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Walden University

College of Counselor Education & Supervision

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Elisa Amaris Niles

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the review committee have been made.

Review Committee
Dr. Laura Haddock, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Susan Carmichael, Committee Member, Counselor Education and Supervision Faculty
Dr. Adrian Warren, University Reviewer, Counselor Education and Supervision Faculty

The Office of the Provost

Walden University
2019

Abstract

Impact of Trauma on Reoccurring Homelessness in the U. S. Virgin Islands

by

Elisa Amaris Niles

MA, Argosy University, 2009

MA, University of the Virgin Islands, 2005

BA, University of the Virgin Islands, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2019

Abstract

Homelessness is a growing concern in the United States Virgin Islands (USVI) especially since 2 major hurricanes in 2017 devastated the islands. The impact trauma has on reoccurring homelessness in the USVI is unknown. Failure to understand the impact trauma may pose on persons who are homeless could hinder stable housing and perpetuate reoccurring homelessness. The purpose of this cross-sectional study was to examine the predictive relationship between trauma and reoccurring homelessness in persons who are homeless living in the USVI. The theoretical framework for this study was Psychological Trauma Theory. Participants were homeless adult persons (N=73) who were surveyed using the Trauma History Questionnaire and the Residential Timeline Follow-Back. A multiple regression analysis was used to examine the prediction of trauma on reoccurring homelessness, while controlling for demographic variables. The results indicated trauma was not statistically predictive on duration of homelessness and housing stability though when gender and education were controlled, there was significance in predicting service utilization with an adjusted R of (.19) of the variance and a value of ($p > .000$). Homeless males were more likely to utilize services than females though both homeless males and females with a high school education or higher were less likely to use services. The outcomes of this study have social change implications including counselor educators, counselors, and community stakeholders collaborating to facilitate trauma-informed care and design gender specific programs to increase service utilization among the homeless.

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Dedication

To John. John was homeless and always hung around the local Methodist Church in Market Square, St. Thomas, U. S. Virgin Islands. He talked about his days in the war, his family, and wanting a better life. However, John did not have any family to support him. He slept on the streets and panhandled as a way to survive. When he died, I was sad and felt compelled to attend his funeral at the Salvation Army. There were only a handful of community members in attendance. I said a few words about John and the need for our community to provide better services to people who are homeless living in America's Paradise.

The Bible discussed how to show compassion to persons who are homeless;

> For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me. The King will reply, Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me (Matt. 25: 35-36;40, New King James Version).

Acknowledgments

The process of completing a dissertation is no small feat and cannot be done alone. The support, encouragement, prayers, and well wishes from family, friends, colleagues, and professors makes the journey to completion doable. There were times when I wanted to give up, but the reassurance from loved ones kept me going.

Firstly, I thank my Heavenly Father for giving me the wisdom, strength and endurance to complete this task. Secondly, I am eternally grateful to my dissertation committee for their guidance, patience and faith in my abilities. Thank you Dr. Laura Haddock (chair), Dr. Susan Carmichael (committee member) and Dr. Adrian Warren (URR). Special thanks to Dr. Zin, Dr. Ozcan, Rachael, and David for helping me figure out multiple regression analysis and SPSS. Shining halos to the staff of Catholic Charities of the Virgin Islands (Ms. Shillingford, Brenda, Ms. Jolly, Ms. Petersen, Jennifer, Ms. Beazer, Mr. Henley, Pops, Johannnaes); staff at MTOC (Ms. Petersen, Ms. David, and the Derimas). Thirdly, I say thank you to my family for their prayers, and words of encouragement. Finally, I am forever grateful to my cheerleading squad: Letitia, Aubrey, Natasha, Tia, Chasity, Sherry, Karimah, Christine, SWFCC staff, Moira, Nivichi, Kerrisha, Mrs. Turnbull-Krigger, Dr. Nuosce, Dr. Hofmann, Dr. Pope, Mario, Celia, my students at Hodges University, my church family, and many more individuals. Again, I say thank you; I appreciate you; I am grateful for each of you; I am honored to have you in my life; I am blessed to be a part of your lives.

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List of Abbreviations

- ACEs- Adverse Childhood Experiences
- CCVI- Catholic Charities of the Virgin Islands
- CoCs- Continuum of Care
- DHS- Department of Human Services
- MI- Mental Illness
- MTOC- Methodist Training and Outreach Center
- PIT- Point-in-Time
- PTT- Psychological Trauma Theory
- RTLFB- Residential Timeline Follow-Back
- SPSS- Statistical Package for Social Sciences
- THQ- Trauma History Questionnaire
- USVI- United States Virgin Islands

Chapter 1: Introduction to the Study

Trauma and Reoccurring Homelessness

Despite recent research on the connection between trauma and homelessness, there are minimal quantitative or qualitative studies conducted on the homeless population in the United States Virgin Islands (USVI). Homelessness is a growing concern in the USVI and more so since the hurricanes in 2017. The Continuum of Care (CoC) is a collaborative taskforce of community stakeholders, with the main agencies being the Methodist Training and Outreach Center (MTOC), Department of Human Services (DHS) and Catholic Charities of the Virgin Islands (CCVI). These agencies provide case management, housing, basic needs, and supportive counseling to people who are homeless.

Many programs, such as the MTOC, DHS, and CCVI use grant funds for supportive housing programs, rental assistance, and other support services (MTOC, n. d.; Virgin Islands Continuum of Care on Homelessness, 2017). Even though these programs and agencies are actively working to reduce homelessness by addressing physical needs, the problem continues. The psychological needs of the homeless are not addressed in the USVI and do not necessarily incorporate a trauma-informed care approach (Hopper et al., 2010).

Although funded programs help to reduce stress related to homelessness, current services for people who are homeless do not address traumatic events specifically. By not addressing traumatic events, people who are homeless continue to experience ongoing post-traumatic stress disorder (PTSD) and other mental illnesses, recurrent and

reoccurring homelessness, and substance use (Hopper et al., 2010; Lippert & Lee, 2015; Wong et al., 2016). In this chapter, I will discuss the problem of homelessness as it relates to the USVI, the nature of the study, its theoretical underpinning, and assumptions.

Background

In many countries throughout the world, homelessness is a significant problem (Lippert & Lee, 2015; Patterson, Currie, Rezansoff, & Somers, 2015). Homelessness affects adult men and women, families with young children, youths, and veterans (Helfrich, Peters, & Chan, 2011; National Alliance to End Homelessness [NAEH], 2016). In 2015, an estimated 564,708 people experienced homelessness in America, and of this number, 15% (83,170) were chronically homeless persons (NAEH, 2016). Although the data shows a 2% decrease in the occurrence of homelessness from 2014 to 2015, it is not a significant decrease, and the issue remains a problem (Lippert & Lee, 2015; NAEH, 2016). More recently, in 2018, data showed a 0.3% increase in the number of persons who experience homelessness (NAEH, 2018). The 2018 Annual Homeless Assessment Report (AHAR) reported 552,830 homeless people on a single night (NAEH, 2018).

Many factors contribute to individuals becoming homeless, such as unemployment, natural and human-made disasters, untreated mental illness, substance abuse issues, and lack of affordable housing (Bonugli, Lesser, & Escandon, 2013; Lippert & Lee, 2015; Patterson et al., 2015). Current trends in the counseling profession include examining the effects of trauma on mental illness and how early trauma experiences influence homelessness (Carlson, Garvert, Macia, Ruzek, & Burling, 2013; Larkin &

Park, 2012; Mailloux, 2014; Patterson et al., 2015; Weinrich et al., 2016). A review of the literature indicated a significant relationship between homelessness and exposure to trauma (Buhrich, Hodder, & Teesson, 2000; Carlson et al., 2013; Helfrich, Peters, & Chan, 2010; Wong, Clark, & Marlotte, 2016). Furthermore, results from national and international studies on homelessness show traumatic experiences affect persons who are homeless (Hamilton, Poza, & Washington, 2011; Hladikova, 2007; Johnstone, Parsell, Jetten, Dingle, & Walter, 2016; NAEH, 2016; Scutella, Johnson, Moschion, Tseng, & Wooden, 2013; Williams & Hall, 2009). Despite supportive services for the homeless, such as substance abuse counseling, case management, and food and shelter services, the problem of homelessness still exists (NAEH, 2016; Patterson et al., 2015). Consequently, homelessness continues to be a concern for the United States.

Problem Statement

The United States Virgin Islands (USVI) is an American territory located in the Caribbean and is comprised of three main islands, which are St. Thomas, St. Croix, and St. John. The USVI participated in the annual homeless count in January 2014 and counted 448 homeless persons (NAEH, 2016). This number represents less than 1% of the entire USVI population, which is 102,951 (Central Intelligence Agency [CIA], 2016). Although this number is less than national numbers, homelessness is still a significant problem in the USVI (Akin, 2015; Norris, 2013). To help ameliorate the problem of homelessness, there is the Virgin Islands Continuum of Care on Homelessness, which is comprised of the following governmental agencies: Department of Human Services (DHS), Department of Health, Division of Mental Health (DOMH), Department of

Housing and Urban Development, Virgin Islands Housing Finance Authority (VIHFA), and the Methodist Training and Outreach Center (MTOC). These agencies collaborate to find solutions for people who are homeless or at risk for homelessness (Virgin Islands Continuum of Care on Homelessness, 2017).

Although there is a DOMH in the USVI, it suffers from a lack of quality clinical mental health services. There are no licensed mental health counselors or licensed professional counselors in the USVI. Although a legislative bill was introduced to establish the Board of Licensed Counselors and Examiners in the Virgin Islands, this board has not yet been established (McLaughlin, 2016). Subsequently, the mental health and substance abuse needs of people who are homeless go unmet. In addition, the services that are available through the DHS, DOMH, MTOC, and CCVI do not offer trauma-informed treatment; even though a relationship exists between trauma and homelessness (Deck & Platt, 2015). What is not known is whether this lack of access to trauma-focused mental healthcare is a contributing factor to the preponderance of homelessness in the USVI.

Since 2013, there has been a rise and fall in the number of sheltered and unsheltered homeless persons. The USVI participates in the point-in-time (PIT) homeless count, which is a national survey that counts the number of homeless living on the streets and in shelters (NAEH, 2016). In 2015, there were 252 unsheltered homeless in the USVI; in 2017, 307 were counted, which showed a 22% increase over the past 2 years. There were 66 homeless persons living in transitional or supported housing (Virgin Islands Continuum of Care on Homelessness, 2017). St. Thomas and St. Croix have one

shelter that houses about 40 males and females, and St. John has no homeless shelters (Akin, 2015). There are 83 emergency shelter beds, 50 transitional shelter beds, and 60 permanent shelter beds in total across all three islands. Most of these beds are dedicated for domestic violence survivors. With this shortage of shelters and lack of mental health services, the plight of homeless people living in the USVI could be an ongoing traumatic event (Buchanan, 2017; Virgin Islands Continuum of Care on Homelessness, 2017). In the 2019 homeless count, 337 people were counted who experienced homelessness. Some of these individuals were a result of 2017 hurricanes in the USVI (Virgin Islands Continuum of Care on Homelessness, 2019). However, it is uncertain if these numbers are truly representative of the homeless population in the USVI.

Homelessness is a concern for the USVI (Norris, 2013). The PIT count identified mental illness and substance abuse as barriers to stable housing (Deck & Platt, 2015; Hamilton et al., 2011; Virgin Islands Continuum of Care on Homelessness, 2017). Furthermore, there are correlations between early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012).

The problem is that services offered by the MTOC DHS, and CCVI are not inclusive of trauma-informed care. Lack of trauma focused services may pose a hindrance to stable housing, thus perpetuating reoccurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. Several studies have utilized the Adverse Childhood Experiences to predict homelessness and the impact that early trauma has on substance use and mental illness (Felitti & Anda, 2010; Herman,

Susser, Struening, & Link, 1997; Larkin & Park, 2012). There is a shortage of research articles that have examined the Trauma History Questionnaire (THQ) and whether it predicts reoccurring homelessness.

Purpose of the Study

The purpose of this cross-sectional multiple regression design was to examine the potential predictive relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), with reoccurring homelessness as measured by housing stability, duration of homelessness, service utilization in persons who are homeless in the USVI. The study may offer evidence to counselors, marriage and family therapists, social workers, and case managers who work with persons who are homeless to support adopting a trauma-informed care approach (Bowen & Murshid, 2016; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Hopper et al., 2010; Mailloux, 2014; Pelletier, 2016; Somerville, 2013). The results of the study may help to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI.

Research Question

RQ: Is trauma predictively related to reoccurring homelessness while controlling for demographic factors?

Hypotheses

H_0: Trauma is not predictively related to reoccurring homelessness while controlling for demographic factors.

H_1: Trauma is predictively related to reoccurring homelessness while controlling for demographic factors.

Framework

The theoretical lens for this study was the psychological trauma theory (PTT) (Goodman, Saxe, & Harvey, 1991). The PTT helps explain the behaviors of homeless persons by examining traumatic experiences before and after becoming homeless. Social disaffiliation and learned helplessness contribute to internal and external states of homelessness, indicating that a person who is homeless is not safe emotionally and may be threatened by their environment (Goodman et al., 1991; Somerville, 2013). Homelessness is multidimensional and involves both internal and external states. An internal state of homelessness means an individual lacks connection with social systems, is unable to cope with stress, and lacks hope and purpose in life (Somerville, 2013). An external state of homelessness means that an individual lacks the necessities for adequate living, such as water, food, clothing, shelter, and access to healthcare (Lippert & Lee, 2015; Somerville, 2013).

From a PTT perspective, internal and external states of homelessness can impact persons who are homeless by interfering with their ability to regain control of their life (Bonugli et al., 2013; Goodman et al., 1991; Lippert & Lee, 2015; Somerville, 2013). Moreover, PTT may help to understand the barriers to stable housing that a homeless

person experiences and help to identify treatment programs such as a trauma-informed care to address traumatic events prior and during periods of homelessness (Deck & Platt, 2015; Hopper et al., 2010). More will be discussed in Chapter 2.

Nature of the Study

Quantitative

The study used a cross-sectional multiple regression design. A multiple regression analysis examined the potential impact and relationships between variables as well as whether independent variables influence outcomes of dependent variables (Drost, 2011; Mason & Perreault, 1991; Levin, 2006). I examined the potential predictive relationship between trauma and reoccurring homelessness while controlling for demographic factors. The independent variables are trauma (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence) and demographic factors (age, gender, education level, mental illness status, substance abuse, employment history). The dependent variable is reoccurring homelessness (housing stability, duration of homelessness, and service utilization).

The independent and dependent variables were measured using existing instruments. The THQ was used as a reliable and valid instrument to capture information pertaining to traumatic experiences from three broad categories, including crime related events, general disaster and trauma, and unwanted physical and sexual experiences (Hooper, Stockton, Krupnick, & Green, 2011). The Residential TimeLine Follow Back (RTLFB) was also used to examine information from several of its eight domains

including housing stability, duration of homelessness, employment, and service utilization (Tsemberis, McHugo, Williams, Hanrahan, & Stefancic, 2007).

People who are homeless are transient and may not have a permanent address. As a result, a probability sampling method may prove difficult. One way that I can potentially use a random sample is by accessing the Homeless Management Information System (HMIS), which is a database of all accounted homeless persons living in the USVI; however, this would mean going to the physical locations of the selected participants, which could be a potential risk and put my safety in jeopardy.

I used convenience and purposive sampling methods. Convenience sampling is the most common type of sampling method because it allows the researcher to select readily available participants (Etikan, Musa, & Alkassim, 2016; Rossi, Wright, & Anderson, 1983). Purposive sampling involves intentionally selecting participants based on the researcher's judgement and yields a representation of the general population (Dudovskiy, 2017; Saunders, Lewis, & Thornhill, 2012). Potential participants were recruited from the MTOC, DHS, and CCVI shelters, since these are the primary agencies that provide services to the homeless population in the USVI. Both sampling methods and recruitment procedures are discussed further in Chapter 3.

Operational Definitions

The constructs of homeless, homelessness, trauma, and reoccurring are operationally defined below:

Homeless

Lippert and Lee (2015) defined homeless as an individual person, who is without shelter or lives in substandard housing (e.g. cars, abandoned buildings, park benches, streets) or in shelters. The Czech Republic defined homeless as "someone who has inadequate resources (not only material) for maintaining day-to-day existence and is not capable of independently procuring said resources" (Hladikova, 2007, p. 608). Combining Lippert and Lee (2015) and Hladikova (2007) definitions, for the purpose of this study, homeless is defined as an adult of any gender who lives in substandard housing, shelters, or transitional homes and lacks adequate resources to be self-sufficient. I used the RTLFB to capture some to the demographic factors, such as gender, age, educational level, mental illness, substance abuse, and employment history (Tsemberis, McHugo, Williams, Hanrahan, Stefancic, 2007).

Homelessness

Homelessness is seen more as a state of being such as in the lack of social networks as well as adequate housing (Hladikova, 2007). Homelessness can also be defined in terms of severity such as chronic, episodic, and transitional (Lippert & Lee, 2015). The construct of the study examined chronic homelessness, which was defined as long periods of being homeless and episodic homelessness, which was defined as fluctuating periods of being housed and homeless (Lippert & Lee, 2015). The Methodist Training and Outreach Center (MTOC) and Catholic Charities of the Virgin Islands (CCVI) and the Department of Human Services (DHS) provides services for the homeless. These organizations house the chronic and episodic homeless. I did not include

transitional homelessness as this was defined as moving from one stable housing to another stable housing and would not align with the purpose of this study in determining the impact of trauma on reoccurring homelessness. Tsemberis et al., (2007) developed the RTLFB to measure homelessness and housing stability. I used this instrument to measure reoccurring homelessness, which includes housing stability, duration of homelessness, and service utilization.

Trauma

Trauma is defined as direct or indirect exposure to physical abuse and/or domestic violence, sexual abuse, and combat exposure (Pavao et al., 2013). Traumatic experiences also include repeated exposure to witnessing violence, natural disasters, car accidents, human trafficking, abandonment, neglect (Mailloux, 2014).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), trauma is defined as:

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being. (p. 7)

As it relates to this study, trauma was defined as an indirect or direct event that causes significant physical or emotional pain and impacts various aspects of an individual’s life.

Reoccurring

It should be noted that the literature does not use the language of reoccurring homelessness but rather recurrent or recurring homelessness. In defining recur, according to Dictionary.com, to occur again, as an event or experience. Whereas recurrent is defined as appearing again repeatedly or periodically (Dictionary.com, 2015). McQuistion, Gorroochurn, Hsu, and Caton (2014) defined recurrent homelessness as having "at least one episode of homelessness following a first-time episode and occurring at any time after obtaining housing (and for any length of time) subsequent to that first episode" (p. 506). Reoccurring is defined as an initial episode of homelessness followed by a period of housing, whether in a shelter, transitional or permanent housing for at least two weeks or more, followed by another episode of homelessness at any point.

Although recurrent and reoccurring seem similar, I make the distinction between the two as in recurrent is an ongoing cycle that does not end, such as in the case of a recurrent payment that happens on the same day each month. Whereas reoccurring is also a cycle but there is a stop in the cycle and then is starts again. I used the RTLFB to measure reoccurring homelessness including housing stability and duration of homelessness (Tsemberis et al., 2007).

Assumptions

Based on the nature of this study, I identified three assumptions. The first assumption is that I would have adequate data samples to determine the null or alternative hypothesis. The second assumption is that trauma does not cause homelessness but can potentially impact various aspects of homelessness. The third assumption was that the

results from the study would facilitate social change in the USVI to focus more on implementing a trauma-informed care approach within service programs for persons who are homeless.

Scope and Delimitations

This study is limited to the homeless population living in the USVI. This population has not yet been examined to determine the impact of trauma on reoccurring homelessness. Other delimitations were that participants were from DHS, MTOC, and CCVI and excluded persons who were not homeless or did not receive services from these organizations. I used the convenience sampling method to recruit participants at CCVI shelters in St. Thomas and St. Croix (St. John does not have a shelter). Adult men and women were used for this study, thus eliminating youths who were homeless. The study also did not include persons at risk for homelessness but only those who are already defined as homeless. Since I am using a nonprobability sampling method, it is not possible to generalize this study to other Caribbean islands.

Limitations

The following are some potential limitations of this study. The use of multiple regression studies does not determine causation but rather examines the predictive nature of among the variables (Cook & Campbell 1979). There may be a potential for selection bias due to nonprobability sampling; however, this could be mitigated by using inclusion and exclusion criteria to select participants. Another limitation is instrumentation; although I used valid and reliable existing instruments, participants may interpret questions differently, thus impacting the results. In addition, due to the variability among

the homeless, some individuals may have difficulty with reading and writing. As a result, I read the questions to participants or provided a recording of the questions if needed; this could change the meaning of questions and alter participants responses. Further discussions regarding limitations are in Chapter 5.

Significance

Considering Hurricanes Irma and Maria in 2017, which devastated the USVI, this study is even more crucial. Many homes were destroyed, and several people were without adequate shelter, thus rendering them homeless. Furthermore, the traumatic events following hurricanes will have lasting impacts. It can be expected that the number of people who are homeless will increase; hence, there is a greater need to understand how trauma impacts homelessness and develop ways to reduce, and hopefully eliminate reoccurring homeless in the USVI.

Within my research, I sought to advocate and facilitate social change and social justice for the homeless of the USVI in the following ways: a) help to develop new programs for the homeless in the USVI that focus on the principles of trauma-informed care (TIC), b) implement training programs to counselors, social workers, and other mental health workers to address trauma in persons who are homeless, and c) validate the need for licensed professional counselors in the USVI to work with people who are homeless, at risk of homelessness, or who suffer from substance abuse and mental illness.

Walden University’s mission aligns with social justice and advocacy and seeks to equip emerging leaders to be social change agents in their respective communities (Walden University, 2014). As a social change agent and a professional counselor scholar

practitioner (PCSP), one of my roles is to advocate for and on behalf of marginalized and oppressed populations (American Counseling Association [ACA], 2014; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). The Association for Multicultural Counseling and Development (AMCD) created multicultural and social justice counseling competencies (MSJCC), which was endorsed by the ACA to assist counselors, clinical supervisors, and counselor educators in providing either direct services or educational training in a way that empowers and affirms the rights of clients and students (Ratts et al., 2016).

The MSJCC are provided to understand the complexities of diversity, recognize the influence of oppression on mental health, understand individuals in their social context and environment, and integrate social justice advocacy in counseling practices. Social change involves social action that empowers clients to make healthy choices (Ratts et al., 2016). Persons who are homeless are often marginalized and oppressed. Through this study, I hope to bring awareness about the effects of trauma on homelessness. In addition, I hope to empower counselors, counselor educators, and other community stakeholders to engage in further research and advocacy for people who are homeless in the USVI as well as throughout the Caribbean Diaspora.

Summary

The USVI suffered significantly from the 2017 hurricanes that left many persons homeless. Recovery efforts are still ongoing as the psychological impact of natural a disaster is far greater. As noted earlier, homelessness can be felt both internally and externally. Although there is a plethora of empirical studies on homeless youth and adults

throughout the United States of America Canada, and Europe, limited research is available on the homeless population in the USVI. In Chapter 2, I will synthesize the literature on trauma and homelessness.

Chapter 2: Literature Review

Introduction

Homelessness is recognized as a national concern and the United States Virgin Islands (USVI) is no exception (NAEH, 2016; Norris, 2013). While several factors contribute to the problem of homelessness, mental illness, and substance abuse are identified as particular problematic and serves as barriers to stable housing (Deck & Platt, 2015; Hamilton et al., 2011; Virgin Islands Continuum of Care on Homelessness, 2017). To specifically understand these barriers, researchers examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012).

The problem is that services offered by the Methodist Training and Outreach Center (MTOC), Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care approach (TIC) and therefore may pose a hindrance to stable housing, thus perpetuating reoccurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design examined the impact of trauma, demographic factors, and reoccurring homelessness in persons who are homeless living in the USVI. Current literature supports the notion of examining trauma in relation to mental illness and substance abuse (Deck & Platt, 2015; Goodman, 2017; McQuistion, Gorroochurn, Hsu, & Caton, 2014). For decades, researchers examined and explored ways to reduce homelessness, address barriers to stable housing, and to

understand the lived experiences of trauma in the lives of people who are homeless (Deck & Platt, 2015; Hamilton, Poza, & Washington, 2011; Hopper et al, 2010; Johnstone et al., 2016; Larkin & Park, 2012; Lippert & Lee, 2015, Patterson, Currie, Rezansoff, & Somers, 2015; Wong, Clark, & Marlotte, 2016).

In this chapter, I listed the search engines and databases I used to analyze and synthesize the literature regarding trauma and homelessness. I reviewed qualitative, quantitative, and mixed methods studies that addressed the variables examined in the study as well as arguments that examined other variables involving trauma and homelessness. I described the theoretical foundation I used to guide the study as well as other supporting theoretical foundations.

Literature Strategy

The issue of homelessness has been around for several decades, thus there were a plethora of literature on homelessness. The databases used were Walden Search Library, EBSCOHost, Health and Psychosocial Instruments, PsycINFO, ScienceDirect, Academic Search Complete, Google Scholar, ProQuest Dissertations and Theses Global, and SAGE Journals. Search terms used were *trauma*, *trauma and the homeless*, *homelessness*, *homelessness and trauma*, *reoccurring homelessness*, *mental illness and homelessness*, *trauma-informed care approach*, and *homelessness*. Articles were selected within published between 2014 and 2019. However, there were a few seminal articles that were relevant and substantiated this dissertation study. All articles were from peer-reviewed and reputable scholarly journals.

Theoretical Foundation

The theoretical lens for this study was the psychological trauma theory (PTT). The PTT helped to explain the behaviors of persons who are homeless by examining traumatic experiences before and after becoming homeless. Social disaffiliation and learned helplessness contribute to internal and external states of homelessness, indicating that an individual, who is homeless, is not safe within or outside of oneself (Goodman et al., 1991; Somerville, 2013). Furthermore, PTT may explain some of the behaviors of homeless persons by looking at their early trauma experiences and how those experiences impacted their ability to cope with life. Some traumatic experiences stem from stress, unemployment, family problems, domestic violence, and childhood abuse. As a result, these traumatic experiences affect persons who are homeless, which could lead to poor choices, such as drug use, mismanagement of money, and unstable housing (Goodman et al., 1991; Lippert & Lee, 2015).

An estimated 202,297 homeless persons suffer from mental illness or substance abuse problems; however, few homeless persons seek mental health treatment (Corrigan, Pickett, Kraus, Burks, & Schmidt, 2015; Milloux, 2015; Substance Abuse Mental Health Services Administration [SAMHSA], 2017). Corrigan et. al., (2015) explored the health care needs and experiences of African-American homeless men. Participants viewed existing services as limited or inaccessible, and healthcare providers were insensitive to the needs of the homeless. With limited resources, the homeless are at a disadvantage for addressing healthcare needs, hence potentially increasing their psychological trauma.

Several studies examined how early childhood trauma are indicators to poor outcomes and homelessness (Coates & McKenzie-Mohr, 2010; Helfrich et al., 2011; Huey et al., 2014; Lippert & Lee, 2015; Wilson, Samuelson, Staudenmeyer, & Widom, 2015). The Adverse Childhood Experiences (ACEs) study was a ground-breaking research that projected the likelihood of an individual suffering from health conditions, such as diabetes, chronic illnesses, substance abuse, mental illness, and suicide (Felitti et al., 1998). Larkin and Park (2012), used ACE to examine service use and service helpfulness among homeless people. Participants with ACEs score of four or higher were less likely to seek help. Although a high score on the ACEs does not necessarily lead to homelessness, traumatic events experienced in childhood can increase the likelihood of mental illness and substance abuse problems, thus, leading to poor outcomes (Felitti et al., 1998; Larkin & Park, 2012; Zoltnick, Tam, & Bradley, 2007).

Social Disaffiliation

Homelessness is multidimensional and involves both internal and external states (Somerville, 2013). An internal state of homelessness means an individual lacks connection with social systems, is unable to cope with stress, and lacks hope and purpose in life (Somerville, 2013). Many persons who are homeless are disconnected from family and tend to be disenfranchised from the system of care (Deck & Platt, 2015; Hopper et al., 2010; Lee, Tyler, & Wright, 2010). As a result, individuals who are homeless do not have a support system to help them out of homelessness. However, within the homelessness system or subculture, there is a level of social support that an individual may receive from others who are also homeless (William & Stickley, 2011). Although

this support may not always be positive, there is a level of camaraderie among persons who are homeless. William and Stickley (2011), explored the lived experiences of people who are homeless living in the United Kingdom; one participant stated, "We've all got our own homeless knit community, where we all look after each other" (p. 436). This level of support may include knowing where good resources are, who to trust, when to seek shelter, and tips on how to survive. In this internal state, the homeless individual is trying to make sense of his or her world.

Learned Helplessness

An external state of homelessness means that persons who are homeless lack basic necessities for adequate living, such as water, food, clothing, and shelter (Lippert & Lee, 2015). Earlier, I described three categories of homelessness, which are chronic, episodic, and transitional. For individuals who are chronically homeless, their external state of homelessness would be more severe than individuals who are experiencing episodic homelessness. An individual experiencing episodic homelessness may have his or her basic needs met but may lack the security of a job or transportation or may have chronic health problems. Borrowing from Maslow's hierarchy of needs, when an individual lacks the basic human needs food, shelter, water, it is difficult for that individual to progress to higher levels of functioning. Likewise, when a person who is externally homeless, they are unable to process or connect with internal states, such as love/belonging and self-esteem, which then leads to social disaffiliation (Goodman et al., 1991; Maslow, 1943).

From a PTT perspective, both states of homelessness impact the individual's ability to regain control of their life (Bonugli, Lesser, & Escandon, 2013; Goodman et al., 1991; Lippert & Lee, 2015; Somerville, 2013). Being disconnected from society and feeling jaded by community resources, the homeless are disenfranchise and may lack the internal motivation to improve their circumstances. Moreover, PTT may help to understand the barriers to stable housing as well as help to identify treatment programs, such as trauma-informed care approach to address the traumatic events prior and during periods of homelessness (Deck & Platt, 2015; Hopper et al., 2010).

Other Theories that Support Psychological Trauma Theory

Other theories that support this study are the social stress framework and the vulnerable populations conceptual model (VPCM) (Bonugli et al., 2013; Flaskerud & Winslow, 1998; Huey, Hryniewicz, & Fthenos, 2014). The social stress framework identifies multiple stressors that impact the ability to cope with being homeless (Huey et al., 2014). Being homeless can be traumatic and stressful (Lippert & Lee, 2015); hence, the difficulty coping with past or current traumas can lead to substance abuse, mental illness, and prolonged periods of homelessness (Huey et al., 2014; Lippert & Lee, 2015).

Huey et al., 2014, examined the consequences of stress on homeless women who engaged in self-injurious behaviors and noted the difficulty of coping with being homeless, lack of social support, and lack of internal coping mechanisms as some of the consequences. Lack of support is like social disaffiliation, as described in Goodman et al., (1991) PTT, in that the homeless are disconnected from their social world. The lack of support and disconnect leads to isolation and further stress of coping with

psychological trauma subsequent to homelessness (Goodman et al., 1991; Huey et al., 2014).

The VPCM was developed by Flaskerud and Winslow. The VPCM identifies three interconnecting concepts which are inadequate resources, excessive exposure to risk factors, and poor health outcomes (Bonugli, Lesser, & Escandon, 2013; Flaskerud & Winslow, 1998). Social groups such as the homeless are vulnerable and this can lead to health disparities and being susceptible to negative health outcomes (Bonugli et al., 2013; Deck & Platt, 2015). People who are homeless lack adequate resources, such as money, housing, employment, and quality health care (Bonugli et al., 2013; Lippert & Lee, 2015). Due to the lack of resources, homeless persons are exposed to ongoing risk factors, such as serious mental illness, substance abuse issues, and threats of violence and abuse. As a result of excessive risk factors, homeless persons experience poor health outcomes, which include untreated chronic mental illness (Bonugli et al., 2013). Furthermore, being in a vulnerable state hinders one's ability to achieve and maintain emotional and psychological balance.

The literature suggested a relationship between trauma and homelessness in North America, Europe, and Australia; however, what is unknown is the impact of trauma on the homeless population in the USVI. Hence, the need for this study. If the results of this study indicate a significant relationship between trauma and homelessness, then it would behoove social service programs to implement a trauma-informed care approach to reduce the impact of psychological trauma on the homeless.

Literature Review Related to Key Variables and Concepts

There are many risk factors and pathways to homelessness such that a researcher can examine each variable in a single study. Several studies have examined the relationship between trauma and homelessness. In the following paragraphs, I discussed each variable related to my study.

Homelessness

Historical overview. As far back as the 19th century, homelessness has been a significant issue in the United States of America and in other part of the world (Hopper, Bassuk, & Olivet, 2010; Jones, 2015; Lee, Tyler, & Wright, 2010; Lippert & Lee, 2015). According to the National Alliance to End Homelessness, homelessness is one of America's "most misunderstood and vexing social problems", (NAEH, 2009, p. 1). Skid Row came into existence at the close of the Civil War, which made several persons destitute and homeless (Wallace, 1965). Skid Row was a conglomerate of deinstitutionalized men and women, runaway youths, and people with substance abuse and mental illness (Jones, 2015; Wallace, 1965). During the 20th century, Skid Row continued to attract refugees, transient immigrants, people with AIDS/HIV, and war veterans (Jones, 2015; Lee et al., 2010). The housing conditions were dilapidated old buildings, abandoned cars and buses, rundown houses, and unkempt parks (Jones, 2015; Lippert & Lee, 2015). Although Skid Row lacked the basic healthy living conditions, it was home to many people who were homeless (Jones, 2015). Although the terminology Skid Row is not used today, the visible signs of homelessness are evident in many communities (Jones, 2015). In addition, the faces of homelessness have also changed

over the past decade and includes families, women, and youths who age out of foster care (Coates & McKenzie-Mohr, 2010; Jones, 2015; Lee et al., 2010; Waldbrook, 2013).

Ending the war on homelessness. The official efforts to end homelessness begun in 1987 with the Stewart B. McKinney Homeless Assistance Act, which was renamed in 2000 to McKinney-Vento Homeless Assistance Act (National Coalition for the Homeless, [NCH], 2006). The act provided funds and policies to assist social service agencies and coalitions in aiding the current homeless and preventing future homelessness (Housing and Urban Development, [HUD], 2016; NAEH, 2016; NCH, 2006; Rossi, 1989). The Housing and Urban Development (HUD) has several programs in place as a result of such funding and policies. Some of these programs are, Section 8, Single Room Occupancy (SRO), Shelter plus Care (S + C), and Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) that provide subsidized housing, free housing, and rental assistance to low-income families, persons at risk for homelessness, and persons who are homeless (HUD, 2016). However, many communities did not want programs for the homeless in their backyard (Hambrick & Johnson, 1998; Philippot & Francq, 2003). This type of attitude, NIMBY (not in my backyard), hindered homeless people from improving their lives, hence, the plight of the homeless continued (Hambrick & Johnson, 1998; Philippot & Francq, 2003).

While efforts to end homelessness are multifaceted, so too are the pathways to becoming homeless (Lippert & Lee, 2015; Patterson, Currie, Rezansoff, & Somers, 2015). An individual may not choose to become homeless but could become homeless due to several factors (Patterson et al., 2015; Lippert & Lee, 2015). Some of these factors

include unmanaged mental health and substance abuse problems, lack of affordable housing, unemployment, poor money management, and lack of family support (Patterson et al., 2015). Furthermore, the faces of homelessness have changed over the decades, such that there is a category of the hidden homeless who may not be counted in the national numbers (Lee et al., 2010; Waldbrook, 2013). The hidden homeless are families with young children, foster care youths who age out of the system, the working poor, families living with parents and grandparents, and the educated (Coates & McKenzie-Mohr, 2010; Jones, 2015; Lee et al., 2010; Waldbrook, 2013).

Despite several homeless program initiatives, research, and homeless organizations, the issue of homelessness continues to baffle policy makers, program evaluators, and social services as to how to help people who are homeless (Lee et al., 2010). The past and the current White House Administrations provided funding to end homelessness in America by 2020 (NAEH, 2016). The Housing Urban Development (HUD) and the Veteran's Administration provide housing assistance to families and veterans to help prevent homelessness (Carlson, 2013; NAEH, 2016). These programs helped many people who ae homeless, yet there are 564,708 people who are homeless in America, which is approximately 17.5% of the entire population in (NAEH, 2015). Of this number, 10% of the homeless are unsheltered, 36% are families who are homeless, 15% are chronically homeless, 7.3% are unaccompanied youths and 10.5% are homeless veterans (NAEH, 2015).

Services for the homeless. The U.S. Department of Housing and Urban Development has several programs that provide housing assistance to people who are

homeless (HUD, 2016). Unfortunately, these programs mainly address the physical needs of the homeless and neglect the psychological needs. However, many local states and cities have non-profit agencies that provide financial, food, clothing, health, and mental health assistance to persons who are homeless. For example, in Port Charlotte, Florida, the Charlotte County Homeless Coalition (CCHC) has a shelter that addresses the physical and psychological needs of people who are homeless (CCHC, 2016). The Salvation Army is another local organization that provides temporary housing assistance and other essential needs for people who are homeless.

In the USVI, the Methodist Training and Outreach Center (MTOC) and the Catholic Charities of the Virgin Islands (CCVI) offer similar services to address the physical needs of the homeless; however, the mental health services are addressed inadequately (MTOC, n. d.). At a time when services are significantly needed, CCVI was forced to close one of its programs, Home at Last, due to lack of funding (Akin, 2017).

The perpetuating theme throughout the literature is that both housing and supportive services are needed to end homelessness. Since many pathways render an individual homeless, a multi-disciplinary approach is needed to resolve homelessness (Hopper et al., 2011; Lee et al., 2010; Lippert & Lee, 2015; Patterson et al., 2015). Resolving homelessness will need an integrative approach to deal with the multiple layers of trauma, physiological needs, psychological need, and safety needs of the homeless. One such integrative approach is Trauma-Informed Care (TIC) (Bowen & Murshid, 2016; Hopper et al., 2011). The TIC model has six principals, which includes safety, trustworthiness and transparency, collaboration, empowerment, choice, and

intersectionality (Bowen & Murshid, 2016). A program that incorporates TIC seeks to understand how traumatic experiences contribute to the cycle of homelessness and helps persons who are homeless to regain control of their life (Bowen & Murshid, 2016; Hopper et al., 2011).

Patterson et al. (2015) explored perceived barriers to services use among people who are homeless. Participants noted that lack of ongoing support, cumulative trauma and loss, lack of social support, and substance abuse were among some of the barriers that perpetuated the cycle of homelessness. The results of the study further noted that even when housing is provided, participants feared becoming homeless and were hesitant to seek services (Patterson et al., 2015). Other studies listed system bureaucracy, attitudes of service workers, lack of transportation, limited resources, and psychological trauma as a hindrance to using support services (Corrigan et al., 2015; Deck & Platt, 2015; Hopper et al., 2011; Lee et al., 2015; Patterson et al., 2015).

Trauma

Several factors contribute to the initiation and maintenance of homelessness. While much is understood about homelessness, there is still more to understand about the vast realm of homelessness. Researchers continue to gain new insights into the how and why of homelessness and what will work to end it. One promising area of research involves the role trauma may play as a contributing factor to homelessness and as a barrier to remain stably housed.

In early literature reviews, trauma was associated with combat experience from war or medical trauma, such as head injuries. More recently, there is a push to focus on

traumatic experiences, which could result from many events. According to the American Psychological Association (APA, n. d.) trauma is an emotional response to traumatic events such as abuse, rape, war, witnessing violence, and natural disasters. Trauma, as defined by SAMHSA, includes an event that is experienced and has significant effects on an individual's wellbeing (SAMHSA, 2014).

People who are homeless may be exposed to a variety of traumas both prior to and during homelessness (Carlson et al., 2013; Clapton, Chenoweth, McAuliffe, Clements, & Perry, 2014; Hamilton et al., 2011). Childhood traumatic experiences among homeless men and women are further compounded by the traumatic experiences of being homeless (Deck & Platt, 2015). The 1994 study by Kaiser Permanente (KP) and Centers for Disease Control and Prevention (CDC) designed a screening tool for adults who had traumatic experiences prior to age 18 (Deck & Platt, 2015; Larkin & Park, 2012). The Adverse Childhood Experiences (ACE) is a questionnaire with yes and no responses in 10 categories (Deck & Platt, 2015; Larkin & Park, 2012). Adults with an ACE score of four or higher were more likely to experience health related issues, mental illness, death, and substance abuse problems (Larkin & Park, 2012). Thus, a high ACE score could also be indicative and a risk factor of homelessness. The ACE captures traumatic events in childhood and covers three main categories, which are abuse, household challenges, and neglect (CDC, 2016). The ACEs questions were used in a significant study that helped to identify psychosocial stressors that contributed to health conditions and predicted the likelihood of which psychosocial stressor were experienced by participants based on the ACEs score (Felitti et al., 1998; Felitti & Anda, 2010).

Since homelessness is a psychosocial stressor, along with substance abuse and mental illness, trauma can be a proponent to psychosocial stressors; hence, in my study, I examined the potential relationship of trauma to reoccurring homelessness and attempted to answer the question, does trauma predict reoccurring homelessness. Several studies used the ACEs to predict homelessness, substance use, mental illness, and suicide among people who are homeless (Herman, Susser, Struening, & Link, 1997; Larkin & Park, 2012; Roos et al., 2013).

Types of trauma. The types of trauma experienced by the homeless may include sexual abuse, physical assaults, witnessing a murder or another type of violence, abandonment, neglect, loss of personal property, lack of shelter during natural disasters and severe weather, inability to treat medical emergencies, being a victim of crime, loss of a child or family member (Briere, Agee, & Dietrich, 2016; Clapton et al., 2014; Kim et al., 2010). Furthermore, not only does a history of trauma increase the likelihood of being homeless later in life, but then once homeless, an individual is at risk for further traumatization. Men are more likely to experience robbery and physical assault, whereas women are more likely to experience sexual assault (Buhrich et al., 2000; Coates & McKenzie-Mohr, 2010). Homeless men and women tended to report higher incidences of trauma than the general population (Briere et al., 2016; Kushel, Evans, Perry, Robertson, & Moss, 2003).

Trauma in homeless youths. Several researchers have identified specific types of traumas experienced by the homeless as well as the impact of trauma on mental illness, substance abuse, service use, and homelessness (Coates & McKenzie-Mohr, 2010;

McKenzie-Mohr, Coates, & McLeod, 2012; Wong, Clark, & Marlotte, 2016). Of the total homeless population in the U. S., 9.7% were unaccompanied youths ages 18-24 (HUD, 2017). Unaccompanied homeless youths also experience the same types of trauma, which are then carried over into adulthood (Blondell, Robertson, Brindis, Papanastassiou, & Bradley, 2017; Wong et al., 2016). Childhood trauma, such as witnessing violence, physical and sexual abuse, substance abuse, and being in foster care have all been associated with homelessness (Coates & McKenzie-Mohr, 2010).

Coates and McKenzie-Mohr (2010) examined trauma in the lives of 100 homeless youths living in Canada and found that at least half of the youths experienced some type of traumatic event prior to homelessness and the other half subsequent to becoming homeless. Another study examined youths 13-25 years old in Los Angeles, California. Of the 413 youths surveyed, 70% grew up in adverse home environments, 58.9% reported emotional abuse and neglect, 51.4% reported physical abuse, and 33.2% reported childhood sexual abuse all prior to homelessness (Wong et al., 2016). During homelessness, 37.3% of youths reported physical assault as the most frequent trauma (Wong et al., 2016). As a result of these traumatic events, youths have difficulty coping with mental illness and thus increases their risk for substance abuse, criminal activity, and risky behaviors, which could lead to health concerns (Bonugli et al., 2013; Coates & McKenzie-Mohr, 2010; McKenzie-Mohr, et al., 2012; Wong et al., 2016).

In a meta-analysis, authors Sundin and Baguley (2015), examined 24 published articles from 1990 to 2013 in three countries. The authors noted that the prevalence of childhood trauma among the homeless were more prevalent in the U. S than in other

world countries. The average prevalence of childhood physical abuse was 37% whereas 32% was the average prevalence of childhood sexual abuse. Although homeless youths were not included in this dissertation study, these youths eventually grow up to be adults, hence, the continuing accumulation of trauma from adolescent to adulthood.

Trauma in homeless women. Buhrich, Hodder, and Teesson, (2000) surveyed homeless women in different states and found that 67% of homeless women report physical abuse in Portland Oregon, 43% of homeless women in New York City reported being raped, and in New England, 89% of homeless women reported both a history of physical and sexual trauma. Veterans make up 17.9% of the homeless population and they may have been exposed to significant amounts of trauma that may lead to both post-traumatic stress disorder (PTSD) (Carlson et al., 2013; Pavao et al., 2013). About 53.3% of homeless veteran women experienced military sexual trauma (MST) (Pavao et al., 2013). In a similar fashion, Hamilton, Poza, and Washington (2011), explored the pathways and experiences of homeless female veterans. There are multiple pathways to homelessness, which also included a history of childhood trauma and trauma experienced while in the military (Hamilton et al., 2011). The results of the study showed, 52% of women reported a history of childhood abuse and domestic violence prior to joining the military and 79% reported being traumatized while in the military (Hamilton et al., 2011).

Trauma in homeless men. In a study of 239 homeless men, 68.2% reported childhood physical abuse and 71.1% reported physical abuse as an adult. The authors further noted 55.6% of men reported childhood sexual abuse and 53.1% reported sexual abuse in adulthood (Kim, Ford, Howard, & Bradford, 2010). Deck and Platt (2015)

examined trauma symptoms of homeless men. The researchers used a combination of semi-structured interviews and self-administered questionnaires to assess the severity of Post-Traumatic Stress Disorder (PTSD) in participants (Deck & Platt, 2015). The findings supported the need for shelter workers to recognize PTSD symptoms and include trauma counseling in support services for the homeless (Deck & Platt, 2015). Deck and Platt (2015) used Goodman et al., (1991) trauma theory to frame the study.

According to Deck and Platt (2015), there are many studies on trauma histories of homeless women, however, there is a gap in the literature on studies done on trauma histories of homeless men. They examined the prevalence of PTSD risk in homeless men, the severity of trauma symptoms, and the correlation between PTSD and mental health issues. The results identified vulnerabilities that homeless persons experience, such as physical and mental health concerns, and substance abuse. Of the 152 homeless men interviewed, 45.2% had one or more forms of abuse during their lifetime. An estimated 44.9% of participants were violently attacked, 19% prior to homelessness, 16% while experiencing homelessness, and 9.5% both before and after experiencing homelessness. Lalonde and Nadeau (2012) sampled homeless men and found that they had an average of 4.24 types of traumatic event in their lifetime. Some of the traumatic events reported were physical aggression, sexual aggression, having an accident, and witnessing aggression or murder. Each of the participants screened positive for PTSD.

Many homeless studies are conducted on homeless veterans (Tsai et al., 2012). Tsai et al., (2012) examined the correlation between types of trauma and housing, clinical outcomes, and psychosocial functioning. Of the 581 homeless female veterans, most

reported multiple types of trauma (Tsai et al., 2012). The study identified six categories of trauma such as being robbed, experiencing accident or disasters, illness or death of others, combat, sexual assault, and physical assault (Tsai et al., 2012). The findings suggested the need to integrate trauma counseling and services into homeless programs (Mallioux, 2015).

The literature in the USVI is sparse; hence, identifying the critical need to examine the relationship between trauma and homelessness and design programs that will address trauma experienced by persons who are homeless. The hurricanes in 2017, left the USVI in a dire situation such that many are living in substandard housings and would be deemed homeless (Buchanan, 2017). As noted earlier, natural disasters can be traumatic for some people; coupled with losing one's home and personal belongings and living in shelter can have a significant impact on an individual's mental health. Although housing needs are essential, it is critical to understand the impact natural disasters and other traumatic events have on the homeless living in the USVI and what is needed to reduce the potential cycle of homelessness. Conversely, trauma that is experienced before homelessness can further perpetuate the cycle of homelessness (McQuistion et al., 2014).

Reoccurring Homelessness

The literature clearly supports trauma as a contributing factor to homelessness; however, what accounts for reoccurring homelessness? Although many studies address recurrent homelessness as a significant problem, few studies address reoccurring homelessness. McQuistion, Gorroochurn, Hsu, and Caton (2014) examined risk factors that contribute to recurrent homelessness. They focused mainly on substance abuse,

family support, and mental illness as risk factors. The results showed that 23.7 % of participants (N=278) had recurrent homelessness due to alcohol or drugs. The study did not look at the impact that trauma may have on participants using alcohol or drugs. McQuistion et al., (2014) further compared risk factors among chronic homelessness and the stably housed. Arrest history was associated with recurrent homelessness among the stably housed versus the chronically homeless. Interestingly, living with family was statistically significant in recurrent homelessness.

The fears experienced by individuals who are homeless impedes their coping abilities, such as the ability to maintain housing, sobriety, medication compliance, social support, and emotional balance, thus creating social disaffiliations and learned helplessness (Clapton et al., 2014; Goodman et al., 1991; Hopper, Bassuk, & Olivet, 2010). There is a clear connection between trauma and homelessness; however, the literature does not address the relationship between trauma and reoccurring homelessness.

Demographic Factors

Throughout the literature the homeless are described as adult men and women, veterans, youths, unaccompanied youths, and families with children (NAEH, 2017). The 2017 PIT estimated 553,742 people were experiencing homelessness in the United States on a single night in January. Of this number, 61% are men, 39% are women, and less than one percent are either transgender (2092) or non-gender conforming (903) (HUD, 2017). About 47% of homeless identified as White, 41% identified as African American, 22% identified as Hispanic or Latino, and 7% identified as multiracial. In 2016 HUD's

annual homelessness assessment report noted that 202,297 have a severe mental illness or substance use disorder and one in five had a serious mental illness or chronic substance use disorder (SAMHSA, 2017).

Furthermore, the faces of homelessness have changed over the decades, such that there is a category of the hidden homeless who may not be counted in the national numbers (Lee et al., 2010; Waldbrook, 2013). The hidden homeless are families with young children, foster care youths who age out of the system, the working poor, families living with parents and grandparents, and the educated (Coates & McKenzie-Mohr, 2010; Jones, 2015; Lee et al., 2010; Waldbrook, 2013).

This study examined if demographic factors predicted reoccurring homelessness. It is unknown specifically the educational level, mental illness status, substance abuse history and employment history of the homeless living in the USVI. Several researchers included these demographics, in addition to age and gender, as a way to understand the characteristics of the homeless (Deck & Platt, 2015; Wong et al., 2016). Furthermore, these variables may help to explain the cyclic nature of homelessness and what types of programs could be implements to address these demographic factors.

Methodology

Researchers who studied the homeless and homelessness used a variety of research methods, namely, quantitative, qualitative, and mixed methods. Each method has value as well as limitations. I used a quantitative method to critically examine the predictive relationship between the independent and dependent variables. As noted earlier, minimal data has not quantified the trauma and reoccurring homeless in the

USVI. Several of the existing literature involved random and convenient sampling methods; however, many authors acknowledged the limitations of the sampling method used. For example, Deck and Platt (2015) used a convenience sample and selected participants at one shelter over a two- month period. The sample was only comprised of men and therefore, could not be generalized to other populations (Deck & Platt, 2015). Deck and Platt (2015) used descriptive statistics and an Independent *t*-test to analyze the results of the PTSD screens to determine differences among the variables. Kim et al., (2010) used a bivariate logistical analysis to identify relationships between two variables at a time. Since I had multiple independent and dependent variables, a multivariate regression analysis was best to analyze the data to predict relationships among the variables; I explained this further in Chapter 3.

Summary

Homelessness is a multifaceted problem and therefore requires a multidimensional view of solving this problem. With the many pathways to homelessness, individuals who are homeless find themselves in a quandary of systemic web. Moreover, coupled with childhood trauma and trauma experienced during homelessness, the reoccurring cycle of homelessness is never ending. Complex and cumulative trauma have been shown to increase symptoms of mental illness such as depression, anxiety, and PTSD as well as substance use (Briere et al., 2016; Deck & Platt, 2015; Helfrich, Peters, & Chan, 2011).

The recurrent nature of homelessness is evident throughout the literature; however, reoccurring homelessness, which suggests a period of stable housing and the

unpredictable cycle of being homeless again, and trauma have not been examined. This study sought to fulfill the gap in the USVI literature related to trauma and homelessness. By studying the homeless population in the USVI, the results from the study helped to identify traumas experienced by people who are homeless and how these trauma influence housing stability, duration of homelessness, service utilization. Furthermore, the results will hopefully highlight the importance of addressing trauma in the lives of people who are homeless by implementing a trauma-informed care approach in to services for persons who are homeless or at risk for homelessness.

Chapter 3: Research Method

Introduction

Researchers have used various research methods and designs to study the homeless and homelessness. These methods include quantitative, qualitative, and mixed-methods. Some of the designs include quasi-experimental, longitudinal, and correlational studies. In this chapter, I discussed the research design and rationale, sampling method, procedures for collecting data, instrumentation, threats to internal and external validity, and ethical concerns.

Research Design and Rationale

In this study, I used a quantitative research design method. I used a cross-sectional design to examine the potential relationships between the independent variable (trauma) and dependent variable (reoccurring homelessness). Quantitative researchers use experiments, quasi-experiments, non-experiments, and cross-sectional designs to test hypotheses and examine differences and relationships and make predictions about the variables (Wendorf, 2004). Cross-sectional designs are common among social science researchers because they do not involve manipulation of the variables and the variables can be measured in their natural settings (Campbell & Stanley, 1963).

People who are homeless are categorized as a vulnerable population; hence, conducting a true experiment could bring potential harm to participants (Protecting Human Research Participants, 2008). Since I did not manipulate the independent variables, the study did not align with an experiment or a quasi-experiment.

Several studies on trauma and homelessness utilized a cross-sectional correlation design, which collects data at one time (Campbell & Stanley, 1963; Carlson et al., 2013; Mitchell, 1985; Kim & Arnold, 2004; Wong et al., 2016). Two strengths of a cross-sectional design are that it is less expensive than true experiments and participants do not have to be randomly assigned to a comparison group (Babbie, 1990; Drost, 2011; Mason & Perreault, 1991). Two limitations are the lack of control the researcher has over confounding variables and the inability to make causal inferences (Drost, 2011; Levin, 2006; Mason & Perreault, 1991). Therefore, when analyzing the data, I cannot conclude that trauma causes reoccurring homelessness. Despite the limitations, by using a cross-sectional design, I collected data at one point and analyzed the data using the Statistical Package for the Social Sciences (SPSS) version 23.

Variables

Using a cross-sectional design, I examined the potential predictive relationship between trauma and re-occurring homelessness while controlling for demographic factors. The independent variables levels of measurement include nominal and ordinal data. Trauma was measured with the Trauma History Questionnaire (THQ) (see Appendix A) and included sexual abuse, physical abuse, combat experience, natural disasters, and witnessing violence. The demographic factors were measured with the Residential TimeLine Follow Back (RTLFB) (see Appendix B) and included age, gender, education level, mental illness status, substance abuse, employment history. The dependent variable, reoccurring homelessness, was also measured with the RTLFB. The

levels of measurements for the dependent variable are continuous and interval data and included housing stability, duration of homelessness, and service utilization.

Research Question

RQ: Is trauma predictively related to reoccurring homelessness while controlling for demographic factors?

Hypotheses

H_0: Trauma is not predictively related to reoccurring homelessness while controlling for demographic factors.

H_1: Trauma is predictively related to reoccurring homelessness while controlling for demographic factors.

Methodology

Population

The USVI is comprised of three main islands; however, I drew samples from St. Thomas and St. Croix as they had more persons who were homeless than St. John. I used the following inclusion criteria, adult males or females who were over the age of 18, met the operational definitions for homeless and homelessness, and were enrolled in or received services such as food stamps, social security disability, supportive housing program, or rental assistance from the Methodist Training and Outreach Center (MTOC), Catholic Charities of the Virgin Islands (CCVI), or Department of Human Services (DHS). The sample did not include homeless youths, persons located in stable housing, or persons who did not receive services from the MTOC, CCVI, or DHS.

Sampling and Sampling Procedure

While the random sampling method has its benefits, due to the transient nature of people who are homeless, it is not always feasible to capture a true random sample. The HMIS could also assist in the random sample; this would necessitate physically going to the location where homeless people congregate and could potentially pose a safety risk to the researcher. Instead, I used two nonprobability sampling methods: convenience sampling and purposive sampling.

Convenience sampling is the most common type of sampling method because it allows the researcher to select readily available participants (Acharya, Prakash, Saxena, & Nigam, 2013; Drost, 2011; Dudovskiy, 2017; Mason & Perreault, 1991). Since my selected population is scattered across two islands, it is cost-effective to use convenience sampling and it saves time in collecting data. The limitations of using convenience sampling are that the results cannot be generalized to other populations, there is a potential for selection bias, and a higher level of sampling error can occur (Acharya et al., 2013; Drost, 2011; Dudovskiy, 2017; Mason & Perreault, 1991).

The executive director of CCVI granted me permission to access clients who were homeless; I went to the shelters on St. Thomas and St. Croix (St. John does not have a shelter) at various times, but mainly between lunch and dinner time. With the shelter managers, I discussed the procedure for engaging participants, which included introducing myself to potential participants and reading the disclosure statement (see Appendix C and Appendix D). Since the homeless population in the USVI is small,

shelter workers were able to identify willing participants. I used a combination of purposive sampling and convenience sampling to select participants from CCVI shelters.

Purposive sampling is unique in that the researcher can be selective with participants who meet the inclusion criteria as well as select participants who would be able to answer research questions and enhance the data (Drost, 2011; Mason & Perreault, 1991; Dudovskiy, 2017). Within homeless shelters, there is a sense of community; hence, shelter workers can direct me to individuals who they know can answer the questions. Purposive sampling has the same limitations as convenience sampling; I chose these two sampling methods because they aligned with the purpose of my study, narrowed my search for participants by being intentional in using organizations that served the homeless, and maximized my time in searching for potential participants.

I also used purposive sampling to select potential participants from DHS and MTOC. I gave participants a flyer inviting them to participate in the research (see Appendix E). The flyer included the date, time and place for participants to complete the informed consent and other data collection materials via self-administered instruments and one interview. The program managers for the supportive housing programs at DHS and MTOC assisted in identifying select participants. I explained the procedure for recruitment in the procedure section.

Sample Size

The study examined the potential predictive relationship between trauma and reoccurring homelessness in the USVI, while controlling for demographic factors. The USVI has 307 homeless of which I selected a sample based on the statistical power and

effect size (Burkholder, n. d.; Rahman, 2013). The statistical power is the probability that a given statistical test will detect a relationship between the independent and dependent variables; whereas the effect size would determine how strong the relationships are among the variables (Burkholder, n. d.; Rahman, 2013).

A large effect size would suggest a small sample size, which would yield greater differences and indicate a stronger relationship between the independent and dependent variables. In addition, a large effect size may help to reduce sampling errors encountered with non-probability sampling methods (Burkholder, n. d.; Rahman, 2013). Based on the multiple linear regression statistical test, I used a medium effect size of .15 with a power of .95 and a confidence level of .05 (Faul, Erdfelder, Lang, & Buchner, 2007; Sample Size Calculator, 2004). Therefore, the estimated sample size was $N = 89$ homeless participants. However, the actual sample was $N = 73$. Although reducing the sample size in quantitative research is not ideal, using a vulnerable population that is also transient, proved difficult to capture all 89 samples. Furthermore, unlike larger cities that have homeless shelters, the USVI has two shelters with a capacity of 40 beds. The homeless population in the USVI is small, this sample size would be adequate to generalize to the homeless population living in the USVI and give a snapshot of the impact of trauma in persons who are homeless. Sample size limitations is further discussed in Chapters 4 and 5.

Procedure

This study was approved by the Walden University Institutional Review Board (IRB) prior to recruitment and data collection. In this study, I examined a population that

is considered vulnerable (Protecting Human Research Participants, 2008). Any research that involves human subjects must be approved by the Institutional Review Board (IRB) affiliated with the university or other institution where the study occurs (Protecting Human Research Participants, 2008). Walden's IRB approval number is 08-16-18-0527949 and expired on 08-15-2019. The following paragraphs details the procedure for the study:

Recruitment

I sent a letter to the MTOC, DHS, and CCVI requesting permission to conduct my research with clients they serve (see Appendix F). I designed a flyer was and distributed to recruit participants at DHS and MTOC using a purposive sampling method (see Appendix E) However, due the location of DHS, it was hard for participants to come to this location. As result, I mainly recruited participants from the MTOC and CCVI. I posted the flyer in the lobby of DHS and at the MTOC office on St. Thomas. I also distributed flyers to CCVI during the food distribution line.

I used convenience sampling method to recruit participants at the CCVI shelters on St. Thomas and St. Croix. St. John does not have a shelter and I did not recruit participants from this island. At various times throughout the day (10am-1pm and 5-7pm) I visited the Shelter on St. Thomas to recruit and collect data. The shelter on St. Croix was destroyed by the hurricane, therefore, no residents were housed. Instead, I rode around in the CCVI van with the shelter worker during food distribution to recruit and collect data. The shelter manger and staff assisted in identifying potential participants based on the inclusion criteria (homeless, adult male or female, over the age of 18 years,

and receive services from MTOC, DHS and CCVI) and I discussed with the shelter manager my procedures for engaging participants, which included introducing myself to potential participants, and reading the disclosure statement. I visited the shelters on St. Thomas and St. Croix for two to three days within a three-week period to collect data until I achieved the desired sample size.

Participants did not receive any monetary incentives and this dissertation study was not funded by any grants. However, using personal resources, I provided each participant with a homeless care kit with basic hygiene products and non-perishable snacks and an informational brochure on trauma and grounding techniques. Regardless of if a participant completed the questionnaires or withdrew, they received the care kit. The care kit included: toothbrush, toothpaste, soap, deodorant, hand sanitizer, non-perishable food items, socks, comb, plastic utensils, and female hygiene products. The sampling procedure was repeated, and I ended with a sample size of N=73.

Participation

Once participants were identified, I read the informed consent, which described the nature of the study, compensation, risks and benefits for participating in the study (Protecting Human Research Participants, 2008) (see Appendix D). Participants signed either with their name or an ‘X’ and dated the informed consent. Participation in this study is completely voluntary and participants had the option to withdraw from the study without any adverse effects at any point. If a participant is unable to read, I provided the participant with a pre-recorded audio of the THQ questions. Once participants completed the questionnaires, I thanked the individual for their time and gave them a care kit.

Data Collection

I used two instruments to collect data, which were the RTLFB, to determine housing stability, demographic factors, and the THQ, to determine types of trauma (see Appendices A and B). I did not need permission to use the THQ; however, I received permission to use the RTLFB (see Appendix G). I used the RTLFB first and then the THQ. My rationale for structuring the instruments this way is that the THQ could potentially trigger participants; thus, placing the RTLFB first would act as a protective measure and participants may feel less threatened and would be more apt to answer the THQ honestly (Bradburn, Sudman, & Wansink, 2004).

The RTLFB is a structured interview that can last from five minutes to 45 minutes; this instrument covered many variables in this study including demographic factors, such as age, gender, education level, mental illness status, substance abuse, and employment history. I also collected data on reoccurring homelessness including housing stability, duration of homelessness, and service utilization. Since I am studying a vulnerable population, 30- to 45-minute interviews will be taxing. I modified the demographics and RTLFB to collect the data via self-report in about 10-15 minutes (see Appendix B). Participants completed the questionnaires in a confidential area in the shelters or at the Department of Human Services on St Thomas and St. Croix. I did not use participants names on the instruments, instead, I assigned a number to each participant so that privacy can be maintained.

I used the THQ to collect data on sexual abuse, physical abuse, combat experience, natural disasters, and witnessing violence. Participants completed this

instrument via self-report, which meant the participant read the questions and answered the 24-item questionnaire. If a participant was unable to read or understand the questions, I provided a pre-recorded audio of the questions and participants listened to the questions and respond accordingly. I made paper copies of each instrument, RTLFB and THQ. I described each instrument in the next section.

Instrumentation and Operationalization

Instruments are used to collect data on various constructs; for example, I examined the constructs of trauma using the THQ, and reoccurring homelessness using the RTLFB (Hopper et al., 2011; Tsemberis et al., 2007). It is important for researchers to select instruments that are reliable and valid as these can affect the outcome of the data. In the following paragraphs, I discussed each instrument including the reliability and validity of each instrument.

Residential Timeline Follow- Back

The RTLFB measures homelessness and covers eight domains, which are participant demographics and history, physical health, housing stability and the extent of homelessness, substance use, mental health symptoms, perceived quality of life, service utilization and illegal activity, and contact with the legal system (Tsemberis et al., 2007). I used five of the domains for the purpose of this dissertation study, demographics and history, housing stability and the extent of homelessness, substance use, mental health symptoms, and service utilization (Tsemberis et al., 2007). I did not use the remaining three domains, physical health, perceived quality of life, and illegal activity, and contact with the legal system as these domains did not align with the purpose of the study. The

RTLFB uses a six-month period for participants to recall his or her housing status (Tsemberis et al., 2007). For example, participants are asked “where have you lived in the past six months?” (Tsemberis et al., 2007). The interviewer then creates a timeline of each living situation as reported by the participant. The measure of homelessness was described in four categories which are: “1) institutional residences, 2) stable residences, 3) temporary residences, and 4) literal homelessness” (Tsemberis et al., 2007, p.35). The RTLFB is administered via a structured interview which ranges from five to 45 minutes depending on the number of moves reported (Tsemberis et al., 2007) (see Appendix B).

Validity and Reliability

The Residential RLFB has good validity and reliability scores (Tsemberis et al., 2007). The authors used test-retest method to determine reliability of the instrument; for example, the intra-class correlation coefficient (ICC) indicated high consistency across residential measures (ICC = 0.83- 0.93) with confidence intervals set at 95% (Tsemberis et al., 2007). The validity scores indicated a strong relationship among types of housing stability, literal homelessness, stable housing, temporary settings, and institutional settings experienced by the homeless. The scores ranged from “0.84 for stable housing to 0.92 for literal homelessness” (Tsemberis et al., 2007, p. 38).

The data gathered from the RTLFB measured reoccurring homelessness by examining housing stability, duration of homelessness, and service utilization. Based on participant’s responses, housing stability and duration of homelessness will be measured by the number of moves and length of interval between moves (Tsemberis et al., 2007). The information presented in the RTLFB is categorical and thus will allow me to measure

reoccurring homelessness as evidenced by patterns of housing stability and service use, and the duration of homelessness as evidenced by number of years and frequency of moves (Tsemberis et al., 2007).

The Residential Time-line Follow Back was designed in Canada, therefore some of the demographic questions will not be relevant to the USVI. As a result, removed the wording (Canada, or other non- related language) to reflect geographical locations and local language relating to the USVI. Although the RTLFB is a valid and reliable, the instrument has not been used on the homeless population in the USVI, thus, there may be some differences in the outcome. I discussed these differences in chapter five. I received permission to use the RTLFB instrument by contacting Sam Tsemberis and Dr. Tim Aubry via email. In addition, the instruments grants permission to be modified based on the researcher's location and needs (see Appendix G).

Trauma History Questionnaire

The THQ was developed by Green (1996); it is a self-reported instrument that measures the lifetime exposure to traumatic events across three categories (as cited in Coates & McKenzie-Mohr, 2010; Hopper et al., 2011). The THQ has 24-items with a response of yes or no to the questions. Participants are also asked to include the number of times the event occurred and at what age the first incident happened (Hopper et al., 2011). The THQ uses nominal scaling to measure the construct of trauma. The scoring protocol include summing the number to traumatic events overall or via the subscales. The THQ is short, easy to use and culturally sensitive (Hopper et al., 2011).

Validity and Reliability

The THQ is a reliable and valid instrument that captures traumatic experiences from three broad categories, which are crime related events, general disaster and trauma, and unwanted physical and sexual experiences (Hooper, Stockton, Krupnick, & Green, 2011). Validity refers to how well the instrument measures the construct, in this case, trauma (Frankfort-Nachmias, 2015). The authors used four types of validity in the THQ, which are construct validity, face validity, content validity, and cultural validity (Hopper et al., 2011). Content validity measures the construct against other instruments; for example, the THQ was compared to other instruments that measured trauma, such as the Stressful Life Event Questionnaire (SLEQ) (Hopper et al., 2011). The results of the Kapp Coefficient indicated a strong correlation between the THQ and the SLEQ (k = .61 to 1.00) (Hopper et al., 2011).

Reliability measure how consistent the instrument is a measuring the construct across various populations and settings (Hopper et al., 2011; Winter, 2000). The authors first piloted the THQ to 432 college students and used a subsample of 25 females to examine the test-retest method to establish the reliability (Hopper et al., 2011). The THQ was administered at two and three-month intervals and the results indicated a range .54 to .92 (Hooper et al., 2011). A coefficient of .70 or greater is acceptable. The THQ also used interrater reliability testing by administering the instrument via an interview format and the results of the Kappa coefficients indicated fair to excellent interrater reliability that ranged from .57 to .82 (Hopper et al., 2011). The THQ is an open access tool and does

not need written permission to use; however, proper acknowledgement and reference will be made on each form.

Data Analysis Plan

Correlational studies help researchers to identify relationships between and among the independent and dependent variables as well as how well these variables predict outcomes (Drost, 2011; Mason & Perreault, 1991; Institute for Digital Research and Education, 2016). I used multiple linear regression analysis since there were more than one independent and dependent variables for this study and I examined the predictive relationship between trauma and reoccurring homelessness while controlling for demographic factors (Institute for Digital Research and Education, 2016). Once the data was collected, I entered and analyzed the data using the Statistical Package for Social Sciences version 23 (SPSS). The results from the study is expected to show the relationship of trauma to reoccurring homelessness, meaning, does trauma predict reoccurring homelessness, as measured by housing stability, duration of homelessness, and service utilization among people who are homeless, while controlling for demographic factors?

Once all data was collected, I reviewed all completed questionnaires and highlighted missing data. I then separated incomplete questionnaires that had more than 50% missing data. I create a codebook in excel spreadsheet with all variables and color coded each variable. I then entered data into SPSS and ran descriptive analysis and multiple linear regression analysis. Data cleaning was done to remove missing values and combine variables that were repetitive. Data analysis was conducted two additional times

to verify results of descriptive statistics and multiple linear regression analyses. Finally, the results are recorded in Chapters 4 and 5.

Data Cleaning

Data cleaning is the process wherein the researcher searches for inaccurate, missing, invalid or incomplete data (Gläser & Laudel, 2013). During data collection, participants may omit a question or answer inaccurately, thereby rendering the data invalid. Invalid data can affect statistical analysis, thus, impacting the outcome of the study. My data cleaning plan included cross checking data entries, eliminating questionnaires that are 50% or more incomplete and creating a codebook. I consulted with committee members to validate data accuracy.

Three important steps to data cleaning are, identifying the number of non-responses or missing data, alterations (editing), and weighting and standard errors (Díaz de Rada, 2014). According to Díaz de Rada (2014), the number of non-responses determines the weighting and standard errors; this means the researcher should factor in how much of the non-responses will positively or negatively influence the data analysis.

Assumptions of Multiple Linear Regression Analysis

In a multiple regression analysis, the researcher is assessing significance across multiple independent and dependent variables, while controlling for covariates (Statistics Solution, 2016). In this study, the covariates are the demographic factors, which would not influence the relationship between the independent and dependent variables (Statistics Solutions, 2016). Some of the assumptions of multiple linear regression analysis are the level of measurements for the independent variable (IV) are categorical or continuous and

the dependent variable (DV) are interval or ratio. There is an absence of multicollinearity, which means that the DVs cannot be correlated to each other. In addition, homogeneity of variance suggests that the difference between the group is equal; and the relationship between covariates and the dependent variables can be assessed by using a correlational analysis (Statistics Solutions, 2016).

Threats to Validity

As with many research studies, threats to validity may impact the data analysis and interpretation. There are two types of threats to validity, which are internal threats and external threats (Drost, 2011; Wendorf, 2004; Winter, 2000). To some degree, the researcher has control over internal threats but not external threats. I addressed both internal and external threats to validity as it relates to this dissertation study.

Threats of Internal Validity

There are eight threats to internal validity, which are history, maturation, testing, instrumentation, statistical regression, research reactivity, selection bias, and attrition (Cook & Campbell, 1979; Winter, 2000). Of the eight threats, instrumentation, selection bias, and attrition could potentially affect my data results. One way to minimize the threat of instrumentation is to use instruments that have good validity and reliability properties as in the THQ and RTLFB. Selection bias may be unavoidable as I used a purposive sampling which uses the subjectivity of the researcher and therefore influences the types of participants selected (Cook & Campbell, 1979; Drost, 2011; Mitchell, 1985). The threat of attrition occurs when participants may discontinue or refuse to answer the questionnaire, thus, impacting the results. To minimize the threat of attrition is to

thoroughly explain the purpose of the study to participants and have a large sample size (Cook & Campbell, 1979).

Threats of External Validity

External validity refers how well the results can be generalized to other populations, settings and time (Cook & Campbell, 1979; Mitchell, 1985, Winter, 2000). Since I am using a non-probability sampling method, it is unlikely that the results will be transferrable to other non-homeless populations. One possible external validity threat is the interaction of setting and treatment, which suggests that the results may not be generalized to the wider general population in the USVI (Cook & Campbell, 1979; Winter, 2000). The threat of interaction setting, and treatment could occur if I tried to generalize the results to persons who are no longer deemed homeless. A second threat to external validity is the interaction of selection and treatment, which means that the results cannot be generalized to men who are incarcerated. One way to circumvent threats to external validity is to conduct the research among various populations and settings.

Ethical Procedures

Threats to validity could be a potential ethical violation if the researcher does not disclose the limitations of the study. The American Counseling Association *Code of Ethics* (ACA, 2014) outlines ethical codes for conducting research with human subjects. Researchers should not bring intentional harm to participants or research assistants (ACA, 2014; Endicott, 2010). People who are homeless are considered a vulnerable population and may feel coerced to participate in a study (Deck & Platt, 2015; Lee et al., 2010; Menih, 2013); however, I abided by the guidelines contained in the Protecting

Human Research Participants (2008) and the Institutional Review Board (IRB), to ensure that I adhere to ethical guidelines when conducting research on vulnerable populations (Menih, 2013; Protecting Human Research Participants, 2008; Walden University, 2014).

The nature of my study could potentially cause unintentional harm to participants. Although the THQ will be completed by the participants, some of the questions maybe emotionally triggering for some participants; as a result, I put protective factors in place to protect the welfare of participants. Some of these protective factors were the disclosure statements and informed consent, which delineated the risk and benefits of participating in the study, offering referrals for free counseling to participants to local psychologists at the conclusion, and a debriefing handout, which includes trauma-informed care principals, ways to cope with trauma and relaxation skills to reduce emotional triggers (Endicott, 2010) (see Appendix H). Some of the studies on the homeless did not identify trauma triggers as a limitation of their study (Tsai, Rosenheck, Decker, Desai, & Harpaz-Rotem, 2012).

Other ethical concerns were the storage of data and files. Since I used paper forms, participants were assigned a number and forms were kept in a locked file cabinet at the Department of Human Services in the Office of the Commissioner. I, along with Mrs. Janet Turnbull-Krigger had access to the files. Completed questionnaires will be kept for a minimum of five years after which all data will be destroyed via shredding and deleting files from the jump drive. Once the data was entered into SPSS, reports and syntax are stored on a secured jump drive that is password protected. In addition, all materials and any handwritten notes taken were stored in a locked file cabinet at the

Department of Human Services in the Office of the Commissioner and access restricted to Mrs. Janet Turnbull-Krigger and I. When the laptop was not in use, it was always in my possession. Once all data was collected in St. Thomas and St. Croix, I returned to Port Charlotte, Florida (FL) with all documents and data, which was stored in my home and placed in a locked storage container in Port Charlotte, FL.

Trauma is a sensitive topic and therefore some of the questions could potentially triggers participants. I am a licensed mental health counselor and a certified clinical trauma professional. If a participant is experienced discomfort, I provided brief interventions, such as grounding and relaxation skills to reorient the participant. For example, I would teach participants deep breathing exercises and grounding technique using the five senses to reduce triggers. I also provided the names of two local psychologists, Dr. Sheena Walker and Dr. Rita Dudley-Grant, should the participant be interested in attending counseling (See Appendix I). Participants received a debriefing brochure with information on trauma-informed care approach and grounding techniques (see Appendix H).

Summary

In the chapter, I described the methodology, instrumentation, data analysis and threats to validity. Ethical research protects participants as well as the integrity of the counseling profession. Although I cannot guarantee confidentiality or no risk, I endeavor to implement ethical practice at outlined in the ACA *code of ethics* (ACA, 2014) and Protecting Human Research Participants (2008). In Chapter 4, I discussed and interpreted

the results of my data analysis. I reported descriptive statistics and answered the research question based on the results of the multiple linear regression.

Chapter 4: Results

Introduction

Data collection is a central aspect of quantitative research. Unlike qualitative research, which involves themes, quantitative research looks at numbers to answer research questions. Through this cross-sectional correlational design, I examined potential predictive relationship of trauma (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence, and other traumatic experiences) on reoccurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the United States Virgin Islands (USVI) , while controlling for demographic factors (age, gender, education level, mental illness status, substance abuse, employment history).

The results of the study may help explain the impact trauma has on homelessness, thereby highlighting the importance for specialized programs, policies, and legislative actions to reduce homelessness in the USVI. I used two instruments to collect data from participants, which were the Trauma History Questionnaire (THQ) and Residential TimeLine Follow Back (RTLFB). The THQ consists of continuous levels of measurements and the RTLFB consists of intervals and categorical levels of measurements. In this chapter, I will discuss the results of the data analysis and whether or not the hypothesis was accepted or rejected.

Research Question

RQ: Is trauma predictively related to reoccurring homelessness while controlling for demographic factors?

Hypotheses

H_0: Trauma is not predictively related to reoccurring homelessness while controlling for demographic factors.

H_1: Trauma is predictively related to reoccurring homelessness while controlling for demographic factors.

Data Collection

Data were collected in St. Thomas and St. Croix between September 17 and 28 and November 7 and 15, 2018. Participants were initially to come to the Department of Human Services (DHS) or Methodist Training and Outreach Center (MTOC) on designated days and times; however, logistically it was not possible for participants to come to the DHS as it was some distance from where the homeless congregated. As an alternative, I used the conference room at the MTOC and CCVI to interview participants. For two days, I visited the Market Square area in St. Thomas to observe potential participants between 10:30 a.m. and 1:00 p.m.; I then approached participants and introduced myself and told them about the study; if they agreed to be interviewed, I took each participant to the MTOC conference room, where I reviewed the consent form and had the participant sign. Once the consent form was signed, I started with the RTLFB questions, followed by the THQ. Once all questions were answered, I thanked participant for their time and proceed to give them the care kit. For about four days, I visited the Bethlehem Shelter between the hours of 9:30 a.m. and 11:00 a.m. and 3:00 p.m. and 6:00 p.m. I used the main office at the shelter to interview participants. Residents of the shelter

were approached and asked if they would be interested in participating in the study. If they agreed, I took them to the main office and proceeded with the consent forms.

For three days, I visited the CCVI and interviewed a few participants in an office; however, most of the participants were recruited and interviewed in the field. The soup kitchen in St. Thomas was a hot meal food distribution line between the hours of 11:30 a.m. and 1:30 p.m. It was difficult to recruit participants as their main focus was receiving lunch. However, I attempted to approach a few individuals and had four participants who agreed to be interviewed. Participants were brought into the office individually, where I proceeded to review the consent form and have them sign the form. Once the consent form was signed, I proceeded with asking participants questions from the RTLFB and THQ. I thanked each participant and gave them the care kit. In addition to the food distribution line, caseworkers went out in the field and delivered hot meals to homeless persons. Since this was a viable means of obtaining participants, I rode with case workers to various areas in St. Thomas, namely Contant, Smith Bay, Tutu, Subbase, and Mitchell Motel. For a total of four days, I visited these areas and recruited and interviewed participants. This is where the purposive sampling method was used as case workers were able to identify potential participants. Selected participants were interviewed out in the open or in a van. Although this was not ideal, it was the only way to capture participants' data. I ensured that no one was around to hear their answers except for the shelter worker, who understood the terms of confidentiality. I spoke in a low voice to maintain some confidentiality. Participants did not seem particularly bothered being interviewed in the open and responded to the questionnaires thoughtfully.

Participants were aware that if they felt triggered, they could withdraw from the study or seek help from Dr. Sheena Walker (in St. Thomas) or Dr. Rita Dudley-Grant (in St. Croix). None of the participants requested counseling services, nor did I use any grounding techniques with participants. However, I used basic counseling skills such as reflecting feelings, reflecting content, summarizing, and validating participants if they appeared triggered.

In St. Croix, the CCVI shelter was damaged by Hurricanes Irma and Maria; case managers delivered food to the homeless. For a total of four days, I drove around with case managers and they identified potential participants that would respond to the questionnaires. I approached participants and introduced myself, and if consent was given, I proceeded to complete questionnaires. In some cases, the shelter workers introduced me to create rapport between participants and myself. At no time did the shelter worker coerce participants to comply. Participants not included in the study were persons who were not homeless, youths, persons under the influence of drugs or alcohol, and those who were in a manic episode or experiencing psychosis.

In the end, of the total number of participants was $N = 73$. The original sample size was to be $N= 89$; however, the nature of the homeless population in the USVI was such that it was difficulty to capture this number of participants. In addition, the two dependent variables, duration of homelessness and housing stability, were not significant. Hence, the R squared values would not have been impacted with a larger sample size. I discussed the sample size limitations in the Chapter 5.

Data Cleaning

In the following paragraphs, I described the data cleaning process. Seventy-three samples were collected (*n* = 73). No samples were discarded. For the trauma variables, initially I had five categories; however, a sixth category, other traumatic experiences, was added to capture all the trauma questions. Each THQ question was placed into each of the variables as follows: sexual abuse-questions 18-20; physical abuse-questions 10, 21-23; combat experience- question 17; natural disaster-questions 6, 8; witnessing violence-questions 7,11-12, and Other Traumatic Experiences- questions 1-5, 9, 13-16, 24. Questions for each variable were then computed to give a composite subscale.

Reoccurring homelessness variables included, duration of homelessness, housing stability, and service utilization. The RTLFB is typically a 45-minute semi-structured interview; however, due the nature of how I collected data, participants spent 10-15 minutes answering questions. Questions 12c-19 were omitted as they were repetitious. In addition, I asked participants open-ended questions to yield more information to answer questions 1-11. Questions with dates were also skipped as many of the homeless had difficulty recalling dates they moved into a particular area. These omitted questions did not have a negative impact on the results. On the RTLFB, question #22 (total time of homelessness) related to duration of homelessness. Participants gave the year, which was then converted to months.

In order for housing stability to be converted in to a scale measurement, I first ranked the housing variables. For example, there were five categories of housing: shelter=1, street=2, family/friend=3, program/jail=4, and abandoned building=5. Housing

stability was ranked from most stable (5) to least stable (1). Therefore, current housing and previous housing were recoded as follows: family/friends=5, program/jail=4, shelter=3, abandoned building =2, and street=1. A subscale for housing stability (HS_subscale) was then calculated by adding current housing and previous housing. Missing data is not accounted for in scaled measurements, therefore, values that were missing were given a value of zero (0). Similarly, service utilization was also recoded into a scale level of measurement. On the RTLFB, questions #6, #14 (services received), and #15 (income sources) were used to determine service utilization. For example, services received, and income sources were recoded and ranked from lowest to highest- 0= no services, 1= food/clothing, 2 mental health/medical, and 3 = disability/SSCK. The subscale, SRVC_UTILZ was created to calculate the frequency of services used by the homeless. Therefore, if a participant answered 1 on services received and 3 on income sources, the participant's service utilization score was 4.

Results

Descriptive Statistics

Demographics. Of the $n = 73$ participants, 20.5% were females and 79.5% were males. The minimum age of participants was 21 years and the maximum age of participants was 73 years. The average age of participants was 49.17 years (SD = 12.03). The cultural identity of homeless population consisted of 64% Black, 15% White, 8% other, 7% Latin American/ Hispanic, and 5% Biracial. Birthplaces varied, and 37% of the homeless population were born on St. Thomas, 25% were from other Caribbean islands, 23% were from the U.S. Mainland, and 15% were from St. Croix. As it relates to marital

status among the homeless population the majority were single (73%), however, 14% were divorced, 8% were separated, and only 1% were married. Most of the homeless sample were high school graduates or GED equivalent (32%), 10% completed college or technical school, 14% attended college or technical school but did not complete their program. In addition, 43% had a fifth to eleventh grade education. Of those sampled, 81% acknowledged that they have worked for at least one year in the past, yet 56% are currently unemployed. Almost a quarter of the participants (23%) considered themselves self-employed and reported jobs such as landscaping, recycling, mechanic, washing cars, and cleaning/janitorial services. Of the 56% who were unemployed, the reasons cited were as follows: 18% could not find work, 25% reported a physical illness or disability, 11% reported mental illness, and 10% reported unemployment due to being homeless. Even though the majority of the homeless sampled were unemployed, 50.7% received food stamps. Persons who are homeless are resourceful, hence many of the participant had some sources of income in order to survive. For example, 8.2% of participants collected recycles or received a disability or social security check.

Studies have shown that 20-30% of the homeless population suffer from mental illness (SAMHSA, 2018). In the USVI, this also proved to be so, as 20.5% of the sample reported having a mental illness or being hospitalized for mental illness and 19% reported having a substance abuse history or receiving treatment for substance abuse or alcohol abuse. Unfortunately, mental health and medical services for the homeless are lacking in the USVI, hence only 5% of the homeless population acknowledged receiving mental health/medical services. Many persons who are homeless have a history of incarceration.

Researchers have also found a connection with incarceration and homelessness (Kim et al., 2010; Mogk, Shmigol, Futrell, Stover, & Hagopian, 2019). The results of this dissertation study showed that 56% of participants denied any prior arrests and 13% had a positive arrest history. See Table 1 for other demographics variables, frequencies and percentages.

Table 1

Frequencies and Percentages for Immigration Status and Language

Variable	*n*	%
Status		
Citizen	61	83.56
Permanent Resident	10	13.70
Immigrant/Visitor	2	2.74
Language		
English	50	68.49
2 Or More Languages	23	31.51

Trauma. Many studies correlated adverse childhood experiences (ACEs) as a risk factor for homelessness and examined the history of trauma among formerly homeless individuals (Larkin & Park, 2012; Roos, 2013). Few studies examined those currently experiencing homeless and types of trauma they experience. Initially, five trauma variables were identified; however, after examining each variable and category, it was determined to add a sixth variable, which was other traumatic experiences.

From the data collected (n = 73), the results showed that 86.3% reported a history of physical abuse, 49.4% reported sexual abuse history, 92% reported experiences with natural disasters (mainly hurricanes), 100% reported witnessing violence, only 8% were in combat (mainly Vietnam War) and 100% reported experiencing other traumatic events. Trauma can occur at any age; however, for the homeless participants in this study, 41% experienced trauma between the ages of 20-35 and 28.8% experienced trauma age 36 or and older. Thus, suggesting that most of the trauma was experienced after becoming homeless. Only 16.4% experienced trauma throughout their lives including childhood, whereas only 6.8% experienced trauma in their adolescent years (13-19). Many times, an individual can experience more than one traumatic event. The homeless participants in this study was no different; 35.6% had at least 1-5 times of repeated trauma, 21.9 % had between 6-10 repeated trauma, 11% had 11-15 repeated trauma, and 27.4% had over 16 times of repeated trauma.

In addition, the THQ gives a cumulative trauma score, which suggests that the higher the score, the more traumatic events the individual witnessed or experienced. The results showed the lowest score was 0 and the highest score was 20. The mean trauma score was 7.27. Figure 1 shows a pie chart of repeated trauma and figure 2 shows trauma age of participants.

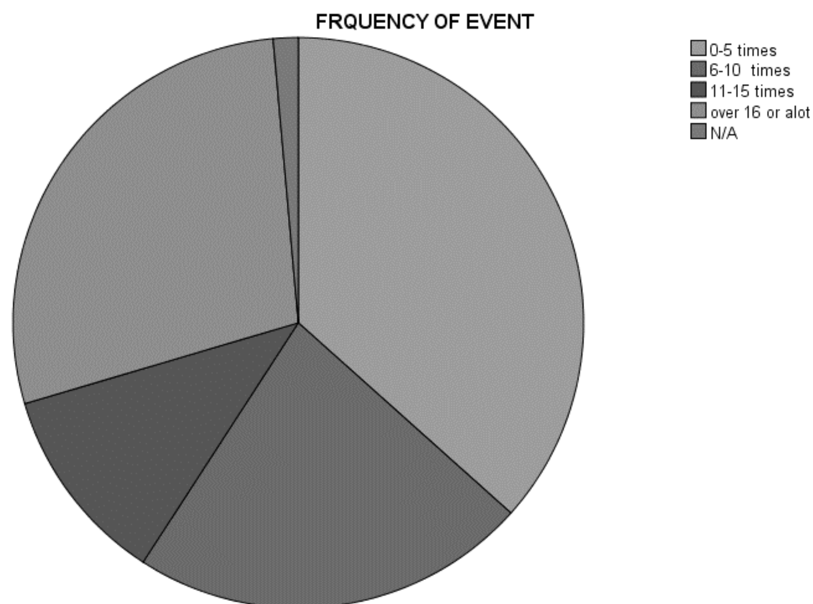


Figure 1. Trauma repeated.

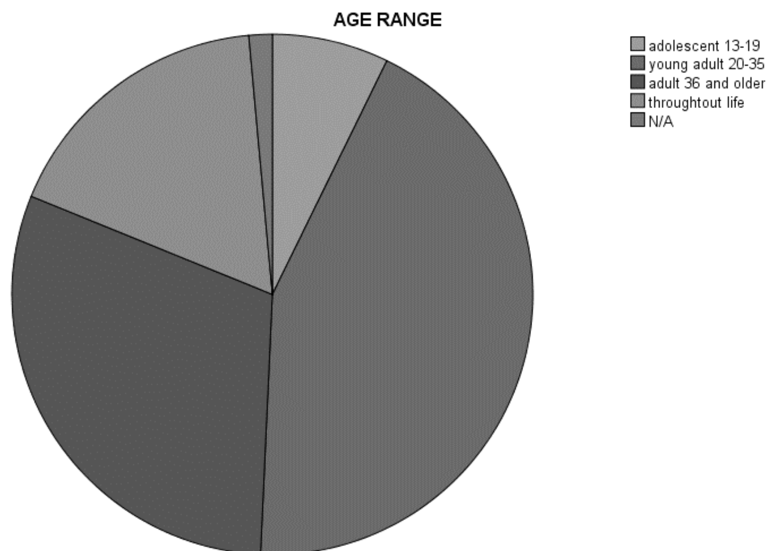


Figure 2. Trauma age.

Reoccurring Homelessness. Reoccurring homelessness was measured as duration of homelessness, housing stability, and service utilization. Duration of homelessness was measured as the total time being homeless. On average, participants

spent 127.07 months (or 10.58 years) homeless (*SD* = 144.31). The longest time participants spent homeless was 123.10 months (or 10.25 years) (*SD* = 140.79). Table 2 presents summary statistics for these variables.

Unlike other urban cities, wherein the homeless can migrate from one town the other, in the USVI, the homeless tend to stay in one central location with little to no movement. As a result, current housing showed that 32.9% of people who were homeless lived on the streets, 23.3 lived in an abandoned building, 15% lived in a shelter, 2.7% were either in a program/jail, and 15.1 lived with family/friends. Some participants indicated they had a previous housing prior to the current housing. As such, 21.9% lived on the street, 6.8% lived in an abandoned building or in a shelter, 5.5% were in a program/jail, and 21.9% lived with family/friends. Thirty-seven percent (37%) did not report a prior move. Seventy-three percent of participants had a second move and 27% had no previous move from the current housing; of this number, 44% lived with family/friends, 12% lived in a shelter or program, and 7% lived on the street. As it relates to the reasons for the second move, 19% indicated it was the only option, 43% left because of an unsafe situation, kick-out of discharged from a program or jail. Only 1% moved due to not liking shelters or preferred being on their own. Housing stability was measured by calculating the type of housing. For example, living on the street is less stable then living with family/friends. As a result, the housing stability subscale showed that 19.2% of the homeless has less housing stability than 13.7% who lived in more stable conditions. It should be noted that some participants went from a stable housing to less stable housing and vis versus. For example, participant 71 went from previous

housing of living on the streets to living with family/friends, whereas, participant 58 when from living with family/friends to living on the streets and participant 36 went from a program/jail to living in an abandoned building. The housing stability subscale had a mean of 4.15 std. deviation of 2.85. See Figure 3 for housing stability subscale.

Table 2

Summary Statistics for Continuous Variables

Variable	Minimum	Maximum	*M*	*SD*	*n*
First Homeless	1970.00	2018.00	2005.28	13.07	68
Total Time Homeless (Months)	2.00	504.00	127.07	144.31	61
Longest Time Homeless (Months)	2.00	504.00	123.10	140.79	61

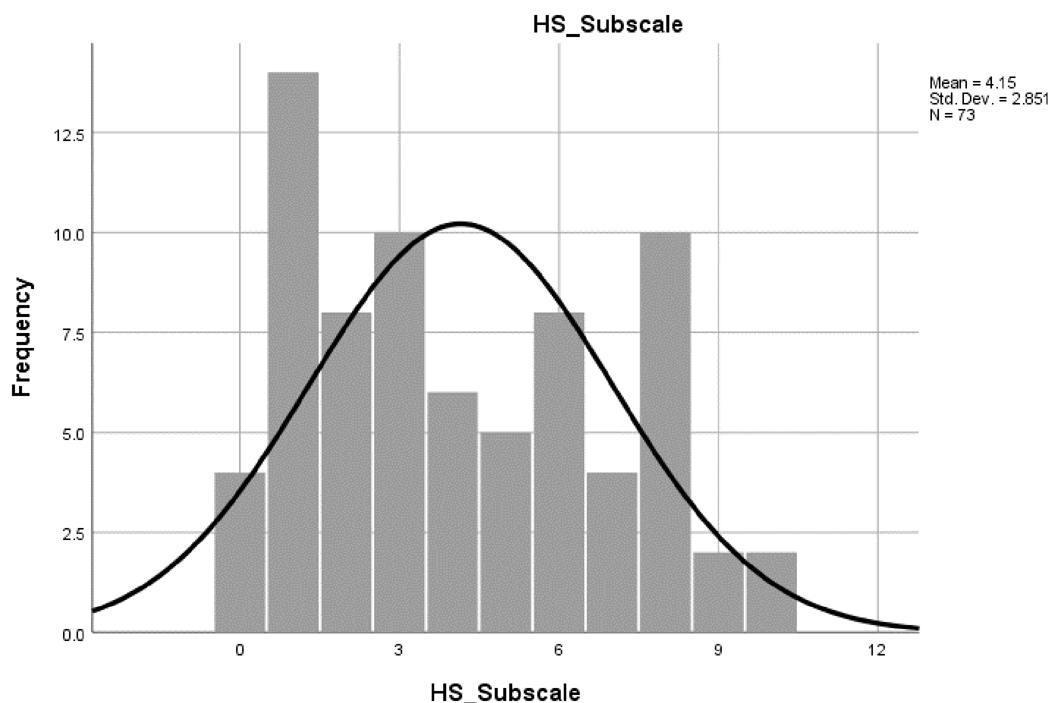


Figure 3. Housing Stability Subscale.

Data Analysis

To test the research question, a multiple regression statistical test was conducted. The multiple regression analysis helped to determine the predictive relationship between one dependent variable and one independent variable while controlling for demographic factors. There were three dependent variables (duration of homelessness, housing stability, and service utilization). There were six independent variables (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence, and other traumatic experiences, and six controlled variables (age, gender, education, employment history, mental illness, and substance abuse). The research question was is trauma predictively related to reoccurring homelessness? From this research question three models were generated to test the hypothesis. All assumptions for the multiple regression analysis were met. The following paragraphs shows the results of the three models.

Model 1: Results of Regression with Dependent Variable of Duration of Homelessness

Research Question

Is trauma predictively related to reoccurring homelessness while controlling for demographic factors?

Results. A multiple linear regression analysis was conducted to evaluate the prediction of duration of homelessness from sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence, and other traumatic experiences. The results of the multiple linear regression analysis revealed the independent variables were not statistically significant predictors to duration of homelessness when demographic

variables were controlled. The table of model summary shows the results and adjust R squared which was only 10% in variance when predictors were controlled. the model 1 when demographics were controlled and model 2. The confidence interval associated with the regression analysis does not contain 0, which means the null hypothesis can be accepted. See Table 3 for model summary for duration of homelessness.

Table 3

Model Summary for Duration of Homelessness (Total Time of Homelessness)

Model	R	R Squared	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.291[a]	.085	-.025	151.025	.085	.773	6	50	.595
2	.431[b]	.185	-.037	151.886	.101	.906	6	44	.500

a. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

Model 2: Results of Regression with Dependent Variable of Housing Stability

Research Question

Is trauma predictively related to housing stability while controlling for demographic factors?

Results. A multiple linear regression analysis was conducted to evaluate the prediction of housing stability from sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence, and other traumatic experiences. The results of the

multiple linear regression analysis revealed the independent variables were not statistically significant predictors to housing stability when demographic variables were controlled. The table of model summary shows the results and adjust R squared which was only 5% in variance when predictors were controlled. the model 1 when demographics were controlled and model 2. The confidence interval associated with the regression analysis does not contain 0, which means the null hypothesis can be accepted. See Table 4 for model summary of housing stability.

Table 4

Model Summary for Housing Stability (HS_Subscale)

Model	R	R Squared	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.346[a]	.120	.029	2.798	.120	1.318	6	58	.264
2	.419[b]	.175	-.015	2.860	.055	.583	6	52	.742

a. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

Model 3: Results of Regression with Dependent Variable of Service Utilization

Research Question

Is trauma predictively related to service utilization while controlling for demographic factors?

Results. A multiple linear regression analysis was conducted to evaluate the prediction of service utilization from sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence, and other traumatic experiences. The results of the

multiple linear regression analysis revealed the independent variables were not statistically significant predictors to service utilization when demographic variables were controlled as in model 2 (see Table 5). However, in model 1, when demographics were isolated from the independent variables, the results showed that gender and education were significant in accounting for about 22% variance (R = .225) in predicting service utilization (see Table 5).

Table 5

Model Summary for Service Utilization

Model	R	R Squared	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.474[a]	.225	.144	1.742	.225	2.799	6	58	.018
2	.523[b]	.273	.106	1.781	.049	.581	6	52	.744

a. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

When other demographic variables were removed, gender and education were significant in predicting service utilization. In Table 6, model 1 showed an adjusted R of 19% of the variance and a p > .000; this means the null hypothesis, can be rejected. Furthermore, when gender and education were added to the trauma variables, there was no significant change to the R-squared (R= .038).

In Table 7, controlling for gender the regression coefficient B = 1.488, 95% C.I. (.518, 2.872) $p < .005$ associated with trauma suggests that gender and service utilization increased by approximately .306. Controlling for education, the regression coefficient B = -.487, 95% C.I. (-.319, -3.001) $p < .004$ associated with trauma suggests that education increases by .162 and Service_Utilization decreased. Therefore, homeless males utilized services more than women and the higher the level of education for both males and females, the less likely they were to use services. The interpretations of these results will be discussed further in chapter 5. Also presented is a histogram of service utilization (see Figure 4) and service utilization probability scatter plot (see Figure 5).

Table 6

Model Summary for Service Utilization while Controlling for Education and Gender

Model	R	R Squared	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.463[a]	.215	.192	1.780	.215	9.572	2	70	.000
2	.503[b]	.252	.159	1.816	.038	.536	6	64	.779

a. Predictors: (Constant), EDUCATION, GENDER

b. Predictors: (Constant), EDUCATION, GENDER, Sexual_Abuse, Natural_Disaster, Combat_Experience, Physical_Abuse, Witnessing_Violence, Other_Trauma

Table 7

Coefficients for Education and Gender

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	1.997	1.166		1.712	.091					
	GENDER	1.488	.518	.306	2.872	**.005****	.337	.325	.304	.990	1.010
	EDUCATION	-.487	.162	-.319	-3.001	**.004****	-.350	-.338	-.318	.990	1.010
2	(Constant)	2.422	1.440		1.682	.097					
	GENDER	1.524	.574	.313	2.656	**.010****	.337	.315	.287	.841	1.189
	EDUCATION	-.514	.171	-.337	-3.006	**.004****	-.350	-.352	-.325	.932	1.073
	Sexual_Abuse	-.165	.266	-.081	-.622	.536	-.098	-.077	-.067	.684	1.463
	Physical_Abuse	.030	.231	.019	.130	.897	-.085	.016	.014	.527	1.898
	Combat_Experience	-.965	.860	-.135	-1.122	.266	-.214	-.139	-.121	.809	1.236
	Natural_Disaster	-.546	.436	-.148	-1.251	.216	-.062	-.154	-.135	.837	1.195
	Witnessing_Violence	.216	.324	.102	.667	.507	-.094	.083	.072	.500	1.998
	Other_Trauma	.051	.150	.060	.338	.737	-.093	.042	.036	.366	2.732

a. Dependent Variable: SrvcUtilz_subscale

b. **Significant

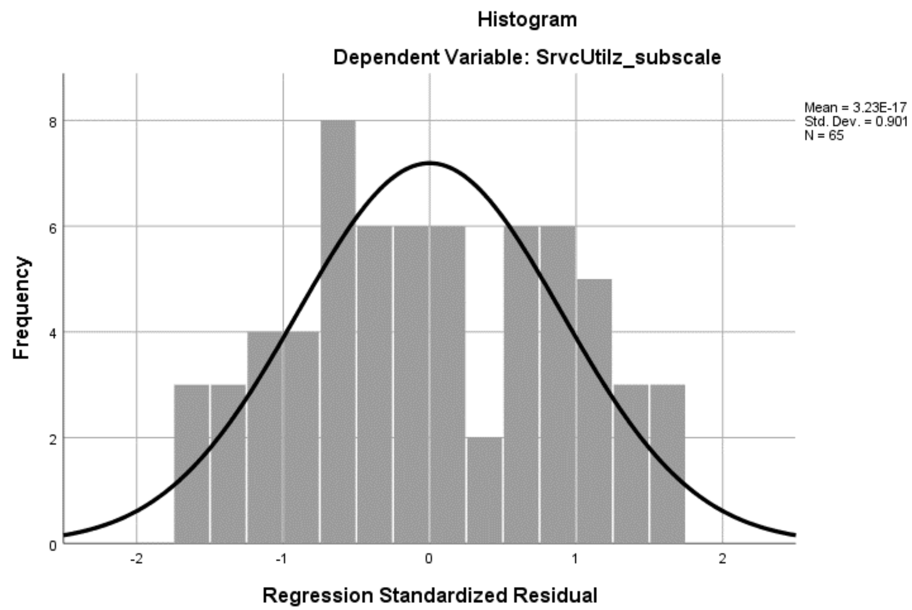


Figure 4. Histogram of service utilization.

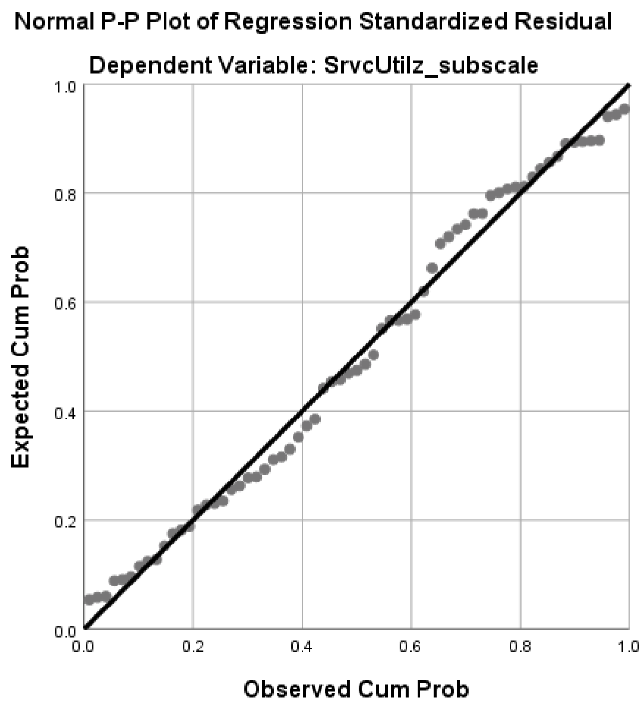


Figure 5. Normal probability plot for service utilization

Conclusion

Based on the multiple linear regression statistical analysis, I answered the question, is trauma predictively related to reoccurring trauma? Three dependent variables were tested against six independent variables and six controlled demographic variables. Two of the dependent variables were not significantly predictive for duration of homelessness and housing stability. However, two demographic variables were significant in predicting service utilization. Homeless males and females with a high school education or higher were predictively significant with service utilization. The implications for these results and social change will be discussed in Chapter 5.

Summary

In this chapter, I discussed the results of my data collection. Although there were some challenges, the results showed two significant variables on one dependent variable. A multiple linear regression was conducted on six independent variables and three dependent variables, while controlling for six demographic factors. Duration of homelessness and housing stability were not predictively significant on sexual abuse, physical abuse, combat experiences, natural disasters, witnessing violence, and other traumatic experiences. However, when controlled with demographic factors, gender and education were predictively significant on the dependent variable, service utilization. More males sought services than females and participants who had higher education had lower levels of service utilization. This and other interpretations are discussed in Chapter 5.

Chapter 5: Discussion, Recommendations and Conclusions

Interpretation of the Findings

In this cross-sectional study, I examined the impact of trauma on reoccurring homelessness in the United States Virgin Islands (USVI). Homelessness is evident throughout the islands. People who are homeless are defined as individuals without a fixed stable and secure place to live (NAEH, 2018). I sought to expand the literature on trauma and reoccurring homelessness and highlight the plight of the homeless living in the USVI.

I collected 73 total participants ($N = 73$) and analyzed six independent variables, which were sexual abuse, physical abuse, natural disasters, combat experience, witnessing violence, and other traumatic experiences and three dependent variables, which were duration of homelessness, housing stability, and service utilization, while controlling for age, gender, education, mental illness, substance abuse, and employment history. I used SPSS to input the independent and dependent variables and used a multiple linear regression statistical test to examine the predictive relationship between trauma and reoccurring homelessness.

I attempted to answer one research question with three statistical models. Two models of the regression analysis were not significant; however, there were two key demographic variables that were significant. These predictive variables were gender and education on service utilization. The results showed that men were more likely to use services than females and the more education a participant had, the less likely they were to use services. As such, I rejected the null hypothesis, which states there is no

statistically significant predictive relationship between trauma and reoccurring homelessness while controlling for demographic factors. The trauma variables were not predictively related to duration of housing or housing stability; however, the results showed that persons who were homeless experienced traumatic events prior to and during periods of homelessness. Participants in this study had significant trauma histories, thus, supporting other research that examined trauma and homelessness (Carlson et al., 2013; Deck & Platt, 2015; Felitti & Anda, 2010; Hamilton et al., 2011; Weinrich et al., 2016).

The American Counseling Association *Code of Ethics* (2014), section G addresses ethical concerns for research. Section G.1. and G.4. discuss the responsibilities of the researcher in conducting and reporting research ethically. Even though models 1 and 2 were not significant, I reported the results. In addition, some of the variables, such as housing stability and service utilization, had to be redefined and recoded to run an accurate statistical analysis such as converting categorical data in to scaled data. In the following sections, I will discuss findings for each of the dependent variables. I will also discuss limitations, recommendation for future research, and implications for counselors and counselor educators.

Demographic Variables

Demographic characteristics of homeless populations vary across national and international lines. Consistent with national homeless demographics data, there were more homeless males than females, and the average age of participants was 47 years (NAEH, 2018). The general public would assume that persons who are homeless lack education and have never been employed. Many of the homeless in the USVI have had at

a minimum a high school education and worked for at least 1 year. In this study, mental illness and substance abuse did not predict reoccurring homelessness, but 20% of the USVI homeless population sampled had some type of mental illness. Substance abuse also did not predict reoccurring homelessness. Other studies have predicted mental illness and substance abuse as barriers to stable housing and accessing services (Bonugli et al., 2013; Deck & Platt, 2015).

More men tend to experience homelessness than women; thus, homeless males accessed services more than women. Services for persons who are homeless are limited in the USVI. Efforts are being made by the Virgin Islands CoC committee to address gaps in services. Some of these gaps include mental health and substance abuse services, additional housing, and shelter beds. Researchers have echoed the need for more accessible and supportive services for persons who are homeless. In addition, homeless men and women have different needs and programs should incorporate specialized services to meet the needs of the homeless (Hopper et al., 2010; Lee et al., 2010; Lippert & Lee, 2015; Patterson et al., 2015).

Duration of Homelessness

The CCVI shelter in St. Croix was destroyed by the hurricanes in 2018 and has yet to be repaired. The shelter in St. Thomas, Bethlehem House, has 28 beds (14 males and 14 females). The shelters have a limited stay of 30 days; however, it can be extended up to 90 days if residents are working or up to 2 years if they qualify for the transitional housing program. The supported housing program at DHS was suspended due to funding loss.

With a lack of shelter and affordable housing, more than half of the participants sampled had no other option but to live on the streets or in substandard housing. Even though 23% were employed, their income was not enough to pay rent. At a minimum, 55% of participants received food stamps; however, according to one participant, lack of transportation to DHS was at times a hindrance to recertify food stamps. Additional studies have examined risk factors and barriers that impact the duration of homelessness. McQuistion et al., (2014) substantiated that alcohol and substance abuse are significant risk factors to recurrent homelessness. Homeless men usually have longer periods of homelessness than women and suffer more from alcohol and substance abuse problems (Deck & Platt, 2015; Clapton et al., 2014; Corrigan et al., 2013).

The homeless are transient and tend to move from city to city or shelter to shelter. In the USVI, which is small compared to Puerto Rico or the mainland, movement is limited within the islands. As a result, periods of homelessness are long since persons who are homeless stay in one localized area. Most of the participants surveyed were in the town areas of St. Thomas and St. Croix, which could be comparable to smaller cities on the U. S. mainland such as Port Charlotte, Florida. Since the last two major hurricanes, many of the homeless were displaced and shelter stays were longer than 30 days.

Even though trauma did not predict duration of homelessness among participants, it does support research on risk factors and pathways to homelessness. Early childhood experiences, such as described in the ACEs study increases the likelihood of individuals being at risk for becoming homeless (Felitti & Anda, 2010; Larkin & Park, 2012, Lippert & Lee, 2015). Trauma by itself does not cause homelessness nor extend duration of

homelessness. The lack of learned helplessness and social disaffiliations, as described in the theoretical framework by Goodman et al., (1991), may help to explain a person's duration of homelessness in terms of lack of support and adequate resources. Earlier, I discussed the role of Maslow's theory and how shelter is a lower order basic need and a sense of belonging is a second order need (Henwood et al, 2016; Maslow, 1943). As a result, persons who are homeless form connections on the street; hence, moving from street living to stable housing potentially creates another disconnect and impedes social connections (Somerville, 2013). Furthermore, the psychological impact of not having resources to having resources could also foster the learned helplessness phenomenon that plagues persons who are homeless (Lippert & Lee, 2015; Somerville, 2013). According to Ravenhill (as cited in Somerville, 2013), the homeless culture is a close-knit community, which relates to Maslow's sense of belonging and makes leaving homelessness more difficult. Furthermore, this sense of belonging could potentially extend the duration of being homeless and repeat the reoccurring patterns of homelessness.

The data showed the average duration of homelessness was ten years for participants. The 2018 point-in-time count did not discuss the duration of homelessness. It was noted that individuals who were chronically homeless decreased by 16%; hence, efforts to end homelessness are showing positive outcomes (HUD, 2018). Despite these positive trends on the U.S. Mainland, the data in the USVI, pointed to long periods of homelessness, which could lead to housing instability. Majority of the participants lived on the streets and maintained this housing status. Unlike the U. S. Mainland where there

are numerous shelters and programs for persons who are homeless, the USVI has minimal shelters and programs. Persons who are homeless are transient and therefore may vacillate between stable and unstable housing, thereby increasing periods of homelessness (Lippert & Lee, 2015). Many of the participants in this dissertation study had at least two moves and had been homeless for at least one year or more. Furthermore, men had longer period of homelessness than females (Corrigan et al., 2013; Johnstone et al., 2016).

Housing Stability

Housing stability was defined as moving from one stable place to an unstable place. The data showed that most of the sample lived in an unstable environment. The homeless are a vulnerable population and access to services can be a barrier to maintaining housing stability. One participant noted that she was taking care of an elderly person and had stable housing. Her patient passed away and as a result, the family members asked her and her partner to leave. The participant did not have any place to go and ended up at the Bethlehem House. Living with family and friends was also common among participants

The USVI is a close-knit community and many of the participants had family members with whom they could live with but either chose to be on their own or was asked to leave. Thus, they ended up on the street or in substandard housing. The Housing First program attempts to house the chronically homeless by removing them from the streets (NAEH, 2018; SAMHSA, 2018). At the time data was collected, 33% of the homeless lived on the streets of St. Thomas and St. Croix. About 22% of the participants

moved from living with family/friends to living on the streets. Another 37% of participants indicated no previously stable housing therefore, suggesting their duration of homelessness did not have periods of stable housing. The USVI lacks adequate housing programs to house persons who are chronically homeless and even those who have episodic homelessness. One shelter is not enough to house over 100 person who are homeless and not counting those who are hidden or dislocated due the hurricanes. The current point-in-time count accounted for 337; however, it is uncertain if this number is accurate as there were not enough volunteers to count the homeless (CoC Meeting Minutes, February 22, 2019).

Research data tends to show that mental illness and substance abuse problems impact housing stability (McQuistion et al., 2014; Patterson, 2015). Homeless persons with these vices are unable to maintain responsibility of budgeting and medication compliance (Lippert & Lee, 2015; Scutella, 2013; Tsai, 2012). Several researchers criticized housing first because it failed to incorporate supportive services, which the homeless need (Hopper et al., 2010; Johnstone, 2016). The data in this dissertation study on housing stability did not significantly predict reoccurring homelessness. The results showed that most of the participants moved from one stable place (friends/family/shelter) to a less stable place (street or abandoned building). Some of the reasons for this movement are that the homeless prefer being on their own, they moved from an unsafe area or there was no other option. Again, the PTT supports this study in that social disaffiliation is continued with the lack of connections and support during periods of homelessness (Goodman et al., 1991).

Service Utilization

Interestingly, females were less likely to utilize services than males; could this be because some homeless services are geared towards females and there could be the perceived notion of "I don't need help" or "if I ask for help, I am weak". This type of thinking would be in-line with the PTT (Goodman et al. 1991). For example, learned helplessness and social disaffiliation are at the core of PTT; hence, female participants may feel more jaded by a system of care that caters to males or perceives females as more stable, therefore, not needing help.

In addition, education was also significant in predicting service utilization among participants; for example, the higher an individual's education, the less likely they would seek services. Keep in mind the services rendered were basic needs, such as food and clothing. Even though physiological needs are critical to moving up the hierarchy, the psychological needs are just as important to maintain balance. Although the study did not significantly predictive trauma to reoccurring homelessness, it does not negate that 36% of participants experienced at least one or more traumatic events. Furthermore, service utilization by participants was low due in part to the limited types of services available to the homeless. Some of the homeless were aware of the services provided by MTOC and CCVI; many were also leery of reaching out for help or even accepting help; thus, perpetuating the psychological trauma theory. It is clear from the literature that more integrative services are needed for the persons who are homeless. As noted earlier, programs and services should also include gender specific, which could increase

utilization among the homeless (Hopper, et al., 2010; Henwood, 2015; Pietrzak, 2009; Sachs-Ericsson, 1999).

Among the homeless participants, 75.34% denied having a mental illness, whereas 20.55% acknowledged having a mental illness and this is consistent with the national average of 20-30% with a mental illness (NAEH, 2018). Having a mental illness does not necessarily correlate to being homeless. However, the inability to cope with psychological stress, lack of access to mental health services can impedes an individual's ability to make healthy choices.

The USVI lacks comprehensive mental health services. Once a month on St. Thomas and St. Croix, health care providers, such as physicians, nurses, dentist, and psychiatrist, render services to the residents of the shelter as well as other homeless individuals. Trauma informed care approach seeks to integrate a systemic service to the homeless population by realizing the prevalence of trauma among the homeless population, recognizing the impact of trauma, resisting re-traumatizing the homeless, and responding in a collaborative manner (SAMHSA, 2018).

Although this study may not have been significant in numbers, it highlights a pivotal need to address the system of care in the USVI. For decades, researchers have examined and explored what and how best to address the problem of homelessness. Consequently, there is no one solution to a complex issue. Governmental agencies, private sectors, and not-for-profit organizations should collaborate and develop programs that are gender specific, trauma-informed and inclusive of a variety of treatment

modalities to address the multifarious of homelessness (Hopper et al., 2010; Sommerville, 2013).

There are two states of homelessness, which are internal and external (Goodman et al., 1991, Sommerville, 2013). The PTT supports the findings in this study, in that persons who are homeless experience traumatic events that impedes their psychological functioning, thus perpetuating reoccurring homelessness. Among the types of trauma reported, witnessing violence (100%), natural disasters (92%) physical abuse (85%), and other traumatic experiences (100%) were the most prevalent. The literature review also noted trauma among persons who were formally homeless and not those who were still actively homeless.

As noted earlier, homelessness is a form of trauma; hence the experiences during homelessness, such as witnessing a sudden death and having a loved one die, can weigh on an individual's psyche, thus making it difficult to find and maintain stable housing, access services and potentially prolong periods of homelessness. The impact of trauma can contribute to the social disaffiliation that Goodman et. al. (1991) discussed. The USVI lacks comprehensive mental health services, including trauma-informed care approach to address the traumatic events among the homeless. By addressing the psychological trauma persons who are homeless face with a trauma-informed care approach, there could be a potential to rebuild social affiliations and resiliency among persons who are homeless in the USVI.

During data collection, I observed how and where the homeless lived. At times, there were a few individuals who did not identify as homeless because they had

somewhere to go (family home) but chose to live on the streets. These individuals, by HUD's standards are homeless. Some researchers have discussed the hidden homeless and the difficulty in assessing their needs (Waldbrook, 2013). In the 2019 PIT homeless count, members of the CoC reported the difficulty in accurately accounting for persons who are homeless (CoC Meeting Minutes, February 22, 2019). The trauma from the 2017 hurricanes are still felt throughout the U. S. Virgin Islands. Many are still displaced and do not have a place to call home; as a result, they are considered homeless. Conversely, these hidden homeless may not define themselves as such, yet, the psychological trauma from the hurricanes and other traumatic events are still present. This study may move member of the CoC to redefine the homeless to fit the cultural milieu of the USVI. One such definition could be, a person who is homeless lacks the internal and external capabilities to control their life and is therefore socially disconnected and helpless.

With the hurricanes from 2017, the USVI is still in a state of recovery mode; hence housing efforts are focused on rebuilding homes and not necessarily housing the chronically homeless population or the hidden homeless. Although many would qualify for services, it seems unclear as to how these individuals would access services. Based on this dissertation research, one possible explanation is due to learned helplessness and lack of trust for the system of care. Subsequently, a cultural appropriate system of care is needed to address both internal and external states of homelessness and socially connect with person who are homeless through programs that will empower and build resiliency to end homelessness.

Trauma and Reoccurring Homelessness

Correlational studies do not assume causation of the dependent variable; however, it provides a plausible reason as to the predictive nature of independent and the dependent variable. In this case, the predictive relationship of trauma to reoccurring homelessness was not significant. Yet, the data highlighted the reality of trauma among persons who are homeless. Other traumatic events, which encompassed witnessing violence, death of a loved one, and so forth were high among both males and females.

Although the data did not show that the types of trauma predicted reoccurring homelessness, the data brought to light to the number of individuals who are homeless in the USVI who have experienced a traumatic event. The USVI endured two significant hurricanes in 2017 and many persons were rendered homeless. Experiencing natural disasters is a traumatic event and can have a lasting impact on an individual's mental health (Gable, Der-Martirosian, & Dobalian, 2018; Wexler & Smith, 2015).

The current study did not predict reoccurring homelessness among participants living in the USVI. Despite the results, the study signified the daily struggles of persons who are homeless, and the traumatic events endured throughout an individual's life. As noted earlier, trauma does not cause homelessness; however, the impact of trauma on one's mental health and ability to maintain stable housing as evidenced by duration of homelessness.

Many of the participants had over five years of being homeless. Some participants reported periods of stability and instability, which impacted how long they remained homeless. Most participants preferred to be on their own, thus, supporting Goodman et

al., (1991) theory and the difficulty the homeless have in maintaining relationships (social disaffiliation). The ACEs study indicates the likelihood of a person being homeless due to early traumatic events. Counselor educators have the task of educating counselors-in-training (CITs) on trauma counseling, trauma informed approach and ways to mitigate retraumatizing a vulnerable population. Clinicians assume the role of both counselor and advocate for marginalized populations, especially the homeless. It is important to capture trauma histories early in the assessment process to help determine the best course of action. Helping clients see how traumatic events could potentially impact their ability to cope, programs can educate persons who are homeless on the ACE study and use the THQ to screen for the presence of trauma.

Limitations of the Study

The current study presented some challenges to the internal validity and external validity of the study. In the following paragraphs, I highlighted some of the challenges I encountered as well as suggestions for future researchers.

Threats to Internal Validity

Of the eight internal validities, four were of main concern for this dissertation study, which are instrumentation, testing, selection bias, and attrition (Cook & Campbell, 1979; Drost, 2011; Mason & Perreault, 1991). Although I used two valid and reliable instruments (THQ and RTLFB), both questionnaires were of a sensitive nature. As a result, participants may have been less truthful in responding to questions, thus, leading to the threat of testing. In addition, most participants were recruited during lunchtime; hence, the focus was on food and not completing a survey. However, most of the

participants were cooperative. I used a convenience and purposive sampling methods, which were ideal for the USVI population. Shelter workers were able to identify potential participants; however, this posed a threat to selection bias. The sample was not random; therefore, participants were selected based on the inclusion criteria as well as suggestions from the shelter worker. Some participants were handpicked to enrich the sample; however, by using a convenience and purposive sampling methods, I did not have a true representation of the homeless population in the USVI. Using sensitive instruments and potentially triggering trauma, attrition was not a significant limitation of the study. Some participants were initially hesitant but then continued with the questions. When conducting surveys of sensitive nature, it is best to build rapport first, even with a simple greeting and brief introduction can help to reduce participant's anxieties (Bradburn et al., 2004; Waldbrook, 2013).

The homeless are a vulnerable population and transient; thus, accounting for the sample size was difficult to obtain. My original sample size was $N = 89$, however, it was very challenging to achieve this sample size. The final sample size was $N = 73$, which is about 20% less than the original sample size. However, the R square values on duration of homelessness and housing stability were .052 and .060 respectively; therefore, the additional 16 participants would not have likely increase the significance. Unlike other homeless research, such as those presented in chapter two, researchers used a large sample size. However, the samples were gathered from homeless shelters that were two to three times more than the shelters in the USVI. Moreover, using a nonprobability

sampling method may have also impacted the low sample size (Acharya, 2013). The low effect size also helped to justify a reduced sample size.

Threats to External Validity

The results of the study cannot be generalized to other populations and was specific to the homeless population living in the USVI. Using a nonprobability sampling method limited the study the study in many ways. For example, the homeless population is difficult to assess; hence, researchers have difficulty finding a true representation of the entire homeless population. Even the annual point-time-count discussed challenges in documenting the homeless population (NAEH, 2017). One possible solution to mitigate threats to external validity is to utilize a random sampling. For future research in the USVI, having one entry point for services may help to document the homeless in a systematic way.

Other Limitations

Using more than one independent and dependent variables proved to limit the significant of the regression analysis (Jeon, 2015). Furthermore, some of the variable may have been related to each other and as such produced results that her non-significant (Jeon, 2015). One possible solution would be to reduce the number of independent variables and dependent variables, eliminate related variables, or increase the sample size (Jeon, 2015). For example, I could have combined physical abuse and other traumatic experiences into one variable. When selecting variables, researchers should select variables that have less multi-collinearity.

Another limitation is that some participants who, by HUDs definition were homeless, did not view themselves as such. As a result, the definition of homelessness and homeless may not have been culturally sensitive to the USVI. Lippert & Lee (2015) described a similar limitation in their study when defining the categories of homelessness. These limitations do not invalidate the study but rather warrants future researchers to be creative in fully assessing persons who are homeless. In addition, grant funding can help to fund projects aimed at implementing programs for the homeless and tracking outcomes of such programs to address the hidden faces of homelessness, the chronically homeless, and the reoccurring homeless in the USVI.

Recommendations

Future Research

Further research is needed to explore the experiences of homeless persons living in the USVI. As noted earlier, some individuals did not identify as homeless, although clearly according to HUDs definition they were homeless. It is also recommended that MTOC, CCVI and DHS implement a trauma-informed care approach to serving the homeless population in the USVI. This will allow participants to gain skills necessary to cope with stressors of being homeless, examine the impact trauma has on their life choices and make changes the promote growth and change. As a result, this would entail providing training to staff, shelter workers and case managers on TIC, trauma, and interventions for homeless populations.

Future quantitative research could examine the efficacy of TIC and housing stability; thus, examining how well TIC predicts housing stability among the homeless. A

second quantitative research could examine trauma symptoms of homeless before and after implementation of TIC. Furthermore, several researchers have examined the relationship of trauma among veterans (Gable et al., 2018; Hamilton et al., 2011; Pietrzak et al., 2009; Tsai et al., 2012). In the 2019 Point-in-time count, homeless veterans were not accounted for. This dissertation study identified 8% of participants as veterans and had combat experience. National data suggests a relationship between veterans and homelessness; however, this data is not reflected in USVI homeless population. Although combat experience was not predictively significant on the three dependent variables, the value was close to significance and bears further scrutiny to examine homeless veterans living in the USVI.

Qualitative research could, explore the trauma experiences of the homeless and their attitudes towards service providers. The USVI has limited data on the homeless population and whether services are effective. Most of the literature review focused on persons who were formally homeless. More research is needed to explore the lived experiences of those who are chronically homeless, which could potentially shed light on reoccurring homelessness. The CoCs are taking an active role in improving the services for persons who are homeless. This dissertation study contributes to the social change component and speaks to the need to advocate for persons who are homeless.

This current dissertation study can be used as a catalyst for social change and further build upon existing homeless research and increase research on homelessness in the USVI. For the current dissertation study, some recommendations include increasing the sample size, reducing the number of independent and dependent variables. In

addition, future researchers can examine the differences in gender, education and service utilization. Some possible research questions could be: what is the difference between homeless males and homeless females in service utilization? Is there are relationship between education level, trauma and service utilization among the homeless? Existing literature separate homeless men and women research; hence future research can compare the two groups and examine the effectiveness of gender-specific homeless services.

Implications

Homelessness is a global problem and requires multifaceted approaches to address the problem. Counselor educators, supervisors, and counselors are social change agents and have an ethical duty to advocate on behalf of marginalized, vulnerable and oppressed populations, such as, persons who are homeless. Training programs should include specific interventions that address coping skills, budgeting, employment skills, and basic independent living skills (Carlson et al., 2013; Hopper et al., 2010). Trauma-informed care approach goes beyond identifying trauma in the lives of people who are homeless and seeks to empower them (SAMHSA, 2017). Many of the homeless did not choose their current situation, but due in part to combination of factors, one of which, is being exposed to trauma. The experiences of being homeless can be and is most often traumatic for many individuals who are homeless (Deck & Platt, 2015). Conditions of street living, short-term stays in shelters, lack of resources and lack of support can impact psychological distress. It behooves the systems of care to implement programs that target trauma healing and reduction as well as empowering persons who are homeless.

Counselor Educators and Supervisors

The homeless population in the USVI is relatively small compared to the national data; however, the effects of homelessness are felt throughout the community. Increased burden on healthcare cost, incarceration, crime and violence, mental illness and substance abuse cripples the community's infrastructure. Through research, stakeholders can identify viable solutions to address the problems of homelessness. One such solution is trauma-informed care approach; this approach seeks to restructure the system of care to realize the impact of trauma, recognize the signs and symptoms of trauma, resist retraumatizing consumers, and respond by developing programs, policies and procedures, and legislation to address the needs of the homeless (Bowen, & Murshid, 2016; Hopper et al., 2010; SAMHSA, 2014).

Counselor Educators and supervisors (CES) are trained to equip counselors-in-training to provide culturally sensitive and competent counseling. In addition, CES also promote social justice and social change among various marginalized populations, such as persons who are homeless. In many counseling programs, one elective is special populations, which tends to cover marginalized populations; however, not all students take this course. In addition, multicultural counseling courses tend to cover minorities. In these are two courses, CES can be creative in showing CITs how to work with the homeless population. As scholar-practitioners, counselor educators and supervisors can also be instrumental in designing quantitative, qualitative and mixed methods research to expand the literature on trauma and reoccurring homelessness.

Counselors

There is no one set theory that will work for persons who are homeless. As noted in previous paragraphs, homelessness has many pathways and as such requires an integrative approach. Maslow's hierarchy of needs maybe a starting point to address basic human needs. From there, clinicians can use a person-centered approach that is focused on identifying individual goals while simultaneously interweaving the principles of trauma-informed care approach. Studies have criticized as well as praised housing first and treatment first models, yet neither are definitive in solving homelessness (Henwood, Derejko, Couture, & Padgett, 2015).

Similar to the practice of social work, counselors advocate on behalf and with their clients. Counselors can use social justice platforms to speak up against the injustice towards persons who are homeless. They can also volunteer their services to shelter programs thereby reducing one barrier to mental health services. Furthermore, counselors can receive specialized training to address the needs of homeless males and homeless females. Intimate partner violence can be a precursor to homelessness; hence, counselors can provide education to homeless individuals on the cycle of abuse and how to stop re-victimization during period of homelessness (Deck & Platt, 2015; Weinrich et al., 2016; Williams & Hall, 2009).

Community Stakeholders

The Methodist Training and Outreach Center (MTOC) and Catholic Charities of the Virgin Islands (CCVI) are the two main organizations that provide services to the homeless population. These two organizations along with other USVI government

agencies comprise of the CoC. The CoC meets monthly to plan, organize and discuss matters pertaining to homelessness in the USVI and ways to eliminate this problem. The CoC plays an integral role in disseminating information and identifying funding sources. They are in the process of developing a centralized processing procedure for documenting persons who are homeless.

The data presented in this dissertation study can be helpful in developing programs that integrate TIC. According to Hopper et al., (2010) most programs for the homeless do not address trauma experiences. More so, programs lack specialized care for male and female homeless trauma survivors. The data in this study showed that males used services more than females; hence services that are gender specific could increase service utilization among persons who are homeless. Untreated trauma hinders persons who are homeless from maintaining work, connecting with others and interferes with service needs. Gender specific homeless services could target trauma from a TIC perspective, thereby further supporting the psychological trauma by Goodman et al (1991) theory supports the need for programs to include focus on trauma. Hopper et al., (2010) further states, “we will be unable to solve the issues of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness” (p.81). I would further add, that persons who are homeless can end reoccurring homelessness if they are given the right tools and connected to the right programs.

To this end, service providers, such as case managers, social workers, counselors, shelter workers, and nurses need to be equipped to work with trauma survivors who are

homeless. Programs should incorporate education as a strength to overcoming homelessness. Some persons who are homeless are high school drops, which increases their likelihood of recurring homelessness (McQuistion et al., 2014). As the current dissertation data showed that men with less education were less likely to access services. Yet, men, overall used services more than females. The USVI CoC could partner with the Department of Education to provide opportunities for persons who are homeless to complete their high school education. In addition, other government and private sectors can collaborate to bring about social change in the USVI by eliminate homelessness and provide the standard of care that addresses trauma.

Programs and Training Needed

Approximately, 56% of participants lived either on the streets or in an abandoned building. The USVI does not have enough shelters to house the homeless. The Bethlehem House has 28 beds and some of the beds are designated as transitional, meaning residents can stay for longer periods. The current study sheds light on the need for more shelters in the USVI as well as programs that will help to move the chronic and episodic homeless to more permanent and stable housing. For example, one program that is needed is a day program, where individuals can receive a hot meal, shower, clothing, educational training and materials, mental health and substance abuse services. Some examples of training needed are psychological first aid, TIC, and suicide assessments.

Service providers at the MTOC, CCVI and other governmental agencies that serve the homeless population should consider implementing trauma-informed care approach into their services. The components of TIC will incorporate trauma awareness,

safety, opportunities to rebuild control, and strengths-based approach (Hopper et al., 2010). In addition, TIC is culturally sensitive and draws on the strengths of homeless males and females. The current dissertation study opens the door for scholar-practitioners, such as me, to collaborate with the CoC in training its members on TIC and develop a strategic plan for implementation.

Conclusion

This study examined the impact of trauma on reoccurring homeless in the U.S. Virgin Islands, specifically St. Thomas and St. Croix. Homelessness is a growing concern in the USVI and more so since the 2017 hurricanes. There are many pathways to homelessness, such as lack of affordable housing, mental illness, substance abuse, unemployment, and trauma are just a few contributing factors to homelessness. More than just a roof over one's head, homelessness is also an internal experience, where an individual does not belong and lacks the necessary skills to re-integrate back into society. The psychological trauma theory undergirded this dissertation study and helped to provide an explanation to the mental health impact of homelessness (Goodman et al., 1991). Lack of physical shelter and emotional shelter leave persons who are homeless vulnerable and more prone to develop serious mental illnesses, substance abuse problems, criminal behavior, health problems, and ultimately traumatic experiences (Bonugli et al., 2013; Deck & Platt, 2015; Felitti & Anda, 2010; Hamilton et al., 2011; Henwood et al., 2015).

Trauma experienced by persons who are homeless perpetuates the cycle and impacts one's ability to function adequately; coupled with mental illness and substance

abuse, person who are homeless are often marginalized and sometimes ostracized by the system that is meant to help. By creating an environment that provides safety, trust, empowerment, and support, trauma-informed care approach can help to reduce the psychological impact of homelessness, and potentially stop the cycle of reoccurring homelessness. Hopper et al. (2010) and several other recent researchers are seeing the value in addressing trauma in the homeless population. Furthermore, trauma-informed care approach seeks to create a system of care that truly addressing the needs of vulnerable populations, such as persons who are homeless (Bowen & Murshid, 2016; Hopper et al., 2010; Pelletier, 2016).

The homeless population in the USVI is small compared to the U. S. mainland, hence eliminating homelessness in the USVI should be in short order. However, programs for the persons who are homeless needs to include trauma informed care components. Trauma does not cause homelessness; yet the traumatic events experienced by persons who are homeless are barriers to housing stability and service utilization. The data showed that gender and education as significant variables in predicting service utilization. As agents of change, the Continuum of care, counselors, scholar-practitioners can collaborate to design programs the promote growth and resist retraumatizing and ultimately stop the cycle of reoccurring homelessness.

Although the current dissertation study did not yield significant results across the various variables, the study serves as a social change platform to provide training to service providers, counselors and counselor educators. The results of this study sheds light on a significant problem that plagues my beautiful home, America's Paradise- the

U. S. Virgin Islands. As a professional counselor scholar practitioner, I seek ways to improve the lives of those around me, whether students, clients or even strangers. In addition, I cast a vision based on the information gathered in this dissertation study.

To this end, I identified four foundational concepts that need to occur when finding solutions to homelessness. Firstly, treating homelessness requires an integrative approach that addresses the psychological trauma persons who are homeless experience daily; this includes a multimodal and multi-theoretical approach to working with persons who are homeless. Secondly, treating homelessness requires a multi-disciplinary and collaborative approach to addressing the needs and plights of persons who are homeless; this include education, health, criminal justice, and other governmental agencies working together as part of the system of care. Thirdly, treating homelessness requires a system of care that has a shift from deficit thinking to strength and resiliency thinking about persons who are homeless. Finally, treating homelessness requires compassion to see broken and hurt human beings who have been traumatized and persons who will advocate and seek social justice for a marginalized group. It is my sincere hope and desire that this study, stirs up the righteous anger to speak up for persons are homeless.

References

Acharya, A. S., Prakash, A., Saxena, P., & Nigam, A. (2013). Sampling: How and why of it? *Indian Journal of Medical Specialties, 4*(2), 330-333. doi: 10.7713/ijms.2013.0032

Adverse Childhood Experiences Questionnaire (n. d.). Retrieved from https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf

Akin, B. (August 3, 2017). Territory abandons homeless program. *The St Thomas Source*. Retrieved from http://stthomassource.com

Akin, M. (February 5, 2015). The homeless are counted. Now what? *The St. Thomas Source*. Retrieved from http://stthomassource.com

American Counseling Association. (2014). *ACA code of ethics*. Retrieved from http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4

Babbie, E. (1990). *Survey research methods* (2nd ed.). Belmont, CA: Wadsworth.

Blondell, A. D., Robertson, M. J., Brindis, C. D., Papanastassiou, A. A., & Bradley, S. J. (2017). Mobile homeless youth, health disparities, and access to care: Using mobile phones and geospatial technologies to document geographies of risk and pathways to care. *Risk, Protection, Provision and Policy*, 309-343.

Bonugli, R., Lesser, J., & Escandon, S. (2013). “The second thing to hell is living under that bridge”: Narratives of women living with victimization, serious mental illness, and in homelessness. *Issues in Mental Health Nursing*, *34*, 827–835. doi: 10.3109/01612840.2013.831149

Bowen, E. A., & Murshid, N. S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health*, *106*(2), 223-229. doi:10.2105/AJPH.2015.302970

Bradburn, N., Sudman, S., & Wansink, B. (2004). *Asking questions: The definitive guide to questionnaire design – For market research, political polls, and social and health questionnaires*. San Francisco, CA: Jossey-Bass.

Buchanan, D. (2017, December 14). Hurricanes exacerbate territory housing problems. *The St. Thomas Source*. Retrieved from https://stthomassource.com

Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry*, *34*, 963–966.

Campbell, D. T., & Stanley, J. C. (1963). Experimental and quasi-experimental designs for research. In N. L. Gage (ed.) *Handbook of research on teaching* (pp. 1-76). Chicago, IL: Rand-McNally.

Carlson, E. B., Garvert, D. W., Macia, K. S., Ruzek, J. I., & Burling, T. A. (2013). Traumatic stressor exposure and post-traumatic symptoms in homeless veterans. *Military Medicine, 178,* 970-973. doi:10.7205/MILMED-D-13-00080

Centers for Disease Control. (2016). About the CDC-Kaiser ACE study. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/about.html

Central Intelligence Agency (2016). World factbook. Retrieved from https://www.cia.gov/library/

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness. *Journal of Sociology & Social Welfare, 37(*4), 65-96.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-Experimentation: Design and Analysis Issues for Field Settings*. Houghton Mifflin.

Corrigan, P., Pickett, S., Kraus, D., Burks, R., & Schmidt, A. (2015). Community-based participatory research examining the health care needs of African Americans who are homeless with mental illness. *Journal of Health Care for the Poor and Underserved*, *26*(1), 119-133. doi: 10.1353/hpu.2015.0018

Deck, S. M., & Platt, P. A. (2015). Homelessness is traumatic: abuse, victimization, and trauma histories of homeless men. *Journal of Aggression, Maltreatment, & Trauma*, *24*(9), 1022-1043. doi: 10.1177/0886260514556770

Díaz de Rada, V. (2014). Analysis of Incidents in Face-to-face Surveys: Improvements in Fieldwork. *Revista Española de Investigaciones Sociológicas, 145*, 43-72. http://dx.doi.org/10.5477/cis/reis.145.43

Drost, E. A. (2011). Validity and reliability in social science research. *Education Research and perspectives*, *38*(1), 105. Retrieved from https://www3.nd.edu/~ggoertz/sgameth/Drost2011.pdf

Dudovskiy, J. (2017). Convenience Sampling. Retrieved from https://research-methodology.net/sampling-in-primary-data-collection/convenience-sampling/

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed

services for women. *Journal of Community Psychology*, *33*(4), 461–477. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/jcop.20063/full

Etikan, I., Musa, S. A, & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics,* (5)1. doi: 10.11648/j.ajtas.20160501.11

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2014). G* Power version 3.1.9.2.

Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*, 77-87.

Flaskerud, J. H., & Winslow, B. J. (1998). Conceptualizing vulnerable populations health-related research. *Nursing Research*, *47*(2), 69-78.

Gable, A. R., Der-Martirosian, C., & Dobalian, A. (2018). Access to care for homeless veterans during disasters. *Journal of Primary Care & Community Health, 9*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6287296/ doi:10.1177/2150132718815382

Gläser, J. & Laudel, G. (2013). Life with and without coding: Two methods for early-stage data analysis in qualitative research aiming at causal explanations. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *14*(2). [Online]. Retrieved from
http://www.qualitative-research.net/index.php/fqs/article/view/1886/3528%23g33

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*(11), 1219-1225.

Hamilton, A. B., Poza, I., & Washington, D. L. (2011). “Homelessness and trauma go hand-in-hand”: Pathways to homelessness among women veterans. *Women’s Health Issues*, *21*(4), S203–S209. Retrieved from http://www.sciencedirect.com/science/article/pii/S1049386711000909

Helfrich, C. A., Peters, C. Y., & Chan, D. V. (2011). Trauma symptoms of individuals with mental illness at risk for homelessness participating in a life skills intervention. *Occupational Therapy International, 18*, 115–123. doi: 10.1002/oti.308

Henwood, B. F., Derejko, K. S., Couture, J., & Padgett, D. K. (2015). Maslow and mental health recovery: a comparative study of homeless programs for adults with serious mental illness. *Administration and Policy in Mental Health*, *42*(2), 220–228. doi:10.1007/s10488-014-0542-8

Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health*, *87*(2), 249-255.

Hladikova, A. (2007). Homelessness in the Czech Republic. *Journal of Social Issues, 63*(3), 607-622.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*, 80-100. doi**:** 10.2174/1874924001003010080

Hooper, L. M., Stockton, P., Krupnick, J. L., & Green, B. L. (2011). Development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma*, *16*(3), 258-283. doi: 10.1080/15325024.2011.572035

Jeon, J. (2015). The strengths and limitations of the statistical modeling of complex social phenomenon: Focusing on SEM, path analysis, or multiple regression models. *International Journal of Social, Behavioral, Educational, Economic, Business and Industrial Engineering*, *9*(5), 1594-1602. Retrieved from https://pdfs.semanticscholar.org/50a9/a4a1cf87575bbb83b43419102d09fc89f942.pdf

Johnstone, M., Parsell, C., Jetten, J., Dingle, G., & Walter, Z. (2016). Breaking the cycle of homelessness: Housing stability and social support as predictors of long-term well-being. *Housing Studies*, *31*(4), 410–426. https://doi.org/10.1080/02673037.2015.1092504

Jones, M. M. (2015). Creating a science of homelessness during the Reagan era. *The Milbank Quarterly, 93*(1), 139-178. doi: 10.1111/1468-0009.12108

Institute for Digital Research and Education (2016). What statistical analysis should I use? Retrieved from http://www.ats.ucla.edu/stat/mult_pkg/whatstat/default.htm

Kim, M. M., Ford, J. D., Howard, D. L., & Bradford, D. W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health & Social Work*, *35*(1), 39-48.

Lalonde, F., & Nadeau, L. (2012). Risk and protective factors for comorbid posttraumatic stress disorder among homeless individuals in treatment for substance-related

problems. *Journal of Aggression, Maltreatment & Trauma*, 21, 626–645. doi:10.1080/10926771.2012.694401

Larkin, H., & Park, J. (2012). Adverse childhood experiences (ACEs), service use, and service helpfulness among people experiencing homelessness. *Families in Society: The Journal of Contemporary Social Services*, *93*(2), 85-93.

Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, 7, 24–25. doi:10.1038/sj.ebd.6400375.

Lippert, A. M., & Lee, B. A. (2015). Stress, coping, and mental health differences among homeless people. *Sociological Inquiry*, *85*(3), 343–374. doi: 10.1111/soin.12080

Mailloux, S. L. (2014). The ethical imperative: Special considerations in the trauma counseling process. Traumatology: *An International Journal, 20*(1), 50–56. doi: http://dx.doi.org/10.1177/1534765613496649

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370.

Mason, C. H., & Perreault Jr, W. D. (1991). Collinearity, power, and interpretation of multiple regression analysis. *Journal of Marketing Research*, *28*(3), 268-280.

McLaughlin, A. (January 28, 2016). ACAVI/ACA partnership results in creation of professional licensing board for counselors in USVI. Retrieved from https://www.counseling.org/news/news-release-archives/by-year/2016/2016/01/28/acavi-aca-partnership-results-in-creation-of-professional-licensing-board-for-counselors-in-usvi

McQuistion, H. L., Gorroochurn, P., Hsu, E., & Caton, C. (2014). Risk factors associated with recurrent homelessness after a first homeless episode. *Journal of*

Community Mental Health, 50 (505). https://doi.org/10.1007/s10597-013-9608-4

Menih, H. (2013). Applying ethical principles in researching a vulnerable population: homeless women in Brisbane. *Current Issues in Criminal Justice*, *25*(1), 527-539.

Mitchell, T. R. (1985). An evaluation of the validity of correlational research conducted in organizations. *Academy of Management Review, 10*(2), 192. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/

Mogk, J., Shmigol, V., Futrell, M., Stover, B., & Hagopian, A. (2019). Court-imposed fines as a feature of the homelessness-incarceration nexus: a cross-sectional study of the relationship between legal debt and duration of homelessness in Seattle, Washington, USA. *Journal of Public Health*, fdz062, https://doi.org/10.1093/pubmed/fdz062

National Alliance to End Homelessness (NAEH, 2016). The state of homelessness in America 2016. Retrieved from http://www.endhomelessness.org/.

Norris, A. (February 2, 2013). Despite efforts, homelessness still high in V.I. *The Virgin Islands Daily News*. Retrieved from http://virginislandsdailynews.com

Patterson, M. L., Currie, L., Rezansoff, S. & Somers, J. M. (2015). Exiting homelessness: Perceived changes, barriers, and facilitators among formerly homeless adults with mental disorders. *Psychiatric Rehabilitation Journal, 38*(1), 81–87. doi: http://dx.doi.org/10.1037/prj0000101

Pavao, J., Turchik, J. A., Hyun, J. K., Karpenko, J., Saweikis, M., McCutcheon, S., … & Kimerling, R. (2013). Military sexual trauma among homeless veterans. *Journal of General Internal Medicine, 28,* 536-541. doi: 10.1007/s11606-013-2341-4

Pelletier, A. (2016). The effects of a trauma-informed care training program on mental health professional's knowledge, skills, and attitudes with the SMI. Retrieved from http://digitalcommons.pcom.edu/psychology_dissertations/387/

Pietrzak, R. H., Johnson, D. C., Goldstein, M. B., Malley, J. C., & Southwick, S. M. (2009). Perceived stigma and barriers to mental health care utilization among OEF-OIF veterans. *Psychiatric Services*, *60*(8), 1118-1122

Protecting Human Research Participants (2008). Retrieved from http://phrp.nihtraining.com/

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K. and McCullough, J. R. (2016), Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28–48. doi:10.1002/jmcd.12035

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American Journal of Public Health*, *103*(S2), S275-S281.

Rossi, P. H. (1989). *Without shelter: Homelessness in the 1980s*. Priority Press Publications: New York.

Rossi, P. H., Wright, J. D., & Anderson, A. B. (1983). *Handbook of Survey Research*, New York: Academic Press.

Sample Size Calculator (2004). Retrieved from www.raosoft.com/samplesize

Sachs-Ericsson, N., Wise, E., Debrody, C. P., & Paniucki, H. B. (1999). Health problems and service utilization in the homeless. *Journal of Health Care for the Poor and Underserved*, *10*(4), 443-452. doi: 10.1353/hpu.2010.0717

Saunders, M., Lewis, P. & Thornhill, A. (2012). Research Methods for Business Students. 6th edition. Pearson Education Limited.

Somerville, P. (2013). Understanding homelessness. *Housing, Theory and Society*, *30*(4), 384–415. doi:/10.1080/14036096.2012.756096

Scutella, R., Johnson, G., Moschion, J., Tseng, Y., & Wooden, M. (2013). Understanding lifetime homeless duration: Investigating wave 1 findings from the journeys home project. *Australian Journal of Social Issues, 48*(1), 83-110.

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed care approach. HHS Publication No. (SMA)14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration

Sundin, E. C., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology*, *50*(2), 183-194.

Statistics Solutions (2016). What is multiple linear regression. Retrieved from http://www.statisticssolutions.com/what-is-multiple-linear-regression/

Stevens, J. P. (2009). *Applied multivariate statistics for the social sciences* (5th ed.). Mahwah, NJ: Routledge Academic.

Tabachnick, B. G. & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Boston, MA: Pearson.

Tsemberis, S., McHugo, G., Williams, V., Hanrahan, P., & Stefancic, A. (2007). Measuring homelessness and residential stability: The residential time-line follow-back inventory. *Journal of Community Psychology, 35*(1), 29–42. doi:10.1002/jcop.20132

Tsai, J., Rosenheck, R. A., Decker, S. E., Desai, R. A., & Harpaz-Rotem, I. (2012). Trauma experience among homeless female veterans: Correlates and impact on housing, clinical, and psychosocial outcomes. *Journal of Traumatic Stress*, *25*(6), 624-632.

U.S. Department of Housing and Urban Development. (2017). Homelessness in the United States: The 2016 annual homeless assessment report to congress. Retrieved from https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

U.S. Department of Housing and Urban Development. (2018). Homelessness in the United States: The 2018 annual homeless assessment report to congress. Retrieved from https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf

Walden University. (2014). *Dissertation guidebook*. Retrieved from http://catalog.waldenu.edu/mime/media/view/7/26833/Dissertation_Guidebook_May%202014_Final.pdf

Wallace, S. E. (1965). *Skid Row: As a way of life*. New York and Evanston: Harper Torch Books.

Wendorf, C. A. (2004). Primer on Multiple Regression Coding: Common forms and the additional case of repeated contrasts. *Understanding Statistics*, *3*(1), 47–57. https://doi-org.ezp.waldenulibrary.org/10.1207/s15328031us0301_3

Weinrich, S., Hardin, S., Glaser, D., Barger, M., Bormann, J., Lizarraga, C., … & Allard, C.B. (2016). Assessing sexual trauma histories in homeless women. *Journal of Trauma & Dissociation*, *17*(2), 237-243. doi: 10.1080/15299732.2015.1089968

Wexler, B. & Smith, M. E. (2015). Disaster response and people experiencing homelessness: Addressing challenges of a population with limited resources. *Journal of Emergency Management, 13*(3), 195-200. doi: 10.5055/jem.2015.0233

Williams, J. K., & Hall, J. A. (2009). Stress and traumatic stress: How do past events influence current traumatic stress among mothers experiencing homelessness? *Social Work Research, 33*(4), 199-207.

Winter, G. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report*, *4*(3), 1-14.

Wong, C. F., Clark, L. F., & Marlotte, L. (2016). The impact of specific and complex trauma on the mental health of homeless youth. *Journal of Interpersonal Violence*, *31*(5), 831-854. doi: 10.1177/0886260514556770

Virgin Islands Continuum of Care on Homelessness (2017). U.S.V.I. Point in Time Analysis: Shelter & Unsheltered Homeless.

Zlotnick, C., Tam, T., & Bradley, K. (2007). Impact of adulthood trauma on homeless mothers. *Community Mental Health Journal, 43*(1). doi: 10.1007/S10597-006-9070-7

Appendix A: Trauma History Questionnaire

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

(a) Crime-Related Events		**(b) Circle one**		*If you circled yes, please indicate*	
				Number of times	**Approximate age(s)**
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were not there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you were there?	No	Yes		
(c) General Disaster and Trauma		**(d) Circle one**		*If you circled yes, please indicate*	
				Number of times	**Approximate age(s)**
5	Have you ever had a serious accident at work, in a car, or somewhere else? (**If yes**, please specify below)________	No	Yes		

6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**<u>If yes</u>**, please specify below)	No	Yes		
7	Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**<u>If yes</u>**, please specify below)	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? (**<u>If yes</u>**, please specify below) ____	No	Yes		
10	Have you ever been in any other situation in which you feared you <u>might</u> be killed or seriously injured? (**<u>If yes</u>**, please specify below) ____	No	Yes		
11	Have you ever seen someone seriously injured or killed? (**<u>If yes</u>**, please specify who below) ____ _________	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**<u>If yes</u>**, please specify below) ____	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? (**<u>If yes</u>**, please specify relationship [e.g., mother, grandson, etc.] below)	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? (**<u>If yes</u>**, please specify relationship below)	No	Yes		
15	Have you ever had a serious or life-threatening illness? (**<u>If yes</u>**, please specify below	No	Yes		

16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**<u>If yes</u>**, please indicate below)	No	Yes		
17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**<u>If yes</u>**, please indicate where below)	No	Yes		
(e) Physical and Sexual Experiences		**(f) Circle one**		*If you circled yes, please indicate*	
				Repeated?	**Approximate age(s) and frequency**
18	Has anyone ever made you have intercourse or oral or anal sex against your will? (**<u>If yes</u>**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below)__________________________________	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**<u>If yes</u>**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) ____________	No	Yes		
20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you <u>without</u> a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		

24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**If yes**, please specify below)	No	Yes		

Appendix B: RTLFB and Demographic (Modified)

Demographics

1. What is your gender? Do you identify as: ☐Male ☐Female ☐Transgender ☐Transsexual ☐Other ☐Decline
2. Where were you born: ☐St. Thomas ☐St. John ☐St. Croix ☐Other Caribbean Island:__________ ☐U. S. Mainland: State:_________ ☐Other:________

2a. Within the U. S. V. I. what is your original home community, that is after you were born and for your early years?____

2c. When did you arrive to the USVI? ______________

2d. When you arrived to USVI, what was your status?

☐US Citizen ☐Permanent resident ☐Visitor ☐Immigrant

3. Where were your parents born? ☐St. Thomas ☐St. John ☐St. Croix ☐Other Caribbean Island:__________ ☐U. S. Mainland: State:_________ ☐Other:________
4. What language do you speak: ☐English ☐Spanish ☐French ☐Other:______________
5. What is your ethnic or cultural identity?

☐Asian

☐Black

☐Latin American

☐Middle Eastern

☐White

☐Bi-Racial:(specify)______________

☐Multi-Racial:(specify)______________

☐Other (specify)____________________

6. What is your level of education?

☐Completed grade 4 or less

☐Completed grade 5 to 8

☐Attended High School, not completed

☐Completed High School

☐Attended business, trade, technical school, not completed

☐Completed business, trade, technical school

☐Attended University, not completed

☐Completed University (Bachelor's)

☐Attended Graduate School, not completed

☐Completed Graduate School

☐Don't know

☐Declined

7. Are you currently:

☐Single, never married

☐Married

☐Separated

☐Divorced

☐Cohabitating with a partner

☐Widowed

☐Don't know

☐Declined

8. How many children do you have under the age of 18? ____.
9. Do they live with you? ☐YES ☐NO (if no, do they live with ☐Family ☐Foster Care)
10. Have you worked continuously for at least one year in the past?
    ☐Yes ☐No ☐Don't know ☐Declined
11. What is your current Primary employment status?
    ☐Employed ☐Unemployed ☐Self-employed ☐Retired ☐Other:
12. What is the main reason you are not working? ☐Homeless ☐can’t find work ☐mental illness ☐physical illness or disability
13. Would you like to have a paid job in the community? ☐Yes ☐No ☐Don’t Know
14. What type of job would you like?_______________________________________
15. What are your current sources of income? ☐Food stamps ☐disability check ☐social security check ☐pan-handling/begging ☐collecting/recycling ☐other:_______________
16. In the past 5 years, have you been hospitalized for a mental illness at any time for longer than 6 months? ☐Yes ☐No ☐Don't know ☐Decline
17. In the past 5 years, have you been hospitalized 2 or more times in any one year period for a mental illness? ☐Yes ☐No ☐Don't know ☐Decline
18. Have you ever received treatment, counseling or harm reduction services for your use of alcohol or any drug, not counting cigarettes?
    ☐Yes ☐No ☐Don't know ☐Decline
19. In the past 6 months, have you been arrested for criminal activity more than once, or been imprisoned at least once, or served probation or other community sanction?
    ☐Yes ☐No ☐Don't know ☐Decline
20. In the past 6 months, did you spend one or more nights in a hospital, detox center, jail or shelter? ☐Yes ☐No ☐Don't know ☐Decline
21. When did you first become homeless (year)? ____________
22. In your lifetime, what is the total amount of time you have been homeless (months)? ____________
23. How long was your longest single period of homelessness (months)? ___________
24. When did your last period of homelessness end? ____________

Residential Time-line Follow-back

ID |_|_|_|_|_|_| Y |2|0|_|_| M |_|_| D |_|_|

Housing Circumstances – Past 6 Months

This is a quick interview, just about your living and work situation. First, I want you to think about where you have been living in the past 6 months. I would like to note all of the places where you've stayed overnight or slept during this time, including street locations, as well as hospitals or jails if applicable. Let's look at this calendar together and I'll make notes [OR if on the phone] please look at the calendar you were given last time. This is (today's date) so the time I'll ask about first is the time between now and when you started with the study, and then I'll ask about the 3 months before you started the study. Does this make sense to you? Why don't we start with where you are living now and work backwards from there, month by month.

Fill in the calendar with all moves first, then go on to the next questions.

Now I need to go over specific information about each of the places that you have lived that were listed on the calendar. We will start with where you are living now and work backwards from there.

1. What's the name of the place you are staying now? [record description according to what they tell you, prompt if necessary to get as specific as possible]:

____

1.a Is this place in the city or out of the city somewhere?

◯ In city ◯ Out of city (skip to 1b)

1.b If out of city (specify name of nearest town or if applicable, FN reserve)

____

2. Place type: (do not ask – just enter code from Prompt List A)

|_|_|_|

2.a If other, specify

____

3. Would you agree you moved in on (best estimate):

|_|_|_|_| Y r |2|0|_|_| M |_|_| D |_|_|

4. Place type category (do not ask just enter one):

Do not read, enter according to what they tell you. Halfway houses count as institutions.

◯ Street place (ask 4a,4b) ◯ Temporary or Unstable Residence (ask 4c,4d)
◯ Stable Residence (ask 4c,4d) ◯ Emergency/Street Crisis (ask 4e,4f)
◯ Institution (ask 4g)

4.a Reasons for being on the street in this period (all that apply):

Do not read, enter according to what they tell you

☐ Don't like shelters – crowding
☐ Don't like shelters - victimized
☐ Don't like shelters – fear of getting sick/not clean
☐ Shelter full
☐ Got kicked out/barred from shelter
☐ Prefer being on my own
☐ Only option available
☐ Had to leave unsafe situation (e.g. family violence/victimization)
☐ Other
☐ Don't know
☐ Declined

4.b If other, specify

____

4.c Reasons for moving into temporary/unstable or stable residence (all that apply):

Do not read, enter according to what they tell you

- ☐ Better neighborhood
- ☐ Better choice than previous situation
- ☐ In a program that forced move to this place
- ☐ In a program that offered choice to move here
- ☐ Return to prior living upon discharge from hospital, detox or jail
- ☐ Only option available
- ☐ Had to leave unsafe situation (e.g. family violence/victimization)
- ☐ Other
- ☐ Don't know
- ☐ Declined

4.d If other, specify

____

4.e Reasons for emergency/crisis stay(all that apply):

Do not read, enter according to what they tell you

- ☐ Just arrived in town, no other place to stay
- ☐ Only option available
- ☐ Familiar with this place
- ☐ Other
- ☐ Don't know
- ☐ Declined

4.f If other, specify

____

4.g Reasons for institutional (incl. halfway house) stay: (probe for specific reasons, in some cases (e.g. detox) it will be evident but in others (e.g. jail) try to determine reason for conviction. For hospital stays try to ensure that both psychiatric and medical reasons are recorded).

____

For Street, Stable or Unstable residence and emergency crisis types ONLY ask Q5 (enter NA for institutions).

5. Who are/were you living with in this place (all that apply):

Do not read, enter according to what they tell you. Count only other contining residents, not brief stays by others/ visitors.

- ☐ NA
- ☐ No one/Alone
- ☐ Spouse/partner
- ☐ Parent(s)
- ☐ Child(ren)
- ☐ Other Family
- ☐ Friends(s)/Other non-family
- ☐ Other not friends or family i.e. strangers
- ☐ Don't know
- ☐ Declined

FOR place codes 101–110 ONLY ask Q. 6

6. You said you stayed at [specified place]. If you received any kind of assistance or supports in this place could you please describe them. By assistance or supports we mean help with shopping, meals, cleaning, OR assistance or supports with any health or mental health concerns. As before, the information you give me will be kept strictly confidential.

____

7. And what about the place before that?[record description according to what they tell you, prompt if necessary to get as specific as possible]:

____

7.a Is this place in the city or out of the city somewhere?

◯ In city ◯ Out of city (skip to 7b)

Residential Time-line Follow-back

ID | | | | | Y 2 0 | | M | | D | |

7.b If out of city (specify name of nearest town or if applicable, FN reserve)

____

8. Place type: (do not ask – just enter code from Prompt List A)

| | | |

8.a If other, specify

____

9. Would you agree you moved in on (best estimate):

| | | Yr 2 0 | | M | | D |

10. Would you agree you moved out on or about (best estimate):

There may be no move out date if the place is a "split residence".

| | | Yr 2 0 | | M | | D |

10.a Does the participant use this place as a "Split Residence"?

Refers to frequent short stays of 15 days or less at the same place during last 6 months, where moving to and from this location are not considered true moves because the participant is splitting time between this place and 1 or more other locations

○ Yes ○ No

10.b How many times has the participant moved into the place over the measurement period?

Remember that the measurement period is "the past 6 months" when administering the RTLFB at baseline, and "the past 3 months" for all other administrations.

| | | |

10.c How many days has the participant lived at the place over the measurement period?

Remember that the measurement period is "the past 6 months" when administering the RTLFB at baseline, and "the past 3 months" for all other administrations.

| | | |

11. Place type category (do not ask just enter one):

Do not read, enter according to what they tell you

- ○ Street place (ask 11a,11b,12a,12b)
- ○ Temporary or Unstable Residence (ask 11c,11d,12c,12d)
- ○ Stable Residence (ask 11c,11d,12c,12d)
- ○ Emergency/Street Crisis (ask 11e,11f,12e,12f)
- ○ Institution (ask 11g)

11.a Reasons for being on the street in this period (all that apply):

Do not read, enter according to what they tell you

- ☐ Don't like shelters – crowding
- ☐ Don't like shelters - victimized
- ☐ Don't like shelters – fear of getting sick/not clean
- ☐ Shelter full
- ☐ Got kicked out/barred from shelter
- ☐ Prefer being on my own
- ☐ Only option available
- ☐ Had to leave unsafe situation (e.g. family violence/victimization)
- ☐ Other
- ☐ Don't know
- ☐ Declined

11.b If other, specify

____

11.c Reasons for moving into temporary/unstable or stable residence (all that apply):

Do not read, enter according to what they tell you

- ☐ Better neighborhood
- ☐ Better choice than previous situation
- ☐ In a program that forced move to this place
- ☐ In a program that offered choice to move here
- ☐ Return to prior living upon discharge from hospital, detox or jail
- ☐ Only option available
- ☐ Had to leave unsafe situation (e.g. family violence/victimization)
- ☐ Other
- ☐ Don't know
- ☐ Declined

11.d If other, specify

____

11.e Reasons for emergency/crisis stay(all that apply):

Do not read, enter according to what they tell you

- ☐ Just arrived in town, no other place to stay
- ☐ Only option available
- ☐ Familiar with this place
- ☐ Other
- ☐ Don't know
- ☐ Declined

11.f If other, specify

____

11.g Reasons for institutional stay: (probe for specific reasons, in some cases (e.g. detox) it will b evident but in others (e.g. jail) try to determine reason for conviction. For hospital stays try t ensure that both psychiatric and medical reasons are recorded).

____

12.a Reasons for leaving the street in this period (all that apply)

Do not read, enter according to what they tell you

- ☐ Weather got bad
- ☐ Got space in shelter or crisis housing
- ☐ Got temporary/unstable housing
- ☐ Got stable housing
- ☐ Admitted to hospital or incarcerated
- ☐ Moved back to home community/reserve
- ☐ Had to leave unsafe situation (e.g. family violence/victimization)
- ☐ Other
- ☐ Don't know
- ☐ Declined

12.b If other, specify

____

12.c Reasons for moving out of temporary/unstable or stable residence (all that apply):

Do not read, enter according to what they tell you

- ☐ Evicted/forced to leave
- ☐ Crowding
- ☐ Building problems (repairs or safety concerns)
- ☐ Building problems (dangerous)
- ☐ Program closed
- ☐ Program problems (too restrictive or rules did not work)
- ☐ Personal safety concerns with others in the building
- ☐ Personal safety concerns with neighborhood
- ☐ Victimized (domestic violence/other abuse)
- ☐ Neighborhood unacceptable
- ☐ Financial/could not afford/lost job/got sick
- ☐ Interpersonal problems with other residents/relationship problems
- ☐ Interpersonal problems with landlord/caretaker/building staff
- ☐ Left to be closer to work or school
- ☐ Wanted to be on own
- ☐ Wanted to move in with someone else incl. significant other
- ☐ Admitted to hospital or jail
- ☐ Wore out welcome
- ☐ Moved back to home community/reserve
- ☐ Infestation
- ☐ Other
- ☐ Don't know
- ☐ Declined

12.d If other, specify

____

12.e Reasons for leaving emergency/crisis stay (all that apply):

Do not read, enter according to what they tell you

- ☐ Reason for ER visit resolved
- ☐ Not satisfied with services
- ☐ Weather got better
- ☐ Told to leave/got banned or barred
- ☐ Got temporary/unstable housing
- ☐ Got stable housing
- ☐ Admitted to hospital or incarcerated
- ☐ Moved back to home community/reserve
- ☐ Other
- ☐ Don't know
- ☐ Declined

12.f If other, specify

____

For Street, Stable or Unstable residence and emergency crisis types ONLY ask Q13 (enter NA for institutions).

13. Who are/were you living with in this place (all that apply):

do not read, enter according to what they tell you.

- ☐ NA
- ☐ No one/Alone
- ☐ Spouse/partner
- ☐ Parent(s)
- ☐ Child(ren)
- ☐ Other Family
- ☐ Friends(s)/Other non-family
- ☐ Other not friends or family i.e. strangers
- ☐ Don't know
- ☐ Declined

FOR place codes 101–110 ONLY ask Q. 14

Residential Time-line Follow-back

ID | | | | | | Y 2 0 | | M | | D | |

14. You said you stayed at [specified place]. If you received any kind of assistance or supports in this place could you please describe them. By assistance or supports we mean help with shopping, meals, cleaning, OR assistance or supports with any health or mental health concerns. As before, the information you give me will be kept strictly confidential.

15. And what about the place before that?[record description according to what they tell you, prompt if necessary to get as specific as possible]:

15.a Is this place in the city or out of the city somewhere?

◯ In city ◯ Out of city (skip to 15b)

15.b If out of city (specify name of nearest town or if applicable, FN reserve)

16. Place type: (do not ask – just enter code from Prompt List A)

16.a If other, specify

17. Would you agree you moved in on (best estimate):

| | | | Yr 2 0 | | M | | D | |

18. Would you agree you moved out on or about (best estimate):

There may be no move out date if the place is a "split residence".

| | | | Yr 2 0 | | M | | D | |

18.a Does the participant use this place as a "Split Residence"?

Refers to frequent short stays of 15 days or less at the same place during last 6 months, where moving to and from this location are not considered true moves because the participant is splitting time between this place and 1 or more other locations

◯ Yes ◯ No

18.b How many times has the participant moved into the place over the measurement period?

Remember that the measurement period is "the past 6 months" when administering the RTLFB at baseline, and "the past 3 months" for all other administrations.

18.c How many days has the participant lived at the place over the measurement period?

Remember that the measurement period is "the past 6 months" when administering the RTLFB at baseline, and "the past 3 months" for all other administrations.

19. Place type category (do not ask just enter one):

Do not read, enter according to what they tell you

◯ Street place (ask 19a,19b,20a,20b)

◯ Temporary or Unstable Residence (ask 19c,19d,20c,20d)

◯ Stable Residence (ask 19c,19d,20c,20d)

◯ Emergency/Street Crisis (ask 19e,19f,20e,20f)

◯ Institution (ask 19g)

Appendix C: Consent and Disclosure Form

CONSENT and DISCLOSURE FORM

Hello! My name is Elisa Niles, and I am a doctoral candidate at Walden University. Thank you for your interest in this research study on the Impact of Trauma on Reoccurring Homelessness in the USVI. This form is part of a process called "informed consent" which allows a potential participant (you) to understand the study before deciding to participate. This research study is under the supervision of Dr. Laura Haddock -Dissertation Chair and Dr. Susan Eaves- Dissertation Co-Chair. If needed, I will read to contents of this form to participants.

Background Information:

Many factors contribute to an individual becoming homeless, such as unemployment, natural and human-made disasters, untreated mental illness, substance abuse issues, and lack of affordable housing. In 2015, there were 252 unsheltered homeless in the USVI; in 2017, 307 were counted, which showed a 22% increase over the past two years. Research shows a relationship between trauma and homelessness and found correlations with early trauma and homelessness. The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a threat to stable housing; thus, repeating the cycle of homelessness. There is limited research on the homeless population living in the USVI. As a result, I am seeking to examine the impact of trauma on the cycle of homelessness. In order to participate in this study, you need to be homeless, adult male or female, over the age of 18 years, and receive services from MTOC, DHS and CCVI. Due to the nature of this study, your input is vital in helping to shape change for the homeless population in the USVI.

Procedures:

If you agree to be in this study:

- I will ask you to complete two questionnaires, which are the Trauma History Screen, and the Residential Timeline Follow Back.
- You will be asked to spend about 5-20 minutes to complete each questionnaire.
- The RTLFB will be conducted in a semi-structured interview in a confidential room.
- If needed, a recorded version of the questionnaires will be provided
- You will be assigned a number in order to protect your confidentiality.
- All data will be stored on a password protected computer and stored in a locked file cabinet.

Voluntary Nature of the Study

This study is voluntary, which means you are free to accept or withdraw from it at any time without penalties or mistreatment from anyone. You can also refuse to answer any

of the questions on the questionnaires. No one at DHS, CCVI or MTOC will treat you any differently if you decide not to participate.

Risks and Benefits of Being in the Study

The risk of being in this study involves the possibility of experiencing similar discomforts that you may encounter in daily life, such as emotional distress during the interview. Participating in this study would not pose a risk to your safety or well-being. Due to the sensitive nature of this topic, I will provide you with resources coping with trauma and for additional emotional support if needed, **Dr. Sheena Walker (5316 Yacht Haven Grande, Suite N101, Unit 61, St. Thomas, USVI 00802 Phone: (340) 715-6463) or Dr. Rita Dudley- Grant (5030 Anchor Way, Suite 7, Christiansted VI 00820; phone: 719-7007)** have volunteered to provide counseling if requested. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI.

Payment

You will receive a care package as a small token of appreciation for your time. This package will include: toothbrush, toothpaste, soap, deodorant, hand sanitizer, non-perishable food items, socks, bottled water, comb, plastic utensils, and female hygiene products.

Privacy

The researcher will keep the identities of participants confidential and will assign a number on each form you complete in the study. Details that might identify participants, such as the location of the study, will also not be shared with anyone outside of the dissertation team. The team will not use your personal information for any purpose outside of this research project. The researcher will keep your data securely stored on a password-protected computer. Data must be kept for a minimum of five years as required by Walden University.

Contacts and Questions

You may ask any questions about the study at any time by contacting the primary researcher via phone at 340-514-7950 or email at elisa.niles@waldenu.edu or email Dr. Laura Haddock, Dissertation Chair at Laura.Haddock@waldenu.edu.
If you would like to talk privately about your rights as a participant, you can call the Research Participant Advocate at Walden University at 612-312-1210. The university's approval number for this study is 08-16-18-0527949 and it expires on 08-15-18

By writing my initials below or placing an X, I agree to the following statements:
____ I have read and understand the contents written in this informed consent.
____ I understand that I can withdraw at any point in the study.
____ I understand that I can ask for help if I feel emotionally upset or triggered by

questions
____ I understand there are potential risks and benefits and I am willing to participate in this study.
_____I agree to participant in the research conducted by Elisa Niles a doctoral candidate at Walden University.
_____ I will receive a copy of this form

Script to be read to participants:

Hello, my name is Elisa, thank you for agreeing to participate in this study. You are asked to participate if you are homeless, adult male or female, over the age of 18 years, and receive services from MTOC, DHS and CCVI. These pages outline the details of this study such as the importance of understanding how trauma may potentially impact homelessness. I will ask you to complete two questionnaires. If you need help, please ask. If you do not wish to answer a question you can skip it. If you do not wish to continue you are free to leave. You will receive a care kit and some information about trauma. Some of the questions are sensitive and my trigger some feelings. You are free to discontinue or if you wish, can ask to speak to someone. Do you have any questions at this time?

Appendix D: Recruitment Flyer

Participants Needed for Research

You are invited to participate in a Research Study conducted

By a Doctoral Student attending Walden University

The study seeks to examine the relationship between trauma

and reoccurring homelessness in the USVI

If you are over the age of 18, homeless, and receive services

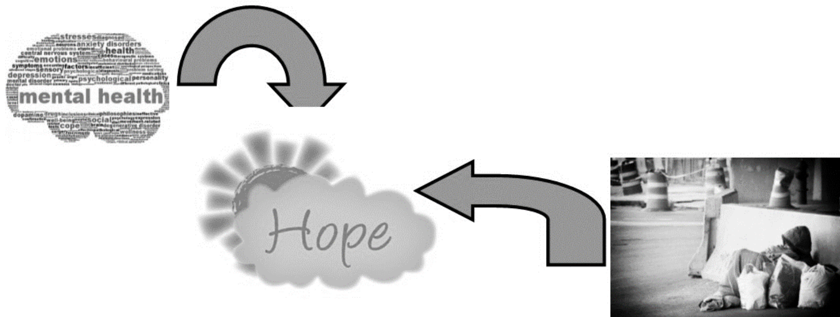
from DHS, MTOC or Catholic Charities of the VI

And would like to participate, come to

the Department of Human Services , St. Thomas/St. Croix

on ____________ between the hours of _____ and _________. Bring

this flyer with you.



This study is my dissertation for my doctoral program. It is not a part of DHS or MTOC services or functions

Appendix E: Letters to Organizations and Responses

March 20, 2018

Mrs. Felicia Blyden
Commissioner
Department of Human Services
Knud Hansen Complex, Bldg. A
St. Thomas, USVI 00802

Dear Commissioner Blyden,

My name is Elisa Niles and I am a doctoral candidate at Walden University. As part of the requirements to complete my PhD. in Counselor Education and Supervision, I am in the process of writing my dissertation and conducting research on the homeless population in the USVI. The title of my research is: The Impact of Trauma on Reoccurring Homelessness in the United States Virgin Islands. My dissertation committee is Dr. Laura Haddock and Dr. Susan Eaves.

Current researchers have examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012). The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a hindrance to stable housing; thus, perpetuating re-occurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design is to examine the relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), and re-occurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the USVI. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI (Bowen & Murshid, 2016; Virgin Islands Continuum of Care on Homelessness, 2017).

To this end, my research study involves individuals who are homeless and receive services from the Department of Human Services. I am therefore requesting permission to recruit participants who are enrolled in the Supportive Housing Program on St. Thomas and St. Croix. I am also requesting permission to use an office where I can meet potential participant to conduct the interviews. If permission is granted, participants will

be asked to come to the Department of Human Services located on St. Thomas and St. Croix and complete three questionnaires. Participants will also receive a care package with personal hygiene items and other essentials.

Research that involves vulnerable populations, such as people who are homeless are at a potential risk for harm; however, this study will be reviewed by the Walden University Institutional Review Board (IRB). Once approval has been granted, I will provide you with the IRB number and expiration date. Should you have any questions or concerns at me at 340-514-7950 or email at elisa.niles@waldenu.edu or email my, Dissertation Chair, Dr. Laura Haddock, at Laura.Haddock@waldenu.edu.

Thank you in advance for your thoughtful consideration.

Sincerely,

Elisa A. Niles, LMHC, NCC, CCTP
Doctoral Candidate
Walden University

Janet Turnbull-Krigger <janet.turnbull-krigger@dhs.vi.gov>

Reply all|
Yesterday, 8:38 AM
Elisa Niles;
Felecia Blyden <Felecia.Blyden@dhs.vi.gov>;
+2 more

Good Morning Ms. Niles:

Thank you for your interest in assisting the homeless in the territory. In order to accommodate your request, we would need the dates you would be here, the days you would be conducting the interviews, and the amount of participants. Once we receive this information, we will try to accommodate your request.

Have a wonderful day.

Janet Turnbull-Krigger
Assistant Commissioner
Department of Human Services
Knud Hansen Complex - Building A
1303 Hospital Ground
Charlotte Amalie
St. Thomas, VI 00802
Tel: (340)774-0930 X 4110 or 4102
Fax: (340) 774-3466

Ms. Andrea Shillingford
Executive Director
Catholic Charities of the Virgin Islands
St. Thomas, USVI 00802

Dear Ms. Shillingford,

My name is Elisa Niles and I am a doctoral candidate at Walden University. As part of the requirements to complete my PhD. in Counselor Education and Supervision, I am in the process of writing my dissertation. The topic is: The Impact of Trauma on Reoccurring Homelessness in the United States Virgin Islands. My dissertation committee is Dr. Laura Haddock and Dr. Susan Eaves.

Current researchers have examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012). The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a hindrance to stable housing; thus, perpetuating re-occurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design is to examine the relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), and re-occurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the USVI. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI (Bowen & Murshid, 2016; Virgin Islands Continuum of Care on Homelessness, 2017).

To this end, my research study involves individuals who are homeless and receive services from the Catholic Charities of the Virgin Islands. I am therefore requesting permission to recruit participants who are housed in the shelters on St. Thomas and St. Croix. If permission is granted, participants will be asked to come to the Department of Human Services located on St. Thomas and St. Croix and complete three questionnaires. Participants will also receive a care package with personal hygiene items and other essentials.

Research that involves vulnerable populations, such as people who are homeless are at a potential risk for harm; however, this study will be reviewed by the Walden University Institutional Review Board (IRB). Once approval has been granted, I will provide you

with the IRB number and expiration date. Should you have any questions or concerns at me at 340-514-7950 or email at elisa.niles@waldenu.edu or email my, Dissertation Chair, Dr. Laura Haddock, at Laura.Haddock@waldenu.edu.

Thank you in advance for your thoughtful consideration.

Sincerely,

Elisa A. Niles, LMHC, NCC, CCTP
Doctoral Candidate
Walden University

Catholic Charities <ccusvi@outlook.com>

Reply all

Yesterday, 3:34 PM

Elisa Niles

Hi Ms. Niles,

Catholic Charities of the VI is excited that you have chosen our agency in your endeavors. As we discussed the population of clients that you will work are the clients that visit our Soup Kitchen and the clients we serve on our Outreach routes.

I look forward to speaking with you soon. Have a Blessed weekend.

Andrea Shillingford
Executive Director
Catholic Charities of the Virgin Islands
P. O. Box 10736
St. Thomas USVI
Email: ccusvi@outlook.com
Tel. 340- 777- 8518

Mrs. Louise Petersen
Executive Director
Methodist Training and Outreach Center
St. Thomas, USVI 00802

Dear Mrs. Petersen,

My name is Elisa Niles and I am a doctoral candidate at Walden University. As part of the requirements to complete my PhD. in Counselor Education and Supervision, I am in the process of writing my dissertation. The topic is: The Impact of Trauma on Reoccurring Homelessness in the United States Virgin Islands. My dissertation committee is Dr. Laura Haddock and Dr. Susan Eaves.

Current researchers have examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012). The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a hindrance to stable housing; thus, perpetuating re-occurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design is to examine the relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), and re-occurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the USVI. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI (Bowen & Murshid, 2016; Virgin Islands Continuum of Care on Homelessness, 2017).

To this end, my research study involves individuals who are homeless and receive services from the Methodist Training and Outreach Center. I am therefore requesting permission to recruit participants who receive services from your organization on St. Thomas and St. Croix. If permission is granted, participants will be asked to come to the Department of Human Services located on St. Thomas and St. Croix and complete three questionnaires. Participants will also receive a care package with personal hygiene items and other essentials.

Research that involves vulnerable populations, such as people who are homeless are at a potential risk for harm; however, this study will be reviewed by the Walden University Institutional Review Board (IRB). Once approval has been granted, I will provide you

with the IRB number and expiration date. Should you have any questions or concerns at me at 340-514-7950 or email at elisa.niles@waldenu.edu or email my, Dissertation Chair, Dr. Laura Haddock, at Laura.Haddock@waldenu.edu.

Thank you in advance for your thoughtful consideration.

Sincerely,

Elisa A. Niles, LMHC, NCC, CCTP
Doctoral Candidate
Walden University

Response

Louise O. Petersen <lpetersen@mtoc.vi>

Reply all

Wed 3/21, 12:00 PM

Elisa Niles

Good Morning Elisa,

You may contact our clients. I am not sure how many of them will respond.

Good luck.

Louise O. Petersen

Executive Director
Methodist Training and Outreach Center
4-A Kronprindsens Gade
PO Box 306816
St.Thomas, VI 00803
Phone (340)714-7782
Fax (340)714-7784
Website http://www.mtoc.vi
email lpetersen@mtoc.vi

Appendix F: Request for Permission and Response to use RTLFB

I hope this email finds you well.

My name is Elisa Niles and I am a 3rd year doctoral student at Walden University. I am currently in the dissertation process and this is my 3rd quarter. I am conducting a quantitative study on the Impact of trauma on reoccurring homelessness in the U. S. Virgin Islands.

To this end, I am requesting permission to utilize the Residential Timeline Follow-Back (RTLFB) as this instrument is crucial to my data collection. I would greatly appreciate any assistance you can provide me in obtaining a copy of the RTLFB and the proper protocol for collecting data.

I have attempted email to Ms. Valerie Williams and Ms. Francine Williams. They were listed on the article by Tsemberis et al.,(2007), but the email returned undeliverable. I obtained your email from the UMass website as you were listed under the national center on homelessness among veterans.

Tsemberis, S., McHugo, G., Williams, V., Hanrahan, P., & Stefancic, A. (2007). Measuring homelessness and residential stability: The residential time-line follow-back inventory. Journal of Community Psychology, 35(1), 29–42. doi:10.1002/jcop.20132

Thank you and I look forward to your response.

Fri 3/9, 11:08 AM
Sam Tsemberis <sam@pathwaysnational.org>;
Elisa Niles;
+1 more

At Home Research Instruments Kit - June 17, 2010.pdf
4 MB

Hi Elisa,

Please find attached the instrument toolkit that we used in the At Hone / Chez Soi project. It includes a description of the RTLFB along with the actual instrument. If you need further information, please don’t hesitate to contact me.

Best,

Tim

Tim Aubry Ph.D, C.Psych.
Directeur / Director
Professeur / Professor
École de psychologie / School of Psychology
Chercheur / Senior Researcher
Centre de recherche sur les services éducatifs / Centre for Research on Educational and Community Services
Chaire de recherche facultaire en santé mentale communautaire et l'itinérance / Faculty Research Chair in Community Mental Health and Homelessness
Doyen associé / Associate Dean
Faculté des sciences sociales / Faculty of Social Sciences
Université d'Ottawa / University of Ottawa
Vanier Hall / Pavillon Vanier, 5002J
Ottawa, ON
K1N 6N5
Tel.: 613-562-5800 x 5232
Fax: 613-562-5188
E-mail: taubry@uottawa.ca
Bio: https://uniweb.uottawa.ca/#!uottawa/members/1026
Twitter: @TimAubry

Sam Tsemberis <sam@pathwaysnational.org>

Thu 3/8, 6:46 PM

Hi Elisa, You are welcome to use the RTLFB for your study. I have copied Professor Tim Aubry who will hopefully be able to be able to send you a copy of the instrument and the protocol or guide you to someone who can help you. Let me know if this does not work

Elisa Niles

Thu 3/8, 5:15 PM

Thank you. Elisa A. Niles, LMHC-S, NCC, CCTP NBCC MFP Fellow(2016) PhD-CES Doctoral Candidate Membership Chair-Chi Sigma Iota-Omega Zeta PO Box 380991 Murdock, FL 33938 elisa.niles@waldenu.edu "From your cocoon, you emerged "

Appendix G: Debriefing Brochure

WHAT IS TRAUMA?

"Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA, 2014, p. 7).

EVENT → EXPERIENCE → EFFECTS

TRAUMA-INFORMED CARE APPROACH (TIC)

- Realize the impact of trauma
- Recognize the symptoms of trauma
- Resist re-traumatization
- Respond

Principles of TIC

- Be and Feel Safe
- Trust others to help you
- Collaborate with people who care
- Empower yourself by making healthy choices,
- Be aware of how unique you are. It is not what's wrong with you, but what happened to you.

Ways to Cope with Trauma

- Talk to someone
- Read
- Meditate/Prayer
- Practice deep breathing exercises

Using your 5 Senses to Stay Calm

Grounding Exercise

Look around you. Identify + name:

5 things you **see**
4 things you **feel**
3 things you **hear**
2 things you **smell**
1 thing you **taste**

STAY CONNECTED... REACH OUT FOR HELP

Dr. Sheena Walker
5316 Yacht Haven Grande, Suite N101,
Unit 61, St. Thomas, USVI 00802
Phone: (340) 715-6463)

or

Dr. Rita Dudley- Grant
5030 Anchor Way, Suite 7, Christiansted
VI 00820
Phone: (340) 719-7007

Other Resources

Department of Health-

St. Croix Office :(340) 718-1311

St. Thomas Office: (340) 774-9000

National Suicide Hotline:
1800-273-TALK

HealthyPlace.com

How to Cope with Triggered Trauma Memories

- **Move your body.** Get your body moving to release endorphins and shift your body's response.
- **Use grounding techniques.** Bring yourself into the present by getting in touch with your senses.
- **Go outside.** This is a great place to apply grounding techniques. Breathe the fresh air.
- **Practice cozy self-care.** Draw a warm bath. Put on your comfiest pajamas.
- **Let emotions be.** Allow yourself to process the emotions with patience.
- **Try tapping.** Tapping calms anxiety, builds self-acceptance and draws your awareness into your senses.
- **Get support.** Having a sense of community is essential to avoid falling prey to isolation.

CREATED BY ELISA

MOVING FROM TRAUMA TO TRIPUMPH

MANAGING TRAUMA

Trauma-Informed Care Approach

Appendix H: Letters to Psychologists

April 4, 2018

Sheena Walker, PhD
Clinical Psychologist
Mind/Body Health & Psychology, LLC-
Synergy Fitness & Wellness Center-
6115 Est. Smith Bay, Suites 334/335
St. Thomas, USVI 00802

Dear Dr. Walker:

My name is Elisa Niles and I am a doctoral candidate at Walden University. As part of the requirements to complete my PhD. in Counselor Education and Supervision, I am in the process of writing my dissertation and conducting research on the homeless population in the USVI. The title of my research is: The Impact of Trauma on Reoccurring Homelessness in the United States Virgin Islands. My dissertation committee is Dr. Laura Haddock and Dr. Susan Eaves.

Current researchers have examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012). The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a hindrance to stable housing; thus, perpetuating re-occurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design is to examine the relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), and re-occurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the USVI. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI (Bowen & Murshid, 2016; Virgin Islands Continuum of Care on Homelessness, 2017).

To this end, my research study involves individuals who are homeless and receive services from the Department of Human Services, Catholic Charities of the Virgin Islands and the Methodist Training & Outreach Center. I will be asking participants questions of a sensitive nature, which could be emotionally triggering. I am therefore

requesting your assistance to provide counseling should a participant request for services. Please note that this will be voluntary as I am unable to provide any compensation for your time. It will be the responsibility of the participant to contact you and set-up a time for session. I will only provide the participant with your name and contact number should you agree to this request.

Research that involves vulnerable populations, such as people who are homeless are at a potential risk for harm; however, this study will be reviewed by the Walden University Institutional Review Board (IRB). Once approval has been granted, I will provide you with the IRB number and expiration date. Should you have any questions or concerns at me at 340-514-7950 or email at elisa.niles@waldenu.edu or email my, Dissertation Chair, Dr. Laura Haddock, at Laura.Haddock@waldenu.edu.

Thank you in advance for your thoughtful consideration.

Sincerely,

Elisa A. Niles, LMHC, NCC, CCTP
Doctoral Candidate
Walden University

Sheena Myong <sheena.myong@gmail.com>

|
Tue 6/12, 6:42 AM
Good morning Ms. Niles,
I hope all is well! Please excuse my delayed response. Congratulations on making it to this point in your education!

I am in support of your research. In the event that a participant is in need of supportive counseling or Psychotherapy, myself and other qualified psychotherapists will make ourselves available.

Good luck in your research!

"You can explore the universe looking for somebody who is more deserving of your love and affection than you are yourself, and you will not find that person anywhere."
Buddhist Saying

April 4, 2018

Rita Dudley-Grant, Ph.D.
Golden Orange Center, #11
Christiansted, VI 00820

Dear Dr. Dudley-Grant:

My name is Elisa Niles and I am a doctoral candidate at Walden University. As part of the requirements to complete my PhD. in Counselor Education and Supervision, I am in the process of writing my dissertation and conducting research on the homeless population in the USVI. The title of my research is: The Impact of Trauma on Reoccurring Homelessness in the United States Virgin Islands. My dissertation committee is Dr. Laura Haddock and Dr. Susan Eaves.

Current researchers have examined the relationship between trauma and homelessness and found correlations with early trauma and homelessness (Deck & Platt, 2015; Johnstone et al., 2016; Larkin & Park, 2012). The problem is that services offered by the Methodist Training & Outreach Center (MTOC) the Department of Human Services (DHS), and Catholic Charities of the Virgin Islands (CCVI) are not inclusive of trauma-informed care and therefore, may pose a hindrance to stable housing; thus, perpetuating re-occurring homelessness. Furthermore, a review of the literature yielded limited research on the homeless population living in the USVI to examine the impact of trauma on the cycle of homelessness. The purpose of this cross-sectional correlational design is to examine the relationship of trauma in its various forms (sexual abuse, physical abuse, combat experience, natural disasters, witnessing violence), demographic factors (age, gender, education level, mental illness status, substance abuse, employment history), and re-occurring homelessness (housing stability, duration of homelessness, service utilization) in persons who are homeless living in the USVI. The benefits of participating in this study include helping the overall counseling profession and U. S. Virgin Islands community to understand the impact trauma has on homelessness, thereby increasing awareness for specialized programs, policies, and legislations to reduce homelessness in the USVI (Bowen & Murshid, 2016; Virgin Islands Continuum of Care on Homelessness, 2017).

To this end, my research study involves individuals who are homeless and receive services from the Department of Human Services, Catholic Charities of the Virgin Islands and the Methodist Training & Outreach Center. I will be asking participants questions of a sensitive nature, which could be emotionally triggering. I am therefore requesting your assistance to provide counseling should a participant request for services. Please note that this will be voluntary as I am unable to provide any compensation for your time. It will be the responsibility of the participant to contact you and set-up a time for session. I will only provide the participant with your name and contact number should you agree to this request.

Research that involves vulnerable populations, such as people who are homeless are at a potential risk for harm; however, this study will be reviewed by the Walden University Institutional Review Board (IRB). Once approval has been granted, I will provide you with the IRB number and expiration date. Should you have any questions or concerns at me at 340-514-7950 or email at elisa.niles@waldenu.edu or email my, Dissertation Chair, Dr. Laura Haddock, at Laura.Haddock@waldenu.edu.

Thank you in advance for your thoughtful consideration.

Sincerely,

Elisa A. Niles, LMHC, NCC, CCTP
Doctoral Candidate
Walden University

G Rita Dudley Grant <rdudleygrant@gmail.com>

|
Thu 4/5, 6:01 PM
I will volunteer my services

Sent from my iPhone

Appendix I: SPSS Output of Dependent Variables

Descriptive Statistics

	Mean	Std. Deviation	N
TOTAL TIME OF HOMELESSNESS	128.40	149.178	57
GENDER	1.81	.398	57
AGE	49.89	11.817	57
EDUCATION	3.56	1.337	57
SUB.ABUSE HX	1.82	.384	57
EMPLOYMENT HX	.88	.331	57
MENTAL ILLNESS	1.77	.423	57
Sexual_Abuse	.37	.837	57
Physical_Abuse	1.19	1.315	57
Combat_Experience	.11	.310	57
Natural_Disaster	1.14	.480	57
Witnessing_Violence	.89	.939	57
Other_Trauma	3.07	2.259	57

Model Summary[c]

					Change Statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.291[a]	.085	-.025	151.025	.085	.773	6	50	.595
2	.431[b]	.185	-.037	151.886	.101	.906	6	44	.500

a. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

c. Dependent Variable: TOTAL TIME OF HOMELESSNESS

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	105807.204	6	17634.534	.773	.595[b]
	Residual	1140420.516	50	22808.410		
	Total	1246227.719	56			
2	Regression	231173.490	12	19264.458	.835	.615[c]
	Residual	1015054.229	44	23069.414		
	Total	1246227.719	56			

a. Dependent Variable: TOTAL TIME OF HOMELESSNESS
b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX
c. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, EMPLOYMENT HX, GENDER, AGE, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	240.886	178.652		1.348	.184					
	GENDER	4.563	54.483	.012	.084	.934	.027	.012	.011	.866	1.155
	AGE	1.838	1.827	.146	1.006	.319	.144	.141	.136	.874	1.145
	EDUCATION	-22.327	15.315	-.200	-1.458	.151	-.201	-.202	-.197	.972	1.029
	SUB.ABUSE HX	-49.831	57.808	-.128	-.862	.393	-.127	-.121	-.117	.828	1.208
	EMPLOYMENT HX	-53.905	63.810	-.120	-.845	.402	-.060	-.119	-.114	.912	1.096
	MENTAL ILLNESS	2.988	49.083	.008	.061	.952	-.010	.009	.008	.943	1.060
2	(Constant)	284.957	189.007		1.508	.139					
	GENDER	-.704	61.260	-.002	-.011	.991	.027	-.002	-.002	.692	1.444
	AGE	3.141	1.965	.249	1.599	.117	.144	.234	.217	.764	1.309
	EDUCATION	-29.963	15.992	-.268	-1.874	.068	-.201	-.272	-.255	.902	1.109

	SUB.ABUSE HX	-57.859	62.018	-.149	-.933	.356	-.127	-.139	-.127	.727	1.375
	EMPLOYMENT HX	-63.488	67.470	-.141	-.941	.352	-.060	-.140	-.128	.825	1.212
	MENTAL ILLNESS	12.076	51.466	.034	.235	.816	-.010	.035	.032	.868	1.152
	Sexual_Abuse	.473	32.676	.003	.014	.989	-.101	.002	.002	.550	1.817
	Physical_Abuse	-13.424	24.617	-.118	-.545	.588	-.109	-.082	-.074	.393	2.545
	Combat_Experience	163.433	80.352	.339	2.034	.048	.110	.293	.277	.666	1.502
	Natural_Disaster	-31.095	46.656	-.100	-.666	.509	-.002	-.100	-.091	.823	1.215
	Witnessing_Violence	-17.286	30.027	-.109	-.576	.568	-.073	-.086	-.078	.518	1.929
	Other_Trauma	-5.175	15.230	-.078	-.340	.736	-.133	-.051	-.046	.348	2.873

a. Dependent Variable: TOTAL TIME OF HOMELESSNESS

Descriptive Statistics

	Mean	Std. Deviation	N
HS_Subscale	4.31	2.839	65
GENDER	1.82	.391	65
AGE	49.31	12.040	65
EDUCATION	3.58	1.322	65
SUB.ABUSE HX	1.83	.378	65
EMPLOYMENT HX	.86	.348	65
MENTAL ILLNESS	1.80	.403	65
Sexual_Abuse	.43	.901	65
Physical_Abuse	1.22	1.281	65
Combat_Experience	.09	.292	65
Natural_Disaster	1.20	.506	65
Witnessing_Violence	.94	.933	65
Other_Trauma	3.20	2.230	65

Model Summary[c]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.346[a]	.120	.029	2.798	.120	1.318	6	58	.264
2	.419[b]	.175	-.015	2.860	.055	.583	6	52	.742

a. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

c. Dependent Variable: HS_Subscale

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	61.878	6	10.313	1.318	.264[b]
	Residual	453.968	58	7.827		
	Total	515.846	64			
2	Regression	90.482	12	7.540	.922	.533[c]
	Residual	425.364	52	8.180		
	Total	515.846	64			

a. Dependent Variable: HS_Subscale

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX

c. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	6.925	2.967		2.334	.023					
	GENDER	-1.076	.982	-.148	-1.096	.278	-.173	-.142	-.135	.829	1.206
	AGE	.037	.031	.159	1.211	.231	.160	.157	.149	.881	1.136

	EDUCATION	.204	.269	.095	.757	.452	.105	.099	.093	.967	1.034
	SUB.ABUSE HX	-1.000	1.020	-.133	-.980	.331	-.227	-.128	-.121	.823	1.215
	EMPLOYMENT HX	.460	1.061	.056	.434	.666	.091	.057	.053	.896	1.116
	MENTAL ILLNESS	-1.004	.886	-.143	-1.133	.262	-.164	-.147	-.140	.958	1.044
2	(Constant)	7.565	3.250		2.327	.024					
	GENDER	-.433	1.113	-.060	-.389	.699	-.173	-.054	-.049	.675	1.481
	AGE	.045	.032	.191	1.397	.168	.160	.190	.176	.845	1.184
	EDUCATION	.124	.283	.058	.438	.663	.105	.061	.055	.916	1.092
	SUB.ABUSE HX	-1.399	1.107	-.186	-1.264	.212	-.227	-.173	-.159	.731	1.369
	EMPLOYMENT HX	.254	1.123	.031	.226	.822	.091	.031	.028	.837	1.195
	MENTAL ILLNESS	-1.119	.951	-.159	-1.176	.245	-.164	-.161	-.148	.869	1.150
	Sexual_Abuse	.270	.501	.086	.538	.593	.021	.074	.068	.627	1.594
	Physical_Abuse	.024	.428	.011	.057	.955	.080	.008	.007	.426	2.349
	Combat_Experience	.719	1.447	.074	.497	.621	.116	.069	.063	.717	1.394
	Natural_Disaster	-.947	.761	-.169	-1.245	.219	-.141	-.170	-.157	.862	1.160
	Witnessing_Violence	.657	.543	.216	1.210	.232	.119	.166	.152	.498	2.006
	Other_Trauma	-.149	.279	-.117	-.536	.594	.032	-.074	-.067	.331	3.022

a. Dependent Variable: HS_Subscale

Descriptive Statistics

	Mean	Std. Deviation	N
SrvcUtilz_subscale	2.98	1.883	65
GENDER	1.82	.391	65
AGE	49.31	12.040	65
EDUCATION	3.58	1.322	65
SUB.ABUSE HX	1.83	.378	65
EMPLOYMENT HX	.86	.348	65
MENTAL ILLNESS	1.80	.403	65

Sexual_Abuse	.43	.901	65
Physical_Abuse	1.22	1.281	65
Combat_Experience	.09	.292	65
Natural_Disaster	1.20	.506	65
Witnessing_Violence	.94	.933	65
Other_Trauma	3.20	2.230	65

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	50.968	6	8.495	2.799	.018[b]
	Residual	176.017	58	3.035		
	Total	226.985	64			
2	Regression	62.019	12	5.168	1.629	.112[c]
	Residual	164.966	52	3.172		
	Total	226.985	64			

a. Dependent Variable: SrvcUtilz_subscale

b. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX

c. Predictors: (Constant), MENTAL ILLNESS, EDUCATION, AGE, GENDER, EMPLOYMENT HX, SUB.ABUSE HX, Natural_Disaster, Physical_Abuse, Combat_Experience, Witnessing_Violence, Sexual_Abuse, Other_Trauma

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.833	1.847		2.075	.042					
	GENDER	1.647	.612	.342	2.694	.009	.293	.333	.311	.829	1.206
	AGE	-.016	.019	-.104	-.846	.401	-.053	-.110	-.098	.881	1.136
	EDUCATION	-.428	.168	-.300	-2.555	.013	-.348	-.318	-.295	.967	1.034
	SUB.ABUSE HX	-.734	.635	-.147	-1.155	.253	-.026	-.150	-.134	.823	1.215
	EMPLOYMENT HX	-.543	.661	-.100	-.822	.415	-.099	-.107	-.095	.896	1.116

	MENTAL ILLNESS	.172	.552	.037	.312	.756	.016	.041	.036	.958	1.044
2	(Constant)	3.950	2.024		1.951	.056					
	GENDER	1.661	.693	.345	2.397	.020	.293	.315	.283	.675	1.481
	AGE	-.020	.020	-.127	-.988	.328	-.053	-.136	-.117	.845	1.184
	EDUCATION	-.429	.176	-.301	-2.436	.018	-.348	-.320	-.288	.916	1.092
	SUB.ABUSE HX	-.590	.689	-.118	-.856	.396	-.026	-.118	-.101	.731	1.369
	EMPLOYMENT HX	-.520	.699	-.096	-.743	.461	-.099	-.103	-.088	.837	1.195
	MENTAL ILLNESS	.134	.592	.029	.226	.822	.016	.031	.027	.869	1.150
	Sexual_Abuse	-.203	.312	-.097	-.650	.518	-.116	-.090	-.077	.627	1.594
	Physical_Abuse	.121	.266	.082	.453	.652	-.025	.063	.054	.426	2.349
	Combat_Experience	-1.116	.901	-.173	-1.238	.221	-.253	-.169	-.146	.717	1.394
	Natural_Disaster	-.425	.474	-.114	-.897	.374	-.030	-.123	-.106	.862	1.160
	Witnessing_Violence	.181	.338	.090	.537	.593	-.072	.074	.063	.498	2.006
	Other_Trauma	.065	.174	.077	.373	.710	-.029	.052	.044	.331	3.022

a. Dependent Variable: SrvcUtilz_subscale