Women</th>
<th></th>
<th>Men</th>
<th></th>
<th>Total Sample</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>50</td>
<td>73.5</td>
<td>76</td>
<td>76%</td>
<td>126</td>
<td>75.0%</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>47</td>
<td>69.1</td>
<td>77</td>
<td>77%</td>
<td>124</td>
<td>73.8%</td>
</tr>
<tr>
<td>Depression</td>
<td>36</td>
<td>52.9%</td>
<td>73</td>
<td>73%</td>
<td>109</td>
<td>64.9%</td>
</tr>
<tr>
<td>Interpersonal Sensitivity Anxiety</td>
<td>46</td>
<td>67.7%</td>
<td>62</td>
<td>62%</td>
<td>108</td>
<td>64.3%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>35</td>
<td>51.5%</td>
<td>59</td>
<td>59%</td>
<td>94</td>
<td>55.9%</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>30</td>
<td>44.6%</td>
<td>62</td>
<td>62%</td>
<td>92</td>
<td>54.8%</td>
</tr>
<tr>
<td>Obsessive-Compulsive Hostility</td>
<td>32</td>
<td>47.1%</td>
<td>54</td>
<td>54%</td>
<td>86</td>
<td>51.2%</td>
</tr>
<tr>
<td>Somatization</td>
<td>26</td>
<td>38.2%</td>
<td>36</td>
<td>36%</td>
<td>62</td>
<td>36.9%</td>
</tr>
</tbody>
</table>

**Depression.** The depression dimension reflects a range of symptoms indicative of clinical depression. Specific symptoms measured by this dimension include sad mood and affect, lack of motivation, withdrawal from interests and people, suicidal thoughts and feelings of hopelessness. Almost two-thirds (64.9%) of the sample scored above a T-score of 63 on the depression dimension. Males were more represented (73%, n = 73) than were females (52.9%, n = 36) among the high scorers (Chi Square (1 df) = 6.93, p < .01).

**Interpersonal sensitivity (INT).** The Interpersonal Sensitivity dimension focuses on feelings of marked
discomfort in interpersonal interactions due to feelings of personal inadequacy and inferiority. It is suggested that high scores indicate acute self-consciousness with others. Almost two-thirds (64.3%) of the sample scored above a T-score of 63 on the interpersonal sensitivity dimension. This included 62% (n = 62) of the male and 67.7% (n = 46) of the female participants.

Anxiety. The anxiety dimension focuses on feelings of nervousness, fearfulness, terror, restlessness, and apprehensiveness as well as physical complaints associated with anxiety. Over half of the sample (55.9%) scored above a T-score of 63 on the anxiety measure. This included 59% (n = 59) of the male and 51.5% (n = 35) of the female participants.

Phobic Anxiety. Derogatis and Spencer (1982) define phobic anxiety as "a persistent fear response to a specific person, place, object, or situation which is characterized as being irrational and disproportionate to the stimulus, and which leads to avoidance or escape behavior (p.14)." The phobic anxiety dimension focuses on specific fearful situations that are not typically experienced by most people. Over half (54.8%) of the sample scored above a T-score of 63 on the phobic anxiety dimension. There were proportionately more males (62%, n = 62) than females (44.1%, n = 30) among the high scorers (Chi Square (1df) = 4.88, p < .05).
**Obsessive-Compulsive (O-C).** Scores on the O-C dimension reflect thoughts, impulses, and actions that are experienced as unrelenting, irresistible, and unwanted by the individual. Over half (51.2%) of the sample scored above a T-score of 63 on the O-C dimension. This included 54% (n = 54) of the male and 47.1% (n = 32) of the female participants.

**Hostility.** The hostility dimension reflects thoughts, feelings, or actions characteristic of anger, e.g., irritability, rage, urges to harm someone. Less than half (46.4%) of the sample scored above a T-score of 63 on the hostility dimension. This included 51.5% (n = 35) of the female and 43% (n = 43) of the male participants.

**Somatization.** Scores on this dimension reflect distress experienced from cardiovascular, gastrointestinal and respiratory complaints, and other perceptions of bodily dysfunctions. It is designed to measure symptom formation as a way of coping and getting needs met, but also may be reflective of true physical disease. Over one-third (36.9%) of the sample scored above a T-score of 63 on the somatization dimension. This included 38.2% of the females (n = 26) and 36% of the males (n = 36) in the sample.

**Alcohol Abuse**

Close to half of the sample (44.6%, n = 75) scored above the cutoff score indicative of alcohol abuse. Of these there was a greater proportion of males (56%, n = 56) than
females (27.9%, n = 19) among the high scorers (Chi Square (1 df) = 12.10, p < .001).

Internal Consistency

Expanded Attributional Style Questionnaire (EASQ)

Internal consistency reliability coefficients were established using Cronbach’s coefficient alpha. The internal consistency of all five scales of the revised version of the EASQ was quite high. Alpha coefficients ranged from .84 for the internal scale to .90 for the helplessness scale and .91 for the hopelessness scale (see Table 3).

Table 3

Internal Consistency of the Revised Version of the Expanded Attributional Style Questionnaire (EASQ)

<table>
<thead>
<tr>
<th>Items from the EASQ</th>
<th>EASQ Scales</th>
<th>All 24 items</th>
<th>15 original items</th>
<th>9 new items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>.84</td>
<td>.70</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>.89</td>
<td>.80</td>
<td>.81</td>
<td></td>
</tr>
<tr>
<td>Global</td>
<td>.88</td>
<td>.81</td>
<td>.83</td>
<td></td>
</tr>
<tr>
<td>Hopelessness</td>
<td>.91</td>
<td>.86</td>
<td>.84</td>
<td></td>
</tr>
<tr>
<td>Helplessness</td>
<td>.90</td>
<td>.85</td>
<td>.80</td>
<td></td>
</tr>
</tbody>
</table>

Fifteen original items of the EASQ

The internal consistency coefficients of scales composed only from the fifteen items that were in the original version of the EASQ were also quite high. For these scales alpha
coefficients ranged from .70 for the internal scale to .85 for the helplessness scale and .86 for the hopelessness scale.

**Nine new items of the EASQ**

The internal consistency coefficients of scales consisting only of the nine items of the EASQ that were developed by the researcher for the current study were comparable to those for the fifteen original items of the EASQ. For these scales alpha coefficients ranged from .74 for the internal scale to .84 for the hopelessness scale.

**Tests of Hypotheses**

**Preliminary Analyses**

An Analysis of Covariance using psychological instability (as measured by the Brief Symptom Inventory) and alcohol abuse (as measured by the Michigan Alcoholism Screening Test) as covariates and gender and length of time homeless as independent variables failed to support the first hypothesis that stated that sheltered homeless people will indicate a more pessimistic explanatory style as the amount of time they have been homeless increases. The results of this ANCOVA indicated that scores on the measure of explanatory style did not significantly differ across the four length of time homeless conditions (F [3, 167] = .83, n.s.). This result was true for the entire sample as well as those who reported experiencing their first episode of homelessness (F [3, 92] = .88, n.s.).
The results of the ANCOVA also failed to support the second hypothesis that stated that homeless women would indicate a more pessimistic explanatory style than homeless men. The main effect for gender was not significant for the entire sample \( F[1, 167] = 1.22, \text{n.s.} \) or for those experiencing their first episode of homelessness \( F[1, 92] = .45, \text{n.s.} \).

Pearson correlations were calculated to insure that the results of the ANCOVA were not being confounded by correlations between the covariates and independent variables as well as between the covariates and the dependent variable. These correlations are presented in Table 4. The results do suggest a possible confounding due to the relationship between alcohol abuse and explanatory style \( r = .27, \ p < .0003 \), alcohol abuse and length of time homeless \( r = .20, \ p < .01 \), and explanatory style and length of time homeless \( r = .15, \ p < .059 \).

In view of the indication of possible confounding and to better understand the relationship between explanatory style, gender, and length of time homeless among the sheltered homeless population, a separate analysis was conducted. The first two hypotheses of the current study were examined with an Analysis of Variance (ANOVA) using gender and length of time homeless to predict scores on the measure of explanatory style.
Table 4
Correlations Between Scales on the EASQ, Alcohol Abuse, Length of Time Homeless, and Dimensions of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>EASQ Composite</th>
<th>Internal</th>
<th>Stable</th>
<th>Global</th>
<th>Alcohol Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of time homeless</td>
<td>.15</td>
<td>.07</td>
<td>.14</td>
<td>.09</td>
</tr>
<tr>
<td>Somatization</td>
<td>-0.02</td>
<td>-0.06</td>
<td>.002</td>
<td>.01</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>.08</td>
<td>-0.009</td>
<td>.09</td>
<td>.09</td>
</tr>
<tr>
<td>Interpersonal Sensitivity</td>
<td>.05</td>
<td>-0.005</td>
<td>.05</td>
<td>.06</td>
</tr>
<tr>
<td>Depression</td>
<td>.03</td>
<td>.01</td>
<td>.03</td>
<td>.03</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.0008</td>
<td>-0.03</td>
<td>-0.01</td>
<td>.04</td>
</tr>
<tr>
<td>Hostility</td>
<td>.09</td>
<td>.002</td>
<td>.08</td>
<td>.10</td>
</tr>
<tr>
<td>Phobic Anxiety</td>
<td>-0.02</td>
<td>-0.06</td>
<td>-0.01</td>
<td>.03</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>.04</td>
<td>-0.07</td>
<td>.03</td>
<td>.11</td>
</tr>
<tr>
<td>Psychoticism</td>
<td>.04</td>
<td>-0.001</td>
<td>.04</td>
<td>.05</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>.27</td>
<td>.20</td>
<td>.19</td>
<td>.17</td>
</tr>
</tbody>
</table>

**Hypothesis One**

The first hypothesis stated that homeless females and males would indicate a more pessimistic explanatory style as the length of time they had been homeless increased. This hypothesis was not supported by the results of the study. Scores for the composite of the internal, stable, and global scales of the EASQ for participants in different length of time homeless conditions were not significantly different.
(see Table 5). Participants who had been homeless for less than one month (M = 13.25), between one and six months (M = 13.19), between six months and one year (M = 13.73), and over one year (M = 14.04) did not indicate an increasingly more pessimistic explanatory style. The range of the scores for the composite of the scales of the EASQ is from 3 to 21 with a midpoint of 12.

**Hypothesis Two**

The second hypothesis stated that homeless females would indicate a more pessimistic explanatory style than homeless males as measured by the Expanded Attributional Style Questionnaire (EASQ; Peterson & Villanova, 1988). Though a significant main effect for gender was indicated on the measure of explanatory style, $F(1, 167) = 4.71$, $p < .03$, it was contrary to the hypothesis (see Table 6).

Results of the ANOVA suggested that homeless males have a more pessimistic explanatory style (M = 13.82) than homeless females (M = 12.99). The reported means are for composites of the internal, global, and stable scales of the EASQ.

This main effect was indicated for the helplessness scale of all twenty-four items of the revised version of the EASQ (reported above), for the helplessness scale consisting only of the fifteen original items of the EASQ ($F(1, 167) = 3.89$, $p < .05$) and for the helplessness scale
consisting of only the nine items developed by the researcher for the current study ($F [1, 167] = 3.93, p < .05$).

Table 5

Mean Scores on the EASQ by Length of Time Homeless

<table>
<thead>
<tr>
<th>Length of Time Homeless</th>
<th>Mean</th>
<th>S. D.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than one month</td>
<td>13.25</td>
<td>2.20</td>
<td>64</td>
</tr>
<tr>
<td>one month--six months</td>
<td>13.19</td>
<td>1.83</td>
<td>42</td>
</tr>
<tr>
<td>six months--one year</td>
<td>13.73</td>
<td>2.00</td>
<td>25</td>
</tr>
<tr>
<td>over one year</td>
<td>14.05</td>
<td>2.53</td>
<td>37</td>
</tr>
</tbody>
</table>

Table 6

Mean Scores on the EASQ by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean</th>
<th>S. D.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>13.82</td>
<td>2.15</td>
<td>100</td>
</tr>
<tr>
<td>females</td>
<td>12.99</td>
<td>2.13</td>
<td>68</td>
</tr>
</tbody>
</table>

Hypothesis Three

The third hypothesis predicted a significant positive relationship between scores on the depression scale of the BSI and scores on the modified EASQ. This prediction was not supported by the analysis. Pearson correlations for the composite of the explanatory style and depression scales were .03 and correlations between the depression scale and the internal ($r = .01$), stable ($r = .03$), and global ($r = .03$) scales also were insignificant.
Hypothesis Four

The final hypothesis predicted a quadratic trend for scores on the EASQ over the four length of time homeless conditions. A quadratic trend ($F \{1, 92\} = 5.20, p < .02$) was indicated only with scores on the stable scale of the EASQ for participants who indicated they had not been homeless before (see Table 7). The quadratic trend for scores on the stable scale were in the direction predicted, indicating an increase in scores between the first ($M = 3.93$) and second ($M = 4.37$) length of time homeless conditions, no significant difference between the second and third ($M = 4.62$) conditions, and a decrease between the third and fourth ($M = 4.19$) conditions. Scores on the stable scale of the Expanded Attributional Style Questionnaire range from 1 to 7, with a midpoint of 4.

Table 7
Mean Scores on the Stable Scale of the EASQ by Length of Time Homeless for Participants Experiencing their First Episode of Homelessness

<table>
<thead>
<tr>
<th>Stable Scores</th>
<th>Mean</th>
<th>S. D.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Time Homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than one month</td>
<td>3.93</td>
<td>.72</td>
<td>36</td>
</tr>
<tr>
<td>one month--six months</td>
<td>4.37</td>
<td>.75</td>
<td>26</td>
</tr>
<tr>
<td>six months--one year</td>
<td>4.62</td>
<td>1.19</td>
<td>14</td>
</tr>
<tr>
<td>over one year</td>
<td>4.19</td>
<td>1.13</td>
<td>17</td>
</tr>
</tbody>
</table>
These results indicated that people who had been homeless between one month and six months and between six months and one year explained negative events with more stable causes than did people who had been homeless less than one month and over one year. There were no significant quadratic trends indicated for scores on the global, internal, or composite scales of the EASQ. This hypothesis received only limited support.

Psychological Instability Among the Homeless

In order to better understand the relationship between psychological instability, and gender and length of time homeless, a Multivariate Analysis of Variance was conducted on the nine primary dimensions of the Brief Symptom Inventory. Results of the MANOVA indicated an overall main effect for gender (Wilks' Lambda = .81, F (12, 151) = 2.27, p < .01). Univariate F tests were used to identify the dependent variables on which homeless men and homeless women differed. Results indicated a main effect for gender on three scales of the Brief Symptom Inventory (see Table 8). Homeless women scored higher (M = 1.38) than homeless men (M = .98) on the interpersonal sensitivity scale, F (1, 166) = 7.02, p < .008. Homeless women also scored higher (M = 1.27) than homeless men (M = .99) on the anxiety scale of the BSI, F (1, 166) = 4.08, p < .04. This pattern was repeated on the paranoid ideation scale of the BSI with homeless women indicating higher scores (M = 1.70) than
Results of this MANOVA did not indicate an overall effect for length of time homeless (Wilks' Lambda = .80, $F(36, 446.87) = .99$, n.s.).

Table 8

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Males Mean</th>
<th>S. D.</th>
<th>Females Mean</th>
<th>S. D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Sensitivity</td>
<td>.98</td>
<td>.84</td>
<td>1.38</td>
<td>1.02</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.99</td>
<td>.86</td>
<td>1.27</td>
<td>.98</td>
</tr>
<tr>
<td>Paranoid Ideation</td>
<td>1.43</td>
<td>.89</td>
<td>1.70</td>
<td>.98</td>
</tr>
</tbody>
</table>

Alcohol Abuse Among the Homeless

In order to better understand the relationship between alcohol abuse, gender, and length of time homeless an Analysis of Variance (ANOVA) was conducted. Results of the ANOVA conducted using gender and length of time homeless to predict alcohol abuse indicated a significant main effect for gender, $F(1, 167) = 21.35, p < .0001$ (see Table 9). Homeless men indicated higher levels of alcohol abuse ($M = 16.68$) than homeless women ($M = 6.30$). There was no significant main effect for length of time homeless indicated by the results of this ANOVA, $F(3, 167) = 1.47$, n.s.

Pearson correlations were calculated to examine the relationship between alcohol abuse and explanatory style among the sheltered homeless population.
calculated between scores on the Michigan Alcoholism Screening Test and scores on the scales of the measure of explanatory style (see Table 10). The strongest relationship was observed between reported alcohol abuse and the hopelessness scale of the EASQ ($r = .22$, $p < .005$). The hopelessness scale is a composite of the global and stable scales of the EASQ. High scores suggest that a person habitually explains negative events with persistent and pervasive causes. Correlations also were significant between scores on the MAST and the internal ($r = .21$, $p < .007$), stable ($r = .19$, $p < .01$), and global ($r = .17$, $p < .02$) scales of the EASQ.

Table 9
Mean Scores on the Michigan Alcohol Screening Test by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean</th>
<th>S. D.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>males</td>
<td>16.68</td>
<td>15.78</td>
<td>100</td>
</tr>
<tr>
<td>females</td>
<td>6.30</td>
<td>8.06</td>
<td>68</td>
</tr>
</tbody>
</table>

Table 10
Correlations between Alcohol Abuse Scores and Scales of the EASQ

<table>
<thead>
<tr>
<th></th>
<th>Hopelessness</th>
<th>Internal</th>
<th>Stable</th>
<th>Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>.22</td>
<td>.21</td>
<td>.19</td>
<td>.17</td>
</tr>
</tbody>
</table>

Scores on the alcohol abuse measure also were related to many of the dimensions of the Brief Symptom Inventory (see Table 11). The strongest relationship was observed between reported alcohol abuse and scores on the Positive Symptom
Total(PST) scale (\( r = .26, \ p < .0006 \)). The PST scale is an indicator of the actual number of symptoms endorsed on the BSI. Reported alcohol abuse also was significantly correlated with the obsessive-compulsive (\( r = .21, \ p < .005 \)), the General Severity Index (\( r = .18, \ p < .01 \)), and anxiety (\( r = .18, \ p < .02 \)), psychoticism (\( r = .15, \ p < .04 \)), and hostility (\( r = .15, \ p < .04 \)) dimensions of the BSI.

Table 11

Correlations between Alcohol Abuse Scores and Scales of the BSI

<table>
<thead>
<tr>
<th>Positive Symptom Total</th>
<th>Obsessive-Compulsive</th>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>0.26</td>
<td>0.21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Severity Index</th>
<th>Psychoticism</th>
<th>Hostility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse</td>
<td>0.18</td>
<td>0.15</td>
</tr>
</tbody>
</table>

Additional Post Hoc Analyses

T-tests were conducted to compare a more pessimistic explanatory style group (participants who scored at or above the midpoint on the stable, internal, global and composite scales of the measure of explanatory style) with a more optimistic explanatory style group (participants who scored below the midpoint on the stable, internal, global and composite scales of the EASQ) on self-reported alcohol abuse, age and on dimensions of psychological instability. Results indicated that only the obsessive-compulsive dimensions of
the BSI and alcohol abuse were found to differentiate the
groups.

Specifically, participants with a more pessimistic
explanatory style obtained scores more indicative of an
obsessive-compulsive type of psychological distress than
participants with a more optimistic explanatory style, \( t \) (166 df) = -2.54, \( p < .01 \). Also, participants who tended
to explain negative events with more global causes had higher
alcohol abuse scores than participants who used more specific
explanations, \( t \) (129.1 df) = -2.80, \( p < .006 \). Similarly,
participants who tended to explain negative events with more
stable causes had higher alcohol abuse scores than
participants who used more unstable explanations, \( t \) (166 df)
= -1.98, \( p < .05 \).

Chi square tests were conducted to compare a more
pessimistic explanatory style group (participants who scored
at or above the midpoint on the stable, internal, global and
composite scales of the measure of explanatory style) with a
more optimistic explanatory style group (participants who
scored below the midpoint on the stable, internal, global and
composite scales of the EASQ) on length of time homeless,
education level, marital status, and ethnicity. Results
indicated that only length of time homeless differentiated
the groups.

As length of time homeless increased percentages of
homeless who tended to explain negative events with global
causes also increased (Chi square (3 df) = 8.04, p < .04. Eighty-six percent of those who had been homeless for over one year tended to explain negative events with global causes. This compares with 76% of those who had been homeless between six months and one year, 59% of those who had been homeless between one month and six months, and 65.6% of those who had been homeless for less than one month.

Analysis of Written Responses

All but two of the participants wrote a response to the question "what do people who have never been homeless need to understand about the homeless?" Written responses were detached from the questionnaire, read, and sorted into categories based on shared content. Eleven recurrent themes emerged from the analysis of the responses. Response frequencies for each theme are presented in Table 12.

Comments about the physical and emotional stress and pain of being homeless, reported by 29% of the homeless respondents, were the most common type of response. The most frequent complaint in this category was that homelessness is stressful, hard, and lonely. For example, respondents wrote:

It's not fun and it is hard for kids. Take it from me. I am only sixteen years old.

When I became homeless I felt as though the world had caved in around me. I felt as though I had lost my last friend in the world.

Some homeless people wrote about the hopelessness and negative thoughts that can affect motivation to get back off the streets. Examples of such responses include:
Being homeless is a very unstabalizing condition; a person can become emotionally and mentally unbalanced if a state of homelessness goes on for too long. Negative thoughts and feelings can become prevalent.

It makes you feel alone, like the things you did in your life were all a waste and there’s no use of even trying.

A number of the homeless respondents wrote about feeling trapped, physically uncomfortable, humiliated, frightened, sad, and struggling with a great deal of loss. Sample responses include:

- Starving is the worst feeling in the world.
- It is humiliating, humbling, destroys self-esteem.

One fourth (25%) of the respondents commented on how homelessness can happen to anybody and can happen unexpectedly. Several comments in this category contained advice for people who are not homeless to avoid becoming homeless. Sample responses include:

- Always be thankful and don't think that it couldn't happen to you—tomorrow is a new day not seen.

- Instability is built into the system; most of us are standing on shakey ground and the bottom can fall out anytime.

Almost one-fourth of the respondents (24%) wrote about how homeless people are human, too. The majority of comments in this category were statements that homeless people are human just like everybody else. A number of respondents also wrote that the homeless have feelings like everybody else and want the same things in life that people who are not homeless. Examples of such responses include:
We are people, too! It's not that you are people because you have a house and we aren't because we don't.

We are trying to get the same things out of life as you are.

Table 12

Recurrent Themes in Written Responses
(n = 166)

<table>
<thead>
<tr>
<th>Theme</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being homeless is physically and emotionally stressful and painful</td>
<td>49</td>
<td>29%</td>
</tr>
<tr>
<td>Being homeless can happen to anybody</td>
<td>41</td>
<td>25%</td>
</tr>
<tr>
<td>Homeless people are humans, too</td>
<td>40</td>
<td>24%</td>
</tr>
<tr>
<td>Don't stereotype, judge, or look down on homeless people</td>
<td>40</td>
<td>24%</td>
</tr>
<tr>
<td>Homelessness is not always a choice and is not always the homeless person's fault</td>
<td>29</td>
<td>17.5%</td>
</tr>
<tr>
<td>Homelessness is not a character flaw</td>
<td>28</td>
<td>16.9%</td>
</tr>
<tr>
<td>Homeless people need help from others</td>
<td>28</td>
<td>16.9%</td>
</tr>
<tr>
<td>Factors contributing to homelessness--personal level</td>
<td>27</td>
<td>16.3%</td>
</tr>
<tr>
<td>We're all in this together; we're all a part of God's plan</td>
<td>20</td>
<td>12%</td>
</tr>
<tr>
<td>Homeless people need to help themselves</td>
<td>17</td>
<td>10.2%</td>
</tr>
<tr>
<td>Homelessness is a growing problem--need to do something about it</td>
<td>15</td>
<td>9%</td>
</tr>
<tr>
<td>Resources for the homeless are inadequate or unavailable</td>
<td>12</td>
<td>7.2%</td>
</tr>
<tr>
<td>Factors contributing to homelessness--societal level</td>
<td>10</td>
<td>6%</td>
</tr>
</tbody>
</table>

Comments requesting others not to stereotype, judge, or look down upon homeless people were reported by 24% of the respondents. The most frequent comment in this category were specific requests not to look down upon homeless people. In
addition to requests to not judge the homeless, respondents wrote about how difficult it is to understand homelessness unless you've experienced it. Respondents also wrote about the uniqueness of each homeless person's experience and inaccuracy that would result from attempts to stereotype the homeless. Samples of responses in this category include:

Homeless people should be respected as people not having a home and should not be put down because of it

Cannot understand unless you walk in my shoes.

You can't lump them or categorize them--people and personalities are varied.

Twenty-nine respondents (17.5%) wrote comments about how homelessness is not always a choice, is not always the homeless person's fault, and is sometimes due to bad luck or things going wrong that are uncontrollable. Sample responses include:

It's not always our fault that we are homeless.

There are some good people here that just ran into bad luck.

The next category includes comments, offered by 16.9% of the respondents, that stated homelessness is not a character flaw. Responses in this category included comments stating that all homeless people are notbums, bad people, drug addicts or alcoholics, criminals, or mentally ill. Examples of such responses include:

All homeless people are not shiftless, worthless pieces of trash.

All homeless people are not bums. Some have a good education, good background, and a sound mind.
We are not criminals, just really poor.

Comments suggesting that homeless people need help from others were offered by 16.9% of the respondents. Comments included in this category are those suggesting that homeless people can become members of society again with help from others and that homeless people deserve a second chance.

Sample responses include:

Some of us really need help. I have a ten year old daughter and nowhere to go and no one to help.

Please give the homeless a chance to get back in society where they belong.

Comments about factors that contribute to homelessness at a personal level were offered by 16.3% of the respondents. The majority of responses in this category were accounts of personal experiences. Specific factors that contribute to homelessness at a personal level suggested by respondents included drugs and alcohol, mental illness, family problems, health problems, eviction, relocating from another area, and unemployment. Examples of responses in this category include:

For young people like me I am where I don't care, can't handle responsibilities and don't want to, have bad self-esteem, turn to alcohol or drugs to get away from my problems. Have a self-destructive attitude and it's hard to break. In a vicious cycle of teenage pregnancy, welfare, and alcoholism. Nobody is stopping me from getting my act together but me.

Came here from Greenville, South Carolina to live in my grandparent's house but when I got here there were no lights, gas, or water and I didn't have the money to get it turned on.
Comments about us all being in this together and all being part of God's plan were offered by 12% of the respondents. Comments in this category suggested that we are all one people, that God has a plan, and that faith will get you through tough times. For example, respondents wrote,

- We need to love one another, share our blessings and remember who was turned away from the inn 2,000 years ago.
- Faith in God can get you through.

Comments about ways that homeless people need to help themselves were offered by 10.2% of the respondents. Respondents noted that most homeless people want to do better, that homeless people need motivation and self-respect, and that help is available if the homeless help themselves and allow themselves to be helped. Examples of such responses include:

- No matter how down and out if you want to better yourself need to motivate yourself to do something about it.
- There must be respect for one's self.

Comments about homelessness being a serious, growing, societal problem that needs to be addressed were offered by 9% of the respondents. Some of the homeless wrote about the increases in homelessness, reasons for the increases, and some efforts that need to be made. Sample responses include:

- They are not an endangered species but a growing one.
- People deny homelessness due to fear.
- Prevention efforts are key to ending homelessness.
Comments about inadequate or unavailable resources for the homeless were offered by 7.2% of the respondents. The majority of comments in this category addressed the need for more shelters and assistance in locating housing. Comments about help not reaching the most needy or sometimes harming those it was intended to benefit were offered by a number of the respondents. Other comments were suggestions for needed services. Specifically, the respondents suggested greater accessibility and centralized locations for shelters, more assistance in finding employment, and more food, clothing, and counseling available. Examples of comments in this category include:

Need more shelter for the homeless and their children.

Those who try to help sometimes cause more injury and harm than good.

Finally, comments about factors that may contribute to homelessness on a societal level were offered by 6% of the respondents. The factors noted most often were a lack of affordable housing, unemployment, and job discrimination. Other factors noted included low minimum wage, low welfare payments, overly strict building codes, and landlord freedom to choose and evict tenants. Examples of such responses include:

There's constant trouble finding affordable housing.

Jobs hard to come by because you are being judged by lack of appearance and background experience and no place to put as an address.

A minimum wage job won't get you a place to live.
CHAPTER IV
DISCUSSION

The current study applied the reformulated theory of learned helplessness as a model for understanding the experience of being homeless. The experience of homelessness was viewed as a series of uncontrollable aversive events. It was suggested that increased exposure to homelessness might be related to a more pessimistic explanatory style which in turn could lead to more persistent and pervasive learned helplessness deficits and a loss of self-esteem. The learned helplessness deficits that have been observed in humans and animals following exposure to an uncontrollable aversive event include decreased appetite and interest in usual activities, depressed mood, self-blame, decreased ability to concentrate and profit from new learning, decreased energy, and passivity (Seligman, 1990). The parallels between these symptoms and symptoms of depression led Seligman to the reformulated theory of learned helplessness as a model for depression.

The current study was conducted with three major purposes in mind. The first purpose was to examine the relationship between explanatory style, gender, & length of
time homeless in a sheltered homeless population. The second purpose was to provide demographic information, and estimates of alcohol abuse and psychological instability among the homeless. The third purpose of the study was to explore the potential benefit of future applications of the reformulated theory of learned helplessness to the homeless experience.

This chapter consists of five sections. The major findings and interpretations are discussed, followed by a discussion of implications of the results for clinical practice, methodological limitations of the current study, suggestions for future research, and summary and conclusions.

**Major Findings and Interpretations**

The first hypothesis for the current study was that the longer sheltered homeless people have been homeless, the more pessimistic their explanatory style. This hypothesis was not supported by the results of the current study. Homeless people indicated a similar explanatory style across all four of the length of time homeless conditions. Two possible explanations are offered for this finding.

The first is that explanatory style may be a stable trait. This explanation is supported by a number of studies that have shown that explanatory style tends to remain consistent over long periods of time (Burns & Seligman, 1989; Peterson, Seligman, & Vaillant, 1988).

The second possible explanation is that the instrument used to measure explanatory style may have measured only
explanations for actual events. Peterson & Seligman (1984) noted that explanatory style is made up of a person's characteristic way of responding to events and the explanations that would be true for certain events. They suggested that when an explanation for an event is not obvious to a person, he or she tends to use a characteristic way of explaining events. The instructions for the measure of explanatory style ask the respondents to imagine that they are experiencing the event that is presented. It is assumed that respondents will treat each event presented as a hypothetical one, instead of a real one. In the current study, however, the nine replacement items were chosen specifically because they were likely to be events that the homeless had experienced. Therefore, it is possible that when providing causes and explanations for the events presented in the nine replacement items, they were responding to events that had happened to them. Furthermore, the internal consistency of all twenty-four items of the measure of explanatory style may suggest that respondents were providing actual causes and explanations for many of the items.

Although participants who had been homeless longer did not seem to have a more pessimistic explanatory style than other homeless participants, they did appear to be more depressed. Scores on the depression dimension of the Brief Symptom Inventory were positively correlated with the four
length of time homeless conditions. As length of time homeless increased, scores on the depression dimension became more indicative of depression, suggesting that sheltered homeless people may be more depressed with prolonged homelessness. This result is consistent with learned helplessness theory which states that humans exposed to uncontrollable events will experience learned helplessness deficits that parallel symptoms of depression.

The second hypothesis of the current study stated that homeless women will indicate a more pessimistic explanatory style than homeless men. The results of the current study did not support this hypothesis. In fact, the opposite pattern was observed. Sheltered homeless men indicated a more pessimistic explanatory style than sheltered homeless women. This suggests that homeless men residing in shelters may habitually explain negative events with more personal, persistent, and pervasive causes than homeless women residing in shelters. These results are inconsistent with results reported by Dweck and Light (1980) who observed that females had more pessimistic explanatory styles than men. The results of the current study, however, are consistent with research indicating that homeless men experience a harsher, poorer quality of life and provision of services and care than homeless women (Morse et al., 1985).

Additional information about the differences in explanatory style observed in the current study between males
and females might be found in the differences observed between males and females on self-reported alcohol abuse. In the current study there were significantly more men than women who scored in the range indicative of alcohol abuse on the Michigan Alcoholism Screening Test. The results also indicated a significant positive correlation between alcohol abuse and explanatory scores. This suggests that observed gender differences in explanatory style may have involved gender differences in self-reported alcohol abuse as well as explanatory style.

The third hypothesis of the current study stated that scores on the depression scale of the Brief Symptom Inventory will indicate a significant positive relationship with scores on the explanatory style measure. This hypothesis was not supported by the results of the current study. These results are inconsistent with results from a large number of studies that have indicated that as explanatory style becomes more pessimistic, scores on depression measures increase (see for example Eaves & Rush, 1984; Ganellen, 1988; Peterson, Bettes, & Seligman; Sweeney, Anderson, & Bailey, 1986).

As mentioned previously, it is possible that the hypothetical events presented in the EASQ were treated as real events by the participants of the current study. If so they may have responded with explanations for actual events rather than from an habitual way of explaining negative events. This explanation is consistent with Peterson,
Villanova, & Raps' (1985) finding that researchers whose sample did not indicate a significant positive relationship between depression scores and explanatory style, had not distinguished well between explanatory style and explanations for real events.

The fourth hypothesis of the current study stated that scores on the measure of explanatory style would be higher (more indicative of a pessimistic explanatory style) for participants in the second and third length of time homeless conditions than in the first and fourth length of time homeless conditions. The results of the current study provided only limited support for this hypothesis. Results indicated that people who had been homeless between one month and six months and between six months and a year were more likely to explain negative events with stable causes than were people who had been homeless for less than one month and over one year. These results are somewhat consistent with Snow and Anderson's (1991) observation that helplessness among homeless people seems to increase after they first became homeless and gradually decreases as they become more adept at negotiating the demands of being homeless. The fourth hypothesis was not supported by the results of the current study for the internal, global, or composite scales of the EASQ.

Demographic information obtained in the current study is consistent with that obtained by researchers, service
providers, and policy makers who have expressed concern about
the changing composition of the homeless population (Fischer
& Breakey, 1991; Rossi, 1990). Almost all of the homeless
participants in the current study were 51 years of age or
younger, and either single, divorced, widowed, or separated.
Close to half of the homeless participants were women, half
reported having children below the age of 18, and over half
classified themselves as belonging to racial minorities.
This information is consistent with researchers who have
noted that the "new homeless" population is younger, with
increasing proportions of women, minorities, and families
(Morse et al., 1985; Ryan, Goldstein, & Bartelt, 1989; Sosin,

The estimate of psychological instability among the
homeless in the current study was quite high. Over two-
thirds of the participants' scores on the Brief Symptom
Inventory were indicative of psychological instability. This
rate of mental illness is much higher than estimates reported
by a number of researchers (Kahn, Hannah, Hinkin, Montgomery,
& Pitz, 1987; Koegel, Burnam, & Farr, 1988; Roth, Bean, Lust,
& Saveanu, 1985). The high incidence of psychological
instability among the homeless in the current study may be
due in part to the use of a sample that included only
homeless people residing in shelters. Although the use of
sheltered homeless samples has been criticized for
representing the highest functioning among the homeless
population, some researchers have noted that rates of mental illness, and alcohol and drug abuse are highest among those sampled in shelters, on streets, and in clinics (see Fischer and Breakey, 1991).

The patterns of psychological instability reported by the homeless in the current study indicated some differences in rates for men and women. In the current study men were more likely than women to have scores indicative of overall psychological instability, and were more likely to have scores above T-63 on the psychoticism, depression, anxiety, phobic anxiety, and obsessive-compulsive dimensions. In contrast, women were more likely to have high scores on the interpersonal sensitivity, and hostility dimensions of the psychological instability measure. Women also indicated significantly higher scores on the interpersonal sensitivity, anxiety, and paranoid ideation dimensions. These findings are inconsistent with results from several studies that indicate that homeless women tend to have higher rates of mental illness than homeless men (Crystal; 1984; Robertson, Ropers, & Boyer, 1985; Vernez, et al., 1988).

Estimates of psychological instability were highest on four dimensions of the Brief Symptom Inventory. Scores for psychological instability were highest for the paranoid ideation, psychoticism, depression, and interpersonal sensitivity dimensions. This finding seems consistent with Fischer and Breakey's (1991) observation that the
psychological difficulties experienced by the homeless are the ones most likely to interfere with their ability to form close relationships.

In the current study almost one-half of the sheltered homeless population obtained scores on the Michigan Alcoholism Screening Test high enough to indicate alcohol abuse. This rate is consistent with ones obtained by researchers who found that 45% of the homeless population tends to abuse alcohol (Koegel, Burnam, & Farr, 1988; U. S. Conference of Mayors, 1989). The rates of alcohol abuse indicated in the current study for homeless men and women are almost six times greater than estimated rates (10% for men and 3-5% for women) for the general population (Fischer & Breakey, 1991).

In the current study participants' scores on the Michigan Alcohol Screening Test (MAST) were correlated with several dimensions of the Brief Symptom Inventory. As MAST scores became more indicative of alcohol abuse participants' scores on the obsessive-compulsive, anxiety, psychoticism, and hostility dimensions became more indicative of psychological instability. These results are consistent with those obtained by researchers who noted that homeless people who abuse alcohol are also likely to suffer from mental illness and impairment in social functioning (Fischer and Breakey, 1991; Koegel & Burnam, 1988).
An unexpected finding in the current study was the high correlation between explanatory style and alcohol abuse. As noted earlier, it is possible that participants responded to some of the items on the Expanded Attributational Style Questionnaire with realistic causes and explanations for actual events that had occurred rather than from a habitual way of responding to hypothetical negative events. If respondents who were alcohol abusers listed alcohol abuse as a cause for one of the hypothetical negative events presented, it is possible that the realistic actual explanations for the cause would be rated as something that is due to them (internal), likely to last for a while (stable), and likely to affect many areas of their lives (global).

An alternative explanation for the correlation between alcohol abuse and explanatory style might be found in an examination of one of the most common methods for treating alcohol abuse, the twelve-step recovery program developed by Alcoholics Anonymous. The first of these steps requires alcohol abusers to admit they have no control over alcohol abuse. Learned helplessness deficits that have been observed in humans and animals did not follow an aversive event, but one that was or was perceived to be uncontrollable.

Methodological Limitations

The first methodological limitation of the current study concerns the generalizability of the results to the homeless
The participants in the current study were homeless people who were residing at a shelter at the time they completed the questionnaire. In addition, the participants were self-selected rather than randomly assigned. These factors suggest that the results should be interpreted with caution when used with non-sheltered homeless people.

A second limitation is the use of a correlational design which does not allow any causal interpretations of the results. The observed increase in depression scores across the four length of time homeless conditions may have been due to prolonged homelessness or may have been due to initial differences in level of depression between people in the different conditions.

A third methodological limitation with the current study is the lack of a control group. The lack of a control group makes it difficult to determine if the results obtained were due to the relationships between the variables of the study or moderator variables. For example, a man who had been homeless for over a year may have been depressed because he was recently divorced rather than because he had been homeless for over a year.

There were two methodological concerns with the instruments used in the current study that limit the interpretability of the test scores. The majority of the respondents' scores on the EASQ fell above the midpoint for
each scale. Since the scores were fairly high for all of the respondents it is possible that a ceiling effect may have precluded greater differentiation of explanatory style. In addition, the lack of norms for the EASQ for homeless people makes it difficult to say that homeless people have a more pessimistic style of explaining events than people with homes.

Scores of most participants on the Brief Symptom Inventory were higher than those for people included in the non-patient norm sample. The lack of norms for the homeless population is particularly problematic for measures of psychological instability. Several researchers have noted that homeless people frequently endorse items on measures of psychological instability that reflect behaviors that may be adaptive for homeless people, but indicative of psychological instability in people with homes (Bean, Stefl, & Howe, 1987; Koegel, Burnam, & Farr, 1988; Snow, Baker, & Anderson, 1986). Information from both the EASQ and the BSI may have limited generalizability to other contexts.

The second methodological concern with the instruments used in the current study is specific to the Expanded Attributional Style Questionnaire (EASQ). In the current study it is difficult to determine if the EASQ was measuring the explanatory style of the sheltered homeless people or their causes and explanations for real events they had experienced. Also, some of the homeless people appeared to
have difficulty with the notion of imagining the negative events. This seems understandable when the context of their life situation is considered. Perhaps being asked to imagine or pretend that an aversive event is happening to you makes less sense when you are experiencing one.

A final question that might be raised about the current study is the accuracy of information obtained by the self-report method. The anonymity of participants may have helped insure that the self-report information was accurate and, in addition, several studies with the homeless population have found that the information obtained through self-report data collection techniques was reliable and valid (see, for example Robertson, Ropers, & Boyer, 1985).

**Implications for Practice**

The results of the current study may offer suggestions for psychologists and other providers of service for the homeless. First, the high rates of psychological instability and alcohol abuse call attention to a need for psychologists to become involved in the development and implementation of programs related to alcohol abuse and psychological instability among the homeless. Programs could be developed for the homeless and for service providers for the homeless, such as shelter staff. The latter could involve training for new staff and periodic workshops.

The current study found that the majority of its homeless participants were disaffiliated from others. Since
research has suggested that social support can moderate the harmful effects of stressful experiences (Cohen & McKay, 1985; Cohen & Will, 1983; Heller & Swindle, 1983; Silver & Wortman, 1980; Thoits, 1982), support groups might be of benefit to the sheltered homeless. Psychologists and service providers could develop and facilitate support groups that focus on topics of importance to homeless people.

One topic that may be of interest to homeless people is the experience of homelessness. Almost all of the participants wrote a response to the question "What do people who have never been homeless need to understand about the homeless?" at the end of the questionnaire. This seemed to be an affirming experience for them, and many stayed after finishing the questionnaire to tell more about their experiences and to express thanks for being given the opportunity to "tell it like it is." This suggests that the possibility of engaging the homeless in a discussion of their experiences and struggles as a homeless person is quite high.

Another way that psychologists and service providers might assist the homeless is to help them increase a sense of personal control over the events they experience. The results of the current study with respect to the incidence of pessimistic explanatory styles, and the relationship found between length of time homeless and level of depression suggest that learned helplessness may be operating with homeless people who reside in shelters. A greater sense of
control over an aversive event, even if that does not alter the intensity or duration of the event itself may help prevent depressive symptoms that may follow an uncontrollable aversive event.

Goodman, Saxe, and Harvey (1991) recommend several ways that a sense of personal control could be increased among homeless people residing in shelters. First, they suggest that shelter residents be given as much responsibility for the organization of the shelter as they are willing to take. This includes allowing the residents to negotiate rules and task assignments and arrange information sharing meetings between staff and residents of shelters. Second, they suggest that shelter staff provide as much information as possible to residents about their entitlement to benefits. Third, they suggest that shelter staff assist residents in developing a feasible set of goals for how to end their homelessness.

**Recommendations for Research**

The results of the current study and its methodological limitations suggest several recommendations for future research. First, research with the homeless needs to include designs that allow for causal interpretations of the results. Longitudinal or time-series designs would be useful for clarifying causal and reciprocal effects of variables of interest. It will be important for future research to address the causal factors by which homelessness affects
explanatory style and depression and exlanatory style and depression affect homelessness. In addition, longitudinal designs would allow researchers to begin to discover other variables that may distinguish people who are only homeless for a short while from people who experience prolonged homelessness.

A second recommendation for research with the homeless concerns the use of a control group. There are a multitude of moderator variables that could be responsible for changes in explanatory style, depression, and other variables among the homeless. In order to rule out potential effects of moderator variables future research needs to attempt to control for the effects of extreme poverty experienced by people with and without homes.

The use of a control group also could be helpful in understanding better the relationship between a pessimistic explanatory style and alcohol abuse indicated in the results of the current study. An experimental design utilizing a sample of inpatient non-homeless, outpatient non-homeless, and homeless people who abuse alcohol might allow researchers to associate a pessimistic explanatory style with homelessness or alcohol abuse with more certainty. This type of design also might permit researchers to rule out an effect due to the loss in personal control that seems to occur when one resides in an institutional setting.
There are several changes that would improve the design of the current study and allow for a better test of the reformulated theory of learned helplessness among the homeless. The diathesis-stress aspect of the reformulated helplessness theory states that depression will be experienced by people with a pessimistic explanatory style following an aversive event. This could be tested by using a large sample of people who may be at-risk for becoming homeless. People living in extreme poverty could be randomly chosen to participate in the study. Explanatory style and level of depression could be measured at the beginning of the study and at subsequent follow-up times. This would allow for a comparison of those who became homeless and those who did not. This design also would allow an examination of the tenets of the reformulated theory that state that homeless people who have a pessimistic explanatory style before becoming homeless are more likely to experience depression following homelessness.

The third recommendation for future research with the homeless concerns the instruments chosen to measure the variables of interest. Research with the homeless would benefit from the development of norms for use with the homeless population for measures of psychological instability and other variables of interest. Future research with the homeless also would benefit from the development of new
instruments that are standardized on the homeless population and that take into account the context of homelessness.

In addition to recommendations for the use of standardized measures with the homeless population, there are some specific recommendations for the use of the Expanded Attributional Style Questionnaire (EASQ) with the homeless. First, it is recommended that the instrument be simplified. One way this could be done would be to provide an event, e.g., "you lost your wallet" and provide three possible explanations. The first explanation would be reflective of an internal explanation, e.g., "you lost it", the second explanation would be reflective of an external explanation e.g., "someone stole it", and the third explanation would allow the respondent to choose neither explanation provided, e.g., "unsure".

A second recommendation for using the EASQ with the homeless is for researchers to provide a means to distinguish between explanatory style and actual explanations of events. One possible way to distinguish between these two constructs would be to ask respondents who have completed the questionnaire to go back over the items presented and put a checkmark beside each event that they have experienced. This would allow researchers to compare the responses given for actual events with those given for hypothetical events.

The fourth recommendation for future research with the homeless considers the heterogeneity of the homeless
population. The homeless population appears to include a great number of different subgroups. For example, the homeless population in the current study includes subgroups of people who abuse alcohol, people who are experiencing some psychological instability, minorities, single-parent families, veterans, people who have been homeless many times, and people with various education levels and financial situations. Future research with the homeless would benefit from examining how individual circumstances and environmental variables affect the difficulties experienced by homeless people. Identification of specific variables that increase the likelihood of prolonged homelessness could assist researchers and practitioners in the development of primary prevention efforts.

There are two final recommendations for future research with the homeless population. First, future research would benefit from the inclusion of non-sheltered homeless people in the research samples. Second, future research would benefit from the inclusion of length of time homeless as a continuous (versus categorical) variable. Finally, future research with the homeless would benefit from examining more directly the level of disaffiliation among the homeless.

**Summary and Conclusions**

The results of the current study suggest that the majority of homeless participants residing in shelters had a pessimistic explanatory style and that prolonged homelessness
was associated with being at risk for experiencing depressive symptoms. Homeless men in the current study appeared to have a more pessimistic explanatory style than did homeless women. Homeless men in the current study also reported a higher rate of alcohol abuse and problems than did homeless women. There was an unexpected finding that alcohol abuse and explanatory style and alcohol abuse and psychological instability were correlated. Overall, there were high rates of both alcohol abuse and psychological instability among the homeless in the current study. The homeless in the current study also tended to be relatively young, with somewhat high proportions of women, minorities, and single parent families.

The current study was an application of a psychological theory to the homeless experience. The results did not clearly provide support for the reformulated theory of learned helplessness. One of the difficulties with the theory is the emphasis on explanatory style without a consideration of the impact of the environment. Future research would benefit by a careful consideration of ways that environmental factors affect explanatory style and depression among the homeless.
REFERENCES


APPENDIX A

DEMOGRAPHIC INFORMATION FORM
Please put the first six numbers of your social security number and the first initial of your last name here _________. These numbers will not be used to identify you in any way. They will be used to locate you if you indicate that you would be willing to participate in filling out another questionnaire at a later time.

Date of birth: month ____ day ____ year ____

Gender: male ____ female ____

1. Have you ever been homeless before now?
   ____ a. no
   ____ b. yes -- number of times previously homeless ____

2. How long have you been homeless this time?
   ____ a. less than one week
   ____ b. one week to one month
   ____ c. one month to six months
   ____ d. six months to one year
   ____ e. over one year

3. With what racial or ethnic group do you identify yourself?
   ____ a. White
   ____ b. Black
   ____ c. Hispanic
   ____ d. Native American/American Indian
   ____ e. Asian/Pacific Islander
   ____ f. Other _______________________

4. What is your current marital/family status?
   ____ a. married -- number of children under 18 ____
   ____ b. separated -- number of children under 18 ____
   ____ c. widowed -- number of children under 18 ____
   ____ d. divorced -- number of children under 18 ____
   ____ e. never been married -- number of children under 18 ____
   ____ f. living together -- number of children under 18 ____

5. What is the highest level of education you have achieved?
   ____ a. no formal schooling
   ____ b. first through eighth grade
   ____ c. ninth through eleventh grade
   ____ d. high school graduate
   ____ e. some college or advanced training
   ____ f. college graduate or above
6. Have you ever been in the armed forces?
   _____ a. no
   _____ b. yes

7. Are you a Vietnam Vet?
   _____ a. no
   _____ b. yes

8. Would you be willing to be contacted to fill out another questionnaire at a later time?
   _____ a. no
   _____ b. yes
APPENDIX B

REQUEST FOR PARTICIPATION FORM
Dr. Lyle D. Schmidt and Jonna Tobin, a professor and a graduate student at The Ohio State University are asking for your help. They are trying to find out if the experience of being homeless makes it hard for homeless people to get back on their feet. They would like to use this information to make recommendations to agencies about how to improve services for people who are homeless. Your participation is completely voluntary and you may refuse to participate at any time you choose. If you choose to participate you will fill out a questionnaire that will take about 30 to 40 minutes to complete. Your name will not appear anywhere on the questionnaire. You will be asked to voluntarily provide the last six numbers of your social security number and the first letter of your last name. This seven-digit code can only be used to determine locations where those participants might be found who indicate they would be willing to fill out another questionnaire at a later date. In any case your participation is completely anonymous. Upon completing the questionnaire you will be paid $5.00 for your participation. Thanks for your help!!
APPENDIX C

STANDARDIZED INSTRUCTIONS FOR
ADMINISTRATION OF THE EASQ
STANDARDIZED INSTRUCTIONS FOR ADMINISTERING THE QUESTIONNAIRE

1. Read request for participation paragraph to the homeless person.

2. If the person is willing to participate ask "Do you want me to set up an appointment for someone to ask you the questions or do you want to fill out the questionnaire yourself?" (an appointment will be set up for those who request it)

3. Fill in the seven-digit code consisting of the last six numbers of the person's social security number and the first initial of the person's last name in the space provided on the bottom of the first page of the questionnaire.

4. Hand the person the questionnaire and ask them to follow along as you read the instructions for the "Interpretation of Events " measure.

5. Read through the instructions and the example.

6. After reading through the example say:

"In this example the person circled the number 2 for the first question. This person thought that someone taking the wallet was almost totally due to others, but not quite. The number 5 that is circled for the second question means that this person thought that someone taking a wallet is something that will be present in the future a little over half the time. The number 7 that is circled for the third question means that having a wallet stolen was something that this person thought would affect all other areas of one's life. Do you have any questions about how to fill out this part of the questionnaire?"

7. After answering any questions say:

"You may begin whenever you like and may take as long as you like to complete the questionnaire. Please continue through each different part of the questionnaire until you are finished. If there is anything that you don't understand or if you are unsure of how to fill out a particular section of the questionnaire please ask. When you are finished bring the completed questionnaire to (fill in designated person's name) and (she, he, one of them) will briefly glance through it to make sure everything is filled out and will pay you for your participation. Again, thanks for your help."
8. Check the completed questionnaire for any unanswered questions. If there are any items the person has left blank, encourage him/her to answer those items and help her/him with anything that was left unanswered because it was not understood.

9. Thank the person for helping out with the research project and give him/her an envelope containing five dollars.
APPENDIX D

INSTRUCTIONS AND SAMPLE ITEM FOR THE
EXPANDED ATTRIBUTIONAL STYLE QUESTIONNAIRE (EASQ)
INSTRUCTIONS AND SAMPLE ITEM FOR THE
EXPANDED ATTRIBUTIONAL STYLE QUESTIONNAIRE (EASQ)

INTERPRETATIONS OF EVENTS

Please try to imagine yourself in the situations that follow. If such a situation happened to you, what would you feel would have caused it? While events may have many causes, we want you to pick only one--THE MAJOR CAUSE IF THIS EVENT HAPPENED TO YOU.

Please write the cause in the blank provided after each event. Next we want you to answer three questions about the cause you provided. First, is the cause of this something about you or something about other people or circumstances? Second, is the cause of this event something that will persist across time or something that will never again be present? Third, is the cause of this event something that affects all situations in your life or something that just affects this type of event?

To summarize, we want you to:

1. Read each situation and imagine it happening to you.
2. Decide what you feel would be the one major cause of the situation if it happened to you.
3. Write the cause in the blank provided.
4. Answer three questions about the cause.
Please read the following example before beginning and if you have any questions please ask them.

**EXAMPLE:**

You cannot find your wallet.

A. Write down the one major cause:

B. Is the cause of this due to something about you or something about other people or circumstances? (circle one number)

<table>
<thead>
<tr>
<th>totally due to others</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>totally due to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. In the future, will this cause again be present? (circle one number)

| always present | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| never present  |   |   |   |   |   |   |   |

D. Is this cause something that affects just this type of situation, or does it also influence other areas of your life? (circle one number)

| just this situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| all situations      |   |   |   |   |   |   |   |
APPENDIX E

THE EXPANDED ATTRIBUTIONAL STYLE QUESTIONNAIRE ITEMS
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146
148
150
152–153

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APPENDIX F

REPLACEMENT ITEMS FOR THE EASQ
APPENDIX G

SAMPLE ITEMS FROM THE BRIEF SYMPTOM INVENTORY
APPENDIX H

MODIFIED MICHIGAN ALCOHOLISM SCREENING TEST