1-1-1997

A comparison of homeless and housed poor children on psychological and environmental factors /

Pamela Anne Bukowski

A COMPARISON OF HOMELESS AND HOUSED POOR CHILDREN ON PSYCHOLOGICAL AND ENVIRONMENTAL FACTORS

by

PAMELA ANNE BUKOWSKI

DISSERTATION

Submitted to the Graduate School of

Wayne State University

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

1997

MAJOR: PSYCHOLOGY
(Clinical)

Approved By:

Paul A. Toro 8/13/97
Advisor Date

Angela Ingersoll

Kathryn Ohlsen

DEDICATION

This paper is dedicated to my parents, Ronald and Nancy Bukowski, for their continued guidance and love and to my fiancé, John W. McCaskill IV, with sincere appreciation for his love and support and as a symbol of the beginning of our lives together.

ACKNOWLEDGMENTS

My special thanks goes to my graduate advisor and mentor, Paul A. Toro, Ph.D., who has been the most influential person in my professional development to date. Without his expertise, patience, and support over the years, the completion of this project would not have been possible. Dr. Toro has been a superior role model professionally and personally and I am honored to have worked with him over the past few years. I would also like to thank my committee members, Dr. Rita Casey, Dr. Angela Tzelepis, and Dr. Kathy Urberg for their endless time, support, flexibility, and advise which greatly contributed to my education and overall quality of the project. A special thank you goes to John McCaskill for his time, patience, and ever supportive attitude in editing many drafts of this paper. My parents, Ronald and Nancy Bukowski, and my grandparents, Joseph and Helen Smulsky, have contributed greatly through their continued interest in my dissertation project as well as encouragement in pursuing my educational goals when I needed it most. Sincere appreciation to Lauri Belyk for her friendship and constant reassurance during times of uncertainty and to my sister, Kimberly Bukowski, and brother, Ronald Bukowski, Jr., for their time, patience, and support in helping me prepare for the final defense. Furthermore, I appreciate the help and reassuring attitude of Susan Ward throughout

this whole process. Robert and Michelle Sabo and Amy and Brian Parent have also continuously shown interest and excitement in my educational pursuits and I appreciate their love and support.

Sincere thanks also goes to other noteworthy members of the research team who greatly contributed to the completion of the project including Renee McLeod, Monique Clinton, Elaine Williams, Courtney Yapchai, Kristen McCabe, Serena King, Marilynn Goldstein, Laurenn Rowland, and Julie Passero Rabideau. Most importantly, this project would not have been possible without the time and cooperation of shelter and soup kitchen staff, mothers, and children who participated in the study.

There have been a few very special people in my life who have indirectly contributed to the completion of this project and my professional degree. My grandmother, Mary Bukowski, has always shown constant love and support. In addition, certain family members whom I've often thought of include Joseph, Kay and Robert Smulsky, Debra Dolenga, and Guy, Janet, Jeff and Tia DelGuidice. Finally, I always carry the loving memories of my grandfather, Stanley Bukowski and cousin, Tony DelGuidice whom I wish could be here in person to share in the joy of the completion of this project and graduate degree.

Table of Contents

A Comparison of Homeless and Housed Poor Children on Psychological and Environmental Factors

Homelessness has captured the media's attention in the last 10-15 years and coverage of the topic has grown in both popular and professional literature (Lee, Link, & Toro, 1991; Toro, Tricket, Wall, & Salem, 1991). Prior to this time, with some justification, homelessness had been thought of as being confined to middle-aged, male substance abusers. However, over thirty-five percent of the homeless are single mothers with children, representing the fastest growing segment of the population (Dail, 1993). Despite these large numbers, relatively little research to date has focused on homeless women and children. Since homelessness is a severe form of poverty, it is useful to first review the larger literature on the effects of poverty on children. Following this review will be a more focused review of the literature on homeless children. An effort will then be made to highlight the differences between homeless and housed poor children. Finally, in response to certain limitations in the existing studies, the current study will be presented.

Children and Poverty

Simply defined, poverty is "the state or condition of having little or no money, goods or means of support" (Random House Dictionary, 1988). According to official government policy, people are considered to be living in poverty if they fall below an agreed-on minimal standard of living. These definitions appear simple and

straightforward; however, they conceal the complexities of what poverty means to children. The 1970s saw an increase in the amount of children living in poverty. This increase was especially apparent during the recession of the early 1980s when child poverty doubled (Huston et al., 1994; Garbarino, 1992). Currently, over 20% of children in the United States are living below the poverty level, a 21% increase since 1970 (Hewlett, 1991). These figures are more than twice what are seen in other industrialized nations. For example, 9% of children in Canada and 2% of children in Sweden were living below the poverty line in the late 1980s (Danziger & Danziger, 1993). According to Hewlett (1991), the poverty rate of young children is more than double the rate for adults. Recent statistics indicate that the fastest growing segment of persons living in poverty appears to be African American children living in inner cities (Duncan et al., 1994).

Although there are many explanations for why poverty among American children has increased and why it is so difficult to combat, three major reasons seem to be most salient (Huston et al., 1994). First, many well-paying blue-collar jobs have been eliminated as a result of economic changes. Over 50% of jobs created in the 1980s did not pay enough money to support a family of four (Garbarino, 1992). Between 1970 and 1986, there was also a marked increase in income disparity between the richest and poorest families in the United States. Second, there has been a

substantial increase in the number of children being raised by single mothers. Estimates of poverty in this group are 40% for European American families and 60% for African American and Latino families (Huston et al., 1994). The poverty rates of single mothers with children are significantly higher for many reasons, including low paying jobs, lower education, poor economic conditions, and the considerable number of single teen mothers. Finally, during the 1970s and 1980s there was a reduction in government benefits such as Aid to Families Dependent Children (AFDC).

The effects of poverty have become even more devastating as a result of other emerging economic trends. There is an increase in the concentration of poor individuals in particular geographic regions within cities, especially notable in northern industrial cities. The concentration rate of poverty has increased from 16% in 1970 to 24% in 1980 (Bane & Jargowsky, 1988). This may be the result of business relocations, labor market transitions, growth in the suburbs, and racial segregation (Coulton & Pandey, 1992). This trend toward the concentration of poverty may increase the isolation of poor people and "expose them to high levels of adverse social and physical conditions that compound their economic difficulties" (Coulton & Pandey 1992, p. 239). Research suggests that homogeneous poverty areas have higher death rates and more child abuse (Garbarino & Sherman, 1980). In addition, these poor segregated individuals are no longer exposed to

employment and networking opportunities (Hughes, 1989; Wilson, 1992) and they are likely to form deviant subcultures as a result of the lack of positive role models (Wilson, 1992; Massey, Gross, & Eggers, 1991).

The trends have also resulted in the more common experience of "persistent poverty" (i.e. poverty that continues uninterrupted over long periods of time). The number of impoverished individuals who are able to come out of poverty within a year has been decreasing since the 1960s (Adams, Duncan & Rogers, 1988). Research indicates that African Americans are more likely to experience persistent poverty. Between 1974 and 1983, African Americans were almost eight times more likely than non-black individuals to be persistently poor (Adams, Duncan & Rogers, 1988). Based on past trends, it appears that poverty will persist for at least 20% of school-aged children and an even higher rate for younger children (Garbarino, 1992).

The Effects of Poverty on Children

Poverty in the United States has increased over the past 30 years and appears to be on the rise. This is especially evident among single African American women with children. The environment of poor children continues to negatively impact natural development and clearly places children at risk (Garbarino, 1992).

Research indicates that infant mortality rates vary as a function of income. Infant mortality rates in the poorest third of a city's neighborhoods are five times higher than

in the most affluent third. This high rate appears to be the result of the lack of adequate prenatal care provided to poor women (Hewlett, 1991). Infants born in impoverished environments are also more likely to have low birth weights putting them at further risk for developmental complications. However, in a study by Coulton & Pandey (1992), this effect disappeared after controlling for births to unmarried mothers and crime. Children born to adolescent mothers are at increased risk for poverty and at greater risk for bearing premature, low birth weight infants. It is also possible that drug use and drug trafficking account for the high crimes and low birth rates. Health concerns continue to be a problem for poor children beyond infancy due to inadequate nutrition and limited health care.

In addition to the clear link between poverty and infant mortality, there is evidence to suggest that economic deprivation is also related to child maltreatment (Garbarino & Crouter, 1978). According to the National Center on Child Abuse and Neglect (1988), families with incomes of less that $7,000 were 13 times more likely to abuse or neglect their children than families with incomes over $25,000. In addition, research has depicted the connection of single parenthood and abuse as being related to poverty (Gelles, 1992). For example, single poor mothers are no more abusive that poor two-parent families. However, poor mothers in general are significantly more likely to be abusive that non-poor mothers (Garbarino, 1992).

Children who experience poverty are also at risk for other problems. In a study done by Duncan, Brooks-Gunn, and Klebanov (1994), it was found that children who experienced poverty had lower IQs and more internalizing behavior problems than children who were never poor. In addition, poverty has been found to be associated with depression, low self-confidence, conduct disorders, and strained peer relations (McLoyd, 1990). Further studies have reported that poor children experience increased adolescent aggression and behavior problems (Dodge, Pettit, & Bates, 1994), delinquency (Sampson & Laub, 1994), and poor academic performance (Zeisemer, 1994). A recent study by Raadal et al. (1994) used the Child Behavior Checklist (CBCL) to examine behavior problems in a large sample of 5 to 11-year-old children from low income families. Results indicate that the total CBCL score and all subscale scores were significantly higher in low income children compared to norms. In addition, the proportion of low income children whose scores fell in the clinical range was 1.5 to 3 times higher than in the CBCL normative sample. The smallest difference was in the Internalizing/Externalizing subscales (1.6 and 1.5 times, respectively) and largest on Thought Problems which was 3 times higher than the normative data. The proportion of children with attention problems in the low income group was 2 times higher than normal.

Low income is clearly a predictor of developmental problems, especially in the United States. As compared to

other industrialized societies, the United States is different in that it does not provide families with maternal and infant health care and basic child supportive subsidies. Other potential explanations of this disparity include ones involving postindustrial economic shifts, conservative policies, cultural values and legal systems resulting in a higher incidence of poverty in the United States (Toro & Rojansky, 1990). This may explain the high correlations between economic deprivation and poor child outcomes in this country (Bronfenbrenner, 1986).

Homeless Families

As outlined above, children comprise the largest age group within the poor population and are clearly at risk for multiple health and developmental problems. This concern for the child population becomes even more alarming when you consider that 1 in 5 of these children will experience homelessness at sometime during childhood (Melnick & Williams, 1987). More than 35% of the homeless population are families and some reports suggest that there are more children in shelters than unattached men (Rafferty & Shinn, 1991; Bassuk, 1987). Homeless children are the fastest growing segment of the homeless population and the numbers are steadily increasing (Gulati, 1990). These shocking estimates signal a desperate need to study this group carefully in an attempt to assess the impact of the loss of their homes (Rivlin, 1990).

Most homeless families consist of single mothers with two to three preschool or young school age children (Bassuk, Rubin, & Lauriat, 1986; Bassuk, 1990). The average age of homeless mothers is 27 years (Bassuk, 1990). Although minorities are over-represented in poor and homeless populations, race does not appear to be the sole factor in determining the demographic composition of homeless families. For example, in a study done in Massachusetts by Bassuk (1986), the majority of the mothers and children were white. Marital status also appears to vary by location, however, the differences are most likely a function of race. Homeless black women are more likely to never marry compared to homeless white women who are more likely to be married with a higher incidence of divorce (Bassuk, 1986, 1990). In a study in the Detroit Metropolitan area, Mills and Ota (1989) reported that most of the families were black (89.7%) with a single mother (average age of 28 years) and two children. The majority of the mothers did not have a high school diploma and had no income. However, this descriptive study may not be representative of homeless families in Detroit in that it was based on only one shelter. In a comparison study of homeless women, homeless women with children and homeless men, Roll, Toro, & Ortola (1995) reported that homeless women generally had poorer economic circumstances than homeless men. In addition, homeless women, especially those with dependent children, were more

frequently the victims of physical abuse (Roll, Toro, & Ortola, 1995).

Causes of Homelessness

Studies repeatedly cite the macrosocial root cause of homelessness as being the lack of affordable housing. Additional factors cited include job difficulties such as unemployment, underemployment and low paying jobs, and inadequate income maintenance programs. Substance abuse and mental illness in combination with the lack of treatment opportunities may also contribute to homelessness (Toro & Rojansky, 1990; Toro et al., 1995; Toro & Wall, 1991). However, severe mental illness does not appear to be a principal causal factor of family homelessness (Masten, 1992). Other immediate factors include domestic violence, involuntary evictions, and termination of public assistance. In a study done in one Detroit shelter, Mills and Ota (1989) found that 47.1% of the families reported eviction as the cause of their homelessness, with domestic violence (21.8%) and unsafe living conditions (20.7%) accounting for the remainder of significant causal factors. It has been suggested that different circumstances may force single and two-parent families into homelessness (Edelman & Mihaly, 1989). Single mothers are more likely to report the cause of their homelessness as being related to domestic violence, while two-parent families, which are relatively rare, identify housing problems alone as the reason for homelessness. Factors central to the population of homeless

women include severe poverty, family break-ups, care of dependent children, and individual problems (Roll, Toro & Ortola, 1995). There are many factors which can account for a family being pushed into homelessness; however, in each case a common factor is evident in that each family cannot afford a roof over their head (Edelman & Mihaly, 1989). Studies of homeless families indicate that living on the street and use of shelters are a last resort. In a study by the Colorado Children's Campaign (1987), 82% of the homeless families lived with friends or family members before using a shelter. Similar results were obtained in a comparison of homeless and housed poor families in that homeless mothers had more contact with families and relied on them more often for housing support in the past year (Shinn, Knickman, & Weitzman, 1991). In Massachusetts, Bassuk (1986) reported that 85% of the homeless mothers with children had been doubled up with friends and family members in overcrowded homes prior to entering the shelter. A small number of families in Bassuk's (1986) study had lived on the streets before coming to the shelter, however, the majority of these families had at one time used an emergency shelter or lived with family or friends. Systematic research on the processes leading to homelessness is very limited to date (Masten, 1992).

According to Goodman, Saxe, and Harvey (1991), homelessness is most likely associated with psychological trauma for families for three reasons: (1) the stress of

losing one's home is sufficient to produce symptoms of psychological distress, (2) shelter conditions may produce traumatic experiences, and (3) the domestic violence is related to psychological trauma especially in the subpopulation of homeless mothers and children. In addition, "a home provides far more than just physical shelter. It anchors a family in the community and provides children with the stability and safety they need to develop and grow" (Edelman & Mihaly, 1989, pp. 91). Having a home allows the family to be connected with supportive people, institutions, and community networks (Bassuk, 1990). According to Rafferty & Shinn (1991) families without homes are often deprived of essential requirements to practice adequate child-rearing including health care, nutrition, housing and status for parenthood. Normal family life is completely disrupted and in a state of disarray, temporarily suspending their lives. Additionally, many shelters are not adequately equipped with heat and hot water, most have very little privacy, and dirty living conditions are prominent. This is particularly impacting the children who live in these conditions in that they have no quiet place to do homework and friends are rarely invited over to play.

Effects of Homelessness on Children

Homeless children are most often from poor families and thus are affected by the many adverse outcomes of poverty on children as outlined above. By the time the children are seen at a shelter, they may have experienced many traumatic

experiences apart from the actual event of losing their home. Many children arrive to the shelters undernourished, having lost their friends and possessions, and feeling the parental strain of trying to survive (Masten, 1992). the initial research on homeless children used single group designs in an attempt to describe problems faced by homeless children.

Poor Health. Studies have consistently found that homeless children are at risk for a wide range of problems. The best documented evidence concerns physical health. The National Health Care for the Homeless Program (Wright, 1990) has documented the elevated rate of health problems in homeless children from 16 cities. The homeless sample consisted of individuals who sought medical treatment in 19 different established Health Care for the Homeless Programs in 19 major US cities. 10% of their sample of 30,000 were homeless children under the age of 15 with equal numbers of boys and girls. Most of the children were ages 1-4 (54% followed by 30% ages 5-12). It appears that the health problems of homeless children are similar to those health problems that all children face. The most common disorders among these children are upper respiratory infections (40%), minor skin ailments (20%), ear disorders (18%), gastrointestinal problems (15%), trauma(10%), eye disorders (8%), and lice infestations (7%). In addition, approximately 16% of the homeless children had one of the following chronic health conditions: cardiac diseases (3%),

anemia (2%), peripheral vascular disorders (2%), neurological disorders (2-3%). There were no significant differences between homeless boys and girls. Additional studies have also reported a high incidence of chronic physical disorders such as cardiac disease, anemia and neurological disorders in the child homeless population (Alperstein & Arnstein, 1988). A study by Miller and Lin (1988) conducted in Washington on 158 homeless children from 82 families in emergency shelters reported that 49% of the children had acute/chronic health problems, 35% had no health insurance, and the children were three times more likely to use emergency rooms as compared to statistics from the United States general population. There is also a higher occurrence of low birth weight, infant mortality, lack of prenatal care, and poor immunization records in the homeless population as compared to norms (Alperstein & Arnstein, 1988). Due to poor nutrition resulting in a lack of various vitamins and minerals, homeless children are also at greater risk of other specific health problems (Acker, Fierman, & Dreyer, 1987; Molnar, Rath, & Klein, 1990). According to Alperstein and Arnstein (1988), the long term consequences of homelessness on physical health are more severe and intense in shelters as compared to poor children in general.

Developmental Delays. In their sample of 81 preschoolers with equal numbers of boys, girls, blacks, and whites, Bassuk & Gallagher (1990) reported that almost half

of the preschoolers suffered from developmental lags as assessed by the Denver Developmental Screening Test. These deficits cut across all areas tested, including language development, fine motor coordination, gross motor skills, and personal social development.

In a study involving observational and teachers' anecdotal accounts of problem behaviors of homeless preschoolers age 30 months to 5 years, Molnar et al. (1990) found many difficulties. Observations most frequently cited include short attention span, withdrawal, aggressiveness, speech delays, sleep disorders, and regressive behaviors such as thumb sucking. In addition, teachers reported inappropriate social interaction with adults especially involving over friendly behavior with strangers, immature peer contact, over-protective behavior towards siblings and immature gross motor behavior such as clumsiness.

Educational Problems. Homeless children miss school more often, repeat more grades, receive more special education services, experience educational delays and display poor school performance more than other school age children (Masten, 1992). This is supported in a study of 50 homeless school age children in Massachusetts (Bassuk & Rubin, 1987). They reported that 43% of the children had repeated a grade, 25% attended special education, and 43% were currently functioning below average or failing in school. Similarly, in a sample of 88 homeless children in St. Louis shelters for homeless families, Whitman, Accard,

Boyer, and Kendagor (1990) observed severe language disabilities and impaired cognitive ability. On the Slosson Intelligence Test, 35% of the homeless children scored at or below the borderline range and 67% showed significant delays in language as measured by the Peabody Picture Vocabulary Test. In 1987, the McKinney Act was passed which required states to provide schooling for homeless children. Although this has allowed more homeless children to attend school, there are still many barriers to their education (Masten, 1992). Homeless children who are in the schools may feel deeply embarrassed by their situation and are often bullied and beaten up by other children. In addition, many teachers may not be aware of their situation and treat them poorly as a result of their increased aggression or withdrawal (Bassuk, 1990)

Psychological Problems. Considering the destructive psychological environments in which homeless children live, it is assumed that they have higher levels of anxiety, depression, and behavioral problems. However, systematic data on the general psychological functioning homeless children are limited. The most well-known and most comprehensive study to date on homeless children was done by Bassuk and her colleagues in Massachusetts (Bassuk & Rubin, 1987; Bassuk, Rubin, & Lauriat, 1986). Subjects consisted of 82 families with 156 children ranging in age from 16 weeks to 18 years in 14 shelters in the Boston area. 65% of the children were less than 6 years old. The number of boys

(N-74) and girls (N=82) were approximately equal and the racial distribution was approximately uniform between whites and nonwhites (black, N=72; white, N=72, Hispanic, N=11, other, N=1). Using the Denver Developmental Screening Test, 47% of the preschoolers (N=81) showed at least one developmental delay in the areas of language skills (36%), personal/social development (34%), gross motor skills (18%), or fine motor coordination (15%). Results obtained using the Simmons Behavior Checklist, indicate that homeless preschool children had a mean total score of 5.6 which was significantly higher than normative samples and disturbed children. When compared to emotionally disturbed children, homeless children scored higher in the areas of sleep problems, shyness, withdrawal and aggression.

School age homeless children were assessed using the Child Depression Inventory, Children's Manifest Anxiety Scale, and Achenbach Behavioral Checklist. More that 50% of the children reported a significant amount of depressive symptomatology (over a cutoff score of 9 indicating the need for psychiatric referral). On the Children's Manifest Anxiety Scale, 30% of the homeless children had a T-score of 60 (85th percentile) or higher indicating a need for further evaluation. Results yielded from the Achenbach Child Behavior Checklist indicate that 66% of the homeless boys and almost 50% of the homeless girls ages 6-11 scored in the clinically elevated range of behavioral problems. The authors report that children with more severe pathology were

more likely to discontinue the interview resulting in a potential under-representation of the severity of emotional and behavioral problems in this sample.

In addition, the occurrence of homelessness always involves loss, putting these children at greater risk for depression (Alperstein & Arnstein, 1988). Wagner and Menke (1990) used the Child Depression Inventory (CDI) to assess 76 homeless children between the ages of 7 and 12. Results indicate that 50% needed further evaluation and 35% were clinically depressed. On average, boys reported more depressive symptoms than girls (11.3 vs. 10.3, respectively). Only one study, based on the House-Tree-Person projective technique, has failed to find any indication of emotional distress in homeless children (Whitman, Accardo, Boyert, & Kendagor, 1990). The criteria for scoring emotional distress were not presented, and no report of comparison groups or reference to normed samples was made.

The Citizen's Committee for Children (1988) reported that 66% of the parents in 83 homeless sheltered families in New York city claimed they noticed substantial behavioral changes in their children since becoming homeless. Specifically, they reported an increase in acting out, restlessness, fighting, depression, and irritability. Molnar, Rath, and Klein (1991) also report a higher incidence of withdrawal, exaggerated fears, disobedience, and destructiveness.

Poor social adjustment. Eddowes & Hranitz (1989) report that 43% of homeless school-age children are not enrolled in any school program. This alone results in fewer contact with peers and less opportunity to interact socially. Stigmatization by peers is also a common problem for homeless children (Gewirtzman & Fodor, 1987). Homeless children are often called "shelter kids" by their peers resulting in a feeling of not belonging and failure to develop long term relationships (Russo 1987, cited in Rosenman and Stein, 1990).

In summary, results across these studies have varied. However, initial descriptive studies of homeless children indicate elevated rates of health problems, developmental delays, education problems, and behavior and emotional problems. However, due to the lack of comparison groups, it is difficult to identify the risks attributable to homelessness apart form the disadvantages associated with general poverty.

General Homeless and Housed Poor Comparisons.

Although research in this area is still in its infancy, a few studies have attempted to separate the effects of poverty from homelessness. Research in this area began with the adult homeless population in an attempt to separate homelessness from poverty. For example, Wood, Valdez, Hayash, & Shen (1990) compared homeless mothers (N=196) from 10 of the largest shelters in Los Angeles to poor families (N=194) seeking assistance at welfare offices.

Welfare offices were chosen based on information about the last stable addresses of the homeless group. Overall, they found that the homeless mothers reported more spousal and child abuse, a higher incidence of hospitalization for mental illness and substance abuse, and less social support as compared to the housed mothers. However, these results are questionable in that the authors reported no data on the validity or reliability of their measures.

Linn, Gelberg, & Leake (1990) attempted to compare rates of substance abuse and mental health in a sample of homeless and housed adults seeking care at a community medical clinic in California. Although their results were also based on measures without established reliability or validity, they found that the homeless group had more hospitalizations for substance abuse and mental illness, were more often arrested for drinking, experienced more delirium tremens, and were more likely to abuse drugs.

Shinn, Knickman, & Weitzman (1991) compared 677 homeless families requesting shelter to 495 housed families on public assistance rolls in New York City. Although no separate information was reported on the children, results overall indicated that the mothers had more contact with family members, had used their families more often in the past year for housing support, and reported more traumatic childhood experiences. The authors suggested that homeless families may have "used up" their social support as compared to housed families who asked for help in moderation.

Goodman (1991) compared the prevalence of abuse among 50 homeless and 50 housed poor mothers in New England. The homeless were recruited from housing meetings for shelter residents in two cities and the housed group was recruited as they came to pick up their checks in social service agencies. Results indicate that the two groups were similar in abuse history although the housed group reported more sexual abuse in adulthood as compared to the homeless group.

Sosin (1992) compared a sample of homeless (N=178) and poor housed (N=353) adults who were obtaining a meal at a shelter, soup kitchen, or inpatient substance abuse/ mental health treatment center. They reported that the poor housed men and women were more likely to become homeless if they experienced problems with social institutions or were denied help by relatives.

Toro et al. (1995) randomly sampled 144 adults from various sites including soup kitchens, shelters, and food pantries, yielding three groups: the currently homeless (n=59), the previously homeless (n=31), and the never-homeless poor (n=54). Results indicate that the homeless were less likely to be receiving public benefits and more likely to meet diagnostic criteria for substance abuse, be victims of recent domestic violence, and be physically abused as children.

In a recent study on a homeless and housed adolescent sample, Wolfe, Toro, & Bukowski (1994) compared a group of 118 homeless sheltered adolescents to a group of 118 housed

adolescents on various psychosocial variables. The groups were matched on demographic variables such as sex, race, age, and geographic region. Results indicate that homeless adolescents report more family dysfunction such as parental abuse/neglect, verbal and physical aggression, higher familial conflict and less cohesiveness. In addition, homeless adolescents were more likely to be diagnosed with Conduct Disorder and Alcohol Abuse as assessed by the Diagnostic Interview Schedule for Children (DIS-C) (Bukowski, Wolfe & Toro, 1994).

Comparative Studies of Homeless and Housed Children

Recently a few researchers have attempted to apply the comparison group sampling strategies used in adult studies to homeless children. A study done by the National Health Care for the Homeless Program (Wright, 1990) was primarily concerned with collecting health information on a sample of homeless individuals across 19 major US cities. In order to compare their results, the authors used data reported by physicians in urban areas on children from the National Ambulatory Medical Care Survey conducted in 1979. They concluded that there are dramatic differences between homeless children and children in general. The homeless children had two to four times the rates of respiratory infections, skin problems, nutritional deficiencies, gastrointestinal disorders, and chronic illness. However, the two samples are only comparable in that they both include persons presenting at ambulatory clinics and the

data were based on physician report. The authors agree that the two data sets are "grossly noncomparable in many other respects" (Wright, 1990, p.72).

In a follow-up study on the Massachusetts sample of homeless children described earlier (Bassuk, Rubin, & Lauriat, 1986), Bassuk & Rosenberg (1988) compared a subset of their homeless sample of 49 families (86 children) from the Boston shelters to a group of 81 low-income housed families (134 children). The homeless families were recruited from six family shelters and the housed sample was obtained by use of the 1980 census information to locate blocks in Boston with a high prevalence of poor families headed by women. Interviewers went door to door and interviewed only those families home at that time. Approximately one half of each group were preschoolers 5 years of age or younger. Over half of the homeless preschool children (54%) manifested at least one developmental lag as compared to 16% of housed pre-schoolers. In addition, homeless children were more likely to lack personal and social development (42% vs. 3%), evidence language delays (42% vs. 13%), lack gross motor skills (17% vs. 4%), and lack fine motor skills (15% vs. 1%). Homeless preschoolers scored significantly higher than the housed children on the following problems: attention, sleep, shyness, speech, withdrawal, and aggression. The only area in which homeless children were significantly better than the housed children was in being

less afraid of new things. However, when comparing a subset of this sample (N=21) to a sample of 33 housed poor children, there were no significant differences (Bassuk & Rosenberg, 1990). Using the Child Depression Inventory, 52% of the homeless children over age 5 (N=31) had scores above the cut-off point of 9 indicating a need for further evaluation compared to 48% of the housed children (N=33). The mean scores for the homeless children (10.3) was higher than the mean score of the housed sample (8.3) although this difference was not statistically significant. On the Children's Manifest Anxiety Scale, 31% of the sheltered children (N=29) had scores in the clinical range which was significantly higher than the 9% of the housed children (N=34) in the clinical range. Mean scores were not presented in the article. On the Child Behavior Checklist (CBCL), 39% of the homeless children were in the clinical range as compared to 26% of the housed children, although this difference was not significant.

In a large scale study, New York City children in grades 3 through 10 who had experienced homelessness from September 1987 to May 1988 (N=3,805) were compared to all available data on New York city students (Rafferty & Shinn, 1991). Homeless children exhibited significantly more educational difficulties. Specifically, only 43% if the homeless children who took the Degrees of Reading Power Test (N=3,805) scored at or above grade level compared to 68% other "normal" children. Results obtained from students who

took the Metropolitan Achievement Test also indicate that the number of homeless children at or above grade level (28%) was significantly lower than other nonhomeless children (57%). In addition, homeless children were more likely to repeat a grade in school (15% compared to 7%). They also found that nearly 50% of all homeless children demonstrated at least one developmental delay, compared to 16% of housed children.

Alperstein and Arnstein (1988) specifically compared health clinic records in a sample of homeless children and housed children seeking health care in New York. Results indicated that 27% of homeless children under the age of 5 (N= 265) were late in getting immunizations compared to 8% of housed children in the same clinic (N=100). Twice as many homeless children (4%) had elevated lead levels in their blood. In addition, homeless children under the age of 18 were twice as likely to be admitted to the hospital as compared to other children seeking outpatient treatment in the same area.

Masten et al.(1993) reported that emotional and behavioral problems in a sample of sheltered homeless children were three to four times higher than that expected in the general population. She compared the homeless sample (N=159) to housed children (N=62) ages 8-17 from food and recreational community programs and did not find a significant difference in the amount of depressive symptomatology. Mean scores on the Child Depression

Inventory were 9.45 in the homeless group and 8.13 in the housed poor group. Similarly, there were no significant differences in mean scores on the Child Behavior Checklist (CBCL), but both groups had significantly higher scores compared to normative samples. However, the means for the externalizing subscales were significantly higher in the homeless sample and significantly more homeless children scored in the clinical range on both internalizing and externalizing problems as compared to the housed children. Homeless children were also more likely to repeat a grade in school than the housed poor children (38% vs. 24%, respectively).

Molnar, Rath & Klein (1990) compared a sample of 84 homeless and 76 housed poor children between the ages of 3 and 5. Results indicate that there were no mean differences on the Child Behavior Checklist and neither group differed from normative data. However, significantly more homeless children (33%) than housed children (11%) had scores in the clinical range.

Rescorla, Parker and Stoley (1991) found that homeless sheltered preschoolers scored significantly higher on several scales of problematic behavior. They compared the cognitive ability of 40 homeless children from ages 3 to 5 with 20 housed children seeking treatment at a pediatric clinic in Philadelphia. Significant differences were found in receptive vocabulary as measured by the Peabody Picture Vocabulary Test with homeless children obtaining a mean

score of 68 compared to the mean score of 78 for housed children. There were also significant differences on the Beery Developmental Test of Visual Motor Integration. The two groups were not significantly different in vocabulary (as assessed by the Stanford-Binet), visual motor development (using the Draw-A-Person), or developmental ability (using the Cubes Test) Marginal differences ($p<.10$) were also found using the Child Behavior Checklist (CBCL) with homeless children (N=43) and housed children (N=25) ages 6-12. 30% of the homeless children compared to 16% of housed children were in the clinical range, however, differences in the extreme scores was only significant with externalizing behaviors. In the preschool sample ages 3-5, 20% of the homeless preschoolers (N=40) as compared to 5% of the housed preschoolers (N=20) were in the clinical range on the CBCL.

In a recent study in Madison, Wisconsin, Ziesemer et al. (1994) compared a sample of homeless elementary school children that had experienced homelessness in the prior three years to a sample of low-income children that qualified for free school lunch. The groups did not differ in reading and math achievement, adaptive functioning or behavior problems (as assessed by the Teacher Report Form), or self-perception (assessed by the Self Perception Profile for Children). However, the school nurses reported that the homeless children had more vision and hearing difficulties. Most recently, DiBiase & Waddell (1995, compared homeless

(n=30) and housed (n=40) preschoolers enrolled in Head Start in Massachusetts on emotional and behavioral functioning. Their sample was racially mixed (33% Caucasian, 40% African American, 11% Hispanic) and contained approximately half boys and half girls in each group. Results based on the Harter Perceived Competence Scale indicated that homeless children reported lower total competence ratings; however, this difference was not found in teacher ratings on the same scale. Although overall results on the internalizing and externalizing subscales of the CBCL were not presented, homeless children were significantly elevated on the subscales of Depression (mean= 65.16 vs. 56.48 in the housed sample); Social Withdrawal (mean = 66.64 vs. 60.67); and Schizoid (mean = 62.29 vs. 56.70). There was also no differences found in emotional development using the Emotional Development Interview (DiBiase, 1995).

Summary

The literature reviewed indicates that homeless children are at risk for health problems, poor nutrition, developmental delays, psychological problems, academic difficulties, and poor social adjustment. In each of these categories, it is implied that children growing up in shelters are worse off than normative groups and housed poor children. This is especially evident in the areas of poor health and educational problems. However, research findings involving direct comparision to poor housed children appear to be inconsistent, especially in the study of psychological

problems with this population. There are many possible explanations for these inconsistent findings. Many of the studies to date are limited in sample size and are not representative of the total homeless population. In fact, the majority of studies have chosen their subjects from one source (e.g., a shelter) and attempted to generalize their results to the whole population of homeless children (Alperstein & Arnstein, 1988; Linn, Gelberg, & Leake, 1990). Many instruments used to assess mental health have been unstandardized, with little evidence of reliability or validity (Wood, 1990; Linn, Gelberg, & Leake, 1990; Goodman 1991; Masten, 1992; 1993). Additional limitations include invalid assessments due to inadequacy of interview space, biased sampling methods, and disparate sample sizes. Most importantly, however, studies have not included appropriate comparison groups of non-homeless poor children (Robertson, 1992; Rafferty & Shinn, 1991). In interpreting these findings, one needs to take into account that the matching procedures used in most studies did not control for many potentially confounding demographic and geographic variables. Studies to date have included either impoverished families with a home or homeless children, and have attempted to make comparisons based on a variety of differences in methodologies including disparate sample characteristics and interview techniques. In basing these comparisons on normative samples of children, the studies have failed to isolate the effects of environmental factors

(e.g. poverty) on various outcomes. Many of the risk factors identified in the homeless child literature are similar to research on impoverished children. The existing studies provide useful descriptions of homeless and poor children. However, there is a need in this literature to separate factors uniquely associated with homelessness from those associated with the more general social problem of poverty (Toro et al., 1995).

There have been some recent satisfactory methods of matching in an attempt to separate the effects of homelessness from those of poverty. Many studies have recruited their comparison groups from welfare rolls (Goodman, 1991; Shinn, Knickman, & Weitzman, 1991). Though such strategies are a major improvement over rough estimates of geographical location, there are still some weaknesses (Sosin, 1992). For instance, mothers on welfare, in their ability to seek and maintain service use through a structured service system may differ from homeless individuals apart from not having a home (Toro et al., 1995). This criticism also applies to studies that have obtained comparison samples from clinics(Alperstein & Arnstein, 1988; Rescorla, Parker, & Stoley, 1991).

The Current Study

Theoretical Background

There are many examples in the literature of documented risk factors for children in psychological research. For example, Rutter et al. (1979) identified variables that were significantly associated with the onset of a child psychological disorder: (1) severe marital discord, (2) low SES, (3) overcrowding or large family size, (4) paternal criminality, (5) maternal psychopathology, and (6) foster home placement of the children. The cumulative effect of these factors accounted for the highest rate of psychiatric disorders in the children of these families. Studies by Kolvin et al. (1988a, 1988b, 1988c) support these findings in their longitudinal study of risk factors and their influence on the development of later criminality. They reported five risk factors of (1) marital instability, (2) parental illness, (3) poor domestic and physical care of the children and home, (4) dependency on the state or community for assistance, and (5) overcrowded housing and poor mothering ability.

Chronic poverty produces cumulative stressors that begin in the prenatal period as a result of poor maternal health and inadequate nutrition during the mother's pregnancy. Poor children often receive poor medical care and education.

In a review of the literature, Masten, Best, & Garmezy (1991) suggest that there are three phases of research in

the study of risk factors. The first phase involves the identification of a risk factor. Most research to date has used retrospective data to identify risk factors. The second phase uses the identified potential risk group in prospective studies and often yields different conclusions. The third phase involves refining the measurement to clearly identify the risk factor. It is necessary to understand the exact nature of the risk factor in order to study resilience.

Literature on homelessness in general has focused on characteristics that may be risk factors for homelessness. However, homelessness itself can be considered an extreme risk factor for various negative outcomes. It is therefore important to identify whether or not it is a risk beyond poverty or low socioeconomic status. Many studies have reported that homeless children have worse outcomes compared to normative samples. The few studies that have attempted to compare this group to a comparable sample of poor children have found inconsistent results. The current study attempts to understand the exact nature of homelessness as a risk factor in carefully controlling socio-demographic variables to separate out the effects of homelessness versus some other stressful situation, such as poverty. Specifically, the current study attempted to investigate whether there is a higher occurrence of psychological and environmental problems in homeless children as compared to a carefully matched sample of housed poor children using the same

interview protocol and procedures.

Improvements on Past Research

The study attempted to improve on past research of homeless youth in the following ways:

(a) Many previous studies have ignored environmental factors by attempting to compare samples from different geographical areas. The present study controlled environmental factors by comparing homeless children to housed children from sociodemographically similar areas. The two groups were compared controlling for basic child and mother demographic variables, such as sex, age, race, and SES. These meaningful comparisons permitted the isolation of the unique characteristics of homeless children, over and above basic sociodemographic characteristics.

(b) This study recruited homeless and housed families from shelters and food programs providing a broad sample which is less biased toward obtaining families who are well-connected to formal human service agencies. Food programs in particular are very informal and require no applications or appointment schedules (Toro et al., 1995). Sampling at food programs also provided opportunities to sample homeless individuals who did not make use of the shelter system. Based on prior research, the inclusion of sampling from food programs in addition to shelters likely accounted for 89% of homeless individuals in Metropolitan Detroit (Toro, 1993).

(c) Many studies with homeless children have been based on measures of questionable psychometric properties.

This study took an empirical approach using measures with established validity and reliability.

(d) Many previous studies gathered their subjects from a single source, therefore limiting their generalizability to the specific site studied. The present study obtained a probability sample of children from a full range of shelters and soup kitchens throughout a large metropolitan area.

(e) Although studies have reported that homeless children have fewer contacts with peers and less opportunity to interact socially, only two recent studies have considered children's self-perception of competence and social acceptance in the child homeless population (Passero-Rabideau & Toro, 1997; DiBiase & Waddell, 1995). This study included a measure on perceived competence in an attempt to differentiate homeless and housed children in this area.

Hypotheses.

This study was designed to investigate differences in psychological problems, behavioral difficulties, perceived social competence, and environmental variables between homeless children and a carefully matched sample of housed children. The specific hypotheses were as follows:

1. Homeless children, when compared to non-homeless children from similar demographic backgrounds, were expected to have a significantly greater incidence of internalizing and externalizing disorders.

2. The homeless children were also expected to show lower total perceived competence scores as compared to housed

children.

3. The mothers of homeless children were expected to report more parenting stress than the mothers of housed poor children.

4. Homeless children were expected to report a higher incidence of community violence compared to housed children. The homeless mothers with children were also expected to report more recent physical/ verbal abuse by their romantic partners as compared to the housed sample. Thus, homeless children were generally expected to be exposed to more recent conflict in their families as opposed to housed children.

Method

Participants.

This study included 90 families with children ranging in age from 4 to 10. Interviews were conducted from January, 1996 through June, 1997, with roughly equal numbers of housed and homeless across seasons. Data were originally collected on an additional 22 homeless and 4 housed families. However, due to the stringent matching procedures used to obtain comparable samples of homeless and housed, these families had to be elimiated from the study. Half of the overall sample included in the study (N=45 families) was homeless and the other half (N=45 families) was housed at the time of the interview. A maximum of 2 children per family was interviewed. The majority of families (N=36 family pairs) had one child that participated in the study; however, in 9 cases, 2 homeless children from the same family were interviewed and demographically matched to 2 children in a housed family. Thus, the effective sample size for the analyses comparing homeless to housed children was 54 + 54 = 108.

Homeless children were defined as those children living with their mothers who (1) do not have their own house or apartment, (2) are living on the streets or in a shelter, or (3) are staying temporarily with friends or family and do not pay them rent. However, the current sample primarily included families that were living in a shelter (87%) with a smaller percentage staying temporarily with friends and not

paying rent(13%).

The families were recruited over a period of 18 months utilizing all major shelters and soup kitchens that serve homeless women with children in the seven-county Detroit metropolitan area (1990 population = 4.2 million). A probability sample of homeless women with dependent children was obtained in the following way. As a first step, based on data obtained from brief surveys of individuals in all the shelters and soup kitchens in the Detroit Metropolitan area (Toro et al., 1997), the number of women reporting dependent children was calculated. Those sites that were identified as having a high percentage of homeless women with children (top 30%) were contacted by project staff. Due to the fluctuation of services for the homeless, some sites from this list were no longer in existence. These sites were dropped from the sampling design and replaced with current new sites serving homeless and housed poor women and children.

In a second step, the number of different families with children aged 4-10 who passed through each shelter or soup kitchen in the course of the year 1996 was determined based on data obtained from site directors. Table 1 (Appendix A) presents the numbers of homeless children obtained from the 5 urban shelters (e.g., COTS, Salvation Army, Door Step, My Sister's Place, and Booth Homeless Shelter), 3 suburban shelters (e.g., First Step, Westland Family Shelter, and Haven Community Shelter), 2 soups kitchens (e.g., Capuchin

and Baldwin Avenue Soup Kitchen) and one homeless agency (e.g., Caregivers). The two largest shelters, Door Step and COTS, each had annual caseloads of over 175 families with children age 4-10. These shelters primarily serve Detroit's urban population. First Step and Westland Family Shelter serve the suburban population in Wayne County. Mothers and children living on the street are rare in the Detroit area and attempts made to locate such mothers through homeless agencies were unsuccessful.

The comparison group of housed poor women with children were recruited from the same soup kitchens and community agencies as the homeless families. Each housed child was matched on age (within one year), race, gender, and neighborhood (socioeconomic status based on the median family income of the family's zip code within $10,000). Neighborhood for the homeless sample was determined by using the zip code of their last place of residence (prior to their current homeless episode). In addition, each housed mother was matched to the corresponding homeless mother's on age (within 7 years) and race (i.e., white and nonwhite).

Measures

Background information. Information was obtained on demographic characteristics, as well as previous shelter use and length of homelessness. Items included questions on gender, race, age, parental education, employment status, and current living situation (see Appendix A).

Child Behavior Checklist. The Child Behavior Checklist

(CBCL) is a parent-report measure of various child behavior problems (Achenbach & Edelbrock, 1983; Achenbach, 1991). The measure consists of 118 items which yield a total problem score and nine narrow-band subscale scores normed according to the gender and age of the child (see Appendix C). The subscales include: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, Aggressive Behavior, and Sex Problems. The CBCL also yields two broad-band scores of Externalizing and Internalizing Problems. The internalizing dimension is compromised of items related to problems such as depression, social withdrawal, and anxiety. The externalizing dimension consists of items related to aggression, hyperactivity, and conduct disorder. Scores for the broad band factors were obtained by converting raw scores to standard t-scores, based in comparison to the norms of appropriate age and gender samples. Parents were asked to rate the frequency of various behaviors in the past year on a 3-point scale. High levels of reliability and validity have been demonstrated. Several studies have utilized the CBCL in studying poor and homeless children (e.g., Bassuk & Rubin, 1987; Bassuk & Rosenberg, 1990; Christopoulos et al., 1987; Masten, 1992; Molnar, Rath, & Klein, 1990; Passero & Toro, 1996).

Perceived Competence Scales. The Perceived Competence Scales were used to assess children's self-perceptions of competence and social acceptance (Harter, 1982; Harter &

Pike, 1984). There were two different forms used, one for children ages 4-7 and one for children ages 8-10 (see Appendix D). The form used for younger children has 24 items and includes the four scales of cognitive competence, physical competence, peer acceptance, and maternal acceptance. The form for older children has 36 items and includes four scales: Cognitive competence, physical competence, social competence, and general self-worth. All items were scored on a 4-point scale in which a score of 4 is the most competent or accepted and a score of 1 is the least competent or accepted. A mean social competence index will be derived by summing across items on all scales and dividing by the number of total items (i.e., 24 or 36 depending on which form). The Total score on the Perceived Competence Scale has been found to have a reliability of .85 - .88 (Harter & Pike, 1984). The PCS has been used in a study of the adjustment of children in a shelter for battered women (Christopoulos et al., 1987) and in a study of the effects of homelessness on the psychological functioning of preschoolers (DiBiase & Waddell, 1995).

Parenting Daily Hassles. The Parenting Daily Hassles (PDH) is a 20 item parent-report measure used to assess the frequency and intensity of potentially stressful events that tend to occur in families with young children (Crnic & Greenberg, 1990; see Appendix F). A 4-point scale from 1=rarely to 4= constantly is used to determine frequency of occurrence. Intensity is rated on a five-point scale from

1=no hassle to 5=big hassle. Both the frequency and intensity scales have acceptable reliability (Cronbach's alpha=.81 and .90, respectively). For purposes of this study, a total hassles score was derived by summing the cross-product of frequency x intensity across each of the 20 items on the scale. Cronbach's alpha for the overall current sample indicated high reliability (alpha = .92).

Housing, Income and Services Timeline (HIST) - Mother and Child Versions. The HIST was designed to reliably assess the life history of homeless adults in the following domains: Housing, homelessness, employment, income, and utilization of social services. The HIST is somewhat similar to the Life Event Calendar Technique, which demonstrated accurate participant recall of events in a five-year longitudinal study (Freedman, Thornton, Camburn, Alwin, & Young-DeMarco, 1988). Test-retest correlations for the HIST lifetime variables based on the study's reliability sample of 31 were: Total number of housing moves (.93), episodes of solitary living (.81), mean quality of living environments (across the 6 global ratings of comfort , safety, spaciousness, privacy, friendliness, and overall quality across living arrangements (.81), episodes of homelessness (.75), total time homeless (.71), total time employed (.74), total income from wages (.94), total income from other sources (including public assistance, disability benefits and family and friends; .81), history of psychiatric hospitalization (1.00), history of outpatient

services (.69). Test-retest correlations were also computed for current monthly income (.70) and current income source (.70). Data was obtained in each of those dimensions for the mother and 1-2 children for the prior year (see Appendix G). Additional information on lifetime variables was obtained including number of moves, homeless episodes, service use (i.e. days in medical hospital, psychiatric hospital, and outpatient services). For school age children questions were included on school attendance, grade repeats, suspensions, and expulsions.

Conflict Tactics Scale (CTS). The CTS is a measure used to assess the extent of domestic violence (Straus, 1979, 1990). The two main scales were used to assess Physical Violence and Verbal Aggression toward the mother by her romantic partner (see Appendix H). Across several studies, internal consistency alphas have ranged from .62 to .88 for these two scales. Validity data indicates that these scales correlate with several risk factors for family violence (including unemployment and alcohol abuse: Straus, Gelles, & Steinmetz, 1980). The CTS is the most widely used measure of domestic violence (Straus, 1990), and it has been recently used in studies of poor and homeless persons (Goodman, 1991; Toro et al., 1995; Passero & Toro, 1996; Wolfe, Toro, & Bukowski, 1995).

Things I Have Seen and Heard. Things I Have Seen and Heard is a 20-question structured interview that probes children's exposure to violence and violence-related themes

in an age-appropriate format (Richters & Martinez, 1990; see Appendix I). The interview consists of 15 pages, each one describing a different form of violence. Test-retest reliability over one week of the composite variable reflecting the sum of all the instances of exposure reported by the child was r=.81 (Richters & Martinez, 1993). This measure has been used with other community samples of young children (Martinez & Richters, 1993; Richters & Martinez, 1993). A measure including the same items was given to the mother of the child in order to obtain maternal report on the child's exposure to community violence (see Appendix I). Reliability for the child version in the current sample was very good (alpha = .88), with lower estimates of reliability in the moderate range for the mother's version (alpha = .71)

Procedure

Interviewer training. Trained male and female interviewers (graduate students and advanced undergraduate psychology majors) conducted all the interviews. In the initial phases of training, each of the 9 interviewers were introduced to the measures through intensive instruction and practice to assure reliability. Each interviewer accompanied a trainer on at least two interviews which was followed by completion of their own interview in the presence of a supervisor. Supervision was available at all times, in addition to weekly meetings to answer questions or concerns. Issues of safety and confidentiality in dealing with marginal populations of families was also addressed.

Interview process. In order to obtain a probability sample, the methods which interviewers were required to use varied depending on the type of site where the interviewer was recruiting and the type of situation the interviewer encountered when he/she arrived at the site. In all cases, the interviewers attempted to approach subjects randomly. There were very few homeless families at soup kitchens, thus interviewers typically approached mothers that had children whom looked to be ages 4-10. After completing the appropriate screening (section 1 of interview), the interviewer determined if that client is homeless or housed. The mother must have had at least one child with her between the ages of 4-10 to be eligible to be interviewed. If the person was not eligible or refused to participate, the interviewer approached the next available mother with her children in line and completed the same process. If this resulted in a refusal or if the prospective client was ineligible, the interviewer continued approaching families in the soup kitchen. In certain situations (e.g., shelters), lists or sign-in sheets of all clients were available. In that case, the interviewer or shelter staff randomly chose a family on list to determine eligibility and offer them participation in the study. If the person was ineligible or refused, the interviewer or shelter staff continued to randomly choose another family on the list and repeated this procedure.

In certain circumstances a mother who was eligible for

the study had more than 2 children between the ages of 4 and 10 with her at the time. In these cases, the interviewer chose two children randomly to interview. This was done by asking the first names of each of the children and choosing the first two children alphabetically to participate.

Interviews took place in a designated private office or secluded corner at each shelter or soup kitchen to insure confidentiality. There was always two interviewers with each family. One of the interviewers verbally administered measures to the mother while the other interviewer simultaneously administered measures to the child(ren) in a separate location to insure confidentiality. In each case, the interviewer carefully went through the parent and child consent form and answered any questions about participation in the study. At this point, the interviewer proceeded to administer the structured interview. The interview protocol was read aloud to the participant and standardized answer sheets were used to record verbal responses. Each mother received $20.00 at the conclusion of the interviews.

Results

The primary goal of this study was to compare psychological and environmental problems of homeless children to those of a carefully matched sample of housed poor children using the same interview protocol and procedures. In the following section, some descriptive statistics on the homeless and housed samples will be presented. Next, the results of the main analyses used to examine the differences in psychological and environmental problems between the two groups (housed vs. homeless) will be discussed.

Descriptive Characteristics of the Sample

The majority of the children in the homeless sample (to whom those in the housed sample were matched) were African American, and about half were male (46%). Nearly half of the children were aged 4-5 years (41%), nearly half 6-8 years (44%), and a smaller portion 9-10 years (15%). The majority of children in both the homeless and housed group had at least weekly contact with a father figure (62% and 59%, respectively; see Table 2, Appendix A). The majority of mothers were ages 21-30 (18-19%) and ages 31-40 (30-31%), while a smaller proportion were older (41-44; 6%). The mean age of the mothers of homeless children was 32.1 while the mean age of the housed mothers was 32.9. Homeless mothers had significantly ($F(1,107) = 13.09$, $p<.01$) higher levels of education, with more of the homeless at least graduating from high school (59%) as compared to the housed mothers

(39%). When considering employment status in the last year, the two groups did not significantly differ from one another (63% of the homeless and 65% of housed had never been employed; see Table 3, Appendix A).

The majority of children in the homeless sample had not been homeless prior to their current homeless situation (96%). However, approximately half of the housed children experienced homelessness at some time in their life (52%). Note that this rate is significantly elevated in comparison with the rates found in studies of general populations of housed women with children in which current estimates indicate the 20% of children will experience homelessness at some time in their childhood (Melnick & Williams, 1987). In secondary analyses reported below, an attempt was made to determine if there were any differences between children who were homeless at the time of the interview, children who were previously homeless, yet housed at the time of the interview, and children who had never experienced homelessness. Within the homeless sample, 24% had been homeless for one week or less at the time of the interview and the majority had been homeless for less than 5 months with only 16% homeless for 6 months or longer. The majority of the homeless women indicated that their reason for homelessness was difficulty finding housing (41%) or relationship difficulties (30%). Smaller proportions reported that personal distress or financial problems resulted in their current homeless situation (see Table 4,

Appendix A).

In order to determine if matching procedures yielded comparable groups of homeless and housed children, a series of simple ANOVAs was computed on the following variables that were purposely matched in the design of the study: age of mother and child(ren), gender of child(ren), race of mother and child(ren), and income. There were no significant differences between these two groups on any of these background characteristics ($p>.15$). In addition to these analyses which were expected to result in non-significant differences between the groups based on the matched design of the study, additional analyses on other demographic variables were also conducted. Simple ANOVA's were computed on public assistance income, maternal education, occupation-based socioeconomic status and years of completed education of the mother's parents, and number of children in the home. Chi Square analyses were conducted on the categorical variables of employment status in the past year and the child's contact with a father figure. A significant difference was found on one of these six variables: The homeless mothers reported higher levels of educational attainment ($F(1,107) = 13.09$, $p<.01$) as compared to the housed mothers.

Main Analyses: Comparisons of the Homeless and Housed

Four MANOVAs assessed whether the two groups (matched on age, sex, and neighborhood socioeconomic status) differed on psychological and environmental factors. These MANOVAS

considered 17 variables in the following four conceptual groupings based on correlations among the variables (see Appendix I): (1) Environmental variables of comfort, safety, spaciousness, privacy, friendliness, and overall quality; (2) violence variables of verbal aggression toward the child's mother by her romantic partner, physical violence toward the child's mother by her romantic partner, child reported community violence, and mother reported community violence; (3) stability variables including the number of times the child moved since age 2, number of schools attended, and total parenting hassles index; and (4) psychological variables of internalizing disorders, externalizing disorders, and total competence score (see Table 5, Appendix A).

In the first MANOVA, multivariate $F(6,99) = 2.92$ ($p<.05$) was significant. A significant ANOVA associated with this indicated that the homeless children, as compared to the housed children, reported less environmental safety ($F(1,104) = 7.76$, $p<.01$). In addition, although not statistically significant, there was a trend that suggested that homeless children lived in environments with less space ($F(1,105) = 2.88$, $p<.10$). There were no differences between the 2 groups in terms of environmental comfort, privacy, friendliness, and overall quality.

The homeless and housed also differed on variables measuring community and personal violence. The multivariate $F(4,21) = 2.45$ was significant at the $p<.10$ level. In order

to decrease the probability of Type II error when interpreting the overall MANOVA, a cutoff of $p<.10$ was used here and throughout this study in order to evaluate the associated ANOVAs. Results indicated that homeless children were more likely to be exposed to community violence based on their mother's report ($F(1, 24) = 8.33$, $p<.01$). In addition, trends in the data indicated that homeless children were also more likely to report being exposed to community violence ($F(1,24) = 3.00$, $p<.10$) and their mothers were more likely to report being verbally abused by their partners as assessed by the Conflict Tactic Scale ($F(1,24) =4.01$, $p<.10$). However, physical abuse toward the mother by their partners did not differentiate the two groups. An additional ANOVA looking at a subset of items measuring violence directly toward the child (i.e., being beat up, threatened to be shot or stabbed, etc.) indicated that the homeless children reported significantly more violence than the housed children ($F(1,25) = 4.57$, $p<.05$). The multivariate $F(1,4)=3.77$ for stability and stress variables was significant ($p<.01$). Associated significant ANOVAs indicated that the homeless children moved more times ($F(1,96)=9.00$, $p<.01$) and attended more schools ($F(1,96) = 6.30$) as compared to the housed children. There was no significant difference between the two groups in terms of mother-reported parenting hassles.

The multivariate F for psychological variables was not significant ($F(6,99)=.71, p>.10$). The mean score on the CBLC

for externalizing and internalizing disorders was 61.86 across the two groups. A t-test was computed to assess the difference between the means of internalizing and externalizing disorders for the combined homeless-housed group and the normative sample for the CBCL (mean = 50, SD=10, n=2368). Results indicate the the means for both groups were significantly above the normal range ($t(2473) = 11.56$, $p<.01$). After adjusting for age and sex and using a cutoff T-score of 70 (97.7th percentile) a large number of children in the combined sample of homeless and housed children fell in the clinical range (40%). In considering the children's scores on the Harter Competence Scale, there were no significant differences ($t(2203) = .97$) between the combined sample (mean = 3.2, SD=.43, n=108) and normative samples (mean = 2.9, SD = .62, n=2097).

Secondary Analyses: Three-Group Comparisons

There were relatively few differences between the housed (n=54) and homeless (N=54), therefore, the children who had never been homeless might be expected to show higher levels of psychological functioning and less environmental problems as compared to children who had ever experienced homelessness. In secondary analyses, the overall sample of children was considered in 3 groups: the currently homeless (n=54), the currently housed who had been previously homeless (n=26), and the currently housed with no history of homelessness (n=28). Approximately half of each of these three groups was ages 4-5, with equal numbers of boys and

girls (see Table 6, Appendix A). Approximately 60% of the children in each group had at least weekly contact with a father figure. The ratio of maternal age, education level, and employment status in the past year was approximately uniform in each group (see Table 7, Appendix A).

In order to determine if these three groups differed on psychological and environmental factors, the same 4 MANOVA's (involving the same 17 variables) were computed. The pattern of results is generally the same (see Table 8, Appendix A).

However, in terms of environmental factors ($F(12,196)= 2.47$, $p<.01$), the children who had never been homeless are the most distinct group. The families that were currently homeless are more similar to the housed families who had a history of homelessness.

Discussion

Sample Characteristics

Demographic characteristics of the present homeless sample (to which the housed sample was matched) were similar to previous studies of homeless mothers with children in shelters. For example, the homeless sample interviewed by Bassuk, Rubin & Lauriatt (1986) consisted largely of preschool age children with approximately equal numbers of boys and girls. Other studies have also found a high proportion of African Americans among homeless children (Zeisemer et al., 1994). Given the large general populations of African Americans in Detroit, our sample showed an even greater preponderance. The mean maternal age of 32 in the present sample is somewhat higher than the average age of 28 for homeless women with dependent children reported in other studies (e.g., Bassuk, 1988; Mills & Ota, 1989). In addition, the mothers in the current sample had an average of 3-4 children while similar studies have reported an average family size consisting of two children (Mills & Ota, 1989; Bassuk & Rosenberg, 1990).

Based on popular literature, one would likely expect that homeless women have lower educational attainment as compared to their housed counterparts. However, the homeless women in our sample reported significantly higher levels of education than the housed women. This finding is similar to the comparison group study of homeless and housed poor children and families by Bassuk & Rosenberg (1990) in

Boston. There is some evidence to suggest that a certain percentage of homeless women come from backgrounds where domestic violence contributed to their homelessness. It is possible that these women came from more affluent neighborhoods than the housed poor women. Such homeless women, while still living with potentially abusive partners, may have had more opportunities to acquire an education as compared to housed mothers who have been living in chronic poverty situations.

Main Analyses: Comparisons of the Homeless and Housed:

Based on the research literature, it appears that homeless children display a high rate of medical, emotional, and behavior problems. However, when compared to children living in poverty rather than only broad normative samples, differences are not consistently found. In the present study, group differences were found on a number of environmental avariables of interest; however, psychological factors failed to yield significant differences.

The finding that homeless children were more likely to be in unsafe environments with little space is expected given the restrictions of the sheltered environment. What is more surprising is the lack of significant differences between homeless and housed poor children on other environmental variables including comfort, privacy, friendliness, and overall quality. This suggests that our housed families may be experiencing similarily poor environments. It is possible that shelters have been

successful at providing comfortable, private, and friendly atmospheres similar to housed settings. Results of the secondary analyses comparing the three groups indicated that the previously homeless families within the housed sample appear to have obscured some of the environmental differences between the two groups. One possible explanation for this pattern of results is that the experience of homelessness may result in feelings of diminished integrity not only on a physical, environmental basis (i.e., currently homeless), but on an emotional level as well (i.e. previously homeless). One may think of this in terms of a ``labeling effect.'' The experience of homelessness is like a marker that the families carry with them and they may feel that because of their negative experience they are destined to live in environments of lower environmental quality. Therefore, self-report measures of their environmental quality are significantly lower than ratings of families who had never experienced homelessness. Another possible explanation is that families that are homeless need a significant amount of time to ``regroup'' economic resources and may be required to live in low quality environments for extended periods of time. The cross-sectional design of the current study does not allow for the evaluation of long-term effects of homelessness.

The finding that homeless children were more likely to be exposed to domestic verbal abuse toward their mothers is consistent with domestic violence being one of the main

causal factors in homelessness for women with dependent children. In addition to the implications of potential witnessing domestic violence, homeless children are also more likely to be directly exposed to violence in the community as compared to housed poor children.

The finding that homeless children are more likely to move around and change schools is also consistent with the existing literature (Bassuk, 1988). One might explain this by concluding that moving around is in fact part of the homeless experience in which shelters only provide a temporary respite. Thus, mothers who are still not able to provide a home for their children after a certain amount of time are forced to move to a new place resulting in a higher frequency of moving around and changing schools. This pattern cannot be healthy for children and they are forced to use resources to cope with the instability of their environments.

Homeless and housed mothers did not report statistically significant differences in the amount and intensity of parenting hassles. The lack of group differences on this and other variables, may be a result of unpredicted flaws in the matched design in which the homeless mothers reported higher educational attainment and moved from higher socio-economic environments prior to becoming homeless as compared to the housed mothers. It is also possible that, although homelessness is a stressful life event, shelters may be providing a temporary respite

with concrete physical assistance needed to reduce the amount of other stressors in the mother's life (e.g., home maintenance, paying bills, cooking and feeding the children, day care) and parenting hassles are somewhat reduced through the structure and support of the sheltered environment. On the other hand, housed mothers must balance multiple daily living responsibilities without the structure and support of the maintained sheltered environment. In addition, the consequences of not attending to their responsibilities have greater implications for the well-being of the housed families (e.g., loss of utilities, lack of food). Thus they may be more likely to be experiencing a cumulative effect of multiple stressors and more likely to view parenting and managing their children's behavior as an additional significant hassle on top of existing stress.

It was hypothesized that homeless children, as compared to demographically matched poor housed children, would have a significantly greater incidence of internalizing and externalizing disorders and lower levels of perceived competence. This hypothesis was not supported by the results. One possible explanation for this lack of findings is, when demographic variables associated with socioeconomic disadvantage are isolated from homelessness, there are fewer discrepancies in psychological and emotional functioning between housed poor and homeless children. Poor economic and family backgrounds could place both housed and homeless children at greater risk for behavioral problems. In fact,

results of the current study indicate both groups had significantly more problems than normal child populations. A full 40% of the overall sample was in the clinically elevated range on the CBCL indicating that many children in both groups are in need of further psychiatric evaluation. These findings suggest that psychological and emotional problems are related to the stresses associated with living in impoverished and unstable living conditions which characterize both the housed poor and homeless children in this study.

Children's reports on perceived competence also did not differentiate the two groups. This is not consistent with one prior study that used the Harter Perceived Competence Scales to compare homeless and housed poor children (DiBiase & Waddell, 1995). However, this prior study had a relatively small sample size (n=30 homeless children) and the two groups of homeless and housed children were not carefully matched on demographic characteristics. Thus, its findings could reflect differences between the groups on variables other than housing status. For example, the study's samples were not matched on race, with the homeless children being African American. In general, self-concept is believed to develop over childhood and feelings of love, significance, and competence are all thought to influence its formation (DiBiase & Waddell, 1995). Given that the homeless and housed groups of children in the current study were demographically similar, it is likely that both groups

were experiencing emotional deprivation and dysfunctional environments to similar degrees which accounts for the lack of differences between the two groups on perceived competence. In actuality, the overall mean scores of the two groups suggest that they have generally positive perceived competence. It may be that young children whose lives are dominated by assaults (i.e., poverty and/or homelessness) to their developing self-competence may defend themselves against the painful reality of their impoverished situation in order to function. It would be interesting to obtain teacher and parent reports of the same items to evaluate convergent validity of this measure using other sources of information.

Strengths and Limitations

The present study attempted to improve on past research in several ways. This study took an objective empirical approach based on measures with established validity and reliability. The study randomly sampled a large number of families from a variety of shelters for homeless people. A probability sample of homeless mothers with children, upon which the housed sample was demographically matched, was attained by sampling from eight different homeless shelters, 2 soup kitchens, and one homeless agency throughout Metropolitan Detroit. Recruiting homeless and housed families from less formal human service agencies (i.e., soup kitchens) resulted in a more representative sample. Another strength of the present study is that it included a measure

of children's self perception of competence which had only been considered in one other recent study to date.

Most importantly, the present study controlled demographic and geographic factors in its comparisons of homeless and housed children. The two groups were compared in terms of psychological and environmental factors controlling for basic demographic variables, such as child's sex, age, and race as well as maternal age and neighborhood income. This is a marked improvement over past research attempts to attain comparable samples of homeless and housed poor families. These meaningful comparisons permitted the isolation of the unique characteristics of homeless children over and above basic background characteristics.

There are some limitations of the current study which could be improved upon in future research. Obtaining a matched housed sample is necessary to attempt to delineate homelessness as a risk factor above and beyond poverty. However, similar to other studies of this nature, this design reflects the problems associated with procuring appropriate control groups. Although this study is a marked improvement over other comparison groups strategies, the problem of matching the two groups on all demographic characteristics was not possible. In fact, data on 22 additional homeless and 4 additional housed subjects were collected and not included due to difficulty matching on all the variables. Matching was especially difficult for neighborhood income. Although the two groups were matched

on this variable, the range of $10,000 allowed for some variability to emerge. Based on the final samples, the homeless women came from environments with somewhat higher median income levels than the housed. More important, the homeless women reported significantly higher educational attainment than the housed mothers. This finding indicates a methodological flaw in the current study which is similar to other studies of this nature (Bassuk, 1988). This bias may help account for the minimal differences found in this investigation. By not matching on this variable, a more conservative approach to finding differences in the two groups was taken. Future research should focus on obtaining exact matched samples on all demographic variables, including maternal education. Given the difficulty in subject recruitment of matched housed families, it may be beneficial to recruit subjects from other non-welfare dependent sources (such as door-to-door). However, this would require a significant amount of financial resources and would put the safety of interviewers at greater risk.

Though having mothers report on their child's symptoms is helpful due to developmental limitations of reports of young children, maternal report may differ from how the child actually feels, especially if the mothers are preoccupied with immediate stresses of living in poverty (i.e., she may be preoccupied and not tuned in to the child's behavior and emotional problems). This could be especially true for an internalizing disorder such as

depression as compared to the disruptive behavior disorders (Weinstein et al., 1990). Although parent report methods have been found to reliably measure mental health problems among children, our reliance on this type of assessment could be viewed as a limitation. Direct observation measures and child reports could also contribute additional information. Considering the structure of the interview process itself, questions from the measures were read to the children and mothers and they were required to respond verbally. It is possible that some of the mothers or children may have purposely tried to present themselves in a more positive or negative light.

The homeless sample in the present study primarily consisted of families who had spent the previous night at a homeless shelter. Although subjects were collected at a variety of shelters in both urban and suburban settings, it is possible that our over-reliance on the shelter population and lack of homeless families living on the streets or doubled up with friends or family may limit the generalizability of our findings. Studying broader samples of homeless families would provide a more comprehensive understanding of the homeless family population.

Both the homeless children and the children with homes came from families that were poor, had been receiving public assistance, and were primarily headed by single mothers who were unemployed. Some of the findings may reflect ongoing life experiences in that the homeless group tended to move

more often, and suffered more family violence than the families with homes. It is difficult to judge which of the differences that resulted were due to homelessness itself. However, it is expected that the chronic moves, lack of stability and uncertainties in daily living might ultimately adversely affect the homeless children. It is possible, given the limited scope of our measures, that differences between these groups were not found on the variables measured, but may in fact still be present and show up on other measures of psychological and emotional functioning, especially over time if homelessness and economic deprivations recur.

The lack of significant findings in the present study combined with the inconsistent findings in previous studies suggest that the outcomes of homeless children may be mediated by the general socio-emotional climate in their home and relationships with significant caretakers. Homelessness, itself, may not account for a large portion of variance in outcomes, at least in the short-term, but rather reflects a complex transactional process occurring between multiple aspects of the child's development and environment and likely results in outcomes that vary from healthy to pathological (Holden et al., 1995). The present study did not measure potential factors based on theories of risk and resilience in children's emotional and psychological functioning. Future studies may wish to include more such measures, including maternal psychopathology and stress,

environmental resources, and social resources. Considering models from developmental psychopathology may be useful in guiding future research on the psychological and emotional functioning of homeless and poor children (Holden et al., 1995).

Finally, the cross-sectional nature of the present study and other related studies does not allow for the implications of the long-term effects of homelessness on the development of children. Future research may wish to consider longitudinal designs to assess the effects of chronic poverty and homelessness on children's future adjustment and emotional functioning.

Implications

Results from the present study could have several implications for research and intervention with homeless children and families. Many researchers who study homeless children emphasize their high rates of psychological and emotional disorders. This study attempted to control demographic characteristics in order to determine if this group was psychologically and environmentally different from children who were still living at home. The present study found that internalizing and externalizing disorders on the CBCL may be important problems for poor housed and homeless children alike. At least in the short run, homelessness may not necessarily be detrimental to children's psychological and emotional functioning, particularly relative to the effects of poverty.

The similarities between the two groups suggest that homelessness is one event along a continuum of the experience of poverty rather than a temporary phenomenon with obvious and immediate effects. This is not to imply that homelessness is not a terrible experience for children, but rather it would be beneficial to focus on the severe detrimental effects of poverty in general. The results of this study support the view that poverty is an important risk factor.

Although the housed and homeless did not differ on all environmental variables of interest, the homeless children, whether currently or previously homeless, were more likely to report coming from unsafe environments with less space and privacy and lower overall quality over the past year than the housed children. This suggests that, although the shelters may be providing a temporary respite so that families can organize their lives again, the mothers are reporting that they are not satisfied with the environments that shelter provides (i.e., unsafe, less space, less privacy, and lower overall quality). However, the results indicate that shelter services are not detrimental to children's psychological functioning above and beyond the risks associated with poverty. Increased funding to support the nature of shelters as temporary respites with as little stress as possible is necessary to decrease the probability of poor adjustment and psychological distress in homeless children.

Because homeless children are likley to be exposed to community violence, measures aimed at decreasing exposure to negative events should be a priority of service providers working with these mothers and children. Many of these children have been witness to domestic violence and the extent of exposure needs to be assessed and addressed by service providers working with this subset of the homeless population.

An attempt must be made to change the conditions that lead to poverty and homelessness and assist children who are already poor and homeless. Past research supported by the current study suggests that there is significant variability in homeless children as a group. Programs need to be developed that respond flexibly to presenting needs taking into account the heterogeneous nature of homeless children. The context in which homelessness takes place must be considered which includes the reason for homelessness and maternal variables that provide a source of security and context within which children are functioning.

A wide range of policies needs to be developed to respond to the diverse needs of children living in all dimensions of poverty. The formative years of these children are often spent without the necessary basic resources necessary for sound emotional and psychological development. More research into the risk and resiliency factors that contribute to positive and negative outcomes is necessary in order to assist service providers working with

this population. Short-term intervention strategies should include reducing the stress that results from chronic poverty and increasing the protective factors that can buffer the effects of poverty and homelessness.

APPENDICES

APPENDIX A

Table 1.
Number of Expected and Obtained cases of Homeless Children Across Setting

SITE	ANNUAL CASES		SAMPLE	
SHELTERS	N	%	Expected N=45	Actual
Urban				
COTS	175	16	7	6
S.A.	100	10	4.5	5
Door Step	250	23	10	10
My Sister's Place	100	10	4.5	4
Booth	100	10	4.5	4
Suburban				
First Step	70	6	3	3
Westland	120	11	5	5
Haven	25	2	1	1
Soup Kitchens				
Capuchin's	100	10	4	5
Baldwin	25	2	1	1
Homeless Agency				
Caregivers	25	2	1	1
TOTAL	**1,090**	**100**	**45**	**45**

Table 2.
Sociodemographic Characteristics of Homeless and Housed Children

	Homeless (N=54)		Housed (N=54)		
Age	**n**	**%**	**n**	**%**	
4-5	22	41	23	42	
6-8	24	44	22	41	
9-10	8	15	9	17	
Gender					
Male	25	46	25	46	$\chi^2(1)=0.00$
Female	29	54	29	54	
Race					
White	6	11	3	06	$\chi^2(1)=1.09$
Nonwhite	48	89	51	94	
Contact with Father					
Little or None	15	38	14	41	$\chi^2(1)=0.056$
At least Weekly	24	62	20	59	

Table 3.
Sociodemographic Characteristics of Homeless and Housed Mothers

	Homeless (N=54)		Housed (N=54)	
Age	**n**	**%**	**n**	**%**
21-30	18	33	19	35
31-40	30	56	31	57
41-44	6	11	4	7
Maternal Education				
Less than H.S	22	41	33	61
High School Grad.	20	37	19	35
Some College	11	20	2	4
College Degree	1	2	0	0
Employment/Past Year				
Unemployed	34	63	35	65
Employed	20	37	19	35

Table 4. Characteristics of Homelessness

	Homeless (N=54)		Housed (N=54)	
Homeless History	**n**	**%**	**n**	**%**
Previously Homeless	22	41	28	52
Never Homeless	32	59	26	48
Amount of Time Homeless (Current Episode)				
1-7 days	13	24		
8-14 days	8	15		
15-29 days	6	11		
1-2 months	11	20		
3-5 months	7	13		
6-11 months	4	7		
12-17 months	4	7		
more than 36 months	1	2		
Reason for Homelessness				
Financial	5	9		
Housing	22	41		
Personal Distress	11	20		
Relationship	16	30		

Table 5.
Univariate Results Associated with Significant MANOVA's Comparing Housed and Homeless Children on Continuous Variables

MANOVA GROUPING Variables	Homeless (n=54)	Housed (n=54)	F
Housing Environment			
Comfort	4.13	3.59	
Safety	3.76	4.61	7.76**
Spaciousness	3.99	4.47	2.88+
Privacy	4.42	4.48	
Friendliness	4.57	4.87	
Overall Quality	4.38	4.63	
Violence			
CTS Verbal Abuse/Mom	18.30	11.63	4.07+
CTS Physical Abuse/Mom	7.26	6.06	
Community/Child report	37.03	32.98	3.00+
Community/Mother report	39.34	30.39	8.33**
Stability and Stress			
# Moves	4.81	2.72	9.00**
# Schools Attended	2.65	1.61	6.30*
Parenting Hassles	105.00	121.76	
Psychological			
Total Competence	3.38	3.20	
Internalizing	60.09	62.89	
Externalizing	60.67	63.62	

*p<.05 **p<.01

+trend = p<.10

Note. Univariate F's only presented when p<.10 for associated MANOVA F.

Table 6.
Child Sociodemographic Characteristics of Currently Homeless, Previously Homeless Housed, and Never Homeless Children

	Currently Homeless (N=54)		Previously Hmls Housed (N=26)		Never Hmls Housed (N=28)	
Age	**n**	**%**	**n**	**%**	**n**	**%**
4-5	22	41	10	9	13	46
6-8	24	44	14	54	8	29
9-10	8	15	2	8	7	25
Gender						
Male	25	46	12	46	13	46
Female	29	54	14	54	15	54
Race						
White	6	11	2	8	1	4
Nonwhite	48	89	24	92	27	96
Father Contact						
Little/None	15	38	5	38	9	43
Weekly or more	24	62	8	62	12	57

Table 7.
Sociodemographic Characteristics of TriGroup Comparison - Mothers

	Currently Homeless (N=54)		Previously Hmls Housed (N=26)		Never Hmls Housed (N=28)	
Age	**n**	**%**	**n**	**%**	**n**	**%**
21-30	18	33	9	35	10	36
31-40	30	56	14	55	17	61
41-44	6	11	3	15	1	3
Education						
Less than H.S.	22	41	15	58	18	64
High School Grad.	20	37	9	35	10	36
Some College	11	20	2	8	0	0
College Degree	1	2	0	0	0	0
Employment/Past Year						
Unemployed	34	63	17	65	18	64
Employed	20	37	9	35	10	36

Table 8.
Univariate Results Associated with Significant MANOVA's for TriGroup Comparison on Continuous Variables

MANOVA GROUPING Variables	Currently Homeless (N=54)	Previously Hmls Housed (N=26)	Never Hmls Housed (N=28)	F	Post-Hoc Tests[a]
Housing Environment					
Comfort	4.13	3.56	3.62		
Safety	3.76	4.46	4.74	4.07*	N>C,P
Spaciousness	3.99	3.96	4.94	4.64*	N>C,P
Privacy	4.42	4.07	5.05	2.76+	N>C,P
Friendliness	4.57	4.56	5.16		
Overall Qual.	4.38	4.09	5.13	4.76*	N>C,P
Violence					
CTS-Verbal Abuse	19.18	14.50	5.23		
CTS-Phys. Abuse	7.48	6.75	3.57		
Community/Child	41.91	38.00	26.71		
Community/Mother	42.91	33.25	29.64		
Stability and Stress					
# Moves	5.02	3.13	2.26	4.80*	C>P,N
# Schools	2.37	1.92	1.41	4.00**	C>P>N
Parent Hassles	106.04	125.85	118.12		
Psychological					
Competence	3.21	3.22	3.18		
Internalizing	59.16	62.05	61.41		
Externalizing	59.67	63.91	61.71		

Note. Univariate F's only presented when $p<.05$ for associated MANOVA F.

[a]For Student-Newman-Keuls tests, a ">" sign indicates a significant ($p<.05$) mean difference and a comma indicates no significant difference; C=currently homeless, P=previously homeless, N=never homeless.

*$p<.05$ **$p<.01$
+trend = $p<.10$

APPENDIX B

SAMPLING SURVEY

1. **Record sex of respondent.** (ask only if necessary)

   0. male 1. female

2. **What is your race/ethnic group?** (ask only if necessary)

   0. White, Non-Hispanic
   1. American Indian / Alaska Native
   2. Black, Non-Hispanic
   3. Hispanic
   4. Other

3-4. **How old are you?**
Record first digit of response on line 3.

5. **What is the highest grade in school that you have completed?**

   0. 8th or below
   1. 9th
   2. 10th
   3. 11th
   4. 12th or GED
   5. 13th
   6. 14th
   7. 15th
   8. 16th
   9. beyond 16th

6. **Do you have any dependent children?** (By dependent we mean that you pay for their support in some way.) **How many?**
If the respondent has no dependent children, blacken 0; otherwise, blacken the circle for the appropriate number of dependent children they do have. If the respondent has more than 9 children, blacken 9.

7. **Have you ever been supported by public assistance?**
0. NO 1. YES

8. **Do you consider yourself to be currently homeless? By homeless we mean: (1) that you do not have your own house or apartment, or (2) that your are living on the streets or in a shelter, or (3) that you are staying with friends or family in their apartment and do not pay them rent.**
0. NO 1. YES...<u>(skip to Q. 10)</u>

9. **Have you considered yourself homeless at all in the <u>past month</u>?** (using the above definition of homeless)
0. NO 1. YES

10. **Have you slept at a homeless shelter in the <u>past month</u>?**

0. NO 1. YES

Part 2: Frequency of Service Use During Past 12 Months

The proper way to record the frequency of service use information should be simple if you follow these steps:

STEP 1: Read the Opening Prompt listed at the bottom of this page.

STEP 2: Begin by asking the respondent if they have used any shelters in the past year. If they say "yes", ask the respondent to name all of the shelters they have used in the past year. If they say "no" to shelter use, go to the SOUP KITCHENS category. If they have used soup kitchens in the past year, you must ask the respondent to name all of the soup kitchens that they used in the past year. If they have not used any in the past year, then go to IN-PATIENT/DETOX PROGRAMS. Follow this pattern until you find a category of services that the respondent has used.

STEP 3: Once you have found a category they have used, ask the respondent to list all of the different services within that category that they have used in the past year. Some of the categories have been broken down into subcategories to facilitate the administration of the survey. When the respondent mentions the first service that they have used, write the three digit code for that service on spaces 11, 12 and 13 of your answer sheet.

STEP 4: Before going on to ask about any of the other services, ask the respondent how many days they have used this service in the past year.

STEP 5: Record the number of days on spaces 14, 15, and 16 of your answer sheet. Make sure to use 0's if the number is a one or two digit number (e.g. 001 days, 009 days, 025 days, etc.)

STEP 6: Go back to STEP 3 and begin the process again, this time recording the information on spaces 17-22. Continue this process, using blocks of 6 on your answer sheet, until the respondent has mentioned all services used in the past year. If more than 18 services have been used in the past 12 months, you should stop recording them here and start recording the data on a piece of paper. Space 120 is needed for Part 3.

NOTE: Do not forget to record data for the site where you currently are administering the survey.

Opening Prompt:

Next I would like to ask you about different services or places around Wayne County and the rest of Southeastern Michigan. I am going to read you a list of different types of services, and I want you to tell me whether you have used any of these places in the past 12 months. If you have any questions, or are not sure what a place or service is, please ask me.

SHELTERS:

WAYNE COUNTY SHELTERS
FEMALES ONLY

103. First Step (Canton)
112. Genesis House II (2015 Webb)
105. Grateful Home Dreamweaver Project (11037 Mack)
106. Heartline (8201 Sylvester)
107. House of Love (296 Erskine)
108. Interim House of the YWCA (Detroit)
109. LaBelle Center (1599 LaBelle)
169. Life and Greer Home (Detroit)
155. My Sister's Place (Detroit)
110. Saint Dominic's Missionaries of Charity

MALES ONLY

115. Detroit City Rescue Mission (3535 Third)
116. East Side YMCA (10100 Harper)
117. Kelly's House (New Life Mission)(2600 18th St.)
119. Moore House (401 Moore - Inkster)
120. New Day Multi-Purpose Community Center (511 Post)
121. Promised Land (7151 Strong)
125 Shar House (5675 Mayberry)
124. Unity Cathedral of Faith (8809 Schoolcraft)
123. YMCA Westside Branch (1601 Clark)

FAMILIES ONLY

151. Michigan Avenue Community Organization
130. Wayne County Family Center (30600 W. MI Ave.)

MALES AND FEMALES ALLOWED

141. Pine Center (formerly Billinghurst) (71 W. Willis)
113. Wigle Warming Center - Operation Get Down (Lodge)
142. COTS (26 Peterboro)
102. Day House (2640 Trumbull)
144. Deacon House (2126 Deacon)
145. Dexter House (15745 Dexter)
146. East Side Emergency (St. John's)(14320 Kercheval)
147. Effective Alternative Community Housing (Detroit)
148. Haven Community (138 W. Columbia)
128. Interfaith Hospitality Drop-In Center (3627 Cass)
150. Kentucky House (16135 Kentucky)
161. Nia House (11105 E. Jefferson)
152. Midtown Care House (640 W. Willis)

153. Miracle Temple (31650 Van Born - Wayne)
154. Mother Waddles (Detroit)
162. Outreach Housing (650 Glynn Ct.)
114. Redford Baptist (25295 Grand River)
157. Roosevelt Home (282 E. Bethune)
126. Salvation Army Downriver Corps. (1258 Biddle)
160. T.C. Simmons Ministries (10501 Orangelawn)
122. The Salvation Army - Sibley Shelter

MACOMB COUNTY SHELTERS

165. MATTS (9844 E. Nine Mile - Warren)
131. MCCares (33 Broadway - Mt. Clemens)
127. MCWarm (14057 E. Nine Mile - Warren)
166. The Salvation Army (34 Grand - Mt. Clemens)
168. The Salvation Army (27300 Van Dyke - Mt. Clemens)
167. Turning Point (Mt. Clemens)

MONROE COUNTY SHELTERS

171. Philadelphia House I (For Men)(119 E. Third)
172. Philadelphia House II (For Men)(119 E. Third)
170. Safehouse (For Women Only)(502 W. Elm - Monroe))

OAKLAND COUNTY SHELTERS

180. HAVEN (Help Against Violent Encounters)(Pontiac)
181. New Bethel Mission(396 Orchard Lake - Pontiac)
182. Pontiac Rescue Mission (For Men & Women)
185. South Oakland Shelter (431 N. Main - Royal Oak)
184. The Salvation Army (34 Oakland Ave. - Pontiac)

ST. CLAIR COUNTY SHELTERS

191. Domestic Assault & Rape Elimin. Svces. (DARES)
192. Pathway Shelter (511 Union - Port Huron)
199. Other shelter not listed above

SOUP KITCHENS:

WAYNE COUNTY SOUP KITCHENS

241. 24-Hour Walk-In Center(Third and MLK)(L 7d/w)
238. Baptist Center (2700 Second)(L 4d/w)
202. Better Living Center (3240 Puritan)(L 3d/w)
203. Calvary Church of God (15025 Fenkell)(L 1d/w)
204. Capuchin Community Ctr (1760 Mt. Elliott)(L 5d/w)
205. Cass United Methodist(3901 Cass)(B 5d/w; L 1d/w)
206. Charles Williams (14954 Meyers)(B-L 1d/w; D 1d/w)
207. Christland Missionary Church (12901 Steel)(L 2d/w)
208. Crossroads (92 E. Forest)(L 1d/w)
210. Detroit City Rescue Mission (3535 Third)(D 7d/w)
211. Divinity Lutheran (2110 Springwells)(L 3d/w)
212. East Side Emergency (14320 Kercheval)(L 6d/w)
213. First Presbyterian Church (2930 Woodward)(L 1d/w)
214. Fort Street Presbyterian (631 W. Fort St.)(B 1d/w)
215. Hare Krishna Community (14224 Jefferson)(D 3d/w)
216. Inner-City Sub-Center (8411 E. Forest)(B 4d/w)
239. Just Love (Grand River)(L 4d/w)

217. Manna Meals (1950 Trumbull)(B 5d/w)
218. Mt. Carmel Tabernacle (9900 Gratiot)(L 2d/w)
219. New Christian Liberty (51490 Lasher)(L 1d/w)
220. New Day Multi-Purpose Community Center (511 Post)
248. Oakland Baptist Church (309 Harper)(L 3d/w)
240. Open Door Rescue Mission (3442 Mc Dougall)(D 4d/w)
221. Operation Feed the People (11465 Mitchell)(L 3d/w)
246. People's Community Church (8601 Woodward)(L 2d/w)
222. Region III Soup Kettle (35408 Beverly)(L 3d/w)
223. Region #4 Community (24250 Telegraph)(D 1d/w)
243. Roosevelt Hotel (2550 14th St.)(L 3d/w)
247. Russel St. Baptist Church (8700 Chrysler)(L 5d/w)
224. Saint Andrew Food Guild (2261 15th St.)(D 3d/w)
225. Saint Christine's Church (22303 Fenkell)(L 1d/w)
245. Saint Christopher House (1117 Field)(L 5d/w)
226. Saint Dominic's(4835 Lincoln)(B 6d/w)
227. St Ladislaus Catholic Church (2730 Caniff)(D 1d/w)
228. St Leo Catholic Church (4860 15th St.)(L 6d/w)
237. Sweet Kingdom (4190 Chene)(L 1d/w)
232. Temple of Love (390 Geneva)(B 2d/w; L 2d/w)
231. The Salvation Army (601 Bagley)(L 1d/w; D 2d/w)
229. The S.A.-Brightmoor(15133 Burgess)(L 1d/w; D 3d/w)
230. The S.A.- Harbor Light Center (2643 Park)(D 7d/w)
233. Trinity Episcopal Church (1519 MLK)(L 1d/w)
242. United Faith Center (4107 Cass)(L 1d/w; D 1d/w)
234. United Sisters-1 (16339 Rosa Park)(L 4d/w)
236. Yes I Can Mission (8811-8837 Linwood)(D 3d/w)
244. Yorba Hotel (4020 W. Lafayette)(D 3d/w)

OAKLAND COUNTY SOUP KITCHENS

250. Baldwin Avenue Center (212 Baldwin)(L 5d/w)
253. Community Baptist Church (309 N. Main - Royal Oak)
249. MATCHAN (150 E.Wide Trek)(L 2d/w)
251. Pontiac Rescue Mission (35 E. Huron)(B,L,D 7d/w)

ST. CLAIR COUNTY SOUP KITCHENS

290. Saint Martin's (805 Chestnut)(L 6d/w; B 6d/w)
299. Other soup kitchen not listed above

IN-PATIENT/DETOX PROGRAMS (psychiatric/substance abuse):

WAYNE COUNTY IN-PATIENT/DETOX PROGRAMS

301. Adult Rehab Center (1627 Fort St.)
302. Annapolis Hospital Westland (2345 Merriman)
303. Christian Guidance Center (3684 Trumbull)
317. Connor House - Eastwood (11542 Connor)
380. Detroit City Rescue Mission - (3535 Third)
371. Detroit Receiving Hospital (4201 St. Antoine)
318. Detroit Riverview Hospital (12523 Third)
325. Doctors' Hospital (2730 Jefferson)
319. Elmhurst Home (12010 Linwood)
323. Genesis House (131 Stimson)
304. Grateful Home (335 E. Grand Blvd.)
326. Harper Hospital (3990 John R.)

305. Hope, Unity and Growth (4875 Coplin)
320. Hutzel Hospital (201 St. Antoine)
307. Mariner's Inn (445 Ledyard)
327. Mercy Hospital (5555 Conner)
321. Michigan Health Center (5435 Woodward)
308. Northville Regional (41001 W. Seven Mile)
316. Oakwood Hospital (18101 Oakwood - Dearborn)
329. Patterson House (1151 E. Grand)
333. Robinson House (51 Midland - Highland Park)
372. Sacred Heart (2203 St. Antoine)
370 Saint Mary's (36475 5 Mile - Livonia)
334. Seaway Hospital (5450 Fort - Trenton)
310. Shar House (1852 W. Grand Blvd.)
328. Shar House (4216 McDougall)
311. Simon House (16260 Dexter)
313. Sobriety House (2081 W. Grand Blvd.)
324. The Salvation Army - Booth (130 W. Grand Blvd.)
309. The Salvation Army - Harbor Light (2643 Park)
322. Veterans' Hospital (3415 Southfield - Allen Park)
314. Walter Reuther Psych Hosp (30901 Palmer)
315. Westland Medical Center (2345 Merriman)

LAPEER COUNTY IN-PATIENT/DETOX PROGRAMS

330. Lapeer Regional Hospital (1375 N. Main - Lapeer)

MACOMB COUNTY IN-PATIENT/DETOX PROGRAMS

340. McRest (14057 E. Nine Mile - Warren)
336. Harper/Warren Chemical Dependency (4050 E.12 Mile)
338. Sacred Heart Rehab Center (400 Stoddard - Memphis)
343. Saint John Hospital (26755 Ballard - Mt. Clemens)
339 The S. A. Harbor Light Ctr. (23700 Van Dyke)
356. The Salvation Army (Nine Mile - Warren)

MONROE COUNTY IN-PATIENT/DETOX PROGRAMS

351. The S.A.-Harbor Light (1018 E. Second)

OAKLAND COUNTY IN-PATIENT/DETOX PROGRAMS

344. Botsford General Hospital (28050 Grand River)
360. Clinton Valley Center (140 Elizabeth - Pontiac)
345. Community Programs (1435 North Oakland)
363. Eastwood Clinic (1515 North Stephenson)
347. Havenwick Hospital (1525 University)
348. Highland Waterford Center (4501 Grange Hall)
331. Pontiac Osteopathic Hospital(50 N. Perry)
353. Pontiac Osteopathic Hospital (16 1/2 E. Huron)
364. Pontiac Rescue Mission (35 E. Huron - Pontiac)
362. Resident Awareness Program (1435 N. Oakland)
354. Saint Joseph Mercy Hospital (900 Woodward)
355. Turning Point Halfway House (121 Prall - Pontiac)

ST. CLAIR COUNTY IN-PATIENT/DETOX PROGRAMS

335. Port Huron Hospital (1001 Kearney - Port Huron)

399. Other in-patient not listed above

OUT-PATIENT PROGRAMS (psy./substance abuse/homelessness only):

WAYNE COUNTY OUT-PATIENT PROGRAMS

401. Annapolis Hospital Westland (2345 Merriman)
438. BAPCO Substance Abuse (17357 Klinger)
439. Boniface Aftercare Services (7737 Kercheval)
402. Boniface Comm. Action Corps (25050 W. Outer Dr.)
443. Center for Behavioral Therapy (24453 Grand River)
458. Community Care Services (1174 Fort - Lincoln Park)
403. Community Care Services (8750 Telegraph - Taylor)
404. Community Comm. on Drug Abuse (13325 Farmington)
444. Det. American Indian Health Ctr. (4400 Livernois)
405. Detroit Central City Comm. (10 Peterboro)
480. Detroit Receiving Hospital (4201 St. Antoine)
407. Development Centers (24424 W. McNichols)
428. Doctors' Hospital (2730 Jefferson)
408. Downriver Guidance Clinic (2959 Bittle)
424. Eastwood Clinics (7 Mile and Hayes)
482. Evergreen Counseling Center (Lifeline)
409. Fairlane Comm. Mental Health Ctr (23400 Michigan)
429. Harper Hospital (3990 John R.)
470. Heritage Hospital (10000 Telegraph - Taylor)
445. Hutzel Hospital (301 E. Hancock)
410. Hutzel Hospital (4201 St. Antoine)
446. Hutzel Recovery Center (13301 Mound Rd.)
449. Insight at Detroit (7404 Woodward)
485. Jefferson House (8311 E. Jefferson)
411. Lafayette Clinic (951 E. Lafayette)
425. Latino Family Services (713 Junction)
434. Latino Family Services (4748 Vernor)
435. Latino Family Services (3815 W. Fort)
481. Mercy Hospital(5555 Conner)
412. Metro East Drug Treatment Corp. (8047 Harper)
433. Metro East Drug Treatment Corp. (13627 Gratiot)
427. Michigan Health Center (5435 Woodward)
453. Michigan Rehab Services (14120 E. 7 Mile)
413. National Council on Alc.(17555 James Cz. Highway)
423. Needy Helping Hands Mission (8631-35 Second St.)
414. New Center Mental Health Svs (2051 W. Grand Blvd)
415. North Central Mental Health Ctr (49 W. Seven Mile)
416. Northeast Guidance Center (13340 E. Warren)
436. Northeast Guidance Center (17000 E. Warren)
437. Northeast Guidance Center (2670 Chalmers)
454. Northwest Treatment Center (14602 Greenfield)
453. Project Life (18641 W. Seven Mile)
487. Redford Counseling Center (25945 West 7 Mile)
417. Renaissance Community Health Srvcs (13940 Tireman)
418. Romulus Help Center (9340 Wayne Rd. - Romulus)
457. Saint Mary's Hospital(36475 Five Mile - Livonia)
419. Shar House (5675 Mayberry Grand)

421. Southwest Community Health Svs (1700 Waterman)
422. Suburban West Community Ctr (11677 Beech-Daly)
426. Veterans' Hospital (3415 Southfield - Allen Park)
471. West Side Mental Health Services (24548 W. Warren)
472. Wyandotte Health Center (2411 Fort - Wyandotte)

LAPEER COUNTY OUT-PATIENT PROGRAMS

430. Alcohol Info. and Counseling Ctr (1575 Suncrest)
432. Lapeer Regional Hospital (1375 N. Main - Lapeer)

MACOMB COUNTY OUT-PATIENT PROGRAMS

497. Harper/Warren Chemical Depend.(4050 E. 12 Mile)
498. Lakewood Substance Abuse Center (26000 Hoover)
705. Saint John Hospital (26755 Ballard - Mt. Clemens)
704. The Salv. Army Harbor Light Ctr (23700 Van Dyke)

MONROE COUNTY OUT-PATIENT PROGRAMS

451. Family Counseling and Shelter Srvs (502 W. Elm)
450. Monroe County Community Health (1001 South)
452. The Salvation Army - Harbor Light (3580 Custer)

OAKLAND COUNTY OUT-PATIENT PROGRAMS

707. Auro Medical Center (2515 Woodward)
721. Eastwood Clinic (1515 N. Stephenson - Royal Oak)
722. Evergreen Counseling (7460 Dixie - Clarkston)
726. Evergreen Counseling (31400 Northwestern Highway)
727. First Step Mental Health Center (2346 S. Commerce)
728. Ganesh Clinic (28165 Greenfield - Southfield)
730. Havenwyck Hospital (1525 University)
731. Henry Ford Health System (1475 W. Big Beaver)
732. Highland - Waterford Center (377 S. Telegraph)
733. Highland - Waterford Center (4501 Grange Hall)
735. Insight at Novi (39555 W. Ten Mile - Novi)
738. Kingswood Hospital (10300 W. Eight Mile)
464. Oakland Family Services (114 Orchard Lake)
741. Oakland Family Services (2045 E W Maple)
742. Oakland Family Services (2351 W. Twelve Mile)
465. Pontiac Hospital Mental Health (461 W. Huron)
744. Procare Out-Patient Services (24 E. Huron)
745. Providence Hospital (16001 W. Nine Mile)
746. Recovery Consultants (1111 Woodward - Royal Oak)
466. Resident Awareness Program (1435 N. Oakland)
747. Saint Joseph Mercy Hospital (900 Woodward)
748. Turning Point Halfway House (121 Prall - Pontiac)
467. Women's Survival Center (157 W. Pike - Pontiac)
749. Woodward Counseling (35 S. Johnson - Pontiac)

ST. CLAIR OUT-PATIENT PROGRAMS

473. Blue Water Mental Health Clinic (1501 Kraft)
474. Blue Water McKinnon Family Ctr.(1010 Lincoln)
475. Blue Water Pine Grove(3847 Pine Grove)
488. Port Huron Hospital (1001 Kearney - Port Huron)
490. Professional Counseling Ctr (515 Parker)
489. Professional Counseling Center (520 Superior)

477. The Center for Human Resources (1001 Military)
478. The Center for Personal Growth (817 Tenth)
476. The Harbor (3061 Commerce - Port Huron)
499. Other out-patient not listed above

HOMELESS AGENCIES/PROGRAMS:

WAYNE COUNTY HOMELESS AGENCIES/PROGRAMS

532. 24-Hour Walk-In Center (54 W. Henry)
501. Arab Community Center(2651 Saulino Ct. - Dearborn)
554. Brewster Project (3455 Woodward)
502. Cass Community United Methodist Church (3901 Cass)
504. Detroit Housing Department (2211 Orleans)
505. Detroit Neighborhood Services Dept (5031 Grandy)
506. Drop In Center (3627 Cass)
533. Freedom Center (1818 Springwell)
534. Herman Kiefer (1151 Taylor)
512. Homeless Intervention Aide (4114 Third St.)
513. Homeless Veterans (2424 W. Grand Blvd.)
515. Inkster Housing Commission (4500 Inkster Rd.)
518. Michigan Ave.Emergency Housing Prog(6608 Michigan)
519. Mt. Venin Baptist (15125 Burt)
581. Operation Get Down (9980 Gratiot)
526. United Community Housing Coalition (47 East Adams)
529. Wayne County Dept of Social Srvs (1200 Sixth St.)
530. Wayne County Legal Services (65 Cadillac Square)
531. Wayne Metro Community Service (16480 Woodward)
528. Detroit Social Services (4733 Conner)
536. Detroit Social Services (3606 E. Forest)
541. Detroit Social Services (8000 Fullerton)
537. Detroit Social Services (1145 W. Grand Blvd.)
523. Detroit Social Services (2550 W. Grand Blvd.)
542. Detroit Social Services (5131 Grand River)
543. Detroit Social Services (17330 Greydale)
509. Detroit Social Services (8655 Greenfield)
544. Detroit Social Services (9641 Harper)
540. Detroit Social Services (6534 W. Jefferson)
517. Detroit Social Services (7608 Kercheval)
520. Detroit Social Services (1950 W. Lafayette)
546. Detroit Social Services (14060 Maddelein)
535. Detroit Social Services (14050 Maddelein)
547. Detroit Social Services (2400 McNichols)
548. Detroit Social Services (6821 Medbury)
549. Detroit Social Services (4505 Oakman)
539. Detroit Social Services (16870 Schaefer)
550. Detroit Social Services (16940 Schaefer)
538. Detroit Social Services (14000 Schoolcraft)
545. Detroit Social Services (4201 St. Antoine)
525. Detroit Social Services (8031 Tireman)
510. Hamtramck Social Services (2400 Denton)
511. Highland Park Social Services (245 Pitkin)
516. Inkster Social Services (27107 Michigan Ave.)
551. Lincoln Park Social Services (999 Fort St.)
552. Redford Social Services (27260 Plymouth)

553. Romulus Social Services (38211 Van Born)
524. Taylor Social Services (22050 Pennsylvania)

LAPEER COUNTY HOMELESS AGENCIES/PROGRAMS

585. Lapeer Co. Dpt of Social Services (1505 Suncrest)

MACOMB COUNTY HOMELESS AGENCIES/PROGRAMS

567. Liberties Incorporated (Mt. Clemens)
590. Macomb County Rotating Emergency Shelter Team
562. Family Counseling and Shelter Services(502 W. Elm)
561. Monroe Co Dept of Social Services (1051 Telegraph)

OAKLAND COUNTY HOMELESS AGENCIES/PROGRAMS

570. Latin Affairs (345 Edison - Pontiac)
571. Madison Hts District IV Office (31170 John R.)
572. Oakland Co. Dept of Social Srvs (196 Oakland)
573. Pontiac Area Lighthouse (109 William - Pontiac)
574. Pontiac Dept of Social Services (1125 N. Perry)
575. Pontiac District IV Office (235 N. Saginaw)
576. Troy People Concerned (930 John R. - Troy)
577. Walled Lake District Office (195 Ladd)

ST. CLAIR COUNTY HOMELESS AGENCIES/PROGRAMS

580. Emergency Needs Program (3111 Electric)
599. Other homeless agency/program not listed above

STREET SETTINGS:

WAYNE COUNTY STREET SETTINGS

601. Care-A-Van
602. Detroit Bus Station
603. Detroit Train Station
607. Meals on Wheels (United Sisters of Charity)
604. Rural Setting within Wayne County
605. Street Outreach Program
606. Streets (Urban Setting)
699. Other homeless setting not listed above

Part 3: Interviewer Log

110. For all REFUSALS you must answer any of the questions that you can make a reasonable guess at (#1 and 2 are easy, #3-4 give best estimate, then code any others you may have talked about.) You also must use one of the following codes to give the reason why they refused or were ineligible for the interview:

0. general refusal/DK
1. no time
2. alcohol/substance impaired
3. language differences
4. refugee
5. non-homeless
6. non-unique to the sector
7. wrong frequency of use
8. completed screening, was eligible, but refused.

DEMOGRAPHICS

1-5. What is your current five digit zip code. If homeless, what is the zip code were you last lived when you were not homeless. (If the respondent does not know the number, then get the name of the city and address. Look up the zip code after completion of the interview. Be sure to write down this information on a separate sheet of paper so you don't forget)

line 1=first digit of zip code
line 2=second digit of zip code
line 3=third digit of zip code
line 4=fourth digit of zip code
line 5=fifth digit of zip code

6-11. What is your birth date? (MM/DD/YY)

line 1=first digit of month
line 2=second digit of month
line 3=first digit of day
line 4=second digit of day
line 5=first digit of year
line 6=second digit of year

12. How long have you been living in your current arrangements?

0. 1-7 days
1. 8-14 days
2. 15-29 days
3. 1-2 months
4. 3-5 months
5. 6-11 months
6. 12-17 months
7. 18-23 months
8. 24-36 months
9. more than 36 months

13. About how long have you been homeless?

0. 1-7 days
1. 8-14 days
2. 15-29 days
3. 1-2 months
4. 3-5 months
5. 6-11 months
6. 12-17 months
7. 18-23 months
8. 24-36 months
9. more than 36 months

14-16. What reason(s) would you give to account for your homelessness?

0. job loss/lack of work
1. eviction
2. lack of affordable housing
3. mental illness/personal crisis
4. drug/alcohol abuse
5. termination of public assistance
6. physical disability
7. disruption of personal relationship/divorce
8. other

Code in the order mentioned by Respondent

Question #14 = First Reason?
Question #15 = Second Reason?
Question #16 = Third Reason?

17. Where did you sleep or stay last night?

0. own place
1. street
2. shelter
3. car/truck/abandoned vehicle
4. abandoned building
5. transitional housing
6. friends/relatives
7. other

18. What is your current marital status?

0. Married
1. Widowed
2. Separated (either legally or informally)
3. Divorced/Annulled
4. Never married

19. Are you currently enrolled in school or college?

0. NO 1. YES, part time 2. YES, full time

20. What was the highest grade in school that your father completed?

0. 8th or below
1. 9th
2. 10th
3. 11th
4. 12th
5. 13th
6. 14th
7. 15th
8. 16th and beyond
9. don't know

21. What is the highest degree your father has attained? (Code the highest one that applies).

0. no High School diploma or no GED
1. High School diploma or GED
2. Degree from Trade or Vocational School
3. Associates Degree
4. Bachelors Degree
5. Graduate Degree
9. don't know

22-24. What was your father's occupation?

Use the Social Economic Status Sheet included in the interview to figure out what the most exact three digit code is for their father's job. Make sure you are very exact in both what the father's job title is, and what the proper code should be. (Record the code in spaces 22-24).

25. What is the highest grade in school that your mother completed?

0. 8th or below
1. 9th
2. 10th
3. 11th
4. 12th
5. 13th
6. 14th
7. 15th
8. 16th and beyond
9. don't know

26. What is the highest degree your mother has attained? (Code the highest one that applies).

0. no High School diploma or no GED
1. High School diploma or GED
2. Degree from Trade or Vocational School
3. Associates Degree
4. Bachelors Degree
5. Graduate Degree
9. don't know

27-29. What was your mother's occupation?

Use the Social Economic Status included in the interview to figure out what the most exact three digit code is for their mother's job. Make sure you are very exact in both what their mother's job title is, and what the proper code should be.

Use lines 27-29 to record the three digit code.

30. How many children do you have? (code up to 9 - all together including 1-2 CHILDREN COMPLETING THE INTERVIEW).

QUESTIONS 31-37 AND 41-47 SHOULD BE CODED ONLY FOR THE TWO CHILDREN COMPLETING THE INTERVIEW (i.e. children ages 3-10). IF THERE IS ONLY 1 ELIGIBLE CHILD THEN LEAVE QUESTIONS 41-47 BLANK AND CODE THE REST OF THE CHILDREN STARTING WITH SPACE 51.

31-36. What is (CHILD 1)'s birth date? (MM/DD/YY)

line 31=first digit of month
line 32=second digit of month
line 33=first digit of day
line 34=second digit of day
line 35=first digit of year
line 36=second digit of year

37. Record sex of Child 1. (ask only if necessary)

0. male
1. female

41-46. What is (CHILD 2)'s birth date? (MM/DD/YY)

line 31=first digit of month
line 32=second digit of month
line 33=first digit of day
line 34=second digit of day
line 35=first digit of year

line 36=second digit of year

47. Record sex of Child 2. (ask only if necessary)
0. male 1. female

QUESTION 48-50 should be left blank, they does not exist.

Begin coding birth dates of other children (beyond 2) on line 51. Line 51-56 should be the birth date of child 3, line 61-66 should be the birth date of child 4, line 71-76 should be the birth date of child 5, etc. If there are no additional children,, then leave blank and go to section 3: Daily Hassles..

51-56. What is (CHILD 3)'s birth date? (MM/DD/YY)
line 51=first digit of month
line 52=second digit of month
line 53=first digit of day
line 54=second digit of day
line 55=first digit of year
line 56=second digit of year

57. Record sex of Child 3.
0. male 1. female

61-66. What is (CHILD 4)'s birth date? (MM/DD/YY)
line 61=first digit of month
line 62=second digit of month
line 63=first digit of day
line 64=second digit of day
line 65=first digit of year
line 66=second digit of year

67. Record sex of Child 4.
0. male 1. female

71-76. What is (CHILD 5)'s birth date? (MM/DD/YY)
line 71=first digit of month
line 72=second digit of month
line 73=first digit of day
line 74=second digit of day
line 75=first digit of year
line 76=second digit of year

77. Record sex of Child 5.
0. male 1. female

81-86. What is (CHILD 6)'s birth date? (MM/DD/YY)
line 81=first digit of month
line 82=second digit of month
line 83=first digit of day
line 84=second digit of day
line 85=first digit of year

line 86=second digit of year

87. Record sex of Child 6.
0. male 1. female

91-96. What is (CHILD 7)'s birth date? (MM/DD/YY)
line 91=first digit of month
line 92=second digit of month
line 93=first digit of day
line 94=second digit of day
line 95=first digit of year
line 96=second digit of year

97. Record sex of Child 7.
0. male 1. female

101-106. What is (CHILD 8)'s birth date? (MM/DD/YY)
line 101=first digit of month
line 102=second digit of month
line 103=first digit of day
line 104=second digit of day
line 105=first digit of year
line 106=second digit of year

107. Record sex of Child 8.
0. male 1. female

111-116. What is (CHILD 9)'s birth date? (MM/DD/YY)

line 111=first digit of month
line 112=second digit of month
line 113=first digit of day
line 114=second digit of day
line 115=first digit of year
line 116=second digit of year

117. Record sex of Child 9.

0. male 1. female

APPENDIX C

CHILD BEHAVIOR CHECKLIST FOR AGES 4-10

Directions: Below is a list of items that describe children. For each item that describes your child now or within the past 12 months, please respond "very true" if the item is very true or often true of your child. Respond "sometimes" if the item is somewhat or sometimes true of your child. If the item is not true of your child, say "not true".

Interviewer: Record the subject's responses on the answer sheet using the following codes:

A. Not True
B. Somewhat or Sometimes True
C. Very True or Often True

1. **Acts too young for his/her age**
2. **Allergy**
3. **Argues a lot**
4. **Asthma**
5. **Behaves like opposite sex**
6. **Bowel movements outside toilet**
7. **Bragging, boasting**
8. **Can't concentrate, can't pay attention for long**
9. **Can't get his/her mind off certain thoughts**
10. **Can't sit still, restless, hyperactive**
11. **Clings to adults or too dependent**
12. **Complains of loneliness**
13. **Confused or seems to be in a fog**
14. **Cries a lot**
15. **Cruel to animals**
16. **Cruelty, bullying, or meanness to others**
17. **Daydreams or gets lost in his/her thoughts**

18. Deliberately harms self or attempts suicide
19. Demands a lot of attention
20. Destroys his/her own things
21. Destroys things belonging to family or other children
22. Disobedient at home
23. Disobedient at school
24. Doesn't eat well
25. Doesn't get along with other children
26. Doesn't seem to feel guilty after misbehaving
27. Easily jealous
28. Eats or drinks things that are not food
29. Fears certain animals, situation, or places
30. Fears going to school
31. Fears he/she may do something bad
32. Feels he/she has to be perfect
33. Feels or complains that no one loves him/her
34. Feels others are out to get him/her
35. Feels worthless or inferior
36. Gets hurt a lot, accident prone
37. Gets in many fights
38. Get teased a lot
39. Hangs around other children who get in trouble
40. Hears things that aren't there
41. Impulsive or acts without thinking
42. Likes to be alone
43. Lying or cheating
44. Bites fingernails

45 Nervous, high strung, or tense

46. Nervous movements or twitching

47. Nightmares

48. Not liked by other children

49. Constipated, doesn't move bowels

50. Too fearful or anxious

51. Feels dizzy

52. Feels too guilty

53. Overeating

54. Overtired

55. Overweight

56. Physical problems without known cause

57. Aches or pains

58. Headaches

59. Nausea, feels sick

60. Problems with eyes

61. Rashes or other skin problems

62. Stomachaches or cramps

63. Vomiting, throwing up

64. Other physical problems

65. Physically attacks people

66. Picks nose, skin, or other parts of body

67. Plays with own sex parts in public

68. Plays with own sex parts too much

69. Poor school work

70. Poorly coordinated or clumsy

71. Prefers playing with older children

72. Prefers playing with younger children
73. Refuses to talk
74. Repeats certain acts over and over; compulsions
75. Runs away from home
76. Screams a lot
77. Secretive, keeps things to self
78. Sees things that aren't there
79. Self-conscious or easily embarrassed
80. Sets fires
81. Sexual problems
82. Showing off or clowning
83. Shy or timid
84. Sleeps less than most children
85. Sleeps more than most children during day and/or night
86. Smears or plays with bowel movements
87. Speech problem
88. Stares blankly
89. Steals at home
90. Steals outside the home
91. Stores up things he/she doesn't need
92. Strange behavior
93. Strange ideas
94. Stubborn, sullen, or irritable
95. Sudden changes in mood or feelings
96. Sulks a lot
97. Suspicious
98. Swearing or obscene language

99. Talks about killing self

100. Talks or walks in sleep

101. Talks too much

102. Teases a lot

103. Temper tantrums or hot temper

104. Thinks about sex too much

105. Threatens people

106. Thumb sucking

107. Too concerned with neatness or cleanliness

108. Trouble sleeping

109. Truancy, skips school

110. Underactive, slow moving, or lacks energy

111. Unhappy, sad, or depressed

112. Unusually loud

113. Uses alcohol or drugs

114. Vandalism

115. Wets self during the day

116. Wets the bed

117. Whining

118. Wishes to be of opposite sex

119. Withdrawn, doesn't get involved with others

120. Worrying

APPENDIX D

HARTER PERCEIVED COMPETENCE - WHAT AM I LIKE? (children ages 8-10)

Instructions to child: **Here are some sentences that we can read together that may or may not describe what you are like. There are no right or wrong answers. Let's try a sample question. I will read it outloud and you follow along with me.** (Read sample question to child). **This question talks about two kinds of kids and I want to know which kids are most like you. So, first decide whether you are more like the kids on the left side who would rather play outdoors or whether you are more like the kids on the right side who would rather watch T.V.** (Let child choose which side). **Now, the second things I want you to think about, now that you have decided which kind of kids are most like you, is to decide whether that is only "sort of true for you" or "really true for you".** (Let child respond). **O.K. that was just for practice. Now I will read some more sentences outloud and you can follow along and make your choice.**

HARTER PERCEIVED COMPETENCE

(INSTRUCTIONS FOR AGES 4-7)

Interviewer: The child is given a sample item at the beginning of the booklet and instructed as follows:

I have something here that's kind of like a picture game and it's called "which boy/girl is the most like me". I'm going to tell you about what each of the boys/girls in the picture is doing.

Sample: (Interviewer points to the picture on the left). **This boy/girl is usually kind of happy and this boy/girl** (interviewer points to the picture on the right) **is usually kind of sad. Now I want you to tell me which of these boys/girls is most like (Child's Name).**

After the child has pointed to the picture appropriate for him/her, the interviewer points to the circles directly below and emphasizes the key qualifying words to help the child refine his/her choice further. The interviewer should always start with the larger circle and proceed to the smaller circle. Thus, if the child points to the happy picture in response to the question concerning which is most like him/her, the examiner would say:

Are you always happy? (pointing to the larger circle)
Or are you usually happy? (pointing to the smaller circle)

Occasionally a child will point to the middle of the two pictures and say that both are like him/her. The interviewer should then say: **Yes, sometimes we do feel both ways, but if you had to pick which of these boys/girls is the way you are most of the time, which one would you choose?**

The number value should be recorded as letter values on you answer sheet. Therefore, the number of the circle that the child chooses should be recorder as follows:

1 = A
2 = B
3 = C
4 = D

The interviewer continues for each plate, reading the descriptions, verbatim as she/he points to the picture accompanying each description. In some pictures there is a target child central to the description, designated by an arrow pointing to that child. Be certain that on these items you point to that particular child.

APPENDIX E

PARENTING DAILY HASSLES

Directions for respondent: **I am going to read you a list of statements the describe lots of events that routinely occur in families with young children. These events sometimes make life difficult. Using the choices on this card (hand respondent card for this section), please indicate how often it happens to you and then indicate on a scale of 1-5 (1 equals no hassle to 5 equals big hassle) how much of a hassle you feel it is for you. If you have more than one child, these events can include any or all of you children.**

Record responses using the following codes:

How Often It Happens:

Rarely	Sometimes	A lot	Constantly	RF/DK
A	B	C	D	E

Hassle Rating:

No Hassle ----------Big Hassle
1 (A) ----- 2 (B) ----- 3 (C) ----- 4 (D) ----- 5 (E)

Interviewer: Record answers for each question on 2 lines of the answer sheet. (For example, for the first question, record how often it happens on line #1 and how much of a hassle it is on line #2.)

1/2. Continually cleaning up messes of toys or food

3/4. Being nagged, whine at, complained to

5/6. Mealtime difficulties (picky eaters, complaining, etc)

7/8. The kids don't listen - won't do what they are asked without being nagged

9/10. Baby-sitters are difficult to find

11/12. The kids' schedules (e.g. preschool, school naps, other activities) interfere with meeting you own or household needs

13/14. Sibling arguments or fights which require a "referee".

15/16. The kids demand that you entertain/play with them.

17/18. The kids resist or struggle over bedtime with you.

19/20. The kids are constantly under foot, interfering with other chores.

21/22. The need to keep a constant eye on where the kids are and what they are doing

23/24. The kids interrupt adult conversations or interactions.

25/26. Having to change you plans because of an unpredictable child need.

27/28. The kids get dirty several times a day requiring changes of clothes.

29/30. Difficulties getting privacy (e.g. like in the bathroom).

31/32. The kids are hard to manage in public (grocery store, shopping center, restaurant)

33/34. Difficulties in getting kids ready for outings and leaving on time.

35/36. Difficulties in leaving kids for a night out or at school or day care.

37/38. The kids having difficulties with friends (e.g. fighting, trouble getting along, or no friends available)

39/40. Having to run extra errands to meet the kid's needs.

APPENDIX F

HIST FLOWCHART

LIVING ARRANGEMENTS (H1, H2 for mom; K1= child 1, K2= child 2)

1-6. MM/DD/YY that respondent began living at site.

7-12. MM/DD/YY that respondent left site.

13. Type of place.

0. child/under care of parents
1. own house/apartment
2. friend's/family's house/apartment
3. supervised setting
4. institutions (hospital/rehab unit, jail/prison)
5. military base or service
6. homeless shelter
7. abandoned building/car
8. public place/streets
9. other

14. Reason for Homelessness (Leave blank if not homeless)

0. job loss/lack of work
1. eviction
2. lack of affordable housing
3. mental illness/personal crisis
4. drug/alcohol abuse
5. termination of access to public assistance
6. physical disability
7. termination of personal relationship/divorce
9. other

15. How would you rate _____(site) in terms of comfort?

1. Very uncomfortable
2. Somewhat uncomfortable
3. A little uncomfortable
4. A little comfortable
5. Somewhat comfortable
6. Very comfortable

16. How would you rate _____(site) in terms of safety?

1. Very unsafe
2. Somewhat unsafe
3. A little unsafe
4. A little safe
5. Somewhat safe
6. Very safe

17. How would you rate _____(site) in terms of spaciousness?
1. Very crowded
2. Somewhat crowded
3. A little crowded
4. A little uncrowded
5. Somewhat uncrowded
6. Very uncrowded

18. How would you rate _____(site) in terms of privacy?
1. Very lacking in privacy
2. Somewhat lacking in privacy
3. A little lacking in privacy
4. A little private
5. Somewhat private
6. Very private

19. How would you rate _____(site) in terms of friendliness?
1. Very unfriendly
2. Somewhat unfriendly
3. A little unfriendly
4. A little friendly
5. Somewhat friendly
6. Very friendly

20. How would you rate _____(site) in terms of overall quality?
1. Very poor
2. Somewhat poor
3. A little poor
4. A little good
5. Somewhat good
6. Very good

ASK IF CHILD 1 (and CHILD 2) HAVE LIVED WITH MOTHER THE WHOLE TIME - IF NO, THEN ONLE CODE SITES THAT ARE DIFFERENT ON K1,K2)

INCOME (I1, I2 for mom only)

1-6. MM/DD/YY that respondent started job/public assistance.
7-12. MM/DD/YY that respondent ended job/public assistance.

13-15. Three Digit Job Code. (Public Assistance=000)
16-20. Five Digit Monthy Income.

SERVICE USE (J for mom; L1= child 1, L2= child 2)

1-6. MM/DD/YY that respondent entered inpatient/outpatient.

7-12. MM/DD/YY that respondent was discharged/ended service.

13. Reason for Hospitalization.

0. Medical Hospital
1. Substance Abuse Hospital
2. Psychiatric Hospital
3. Outpatient Services

APPENDIX G

CONFLICT TACTICS SCALE (CTS)

1. Are you currently married?

.....If YES, blacken the first circle for question #1, read directions below, and go to question #4.
.....If NO, continue with question #2.

2. Are you currently living with someone as though you were married?

.....If YES, blacken the first circle for question #2, read directions below, and go to question #4.
.....If NO, continue with question #3.

3. Have you had a relationship in the last year, where you were married or living with someone as though you were married, or have you been involved in a romantic relationship in the last year that lasted more than six months?

.....If YES, blacken the first circle for question #3, read the directions below, and go to question #5.
.....If NO, go to next section

Directions for Respondent if answered "Yes" to 1, 2, or 3:
No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or just have spats or fights because they're in a bad mood or tired, or for some other reason. They also use many different ways of trying to settle their differences. I'm going to read a list of some things that your partner may have done when you had a dispute, and would like you to tell me how many times your partner has done these things in the past year.

Hand respondent the card for section #13, and use the following codes on the answer sheet.

0. never
1. once
2. twice
3. 3-5 times
4. 6-10 times
5. 11-20 times
6. more than 20 times
7. don't know/ refuse

Begin coding answers here with q. 4 on the answer sheet.

I would like to know how many times your partner has done these in the past year. (Hand respondent card for CTS).

How many times has <u>your partner:</u>

4. Discussed the issue calmly.

5. Got information to back up their side of things.

6. Brought in/tried to bring in someone to settle things.

7. Insulted or swore at you.

8. Sulked or refused to talk about it.

9. Stomped out of the room, house, or yard.

10. Cried.

11. Did or said something to spite you.

12. Threatened to hit or throw something at you.

13. Threw, smashed, hit, or kicked something.

14. Threw something at you.

15. Pushed, grabbed, or shoved you.

16. Slapped you.

17. Kicked, bit, or hit you with fist.

18. Hit or tried to hit you with something.

19. Beat you up.

20. Threatened you with a knife or gun.

21. Used a knife or gun.

APPENDIX H

THINGS I HAVE SEEN AND HEARD
CHILD VERSION

This next Questionaire is called "Things I have seen and Heard". It asks about some of the things that happen to kids growing up in the city these days. As always, please try to answer honestly. There are no right or wrong answers. (Interviewer: Make sure that the child understands that all questions refer to real-life instances of violence or violence-related themes that the child actually witnessed, not including media depictions of violence.)

1. I have heard guns being shot.

2. I have seen somebody arrested.

3. I feel safe when I am at home.

4. I have seen drug deals.

5. I Have seen somebody being beat up.

6. I have been beat up.

7. I have seen somebody get stabbed.

8. I have seen somebody get shot.

9. I have seen a gun in my home.

10. I have seen drugs in my home.

11. I feel safe when I am at school.

12. Somebody threatened to kill me.

13. I have seen a dead body outside.

14. Somebody threatened to shoot me.

15. Somebody threatened to stab me.

16. Grown ups are nice to me

17. Grown ups in my home hit each other.

18. Grown ups in my home threaten to stab or shoot each other.

19. Grown ups in my home yell at each other.

20. I have seen somebody in my home get shot or stabbed.

THINGS I HAVE SEEN AND HEARD
MOTHER VERSION

This next Questionaire is called "Things Your child has seen and Heard". It asks about some of the things that happen to kids growing up in the city these days. I will be reading a list of events and I would like you to think about your knowledge of (CHILD's) experiences. As always, please try to answer honestly. There are no right or wrong answers. (Interviewer: Make sure that the mother understands that all questions refer to real-life instances of violence or violence-related themes that the child actually witnessed, not including media depictions of violence.)

Use the following choices:

a. 0 times
b. 1 time
c. 2 times
d. 3 times
e. many times
Blank = don't know

1. He/she has heard guns being shot.

2. He/she has seen somebody arrested.

3. He/she feels safe when he/she is at home.

4. He/she has seen drug deals.

5. He/she has seen somebody being beat up.

6. He/she has been beat up.

7. He/she has seen somebody get stabbed.

8. He/she has seen somebody get shot.

9. He/she has seen a gun in his/her home.

10. He/she has seen drugs in his/her home.

11. He/she feels safe when he/she is at school.

12. Somebody threatened to kill him/her.

13. He/she have seen a dead body outside.

14. **Somebody threatened to shoot him/her.**

15. **Somebody threatened to stab him/her.**

16. **Grown ups are nice to him/her.**

17. **Grown ups in his/her home hit each other.**

18. **Grown ups in his/her home threaten to stab or shoot each other.**

19. **Grown ups in his/her home yell at each other.**

20. **He/she has seen somebody in his/her home get shot or stabbed.**

APPENDIX I

SIGNIFICANT CORRELATIONS OF MAIN VARIABLES USED IN ANALYSES*

Comfort

Safety	+
Privacy	+
Friendliness	+
Overall Quality	+
Father contact	-
#foster care	-
#kids	-

Safety

Comfort	+
Spaciousness	+
Privacy	+
Friendliness	+
Overall Quality	+
Mom comm. viol	-
Mom age	-

Spaciousness

Safety	+
Privacy	+
Friendliness	+
Overall Quality	+
Child Violence	+
#moves	-
#homeless	-
income	-

Privacy

Comfort	+
Safety	+
Friendliness	+
Overall Quality	+
Child violence	-
mom comm. viol	-
#homeless	-

Friendliness

Comfort	+
Safety	+
Spaciousness	+
Privacy	+
Friendliness	+
Overall Quality	+
CBCL Total	-
Externalizing	-
Mom comm viol	-
#moves	-
#homeless	-
verbal aggress	-
physical aggress	-

Overall Quality

Comfort	+
Safety	+
Spaciousness	+
Privacy	+
Friendliness	+
Mom comm. viol.	-
#moves	-
#homeless	-
mom age	-

Verbal Aggres

competence	+
cvtot	+
momcv	+
# moves	+
# homeless	+
phys. agress	+
father cont.	-
friendliness	-

Phys. Aggres

Total CBCL	+
Momcv	+
Verbal Agres.	+

Comm Viol.

mom comm viol.	+
# moves	+
#homeless	+
verbal agress.	+

Mom Comm. Viol.

Child comm. viol	+
Total CBCL	+
Externalizing	+
#moves	+
#homeless	+
#schools	+
verbal aggress	+
physical aggress	+
safety	-
privacy	-
friendliness	-
overall quality	-

Hassles

Total CBCL	+
Internalizing	+
Externaling	+
#foster care	+
Mom educ.	-

#schools

job past/yr	+
child age	+
momcvt	+
#moves	+
mom educ.	+

#foster care

job past/yr	+
father contact	+
hassles	+
comfort	-

moves

child age	+
comm. viol	+
mom comm viol	+
#homeless	+
#schools	+
mom educ	+
verbal aggress	+
spaciousness	-
friendliness	-
overall quality	-

Total Competence		Externalizing		Internalizing	
Verbal agress.	+	Total CBCL	+	Externalizing	+
Job past yr.	-	Internalizing	+	Hassles	+
		Mom comm. viol	+	Mom educ	-
		friendliness	-		

Mom Education		Income		# Kids		Mom age	
Job/past yr.	+	Public asst.	+	Public asst.	+	child age	+
Child age	+	Safety	-	Mom age	+	mom educ`	+
# moves	+			Comfort	-	#kids	+
#homeless	+					safety	-
#schools	+					overallenv.qual`	-
Mom age	+						
Child violence	-						
CBCL Total	-						
Internalizing	-						
Hassles	-						

Child age		Public Asst.		Job Past Yr.		Father Contact	
job past yr.	+	#kids	+	Child age	+	Job past yr.	+
#moves	+	job past yr	-	Father contact	+	#foster care	+
#schools	+			#schools	+	Comfort	-
mom age	+			mom educ	+	Verbal aggress.	-
mom educ.	+			total competence	-		
child violence	-			public asst.	-		

*p<.05

References

Achenbach, T.M., and Edelbrock, C.S. (1983). Manual for the Child Behavior Checklist and Revised Behavioral Profile. Burlington, VT: Queen City Publishers.

Achenbach, T.M. (1991). Manual for the Child Behavior Checklist 4-18 and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Acker, P.J., Freeman A.H., & Dreyer, B.(1987). An assessment of parameters of health care and nutrition in homeless children. American Journal of Disorders in Children, 141: 388.

Adams, T.K. Duncan, G.J. & Rogers, W.C.(1988). Persistent Urban Poverty: Prevalence, Correlates, and Trends. Ann Arbor: Survey Research Center, University of Michigan.

Alperstein G. and Arnstein E., (1988) Homeless children--A challenge for pediatricians. The Pediatric Clinics of North America, 35 (6), pp. 1413-1425.

Bane, M.J. & Jargowsky, P.A. (1988). Urban Poverty Areas: Basic Questions Concerning Prevalence, Growth, and Dynamics. Cambridge. Harvard University Press.

Bassuk, Rubin, & Lauriat (1986) Characteristics of sheltered homeless families. American Journal of Public Health, 76(9), 1097-1101

Bassuk, E.L. (1990). Who are the homeless families? Characteristics of sheltered mothers and children. Community Mental Health Journal, 26(5), pp. 425-434.

Bassuk, E.L. and Gallagher, E.M. (1990). The Impact of Homelessness on Children. Haworth Press, Inc.

Bassuk, E.L., and Rosenberg, L. (1990). Psychosocial characteristics of homeless children and children with homes. Pediatrics, 85 (3), pp. 257-261.

Bassuk E. and Rosenberg L. (1988). Why does family homelessness occur? : A case-control Study. American Journal of Public Health, 78 (7), pp.783-787.

Bassuk, E., and Rubin, L. (1987). Homeless children: A neglected population. American Journal of Orthopsychiatric, 57(2), pp. 279-286.

Bronfenbrenner (1986). Ecology of the family as a context for human development research perspectives.

Developmental Psychology, 22, 723-742.

Bukowski, P.A., Wolfe, S., Toro, P.A. (1994). Homeless and matched housed adolescents: A comparative study on mental disorders. Annual Convention, Midwestern Psychological Association, Chicago, IL.

Christopoulos, C., Cohn, D.A., Shaw, D.S., Joyce, S., Sullivan-Hanson, J., Kraft, S.P. & Emery, R.E. (1987). Children of abused women: I. Adjustment at time of shelter residence. Journal of Marriage and the Family, 49, 611-619.

The Citizen's Committee for Children. (1988). Children in Storage: Families in New York City's Barracks-style Shelters. New York: Author.

Colorado Children's Campaign (1987) No Room at the inn: A study of Colorado's homeless parents and children: Who are they, why are they homeless, what can be done?, Denver: Author.

Coulton, J.C. and Pandey, S. (1992). Geographic concentration of poverty and risk to children in urban neighborhoods. American Behavioral Scientist, 35 (3), pp. 238-257.

Crnik, K.A. & Greenberg, M.T. (1990). Minor parenting stresses with young children. Child Development, 61, 1628-1637.

Dail, P. V. (1993). Homelessness in America: Involuntary Family Migration. Hatworth Press, Inc., pp 55-75.

Danziger, S. & Danziger, S. (1993). Child poverty and public policy: Toward a comprehensive antipoverty agenda. Daedalus: America's Childhood, 122, 57-84.

DiBiase, R. & Waddell, S. (1995). Some effects of homelessness on the psychological functioning of preschoolers. Journal of Abnormal Child Psychology, 23(6), 783-792).

Dodge, K.A., Pettit, G.S., Bates, J.E. (1994). Socialization Mediators of the relation between socioeconomic status and child conduct problems. Child Development, 65, pp. 649-665.

Duncan, G.J., Brooks-Gunn, J., and Klebanov, P.K. (1994). Economic deprivation and early childhood development. Child Development, 65, pp. 296-318.

Eddowes, E.A. & Hranitz, J.R. (1989). Educating children of the homeless. Childhood Education, 65, 197-200.

Edelman and Mihaly (1989). Homeless families and the housing crisis in the United States, Children and Youth Services Review, 11, pp. 91-108.

Erikson, E. (1963). Childhood and Society. New York: W.W. Norton.

Freedman, D., Thornton, A., Camburn, D., Alwin, D. & Young DeMarco, L. (1988). The life history calendar: A technique for collecting retrospective data. Sociological Methodology, 18, 37-68.

Garbarino (1992). The meaning of poverty in the world of children. American Behavioral Scientist, 35 (3), 220-237.

Garbarino & Crouter (1978). Defining the community context of parent-child relations: The correlates of child maltreatment. Child Development, 49, 604-616.

Garbarino & Sherman (1980). High risk neighborhoods and high-risk families: The human ecology of child maltreatment. Child Development, 51, 188-198.

Gelles, R.J. (1992). Poverty and violence toward children. American Behavioral Scientist, 35(3), pp. 258-274.

Gewirtzman, R. & Fodor, I. (1987). The homeless child at school: From welfare hotel room to classroom. Child Welfare, 66, 237-245.

Goodman, L. (1991). The prevalence of abuse among homeless and housed poor mothers: A comparison study. American Journal of Orthopsychiatry, 61(4), pp. 489-500.

Goodman, L., Saxe, L., and Harvey, M. (1991). Homelessness as psychological trauma. American Psychologist, Vol. 46 (11), pp. 1219-1225.

Gulati, P. (1990) Ideology. Public policy and homeless families. Journal of Sociology and Social Welfare, pp. 113-128.

Harter, S. (1982). The perceived competence scale for children. Child Development, 53, pp. 87-97.

Harter, S. & Pike, R. (1984). Pictorial scale of perceived competence and social acceptance for young children. Child Development, 55, 1969-1982.

Hewlitt, S.A. (1991). When the Bough Breaks: The Cost of Neglecting Our Children. New York: Basic Books.

Holden, E.W., Horton, L., Danseco, E. (1995). The mental health of homeless children. Clinical Psychology Science & Practice, 2(2), pp. 165-178.

Hughes, M.A. (1989). Research Report on America's Cities: Poverty in Cities. Washington DC: National League of Cities.

Huston, A.C., McLoyd, V.C., and Coll, C.G. (1994). Children and poverty: Issues in contemporary research. Child Development, 65, pp. 275-282.

Kazdin,A. E. (1988). Childhood depression. In E.J. Mash & L.G. Terdale (Eds.), Behavioral Assessment of Childhood Disorders (2nd. ed., pp. 157-195). New York: Guilford.

Kazdin,A. E. (1990). Childhood depression. Journal of Child Psychology and Psychiatry, 31, 121-160.

Kovacs. M. (1983). The Children's Depression Inventory: A Self-Rated Depression Scale for School-Aged Youngsters. Pittsburg: University of Pittsburg School of Medicine.

Lee, B.A., Link, B.G., & Toro, P.A. (1991). Images of the homeless: Public views and media messages. Housing Policy Debate, 2, 649-682.

Linn, L.S., Gelberg, L. and Leake, B. (1990). Substance abuse and mental health status of homeless and domiciled low-income users of a medical clinic. Hospital and Community Psychiatry, 41 (3), pp. 306-310.

Martinez, P. & Richters, J. (1993). The NIMH community violence project: II. Children's distress symptoms associated with violence exposure. Psychiatry, 56, pp. 22-35.

Massey, D.S., Gross, A.B., and Eggers, M.L. (1991) Segregation, the concentration of poverty and the life chances of individuals. Social Science Research, 20, pp. 397-420.

Masten, A. (1992). Homeless children in the United States: Mark of a nation at risk. American Psychological Association, 1 (2). pp. 41-44.

Masten, A.S., Miliotis, D., Graham-Bermann, S.A., Ramirez, M. and Neemann, J. (1993). Children in homeless families: Risks to mental health and development. Journal of Consulting and Clinical Psychology, 61 (2), pp. 235-343.

McLoyd, V.C. (1990). The impact of economic hardship on

black families and children: psychological distress, parenting, and socioemotional development. Child Development, 61, pp. 311-346.

Melnick, V. & Williams, C. (1987, May). Children and families without homes: Observations from thirty case studies. Washington: University of the District of Columbia, Center for Applied Research and Urban Policy.

Miller, D.S., and Lin, E.B. (1988). Children in sheltered homeless families: Reported health status and use of health services. Pediatrics, 81 (5), pp. 668-673.

Mills, Crystal, and Ota, Hiro. (1989). Homeless women with minor children in the Detroit metropolitan area. Journal of Social Work, pp. 485-489.

Molnar, J.M., Rath, W.R., and Klein, T.P. (1990). Constantly compromised: The impact of homelessness on children. Journal of Social Issues, 46(4), pp. 109-124.

National Center on Child Abuse and Neglect. (1988). Study findings: Study of national incidence and prevalence of child abuse and neglect: Washington, DC: U.S. Department of Health and Human Services.

Passero-Rabideau, J. & Toro. P.A. (1997). Social and environmental predictors of adjustment in homeless children. Journal of Prevention & Intervention in the Community, 15(2), pp. 1-17.

Random House Dictionary (1991). New York: Random House.

Raadal, M., Milgrom, P., Cauce, A., and Mancl, L. (1994). Behavior problems in 5 to 11 year old children from low income families. Journal of the American Academy of Child and Adolescent Psychiatry, 33 (7), 1017-1025.

Rafferty, Y. and Shinn, M. (1991). The impact of homelessness on children. American Psychologist, 46(11). pp. 1170-1179.

Rescorla, Phd., L., Parker, MD., Ruth, and Stolley,MD., P. (1990). Ability, achievement, and adjustment in homeless children. American Journal Orthopsychiatry, 61(2), pp. 210-220.

Richters, J. & Martinez, P. (1993). The NIMH community violence project: I. Children as victims of and witnesses to violence. Psychiatry, 56, pp. 7-21.

Richters, J. & Martinez, P. (1990). Things I Have Seen and Heard: A Structured Interview for Assessing Young Children's Violence Exposure. National Institute of Mental Health.

Rivlin Ph.d.., Leanne G. (1990). Home and Homelessness in the Lives of Children. The Haworth Press, Inc..

Roll, C.N., Toro, P.A., & Ortola, G.L. (November, 1995). Characteristics and experiences of homeless adults: A comparison of single men, single women and women with children. Annual Meeting, American Public Health Association, San Diego, CA.

Rosenman, M. & Stein, M. (1990). Homeless Children: A New Vulnerability. Child and Youth Services, 14, 89-109.

Sampson, Robert J., and Laub, John H. (1994) Urban poverty and the family context of delinquency: A new look at structure and process in a classic study. Child Development, 65, pp. 523-540.

Shinn, M., Knickman, J.R., and Weitzman, B.C. (1991). Social relationships and vulnerability to becoming homeless among poor families. American Psychologist, 46 (11), pp. 1180-1187.

Sosin, Michael. (1992). Homeless and vulnerable meal program users: A comparison study. Social Problems, 39 (2), pp. 170-188.

Strauss (1979). Measuring conflict and violence: The Conflict Tactics (CT) Scales. Journal of Marriage and the Family, 41, 75-88.

Strauss (1990). The conflict tactics scale and its critics: An evaluation and new data on validity and reliability. In M.A. Straus and R. J. Gelles, Physical violence in American families: Risk factors and adaptations to violence in 8,145 families. New Brunswick, NJ: Double Day/Anchor.

Strauss, M. Gelles, R.J., & Steinmetz, S.K. (1980). Behind Closed Doors: Violence in the American Family. New York: Double Day/Anchor.

Toro, P.A., Bellavia, C.W., Daeschler, C.V., Owens, B.J., Wall, D.D., Passero, J.M., and Thomas, D.M. (1995). Distinguishing homelessness from poverty: A comparative study. Journal of Consulting and Clinical Psychology, 63 (2), pp. 280-289.

Toro. P.A. & Wall.,D.D. (1991). Research on homeless persons: Diagnostic comparisons and practice implications. Professional Psychology: Research and Practice, 22, pp. 479-488.

Toro, P.A. & Rojansky, A. (1990). Homelessness: Some

thoughts from an international perspective. Community Psychologist, 24 (1), pp. 8-11.

Toro, P.A. (August, 1993). A systematic, three-step methodology for representative sampling of homeless persons. In P.A. Toro (symposium chair), Conceptual and methodological innovations in research on homelessness. 101st Annual Convention, American Psychological Association, Toronto, Canada.

Toro, P.A., Trickett, E.J., Wall, D.D., & Salem, D.A. (1991). Homelessness in the United States: An ecological perspective. Special Issue on Homelessness, American Psychologist, 46, 1208-1218.

Toro, P., Wolfe, S. Bellavia, C., Thomas, D., Rowland, L,m Daeschler, C., & Bukowski, P. (1997; unpublished report). Wayne State University. Obtaining representative samples of homeless persons: A two-city study.

Wagner, J. and Menke, E. (1991). The depression of homeless children: A focus for nursing intervention. Issues in Comprehensive Pediatric Nursing, 114, pp. 17-29.

Whitman, B.Y., Accardo, P., Boyert, M. and Kendagor, R. (1990). Homelessness and cognitive performance in children: A possible link. National Association of Social Workers, Inc., 35 (6), pp. 516-519.

Wilson, C (1992). Restructuring and the growth of concentrated poverty in Detroit. Urban Affairs Quarterly, 28(2), pp. 187-205.

Wolfe, S. Toro, P. & Bukowski, P. (1994). A comparative study of homeless and housed adolescents.

Wood, P., Valdez, R.B., Hayash, T., and Shen, A.(1990). Homeless and housed families in Los Angeles: A study comparing demographic, economic, and family function characteristics. American Journal of Public Health, 80 (9), pp. 1049-1052.

Wright, James D. (1990). Homelessness Is Not Healthy for Children and Other Living Things. The Haworth Press, Inc.

Ziesemer, C., Marcoux, L., and Marwell, B. (1994). Homeless children: Are they different from other low-incom children?. Social Work, 39 (6), pp. 658-668.

ABSTRACT

A COMPARISION OF HOMELESS AND HOUSED POOR CHILDREN ON PSYCHOLOGICAL AND ENVIRONMENTAL FACTORS

by

PAMELA ANNE BUKOWSKI

December, 1997

Advisor: Paul A. Toro, Ph.D.

Major: Psychology (Clinical)

Degree: Doctor of Philosophy

Relatively little of the existing research on homelessness has focused on children. Those studies that do exist suggest that homeless children experience serious psychological and environmental problems. However, findings are inconsistent and most are comprised of nonrepresentative samples, have a limited range of measures with no evidence of reliability and validity, and, most importantly, lack appropriate comparison groups on which to base their results. The present study attempts to determine if there is a higher occurrence of psychological and environmental problems in homeless children when compared to a carefully matched sample of housed children using the same interview protocol and procedures. This study attempts to compare a representative sample of 54 homeless children (ages 4-10) to 54 demographically matched housed poor children on various psychological and environmental variables. A representative sample of homeless mothers with dependent children were

recruited in the Detroit Metropolitan area. The comparison groups of housed mothers with dependent children were matched for age, gender, race, maternal age, and neighborhood (same zip code as the previous home of the currently homeless family). Mental health status was measured using the CBCL and Perceived Competence Scales. Environmental variables included privacy, safety, comfort, spaciousness, friendliness, overall quality, exposure to domestic and community violence. A series of MANOVAs and Chi Squares were used to examine differences between the two groups (housed vs. homeless). Results indicated that the homeless children came from environments with more violence, less safety, spaciousness, and overall quality. The two groups did not differ on psychological variables; however, both the homeless and the housed had signficantly higher scores on the CBCL than normative samples. Implications of this study suggest that, at least in the short-term, homelessness may not necessarily be detrimental to children's psychological functioning, particularily relative to the effects of poverty.

Autobiographical Statement
Pamela Anne Bukowski

Education:

Wayne State University — B.A. 1992; M.A. 1994
Detroit, Michigan — Major: Psychology

Professional Experience:

Psychology Intern, University of Florida, 1996-1997
Instructor, Wayne State University, Fall, 1994
Psychological Assistant, Aurora Hospital, 1992
Psychological Assistant, Med. Ctr. of Psych. Assoc, 1991.

Research Experience

Research Assistant to Dr. Paul Toro, Wayne State University, 1992-1996.
Research Assistant to Dr. Hilary Ratner, Wayne State University, 1991-1992.
Research Assistant to Dr. Alan Delamater, Wayne State University, 1991-1992.
Research Assistant to Dr. John Mullennix, Wayne State University, 1/91 to 8/91.

Honors and Awards

John Teahan Award for Outstanding Clinical Psych. Student
Individual Student Leadership Award, 1992
Deans Honor List 1988 - 1994

Professional and Honorary Societies

Phi Beta Kappa
Psi Chi National Honors Society. President
Golden Key National Honors Society
Phi Eta Sigma Honors Society
The American Psychological Association

Publications and Presentations (most recent)

Boesky, L., Toro, P., & Bukowski, P. (1997). Differences in psychosocial factors among older and younger homeless adolescents found in youth shelters. Journal of Prevent. and Interv. in the Community,15(2),pp.19-36.

Bukowski, P.A., Wolfe, S. & Toro, P. (August, 1994). Mental health outcomes in a sample of homeless adolescents and their peers. Presented at The Meeting of the American Psych. Assoc., Los Angeles, CA.

Bukowski, P.A., Wolfe, S. and Toro, P. (May, 1993). Homeless and matched housed adolescents: A comparative study on mental disorders. Presented at The Conference of The Midwestern Psych. Assoc., Chicago, Illinois.

Wolfe, S., Bukowski, P. and Toro, P. (August, 1994). A comparative study of housed and homeless adolescents. Presented at the Meeting of the American Psychological Association, Los Angeles, CA.