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Attribution Style and Depressive Symptoms Among African American Women

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Walden University
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Abstract

Attribution Style and Depressive Symptoms among Homeless African-American Women

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M.Ed., University of North Carolina at Charlotte, 1992

B.A., University of North Carolina at Wilmington, 1985

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Homelessness is a major social problem in the United States and this nation has the largest number of homeless women. Minority women appear to be more affected than other individuals. Specifically, they are more vulnerable, impoverished, and disenfranchised than all other groups in the nation. These factors affect their emotional well-being and ability to move toward and achieve sustainability. Particularly, African-American women are disproportionately represented in the homeless population, yet they have not been adequately examined in research studies and there are minimal empirical studies that focus on homeless African-American women. Beck's cognitive behavioral therapy (CBT) and Weiner's attribution theory provided the theoretical foundation for this study. The purpose of this quantitative research was to investigate whether the length of time African-American women are homeless and their attribution style are associated with symptoms of depression. The data were obtained by administering a demographic questionnaire, the Beck Depression Inventory-II (BDI-II), and the Attributional Style Questionnaire-revised (ASQ-revised) to 70 African-American women living in a shelter and 2 transitional living centers in Charlotte, North Carolina. Data were analyzed using hierarchical multiple regression. The findings revealed no significant relationship between length of time homeless and depression or between attribution style and length of time homeless. There were no moderation effects. However, there was a significant positive relationship between attribution style and depression. The implications for positive social change include influencing polices pertaining to managing depressive symptoms of homeless African-American women to increase their chances of becoming re-housed.

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Dedication

This effort is dedicated to Makayla, Calien, Amaya, and Sydney to prove to each of you as beautiful African-American girls and young ladies that you can do anything you want. Set your sights high and reach for the heavens. Everything is possible if you believe.

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Chapter 1: Introduction to the Study

Introduction

African Americans represent 11–12 percent of the general population in the United States. However, they make up 42 percent of the homeless population (Gash, Washington, Moxley, & Feen-Calligan, 2014; National Coalition for the Homeless, 2009). Moreover, African-American women are at greater risk for homelessness than other populations (Gash et al., 2014; Moxley, Feen-Calligan, Washington, & Garriott, 2011). However, there is little research addressing this specific population.

Among all industrialized nations, the United States has the largest number of homeless women (Colorado Coalition for the Homeless, 2012). Minority women appear to be affected more than other groups, and are particularly affected by wage inequality. In 2010, it was reported that women made 77 cents for every dollar earned by their male counterparts; however, African-American women earned only 63 cents for every dollar earned by their non-Hispanic, Caucasian male counterparts (Colorado Coalition for the Homeless, 2012).

Research documents that low-income and homeless women have similar experiences (Colorado Coalition for the Homeless, 2012). Both low-income housed and homeless women are often victims of domestic violence (Colorado Coalition for the Homeless, 2012; Weller & Fields, 2011). However, homeless women experience violence at a 63.3 percent rate and poor, housed women experience violence at a 58 percent rate (Colorado Coalition for the Homeless, 2012; Weller & Fields, 2011). The life expectancy for homeless women is five years lower than that of low-income women (Colorado Coalition for the Homeless, 2012; Weller & Fields, 2011).

Although the plight of homeless women is serious, it is more serious for homeless women of color (Colorado Coalition for the Homeless, 2012). These women typically work in low-income service sector jobs, and are usually hired last and are the first to be fired (Colorado Coalition for the Homeless, 2012). With the lack of affordable housing, extremely low-income women pay more than 50 percent of their income toward housing costs; therefore, a combination of these issues over time leads to homelessness (Colorado Coalition for the Homeless, 2012).

There are several factors that contribute to women becoming homeless, although economics is a key issue because it affects every area of a person's life (housing, physical health, mental health, food, etc.). While African-American women's rates of homelessness are extremely high, the majority of research has focused on risk factors contributing to homelessness generally and homeless women and children (Douglas, Jimenez, Lin, & Frisman, 2008; Finfgeld-Connett, 2010; Lehman, Kass, Drake, & Nichols, 2007; Nemiroff, Aubry, & Klodawsky, 2011). Given the increased numbers of homeless women overall, it is striking that there is a void of studies that investigate length of time spent being homeless, attribution style, and depressive symptoms among homeless African-American women.

Throughout history, individuals have been displaced due to causes such as industrialization, wars, natural disasters, racial inequalities, widowhood, medical problems, and government policies relating to systemic issues (e.g. education, access to mortgages, equal pay, and racial messages/institutional racism); these factors contributed to homelessness (Fisher, 2011; Kusmer, 2002). Still, as far back as the 1600s, homeless persons were viewed as having a moral deficiency or character flaw (Fisher, 2011).

Specifically, homeless people or families were thought to have fallen from God's grace, to be deserving of their plight (Fisher, 2011), and were viewed as lazy and corrupt (Piliavin, Sosin, Westerfelt, & Matsueda, 1993). The societal outlook had not changed much by the late 1970s, when a conservative federal government's ideology was that the poor, including the homeless, were undeserving of public assistance (Kusmer, 2002).

Toward the end of the American Civil War, people were left without homes, which introduced terms such as hobohemia (hobo), tramp, and bum (Fisher, 2011) into the American lexicon. Additionally, five years after the Civil War, homelessness emerged as a national issue when veterans were unemployed and their families lost property and homes (Kusmer, 2002). In the 1950s, homeless individuals made up 10 percent of the population. The typical homeless person was a Caucasian male in his 50s (Kusmer, 2002; National Coalition for the Homeless, 2009). Demographics from this period did not include minorities or women; they were not included in the research. Consequently, there was minimal information on homeless African-American men and no demographic information on homeless African-American women (National Coalition for the Homeless, 2009).

In the 1980s, the United States saw a rise in the number of homeless persons and families, composed largely of single parents, minor children, African Americans, and other minorities (Kusmer, 2002). Literature examining the causes of homelessness explained that poverty and homelessness are intricately linked (National Coalition for the Homeless, 2014). Today, as in the 1980s, communities continue to experience an increase in the number of homeless persons due to a lack of affordable housing, livable wages, and public assistance (National Coalition for the Homeless, 2009; Notaro, Khan, Kim,

Nasaruddin, & Desai, 2013). While poverty is the main cause of homelessness, other factors such as the lack of affordable health care, domestic violence, mental illness, being a veteran, and addiction disorders have forced numerous individuals and families into homelessness (National Coalition for the Homeless, 2009; U.S. Department of Health and Human Services, 2010).

There is a wealth of information regarding homelessness overall; however, the numbers are not exact. The majority of studies are limited to individuals living in shelters and transitional living centers (National Coalition for the Homeless, 2009). There is very little information from those living on the streets, in abandoned buildings, or in their cars (National Coalition for the Homeless, 2009). Specifically, there is no definitive tool used to count the number of homeless individuals in the United States. This is due to the fluidity of the population, the category of people counted (children, students, veterans, families, individuals), methodologies used to collect data (point-in-time counts, period prevalence counts), and the data sources, such as U.S. Census and U.S. Department of Housing and Urban Development (HUD), that are used (National Alliance to End Homelessness, 2015).

A recent national estimate, taken from the January 2014 point-in-time count, identified a drop in homeless persons from 714,313 in 2005 to 578,424 (National Alliance to End Homelessness, 2015). The point-in-time count included individuals living in emergency shelters, transitional living housing, and those living on the streets. In all likelihood, these numbers are not accurate (National Alliance to End Homelessness, 2015). There has been a decrease in the number of homeless persons in the United States,

but the country still has the largest number of homeless women of all industrialized countries (Colorado Coalition for the Homeless, 2012).

The representation of socioeconomically disadvantaged minorities among the ranks of the homeless is disproportionately high (40-49 percent), especially for individuals who self-identify as African Americans (National Alliance to End Homelessness, 2014; National Alliance to End Homelessness, 2012; National Coalition for the Homeless, 2009; Notaro et al., 2013; Zlotnick, Tam, & Bradley, 2010). African-American women are disproportionately represented in the homeless population; however, the majority of studies pertain to risk factors contributing to homelessness and homeless women and children (Douglas, Jimenez, Lin, & Frisman, 2008; Finfgeld-Connett, 2010; Lehman et al., 2007; Nemiroff et al., 2011).

The National Alliance to End Homelessness (2014) reported the national average, indicating that for every 10,000 persons, 19 of those individuals are homeless. Research has documented that 38 percent of the homeless population are women and 37 percent are African Americans. African-American women were not studied as a single group, as they were included in both populations (Substance Abuse and Mental Health Services Association, 2011).

Many studies have shown an association between homelessness and mental illness. Data indicate that approximately 29 percent of homeless adults in the United States contend with mental illness, although there is no direct link between homelessness and mental illness (Curtis, Corman, Noonan, & Reichman, 2014; Nemiroff et al., 2011; SAMHSA, 2011). Depression affects one in five persons in the United States (Sohail, Bailey, & Richie, 2014); however, women in general have higher rates of depression than

men (Wahowiak, 2014). Duncan et al. (2014) argued that multiple surveys have shown that compared to Caucasian women, African-American women are less likely to meet the criteria for a lifetime diagnosis of major depressive disorder. This finding is contradictory in that African-American women are exposed to higher environmental stressors and have greater physical health burdens than Caucasian women (Duncan et al., 2014). Additionally, African-American women are more likely to experience major depression, although they are less likely to receive treatment for depression due to a mistrust of mental health services (Wahowiak, 2014; Washington, 2005). Gash et al. (2014) argued that when major depressive disorder (MDD) develops in African Americans, it is more debilitating and persistent than in Caucasians. The majority of African Americans with MDD do not receive treatment for this disorder (Gash et al., 2014).

In the United States, homeless individuals have twice the rate of depression as that of the general population. Specifically, "47 percent of homeless women meet the criteria for a diagnosis of major depressive disorder – twice the rate of women in general" (APA, 2014, para 7; Deforge, Belcher, O'Rourke, & Lindsey, 2008). Some researchers have examined the complex interconnected stressors and the emotional effects that impact homeless women (Nemiroff et al., 2011; Yeater, Austin, Green, & Smith, 2010). Others have researched the use of attribution theory to assist individuals with their understanding of distress and stress-related disorders, as well as how a negative explanatory style and uncontrollability (belief that outcomes are caused by factors such as luck or fate) relate to depressive symptoms (Brooks & Clarke, 2011; Gaber & Seligman, 1980; Sanjuan & Magallares, 2011). However, there is inadequate research addressing attribution style and depressive symptoms among homeless African-American women.

Examining differences in attribution style and depressive symptoms among African-American women relating to the length of time they have been homeless would provide an opportunity to understand the experiences of this population. This study can be replicated with other homeless populations living in shelters or transitional living centers using the instruments, sample size, and protocol to identify and address psychological distress. Moreover, the study has implications for the need of mental health components addressing depression and attribution style that may impede housing stability.

In this chapter, I discuss the background, the problem studied, and the purpose of the study. Additionally, the research questions and hypotheses, the theoretical framework, the nature of the study, definitions, assumptions, and the scope and delimitations are described in this chapter. Furthermore, in this chapter, I identify the limitations, explain the significance of the study, and summarize the study's main points.

Background

Research has identified several mental health and addiction issues relating to homelessness among women. These include depression, post-traumatic stress disorder (PTSD), alcohol use, trauma exposure of ethnically diverse women, emotional abuse, and anxiety; however, there is limited data concerning the connection of these diagnoses to the length of time homeless (Finfgeld-Connett, 2010; Nemiroff et al., 2011; Yeater et al., 2010).

Literature pertaining to attribution examined the processes that make some individuals resilient and optimistic in the face of negative events and others less resilient and more pessimistic (Gaber & Seligman, 1980; Rosen, 2011). Rosen (2011) asserted

that when something happens to a person, the way he or she thinks about the situation dictates whether the person has a pessimistic or optimistic response to the outcome. These thought processes may be used to identify attributional or explanatory style.

Specifically, those who use an optimistic explanatory style tend to be more resilient when facing challenges, while individuals who are less optimistic tend to have lower resilience, greater helplessness, and, in some cases, exhibit symptoms of depression (Rosen, 2011). Research has shown that when people are exposed to negative events that they cannot escape, they become passive, stop trying (e.g. learned helplessness), and, as a result, exhibit greater levels of anxiety and depression (Forgeard et al., 2011). This study attempts to fill a gap in the literature regarding the length of time homeless, attribution style, and depressive symptoms among African-American women. Ultimately, this type of research could provide social service providers, housing agencies, transitional living centers, and homeless service agencies with insights to design programs and formulate policies to meet the mental health needs of homeless individuals, which could result in education to end homelessness and prevent future occurrences of homelessness.

Problem Statement

The research problem addressed in this study examined length of time homeless, attribution style, and depressive symptoms among homeless African-American women. There is research addressing the emotional impact of homelessness and how this affects an individual's ability to move toward and achieve sustainability. Nemiroff et al. (2011) proposed that homeless individuals and families feel disaffiliated and disenfranchised from society and social structures, and view homelessness as a life crisis. The past decade

has seen an increase in the number of studies focusing on homeless women and homelessness' association to a number of adjustment problems and mental illnesses including anxiety, depression, PTSD, attribution style, and self-blame. Studies such as Finfgeld-Connett's (2010) and Yeater et al.'s (2010) examined the complex interconnected stressors that impact homeless women, including anxiety, mood disorders, PTSD, and psychosis, as well as limited problem-solving and decision-making skills. These studies provided direction for therapeutic intervention, treatment, services, and program design for shelter environments aimed at helping homeless women.

Studies examining length of time homeless have investigated its effect on employment, self-efficacy, and the impact on the emotional and physical health of homeless African-American women (Guarnaccia & Henderson, 1993; Piliavin et al., 1993; Washington, 2005; Wenzel, 1992). Investigating the length of time homeless and employment outcomes for homeless persons in job training programs, Wenzel (1992) found that individuals with lower levels of psychological resources and social support were not successful. Piliavin et al. (1993) studied the conditions affecting the period of time a person was homeless, defined as homeless careers. The authors found that individuals whose homeless careers were longer differed systematically from those with shorter homeless careers (Piliavin et al., 1993). Specifically, persons who were raised in foster care and had shorter employment histories were homeless longer, and individuals who had psychiatric hospitalizations had shorter lengths of homelessness (Piliavin et al., 1993). Washington (2005) investigated the demographics and health characteristics of 100 older homeless African-American women. Researching whether the length of time homeless affected the physical and emotional health of older African-American women,

the author found that African-American women who were homeless for more than 12 months experienced a number of psychosocial or emotional problems as well as physical problems such as ulcers (Washington, 2005). Guarnaccia and Henderson (1993) examined the effect of length of time homeless on homeless persons' self-efficacy, interpersonal competence, and social desirability. The authors found that length of time homeless did not relate to self-efficacy or interpersonal competence; in fact, the participants in the study saw themselves in positive terms (e.g. willing to initiate interactions in society and expecting to succeed; Guarnaccia & Henderson, 1993).

Researchers have also examined the impact of attribution style, shame, self-blame, and personal versus universal helplessness and ways individuals respond to uncontrollable events (e.g. learned helplessness) as it relates to depression (Abramson, Seligman, & Teasdale, 1978). There is a void in the literature relating to attribution style and homeless African-American women. Examining attribution style may explain their motivation to move from homelessness to permanent housing. Much of the literature discussing the reformulation of learned helplessness identified "three main attributional dimensions: (a) internal – external; (b) stable – unstable; and (c) global – specific" (Gaber & Seligman, 1980, p. 8) to describe how the expectation of noncontingency is the main factor of the symptoms of learned helplessness (Gaber & Seligman, 1980). Individuals who exhibit learned helplessness view negative or uncontrollable life events as stable, with global consequences and they blame themselves for these events. This is identified as "pessimistic explanatory style" (Forgeard et al., 2011, p. 281). Additionally, these individuals remain helpless long after the negative event has ended (Forgeard et al., 2011). Learned helplessness in humans can be described as giving up and can lead to

depression. Forgeard et al. (2011) argued that homeless individuals tend to enhance negative situations and minimize positive events.

Studies have shown an association between homelessness and mental illness. Approximately 29 percent of homeless adults in the United States have a mental health diagnosis, but there is no direct link between homelessness and mental illness (Curtis, Corman, Noonan, & Reichman, 2014; Nemiroff et al., 2011; SAMHSA, 2011). Reportedly, 47 percent of homeless women meet the criteria for the diagnosis of major depressive disorder (MDD), which is two times higher than that of the general population (APA, 2014; Deforge et al., 2008). Additionally, studies have found that biological, environmental, and psychosocial risk factors (daily life stressors, intimate partner violence [IPV], negative life events, childhood abuse, and homelessness) are associated with depression among minority women (Wong & Miller, 2014).

Research that investigates length of time homeless, attribution style, and depressive symptoms among African-American women would provide insight into ways transitional programs could aid homeless African-American women in progressing towards self-sufficiency. Numerous studies have been conducted relating to the varied risk factors that contribute to homelessness; however, there is not sufficient research to address length of time homeless, attribution style, and depressive symptoms among African-American women (Finfgeld-Connett, 2010; Nemiroff et al., 2011).

Purpose of the Study

The purpose of this quantitative, correlational research design was to investigate whether length of time homeless and attribution style are associated with symptoms of depression among African-American women. In this study, the independent variables

were the length of time homeless and attribution style and the dependent variable was depressive symptoms. Specifically, I examined whether the length of time African-American women are homeless and their attribution style are associated with symptoms of depression among this population.

Studies have been conducted examining the risk factors contributing to homelessness among women as a whole; however, there is a void in the literature pertaining to how they may interpret their situation as it relates to their thinking and behavior. More often than not, homeless individuals primarily have continuous thoughts focusing on their current state of homelessness, the lack of permanent housing, safety, and finances and do not attend to their actual feelings that impact their current and past behaviors (Davis, Palladino, & Christopherson, 2013).

Attributional style has been researched in the areas of academia and employment (Abramson et al., 1978; Harvey & Martinko, 2011); however, there are no empirical studies relating to attributional style and depressive symptoms among homeless African-American women. There is a need to examine length of time homeless, attribution style, and depressive symptoms among African-American women.

Research Questions and Hypotheses

A correlational research design was used to examine whether the length of time homeless correlates with depressive symptoms among African-American women when controlling for attribution style, and if attribution style correlates with depressive symptoms among African-American women when controlling for length of time homeless. The analysis provided answers to the following research questions and hypotheses:

RQ1: Does the length of time homeless correlate with greater depressive symptoms among African-American women when controlling for attribution style?

$H_0$1: The length of time African-American women are homeless does not correlate with greater depressive symptoms when controlling for attribution style.

H_a1: The length of time African-American women are homeless does correlate with greater depressive symptoms when controlling for attribution style.

RQ2: Does attribution style correlate with greater depressive symptoms among homeless African-American women when controlling for length of time homeless?

$H_0$2: Attribution style does not correlate with greater depressive symptoms when controlling for the length of time African-American women are homeless.

H_a2: Attribution style correlates with greater depressive symptoms when controlling for the length of time African-American women are homeless.

RQ3: Does attribution style moderate the association between length of time homeless and depressive symptoms among homeless African-American women?

$H_0$3: Attribution style does not moderate the association between length of time homeless and depressive symptoms among homeless African-American women.

H_a3 Attribution style moderates the association between length of time homeless and depressive symptoms among homeless African-American women.

Theoretical Foundations

This study utilized two theoretical foundations. The cognitive behavioral therapy (CBT) model provided insight into depressive symptoms of homeless African-American women and their length of time homeless. Attributional theory explained how homeless African-American women interpret the cause(s) of their length of time homeless.

Aaron T. Beck developed the CBT model to treat psychological problems, specifically depression (King, 2013). This model helps individuals change their illogical thoughts about themselves, their world, and their future (Davis et al., 2013; King, 2013). Additionally, this model can be used to assist people with overcoming their difficulties by changing their behavior and emotional responses (King, 2013). The CBT model in this study provides insight into the degree of depressive symptoms of homeless African-American women and its relationship to their length of time homeless.

Fritz Heider proposed the psychological theory of attribution in 1958 in his book "The Psychology of Interpersonal Relations" (Batool & Akhter, 2012), although Bernard Weiner and colleagues developed the original theoretical framework, which explains how individuals interpret events and in turn how this relates to their thinking and behavior (Dindelegan & Serac-Popa, 2014; Weiner, 1986, 2006). The theory explains how people link actions and emotions to particular causes, both internal and external (Dindelegan & Serac-Popa, 2014; Weiner, 1986, 2006). Attribution theory is a psychological theory

utilized to describe motivated behaviors in humans (Korn, Rosenblau, Rodriquez Buritica, & Heekeren, 2016).

In this study, attribution theory explained the impetus of African-American women's movement from homelessness to permanent housing. The focus of attributions on motivation can be viewed through the dimensions of locus of causality (an individual's perception of whether the cause of his or her failure or success is due to internal or external factors) and stability (Harvey & Martinko, 2011). Harvey and Martinko (2011) argued that the formation of causal attribution is important for adapting to a changing environment and to overcoming challenging events in one's daily life (e.g. homelessness). Researchers have examined the social, cultural, and psychological factors behind how individuals respond to stigmatized groups (e.g. homeless people) and found that locus and controllability were significantly correlated with attitudes held by participants in their study towards homeless people (Baumgartner, Bauer, & Bui, 2012). Participants associated unemployment, poverty, and homelessness with internal causes and believed government support caused "dependence amongst the poor" (Baumgartner, Bauer, & Bui, 2012, p. 27). Attribution theory can be used to describe how homeless African-American women explain the cause(s) of their length of time homeless and whether they believe their homelessness is stable or unstable and specific or global (King, 2013).

This study's approach and research questions aligned with the psychometric assessments (demographic questionnaire, the Beck Depression Inventory-II [BDI-II]) (Beck, Steer, & Brown, 1996), and the Attributional Style Questionnaire-revised [ASQ-revised] (Dykema, Bergbower, Doctora, & Peterson, 1996b), the theoretical foundations

(attribution theory and CBT) to explore the relationship between length of time homeless, attribution style, and symptoms of depression among African-American women. Both theoretical foundations of CBT and attribution theory are covered in more detail in Chapter 2.

Nature of the Study

In this quantitative correlational study, the independent variables were the length of time homeless and attribution style, and the dependent variable was depressive symptoms. The correlational research design included single homeless African-American women who were living in the shelter and transitional living centers. According to Lodico, Spaulding, and Voegtle (2010), correlational research measures two or more variables and examines whether there are relationships among the variables. Additionally, this research design allows the researcher to investigate naturally occurring variables that may be unethical or impractical to test (Lodico et al., 2010). In a correlational design, when variables are related there is a pattern in the data that shows an association between the variables (Lodico et al., 2010).

I performed a multiple regression analysis in this study to examine the relationship between length of time homeless and symptoms of depression, and attribution style and symptoms of depression among homeless African-American women. Field (2009) explained that "regression analysis is a way of predicting an outcome variable from one predictor variable (simple regression) or several predictor variables (multiple regression)" (p. 198). According to Gravetter and Wallnau (2009), multiple regression is "the process of using several predictor variables to help obtain more accurate predictors" (p. 580). In this study, multiple regression tested the relationship

between the operational variables (length of time homeless and attribution style, and symptoms of depression).

The population included women of African-American ethnicity ranging from 18 to 66+ years old with varied backgrounds living in the shelter and transitional living centers. The participants completed the ASQ-revised (Dykema, Bergbower, Doctora, & Peterson, 1996b), the BDI-II (Beck, Steer, & Brown, 1996), and a demographic questionnaire. First, administering the ASQ-revised in this study yielded scores for the participants' differences in their tendencies to attribute causes of negative events to stable or unstable and global or specific factors. Secondly, the administration of the BDI-II determined the severity of depression each person had based on their test score. Finally, the demographic questionnaire provided information pertaining to the length of time homeless, age, substance or alcohol use and ethnicity.

Definitions

African American: Refers to a person having origins in any of the Black racial groups of Africa (U.S. Census Bureau, 2010).

Attribution Style: The way individuals assign or use certain language to explain causes of events, either good or bad (Dindelegan & Serac-Popa, 2014; Rosen, 2011). Attributions may be internal or external, stable or unstable, global or specific (Dindelegan & Serac-Popa, 2014; Weiner, 1986; Abramson et al., 1978).

Attribution Theory: This theory is used to explain how individuals interpret events and how they link actions and emotions to a particular cause (Weiner, 1986; 2006; Sanjuan & Magallares, 2009; Brooks & Clark, 2011).

Cognitive Behavioral Therapy (CBT): A therapeutic approach that combines cognitive and behavioral theories and practices with an emphasis on reducing self-defeating thoughts and changing behaviors (King, 2013; Davis et al., 2013).

Depression: A depressed mood for a period of at least two weeks in which persons experience a loss of interest or pleasure in nearly all activities. Symptoms can include a "change in appetite or weight; sleep; psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideations or suicide plans or attempts" (APA, 2013, p. 163).

Homelessness: Defined as individuals lacking a fixed, regular, and adequate place to sleep. They are couch surfing, or living in shelters, transitional centers/housing, in a motel with a voucher, under bridges, inside abandoned buildings, bus and train stations, cars/vehicles, and on the streets (National Coalition for the Homeless, 2009; Lehmann et al., 2007).

Length of Time Homeless: The length of time a person is without a permanent place to live.

Assumptions

There were a number of assumptions in this study. First, it was assumed that participants provided accurate and honest answers to the questionnaires. Second, during the course of the study, it was assumed that there were no historical event variables for the participants that influenced their responses. Third, correlation research made several assumptions: (a) the relationship between the independent variables and dependent variable was linear; (b) variables were normally distributed; and (c) the data was

normally distributed about the regression line (homoscedasticity). Fourth, multiple regression analysis made several key assumptions: (a) there was a linear relationship between the independent variable and the dependent variable; (b) that variables had normal distributions; (c) variables were measured without error; and (d) there was an assumption of homoscedasticity.

Scope and Delimitations

This study compared the impact of length of homelessness and attributional style on symptoms of depression among African-American women using the ASQ-revised and the BDI-II. The participants included single homeless African-American women between the ages of 18 and 66+ living in the shelter and transitional living centers. A non-randomized convenience sample was used, which could pose a possible threat to internal validity due to individual differences relating to cognitive levels and personality (Schenker & Rumrill, 2004). Because this was a non-randomized sample, it has limited generalizability to the population (Schenker & Rumrill, 2004). The sample size was not very large; therefore, it did not represent the general homeless population.

This study included homeless African-American women living in the shelter and transitional living centers; it excluded women living on the streets and those living in motels with vouchers. Ethnicities other than African-American women were excluded from this study; research has shown that African-American women are a growing and overrepresented subgroup of the homeless population (Moxley et al., 2011). While there have been increased numbers of families identified as homeless, this research did not include that demographic.

Limitations

This study had at least three limitations. First, correlational research does not imply causation, Even if there is a strong association between variables, it cannot be assumed that one has caused the other (Lodico et al., 2010). Second, the participants were a convenience non-random sample; therefore, there was less chance that individuals in the study were representative of the general homeless population (Creswell, 2009; Lodico et al., 2010). The experiences of this sample may not be the experiences of other homeless women, in that the sample of women in this study were African-American living in the shelter and transitional living centers. Third is a possible limitation related to the test instruments: Participants only responded to the questions asked—they were unable to ask questions for clarification. Both the ASQ-revised and the BDI-II are reliable and stable for this age group.

Significance

Research has shown that the way in which individuals attribute their experiences impacts their emotional well-being and their ability to handle setbacks, challenges, failures, and specifically homelessness (Forgeard et al., 2011). It may be expected that when a woman becomes homeless, she might exhibit symptoms of depression. This study examined whether these symptoms are related to the length of time she has been homeless and the language she uses to explain her circumstance**.** Understanding an individual's attribution style may allow shelter environments and agencies assisting homeless persons to develop programs and services to address the ways individuals describe the events that led them to their current situation and move them into stable and secure housing. Additionally, understanding this population would benefit society as a whole by possibly influencing housing policies relating to homeless individuals and

providing knowledge to social service agencies and other programs to increase efforts with re-housing the homeless.

Summary

Reportedly, African-American women are a growing subpopulation among the homeless (Moxley et al., 2011). Zlotnick et al. (2010) argued that the rate of homelessness is disproportionately high among socioeconomically disadvantaged minorities, particularly those who self-identify as African Americans. As previously stated, of all the risk factors contributing to homelessness, wage inequality affects every area of a person's life. This is compounded for minority women and particularly African-American women, who make 63 cents for every dollar their non-Hispanic male counterpart makes (Colorado Coalition for the Homeless, 2012). Additionally, low wages and lack of economic resources lead to poverty and poverty and homelessness are intricately linked (National Coalition for the Homeless, 2014).

Literature has also shown that African-American women are more likely to experience major depression than any other group, which is usually related to increased poverty, poor health, and the stigma associated with mental health issues (Curtis et al., 2014; Duncan et al., 2014; Wahowiak, 2014; Watson, Roberts, & Saunders, 2012). Much of the literature has studied the risk factors associated with homelessness (e.g., domestic violence, mental health issues, past childhood physical and sexual abuse, drug addictions, poverty, and lack of affordable health care) and depression (e.g., daily life stressors, intimate partner violence (IPV), negative life events, childhood abuse, and homelessness) (National Coalition for the Homeless, 2009; U.S. Department of Health and Human Services, 2010; Wong & Mellor, 2014). However, these factors have not been examined

relating to the length of time African-American women have been homeless. While African-American women are overrepresented among the homeless population, there remains a void of empirical data examining the differences in attribution style, depressive symptoms, and length of time homeless among this group. This research study sought to examine whether there is a difference utilizing a demographic questionnaire, the ASQ-revised, and the BDI-II.

This chapter provided the background relating to homelessness, attribution style, depression, and other factors relating to poverty that affect African-American women. The problem statement and purpose of the study was described as well as the nature of the study, the research questions and hypotheses, and the research design. Additionally, CBT and attribution theory were introduced as the theoretical foundations for the study. The assumptions, limitations and delimitations, the scope, and the significance of the study were also defined. Chapter 2 provides a review of the literature related to the differences in attribution style, depressive symptoms, and length of time homeless among African-American women. Chapter 3 describes the research design and approach, data collection and analysis. Chapter 4 presents the results of the research, and finally Chapter 5 outlines the interpretation of the findings, limitations, and offers recommendations for future research.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative, correlational study was to investigate length of time homeless, attribution style, and the symptoms of depression among African-American women. Specifically, I examined whether the length of time African-American women are homeless and attribution style are associated with symptoms of depression among this group. Given the increased numbers of homeless women overall, it is striking that there is a void of studies that include African-American women.

Literature has documented that homelessness in the United States has never been eliminated; while there have been times of improvement there have always been homeless people (Bassuk & Franklin, 1992). Individuals and families lost their jobs and homes during the Great Depression, which lead to migration looking for work, food, and shelter (National Policy and Advocacy Council on Homelessness, 2011). Homelessness became an epidemic during this period (Fisher, 2011). As the Depression ended, situations improved (Donohoe, 2004).

Homelessness in America is not a new phenomenon; however, the number of women who are homeless (including single women and women with children) increased by 28 percent from 2007 to 2010 and they suffer disproportionately more than men relative to their gender and race (Colorado Coalition for the Homeless, 2012; Stohs-Krause, 2013). Women living on the streets for more than 6 months experience a higher prevalence of sexual assault or rape (Colorado Coalition for the Homeless, 2012; Stohs-Krause, 2013). To avoid this danger, the women adopt a survival tactic: They make themselves invisible (Colorado Coalition for the Homeless, 2012). The issue of

homelessness is a reality and a challenge in the lives of poor, disenfranchised women, precisely African-American women who are an "overrepresented and growing subpopulation" among the homeless (Moxley et al., 2011, p. 114). Numerous studies have been conducted documenting the various risk factors contributing to homelessness among women, such as childhood and adult exposure to violence, shortage of affordable housing, domestic violence, poverty, wage inequality, mental illness, and substance abuse (Colorado Coalition for the Homeless, 2012; Finfgeld-Connett, 2010; Nemiroff et al., 2011). There is no significant research addressing length of time homeless, attribution style and depressive symptoms among African-American women.

There is minimal information pertaining to homeless African-American men and even less demographic information relating to homeless African-American women (National Coalition for the Homeless, 2009). The national average indicated that for every 10,000 persons, 19 of those individuals are homeless. Approximately 62 percent of this population are men (47 percent are African-American men) and 38 percent are women (National Alliance to End Homelessness, 2014; National Alliance to End Homelessness, 2012; National Coalition for the Homeless, 2009; Peterson, Anthony, & Thomas, 2012; Substance Abuse and Mental Health Services Association, 2011). Yeater et al. (2010) examined the complex interconnected stressors that affect homeless women, which include anxiety, mood disorders, PTSD, and psychosis. Along with limited problem-solving and decision-making skills, this increases the probability that a resolution to homelessness will be unsuccessful.

There is research examining the use of attribution theory to assist clients with their understanding of distress (Brooks & Clarke, 2011). Peters, Constans, and Matthews

(2011) suggested identifying cognitive attributions (e.g. assigning causal mechanisms for negative life events) that would be useful in treating stress-related disorders (Brooks & Clarke, 2011). While there is a surplus of research focused on negative explanatory style, uncontrollability, depressive symptoms (Sanjuan & Magallares, 2011), negative experiences impacting an individual's emotional well-being, pessimistic explanatory style (Forgeard et al., 2011), and the causes, demographics, and emotional impact of homelessness, there is a void of empirical studies related to attribution style, length of time homeless and depressive symptoms among homeless African-American women (Nemiroff et al., 2011).

Past research suggests a decrease in motivation can be identified as learned helplessness (Gaber & Seligman, 1980). Learned helplessness occurs when individuals believe they have no influence over what happens in their lives and the situation will not change. In these situations, people may give up and in some cases, develop anxiety or depression (Ulusoy & Duy, 2013). Learned helplessness has also been used to describe the responses of women in abusive situations (Bargai, Ben-Shakhar, & Shalev, 2007). Palker-Corell and Marcus (2004) argued that battered women exposed to repeated, unpredictable, and uncontrollable abuse become helpless and feel that they have no control over the situation, which may lead to the development of learned helplessness or a negative attribution style. However, the author's findings did not attribute women's exposure to repeated abuse to learned helplessness or a negative attribution style (Parker-Corell & Marcus, 2004). Examining attribution style among homeless African-American women may help to explain why some are more resilient than others in their state of homelessness.

This literature review begins with the exploration of homelessness and African-American women. I explored whether the length of time African-American women are homeless and their attribution style affect their ability to move beyond homelessness. In the literature review, I examined depressive symptoms among African-American women and their length of time homeless. Finally, I examined whether there was a connection between depression and attribution style, and if there was, if it could affect an individual's ability to move from homelessness to permanent housing.

Literature Search Strategy

Search of the literature for this review included articles and information from multiple sources such as books and psychological, scholarly, or peer-reviewed journals. I conducted online searches through the Walden University online library using Academic Search Complete, PsycINFO, PsycARTICLES, MedLine, ProQuest Central, Tests and Measures, Google Scholar, and Thoreau databases. Additionally, I researched the library database at the University of North Carolina at Charlotte using Medscape and MedLine. My search criteria for article selection was based on key words and terms that included *depression and women, depression and African-American women, attributional style and women, attributional style and African-American women, domestic violence and attributional style, domestic violence and African-American women, homeless, homelessness, learned helplessness, length of time homeless, strong black woman, depression, poverty and depression, black women and poverty, trauma and motivation, multiple regression,* and *correlational design.* I conducted an exhaustive review of research on homelessness, attributional style, and depression to obtain historical and current theoretical literature. This search included broader terms and less restricted dates

to capture authors who covered homelessness, attributional theory, learned helplessness, and cognitive behavioral therapy. Specifically, the initial search had no date restrictions in order to gather the historical literature and the current search included key search terms for literature published from 2010 through 2015.

While the risk factors for homelessness were mentioned, studies relating to these causes were excluded from this literature review with the exception of studies relating to poverty. Important information and statistics were gathered from websites such as the National Alliance to End Homelessness, Colorado Coalition for the Homeless, the National Coalition for the Homeless, and the National Women's Law Center.

This study used two theoretical foundations. The cognitive behavioral therapy (CBT) model provided insight into depressive symptoms of homeless African-American women and their length of time homeless. Attributional theory was used to explain homeless African-American women's attribution style and length of time homeless.

Cognitive Behavioral Therapy

Between 1962 and 1964, Aaron T. Beck described his treatment method as cognitive therapy, later known as the cognitive behavioral therapy (CBT) model, to treat psychological problems, particularly depression (Bloch, 2004; King, 2013; Rosner, 2012). Davis et al. (2013) and King (2013) defined CBT as a therapeutic approach that combines cognitive and behavioral theories and practices with an emphasis on reducing self-defeating thoughts and changing behaviors. Beck broke with psychoanalytic theory around 1962 after his application for membership in the American Psychoanalytic Association was rejected twice (Rosner, 2012). At that time, he was studying cognitive and developmental psychology and began to look at depression differently (Rosner,

2012). Beck's original hypothesis was that depression was a "form of inverted hostility" (p. 2); however, his experimental study of the psychodynamics of depression did not support this hypothesis (Rosner, 2012). Beck tested several psychoanalytic concepts of depression and found that his patients, when experiencing depression, had thoughts or cognitions that arose spontaneously. He referred to these cognitions as automatic thoughts (Bloch, 2004; Rosner, 2012). This also inspired the development of the Beck depression inventory (Rosner, 2012). Additionally, Beck asserted that individuals develop dysfunctional beliefs that create negative thoughts (Deforge et al., 2008). I selected CBT as one of the frameworks for this study because this model, when practiced in therapy, helps individuals change their dysfunctional beliefs and their illogical thoughts about themselves, their world, and their future (King, 2013; Rosner, 2012).

Characteristics of individuals experiencing homelessness include emotional disturbances such as major depressive disorder (MDD), of which 47 percent of homeless women meet the criteria for this diagnosis (APA, 2014; Deforge et al., 2008); PTSD; and anxiety disorders, to name a few. The best method of treatment for these disorders, according to the APA's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; APA, 2013) is CBT (Forgeard et al., 2011).

CBT can also be combined with other methods to treat mental health disorders. Sun's (2012) study of homeless individuals with co-occurring disorders treated with modified CBT in combination with motivational interviews proved effective in treating PTSD, depression, and anxiety disorders as well as substance use.

Evidence-based research shows an abundance of intervention models for depression for the population at large; however, there is inadequate research for ethnic

minority groups, especially women and specifically homeless African-American women (Foster, 2007). While mental health treatment for homeless individuals is important, government policies and funding are directed toward transitional and permanent housing, not treatment of mental diagnoses (Foster, 2007). Foster (2007) investigated treating depression in vulnerable urban women, examining the use of cognitive behavioral treatment with disadvantaged populations. The findings showed positive clinical outcomes for depression, with a decrease in depressive symptoms from baseline to posttreatment and four months later (Foster, 2007).

More recent research conducted by Cuijpers et al. (2013) provided an updated meta-analysis of "CBT for the treatment of adult depression" (p. 377). The authors examined 12,368 abstracts and retrieved 1237 full text papers, and of that number, only 115 studies met the criteria of the meta-analysis (Cuijpers et al., 2013). The criteria included studies that recruited adults from the community with a diagnosis of major depression as the primary presenting problem, studies in which individuals received between 8 and 16 sessions as identified in the manual by Beck, and studies that were conducted in the United States (Cuijpers et al., 2013). The study found that CBT is an effective form of treatment for adult depression, and that CBT and pharmacotherapy was more effective than pharmacotherapy alone for treating depression (Cuijpers et al., 2013). While many adults with depression benefit from CBT, some may not; however, this is the most effective treatment so far for major depression (Cuijpers et al., 2013). Thus, treating depression in homeless African-American women with CBT can be beneficial.

Research has shown that women are more likely than men to be diagnosed with depression (CDC, 2012; Wong & Mellor, 2014). Homeless women meet the criteria for a

diagnosis of MDD at a rate twice that of the general population (APA, 2014). Furthermore, African-American women experience depression at higher rates than other groups; however, in many cases it goes undiagnosed, under-diagnosed, under-treated, and under-reported (Curtis et al., 2014; Duncan et al., 2014; Martin et al., 2013; Wahowiak, 2014). CBT is one of the best methods of treatment for depression and it produces long-lasting change (Rosner, 2012). This supports the rationale for the choice of CBT as one of the theoretical foundations for this study.

Attribution Theory

In his 1958 book "The Psychology of Interpersonal Relations," Fritz Heider proposed the psychological theory of attribution (Batool & Akhter, 2012). In the 1970s and '80s, the psychologist Bernard Weiner and his colleagues from the University of California, Los Angeles developed a theoretical framework for attribution theory that examined how individuals interpret events and in turn how this interpretation relates to their thinking and behavior (Rosen, 2011; Weiner, 1986, 2006). Weiner's theory suggested that some people achieve more than others because they think about achievement differently and they view obstacles as temporary challenges that can be overcome with hard work (Rosen, 2011). Weiner argued that the way a person thinks about what happens to them determines whether they have a pessimistic or optimistic response to events (Rosen, 2011).

In 1978, Martin Seligman and two other researchers, Lyn Abramson and John Teasdale, reformulated the learned helplessness hypothesis using an attributional framework to resolve many of the theoretical controversies about uncontrollability (outcomes) in humans (Abramson et al., 1978; Gaber & Seligman, 1980). Seligman's

reformulation of the hypothesis addressed the inadequacies of the old helplessness hypothesis, which stated that individuals implicitly or explicitly ask why when something happens (Abramson et al., 1978).

Using the attributional framework, the researchers examined optimism and used cognitive therapy to explain that it is a trait that can be developed (Rosen, 2011). Specifically, if one's mind is trained to develop positive thoughts, one will tend to exhibit positive behaviors (Rosen, 2011). Rosen (2011) examined how understanding attribution styles could create more optimistic classrooms in law school to assist law students with cultivating optimistic thinking habits to alleviate the feelings of depression that tend to come with the law school experience. This concept could be used to help homeless African-American women who may display a negative explanatory style develop a positive style.

Attributional theory is used to explain how individuals interpret events and how they link actions and emotions to a particular cause (Brooks & Clark, 2011; Sanjuan & Magallares, 2009; Weiner, 1986; 2006); particularly, attribution style is the way individuals use certain language to explain the causes of events either good or bad (Dindelegan& Serac-Popa, 2014; Petersen et al., 2004; Rosen, 2011). Weiner (1986) explained the underlying properties of attribution theory as causal dimensions. There are three primary dimensions: locus of causality (internal or external), stability (stable – permanent or unstable – temporary) and controllability (whether the individual can regulate the cause). An attribution style is the cognitive construct people use to explain events, negative or positive (Abramson et al., 1978; Dindelegan & Serac-Popa, 2014). Individuals in Western cultures tend to attach the most importance to their perceived

competencies and how hard they try (Weiner, 1986). A negative view is described as a pessimistic attributional style which individuals tend to view the causes of negative events in their lives as global, stable, and internal (Abramson et al., 1978; Forgeard et al., 2011). Additionally, pessimistic attributional style was found to be a precursor of depression or an antecedent to depression and individuals with a pessimistic explanatory or depressogenic style have a tendency toward learned helplessness and lower resilience, as well as hopelessness when faced with stressful situations (Abramson et al., 1978; Chaney et al., 2004; Forgeard et al., 2011; Harvey & Martinko, 2011; Peters et al., 2011; Petersen et al., 2004; Rosen, 2011; Sanjuan & Magallares, 2009). Sanjuan and Magallares's (2009) longitudinal research examined the association between negative explanatory style and uncontrollability in the prediction of depressive symptoms. The results showed individuals who explained negative events through uncontrollable causes exhibited higher levels of depressive symptoms (Sanjuan & Magallares, 2009). Research suggested that homeless individuals are simply bodies trapped by an insurmountable present and they cannot see how their past choices or actions got them in the situation or how to change their behavior to plan for a better future (Loehwing, 2010; Peterson et al., 2012). Thus, examining one's attribution style would perhaps assist homeless persons with understanding how their past influences present and future events.

It is expected that when a woman becomes homeless, she might experience feelings of depression; do these feelings prevent her from moving forward or push her to change her circumstances? To determine whether homeless African-American women's experience with life events (loss of stability and home) and examine the connection between depression and attribution style, it was appropriate to use the cognitive

behavioral therapy model and attributional theory as the premise for this study. It investigated whether homeless African-American women attribute their current life situation to stable or unstable causes. In addition, it compared the level of depression and length of time homeless.

While this study was a quantitative, correlational design utilizing multiple regression to examine whether length of time homeless and attribution style is associated with depressive symptoms among African-American women, previous research has not investigated these variables collectively. However, correlational research designs have been used in studies to investigate the use of an occupational therapy assessment of executive and performance functioning and indicators of previously homeless and substance abusing adults adjusting back into the community (Raphael-Greenfield, 2012). Baumgartner et al. (2012) utilized this design to examine a correlation between attitudes toward homeless people and individuals' belief in a just world, collectivism orientation, locus, and controllability. Additional research studied the relationship between attributional style (involving internal, stable, global) and composite causes for negative outcomes and depression (Hu, Zhang, & Yang, 2015). Ward and Heidrich (2009) used this design to examine African-American women's representations/beliefs about mental illness, preferred coping behaviors if faced with mental illness, and perceived stigma associated with treatment-seeking and the relationship to beliefs and coping preferences.

Homeless African-American Women

Homelessness is a major social problem in the United States today. In the past two decades, according to a 2008 report by the U.S. Conference of Mayors, the number of homeless individuals has tripled in the United States (National Coalition for the

Homeless, 2009). The history of homelessness in America can be traced back to the 1870s (National Coalition for the Homeless, 2009). From this era through the 1950s, homeless individuals made up 10 percent of the population and the typical homeless person was a Caucasian male in his fifties (National Coalition for the Homeless, 2009). Demographics from this period did not account for women, especially African-American women, because this population among the homeless was not included in the research. Research has documented that 38 percent of the homeless population are women and 41 percent are African Americans. African-American women were not studied as a single group, but they were included in both populations (Substance Abuse and Mental Health Services Association, 2011).

Each year at the end of January, HUD collects data from the continuums of care throughout the United States for a point-in-time (one specific night) count of homeless individuals (Fargo, Munley, Byrne, Montgomery, & Culhane, 2013). According to Fargo et al. (2013), one night in January 2013 there were "394,379 single adults, 62 percent of the total number experiencing homelessness in the United States" (p. 340), with families making up the other 38 percent. Furthermore, on a single night in January 2012, nearly 634,000 people were listed as homeless and of that number, 40 percent were women (Ponce, Lawless, & Rowe, 2014). Homelessness is defined as individuals lacking a fixed, regular, and adequate place to sleep; they are living in shelters, transitional centers/housing, in motels with vouchers, under bridges, inside abandoned buildings, in bus and train stations, in cars/vehicles, and on the streets (Lehmann et al., 2007; National Coalition for the Homeless, 2009).

In recent years, the face of homelessness has changed to include single women and women with children. The United States has the greatest number of homeless women of all industrialized countries (Finfgeld-Connett, 2010). This group of homeless persons is the most vulnerable and poverty-stricken in the nation and because they are impoverished and disenfranchised, they are more likely to experience "threats to their health and well-being" (Ryan et al., 2009, p. 536). Moreover, individuals without stable housing have less access to social support, viable employment, and affordable housing (Alexander-Eitzman, Pollio, & North, 2013).

There is literature that addresses the emotional impact of homelessness and how this affects an individual's ability to move toward and achieve sustainability. Nemiroff et al. (2011) proposed that homeless individuals and families feel disaffiliated, disenfranchised from society and social structures, and view homelessness as a life crisis. It is important to understand these feelings because a home is not as simple as being surrounded by four walls and a roof over one's head. It is "a physical, emotional and psychological place and state" (Peterson et al., 2012, p. 249).

Research has shown that there exists a disproportionately high rate of homelessness among socioeconomically disadvantaged minorities, specifically individuals who self-identify as African Americans (Zlotnick, Tam, & Bradley, 2010). African Americans are only 11-12.4 percent of the general population, although they represent 37-40 percent of the homeless population. The majority of the studies are pertaining to risk factors contributing to homelessness and homeless women and children (Douglas et al., 2008; Finfgeld-Connett, 2010; Lehmann et al., 2007; National Coalition for the Homeless, 2009; Nemiroff et al., 2011; Radu, 2012). Statistics regarding homeless

African-American women are grouped with homeless African-American men or homeless women as a whole (Substance Abuse and Mental Health Services Association, 2011).

As it relates to homeless African-American women, eviction rates among this group have received very little attention. Desmond's (2012) article on eviction and urban poverty explored the occurrence and consequences of evictions, although homelessness was only briefly mentioned. The author conducted a mixed-method study, analyzing administrative and survey data and ethnographic data based on fieldwork (Desmond, 2012). Among several things, the research found that eviction is common in inner-city neighborhoods that are predominately African-American and African-American women were evicted at a significantly higher rate than men (Desmond, 2012). Desmond (2012) argued that poor families have a high mobility rate within disadvantaged neighborhoods, moving from one poor neighborhood to another. The author cited several reasons such as neighborhood or housing dissatisfaction, gentrification and neighborhood revitalization, and slum clearance (tearing down public housing projects); however, a more prevalent cause is eviction, which has been understudied (Desmond, 2012). Particularly, Desmond's (2012) study analyzed eviction records from Milwaukee, Wisconsin between 2003 and 2007 and found that approximately 16,000 adults and children were evicted from 6,000 units in predominately African-American inner-city neighborhoods. The neighborhood's racial composition included an estimate of 15,983 people, which included 7,352 (46 percent) from African-American neighborhoods, 3,197 (20 percent) from Caucasian neighborhoods, 639 (4 percent) from Hispanic neighborhoods, and 4,795 (30 percent) from mixed neighborhoods (Desmond, 2012). As it related to evictions, in

Caucasian neighborhoods the number of evictions for men and women were about equal; however, in African-American and Hispanic neighborhoods, women's rates of evictions were significantly higher than the rates for men (Desmond, 2012). The greatest discrepancy in eviction rates was in African-American neighborhoods, where on average 5.55 percent of women and 2.04 percent of men were evicted annually. African-American women's eviction rate was 1.87 times higher than male renters in those neighborhoods and 5.24 times higher than women in Caucasian neighborhoods (Desmond, 2012). There were several reasons for the evictions, with drastically high unemployment and low-wage jobs topping the list for single men and women and for women with children paying approximately 80-90 percent of their income to landlords for rent (Desmond, 2012). The lack of financial resources leads to a downward spiral into homelessness. To avoid eviction and ultimately homelessness, individuals try to work overtime at jobs and if that is not likely, they resort to "relying on social contacts, hustling in the underground economy, or making money in other informal ways (e.g. donating plasma)" (Desmond, 2012, p. 108). The author explained the different reactions of men and women to eviction notices; specifically, men usually confronted the situation by either displaying anger or agreeing to work to pay off the rent, whereas women oftentimes avoided the landlord if they did not receive assistance from public service or family and friends (Desmond, 2012). As mentioned, African-American women have higher eviction rates than other groups. While low-wage jobs and limited income are major factors, additional elements include the lack of resourceful networks of relatives and friends and connections to people in high positions (Desmond, 2012). With so many negatives, homelessness is soon to occur. Landlords are unwilling to rent to individuals

with an eviction on their record within the past two to three years and some landlords will not rent to persons whose evictions have been dismissed (Desmond, 2012). Another downward spiral towards homelessness involves moving to dilapidated housing in high-crime areas and eventually to a homeless shelter (Desmond, 2012) if space is available or, if not, out on the street. While there is limited research pertaining to African Americans and evictions, there is no empirical research addressing length of time homeless, attribution style, and depressive symptoms among homeless African-American women.

Length of Time Homeless

The length of time a person is homeless can have a major impact on one's life. Research exists pertaining to length of time homeless relating to employment, self-efficacy, and the impact on the emotional and physical health of homeless African-American women (Guarnaccia & Henderson, 1993; Piliavin et al., 1993; Washington, 2005; Wenzel, 1992). Wenzel (1992) investigated the length of time homeless and employment outcomes for homeless persons in job training programs. The findings showed individuals with lower levels of psychological resources and social support were homeless longer and their employment outcomes were less successful (Wenzel, 1992). Homeless persons may feel socially isolated from the general population. However, the longer they are homeless, the more they form relationships with and gain support from other homeless persons, and they tend to embrace the role and identity of homelessness (Wenzel, 1992). The author argued that homeless individuals adopt the role and identity of homelessness in order to overcome the stigma associated with their situation and re-establish a favorable self-concept (Wenzel, 1992). Piliavin et al. (1993) suggested that the longer persons are homeless, the more they adapt to and become knowledgeable of street

life and identify with other homeless individuals, which can make it more difficult to reenter conventional society. The authors examined the conditions affecting the period of time a person was homeless (homeless careers; Piliavin et al., 1993). They hypothesized that individuals whose homeless careers were longer differed systematically (foster care, length of employment, psychiatric hospital stays) from those with shorter homeless careers (Piliavin et al., 1993). The authors found that individuals who grew up in foster care were homeless longer and had shorter employment histories; however, persons who had psychiatric hospitalization stays had shorter lengths of homelessness (Piliavin et al., 1993).

Washington (2005) examined the demographics and health characteristics of 100 older homeless African-American women. One of the research questions asked if length of time homeless affects the physical and emotional health of older homeless African-American women (Washington, 2005). The findings indicated that African-American women homeless for more than 12 months experienced a number of psychosocial or emotional problems and ulcers (Washington, 2005). The author did not use an objective measurement for psychiatric disorders. However, during the interview, 42 percent of the participants reported some form of persistent psychiatric disorder (Washington, 2005). Additional research on length of time homeless examined self-efficacy, interpersonal competence and social desirability among homeless individuals (Guarnaccia & Henderson, 1993). The authors argued that the physical and social conditions of homelessness would have a major impact on how individuals think about themselves (Guarnaccia & Henderson, 1993). However, they found that length of time homeless did not relate to self-efficacy or interpersonal competence; in fact, the participants in the

study saw themselves in positive terms (e.g., willing to initiate interactions in society and expecting to succeed) (Guarnaccia & Henderson, 1993).

Attribution Theory and Homeless African-American Women

Attribution theory has been studied in academia to explain a student's effort or ability in the classroom and to evaluate an employee's ability in the workplace; it has not been applied to describe the motivations of homeless African-American women (Abramson et al., 1978; Harvey & Martinko, 2011). Specifically, attribution theory can be used to explain the impetus of a homeless African-American woman's movement from homelessness to a place of permanency. To examine the motivation of homeless African-American women the focus of attributions on motivation can be viewed through the dimensions of locus of causality and stability (Harvey & Martinko, 2011). Harvey and Martinko (2011) argued that the formation of causal attribution is important for adapting to a changing environment and overcoming challenging events in one's daily life (i.e. homelessness). Weiner (1986) explained that the dimensions of locus relates to self-esteem and pride; therefore if a homeless woman makes an internal attribution following a negative experience, she would tend to have decreased self-esteem or a pessimistic attribution style (i.e. attribute events to internal stable factors) (Harvey & Martinko, 2011). Wells, Thorsteinsson, and Brown (2012) examined control cognitions and causal attributions as predictors of fatigue severity and found that dimensions of stability and personal control were the "most strongly related cognitions to fatigue severity than physical and psychosocial causal attributions" (p. 194). Although the authors studied causal attributions relating to fatigue severity, perhaps this concept could be applied to examining the causal attributions of homelessness, specifically how an

individual views the underlying cause(s) of why she is homeless (Wells et al., 2012). Wells et al. (2012) explained that understanding causal attributions relating to fatigue severity would increase a person's sense of control over his or her illness; this could be studied among homeless African-American women to explain how they cope with their circumstances.

If homeless African-American women had learned to understand their causal attributions to increase their control over situations during times of uncertainty and unexpectedness (Wells et al., 2012), it possibly could have prevented their current episode of homelessness and could prevent any future incidents. Is it possible that a homeless African-American woman who believes that she has no control over her life and that her situation will not change may exhibit passive coping skills and decreased motivation to move beyond her circumstance? Specifically, she may be attributing the negative event (homelessness) to stable and uncontrollable aspects, and believe that nothing in the future will change (Abramson et al., 1978; Harvey & Martinko, 2011; Ulusoy & Duy, 2013; Wells et al., 2012). A decrease in motivation can be identified as learned helplessness (Gaber & Seligman, 1980). Seligman explained that when individuals believe they have no influence on what happens in their lives, specifically that no matter what they do, the situation will not change, they give up and do not try harder (Ulusoy & Duy, 2013). They procrastinate and in some cases depression or anxiety can occur (Ulusoy & Duy, 2013). Most homeless individuals would experience feelings of sadness, helplessness, or even feel discouraged. Are these feelings attributed to their attribution style, their situation, or both? Attribution style (linking negative events to

internal-stable-global causes) is central to attribution theory as it relates to the characteristics that make a person vulnerable to depression (Schroder & Ollis, 2013).

While this study examined homeless African-American women's interpretation of their plight, several studies have examined the way attribution theory has been used to explain service providers and the general public's interpretation of homelessness. Specifically, Baumgartner et al. (2012) referenced studies that examined social, cultural, and psychological factors that explain how individuals respond to stigmatized groups (i.e. homeless people) and found that locus and controllability were significantly correlated with attitudes towards homeless people. Particularly relating to social factors, participants associated unemployment, poverty, and homelessness with internal causes and believed government support caused "dependence amongst the poor" (Baumgartner et al., 2012, p. 27). The authors explained that the majority of literature studied individual and psychological factors that form individuals' responses to the homeless and found that the three common dimensions of attribution theory (locus, stability, and controllability) were used to define how they dealt with them (Baumgartner et al., 2012). Each was examined separately. First, locus was studied and the authors argued that individuals who attributed homelessness to internal factors were more likely to blame the person, whereas those who attributed homelessness to external factors were more likely to blame the system (political entities) (Baumgartner et al., 2012). Second, those who attributed homelessness to external factors were more compassionated and sympathetic (Baumgartner et al., 2012). The study also revealed a positive relationship between internal attributions and negative comments when individuals exhibited challenging behaviors (Baumgartner et al., 2012). As it relates to stability, the study found that individuals who viewed others'

attitudes and traits as "malleable and capable of change" (p. 28) were more likely to invest their time and resources in homeless persons and held a more positive view of their plight (Baumgartner et al., 2012). However, people who believed that human traits were stable tended to have a more negative view of homeless individuals (Baumgartner et al., 2012). Finally, the results of the study revealed that individuals who held the belief that homelessness is controllable had a more negative attitude towards homeless people (stigmatized group) and were less sympathetic (Baumgartner et al., 2012).

As shown, people tend to have particular views and feelings toward the homeless. Loehwing (2010) illustrated this in an essay in which he examined democratic citizenship and present-centeredness of homeless persons as depicted in a documentary film by Wayne Powers entitled *Reversal of Fortune* (ROF). This film was described as a "social experiment" (p. 380) that wanted to demonstrate whether and how a homeless man (Ted Rodrigue) finding $100,000.00 (planted by the film crew) would either solve his problems, create new problems, or turn his life around (Loehwing, 2010). Within six months of finding the money, Rodrigue ran through it and was worse off than before (Loehwing, 2010). The film first aired on Showtime in 2005 and was subsequently featured on *The Oprah Winfrey Show* in 2006 (Loehwing, 2010). Beyond the members of the audience judging the film's ethics and commenting that Rodrigue was exploited, the majority of the audience voiced the idea that a homeless man finding $100,000 in cash would only spend all of the money and they believed Rodrigue to be extremely careless. The audience's responses reinforced the view that he was homeless because of his own actions and that he made poor choices (Loehwing, 2010). Furthermore, other audience participants said that Rodrigue lost the money because many homeless individuals have

untreated mental illnesses and need someone to manage their money (Loehwing, 2010). The audience expressed numerous stereotypes held by many about homeless people. Loehwing (2010) argued that the film perpetuated the idea that homelessness is a condition that only focuses on the now, meaning that those who suffer from homelessness lack the ability to function as productive members of a democratic society, because they can only focus on their current condition and not the future. This view validated an argument by Nemiroff et al. (2011) that homeless individuals and families feel disenfranchised and disaffiliated from society and social structures.

The other side of the spectrum is when an individual makes an internal attribution after experiencing success and feels a sense of pride and generally is motivated to expect success with other experiences (Weiner, 1986). Seligman described this type of person as someone with an optimistic explanatory style and one who is more resilient when facing challenges (Rosen, 2011). The dimensions of stability relating to an expectancy of future success attributes the cause to stable factors such as ability (Weiner, 1986). This was demonstrated in Cheng and Furnham's (2003) study of attributional style and self-esteem as predictors of psychological well-being, which found that the causal relation between attribution style and self-esteem predicts happiness. Harvey and Martinko (2011) referred to this dimension of stability as an optimistic attribution style, in that individuals attribute positive outcomes to their own abilities.

While both Seligman and Weiner examined learned helplessness and attribution theories, Seligman's focus was on emotional problems and their treatment and Weiner's emphasis was on success; each explained causality. Previous studies have researched areas such as self-esteem and pride, fatigue severity, success on the job and in the

classroom, and leadership in organizations (Cheng & Furnham, 2003; Harvey & Martinko, 2011; Ulusoy & Duy, 2013; Wells et al., 2012); however, no experiential research has been conducted to study the attribution style of homeless African-American women.

Depression and Homeless African-American Women

The DSM-5 (APA, 2013) defines depression/MDD as a depressed mood for a period of at least two weeks in which a person experiences a loss of interest or pleasure in nearly all activities. Additionally, he or she must experience at least four other symptoms from the diagnostic criteria, including changes in sleep, weight, appetite, psychomotor activity, difficulty thinking or concentrating, difficulty making decisions, decreased energy, and suicidal ideations, plans or attempts (APA, 2013). This diagnosis is documented as the most pervasive psychiatric disorder in the world (Martin, Boadi, Fernandes, Watt, & Robinson-Wood, 2013). Maass-Robinson (2001) described depression as a chronic illness which can be genetically based and induced by prolonged and chronic stress (i.e. socioeconomic factors including economic class, marital stress, and physical illnesses). Specifically, individuals at the lowest socioeconomic levels are roughly two to three times more likely to experience emotional disorders and psychological distress than those in the highest socioeconomic levels (Washington, 2005). According to Washington (2005), the gradual or sudden loss of a stable home can produce symptoms associated with psychological trauma. According to the Centers for Disease Control and Prevention (CDC, 2012), nearly 8 percent of individuals 12 years of age and older (6 percent of U.S. men and 10 percent of U.S. women) report a current diagnosis of depression and more than 18.8 million adults annually in the United States

are affected by depression (Martin et al., 2013). Reportedly, women have higher rates of depression than men; specifically, women between the ages of 40 and 59 years have higher rates of depression (12 percent) than women between 12 and 17 years (8 percent) and women 60+ years (7 percent) (CDC, 2012). Furthermore, studies have shown that major depression is common among women in the United States, specifically 17 percent of women 18 years and older (Duncan et al., 2014). These women reported at least one major depressive episode (Duncan et al., 2014). According to Wong and Mellor (2014), women are twice as likely to be diagnosed with depression as men. Additionally, studies have found that multiple risk factors in biological, environmental, and psychosocial areas can cause depression (Wong & Mellor, 2014). These factors include daily life stressors, intimate partner violence (IPV), negative life events, childhood abuse, and homelessness (Wong & Mellor, 2014). Maass-Robinson (2001) argued that before menopause, women are at greater risk of developing depression compared to men. This may be related to the female hormones estrogen and progesterone, which are major factors in women's physical and emotional health (Maass-Robinson, 2001).

Fitzpatrick, Myrstol, and Miller (2015) asserted that depressive symptoms are the most common mental health problem among homeless individuals. Research shows a strong association between homelessness and mental illness, and data indicates that approximately 29 percent of homeless adults in the United States have a mental health diagnosis, although there is no direct link between mental illness and homelessness (Curtis et al., 2014; Nemiroff et al., 2011; SAMHSA, 2011). Curtis et al. (2014) argued that data comparing mental illness between homeless and non-homeless individuals is limited and the current numbers are based on small or specific samples. The American

Psychological Association (APA, 2014) explained that the rate of mental illness among homeless persons in the United States is double the rate of the general population. Approximately 47 percent of homeless women meet the criteria for a diagnosis of major depressive disorder, which is twice the rate of women in the general population (APA, 2014).

According to Sohail et al. (2014), nontraditional symptoms such as hypertension among African Americans may be associated with depression. The authors argued that culturally based expressions among African Americans such as falling out (sudden collapse after feeling dizzy) or sleep paralysis (inability to move while awakening) may be symptoms associated with depression (Sohail et al., 2014). Sohail et al. (2014) suggested a more diverse treatment process to address mental health issues among African Americans; particularly, cognitive psychotherapy, holistic therapies, and religion have been found to be effective.

While women in general have higher rates of depression, African-American women are more likely to experience major depression than any other group, although they are less likely to meet the criteria for a lifetime diagnosis of major depressive disorder (Curtis et al., 2014; Duncan et al., 2014; Maass-Robinson, 2001; Wahowiak, 2014). Although many studies indicated that African-American women have higher rates of depression than other groups, some data demonstrated lower rates of depression and anxiety that may be attributed to "psychosocial resources, emotional resilience, social support, and ethnic identity" (Watson et al., 2012, p. 1). These authors explained that higher rates of depression and anxiety were usually related to increased poverty, poor health, and the stigma associated with mental issues (Watson et al., 2012). Watson et al.

(2012) argued that poverty is consistent with mental health disorders among women; specifically, the risk of depression among low-income women is double that of women with higher socioeconomic status. While it is documented that the risk for depression is double among low-income women, it continues to be an unacknowledged and devastating illness among this population (Joy & Hudes, 2010). The higher rate of depression within this group can be attributed to the day-to-day battles of economic and health concerns—they are caught in a cycle of poverty that causes feelings of despair, acute stress, decreased self-worth, and chronic hopelessness (Joy & Hudes, 2010). Joy and Hudes (2010) explained that while providing food and shelter might be the first step in treating poverty, equipping this group with the tools to handle the emotional aspects is the next and possibly more important step. The authors asserted that, over time, depression puts individuals at risk for financial stress and unemployment, which in turn can lead to homelessness (Joy & Hudes, 2010).

In an earlier study, Meadows and Kaslow (2002) investigated the link between a history of childhood maltreatment (sexual abuse, physical neglect, emotional neglect, and physical/emotional abuse) and a sense of hopelessness among African-American women ages 18 to 64. They were divided into two groups identified as suicide attempters and non-attempters (Meadows & Kaslow, 2002). The attempters group was on average younger, less likely to be employed, and more likely to be homeless and less educated (Meadows & Kaslow, 2002). Kaslow et al.'s (2000) study also found that low-income African-American women who attempted suicide were less educated, likely to be unemployed, and had more children living with them. Meadows and Kaslow (2002) asserted that hopelessness is a cognitive manifestation of depression and is associated

with suicide attempts and completions more than affective aspects of depression. The results of the study indicated that hopelessness mediated the relationship between childhood sexual abuse and adult suicide attempts (Meadows & Kaslow, 2002).

Kaslow et al. (2000) examined the psychological and interpersonal risk factors for suicide attempts between two groups (suicide attempters and non-suicide) of low-income African-American women. The 18-month case-control study included 285 African-American women between the ages of 18 and 64 (Kaslow et al., 2000). The findings indicated that while psychological and interpersonal risk factors for suicide attempters were psychological symptoms, PTSD, hopelessness, drug abuse, relationship discord, partner abuse, childhood trauma, and social support, the most significant factor for suicidal behavior was hopelessness (Kaslow et al., 2000).

Additional research found that among African Americans, depression is often misdiagnosed, undiagnosed, under-treated, under-diagnosed, under-reported, and under-studied (Martin, et al., 2013; Sohail et al., 2014). Reportedly, the rate of African-American women with depression is 50 percent higher than that of Caucasian women and the 2003 California Black Women's Health Project found that 60 percent of African-American women experienced symptoms of depression, although only 7 percent sought treatment (Joy & Hudes, 2010; Martin et al., 2013; Ward & Heidrich, 2009). Previous literature has documented that environmental stressors and other psychosocial factors contribute to depression among African-American women (Abu-Bader & Crewe, 2006). The authors argued that women of color experience several socioeconomic conditions that place them at greater risk for depression (i.e. poor health, racial/ethnic discrimination, lower education, low income, unemployment, and larger families; Abu-

Bader & Crewe, 2006). Social support was a factor in both a decrease (Watson et al., 2012) and increase (Kaslow et al., 2000) in levels of depression (Kaslow et al., 2000) among African-American women. Abu-Bader and Crewe (2006) suggested African-American women who had close and confiding relationships were buffered against stressors and were less likely to experience depression than women without confidants.

Historically African-American women have always cared for others at the expense of their own self-care. Holmes, White, Mills, and Mickel (2011) explained that African-American women who identify with the concept of the Strong Black Woman (SBW) "learned to minimize their feelings, wants, and desires to accommodate the needs of others" (p. 74). In the past, they had to be strong, specifically during slavery facing rape and separation from their children and family (Gay, 2012). Even after slavery, they worked as domestic servants, raising other people's children as well as their own (Gay, 2012). African-American women historically have been forced to handle numerous stressful factors of life on their own; standing strong in the midst of struggle has been drilled and passed down through generations (Martin et al., 2013). African-American women are reared to be tough, resilient, self-sufficient, and to preserve even during adversity (Martin et al., 2013). They are expected to keep it together at all costs (Martin et al., 2013). This version of a strong woman exhibiting strength, individuality, ability and self-sufficiency gave rise to the term Strong Black Woman (SBW; Davis, 2015; Holmes et al., 2011). She selflessly cares for others while neglecting her own health. African-American women have been characterized or stereotyped as the SBW (Black & Peacock, 2011; Holmes et al., 2011), which society and African Americans themselves have historically seen as the backbone of the community and the family. For many there

is empowerment in this term. However, is it beneficial when African-American women suppress their desires and interests while caring for everyone else's, particularly when neglecting their physical and mental health (Black & Peacock, 2011)? Black and Peacock (2011) argued that African-American women are diagnosed with mental illness less often than Caucasian women; they have higher rates of morbidity and less access to mental health services. Possibly, the attributes of the SBW script (self-reliance, self-sacrifice, self-silence) and the African-American woman's need to adhere to these attributes deters her from seeking help (Black & Peacock, 2011). While the SBW syndrome may benefit some individuals, the inability to show weakness can be problematic for African-American women in that it impedes them from sharing vulnerability and emotionality (Davis, 2015). As African-American women exhibit dignity and strength, there needs to be an openness and acceptance from others for them to show their vulnerability and emotionality (Davis, 2015).

An additional factor that is linked to depression in African-American women is race (Martin et al., 2013; Watson, Roberts, & Saunders, 2012). Although race has not been identified as a particular cause of homelessness among African-American women in this study, it has been studied as a factor relating to poverty in much of the literature. Precisely, Martin et al. (2013) examined African Americans' vulnerability to depression relating to environmental stressors, such as racism and poverty, to name a few. The researchers found a significant correlation between race-related stress and mental health among African-American women, which was linked to depression and lowered self-esteem (Martin et al., 2013). Race-related stress when chronic can lead to severe psychological symptoms such as "depression and feelings of worthlessness" (Martin et

al., 2013, p. 4). Thus, race in conjunction with poverty can be identified as another risk factor for depression among African-American women.

There is a paucity of current literature addressing homelessness, depression, and African-American women collectively. Specifically, the databases listed nine articles with dates from 2000 to 2010 addressing depression and African-American women and depression and African Americans in general. Of the three articles dated 2010, the first studied health and health care disparities among homeless women (Teruya et al., 2010). The second study examined three primary goals: (a) whether higher racial private and public regard had a direct relationship with depression; (b) whether the relationship between racial regard and depression would differ depending on African-American women's level of racial significance; and (c) investigating the role of self-esteem in mediating the relationship between racial regard and depression (Settles, Navarrete, Abdou, Pagano, & Sidanius, 2010). The third study pertained to HIV prevention intervention for African-American women who smoke crack cocaine (Wechsberg et al., 2010). Thus, there is no empirical research addressing length of time homeless, attribution style and depressive symptoms among African-American women.

Connection between Depression and Attributional Style among Homeless African-American Women

An exhaustive search of the literature found no research study investigating the combined variables of depression, attribution style and length of time homeless for African-American women. However, research examining depression and attributional style was found. Some research has suggested that depression is a result of vulnerability factors, specifically cognitive attributions related to negative life events, which implies

that depression is trait-like (Abramson et al., 1978; Ball, McGuffin, & Farmer, 2008; Forgeard et al., 2011; Harvey & Martinko, 2011; Peters et al., 2011; Rosen, 2011; Sanjuan & Magallares, 2009; Vargas & Arnett, 2013). Ball et al. (2008) investigated whether attributional style is a lasting vulnerability trait for recurrent depression. The researchers used the Attributional Style Questionnaire (ASQ) and the Beck Depression Inventory (BDI) and found a stronger relationship between current mood and attributional style among some individuals than those with a current clinical diagnosis of depression or history of depression (Ball et al., 2008). The authors asserted that vulnerability factors are not trait-like but state-like; however, previous research found individuals who attributed negative events to internal events were associated with a diagnosis of depression rather than current mood (Ball et al., 2008). According to the researchers, this appeared to be more prevalent among persons who were currently depressed and those with previous episodes of depressive disorders (Ball et al., 2008). Attributing experiences to past negative events is less of a risk factor for depression and more of a symptom of depression than previously documented (Ball et al., 2008). The authors argued personality is a vulnerability factor for depression (Ball et al., 2008). While attributional style might be associated with depression due to factors in the environment that may predispose individuals to negative attributions and a diagnosis of depression, attributions do not have a direct role in the development of depression (Ball et al., 2008). Therefore, will the examination of length of time homeless, attribution style and depression among homeless African-American women find that they are depressed due to their current situation or their attribution style?

As previously mentioned, Seligman and his colleagues reformulated the learned helplessness (LH) theory using an attributional framework (Abramson, Seligman, & Teasdale, 1978), which sought to describe how individuals assign causal explanations for life events. Some researchers have argued that the reformulation of LH theory explains that persons with a pessimistic explanatory style that attributes "negative events to internal, stable, and global causes are more vulnerable to depression" (Vargas & Arnett, 2013, p. 81; Harvey & Martinko, 2011; Peters et al., 2011; Rosen, 2011; Abramson et al., 1978; Forgeard et al., 2011; Sanjuan & Magallares, 2009).

Vargas and Arnett (2013) conducted a cross-sectional study to examine differentiated attributional style among 52 individuals diagnosed with multiple sclerosis (MS) to test the LH theory to determine whether there was a difference between illness-related or non-illness-related attributions and depression relating to daily or disability stressors. The analysis of the Attributional Style Questionnaire (ASQ) indicated that the majority of the participants did not necessarily see their diagnosis of MS as affecting many areas of their life (Vargas & Arnett, 2013). To measure depression, the authors administered the Beck Depression Inventory–Fast Screen (BDI-FS), a shorter version of the Beck Depression Inventory-II (BDI-II), valid for MS patients (Vargas & Arnett, 2013). Like healthier populations, MS patients can maintain several different aspects of their lives (Vargas & Arnett, 2013). However, MS patients described as more-disabled attributed more negative events to MS than did patients described as less-disabled, who were able to separate their MS from other areas of their lives (Vargas & Arnett, 2013). The authors argued that depression is seen in an estimate of 50 percent of MS patients, and predicted that on the ASQ the MS or non-MS domain would act as the mediator

between daily ability or daily hassles (stressors) and depressive symptoms (Vargas & Arnett, 2013). However, they found that the relationship between attributional style in the non-MS domain and depressive symptoms was mediated by the effect of daily hassles (Vargas & Arnett, 2013).

Limitations of this research were that some MS symptoms are also symptoms of depression and the ASQ was not designed to measure MS-related and non-MS-related causes specifically. Because the participants used the BDI-FS, they did not have a diagnosis of major depressive disorder; the results of the study may not apply to individuals with more severe depression (Vargas & Arnett, 2013). This research utilized the ASQ and the BDI-FS, among other tools, to examine whether there was a difference between illness-related or non-illness-related attributions and depression relating to daily or disability stressors among MS patients (Vargas & Arnett, 2013).

Attribution style and depression were examined in individuals diagnosed with PTSD and schizophrenia in studies conducted by Addington, Addington, and Robinson (1999) and Gonzalo, Kleim, Donaldson, Moorey, and Ehlers (2011). Addington et al. (1999) conducted a longitudinal study examining whether there was an association between level of depression and negative attributional style among individuals diagnosed with schizophrenia. The study consisted of 111 participants recruited from hospitals in Calgary, Canada and assessed 3-10 days after admission to an acute psychiatric ward (Addington et al., 1999). The ASQ was administered to assess attributional style and the Calgary Depression Scale for Schizophrenia (CDSS) to assess depressive symptoms (Addington et al., 1999). The results revealed an association between depression and attributional style, specifically a correlation between internal and global attributions and

the composite score for negative events on the CDSS (Addington et al., 1999). The authors concluded that if global and internal attributions and the composite score for negative events are specific to depression, then negative attributional style is related to depression and not to a general characteristic of psychopathology even among individuals with other psychiatric symptoms (Addington et al., 1999). Additionally, the authors proposed that this relationship supports the possible role of cognitive therapy in treating depression in schizophrenia (Addington et al., 1999). The limitations of this study were that only 13 percent of the participants met the criteria for major depression (MD) and some individuals required assistance in completing the ASQ (Addington et al., 1999).

Just as Addington et al. (1999) concluded and Gonzalo et al. (2012) argued, there is experiential evidence that attributional style is a factor in the development and maintenance of depression. Gonzalo et al. (2012) compared participants diagnosed with depression only, PTSD only, and PTSD comorbid with depression to investigate whether depressed persons endorse depressive attributions to a greater extent than individuals with PTSD. A total of 164 individuals were recruited from local hospitals and participated in the study, the researchers divided them into groups: patients with MD, trauma survivors with PTSD, and control participants (Gonzalo et al., 2012). The researchers administered the Depression Attributions Questionnaire (DAQ) to assess negative stable attributions, negative internal attributions, negative global attributions and helplessness; the BDI measured the severity of depression; and other instruments measured PTSD (Gonzalo et al., 2012). The findings indicated that individuals with MD only had a significantly higher level of depressive attributions than those with PTSD and the health control participants (Gonzalo et al., 2012). The authors performed several

statistical analyses. Pearson's correlation demonstrated attributions correlated with both the severity of depression and PTSD symptoms; possibly due to the overlap of symptoms of both disorders (e.g. sleep disturbance, difficulty concentrating; Gonzalo et al., 2012).

The researchers in the studies reviewed above administered the ASQ, BDI, BDI-FS, CDSS, and DAQ to measure attribution style and severity of depression; the administration of the ASQ-revised and the BDI-II in my research could determine whether a negative attribution style or their current living situation attributes to depression among homeless African-American women.

Summary and Conclusions

Research on homelessness has focused on women and children, families, veterans, and minorities, however there is limited discussion pertaining to homeless African-American women as a single group. Homelessness is a national tragedy, particularly for women. Collecting accurate data on homeless persons is a problem in the literature, especially on individuals living on the streets or in uninhabitable places, with the exception of the point-in-time count of homeless individuals taken every January (Fargo et al., 2013). The literature specific to homeless African-American women, attribution style and depressive symptoms is scarce. However, studies have defined the risk factors that lead to homelessness, the changing face(s) of homelessness (women and children, families, and minorities), and the prevalence of depression and mental illnesses among the homeless (Colorado Coalition for the Homeless, 2012; Finfgeld-Connett, 2010; Nemiroff et al., 2011).

Previous research has applied attribution theory to examine motivation and the ability of students in the classroom and employees in the workplace; it has not been

applied to homeless African-American women. Additional studies have examined attribution theory related to motivation through dimensions of locus of causality (Harvey & Martinko, 2011), dimensions of locus relating to self-esteem and pride, and pessimistic attributional style (Weiner, 1986; Harvey & Martinko, 2011). However, this research has not included length of time homeless and African-American women.

Studies have examined depression and African-American women, however there are few related to depression and homeless African-American women. Research has demonstrated that African-American women have higher rates of depression than European-American women; however, they are less likely to seek treatment (Black & Peacock, 2011). Research revealed several intervention models used to treat depression among the population at large, however there were limited studies relating to minority groups, especially homeless African-American women.

Examining the motivations of homeless African-American women through the dimensions of locus of causality and stability can aid in understanding their attribution styles and their ability to move from homelessness to stability. It is understandable that an individual who becomes homeless would experience overwhelming feelings of sadness, fear, loss, and possible anger; do these feelings over time turn into depression? Is depression is a characteristic of homeless individuals or is it a result of homelessness? The literature has reported that African-American women have higher rates of depression than other groups, although they are less likely to receive treatment. Are the statistics the same for homeless African-American women? Studying length of time homeless, attributional style, and depressive symptoms among African-American women may provide these answers.

Chapter 3 discusses in more detail the research methodology for this study, including research design and approach (quantitative, correlational design and multiple regression analysis), setting and sample, instrumentation and materials, data collection and analysis, and measures taken for protection of participants' rights.

Chapter 3: Research Method

Introduction

The purpose of this study was to investigate length of time homeless, attribution style, and the symptoms of depression among homeless African-American women. Self-reported instruments were used to gather data on length of time homeless, symptoms of depression, and attributional style. This chapter describes the methodology used to obtain answers to the research questions identified in the following sections: (a) Research Design and Rationale, (b) Research Setting and Sample, (c) Instrumentation and Materials, and (d) Ethical Considerations.

Research Design and Rationale

I used a quantitative, correlational method as the design of this study. Correlational research measures two or more variables and examines whether there are relationships among the variables (Lodico, Spaulding, & Voegtle, 2010). This design allowed me to measure several variables at a single point in time and the collection of data from a large number of participants of a specific demographic outline (Field, 2009). Correlational design permitted me to investigate naturally occurring variables (e.g. homelessness) that may be unethical or impractical to manipulate, thus a nonexperimental research design was appropriate (Lodico et al., 2010).

Lodico et al (2010) explained that when variables are related, it simply means that there are patterns in the data that show an association between the variables. Additionally, Lodico et al (2010) asserted that correlational research explores relationships among continuous variables. In this study, the independent variables were length of time homeless and attribution style and the dependent variable was depressive

symptoms. There were no time or resource constraints related to the design; however, I encountered a time constraint at one of the sites. The director at the site specified that research had to be conducted on 1 day for 4 hours.

While there is a void of correlational design studies pertaining to length of time homeless, attribution style, and symptoms of depression among African-American homeless women, previous research examined the prevalence of depressive symptoms and a relationship to the severity of self-reported stressful life events among college students in Cyprus (Sokratous, Merkouris, Middleton, & Karanikola, 2013). Additional research by Raphael-Greenfield (2013) investigated the use of an occupational therapy assessment of executive and performance functioning and indicators of community adjustment among 60 adults with histories of homelessness and substance abuse. Anderson, Miller, Riger, Dill, and Sedikides (1994) utilized a correlational design to examine whether characterological and behavioral attributions correlated with measures of depression and loneliness.

Quantitative research is most appropriate when testing hypotheses and it explains a phenomenon using statistics (Creswell, 2009; Lodico et al., 2010). I used this design to analyze whether symptoms of depression and attribution style are associated with the length of time African-American women are homeless. Additionally, a quantitative approach allowed me to understand how prevalent this problem is as well as whether it is generalized to the larger homeless population.

I reviewed Creswell's (2009) description of qualitative research design and deemed it inappropriate for this research. Specifically, this study did not examine the lived experiences of the homeless women: I did not focus on a single concept of their

lives, nor did I play an interactive role with the participants at the shelter or the transitional living centers where they live (Lodico et al., 2010). However, this study measured the length of time homeless and depressive symptoms, and attribution style and depressive symptoms among African-American women.

Methodology

Participants

Participants in this study were recruited from the local shelter and transitional living centers in Charlotte, North Carolina, which has an approximate metropolitan population of 792,862. In January 2015, data collected during the point-in-time count of the city revealed there were 1,231 homeless adults. Of these, 43 percent were women and 82 percent were African Americans (Clark, Brown, & Lane, 2015; Continuum of Care, 2014). Based on a power analysis for linear multiple regression, fixed model, R^2 deviation for two predictors, with a power of .80, a medium effect size of 0.15 and an alpha level of 0.05, the minimum number of participants needed for this study was 68 homeless African-American women (G*Power; Faul, 2014) drawn from the city's homeless population.

Seventy African-American women ranging in age from 18 to 66+ were recruited for the study using a convenience sample method. Convenience sampling allows for relatively faster and less expensive data collection and participants are more accessible than in a random sample (Creswell, 2009; Glenn, 2013). Women under the age of 18 and all ethnicities other than African-American were excluded from this study.

The stakeholder of each site granted permission for me to conduct research at the location. One organization asked me to meet with the social work team to present the

study prior to beginning the research. Another organization requested a flyer to be posted indicating that surveys for research would be conducted, offering a stipend (i.e., 1 day unlimited transit passes equaling $6.60 or $5.00 Target or Walmart gift cards provided to all participants) and giving permission to enter the facility on a Saturday afternoon for 4 hours. I designed a flyer for all organizations to post (see Appendix A).

Participation in the study was voluntary. The research participants were anonymous. I ensured anonymity by coding all test instruments with code numbers, which was assigned to each person, and my personal contact number was provided. If a participant wanted the results, she could call me and provide the code number given at the site. While the organizations have different protocols, they all required me to sign a confidentiality agreement. All of the organizations provided a private area to conduct the research. Individuals volunteered to participate in the research study. I made introductions and presented an envelope that included the consent form and test instruments. I read the rationale for the study to the participants. I read the explanation of the consent form (to include risks, confidentiality, and an option to exit the study) and the length of time to complete the process (approximately 40 to 50 minutes) to participants.

Only women who self-identified as African-American were exposed to the inventories. The flyer indicated participants sought for the study were African-American women between the ages of 18 to 66+ living in the shelter or transitional living centers. Additionally, I explained confidentiality to the participants and how the data would be used. I collected and reviewed the data and explained that the data will be stored at the university for 6 years and destroyed afterward. They were informed that participation was voluntary and would not impact the current or future services they receive.

The informed consent included participants' rights, the purpose of the research, the benefits of participating, and my contact information. The forms were distributed to the participants, questions were answered and I read the materials aloud. I collected and signed the forms. To maintain anonymity, the Institutional Review Board of the university approved the exclusion of the participants' signatures. I had no way to assess the literacy level of the participants; therefore, I read all questions aloud. I debriefed all participants prior to them leaving the room and distributed my contact information for questions that may arise in the future (Creswell, 2009). Data collection occurred once at each of the two transitional living facilities and twice at the shelter due to the number of individuals it serves.

Materials and Procedures

The collection of data consisted of three parts: a demographic questionnaire (see Appendix B) with four questions; the Beck Depression Inventory-II (BDI-II) (see Appendix C) containing 21 items with four options; and the Attributional Style Questionnaire-Revised (ASQ-revised) (see Appendix D), which lists 12 bad events that the participant responds to in written format. The publishers of the BDI-II and the ASQ-revised granted permission for use in my research.

The variables were operationalized as follows: Depressive symptoms were operationalized using the BDI-II (Beck et al., 1996), which measures the severity of depression in individuals 13 years of age and older. Attributional style was operationalized utilizing the ASQ-revised (Dykema et al., 1996b) for individuals 18 years of age and older to assess explanatory or cognitive personality variables that explain how people describe negative events in their lives. Length of time homeless was

operationalized using the demographic questionnaire to determine their age, ethnicity, and length of time homeless. Specifically, length of homelessness was measured as a continuous variable number of months homeless (e.g. 2, 3, 5, 10, 13, 20, etc.).

Demographic Questionnaire: Four items were used to obtain demographic information about age, ethnicity, substance and or alcohol use, and length of time homeless. No identifying information was obtained; numbers were assigned to the test instruments for identification.

Depression: Depressive symptoms were measured with the BDI-II (Beck, Steer, & Brown, 1996b). The BDI-II was developed as a screening tool to assess symptoms corresponding to criteria listed in the DSM-IV diagnosing depressive disorders. It is the most recent version of the self-reported measure of depression severity designed for individuals 13 years of age and older and it can usually be completed in 5 to 10 minutes (Beck et al., 1996). The BDI-II was designed to measure symptoms of depression in adolescents and adults while assessing different symptoms and attitudes by asking the examinee to consider a group of graded statements based on levels of severity (Arbisi, 1996; Beck, Steer, Ball, & Ranieri, 1996). This is the second revision of the original instrument published in 1961 and the most recent in 1996. The BDI-II consists of 21 items with four options under each item assessing a different symptom or attitude, scoring from *not present* (0) to *severe* (3) (Beck et al., 1996). A total score is derived from the sum of the scores of the 21 items, which ranges from 0 to 63 (Grey, 2011). The breakdown of the scores is as follows: “scores from 0 to 13 indicate minimal depression, from 14 to 19 indicate mild depression, from 20 to 28 indicate moderate depression, and from 29 to 63 indicate severe depression” (Beck, Steer, Ball, & Ranieri, 1996; Grey,

2011, p. 17). The authors of the BDI-II replaced and reworded some questions so that the instrument had greater utility across varied populations (Wang & Gorenstein, 2013). The words weight loss, distorted body image, somatic preoccupation, and inability to work were replaced with agitation, worthlessness, difficulty concentrating, and energy loss because these phrases are better descriptors of depressive symptoms and behaviors (Wang & Gorenstein, 2013). Wang and Gorenstein (2013) explained that the BDI-II does not reflect a particular theory of depression, as did the BDI. This version examines psychological and somatic manifestations of a 2-week major depressive episode (Wang & Gorenstein, 2013).

The items on the BDI-II were evaluated utilizing a sample of 500 (63 percent women, 91 percent white) outpatients from four clinics on the East Coast of the United States and a convenience sample of 120 Canadian college students (56 percent women, predominantly white) (Arbisi & Farmer, 1996). Wang and Gorenstein (2013) explained that most studies comparing the internal consistency of both the BDI and the BDI-II reported the BDI-II showed relative stability with good to excellent coefficients ranging from 0.73 to 0.96 with an average alpha coefficient ranging from 0.83 to 0.96, and the retest reliability (Pearson's *r*). The administration of the BDI-II in this study determined the severity of depressive symptoms each person exhibited based on the score of the instrument as it related to the length of time homeless.

Attribution Style: To assess attribution style, participants completed the ASQ-revised (Dykema et al., 1996b). The ASQ was revised in 1996 with the purpose of assessing explanatory style or cognitive construct that reflects how individuals explain negative events that happen in their lives. It is used to show the link between attributions,

helplessness, and depression (Schroder & Ollis, 2012). The ASQ measures individual differences using attributional dimensions: internal versus external; stable versus unstable; and global versus specific (Dykema et al., 1996a).

The ASQ-revised is a self-reported measure designed for individuals 18 years of age and older, with a completion time of 20 minutes (Dykema et al., 1996a). This revision was developed to correct the flaws of the earlier versions; specifically, items were deleted that were only relevant to college students and particular segments of the population (Dykema et al., 1996b). In this revised version, the language was simplified, only the bad events were included, and it was shortened from 24 to 12 items. The participants read the 12 items and wrote "what they think the main cause for this situation would be if it happened to them" (Dykema et al., 1996a, p. 1). The individual administering the ASQ-revised asks two questions for each item and the participants write down the response (cause). To obtain the scores for both stability-versus-instability and globality-versus-specificity, ratings are made on a 7-point scale from -3 to +3 (Dykema et al., 1996a) as follows:

> How likely is it that the causes you gave will continue to affect you? (Rated from -3 = will never affect you to +3 = will always affect you) and (2) Is the cause you gave something that just affects [this situation], or does it affect other areas of your life? (Rated from-3 = just affects [this sort of event] to +3 = affects all areas (Dykema et al., 1996, p. 1).

The ASQ-revised is an efficient tool to obtain attributions for several events and has been shown to be a predictor of depression (Dykema et al., 1996a).

The authors evaluated the revised ASQ utilizing college students. Of the 146 questionnaires mailed, 102 participants (53 men and 43 women; 77 percent of whom were Caucasian) completed and returned surveys. The ASQ-revised is a satisfactory instrument with reliabilities of the stability and globality dimensions rated an alpha coefficient of .88. The test-retest reliability was not established; however, attributional dimensions were relatively stable over time (average *rs* > .60; Dykema et al., 1996a).

Administering the ASQ-revised in this study did not yield scores for the participants' differences in their tendency to attribute events such as homelessness to stable or unstable and global or specific factors. According to Dykema et al (1996a), numerous studies found that internality versus externality ratings were less reliable than those of globality and stability dimensions, possibly because internality is seen as a heterogeneous construct. Therefore, this dimension was deleted. The generality (AttribGEN) scores of the stability and globality dimensions were reported in this study.

Research supports both the ASQ-revised and the BDI-II. Specifically, recent research examined self-efficacy as a mediator of the relationship between pessimistic attributional style and poor health among cardiac rehabilitation individuals, utilizing the ASQ-revised (Bennett, Adams, & Ricks, 2012). While this self-reported instrument was supported, there were some mixed reviews such as more researchers recently focused on the stable and global dimensions that create a generality score because internality (as described by Abramson et al., 1978) has produced mixed outcomes (Bennett et al., 2012). The generality score is the combination of responses to the stable and global questions (Bennett et al., 2012).

Dere et al. (2015) investigated depressive symptoms reported on the BDI-II between 933 Chinese-heritage (CH) and 933 European-heritage (EH) college students in Canada. The authors were interested in examining whether there were differences in depressive symptoms (psychological and somatic) using the BDI-II (Dere et al., 2015). Specifically, their objectives were to determine an optimal factor structure for the BDI-II between the two groups, examine the measurement invariance (MI) of the BDI-II in the groups across culture and gender and examine cultural and gender differences in self-reported depressive symptoms using the BDI-II (Dere et al., 2015). The results suggested conducting MI on a bi-factor (cognitive- and somatic-affective factors) model of the BDI-II across culture and gender provided evidence of the advantage for this approach for determining a factor structure for the BDI-II. (Dere et al., 2015). Specifically, the bi-factor model allowed researchers to examine the cognitive and somatic dimensions of depression beyond the general severity aspect (Dere et al., 2015). Furthermore, the authors asserted that when assessing the cross-cultural use of the BDI-II, they found strong MI in their groups across gender and culture and they contended that it was a good choice as a self-report measure of depressive symptoms (Dere et al., 2015).

Data Analysis

After the collection of the quantitative data, responses were recorded in a database: the IBM Statistical Package of the Social Sciences (SPSS 23.0). Descriptive statistics was used to simplify, organize, and summarize the data obtained from the test instruments and inferential statistics were utilized to analyze the data from the sample to make generalizations about the population beyond this sample (Gravetter & Wallnau, 2009). As previously stated, the minimum sample size for this study suggested by

G*Power Version 3.1.9.2 (Faul, 2014) was 68, based on estimates for a medium effect size of .15, a power of .80, and a probability error of 0.05. Additionally, descriptive statistics were calculated for the dependent variable, symptoms of depression and the independent variables for length of time homeless and attribution style, as well as the mean, standard deviation, skewness and kurtosis.

The data cleaning and screening process for the study was as follows: Ensure that all of the participants' responses were checked for any missing values on each instrument. All participants' forms included complete responses. Participants who did not meet the inclusion criteria (single, African-American women able to speak and understand English, age 18 and older, and homeless) were excluded from the study.

A correlational research design was used to examine whether the length of time homeless correlated with greater depressive symptoms among African-American women when controlling for attribution style, and if attribution style correlated with greater depressive symptoms among African-American women when controlling for length of time homeless. The analysis provided answers to the following research questions and hypotheses:

RQ1: Does the length of time homeless correlate with greater depressive symptoms among African-American women when controlling for attribution style?

$H_0$1: The length of time African-American women are homeless does not correlate with greater depressive symptoms when controlling for attribution style.

H_a1: The length of time African-American women are homeless does correlate with greater depressive symptoms when controlling for attribution style.

RQ2: Does attribution style correlate with greater depressive symptoms among homeless African-American women when controlling for length of time homeless?

$H_0 2$: Attribution style does not correlate with greater depressive symptoms when controlling for length of time African-American women are homeless.

$H_a 2$: Attribution style correlates with greater depressive symptoms when controlling for length of time African-American women are homeless.

RQ3: Does attribution style moderate the association between length of time homeless and depressive symptoms among homeless African-American women?

$H_0 3$: Attribution style does not moderate the association between length of time homeless and depressive symptoms among homeless African-American women.

$H_a 3$ Attribution style moderates the association between length of time homeless and depressive symptoms among homeless African-American women.

The hypotheses were tested through statistical analysis of collected data for all participants using multiple regression (Gravetter & Wallnau, 2009). Multiple regression analysis was tested with an alpha of .05 and a confidence level of 95 percent (Field, 2009; Gravetter & Wallnau, 2009). With a power of .80, there is an 80 percent chance of

finding a significant effect if there is an effect (Field, 2009). Gravetter and Wallnau (2009) stated, “Multiple regression is the process of using several predictor variables to help obtain more accurate predictors” (p. 580). Specifically, the equation for multiple regression is $\hat{Y} = +b_1X_1 + b_2X_2 + ... + \alpha$ (Gravetter & Wallnau, 2009). In this study, multiple regression tested the relationship between the operational variables (length of time homeless; symptoms of depression; and attribution style). The dependent variable was:

$\hat{Y}$ = *Symptoms of depression*

The independent variables were:

X_1 = *Length of time homeless*

X_2 = *Attribution style*

Additionally, I performed a hierarchical regression for Research Question Three (RQ3) to assess the relationship between the independent or predictor variables of attribution style, length of time homeless, the interaction between attribution style and length of time homeless and the dependent or outcome variable of depression (D. P. Cooper, personal communication, December 31, 2015; Field, 2009; Tabachnick & Fidell, 2013). Hierarchical regression is testing successive regression models, adding in additional predictor variables with each model (Field, 2009; Tabachnick & Fidell, 2013).

Multiple regression analysis makes several key assumptions, such as there is a linear relationship between the independent variable and the dependent variable, and violations of this assumption underestimate the relationship (Field, 2009). Researchers have suggested a more direct assessment is to plot the standardized residuals as a function of the standardized predicted values; this can be observed in a scattergram of the

residuals and predicted values using SPSS (Osborne & Waters, 2002). This assumption was met as shown in the scatterplot (Figure 1). There was also an assumption that variables have normal distributions (Field, 2009). Osborne and Waters (2002) explained that most variables are normally distributed in the population; however, the question is whether the variables themselves are normally distributed, which can be tested by looking at data plots (e.g., histograms, box plots, skew, kurtosis). Analysis of skewness and kurtosis suggested that of all the variables, length of time homeless did not meet the assumption of normality due to outliers. Length of time homeless might have been slightly skewed to the right (1.962) due to three participants having been homeless for 10 years or more. Thus, outliers were removed (Homeless > 100) months and the analyses were re-run and the analyses were re-run. There was no difference in the results. Therefore, the outliers were retained. Variables were assumed to be measured without error; specifically, the measurement scales were reliable, which can be tested using Cronbach's Alpha in SPSS (Osborne & Waters, 2002). Both instruments were shown to be reliable for the current sample: the ASQ-revised was highly reliable .94 and the BDI-II had a good reliability of .89. Finally, there was an assumption of homoscedasticity—the assumption that the variance of the errors was the same across all levels of the independent variable (i.e. variance is the same at low, moderate, and high levels of the predictor variable; Osborne & Waters, 2002). This was assessed by plotting the standardized residuals (errors) by the regression standardized predicted value (Osborne & Waters, 2002). The results indicated that the assumption was met as shown in the scatterplot (Figure 1).

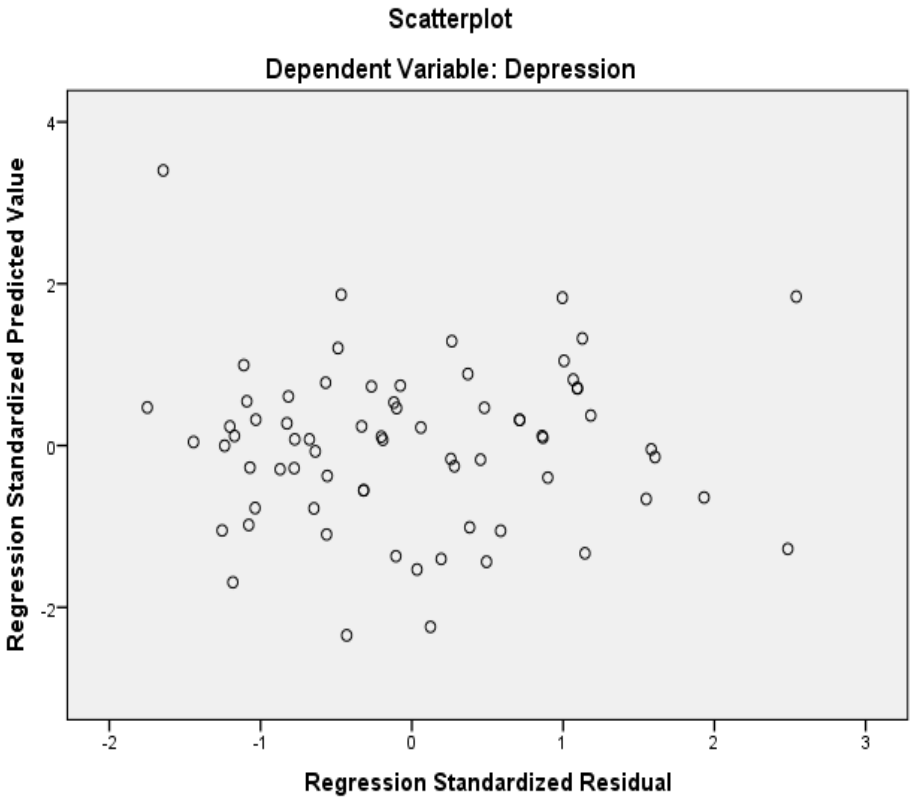

Figure 1. Scatterplot of Attribution Style, Length of Time Homeless, and Depression

Next, the output in the SPSS coefficient table was examined to see if individual predictors were significant using a *t* test that reported the beta (regression coefficient), the standardized error, the t-value and the p-value (D. P. Cooper, personal communication, December 31, 2015; Field, 2009; Tabachnick & Fidell, 2013). Additionally, SPSS produced an R^2 for each model, which assessed the amount of variance in the dependent variable explained by the predictor. For each successive model, SPSS provided the R^2 change and whether the change is significant (D. P. Cooper, personal communication, December 31, 2015). Particularly, it tested whether adding the second predictor to the model significantly increased the variance in the dependent variable (D. P. Cooper, personal communication, December 31, 2015).

Threats to Validity

Possible threats to external validity in this study were: (a) non-random sampling can limit generalizability. Because the population is accessible, it cannot be assumed that it is representative of the target population. Additionally, it cannot control for individual differences. (b) Volunteer bias can be a threat to external validity. People volunteer to participate in research for different reasons, which can influence how they respond during the research process (Laerd Dissertation, n.d.). The sample in my study consisted of homeless African-American women; they were not a perfect representation of the general homeless population, which can reduce homogeneity (Laerd Dissertation, n.d.).

Threats to internal validity in this study were as follows: (a) The inability to control for extraneous variables, which could explain away any results found. For example, educational or reading levels of the participants may have affected the results. I read the test instruments aloud to control this. (b) Locations could have been a threat to internal validity. Data was collected at three locations, and the location conditions differed (i.e. the temperature of the rooms or lighting). Each site had a room similar to a classroom where group counseling or educational instruction was conducted, the testing was held in that space.

Ethical Considerations

Verbal permission was granted to conduct research at the sites. I also received written verification in the form of signed Letters of Cooperation (see Appendix E) from all three facilities.

This population was categorized as vulnerable; therefore, I took precautions to ensure anonymity for all who participated. I read the demographic questionnaire, the two

test instruments, and the informed consent aloud prior to the participants completing the documents. The informed consent included their rights as research participants, my contact information, the purpose of the research, and the benefit for participating. They were informed that all information was anonymous (no personal identifying information was collected). I collected all informed consent forms and only the individuals who acknowledged in the affirmative that they understood and were willing to participate in the research completed the demographic form and the two test instruments.

It was not anticipated that this study would cause any harm or pose any risks or danger to the participants. However, participants were directed to speak with me or the social worker at the site if they experienced any feelings of distress while completing the instruments. The participants were informed that I would review the BDI-II before they left the room and if answers 1, 2 or 3 were circled on Question 9, the participant would be referred to the social worker or counselor at the facility. I reviewed each participant's BDI-II and of the 70 participants only 4 circled Answer 1 to Question 9 on the BDI –II, which stated "Suicidal thoughts or wishes – 1. I have thoughts of killing myself, but I would not carry them out." These individuals were referred to the social worker or counselor at the facility. They were informed that they could discontinue participation at any time and that it would not affect the services they currently received. Additionally, I was available via the telephone number provided. The results of the study will be available to the participants following the dissertation approval. The research is kept confidential, and password-protected raw data will be maintained for 6 years on my personal computer, and only I will have access to the data. I will dispose of the data in

January 2022. After approval from the Walden University Institutional Review Board (IRB) (05-24-16 0057925), data collection for this study was initiated.

Summary

This chapter focused on providing an in-depth description of the research design. An attribution style was associated with the length of time African-American women are homeless. Specifically, I examined whether the length of time African-American women are homeless and attribution style were associated with symptoms of depression. Multiple regression analysis was used to analyze the data and determine the results.

Chapter 4 provides a description of the results of this study.

Chapter 4: Results

Introduction

The purpose of this quantitative, correlational research study was to investigate the relationship between length of time homeless, attribution style, and symptoms of depression among African-American women living in the local shelter and two transitional living centers. I examined the relationship between depression and the two predictor variables using quantitative techniques, including a Pearson's correlation test and hierarchical regression. The research questions and hypotheses for this study were as follows:

RQ1: Does the length of time homeless correlate with greater depressive symptoms among African-American women when controlling for attribution style?

$H_0$1: The length of time African-American women are homeless does not correlate with greater depressive symptoms when controlling for attribution style.

H_a1: The length of time African-American women are homeless does correlate with greater depressive symptoms when controlling for attribution style.

RQ2: Does attribution style correlate with greater depressive symptoms among homeless African-American women when controlling for length of time homeless?

$H_0$2: Attribution style does not correlate with greater depressive symptoms when controlling for length of time African-American women are homeless.

H_a2: Attribution style correlates with greater depressive symptoms when controlling for length of time African-American women are homeless.

RQ3: Does attribution style moderate the association between length of time homeless and depressive symptoms among homeless African-American women?

H_03: Attribution style does not moderate the association between length of time homeless and depressive symptoms among homeless African-American women.

H_a3 Attribution style moderates the association between length of time homeless and depressive symptoms among homeless African-American women.

In this chapter, I discuss the data collection process, the demographic characteristics of the sample, and the internal consistency of the measuring instruments used Cronbach's alpha analysis. I also explain the descriptive statistics of the variables, the research questions, hypotheses, results and analysis from the two surveys.

Data Collection

The process of recruiting participants for this study occurred from May to July 2016. After approval by Walden University IRB (05-24-16-0057925), I emailed the participating stakeholders to inform them that the university IRB had approved the research study. The following data collection sites were approved by the IRB: Friendship Community Development Cooperation (FCDC), the Salvation Army of Greater Charlotte Center of Hope, and the YWCA Women in Transition (WIT) Program.

All of the data sites were located in Charlotte, North Carolina. The flyer that I designed was posted on community bulletin boards in common areas where the residents congregate (see Appendix A). The flyer asked African-American women between the ages of 18 to 66+ who lived in the shelter or transitional living facilities to participate in a voluntary, anonymous research study. It explained that the participants would be asked to complete three questionnaires, the length of time the process would take, the benefits of the study, the stipend, the date, the room, and the time of the session. Only African-American women were invited to participate. There was no penalty or coercion for choosing not to participate or complete the study. Seventy African-American women consented to participate by turning the form face down on the tables after I read the consent form and answered questions. I collected the forms. No signatures were collected because the research was anonymous. At one location one individual left, stating that she thought she could "complain about the shelter." Although the director originally stated the research was to be conducted in one day, data collection took place twice at the site. The additional day was added based on program scheduling and activities, to provide greater access to participants for data collection.

Demographic Characteristics of the Sample

All participants completed a demographic questionnaire that I designed, aimed at gathering information about age, length of time homeless, and current or past history of drugs or substance abuse. For length of time homeless (defined as HomeMonths in the tables), participants were asked to state the number of months and/or years that they were homeless. Additionally, participants indicated "yes" or "no" to the question regarding drug or substance abuse.

The sample size for this study was 70 homeless African-American women living in a shelter and transitional living centers, with an age range between 19 and 69 years old, and a mean age of 46.14. Data indicated that 19, or 27 percent, of the participants had drug or substance abuse issues and 51, or 73 percent, did not. Table 1 summarizes the other demographic characteristics of the study sample.

Table 1

Descriptive Statistics for Age and Length of Time Homeless

Variables	N	M	SD	Median	Min	Max
Age	70	46.14	11.60	49.00	19.00	69.00
HomeMonths	70	22.48	27.36	12.00	.25	120.00

Additional analysis indicated that age correlated with length of time homeless ($p = .250$). Results are presented in Table 2.

Table 2

Pearson's Correlation for Age and Length of Time Homeless

		Age	HomeMonths
Age	*R*	1	.250*
	Sig (2-tailed)		.037
	N	70	70
HomeMonths	*R*	.250*	1
	Sig (2-tailed)	.037	
	N	70	70

*Correlation is significant at the 0.05 level (2-tailed)

Internal Consistency of Measures

I conducted a Cronbach's alpha reliability analysis on the BDI-II and the ASQ-revised to determine the internal consistency of the instruments with the current sample. The obtained reliability levels of the BDI-II were shown to have a good reliability (α = .89), and the ASQ-revised was also found to be highly reliable (α = .94) for the current sample.

Descriptive Statistics of Study Variables

Data collected from the BDI-II suggested that 50 percent of participants' scores indicated mild to severe depression. Thirty-five (50 percent) of the participants scored in the minimal depression range, 16 (23 percent) scored in the mild depression range, 11 (16 percent) scored in the moderate depression range, and 8 (11 percent) scored in the severe depression range. Additional data collected from the ASQ-revised showed that 33 or 47 percent of the participants self-reported a negative attribution style.

Table 3 presents the descriptive statistics as well as tests of normality for the variables of depression and attribution style generality (AttribGEN).

Table 3

Descriptive Statistics for Depression and Attribution Style

	Mean	SD	Min	Max	Skewness	Kurtosis
Depression	16.79	10.53	.00	48.00	.59	-.20
AttribGEN	19.33	33.03	-63.00	129.00	.27	.94

Findings

The study was framed by three research questions and their associated hypotheses. I tested each question and hypothesis utilizing statistical analyses.

Additionally, the findings of the statistical significance resulted from utilizing a criterion alpha level of .05. This section presents the quantitative measures and results of data analyses in relation to these research questions and hypotheses.

The first research question asked: Does the length of time homeless predict greater depressive symptoms among African-American women when controlling for attribution style? It was hypothesized that the length of time African-American women are homeless predicts greater depressive symptoms when controlling for attribution style. Research Question 2 asked: Does attribution style predict depressive symptoms when controlling for length of time homeless? It was hypothesized that attribution style predicts greater depressive symptoms when controlling for length of time African-American women are homeless. Research Question 3 asked: Does attribution style moderate the association between length of time homeless and depressive symptoms among homeless African-American women? It was hypothesized that attribution style moderates the association between length of time homeless and depressive symptoms among homeless African-American women.

I conducted a hierarchical regression to test these hypotheses. This was done by running a linear regression with each predictor variable entered successively to the model to determine how the addition of each predictor variable affects R^2. In the first step, the predictor variables of attribution style and length of time homeless (centered around their means) were entered. This step tested Research Questions 1 and 2. In the second step, the interaction of attribution style and length of time homeless (centered) was entered to test the third research question (D. P. Cooper, personal communication, December 31, 2015; Field, 2009; Tabachnick & Fidell, 2013). Each model was examined to determine: (a) if

the predictor variable was significant, (b) the R^2 explained by the predictor, and (c) if the change in R^2 was significant, suggesting that the addition of the predictor variable explained more of the variance than the first predictor by itself (D. P. Cooper, personal communication, December 31, 2015).

The test was performed as follows***:*** Mean-centered attribution style and mean-centered length of time homeless were entered in the regression model first. Results revealed (see Table 4) that only attribution style was a significant predictor of depression (p =.05). A negative attribution style was associated with a self-report of greater symptoms of depression. Length of time homeless was not a significant predictor of depression (p =.44). The interaction term for mean-centered attribution style and mean-centered length of time homeless were added into the regression equation were entered second. The results revealed (see Table 4) that attribution style did not moderate the relationship between length of time homeless and depression (p = .60).

Table 4

Summary of Hierarchical Regression Analysis for Variables Depicting Depressive Symptoms

Variable	*β*	*SE*	*SEB*	*t*	R^2	ΔR^2	*p*
Step 1					.07	.07	.10
AttribGEN	.08	.04	.30	2.01*			
HomeMonths	-.04	.05	-.09	-.80			
Step 2					.07	.004	.60
AttribGEN X HomeMonths	.01	.002	-.06	-.54			

Note: * $p < .05$

Summary

The statistical analysis of the study did not support the research hypotheses. For Hypothesis 1, the results of the data suggested that there was no relationship between length of time homeless and depressive symptoms when controlling for attribution style**.** For Hypothesis 2, the findings indicated a significant relationship between a negative attribution style and greater depressive symptoms when controlling for length of time homeless. Finally, the analysis for Hypothesis 3 found no significant indication that attribution style moderated an association between length of time homeless and depressive symptoms among African-American women. Chapter 5 presents the interpretation of the findings of this study, its limitations and offers recommendations for future research.

Chapter 5: Discussion, Recommendation and Conclusions

Introduction

The purpose of this dissertation was to investigate the relationship between length of time homeless, attributional style, and symptoms of depression among African-American women living in a local shelter and two transitional living centers. In this chapter, I present the summary of the results of the study, the interpretations of the findings, theoretical exploration of the results, limitations of the study, recommendations, implications for social change, recommendations for actions and conclusions.

African-American women are disproportionately represented in the homeless population, yet they have not been adequately examined in research studies and there are minimal empirical studies that focused on homeless African-American women. While existing research has included homeless African-American women with homeless women and children, other homeless women, and homeless African-American men, they have not been studied as a single group. Moreover, there is no empirical research addressing length of time homeless, attribution style, and depressive symptoms among African-American women. Therefore, I designed this study to address the gap in the literature and serve as a gateway for future research.

Summary of Results

Three research questions and hypotheses guided this investigation. For Research Question 1, it was predicted that the length of time African-American women are homeless would correlate positively with greater depressive symptoms when controlling for attribution style. Findings revealed there was no significant relationship between length of time homeless and depression when controlling for attribution style. The

findings support the null hypothesis. Research Question 2 investigated whether attribution style predicts depressive symptoms when controlling for length of time homeless. The results revealed that a more negative attribution style predicted greater depressive symptoms when controlling for length of time homeless. These findings supported the alternative hypothesis. Research Question 3 examined whether attribution style moderated the association between length of time homeless and depressive symptoms among homeless African-American women. The results indicated that attribution style did not moderate the relationship between length of time homeless and depression. Thus, the null hypothesis was supported.

Interpretation of the Findings

For Research Question 1, I hypothesized that the length of time African-American women are homeless would correlate positively with greater depressive symptoms when controlling for attribution style. The results indicated that there was no significant relationship between length of time homeless and depression. Previous research that examined length of time homeless and physical and emotional health and self-efficacy differed in their findings. For example, Piliavin et al. (1993) proposed that the longer individuals are homeless, the more they adapt and become more knowledgeable about homeless life and identify with other homeless persons. Guarnaccia and Henderson (1993) asserted that length of time homeless did not affect individuals' self-efficacy or interpersonal competence, in fact, participants in their study saw themselves in a positive light. Washington (2005), however, found that African-American women participants who were homeless for more than 12 months experienced more psychosocial or emotional problems and ulcers than women homeless for shorter periods of time

(Washington, 2008). In sum, previous findings have been mixed, and the current study's findings are similar to those that have found no associations between length of time homeless and negative outcomes.

For Research Question 2, I hypothesized that attribution style correlates with greater depressive symptoms when controlling for length of time African-American women are homeless. The findings showed a significant relationship between attribution style and depression. Specifically, a negative attribution style was associated with a self-report of greater symptoms of depression. This was consistent with Hu et al.'s (2015) findings that attribution style was positively associated with depression. Sanjuan and Magallares (2009) suggested that individuals who explain negative events through uncontrollable causes such as homelessness exhibited higher levels of depressive symptoms. Additionally, Abramson et al. (1978) and Forgeard et al. (2011) asserted that individuals identified with depressed affect exhibit components of a negative attribution style. Particularly, they attributed negative outcomes to internal, stable, and global causes (Abramson et al., 1978; Forgeard et al., 2011).

In both RQ1 and RQ2, length of time homeless did not have a significant relationship to attribution style or depressive symptoms. Explanations for these results may have been that individuals homeless for a longer time have adapted to their situation, perhaps participants wanted to present their situation more positively in their responses to the BDI-II and the ASQ-revised, or they did not fully understand the questions (specifically the ASQ-revised). These results are reflected in past research, which has suggested that the longer individuals are homeless the more they adapt to and embrace their situation, and identify with other homeless persons. They adopt the role and identity

of homelessness in order to overcome the stigma and reestablish a favorable self-concept (Piliavin et al, 1993; Wenzel, 1992).

Research Question 3 examined whether attribution style moderated the association between length of time homeless and depressive symptoms among homeless African-American women. Length of time homeless was not a significant predictor of depression, nor did attribution style moderate the relationship between length of time homeless and depressive symptoms. Much of the literature has established that negative attribution style is positively associated with greater depressive symptoms (Hu et al., 2015), and depression is the most common mental health problem among homeless individuals (Fitzpatrick et al., 2015). However, previous literature did not include studies identifying attribution style as moderating the relationship between length of time homeless and depressive symptoms; thus, future research should continue to explore these relationships.

Theoretical Explanation of the Results

I proposed in this study that Aaron T. Beck's cognitive behavioral therapy (CBT; Rosner, 2012) and Bernard Weiner's attribution theory (1986, 2006) might inform the possible explanations for the results of this research. The findings of the analyses indicated attribution style was a significant predictor of depression and length of time homeless was not a significant predictor of depression.

CBT is a therapeutic approach that combines cognitive and behavioral theories and practices with an emphasis on reducing self-defeating thoughts and changing behaviors (Davis et al., 2013; King, 2013). Bloch (2004), King (2013) and Rosner (2012) argued that CBT is a treatment for psychological problems, specifically depression.

Depressive disorders in the DSM-5 (APA, 2013) include eight different diagnoses with common features such as the presence of sadness, feeling empty, irritable mood, or cognitive and somatic changes that have a significant effect on an individual's ability to function. The DSM-5 (APA, 2013) requires that practitioners assess whether a person reports depressed feeling or a loss of interest or pleasure in almost all of their activities along with four of the other symptoms described in the literature review for at least 2 weeks. Therefore, before utilizing CBT, practitioners should develop a treatment plan to address the mental health concerns of homeless individuals seeking services.

The CBT deals with perception and is used in therapy to help individuals change irrational thoughts about themselves, their world, and their future (King, 2013; Rosner, 2012). Participants in this study who self-reported symptoms of depression were consistent with Deforge et al.'s (2008) argument that homeless individuals experience emotional disturbances such as major depressive disorders. Research has shown that cognitive behavior therapy can have positive clinical outcomes for vulnerable populations, specifically a decrease in depressive symptoms (Foster, 2007). The BDI-II in this study was not used to diagnose participants. It does, however, support previous researchers' claims that depressive symptoms are the most common mental health problem among homeless individuals (Fitzpatrick et al., 2015) and that homeless women are twice as likely to meet the criteria for a diagnosis of major depressive disorder than women in general (APA, 2004).

I also used the attribution theory in this study as a possible explanation for the findings. Specifically, Weiner and colleagues (Dindelegan & Serac-Popa, 2014; Weiner, 1986, 2006) argued that attribution theory explains how people link actions and emotions

to specific life causes. Attribution style reflects the lens individuals use to view events that influences their perceptions. In this study, 33 of the 70 participants self-reported a negative attribution style. Researchers have suggested that these individuals would exhibit a negative explanatory style and describe bad events such as homelessness through stable and global causes and are more prone to develop or display depressive symptoms (Sanjuan & Magallares, 2009). Hu et al. (2005) asserted that attribution style is associated with depressive symptoms. I anticipated an association between a negative attribution style and depression, which the findings supported.

The attribution theory is one of the psychological theories used to describe the motivation behind human behaviors (Korn, Rosenblau Buritica, & Heekeren, 2016). Thus, it can be used with this population to alter their negative attribution style, making it more positive and as a result reduce depressive symptoms. Combining attribution theory and CBT can possibly assist in changing homeless African-American women's irrational thoughts and in turn increase their motivation to move from homelessness to permanent homes. Thus, helping homeless African-American women to recognize their prior experiences and understand that they have control over current situations can assist them in gaining the tools to change their behavior to plan for a better future (Loehwing, 2010; Peterson et al., 2012).

Limitations of the Study

There were several limitations to this study. The first limitation was that the participants in this study were a nonrandomized sample; therefore, they were not a representation of the general homeless population. This study targeted a specific subset of the homeless population: African-American women living in a shelter and two

transitional living centers. A second limitation was that I excluded men, women of other ethnicities, families, and individuals living on the streets and in motels from the study. Reportedly, families are a growing demographic of the homeless population (National Alliance to End Homelessness, 2014).

The size of the sample could be considered a limitation; a larger sample might have a greater impact on the results. A larger sample size can increase the chance of significance because it more reliably reflects the general population (Field, 2009). Additionally, data in this study indicated that age correlated with length of time homeless. Age was not included in the hypotheses of this study; however, this variable could be studied in future research relating to length of time individuals are homeless, attribution style and depression.

Another limitation in this study was that there were wide ranges in participants' ages and lengths of time homeless. Future research should identify whether length of time homeless is defined as chronic (homeless for one year or more; at least four episodes of homelessness in the past three years) or acute (homeless for six months or less) (National Alliance to End Homelessness, 2015) to control for the wide range of time homeless. Additionally, narrowing the age range to early adulthood (20s to 30s), middle adulthood (40s to 50s) or late adulthood (60s and above) should perhaps control for the wide age range.

A final limitation of this study could be the self-reported instruments (i.e., BDI-II and ASQ-revised). The participants possibly reported what they thought I expected to see or what reflected positively on their abilities or beliefs. Additionally, the ASQ-revised may have been a challenge for this sample; it appeared that several of the participants had

problems understanding the concept of imagining themselves in the situations presented. This was evident when I was reading the questions, as some participants stated that they "would not do that or act that way." Future research could explore alternative ways of measuring attribution style with this population.

Recommendations

I anticipated that length of time homeless and a negative attribution style were associated with greater depressive symptoms. However, the results of the study indicated that length of time homeless was not a significant predictor of self-reported symptoms of depression, although a negative attribution style was associated with self-reported symptoms of depression. Based on the results of this study, the following recommendations are suggested for possible future research studies. The recommendations were formulated based on the void in the literature and outcomes of this study.

Many participants in this study self-reported a negative attribution style, which suggested that they may view themselves as trapped and lacking the ability to control circumstances in their lives. Research has asserted that a person with a negative attribution style who describes negative experiences as uncontrollable tends to exhibit higher levels of depressive symptoms (Abramson et al., 1978; Chaney et al., 2004; Forgeard et al., 2011; Harvey & Martinko, 2011; Hu et al., 2005; Peters et al., 2011; Rosen, 2011; Sanjuan & Magallares, 2009). This may explain the findings that 50 percent of participants in this study self-reported mild to severe levels of depression on the BDI-II. Programs serving homeless African-American women should design clinical services

that include CBT to address the needs of those who are likely to report mild or moderate depressive symptoms and to decrease symptoms (Foster, 2007).

Furthermore, homelessness is more than a lack of a permanent place to sleep each night; it is a loss of social support, safety, security and belonging. Utilizing attribution theory in programs for homeless African-American women would permit clinicians and social workers to develop strategies to elicit motivation from them to move toward sustainability. Although there was no correlation between the length of time African-American women were homeless and greater depressive symptoms, future research should define length of time homeless as either chronic or acute to ascertain if there is a significant relationship with depressive symptoms. Perhaps a designation of chronic or acute homelessness in future studies may yield more of a correlation with depressive symptoms.

Implications for Social Change

This study has introduced the possibility of investigating the phenomenon of attribution style, length of time homeless and depression among homeless African-American women to the body of literature. The results of this study, while limited, supported previous research that suggested a connection between negative attribution style and depressive symptoms.

This study focused on homeless African-American women. African-American women have been identified as being at greater risk for homelessness and are represented at a disproportionately high rate among homeless women. One implication for social change is influencing polices pertaining to managing depressive symptoms of homeless African-American women to increase their chances of becoming re-housed. An

additional implication for social change is that understanding individuals' mental processes while they are homeless, particularly their perceptions and language used to interpret their situation, instead of focusing on the risks or causes of homelessness, would assist individuals with their motivation to move forward.

Recommendations for Action

The present study was designed to investigate the relationship between length of time homeless, attributional style and symptoms of depression among homeless African-American women. A hierarchical regression was conducted for Research Questions 1 and 2 and results indicated there was no significant relationship between length of time homeless and depressive symptoms. However, there was a significant relationship between attribution style and depressive symptoms. The results of the scores on both of the instruments explained this relationship. Specifically, a negative attribution style correlated with a self-report of greater symptoms of depression. A hierarchical regression was also conducted for Research Question 3 and findings revealed attribution style did not moderate the relationship between length of time homeless and depressive symptoms. The results of all three research questions indicated that the greater negative attribution style one has, the greater the symptoms of depression.

Clinicians and social workers working in programs that service homeless African-American women should apply both attribution theory and CBT to address their perception of past events that led to their current state of homelessness and the language they use to explain these events. Utilizing CBT would assist homeless African-American women with changing their behavioral and emotional responses to their current and future situations. Specifically, individuals with a negative attribution style have a

tendency to make stable and global explanations for negative events in their lives, which is a risk factor for depression (Petersen et al., 2004). Negative events such as housing instability (homelessness) or increased stress or distress over a long period can cause individuals to view their future life events as hopeless and negative (Deforge et al., 2008). Thus, they begin to engage in negative thinking, which in turn can result in depression (Deforge et al., 2008). The results of this study indicated that participants attributed the negative situations on the ASQ-revised as being stable and global. The responses appeared to indicate that participants believe their situations will continue into the future and affect all areas of their lives. Deforge et al. (2008) suggested that the psychological mechanism that results in depression is that individuals engage in negative thinking when they place expectations on positive future life events that they believe will not occur. CBT would assist with decreasing such negative thinking. Furthermore, clinicians could provide homeless African-American women with skills to be proactive and consider all circumstances in order to make better decisions. Moreover, shelter environments and agencies providing services to the homeless African-American women should encourage clinicians and social workers to design interventions to assist these individuals with developing skills to identify areas in their lives where they are successful. Finally, although this research found that length of time homeless was not a predictor of depression, programs provided by shelter environments and agencies should target all women no matter how long they have been without a home.

Conclusions

The purpose of this research was to determine whether there was a relationship between length of time homeless, attribution style and depressive symptoms among

African-American women living in a shelter and two transitional living centers. There was no prior literature available to practitioners or researchers addressing homeless African-American women, attribution style and depressive symptoms.

While it was hypothesized that both length of time homeless and attribution style would predict greater depressive symptoms, only negative attribution style predicted depressive symptoms. In this study, there was no significant relationship between length of time homeless and greater depressive symptoms. It is quite possible that length of time homeless was a non-factor or, as previously mentioned, homeless persons learn to adapt to their situation and become more knowledgeable about homeless life. A negative attribution style was a greater predictor of depressive symptoms in this study as identified in previous research. Some researchers have argued that negative attribution style is linked to depression or is a factor in the development of depressive symptoms (Addington et al., 1999; Gonzalo et al., 2012), while others have asserted it is a symptom of depression and does not have a direct role in the development of depression (Ball et al., 2008). Many have concluded that CBT or a form of cognitive therapy would be effective in treating depressive symptoms by addressing negative attribution style (Addington et al., 1999; Cuijpers et al., 2013; Foster, 2007; Rosner, 2012). Results of the current study support this proposition.

The value of this research would allow programs to develop goals and objectives to meet the mental health needs of homeless African-American women. Practitioners can develop treatment plans to address the thoughts, decisions, and behaviors that have contributed to their homelessness. Programs that serve homeless individuals should incorporate these components to meet the mental health needs of their population. The

addition of these services would assist African-American women's movement from homelessness to sustainability.

It is documented that the U.S. has the largest number of homeless women, and minority women are affected more than other groups. Recognizing the correlation between negative attribution style and symptoms of depression, providers of homeless services should place priority on identifying attribution style at program entry. As previously mentioned, depression can impact expectations on future life events. Specifically, this becomes important in setting goals, promoting change or implementing change to achieve desired results within time-limited programs. Understanding the impact that this has on society as a whole should motivate social service providers, homeless service agencies, and policy makers to treat mental and emotional issues. Additionally, through treatment and education, homeless African-American women will be encouraged to move from their current state of homelessness and acquire tools to prevent future episodes of homelessness.

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Appendix A: Recruitment Flyer for Participants

Research Volunteers Needed

Research studies have not always included African American women's voices.

African American women needed!

Your opinion is valued.
Seeking 150 volunteers to take part in a Walden University dissertation study who are:

- **African American Female**
- **Between the ages of 18 to 66+, AND**
- **Live in a shelter or transitional living facility**

As a participant in this study, you will be asked to complete three questionnaires anonymously to look at how your emotional well-being is impacted by homelessness and how you see and respond to life events.

In appreciation of your time, you will receive a one-day unlimited transit pass equaling $6.00 or a $5.00 gift card from Target or Wal-Mart.

It is your decision of whether or not you choose to be in the study no one will treat you differently. No one here will see the information you share.

The benefits of these research findings can increase awareness of the impact of homelessness on African American women and can help enhance county service delivery to homeless women.

The risk for participation in this study is no greater than ordinarily encountered in daily life.

Your participation will involve one session, which is approximately 60 minutes. Saturday, _____ at _____.

Research is conducted by Pamela Robinson, doctoral student at Walden University under the supervision of Dr. Stephen Rice in the department of Psychology.

For more information about this study, please contact: Pamela Robinson
at
770-820-8764
Email: pamela.robinson@waldenu.edu

The study has been reviewed and approved by the Institutional Review Board, Walden University.

Appendix B: Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

---

1. Please circle the racial category or categories with which you most identify.

1	2	3	4	5	6
American Indian	Asian	African American/Black	Caucasian/White	Hispanic/Latino	Other

2. How old are you?

3. How long have you been homelessness?

   Years _____ Months _____

4. Do you have a current or past history of drug or substance abuse?

   Yes ☐ No ☐

Appendix C: Beck Depression Inventory-II

PsycTESTS®

Beck Depression Inventory–II

Instrument Type:
Inventory/Questionnaire

Test Format:
Each question has a set of at least four possible answer choices, ranging in intensity.

PsycTESTS™ is a database of the American Psychological Association
doi: 10.1037/t00742-000

Items

Expert and Adolescent Ratings of the Beck Depression Inventory—II Items

1. Sadness
2. Pessimism
3. Past failure
4. Loss of pleasure
5. Guilty feelings
6. Punishment feelings
7. Self-dislike
8. Self-criticalness
9. Suicidal thoughts or wishes
10. Crying
11. Agitation
12. Loss of interest
13. Indecisiveness
14. Worthlessness
15. Loss of energy
16. Changes in sleeping pattern
17. Irritability
18. Changes in appetite
19. Concentration difficulty
20. Tiredness or fatigue
21. Loss of interest in Sex

BDI-II

Date:

[redacted] 20 0000 [redacted] Age: _____ Sex: _____

[redacted] [redacted]:

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism
- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- 0 I don't feel particularly guilty.
- 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike
- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness
- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying
- 0 I don't cry any more than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

_____ Subtotal Page 1 **Continued on Back**

Appendix D: Attributional Style Questionnaire-revised

PsycTESTS®

Attributional Style Questionnaire—Revised
Version Attached: Full Test

Instrument Type:
Inventory/Questionnaire

Test Format:
The revised ASQ offers 12 bad events that respondents read and then write down what the main cause for the situation would be if it happened to them. Two questions are then asked and rated on 7-point scales for each cause that respondents write down. (1) "How likely is it that the cause you gave will continue to affect you?" (rated from -3 = "will never affect you" to +3 = "will always affect you") and (2) "Is the cause you gave something that just affects [this situation], or does it affect other areas of your life?" (rated from -3 = "just affects [this sort of event]" to +3 = "affects all other areas").

PsycTESTS™ is a database of the American Psychological Association
doi: 10.1037/t16332-000

Items

Try to imagine yourself in the following situation . . .

1. . . . you have trouble sleeping.
2. . . . you feel sick and tired most of the time.
3. . . . you have a serious injury.
4. . . . you can't find a job.*
5. . . . you can't get the work done that others expect of you.*
6. . . . you are fired from your job.
7. . . . you don't help a friend who has a problem.*
8. . . . you have financial problems.
9. . . . you don't understand what your boss wants you to do.
10. . . . a friend is a very angry with you.*
11. . . . you are guilty of breaking the law.
12. . . . you have a serious argument with someone in your family.

---

*Similar event included in the original ASQ (Peterson et al., 1982).

Appendix E: Letters of Cooperation

February 29, 2016

Dear Pamela M. Robinson,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Attribution Style and Depressive Symptoms among Homeless African American Women within the Friendship Community Development Corporation (FCDC)/My Sister's House. As part of this study, I authorize you to post advertisement flyers and conduct the study at FCDC/My Sister's House on a Saturday afternoon. The researcher will collect data from participants who volunteer to participate in the study. African American women 18 to 66+ are eligible to participate. No identifying information will be collected or requested during this process. At the conclusion of the study, the results, insights and recommendations regarding length of time homeless, attribution style and depressive symptoms among African American women will be distributed to the FCDC/My Sister's House. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: access to the classroom with tables and chairs to conduct the study as well as restroom facilities on the site. No other resources will be provided. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Jennifer Coble, Esq.
Executive Director
704.391.6697

Friendship Community Development Corporation
3239 Beatties Ford Road
Charlotte, North Carolina 28216 USA
Voice: (704)-200-2807
Fax: (704) 391-3433
email: jcoble@friendshipcdc.org
website: www.friendshipcdc.org

THE SALVATION ARMY

DOING THE MOST GOOD

February 29, 2016

Dear Pamela M. Robinson,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Attribution Style and Depressive Symptoms among Homeless African American Women within the Salvation Army Center of Hope. As part of this study, I authorize you to post advertisement flyers and conduct the study at the Salvation Army Center of Hope on a Saturday afternoon. The researcher will collect data from participants who volunteer to participate in the study. African American women 18 to 66+ are eligible to participate. No identifying information will be collected or requested during this process. At the conclusion of the study, the results, insights and recommendations regarding length of time homeless, attribution style and depressive symptoms among African American women will be distributed to the Salvation Army Center of Hope. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: access to the classroom with tables and chairs to conduct the study as well as restroom facilities on the site. No other resources will be provided. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Deronda Metz, LCSW
Director of Social Services
704-621-6370

eliminating racism
empowering women
ywca
central carolinas

March 10, 2016

Dear Pamela M. Robinson,

Based on my review of your research proposal, I give permission for you to conduct the study entitled Attribution Style and Depressive Symptoms among Homeless African American Women within the YWCA Women in Transition (WIT). As part of this study, I authorize you to post advertisement flyers and conduct the study at the YWCA WIT on a Saturday afternoon. The researcher will collect data from participants who volunteer to participate in the study. African American women 18 to 66+ are eligible to participate. No identifying information will be collected or requested during this process. At the conclusion of the study, the results, insights and recommendations regarding length of time homeless, attribution style and depressive symptoms among African American women will be distributed to the YWCA WIT. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: access to the classroom with tables and chairs to conduct the study as well as restroom facilities on the site. No other resources will be provided. We reserve the right to withdraw from the study at any time if our circumstances change.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

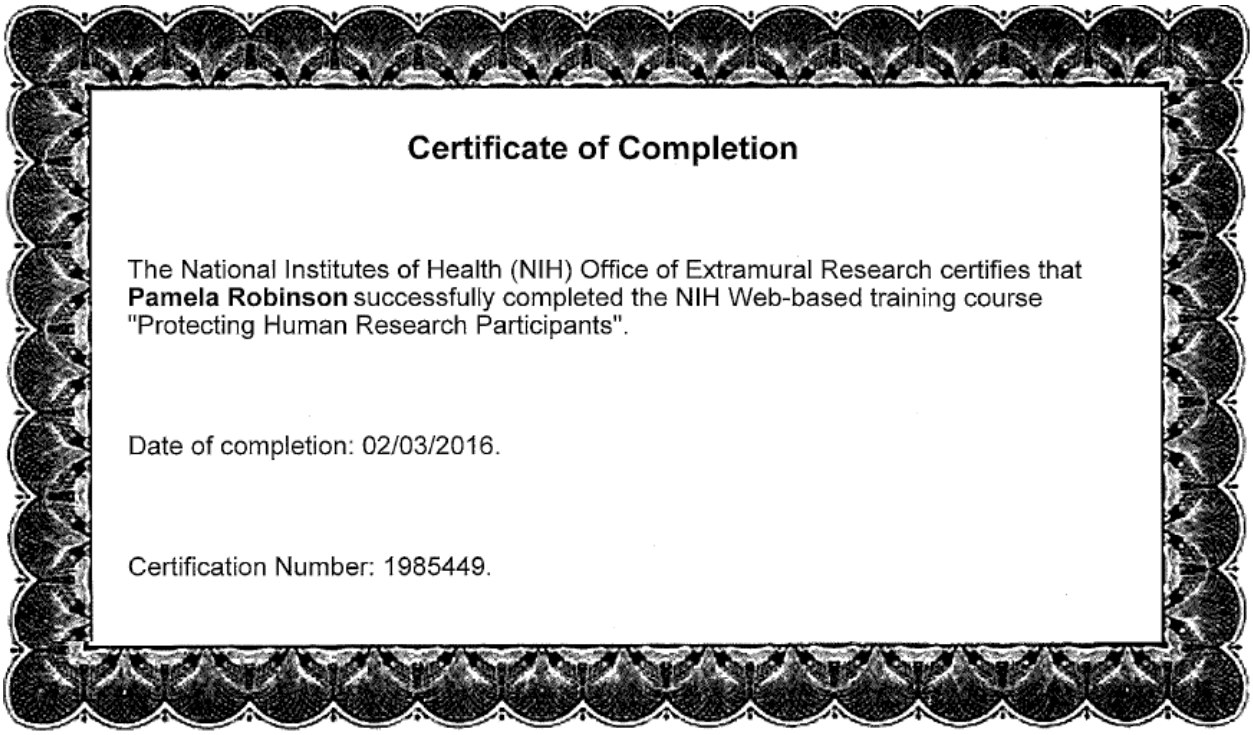
I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Carrington Cosby, MSW, LCSWA
Director
Women In Transition
704-525-5770 x2230
ccosby@ywcacentralcarolinas.org

c: Kirsten D. Sikkelee, Chief Executive Officer, YWCA Central Carolinas

Appendix F: Certificate of Completion NIH



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Pamela Robinson** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 02/03/2016.

Certification Number: 1985449.