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Homelessness Status Among Female Veterans: Posttraumatic Stress Disorder, Depression, and Hopelessness

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November 2019

Abstract

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MA, Long Island University, 2005

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Dissertation Submitted in Partial Fulfillment of

the Requirements for the Degree of

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Abstract

Homelessness among female veterans is a problem that is likely to increase as growing numbers of women in the United States military reestablish themselves into their communities as veterans. The purpose of this quantitative quasi-experimental study was to determine whether there are differences in posttraumatic stress (PTSD), depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least 1 U.S. military deployment. Four theories served as the basis for this research: the cognitive theory of depression, conditioning theory, ecological theory, and the hopelessness of depression theory. The data were collected from 88 female veterans who were deployed at least once. The variables were assessed using the Posttraumatic Checklist–Military Version posttraumatic stress disorder total score, the Beck Depression Inventory-II, total score and, the Beck Hopelessness Scale total score. The 1-way MANOVA findings indicated that there was a statistically significant difference between homeless and nonhomeless female veterans who experienced PTSD and depression but not hopelessness. This research will better serve the VA, clinicians, and communities to assist providing for the psychological and mental health needs required by these soldiers. The research findings may contribute to the provision of permanent and supportive housing for female veterans reintegrating back into civilian life.

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Dedication

This dissertation is dedicated to my family who shared my vision. Many sacrifices were made on both ends throughout my entire dissertation journey. Also, and mainly my husband, "Honey bunchie," who always believed in me and who was always been there and supported me when I felt that the completion of all and any in my journey would never occur. You are my rock. I also want to dedicate this dissertation to all my children who were also always supported and believed in their mom throughout my entire journey. Especially, my oldest daughter, Dr. Sharnine Herbert, who was continuously there in my time of need no matter what it may have been. And lastly, my "study buddy doggie" who remained by my side many long nights and days and never strayed away from my side the entire journey, my faithful "nippy."

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Chapter 1: Introduction to the Study

Significant stressors hinder female veterans from successfully reintegrating into society (Mattocks, Krebs, Justice, Yano, & Brant, 2012). Often, female veterans do not know where to obtain the various types of support required following their deployments (Di Leone et al., 2013). In addition, the U. S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's (USDHHSSAMHSA, 2013) current global conflicts have left female veterans in danger of psychopathology linked with a trauma that could hinder their ability to acquire shelter and services to address their psychological needs. As a result, military women returning to civilian life experience a higher rate of homelessness. The percentage of female, veteran homelessness is greater than that of either the general or the male military population (Fargo et al., 2012; Kane, 2013; The National Coalition for Homeless Veterans [NCHV], 2012; Tucker & Hall, 2012; U.S. Veterans Integrated Services Network [VISN], 2012).

Researchers (NCHV, 2012) have found that, from October 2011 through September 2012, approximately 21,000 female veterans, aged 18-29 with and without children, become homeless or were at risk of becoming homeless. Women are joining the military at a ratio of 4 to 1, and they are on the battlefield in several theaters of operation around the world (Burmiler Shanker, 2013). There are 1.8 million women veterans and 1.5 million women soldiers on active duty; the total number of sheltered male veterans in 2010 was 141,975, while the number of sheltered female veterans was only 6,976 (U.S.

Department of Veterans Affairs National Center for Veterans Analysis Statistics (USDVA-NCVAS, 2012a). The population of women veterans from 2006 until 2010 significantly increased from 6,000,000 to 1,860,000 (USDVA-NCVAS, 2012b), suggesting that greater numbers of female veterans might require shelter and social services. Additionally, women in combat are more likely to experience military physical trauma(Hassija, Jakupcak, &Shipherd, 2012). Moreover, posttraumatic stress disorder (PTSD) is also common among female veterans who have not been in any conflicts due to exposure to other of the traumatic ordeals of war(James, Van Kampen, Miller, & Engdahl, 2013; NCHV, 2012; Ready et al., 2012; Washington et al., 2011). Washington et al. (2011) further suggested that people with PTSD and other mental health disorders are at an increased risk of homelessness.

Scholars have revealed a link between female soldiers' battlefield experiences and their greater postdeployment psychiatric morbidity (Schnurr&Lunney, 2011; USDVA, 2012a; Wilkins, Lang, & Norman, 2011). The U. S. Department Veteran Affairs Health Care for Homeless Women Veterans (USDVA-HCHWV, 2011) asserted that PTSD is one of the largest mental health challenges facing returning veterans. Female veterans are more likely than female civilians to experience several psychiatric disorders in addition to PTSD and depression (James et al., 2013; NCHV, 2012; Ready et al., 2012; Washington et al., 2011). Research that is about the disorders of PTSD and depression of the homeless female veterans is necessary to clarify the needs of women veterans and to drive improvements in services for this vulnerable population.

In Chapter 1, I describe this study by providing background information, a problem statement, information about the purpose of the study, the research questions and hypotheses, the theoretical framework, the nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a summary.

Background

Women have been integral to U.S. military services for approximately 220 years, beginning with the Civil War (Cook, 2002). Women worked as volunteer nurses, laundresses, and cooks during the civil war. In World War I, 35,000 female service members served in the U.S. military; in World War II, this number grew to 400,000 (Washington et al., 2011). During World War I, the U. S. Department of Defense (DoD, 2013) did not permit women to enlist in the U.S. Navy and Marine Corps branches. However, more than 120,000 women enlisted in the Army and Airforce, and approximately 400 died during the war(U. S. Bureau of Labor Statistics, 2013).Nurses in the military were not officially members of any branch of the services and were regarded as nonessential to the war effort (Stein, Dixon, &Nyamathi, 2008). During this period, an additional 6,000 women were also Red Cross workers who served in FranceCook, 2002).In World War II, 350,000 women served in the U.S. military; an additional 60,000 women served as Army nurses, and more than 14,000 served as Navy nurses (USDVANCVAS, 2012). In 1942, more than 84,000 women were accepted for volunteer emergency service joined the Navy (Wood, 2014). In February 2012, the Pentagon began to appoint women permanently to battalions as medics, tank mechanics, and radio operators (Burmiler&Shanker, 2013).

Presently, military policies permit women to be involved in all phases of combat, including ground combat (USDVA, 2012a). Congress passed a bill on January 24, 2013that permitted women to engage in ground combat support through limited branches (DoD, 2013). Beginning on December 3, 2015, the DoD allowed women to enter into all aspects of warfare, including ground combat and armed roles such as infantry and artillery (Bumiller & Shanker, 2013). As of 2012, 15% of active U.S. duty military personnel consisted of women (Mattocks et al., 2012). Since October 2011, more than 100,000 deployed women in the armed forces have served in multiple conflicts (U. S. Government Accountability Office [GAO], 2012). That number consists of approximately 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in the Marine Corps (GAO, 2012). The NCHV (2012) reported that 214,000 women are presently on active duty and that approximately 240,000 deployed women are in conflict situations since 2001. Women's positions in the military have evolved significantly, especially in the conflict in Afghanistan, where female veterans experienced the traumas of combat.

Female Veterans and Homelessness

Although women comprised 7.2% of the general veteran population in 2011, they consisted of 9.8% of the population of veterans facing homelessness (U.S. Bureau of Labor Statistics [BLS], 2013). Scholars (Montgomery & Byrne, 2014; Thompson &Bridier, 2013) have revealed that more women are serving in the U.S. military while homelessness among female veterans is increasing. Homeless female veterans were also much more likely to have dependent children with them and to live with family members

in supported housing. The first contributing factor to homelessness among female veterans may be the inadequacy of healthcare and how this differs by gender for the military and veterans. Female veterans are the fastest growing division in the military. They have different military experiences than the male veterans, and these experiences are connected with postmilitary shelter and mental health service inadequacies (Montgomery & Byrne, 2014). As a result of their combat exposure, women must cope with the enduring effects of PTSD and depression. According to the Veterans Administration (VA, 2016), women are more likely to be apprehensive and have more stress as well as avoid things that remind them of the trauma than men. The VA(2013) found that men are more likely to feel angry and to have trouble controlling their anger than women. In addition, women with PTSD are more likely to feel depressed and worried, while men with PTSD are more likely to have difficulties with alcohol or drugsNational Institute of Mental health (NIMH, 2015). Women and men who experience PTSD may develop physical health complications (NCHV, 2011; Vogt et al., 2011). Since October 2011, more than 100,000 deployed women in the armed forces have been engaged in multiple conflicts (GAO, 2012). The NCHV (2012) reported that homelessness regarding women veterans is on the rise.

Fargo et al. (2012) confirmed that female veterans are more likely to be homeless than female nonveterans in the general population. Fargo et al. also found that vulnerability for experiencing homelessness among women decreased with age at an increasing rate in both the overall and poverty populations. Fargo et al. indicated that older women veterans were at the lowest danger for homelessness compared with

younger female veterans. Washington et al. (2011) concluded that nonveteran women in poverty and female veterans are more than three times as likely to be homeless compared to their male counterparts. Moreover, female soldiers who returned from the conflicts in Iraq and Afghanistan were three to four times as likely to be homeless than nonveteran women. Most homeless female veterans have dependent children, thus adding to their many challenges (Tsai, Alvin, &Rosenheck, 2012). Housing their children is often an obstacle to the acquisition of permanent shelter or housing within the VA system (Tsai et al., 2014).

Female Soldiers and Health Care

The NCHV (2012) has historically provided shelter and medical and mental healthcare for a predominantly male population. The U. S. Veteran Health Administration (VHA, 2013) is the largest integrated health care operation in the nation, covering 1,700 localities of care and assisting 8.76 million veterans every year. The VHA disclosed that 1.25 million men and women had returned home from the Iraq and Afghanistan conflicts (USDVA, 2016). Goldberg (2007) predicted that Iraq and Afghanistan veteran health expenses would cost the United States $7 to $9 billion. An allotment of $44 billion in 2008 made the total cost of $44 billion, and in 2011, an additional fee of $32 billion was provided to healthcare of veterans' expenses such as medical and disability needs(Montgomery & Byrne, 2014).Congress funded $44 billion for these soldiers' health expenses requirements in 2009 and financed $48 billion in 2010, which was an 8% increase (Montgomery & Byrne).

The VA requested an appropriation of $52 billion an additional 8% for 2011, creating a budgetary concern among government agencies such as the NCHV and the U. S. Department of Housing and Urban Development (USDHUD; Montgomery & Byrne, 2014). The VA has noted significant financial and operational responsibility for veterans and pointed out the significance of recognizing circumstances that may ameliorate the consequences of veteran illness (USDVA, 2012a). Health officials have reported that there are healthcare provisions needed for the estimated 1.5 million female veterans who served in the various conflicts (USDVA, 2012a). The cost of their care increased from $4,962 per woman in 2000 to $6,570 in 2008 (Yoon, Scott, Phibbs, & Frayne, 2012). Newer health services are just beginning to focus on the healthcare requirements of female soldiers (Haskell et al., 2010; USDVA, 2012a; USDHUD, 2012). Female military members who did not participate in combat cannot at present receive the same social services or health supports as their male counterparts (USDVA, 2012a). Stein et al. (2008) recommended mandated requirement for evidence-based, efficient interventions for female veterans who are experiencing PTSD and homelessness. Curriculums such as the Evidence-Based Synthesis Program (ESP) would provide convenient and reliable healthcare needs to the soldiers (USDVA, 2016). These programs would execute adequate services for the betterment of the female veterans' wellbeing and assist the VA. The ESP will establish the direction for prospective research to discuss gaps in clinical knowledge and to promote clinical strategies implicated by evidence-based research (USDVA, 2016).

Posttraumatic Stress Disorder and Increased Homelessness

Approximately 20 out of every 100 female veterans have a diagnosis of PTSD(Tsai et al., 2014). The women in the military are more likely to be in the line of fire than those serving in earlier wars; that means they are also at a higher risk of experiencing PTSD and depression. Female soldiers in the services are at a high risk of experiencing traumatic undertakings, particularly during the duration of combat. An increasing number of women are being exposed to conflict that contributes to their experiencing higher levels of PTSD (Maguen, Luxton, & Madden, 2012; Tsai et al., 2014).

Problem Statement

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The variables were measured using the Posttraumatic Checklist–Military Version (PCL-M PTDS) total score (Weathers, Litz, Huska, & Keane,1994), the Beck Depression Inventory (II BDI-II) total score (Beck et al., 1996), and the Beck Hopelessness Scale (BHS) total score (Beck, 1988).

The NIMH (2015) and the National Academy of Science (NAS, 2013) reported that depression is one of the top three diagnostic categories that women veterans examined at the VA are diagnosed as having. According to Resnick, Mallampalli, and Carter (2012), the disorder of depression is more prevalent in women compared to men

(15%–25% versus 4%–12%). As of 2015, the number of women diagnosed with PTSD was 26,500 (Resnick et al.,2012).As of 2008, there were 1.5 million female soldiers who would eventually return home from the battlefield (Fredman, Monson, & Adair,2009). Also, women are twice as likely to have a diagnosis of depression as men, a diagnosis that may result in homelessness (Luxton, Skopp, &Maguen 2010; Ready et al., 2012).

Military soldiers have higher levels of PTSD symptoms due to combat exposure. Furthermore, the exposure to combat promotes higher levels of depression and PTSD symptoms in women than to men. Higher levels of combat exposure are also strongly associated with depression and PTSD symptoms in women compared to men (Ready et al., 2012). Screening of PTSD symptoms linked to higher levels of combat exposure is more associated with depression and PTSD symptoms in women compared to men.

Lehavot, Der-Martirosian, Simpson, Sadler, and Washington (2013) identified areas of vulnerability of female veterans with comorbid PTSD and depressive symptoms. There are unmet medical needs and barriers to healthcare among women veterans who screen positive for lifetime PTSD and current depressive symptoms. Despite information being available about their higher risk, women have largely been omitted from studies of psychological outcomes in military populations. Mattocks et al. (2012) advocated for further research concerning female veterans as little information is available regarding how women veterans cope with the traumatic experiences of combat once they return from deployment. Washington et al. (2011) found that female veterans returning to civilian life faced a transformation, and the psychological damage of their experiences causes difficulties in obtaining and maintaining housing. Researchers (Hamilton, Poza,

Hines, & Washington 2012; Hassija et al., 2012) noted the need to respond to trauma in women veterans and to develop provisions for implementing trauma-informed care. There is a need for an empowerment-oriented approach to increasing resilience (Hamilton et al., 2012).

All branches of the military are estimating the number of women they are able to allow to participate in several of conflicts. Various armed services have petitioned the Pentagon for exceptions for the original post that will introduce new positions for women soldiers in the services (Suris& North, 2011). Women in combat may have positions that are equal to the men in conflict, especially because there are branches of the military that continue to disallow women to serve in operations (Burmiler & Shanker, 2013). Female service members in the Armed Forces were deployed in support of OEF and OIF and had continued to deploy to Afghanistan since September 11, 2001. During this period, deployed women have comprised about 44% of enlisted personnel and 13% of deployed officers who have served two or more times (USDVA-NCVAS, 2012).Thousands of women veterans are in jeopardy of eventually becoming homeless throughout the next decade (Hamilton, Poza, & Washington, 2011; USDVA-NCVAS, 2013; USDVA, 2012b; VISN, 2012).

According to NIMH (2015), there is limited research regarding gender differences in healthcare use among newly returning veterans who experience PTSD, depression, and hopelessness. Female veterans undergo 13 times more PTSD and depression than male veterans (Wells et al., 2010). Female veterans are twice as likely as males to have mental health hospitalizations with both PTSD and depression (Maguen, Ren, Bosch, Marmar, &

Seal, 2010). The NIMH (2015) has found that homeless female veterans are five times as likely to screen positive for PTSD. Diagnoses of comorbid PTSD and depression are presently affecting 72% of women and 57% of men who are veterans(Lehavot et al., 2013).A person who is hopeless has categorically given up and accepted not having control over his/her life (Hamilton et al., 2011). Such a deep-rooted sense of hopelessness is a likely reason why major depression is hard to treat (Florida State University, 2007). Hopelessness and depression are correlated concepts, and there is a consistent positive association between BHS scores and measures of depression (Iliceto & Fino, 2015; Marsiglia, Kulis, Perez, &Parsai, 2011).

Scholars (Lapierre, Schweger, &LaBauve, 2007; Rosenfeld et al., 2011) have not revealed factors determining whether women confronted with trauma challenges will develop PTSD, hopelessness, or depression. There continues to be an increase in the numbers of female soldiers in combat zones, and this has resulted in their exposures to trauma, injury, and increased environmental risks associated with the current wars. Some of those dangers present new health hazards, particularly related to women who have been deployed to or recently returned from Iraq or Afghanistan or both. Researchers have not determined whether women veterans will withstand such challenges to their mental wellbeing. The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The current study may contribute to clinicians' understanding of the prevalence and severity of homelessness and the effects that mental disorders have on

female veterans' homeless status. The study may also contribute to clinicians' understanding of the relationship among the variables.

Purpose of the Study

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The assessment instruments incorporated the PCL-M PTDS total score (Weathers et al., 1994), the II BDI-II total score (Beck et al., 1996), and the BHS total score (Beck, 1988).The dependent variable, PTSD, was measured by the PTSD checklist for the military (PCL-M; Weathers et al., 1994),an instrument used to identify PTSD caused by military involvement. The instrument is a 17-item self-report measure for PTSD that incorporates the criteria from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1994, 2013). The self-report BDI-II (Beck et al., 1996) assesses the severity and extent of depression symptoms, and it was used to measure the dependent variable of depression. The self-report measure BHS (Beck, 1988) was used to measure the dependent variable, hopelessness, and also to measure three significant aspects of hopelessness: (a) beliefs about the future, (b) loss of motivation, and (c) expectations. The BHS measures the intensity of the respondents' negative emotions or pessimism about the future. The independent variable was female veterans' homeless/nonhomeless status. The study may also contribute to clinicians' understanding of the relationship among the variables.

Research Questions and Hypotheses

Three research questions drove the methodology of the quantitative, quasi experimental study. The three research questions and corresponding hypotheses are the following:

1. Is there a difference in frequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat?

$H_0$1: Homeless female veterans will not have a significant difference in the occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

$H_1$1: Homeless female veterans will have a significant difference inthe occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

2. Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat?

$H_0$2: Homeless female veterans will not have a significant difference in the occurrence depression from nonhomeless female veterans who have experience combat, as measured by the Beck Depression Inventory BDI-II.

$H_1$2: Homeless female veterans will have a significant difference in the occurrence of depression from nonhomeless female veterans who have experienced combat, as measured by the BDI-II.

3. Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat?

$H_0$3: Homeless female veterans will not have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat, as measured by the BHS.

$H_1$3: Homeless female veterans will have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat as measured by the BHS.

Theoretical Frameworks for the Study

The theoretical framework for this study was four-tiered. To answer the research questions, all ofthe following theories were employed. The conditioning theory developed by the Pavlov (1902) and employed by Orr et al. (2000) was the essential supportive framework for the dependent variable PTSD. Although Pavlov developed the conditioning theory in 1902, Orr et al. employed the theory to explain an individual's response to an experience described as a stimulus that can be altered by learning or conditioning. According to McLeod (2014), Skinner in 1913, Watson in 1903, and Rayner in 1920 also employed the conditioning theory to explain the conditioning stimulus.

Pavlov's (1902) conditioning theory consisted of three stages. In the first stage, unconditioned stimulus (UCS) produces an unconditioned response (UCR) in an organism. A stimulus in the environment has created a response that is unlearned.Throughout this period, no new behavior has been learned. A neutral stage is associated with the UCS, which is known as the conditioned stimulus. The third stage after conditioning is known as the conditioned stimulus, which has been linked with the

UCS that creates a new conditioned response. Among current returnees pursuing care at VA, PTSD rates among men and women are unequal(Inslicht et al., 2013; USDVA, 2013).

The second theory is the ecological systems theory, developed by Bronfenbrenner(1977),that provided the supportive framework for the independent variable, female veteran homeless/nonhomeless status. Bronfenbrenner concluded that a person's development was affected by all in his or her encompassing environment. Bronfenbrenner split the individual's environment into five distinct levels.

The third theory was the cognitive theory of depression developed by Beck (1967), which offered the supportive framework for the dependent variable, depression.

The fourth theory was the hopelessness theory of depression developed by Abramson, Metalsky, and Alloy (1989), which was the framework for the dependent variable, hopelessness. These theories are summarized and discussed in greater depth in Chapter 2.

Conditioning Theory

In the conditioning theory, Pavlov (1902) applied the behavioral process to how a response produces more frequently to a stimulus as an impact of reinforcement that is a reward for a reaction in a circumstance. The conditioning theory involves learning a new behavior through association (McLeod, 2014). Combat or being in proximity with conflict may promote the development of adverse responses, such as a person’s internal mental state that influences his or her perceptions, emotions, and disturbances that might be present in those experiencing PTS. According to Pavlov, conditioning is the capacity

to induce a response that is initially evoked by another stimulus. This theory underlines the research question: Is there a difference infrequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat?

The conditioning theory presents explanations for the development of PTSD in trauma-exposed individuals. The theory offers a framework for the explanation of what might occur during trauma and why the ordeal creates the capacity to elicit fear. The conditioning theory describes the role of avoidance of the conditioned stimuli, either through disruption, memory obstruction, or new behaviors. The conditioning theory can be used to describe how female veterans remembering being in a warfare environment that creates fear and paired with the UCS will produce a conditioned stimulus, such as PTSD. Pavlov's theory was used to describe the dependent variable PTSD. I used the theory to determine if repeated exposure to spontaneous memories that female veterans' experience might not be sufficient to eliminate these associations. The conditioning theory explains how female veterans' conditioning of negative responses linked with their combat experiences makes reexperiencing more plausible when located in the different environments. The method used to measure the mean of the variable PTSD was the multivariate analysis of variance (MANOVA) to determine whether changes in the independent variable homelessness status have a notable effect on this dependent variable.

Ecological Systems Theory

In the ecological theory, Bronfenbrenner (1977) proposed that although individualsenter into different environments during their lifespan, their responses vary by

degrees. This theory links individuals' environment with their perception of their surroundings (Sallis, Owen, & Fisher, 2009). The ecological systems theory of human development was the overarching framework for homelessness in this study. Researchers (Kline et al., 2010; Vogt et al., 2011) have focused only on the characteristics of homeless individuals, rather than how and in what way the social environment may contribute to the cycle of homelessness. There is a need to explore the safety of female veterans, especially when they are existing in undesirable environments that will have harmful impacts on their lives and may contribute to their becoming homeless when reintegrating civilian life. The ecological theory is dissimilar from other approaches that concentrate on the biological or stress characteristics of the homeless individual; the ecological approach focuses on various systems as well. The ecological systems theory is an approach to a study of human development that consists of a scientific study regarding the progressive, mutual accommodation, during the life path within an existing, expanding human being (Bronfenbrenner, 1977).

The ecological theory(Bronfenbrenner, 1977)consists of five systems: (a) the microsystem; included in the microsystem's setting is the immediate environment people have in their lives- relatives, associates, classmates, educators, neighbors, and other individuals who have a direct association; (b) the mesosystem, which includes the relationships between the microsystems in a person's life; (c) the ecosystem, which are experiences in different social settings; (d) the macro system, which involves culture and beliefs, such as the socioeconomic status of a person or their relatives or their ethnicity; and (e) the chronosystem, which is the transformations and changes in a person's lifespan.

Cognitive Theory of Depression

The cognitive theory of depression, as developed by Beck (1967), describes the formation of dysfunctional beliefs that leads to negative self-views and to depression. The cognitive theory of depression related to the dependent variable depression because the theory clarifies how negative thoughts connect with depression. The cognitive theory of depression was used to address the following research question: Is there a difference infrequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat. The theory is used to explain how experiences can lead to the development of dysfunctional beliefs; these beliefs result in negative selfviews, which can lead to depression (Beck, Kovacs, & Weissman, 1975).

One of the most common psychological difficulties experienced by female veterans is depression. Approximately 25-30% of women veterans of the Iraq and Afghanistan conflicts reported having symptoms of a mental disorder(Boyd, 2013). The most common psychological diagnosis given to female veterans was depression (Hassija et al., 2012). A direct relationship exists between the measure and severity of the different negative ideas and the severity of depressive symptoms. When people experience depression and have mostly negative thoughts, they will experience greater depression. Beck (1976) reported that negative cognitive schemas affect an individual's ability to construe situations and events as either hopeful or hopeless. According to the cognitive theory of depression(Beck, 1967), a person's assessment and way of distinguishing stimuli and occurrences in life play a part in how an individual perceives him or herself. Feeling inferior creates negative thoughts that concern wellbeing, which

would be experienced and expressed as depression (Beck, Ward, Mendelson, Mock, &Erbaugh, 1961). The cognitive theory of depression(Beck, 1967)was used to study the dependent variable depression, with scores measured on the BDI-II (Beck et al., 1996). The theoretical underpinnings clarify the severity of the negative ideas and depressive symptoms that individuals experience (Beck et al., 1975).

In the cognitive theory of depression, a person's conceptual assessments that are his or her way of distinguishing stimuli, and the situations he or she encounters in life, play a part in determining the ways that the individual perceives the self. Another factor is the manner in which he or she relates to others and whether he or she regards his or her future in a hopeful or hopeless demeanor. The cognitive theory of depression (Beck, 1967) is directly relevant to the homeless female veteran. Specifically, it is relevant regarding self-appraisals of inferior status, leading to thoughts that are negative that affects psychological wellbeing (Beck et al., 1961).

Hopelessness Theory of Depression

The hopelessness theory of depression, developed by Abramson et al. (1989), served as the framework for the dependent variable of hopelessness. The hopelessness theory of depression was used to examine the following research question: Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat. The hopelessness theory of depression is used to explain the mechanism by which people can experience negative predictions for their future and their self-esteem. Proponents of the hopelessness theory stress the importance of cognitive processes in the maintenance and treatment of depression (Abramson et al.,

1989).According to this theory, some individuals have a cognitive vulnerability that combines with stress and leads to depression because they tend to create interpretations of stressful life experiences that have negative associations for their future and their selfworth. People who form these negative ideas develop hopelessness. Abramson et al. reformulated the theory of helplessness and depression, resulting in the development of an advanced theory of depression with a focus on the hopelessness aspects within the established construct of depression. In the hopelessness theory, some individuals have a cognitive vulnerability that leads to depression (Haeffel, Abramson, Brazy, & Shah, 2007). In such persons, cognitive vulnerability to depression interrelates with stress to produce hopelessness. The vulnerability affects the interpretations of stressful life situations, and this may lead to negative beliefs about fate and self-worth appraisal. The hopelessness theory hypothesizes the existence of a subtype of depression: hopelessness depression.

Events faced by female veterans may create hopelessness that may impact their homeless status. Hopelessness brings about responses such as low self-esteem, loss of goals and self-respect, lack of ambition, despair, despondency, and several other mood dispositions (Haeffel, 2010). Iacoviello, Alloy, Abramson, Choi, and Morgan (2013) indicated that hopelessness and other symptoms appeared to correspond to the hopelessness theory of depression. The responses of low self-esteem, loss of goals and self-respect, lack of ambition, despair, despondency, and several other mood dispositions form the nucleus syndrome of hopeless depression episodes. Female veterans might be experiencing hopelessness, making locating shelter much more challenging.

Nature of the Study

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The variables were evaluated using the PCL-M PTDS total score (Weathers et al., 1994), the BDI-II, total score (Beck et al., 1996), and the BHS total score (Beck, 1988). Three dependent variables were assessed: PTSD, depression, and hopelessness. The PCL-M (Weathers et al., 1994) was used to measure the dependent variable PTSD; the BDI-II Beck et al. (1996) was used to measure the dependent variable depression; the BHS Beck (1988) was used to measure the dependent variable hopelessness. Several demographic questions were used to affirm female veteran responders' eligibility to participate, their ages, how many years they served in the military conflicts, and length of service (to be found in Appendix B).

An MANOVA is an appropriate test for analyzing the results from many different types of study designs. The MANOVA is an extension of the analysis of variance (ANOVA; Laerd Statistics, 2016). I assessed the probability that an observation falls into one of the two categories of a dichotomous independent variable. Using a quantitative approach for this study was appropriate because validated quantitative instruments exist that can be used to score respondents on the three dependent variables. Such results were used to describe significance or nonsignificance in the relationship between variables. A quantitative approach met the needs of data collection and analysis.

After the approval of the institutional review board (IRB), I conducted female to participate in the study from homeless shelters, armories, and various areas of Northern New York. Participants were initially be recruited using a convenience and snowball sampling method because the techniques permit the researcher to depend on research respondents who are immediately attainable (Babbie, 2002). According to Sadler, Lee, Lim, and Fullerton (2010), snowball sampling can be employed in the recruitment of participants from traditionally underserved or vulnerable populations. The snowball sampling technique allows the researcher to obtain access to vulnerable population groups of interest. The use of culturally sensitive recruitment procedures is both appropriate and efficient in recruiting members of vulnerable populations (Sadler et al., 2010).

Each participant received a letter of consent to sign to take part in the study. The consent form included information regarding the purpose of the study, the instruments used in the survey, and the time the study will take. Complete instructions were given to each participant (to be found in Appendix D). The criteria for inclusion in the study included having had a minimum enlistment of 4 years and being female between the ages of 22 to 65 years. A detailed description is in Chapter 3.Therewas face-to-face communication with the participants and a request to participate in person. Both descriptive and inferential statistics were used to determine if there is a difference in PTSD, depression, and hopelessness between homeless and nonhomeless female veterans' status.

Definitions

Combat trauma: Combat trauma is the exposure to stereotypical warfare events, such as firing a weapon, being fired upon, observing injury or death, going on special missions and patrols, and engaging during such occurrences (Vogt et al., 2011).

Depression: Depression is a prevalent mood disorder that causes severe symptoms that affect how a person responds, thinks, and manages everyday activities, such as resting, eating, or working (American Psychiatric Association, 2013).

Homeless: Homeless individuals do not have a permanent or primary nighttime residence, or their primary nighttime residence is a temporary supervised shelter, institution, or place inappropriate for sleeping (Legal Information Institute, 2005).

Hopelessness: This is a negative state of mind (Beck et al., 1975). Individuals with a negative state of mind may contemplate life as hopeless.

Operation Enduring Freedom (OEF): OEF is the official name used by the U.S. government for the war in Afghanistan, together with some smaller military actions, under the umbrella of the Global War on Terror (GWOT). Combat operations began in October 2001 (USDVA, 2012b).

Operation Iraqi Freedom (OIF): OIF is the name the U.S. government uses for the war in Iraq. Combat operations began in March 2003 (USDVA, 2012b).

Posttraumatic stress disorder (PTSD): According to the American Psychiatric Association (2013), PTSD results from exposure to actual or threatened death, serious injury, or sexual violence in one (or more) ways. PTSD may involve the direct experience of the traumatic event(s) or witness the event(s) as it occurs to others.

Veteran: A veteran is a woman or man who has served in the active armed forces, naval, or air service and was discharged or released under contingencies other than dishonorable (USDVA, 2012a).

Women war veterans: These are service deployed women who served full-time active duty in OIF/ OEF (USDVA, 2012b).

Assumptions

The study included those who were in proximity of combat in the OEF, OIF, and other conflicts. One of the primary assumptions of the present study was that each participant will respond to the best of her capabilities. Another assumption was that the participants will accurately comprehend the nature and significance of the study. I also assumed that there was a correct usage of the instruments and that the test measures accurately measure the characteristics that they have been designed to measure.

Scope and Delimitations

The study took place in various areas of Northern New York. I determined the total scores of the PCL-M instrument (Weathers et al., 1994) for PTSD, the BDI-II instrument (Beck et al., 1996) for depression, and the BHS instrument (Beck, 1988) for hopelessness. Furthermore, the scores of the three instruments administered to the homeless and nonhomeless female veterans were examined and compared correctly. A convenience and snowball sampling method within the Northern New York State geographic areawas used to solicit participants. Only female veterans who resided solely in the north region of New York were involved in the study. The sample included homeless and nonhomeless female veterans.

This study did not report on internal validity. Internal validity is the particular truth regarding cause-effect or causal relationships (Trochim, 2009). External validity is the degree to which the conclusions in the study can readily be compared with results from other persons in other places and at different times (Trochim & Donnelly, 2008). As stated above, the participants were from one region; thus, the findings may not be generalizable to areas other than New York State.

Limitations

Limitations of a study are the structures in the methodology and design that place boundaries of the application or interpretation of the results on the study (Mitchell & Jolley, 2004). There may be limitations on the validity, generalizability, and value of the results from the sample population that make it difficult to form conclusions about the larger population. The first limitation that may occur in the study was from the sample acquired. By using a convenience and snowball sampling method, there may be sample selection bias based on the particular participants who volunteered. To lessen sample selection bias in this study, participants was recruited from multiple locations to assist in obtaining a more diverse population. The second research limitation in this study evolved from the self-report type of the testing instruments, which might tempt the participants to over or underreport. Participants were reassured that all responses will remain confidential to reduce the possibility that participants might answer in a deceptive manner.

Significance

Ghahramanlou-Holloway, Cox, Fritz, and George (2011) reported that there currently are more psychologists administering services to female soldiers who were previously or are presently in military service than at any time in history. Ghahramanlou Holloway et al. revealed that numerous individuals who assist the women soldiers have little psychological knowledge or training specific to the needs of this understudied population. Therefore, elucidating the link between female veterans' psychological needs and their homelessness status is critical to highlighting the needs of these members of society and ensuring that they receive the services they deserve. The study may clarify whether there is a difference based on the female veterans' homeless/nonhomeless status in their diagnoses of PTSD, depression, and hopelessness. The findings may present statistical data that will help fill the gap in the psychology literature regarding the relationship of PTSD, depression, and hopelessness to homelessness among female veterans, which may prompt action to address the needs of this population.

Summary

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in posttraumatic stress, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The variables were measured applying the PCL-M PTDS total score (Weathers et al., 1994), the BDI-II total score (Beck et al., 1996), and the BHS total score(Beck, 1988). In Chapter 1, I introduced the problem statement, research questions,

and the purpose of this study; I further described my justification for choosing a quantitative method. I presented a list of definitions and terms, as well as my assumptions, limitations, and delimitations. Four theories served as the basis for this research: the cognitive theory of depression, conditioning theory, ecological theory, and the hopelessness theory of depression. An MANOVA was employed, as the method allowed for the testing of statistically significant differences between the groups.

The study involved only female veterans, given the need to understand the experience of women soldiers after they return from conflict. This study will help to fill part of the gap in the literature on female veterans by addressing the homelessness issue in more detail. Traditionally, psychological research on veterans has focused on only male veterans' homelessness, PTSD, and depression (Luxton et al., 2010; Ready et al., 2012). This study of female veterans' experience with PTSD, depression, and hopelessness will expand the knowledge regarding the link between these mental health conditions and their homelessness.

In Chapter 2, I will present a review of the literature concerning female veterans and PTSD, depression, hopelessness, and homelessness. I will also present the literature search strategy, theoretical framework, literature review findings, summary, and conclusion.

Chapter 2: Literature Review

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military

deployment. The variables were measured using the PCL-M version introduced by Weathers et al. (1994), the II BDI-II created by Beck et al. (1996), and the BHS total score devised by Beck (1988).

In this literature review, I discuss the variables of homelessness among female veterans and the association between homelessness and PTSD, depression, and hopelessness. Chapter 2 involves a comprehensive review of the literature, the theoretical framework, a discussion of the research variables, and literature related to the methodology. Also, I present the literature search strategy, theoretical framework, literature review findings, summary, and conclusion.

Literature Search Strategy

Literature for the review included information obtained from U.S. Government agency reports, government records, peer-reviewed journals, and books that contain information about homelessness and the relevant mental health topics being studied. I consulted government organization data from such sources as the USDVA, the USDVAHV, the NCHV, and the USDVA-NCVAS that pertain to issues related to female veterans. I acquired most of the literature through the Walden University Research Comprehensive Database online library and other sources such as my local library. I reviewed journals from online databases that included PSYCINFO, PSYCARTICLES, PSYCBOOKS, and ProQuest. The search was conducted using the following keywords: *hopelessness theory of depression, homeless female veterans, posttraumatic stress disorder, housing the homeless, homeless women, homeless female veteran, shelters, mental health, health sciences, nursing, human services, OEF, OIF, trauma and*

homelessness, dual diagnoses, and *military to civilian reintegration*. The available research does not focus primarily on female veterans and their psychological distress once returning home. The majority of the publications in the study were within the last 5 years, with several notable books dating back 7 years. Research instruments from earlier studies published in the 1920s that were also considered to be relevant.

Theoretical Foundations

In this quantitative study, four theories formed the framework. As mentioned in Chapter 1, the conditioning theory developed by Pavlov (1902) and used by Orr et al. (2000) offered the ideas behind the use of the dependent variable, PTSD, because the conditioning theory explains the process of negative reinforcement. Orr et al. illustrated that the fear conditioning depicts the manner by which a neutral stimulus becomes the means in which there is provoking of fear that follows its repeated pairing with an aversive stimulus.

The Conditioning Theory

The conditioning theory relates to the following research question: Is there a difference infrequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat. Conditioning theory is used to explain destructive behaviors that have been trained via conditioning are not voluntary actions.

Female veterans who experienced combat exposure may have involuntary fears associated with avoidance or feelings of emotional distress where they avoid people, places and things, and undesirable memories of the traumatic events that continue to return. These types of uncontrolled conditionings would be deterrents in successfully

moving through complex procedures to obtain essential shelter. Friedman (2009) established that individuals with PTSD develop negative conditioned responses more readily to aversive occurrences; in general, these common conditioned responses are challenging to overcome.

The conditioning theory applies to PTSD because behaviors are learned by conditioning. Female veterans may experience frequent exposure to spontaneous negative memories, such as described by classical conditioning theory(Cook, Dinnen, Rehman, Bufka, & Courtois 2011). Pacella, Hruska, and Delahanty (2012) pointed out that female veterans' conditioned reactions could be an obstacle when seeking needed shelter. Female veterans' conditioned reactions include the experiencing of physical health symptoms that fall into four groups: neuromuscular, anxiety, sleep, and gynecologic manifestations that prevent their abilities to attain required housing (Pacella et al., 2012).

The conditioning theory provides a description of what occurs during trauma. Also, the theory explains how trauma initiates fear; the role played by avoidance of the conditioned stimuli (through disruption or obstructing of memories or other behaviors)would be reinforced by a reduction in fear, leading to the maintenance of PTSD. Although the conditioning theory does not differentiate the causes or origin of PTSD from that of various anxiety disorders, the theory does provide an account of numerous features of PTSD (Orr et al., 2000). The NIMH (2015) found that PTSD has an association with arrange of potential trauma reminders. The traumas manifest as physiological and emotional arousal evoked by these reminders. The negative stimuli to

which a person is continually exposed are the triggers associated with the original trauma. In PTSD, the sufferer experiences continuing episodes of fear, sadness, dissociation, and thoughts of danger (Kane, 2013).

Almost 20 of every 100 (or 20%) women veterans of the conflicts in Iraq and Afghanistan experience PTSD (Pittman, Goldsmith, Lemmer, Kilmer, & Baker, 2012). The mental disorder of PTSD is one of the greatest mental health difficulties confronting returning female veterans. Without intervention, these concerns can put women veterans at higher risk of homelessness (USDVA, 2016). PTSD makes it harder to seek permanent housing because the symptoms of PTSD can cause difficulties in the individual's daily life. They may experience manifestations of emotional numbing, insomnia, and traumatic brain injury (TBI; USDVA, 2016).

The security of nations needs young men and women to prepare for combat. Programming is needed in this regard including particular training techniques (DoD, 2013). These techniques could be linked to psychological trauma experienced by veterans. These training preparations create a conditioning of the individual who might, when returning to civilian life, not be responsible for her/his decision making. Research findings related to these preparation techniques apply also to female veterans who are returning from the conflicts of war and who recurrently experience PTSD symptoms. Brutalization is one of the four mandated primary training preparation techniques that soldiers experience in combat (DoD, 2013). Brutalization is the psychological methodology employed to break down the natural reserve by conditioning soldiers to stop having misgivings about destroying a life. Brutalization is a training procedure in boot

camp where the soldier endures verbal and physical abuses designed to suppress personal emotions and responses that would substitute them with new, dehumanized principles of behavior. The primary goal of boot camp is to develop the soldiers to become combatants and, possibly, to be able to defend themselves in circumstances where they might become harmed or suffer the loss of life. The training helps them to resist all psychological reasoning that goes against the usual human instinct of not hurting others (Cook et al., 20011). For soldiers to prepare in the taking of someone's life in combat, training in brutalization is the primary preparation that will assist them emotionally and physically (DoD, 2013).The training preparations can be the phase where the individual experiences a loss of his or her self-worth. Having received this type of training, some soldiers may not be in control of their responses upon return to civilian life. Classical conditioning involves a learning process whereby a subject initially responds in a way to a neutral stimulus. A soldier who is trained to react to the noise of gun firing will have a similar reaction in the future rather than the earlier learned response. Operant conditioning isa process that endeavors to transform behavior through the recurrence of positive and negative reinforcement, such as the trainings a soldier would experience in basic training. The conditioning theory is used to describe how people's reactions to adverse events can also create conditioned reactions, such as flashbacks or nightmares that are symptoms of PTSD. Orr et al. (2000) provided an account of several aspects of PTSD. Orr et al. described the range of traumas, such as fears resulting from some form of physical or mental threat that can occur. The avoidance of these triggers is significant for those experiencing PTSD (Brewin & Holmes, 2003). Orr et al. revealed

that soldiers experience other physiological reactions in addition to heightened heart rates during combat and combat simulation. The responses also include intensified psycho physiological reactivity to trauma-related reminders.

Examples of the type of trauma reminders are fear conditionability and adverse intrusive memories. Lissek et al. (2011) explained that both fear and anxiety are natural adaptive responses to an environmental threat. However, when experienced over a lengthy period, they can have an overwhelming impact. Female soldiers may be more vulnerable to pathological anxiety than male soldiers' behavioral tendencies. This could be a point towards understanding why the female soldier adaptive fear reactions might go astray (Lissek et al., 2011). Orr et al. (2000) showed that people with PTSD develop reactions that have become conditioned responses more readily due to unfavorable events, and these responses are harder to extinguish. Individuals experiencing PTSD who have exposure to the traumatic event exhibit their feelings by displaying different behaviors. PTSD can become a chronic and disabling disorder that is frequently comorbid with major depression (Ready et al., 2012). Although this could be the result of PTSD, it may also reflect genetic or acquired pre-trauma differences in conditionability. The conditioning theory does not distinguish the cause or origin of

PTSD.

The Cognitive Theory of Depression

The cognitive theory of depression originated by Beck (1967) can be used to better understand the following research question: Is there a difference infrequency of the occurrence of depression between homeless and nonhomeless female veterans who have

experienced combat. According to the cognitive theory. depression results from distorted thoughts and judgments. The cognitive theory of depression is used to examine and address mental experiences, such as an individual's thoughts and emotions. According to the cognitive theory, individuals with depression reason more negatively than people who are not depressed. The difference in reasoning is what makes them depressed. Female veterans experience depression because they view themselves, their environment, and their future negatively. The individual also has the tendency to distort events in adverse ways and condemns him or herself to each adverse occurrence. The constant negative thoughts may make a person with depression perceive circumstances as having been worse than they were at the actual time of occurrence. For female veterans, this may increase the risk that they would exhibit depressive symptoms in response to the stressful military experiences. According to the cognitive theory of depression (Beck, 1967), all persons who experience depression display corresponding negative cognitions. The cognitive theory of depression (Beck, 1967) is used to describe how an individual holds self-negative views and accounts for the multitude of other depressive symptoms. The theory can provide a framework on how different kinds of unforgettable negative experiences can influence an individual to formulate all sorts of dysfunctional beliefs. Depression can be the cause of despair moods that can be counterproductive in every aspect of life, particularly homelessness.

According to the cognitive theory of depression (Beck, 1967), the person associates negative views concerning him or herself, what is to transpire in the future, and unfavorable occurrences. According to Beck (1976), the theory has three main aspects

that concern the event preceding and during the depression. Also, Beck explained that negative unconscious thoughts, formed by dysfunctional views, are the reason for depressive symptoms, and not vice versa.

Teasdale (1983) mentioned that once there is significant stimulation, the use of cognitive biases intensifies feelings of depression, which then starts to further cognitive biases. According to Beck (1967), the individual will feel different underlying beliefs, and these feelings separate them from other disorders such as depression and anxiety disorders. These involve extreme reasoning, selective abstraction, and overgeneralization. Such feelings increase failure. A person who is depressed cannot sense any importance in him or herself or his or her future. The all-or-none rationalizing is intense, so even a little waiver from perfection is deemed a failure. Abela and D'Alessandro (2010) confirmed that persons with continuous cognitive vulnerabilities have challenges with stressful life endeavors and that the stressors and concerns can destructively contribute to the beginning of depressive symptoms in an individual.

In the cognitive theory of depression(Beck, 1967), the person attributes negative views concerning self, and what is to transpire in the future, to adverse occurrences. Abramson et al. (1989) noted that individuals who have low self-esteem are more likely to develop depressed attitudes when experiencing stressful life events than people who do not have such cognitive styles. Proponents of the cognitive theory of depression describe how challenging mentally and emotionally depression can be for sufferers, including female veterans who must cope with daily life obligations.

Ecological Theory

The ecological theory (Bronfenbrenner, 1977) was used to examine the variable of homeless status for female veterans. The hopelessness theory of depression (Abramson et al., 1989) is used to explain how negative thoughts affect a person's emotional state of mind and self-worth. The theory clarifies the effects of certain risk factors that form an individual's environment and socioeconomic circumstances. The ecological theory (Bronfenbrenner, 1977) was used to examine the independent variable, homeless status. The ecological theory is a suitable approach for the following three research questions: Is there a difference infrequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat: Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat: Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat?

The ecology theory consists of five systems. The first system is the microsystem. The microsystem is the primary environment, composed of friends, classmates, family, educators, neighbors, and additional people with whom people have a personal connection. The microsystem is the context in which people have direct social communications with groups. According to the theory, people are not just recipients of experiences they have when socializing with individuals in the microsystem environment; they are also adding to the foundation of this environment. The second system is the mesosystem. The mesosystem comprises the connections linking the microsystems in an

individual's experience. For example, the association of a person's family experience might be with his or her school experience. The third system is the ecosystem, which is the larger social system that includes environments in which the individual does not directly function. Fourth is the macro system environment, which is the actual culture of an individual. These cultural connections include socioeconomic, racial, and ethnic components. The fifth system is the chronosystem. The chronosystem includes the changes and transformations across an individual's lifespan, as well as sociohistorical connections. Inclusive of these personal experiences are (a) family, peers, and locality; (b) the relationship between microsystems; (c) experiences in different social settings, such as work experiences that affect other relationships; (d) culture and beliefs; and (e) events and transitions over the course of the person's lifetime (Santrock, 2007).

The ecology theory is a person-centered approach that focuses on the individuals' current status vis-à-vis their communities, church, family, school, friends, employment, and their culture. Furthermore, the theory includes how two or more of the factors connected to one another. The ecology of homelessness is used to portray the relationships and fundamental interactions among the parts of the model and encourages a multifaceted response by individuals, agencies, and communities to prevent and resolve homelessness (Nooe& Patterson, 2010).

The ecological theory(Bronfenbrenner, 1977)was relevant to this study because homelessness can be understood, not by evaluating the characteristics of the individual, but by understanding the environmental and social circumstances of that individual. The most important aspects of observing are the socioeconomic frameworks and the

dangerous elements the person must cope with daily (Bronfenbrenner, 1977). Researchers employing the ecological theory have included various circumstances and distinctive demographic groups, such as race, military service, physical health, mental health, ethnicity, personality, and developmental experiences. Nooe and Patterson (2010) developed an ecological model of homelessness that stems from a review of research. The study of the ecological theory(Bronfenbrenner, 1977) includes the spectrum of biopsychosocial risks associated with pathways to homelessness, social and personal consequences after intervals of homelessness and the societal as well as individual concerns resulting from periods of homelessness. There are various causes of homelessness; focusing on only one source permits only a limited understanding of homelessness. Mental health issues are one of the multiple causes of homelessness.I will now look at Chapter 3.

Nooe and Patterson (2010) concluded that the ecological homelessness theory applies to interactions among risk factors stemming from conditions and to socioeconomic structures and environmental circumstances. Toro, Trickett, Wall, and Salem (1991) explored the experiences of homeless female veterans and examined the background segments of their lack of environmental resources. Toro et al. recommended that researchers evaluate the obstacles of homelessness at varied levels and observe homelessness as a consequence of the individual's vulnerabilities.

The ecological theory (Bronfenbrenner, 1977) encompasses an increasing body of research. This research includes the procedures and conditions that determine the lifelong course of human development in the environments in which people live. An

ecological perspective is relevant for expanding the types of research questions, intervention options, and policy initiatives related to homelessness. In an ecological viewpoint, homelessness is not conceptualized as a person-based problem (Toro et al., 1991). The ecological viewpoint is used to explain the interaction between individuals and their social connections (Toro et al., 1991).The ecological theory(Bronfenbrenner, 1977)is relevant to the issue.

The Hopelessness Theory of Depression

The hopelessness theory of depression (Abramson et al., 1989) is used to explain how negative thoughts affect a person's emotional state of mind and self-worth; therefore, it was chosen as part of the framework for this study. Hopelessness can have an impact on the individual's physical and emotional wellbeing (Rosenfeld et al., 2011). Joiner (2000) and Metalsky and Alloy (1989) reported that hopelessness is a negative discernment concerning self and a pessimistic viewpoint about the future or improvement of s person's circumstance. Joiner and Metalsky and Alloy established three cognitive views: (a) attaching adverse events to significant causes; (b) the portrayal of negative assumptions and attaching s person's self to the adverse event; and (c) assuming one evil occurrence will lead to others in the future, and when there is a combination of high stress, they unite with depression. The interplay between negative cognitive styles and negative life events causes a sense of hopelessness (Joiner, 2000; Metalsky& Alloy, 1989).

The experiencing of hopelessness may not be by an individual independent of depression, and the experiencing of depression can be without hopelessness. The study

of hopelessness has been limited because researchers have previously considered depression and hopelessness as having a correlated relationship (Abramson et al., 1989; Beck, Weissman, Lester, & Trexler, 1974). The deficiency of research and data concerning hopelessness has impeded an understanding of this mental condition. Veterans struggling with hopelessness were more likely to commit suicide than the general population (Thomas et al., 2014). Also, a conflict with both hopelessness and substance abuse can have an impact on the sufferer's physical and emotional wellbeing (NIMH, 2015).

Hopelessness is known to be one of the largest continuous predictors of suicidal ideation conjointly with suicidal intent and concluded suicide (Beck et al., 1975; Hirsch & Conner, 2010; Panagiot, Gooding, & Tarrier, 2012). Thomas et al. (2014) found that hopelessness is an emotional precursor to suicide events for all patients. The hopelessness theory of depression (Abramson et al., 1989) relates to the following research question: Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat? The hopelessness theory underscores the importance of cognitive processes in the etiology, maintenance, and treatment of depression. According to this theory, cognitive vulnerability to hopelessness could interact with stress to cause depression; the theory posits that individuals who tend to interpret stressful life events as having negative implications for their future and self-worth are vulnerable to depression (Abramson et al., 1989).

Hopelessness is the expectation that negative outcomes are inevitable or that positive results will not develop. Hopelessness expectation is a cause and not a symptom of depression (Hirsch & Conner, 2010). Beck's (1967) hopelessness theory is a construct within the cognitive theory of depression because people who experience depression might describe adverse events because of their failings or lack of potential for happiness. According to this model, hopelessness depression is a subtype of depression, one that is characterized by motivational barriers and sad affect (Abramson et al., 1989). Beck (1967) explained that hopelessness has a direct, underlying relationship with depression.

Abramson et al. (1989) described a continuity of causal circumstances that manages to distort thoughts and cause hopelessness. The sequence starts with the understanding of a life event as negative and an expectation that a person can do nothing to improve the event or the conclusion's consequences. Individuals create assumptions at this point that contribute to hopelessness. Conclusions include (a) cause, (b) consequences, and (c) characteristics concerning oneself. Humans consistently and repeatedly apply beliefs as assumptions and make conclusions based on those assumptions.

Whipple et al. (2011) examined 559 women experiencing the disorders of depression and hopelessness reported that, among these middle-aged women, scores on the BHS instrument indicated elevated levels of hopelessness. Although Whipple et al. did not include female veterans, Whipple et al. did include middle-aged women, who are in the same age group as the majority of women veterans; 41% of the homeless female veteran population are aged between 30 and 50 years of age (NCHV, 2012; USDVA,

2012b). The hopelessness theory includes the interplay between a hypothesized cognitive diathesis and adverse life experiences in the prediction of hopelessness depression. The hopelessness theory of depression has a multistep connecting chain in the progress of depression (Abramson et al., 1989). Hopelessness is a feeling of despair or loss of faith in the probability of a positive outcome. Furthermore, it is a loss of positive expectations in a person's prospects that may contribute to increases in depression, desperation, or antisocial behaviors grief reactions and a feeling of helplessness(Medical Dictionary, 2009). Clinicians have proposed that depression is not considered to be a single disorder but a group of disorders; some symptoms characterize hopelessness depression. There are two symptoms included in the hopelessness theory. They are (a) retarded initiation of voluntary responses (a motivational symptom), and (b) sad affect (an emotional symptom; Abramson et al., 1989).

Overview of Literature Related to Key Variables

Female veterans are a highly traumatized population with substantial mental and physical health needs (USDHHS-SAMHSA, 2011). No scholar has identified the number of homeless female veterans or the mental disorders they are experiencing (USDHHS-SAMHSA, 2011). Researchers (GAO, 2011; Thomas et al., 2014; Vogt et al., 2011; Wells et al., 2010; Whipple et al., 2011) have established that it is necessary to address female veterans' homelessness, especially because there has been an expansion in female enlistments. Female soldiers are experiencing postmilitary mental health issues. Female veterans' increased exposure to combat provides a need to study gender differences in combat-related PTSD, depression, and hopelessness mental health services.

Mattocks et al. (2012) conducted semistructured interviews with 19 OEF/OIF women veterans from all of the services who had received VHA health care after returning from deployment. Mattocks et al. sought to explore the female veterans' stressful military experiences and postdeployment reintegration problems as major stressors. Mattocks et al. found that women veterans acknowledged stressors that fell into two broad categories: stressful military experiences and postdeployment reintegration problems. Mattocks et al. reported that these women came under direct fire continually and experienced combat-related injuries and death. Mattocks et al. showed that these women were struggling with major mental health disorders such as PTSD and depression. Many women in combat experience different stressors than the men that are related to combat and their multiple deployments. A few of the stressors are related to trauma from combat exposure that requires women veterans to search for improvised explosive devices or deployed female military members struggling with gender-based violence and military sexual trauma. Nevertheless, there was insufficient data concerning how female veterans of the OIF/OEF wars contend with their combat and military trauma (Mattock et al., 2012). Women came under direct fire continually and experienced combat-related injuries and death.

Scholars (Fargo et al., 2012; Hamilton et al., 2011) also emphasized the importance of understanding the multiple risk factors regarding female veterans' homelessness and trauma, such as how trauma's enduring impact on mind, body, and spirit have affected female veterans and impeded their ability to obtain and sustain housing. Kane (2013) found that female veterans continue to struggle with experiences

of mental disorders after returning from deployment; PTSD, depression, and hopelessness are the most prevalent. Keane, Fairbank, Zimering, Taylor, andMora(1989) found that these disorders may be direct consequences of deployment experiences and of the challenges associated with returning to everyday environments.

Homelessness

Homelessness is a persistent domestic and worldwide societal crisis. The definition of a homeless person id as follows: (a) an individual who lacks a fixed, regular, and adequate nighttime residence; (b) a person who has a primary nighttime residence that is a privately-operated shelter designed to provide temporary living accommodations including welfare hotels, congregate shelters, and transitional housing for the mentally ill; an institution that provides a temporary residence for individuals intended to be institutionalized; or a public or private place not designed for, or ordinary used as, a regular sleeping accommodation for human beings (USDVA-HCHWV, 2011).

Although the overall number of homeless male veterans is declining, the number of homeless women veterans is increasing (Kane, 2013). Women veterans are the fastest increasing segment of the homeless population and are experiencing a greater risk of homelessness. (USDVA, 2012b). The VA (2013) found that additional access to current mental health services may contribute to reductions in newly homeless veterans and that a focus on prevention should persist. The VA found that homeless veterans, particularly women, had received disproportionally more treatments than domiciled veterans, even before their first homeless episode. The USDVA's Women Veterans Health Study (2012b) also found that more research about female veterans' homelessness is needed; in

particular, a greater understanding of homelessness and the circumstances connected with increased homelessness risk are necessary. The need is twofold: (a) to decrease female veterans' homelessness and (b) to adequately address the mental health requirements of the veteran female population. The USDVA's Women Veterans Health Study indicated that, although the VA continues to work toward reducing veterans' homelessness, the number of female veterans who are homeless has continued to increase. Moreover, deficiencies in mental health services are related to homelessness among female veterans (Goldzweig, Balekian, Rolón, Yano, & Shekelle,2006). These services are meant to serve those returning from combat with psychological health concerns and disabilities (Feczer& Bjorklund, 2009; Hamilton et al., 2011; Kane, 2013; Rosenfeld et al., 2011). Until 2013, most of these services were not available to female veterans who had not engaged in ground combat (DoD, 2013).

History of the posttraumatic stress disorder diagnosis. The variable PTSD correlates with the following research question: Is there a difference in frequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat: The disorder of PTSD relates to a pattern of symptoms that follow exposure to traumatic events. The PTSD diagnostic criteria were updated in *DSM5*(American Psychiatric Association, 2013). Revisions to the diagnostic standards in the PTSD and acute stress disorder include only seven symptoms that are not the same as those in the *DSM-IV*. There are eight criterion symptoms reported in the *DSM-V* that includes stressor, intrusion, avoidance, negative alterations in cognitions and mood, changes in arousal and reactivity, duration, functional significance, and exclusion. In the*DSM-V*, PTSD and acute stress disorder moved from the class of anxiety disorders

into a new category of trauma and stressor-related disorders (American Psychiatric Association, 1994).

Omitted are the changes to PTSD in the criteria that indicates that the response involves fear, helplessness, and horror. Rather than including three major symptom clusters for PTSD, there is now a listing for four groups. The *DSM-V* now includes the addition of two new subtypes PTSD preschool subtype and PTSD dissociative subtype. The updating of acute stress disorder in the *DSM-V*is now similar in ways to the PTSD criteria. The terms "shell shock" and combat exhaustion were originally the names given by medical providers and psychiatrists to describe the medical condition of PTSD (Jones, 2012). The only accepted combat-related disorder after World War I in the medical population was shell shock because of the disorder's association with neurological damage.

To present a clearer rationale for postwar psychological distress, such a disorder was considered to be the traumatic neurosis. They labeled symptoms that soldiers expressed such as delirium, fear, fatigue, and hysterical paralysis as shell shock. Many historians have explained that shell shock presented a suitable means for doctors to distinguish the mental ordeals displayed by soldiers from having the feminine qualities regarded as hysteria (Linley, Felus, Gillett, & Joseph, 2011). In the winters of 1914 and 1915, shell shock became a medical and military dilemma. The disorder struck many of frontline troops serving in World War I. The doctors of the British Army had difficulty understanding how to control the disorder. Signs of the disorder included impaired sight and hearing, nightmares, tremor, fatigue, and confusion. Also, soldiers received this

diagnosis when they could not function, but no apparent reason could be determined (Loughran, 2010). Because the various symptoms were physical, the disorder exhibited limited similarity to the recent diagnosis of PTSD. None of the symptoms observed by physicians would be viewed as indications of PTSD (Linley et al., 2011).

Posttraumatic stress disorder in female veterans. During 2004-2008, the number of veterans seeking aid for PTSD in the VA system increased from 274,000 to 442,000 (GAO, 2012). Female soldier's experience included recurring, unwanted, distressing recalls of traumatic events, and prophetic dreams concerning the traumatic events. The U. S. Department of Veterans Affairs PTSD Study(USDVA, 2013)also reported that women are twice as prone as men to develop PTSD. However, among current returnees endeavoring care at the VA, the PTSD levels among men soldiers and female soldiers were found to be equal. Women reacted more vigorously to the well-known signals such as bombings in conflict than men did (USDVA, 2013). Also, women veterans are more susceptible to developing PTSD than men (USDVA, 2013). Statistics imply the necessity to understand the performance of gender in PTSD better, particularly as it will affect the veterans attempting to receive care. Although depression is now the most wide-spread mental disorder among female veterans, among the various psychiatric conditions of the OEF/OIF populations, PTSD is the most prevalent (Di Leone et al., 2013; McDonald & Calhoun, 2010; Pittman et al., 2012; Vogt et al., 2011).PTSD and depression have more disruptive effects on interpersonal and family functioning than trauma (Pittman et al., 2012). Moreover, there is a connection between having some form of injury or trauma such as PTSD and homelessness

(Pietrzak, Goldstein, Malley, Rivers, & Southwick, 2010; Washington et al., 2011).

Gender disparities in posttraumatic stress disorder. Women's quality of life is inferior to that of men who have had exposure to similar experiences of trauma (NIMH, 2015).Also, women in the war zone experienced prolonged periods of stress, and the duration of exposure to combat intensified PTSD gender disparities (Fontana, Rosenheck, & Desa, 2010; Vogt et al., 2011). Both PTSD and depression mental disorders have a positive correlation. Gender dissimilarities in PTSD are debatable, and PTSD in female military veterans is a complication. There are several barriers for women veterans to access and use healthcare through the VA(USDVA, 2012b).Gender differences regarding PTSD symptoms resulting from exposure to conflicts in the OEF/OIF wars are perplexing. Many other aspects regarding women have to be taken into consideration such as women's gendered social roles, women being more prone to mental health consequences because they are more likely to experience trauma inside their established relations,and their traumatic experiences are more continuing than those experienced by men (USDVA, 2012b).

Although data from Army official databases employing limited analysis showed increased vulnerability among female soldiers, Ready et al. (2012) found no gender differences in postdeployment mental health consequences when comparing levels of combat exposure. The USDVA 2012b) reported that female veterans are exposed to PTSD combat trauma equally with male veterans, although not as directly or as frequently; however, PTSD symptoms differ between men and women. For example, women with PTSD were found to be more prone to be apprehension, have increased

difficulty sensing emotions, and were more likely to evade things that suggest trauma. In contrast, men were more liable to feel resentful and to have problems controlling their rage. Women with PTSD were more likely to feel depressed and anxious; men with PTSD were more inclined to have problems with alcohol or drugs.

The USDVA (2016)revealed that female veterans exposed to combat have emotional experiences that negatively conditioned them psychologically and physiologically to the mental disorder of PTSD. The USDVA showed that high levels of social support for these female veterans after the war were significant for those women veterans. Also, it was important for the returning female veterans to feel that they could rely on others to support them with responsibilities in periods of need. The USDVA found that veterans who had this system of support suffered less from PTSD.

In the conflict zone, soldiers are challenged physically and emotionally in actions that are unusual for them. The physical requirements of combat activities should not be underrated, particularly the behavioral and emotional consequences placed upon soldiers' stress hormones. Combat actions activate the body's alarm response and include reactions such as jitteriness, appetite suppression, sleep disruption, and hypervigilance.

Both women and men who experience PTSD may have increased physical health concerns. Scholars (Cook et al., 2011; Hall, Elhai, Grubaugh, Tuerk, & Magruder, 2012; Ready et al., 2012; Suris& North, 2011) pointed out that female veterans reported higher rates of PTSD and that female veterans have greater complications reentering civilian life than male veterans. Women veterans experiencing PTSD have a more difficult time acquiring employment, and the homeless women veterans encounter obstacles to

employment. According to the VA, 77% of homeless female veterans are unemployed (cited in U. S. Bureau of Labor Statistics, 2013). The reason for this percentage may be due to the scarcity of available and affordable childcare. Moreover, community providers listed child care as the highest unmet demand for homeless female veterans (Cook et al., 2011; Pacella et al., 2012).Quantitative scholars (Feczer& Bjorklund, 2009; Kubany, Ralston, & Hill, 2010; Vogt et al., 2011) revealed that females in the military are in crisis because of exposure to or being in proximity to combat. Moreover, veterans who were not combat in the Iraq and Afghanistan wars did not present the mental injuries of combat. The VA (USDVA, 2012b) reported that female veterans experience trauma at a ratio of 2:1 compared to male veterans. There is a correlation between observed threats during conflict deployment and PTSD.

Posttraumatic stress disorder and physical and mental dysfunction. PTSD is linked with other psychiatric disorders, such as depression, social phobia, panic disorder, substance-related disorders, and other mood and anxiety disorders (Pacella et al., 2012). The USDVA (2012a, 2012b) reported that 30% of the female veterans of Iraq and Afghanistan required medical care after separating from the military. Moreover, the female veterans have displayed possible symptoms of mental and emotional stress. Researchers (Ghahramanlou-Holloway et al., 2011; Glanz, Rimer, & Lewis, 2011) have shown that PTSD and subclinical PTSD symptoms correlate with negative health symptoms; there is a harmful impact of this potential two-fold burden on PTSD severity.

The highest prevalence of PTSD among deployed soldiers were a result of the Iraq and Afghanistan current wars. PTSD symptoms appeared shortly after the traumatic incident, and the disorder subsides in several survivors and continues in others into chronic PTSD.

Biehn, Elhai, Fine, Seligman, and Richardson (2012) conceptualized the difference between 230 mostly male soldiers who experienced PTSD and 148 who did not; Biehn et al. showed that soldiers with PTSD experienced the distress of reexperiencing trauma symptoms. Biehnet al. showed that the female veterans had greater PTSD severity. Although the research was not concentrating on gender, the number of femalesoldiers experiencing PTSD was greater than the male soldiers who did not experience PTSD (Biehn et al., 2012).

Lehavot et al. (2013) examined the obstacles to healthcare among female veterans who were positive for lifetime depression and PTSD. Additionally, Lehavot et al. compared individuals with and without mental health conditions or barriers. Lehavot et al. identified unmet medical care requirements, delayed care, and barriers to accessing VA care. Also, Lehavot et al. hypothesized that women with comorbid PTSD and depressive symptoms would describe a higher rate of unmet medical care requirements and higher rates of perceived barriers to care than the other groups. Lehavot et al. did not determine the justifications for the obstacles hindering the required medical and mental care needed by the female veterans. Lehavot et al. indicated that there is a need for supplementary services for female veterans and a requirement for a better understanding of women veterans' health needs.

Pittman et al. (2012) examined veterans with PTSD and depression to determine how each disorder contributed to poor health-related quality of life. Pittman et al.found that veterans had severe levels of depression. When evaluating the effects of PTSD and depression on the mental and physical health-related quality of life in 220 OIF and OEF combat veterans, the diagnoses of PTSD of 46% was prevalent, and all the veterans displayed some level of depression. The veterans exhibited minimal to severe levels of PTSD and depression (Pittman et al., 2012). Pittman et al. showed that PTSD and depression had adverse effects on the veterans' health. A few of the symptoms experienced were insomnia and difficulty concentrating. Only in the mental health category, not physical health group, was there a reduced quality of life (Pittman et al., 2012).

Possemato, Wade, Andersen, and Ouimette (2010) established that female veterans experienced PTSD and depression and that each condition has an adverse impact on their quality of life. Possemato et al. showed that these female veterans had negative feelings concerning their future, lack enthusiasm, and lack faith or hope. Furthermore, Possemato et al. determined that homeless female veterans might remain homeless if they experience PTSD and hopelessness. Possemato et al. determined that OEF/OIF veterans described connections between PTSD, depression, and self-reported health problems. Comorbid depression and substance misuse can increase the correlation between PTSD and self-reported health issues. As problems develop, it will change into greater medical care requirements. Additionally, required were both primary care and specialty care assistance that treat conditions found to be widespread, including, nervous system disorders, digestive, and musculoskeletal.

Suris and North (2011) also advocated for studies on the impact of the potential double burden of PTSD severity on physical and mental functioning because they found that female veterans experience PTSD concurrently with other mental disorders related to trauma. Scholars (Thompson &Bridier, 2013; Yarvis, 2013) found that female veterans experience higher PTSD scores on assessment instruments. Female veterans have a greater need for medical services in comparison to younger female veterans and younger female civilians**.** PTSD connects with other psychiatric disorders such as depression, social phobia, panic disorder, substance-related disorders, and other mood and anxiety disorders. Also, PTSD correlates with deficient psychiatric and physical functioning (Pacella et al., 2012). The USDVA (2012a, 2012b) reported that 30% of the female veterans of Iraq and Afghanistan required medical care after separating from the military.

Posttraumatic stress disorder and trauma. Scholars (Cook et al., 2011; Nunnink et al., 2010; USDVA, 2012b; Yano et al., 2012) showed that trauma is prevalent in women who serve in the military; five out of 10 women experienced a traumatic event while serving in proximity of combat such as PTSD as well as trauma disorders that create psychological abnormalities resulting from injury. There is a range of evaluation categories concerning trauma exposure. There are two forms of depression and PTSD. Psychological trauma requires a concrete pathway to improving a person's emotional health. Female veterans' PTSD symptom severity was significantly associated with the exposure to combat(Yarvis, 2013). There continues to be a gap in the research concerning military females, notably active duty enlisted women and officers. There has been

insufficient research on the impact of military service on servicewomen, particular deployment throughout wartime (Fontana et al., 2010). Scholars (Rozynko & Dondershine, 2001; Wolfe, Mori, &Krygeris, 1994)have determined that PTSD is a permanent health problem affecting survivors of combat. Fontana et al. (2010) showed that trauma and combat injury in both men and women almost guaranteed PTSD. Researchers (Bonanno& Mancini, 2010; DePrince, Chu, & Pineda, 2011) showed the significance of learning the correct assessment processes of the soldiers connected with unique forms of PTSD trauma-related anxiety.

Depression

The variable depression correlates with the following research question: Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat? Depression causes an individual to experience low energy, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness (American Psychiatric Association, 2013). Depression is now beginning to be looked upon not as a single disorder but rather as a group of disorders with unique symptoms (Abramson et al., 1989; Keller, Feeny, & Zoellner, 2013; NIMH, 2015; Resnick et al., 2012).

Clinical depression is a severe medical illness that involves more than a temporary feeling of sadness; clinical depression is often characterized by a persistent sense of guilt, worthlessness, hopelessness, and emptiness (Lee & Oh, 2011). The USDVA (2012b) reported that depression is a severe and shared problem among veterans, that depression can occur following trauma, and that depression can get in the way of regular life and

cause daily challenges to functioning. Scholars (Burnett-Zeigler et al., 2012; Chapman, 2008; Haskell et al., 2011; Vogt et al., 2011) have found that depression is the most common mental disorder. Researchers (Luxton et al., 2010; Pittman et al., 2012) identified an association between combat exposure and depression after deployment in Iraq and Afghanistan.

Posttraumatic stress disorder and depression. Scholars (Grieger et al., 2006; Luxton et al., 2010) acknowledged the association between combat exposure and PTSD and depression. Lehavot et al. (2013) showed that the soldiers experienced unmet medical needs, and that many had lifetime depression and PTSD. Lehavot et al. also found that female veterans' PTSD levels were higher than male levels and were strongly related to depression. Pittman et al. (2012)also found PTSD and depression to be comorbid conditions; they confirmed that PTSD and depression had similar severity pertaining to health-related quality of life concerns. Depression has a more adverse effect on an individual's health-related quality of life than PTSD.

Gender disparities. Yano et al. (2011) found that women and men in combat deployment were at increased danger of a new onset of depression when contrasted with nondeployed women and men, and that female veterans were less likely than male veterans to be screened for depression, particularly in primary care settings. Women in the military are 1.7 times more likely to experience depression than men in the military(NIMH, 2015). Also, female veterans experience depression at a rate that is twice that of male veterans(NIMH). Moreover, younger eligible female veterans are more likely to require treatment for depression (Burnett-Zeigler et al., 2012; Chapman, 2008;

Farr, Dietz, Gibbs, Williams, &Tregear, 2011; Haskell et al., 2010). Depression is more than twice as prevalent in young women as men(Maguen, Ren, Bosch, Marmar, & Seal 2010). Triggers among women are more complex. Women more frequently display with internalizing symptoms and men present with externalizing symptoms (Albert, 2015).

Scholars (James et al, 2013; Schell et al., 2011; Wells et al., 2010) reported that there is an unusually large frequency of depression experienced by OEF/OIF female veterans. The OEF/OIF female veterans screened as being 20% positive for depression while the men screened at 12%, which is a 68% increase prevalence for the women (NIMH, 2015). However, younger women were less worried about the stigma associated with obtaining treatment. The USDVA (2012b) reported having intensive treatments available for both male and female soldiers. The USDVA showed that (a) women not involved in ground combat but, near to the combat zone, such as being in proximity to mortar fire or seeing other soldiers seriously injured or worse, will present high scores on combat-exposure depression; (b) women not involved in ground combat but, in proximity to the battlefields, present high scores of combat-exposure depression; (c) there is a connection between depression and PTSD; and (d) that major depressive disorder (MDD) is one of the most prevalent psychiatric disorders with 12-month prevalence estimates ranging from 5–10% of the general female adult population.

Women and men in combat deployment have an increased danger of a new on se to depression and PTSD compared to nondeployed women and men (Wells et al., 2010). The NIMH (2015) reported that 11% of male veterans aged 65 years and older have a

diagnosis of MDD; the diagnosis of MDD in women is more than twice as high (25%; NIMH, 2015). The percentage of MDD in the younger population of female veterans is 35% (Maguen et al., 2012; USDVA, 2012b).

Hopelessness

Hopelessness involves a lowered expectation for attaining individual goals and a diminished belief in the probability of achievement (Melges & Bowly, 1969). The variable hopelessness is related to following the research question: Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat. There is insufficient research concerning hopelessness and female veterans. Psychology literature presents hopelessness in various ways. Beck et al. (1975) offered a conceptualization of hopelessness that was considered the primary connection of depression to suicidal behavior. Beck et al. (1993) reported that the clinical study of depression completed in the 1970s found that hopelessness was the dominant theory when studying depression. The conceptualization of hopelessness as a symptom of depression is a suitable approach to studying Beck's (1967) theory of depression. However, Abramson et al. (1989) conceptualized hopelessness as a forerunner to a subtype of depression (i.e., hopelessness depression), not as a symptom. Abramson et al. (1989) proposed that the hopelessness theory underscores the significance of cognitive developments in the etiology, maintenance, and treatment of depression. The symptoms connected to hopelessness depression have affected both men and women (Iacoviello et al., 2013). Hopelessness could develop into depression symptoms, such as hopelessness depression, with time. The disturbing element of hopelessness involves negative

thoughts and feelings toward altering the future (Beck et al., 1974).For example, a female veteran may feel that she is not capable of resolving her homelessness crisis. Hopelessness is a consequence of the feeling of unimportance, which can develop from a brief anxiety response into a persistent psychiatric disorder (Iacoviello et al., 2013). In addition, hopelessness includes the presence of a depressed mood and/or lack of interest or pleasure in activities, as well as various other potential symptoms. A Hopelessness can develop into a negative psychological state (Beck et al., 1975). There are three significant points concerning hopelessness. First, to avoid repetition, measures of depression used in research need not contain measures of hopelessness probability or feelings of defeat and entrapment (Iacoviello et al., 2013). Second, hopelessness depression has various manifestations, such as having a depressed mood nearly each day for extended periods of time, a loss of interest or enjoyment in practically all activities, an increase or decrease in sleep, and or difficulty making decisions (Iacoviello et al., 2013). Other examples would be diminished interest, fatigue or loss of energy, displays of hopelessness depression (i.e., suicidal contemplations and attempts), sleep disorders, and trouble with concentrating (Abramson et al., 1989). The latter two symptoms are manifestations of fretting about unattainable outcomes and reflection regarding a person's hopelessness. Self-esteem deficits include feelings of an overall attribution of negative life events. Third, hopelessness depression is a sense of despair.

Some individuals have a cognitive vulnerability that interacts with stress to produce depression. According to the hopelessness theory, people are vulnerable to depression because they tend to create ideas of stressful life situations that have negative

assumptions about their future and their self-worth (Abramson et al., 1989). Douglass (2001) revealed that 93% of the screened participants who remained at risk of depression did not show they experienced hopelessness, and 44% of those screened for hopelessness did show they were in danger of experiencing both the disorders of hopelessness and depression. Douglass established that an individual who is hopeless is most likely depressed, but a person who is depressed is not always hopeless. However, Lindert, Müller-Nordhorn, and Soares (2009) posited that depression might be a symptom of hopelessness. Lindertet al. showed the rate of depression, PTSD symptoms, and the hopelessness that female veterans might experience. The prevalence rate of depression varied from 12.5% to 14.1%, the rate of PTSD symptoms ranged from 23.5% to 33.3%, the rate of hopelessness ranged from 11.5% to 16% (Lindert al., 2009). Depression and hopelessness can be measured and analyzed separately. Moreover, hopelessness predictably leads to hopelessness depression. Beck et al. (1974) noted that this disorder is quantifiable, and that hopelessness can develop into a depressed state.

Quantitative scholars (Marsiglia et al., 2011; USDVA, 2013; Washington et al., 2011) focused on female veterans' hopelessness and suicide. Female veterans experience the mental disorder of hopelessness. Currently, the mental disorder of hopelessness has not been acknowledged by the *DSM* of the American Psychiatric Association (2013), nor is its relationship to the formal diagnostic categories directly accessible in other related literature. There has not been a significant amount of empirical work or research concerning hopelessness; the last reformulation of research generated concerning any observational work on hopelessness was in the 1980s (Rosenfeld et al., 2011). Whipple

et al. (2011) analyzed the correlation between hopelessness and depressive symptoms in a population of 3074 women. The average age of the female veteran experiencing hopelessness was between the ages of 40 and 59 (Whipple et al., 2011). Also, middleaged women had higher scores of hopelessness and greater association with unusual higher depressive symptoms (Whipple et al., 2011). Marty and Segal (2010) found that hopelessness was more prevalent among younger adult females, and depression was more prevalent in the middle-aged women. Marsiglia et al. (2011) studied 136 women and found that hopelessness predictably leads to hopelessness depression. Researchers (Marsiglia et al., 2011; USDVA, 2013; Washington et al., 2011) focused on female veterans' hopelessness and suicide and found that female veterans experience the mental disorder of hopelessness.

Homeless female veterans with children. Scholars (Cascone, Zimmermann, Auckenthale, & Robert-Tissot, 2011; Mott, Graham, & Teng, 2012; Tsai et al., 2014) found that many homeless female veterans had sustained major forms of trauma that can become an impediment when attempting to obtaining shelter. Researchers (Hamilton et al., 2011; NCHV, 2012) also discovered that homeless female veterans experience hindrances when attempting to obtain housing and that those with children face additional barriers. There are only 52 government organizations offering to help house female veterans; seventy percent place significant constraints on age limits and the number of children they are willing to house(U. S. Bureau of Labor Statistics, 2013).

These challenges are dissimilar from those of male veterans, for women veterans who are raising children single-handedly. Nearly half (40%) of active-duty women do

have children(U. S. Bureau of Labor Statistics). Moreover, 11% are single mothers who may require shelter, social support, and other resources (NCHV, 2011).

Female veterans encounter more obstacles in locating housing that can provide sufficient accommodations for their dependent children (Kelley, Britt, Adler, &Bliese, 2014). Furthermore, homeless female veterans face challenges concerning child-oriented services, schooling, and safety. Many women veterans who are single parents would like to take advantage of employment services, but various issues limit their efforts. Too often, childcare is either not available or not affordable (U. S. Bureau of Labor Statistics, 2013).

Existing programs, including those run by government organizations, have inadequate resources to provide shelter for female veterans with children (GAO, 2012). Devoid of interventions, female veterans and their children are at greater risk of becoming homeless. Male veterans are more likely to reside in transitional housing than female veterans. The gender disparity in available transitional housing might originate from a lack of transitional housing and residential programs accessible to women veterans (Hamilton et al., 2012). Rukmana (2010) pointed out that for female veterans, and those with children, concerns regarding privacy, safety, and security are of importance. Scholars (Cascone et al., 2011; Mott et al., 2012; Tsai et al., 2014) indicated that many homeless female veterans had sustained forms of trauma that can become an impediment when obtaining shelter. Youth Protective Services considers the circumstances of homeless children to be dangerous, and they remove the children from parental custody

(NCHV, 2012); this creates a frightening possibility for homeless female veterans with children.

Gender Disparities in Mental Health Treatment for Veterans

Women veterans' difficulties are different from those of their male counterparts because they must often raise children on their own while contending with combat related mental health issues and the psychological effects of deployment (Boyd, 2013; Suris& North, 2011). Researchers (Frayne et al., 2011; Maguen et al., 2010; Williamson, 2009) disclosed that men had been the main population of veterans to visit the VA facilities. The USDVA (2012b) reported that the organization is making strides in eliminating the gap in services offered to military women and men. The VA(2012a)reported that as of 2008, 281,000 female veterans acquired healthcare from the VA. The number of women visiting the VA has increased by approximately 12% since 2006, and the prediction is that this statistic will increase 17% by the year 2033 (NCHV, 2011). Despite this positive claim, gaps persist between men and women veterans concerning essential quality healthcare (Washington et al., 2011). The USDVAWVTF (2011) found that the VA is at a significant crossroads because of the limited studies revealed to the healthcare of female veterans in the VA (Schell et al., 2011). Galovski, Mott, andResick (2011) identified the need for additional research regarding the differences between medical and psychological services provided to women versus men. Scholars (Frayne et al., 2011; Gade& Wenger, 2011; Schell et al., 2011) established that most research regarding veterans' mental disorders such as PTSD

focused on older male veterans who have experienced current PTSD for decades, and only a few scholars concentrated on women veterans' PTSD after deployment.

There is limited literature regarding gender differences in younger generations of veterans, particularly among veterans seeking VA healthcare (Maguen et al., 2010). Wells et al. (2010) found small, if any, gender disparities in PTSD rates. Researchers (Fontana et al., 2010; Haskell et al., 2010; Maguen et al., 2010) showed that female veterans have more positive screens for depression and PTSD than male veterans. Also, the number of female veterans receiving VA medical support has increased by 83% over a decade, from approximately 160,000 to over 292,000 between fiscal years 2000 and 2009; this contrasts with a 50% increase for men ((2012a, 2012b). Disturbances about gender-based health disparities remain. There is a need to better address living condition undertakings and to redress women's healthcare insufficiencies. Montgomery and Byrne (2014) reported that female veterans are typically more prone to use outpatient services, while male veterans are more likely to use inpatient services.

Veterans experiencing homelessness who do not use VA homeless assistance services are less engaged with preventative VA health and behavioral healthcare (Montgomery & Byrne, 2014). The USDVA (2012b) disclosed dissimilarities in services provided to women according to war periods and the type of services provided to women versus men. Only a small number of scholars have examined female veterans' experiences in conflict and to what degree they can successfully cope when they returned to civilian life, and female veterans have concurrent medical conditions and have worse

health related quality of life than male veterans (Montgomery & Byrne, 2014; Pacella et al., 2012). Researchers (Feczer& Bjorklund, 2009; Inslicht et al., 2013; Luxton et al., 2010) found that there may be a gender bias concerning the diagnosis of PTSD within the VA healthcare system. Although women have demonstrated more PTSD symptoms than males, PTSD diagnoses were 3.4 times more frequent in men(Lehavot et al., 2013) Studies assessing differences in initial symptom severity of PTSD between male and female soldiers yielded inconsistent results (Maguen et al., 2012; Schell et al., 2011). There are particular mental health needs and deficiencies in mental healthcare for female veterans, as well in female veterans' postdeployment housing needs.

Summary and Conclusions

The objective of this chapter was to provide a review of studies on female soldiers' medical, psychological, and shelter needs. Literature was reviewed that recognized that female veterans' homelessness has increased (NCHV, 2012; Ready et al., 2012; Tsai et al., 2014). I also illustrated how the prevalence of PTSD, depression, and hopelessness of female veterans might affect their acquiring needed shelter. More women are joining the military, and therefore, added shelter, psychological, and medical services will be required to accommodate the discharged female veterans. The gap in the research literature concerns the relationship of PTSD, depression, and hopelessness to women veterans' homeless and nonhomelessness status. Also, there is a gap regarding studies of discharged female veterans.

In Chapter 3, I present the research methodology, research design and rationale, threats to validity, and a summary.

Chapter 3: Research Method

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. Used to measure the variables in the study were the PCL-M PTDS total score(Weathers et al., 1994), the II BDI-II total score (Beck et al., 1996), and the BHS total score(Beck, 1988). There is a gap in the psychology literature related to what happens to female veterans when they return to civilian life. Countless women veterans face challenges when returning to civilian life. There has been inadequate research on how the military services has affected women veterans. Various challenges are confronting the female veterans when returning to civilian life. Several significant problems such as homelessness, and various mental disorders female veterans are experiencing, require further research (Gore et al., 2013). Scholars have suggested that female veterans' homelessness has increased and that these women are experiencing mental disorders such as PTSD, depression, and hopelessness (NCHV, 2012; Ready et al., 2012; Tsai et al., 2014; Whipple et al., 2011).

Research Design and Rationale

A quantitative, quasi-experimental design was used to identify existing differences between groups, as suggested by Creswell (2009). Quasi-experimental research is used to identify quasi-cause and effect, meaning; in this case, I determined whether there are differences in the levels of PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S.

military deployment. The evaluation of the variables was conducted by applying the three instruments of PCL-M PTDS total score (Weathers et. al., 1994), the BDI-II total score (Beck et al., 1996), and the BHS total score(Beck, 1988). I employed a MANOVA method. The MANOVA uses the variance-covariance between variables. The MANOVA is an extension of the one-way ANOVA that includes two or more dependent variables as opposed to just one dependent variable. The dependent variable, PTSD, correlated with the first research question of this quantitative study: Is there a difference in frequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat? The dependent variable, depression, corresponded to the second research question: Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat? The dependent variable, hopelessness, correlated to the third research question of this quantitative study: Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat?

Maxwell (1996) indicated that qualitative researchers focus on exact situations or people, and the emphasis is on words as opposed to numbers. The psychology discipline has approached the problem of women veterans' homelessness using a qualitative method (Ready et al., 2012; Washington et al., 2011; Wells et al., 2010). The qualitative method consists of observations and interviews that capture the experience of the individual (Trochim, 2009). A qualitative research approach was not the chosen analytical method because the method provides a subjective analysis of what female veterans may or may

not experience. A descriptive, quantitative, quasi-experimental research method was selected for this study because this method is used to describe the variables the researcher is measuring. Also, this approach involves obtaining a considerable amount of raw data; descriptive statistics are significant in reducing the data to an easier form. Additionally, the research questions in the study attempt to quantify the variables the researcher is studying, as suggested by Laerd Statics (2016). Quantitative researchers clarify phenomena by gathering numerical data that are analyzed using mathematically based methods (Creswell, 2009; Hopkins, 2000). Quantitative research results are descriptive or experimental (Creswell, 2009). The data obtained in this study were useful because the statistical analysis contributed to the existing literature on the PTSD, depression, and hopelessness among female veterans. I chose this study design to acquire information that may confirm the need to develop and enhance treatment options for women veterans experiencing PTSD, depression, and hopelessness.

Methodology

Population

The target population included both homeless and nonhomeless female veterans. A power analysis was administered to determine the minimum number of participants appropriate for this study (N= 86; Shieh, 2005). Each group included 43 female veterans, to ensure a 95% confidence level with a margin of error of 0.05. The determination of the confidence level and margin of error were by Star Trek's Sample Planning Wizard (StatSoft, 2013).

Sampling and Sampling Procedures

I used a convenience and snowball sampling method. The sample for this study was female veterans who had been in conflict at least once and were between the ages of 22 to 65. A convenience sample is appropriate when participants who are agreeable to participate in the study are readily available (Fink, 2009). This method enables the experimenter to depend on research respondents who are immediately attainable (Babbie, 2002). Sadler et al. (2010) described snowball sampling as an approach for locating populations that are unusually difficult to find or not readily available but are essential subjects. The snowball method is a nonprobability sampling method that researchers employ to identify possible subjects in studies whenever participants are difficult to find (Sadler et al., 2010). The convenience and snowball sampling methods were the best procedures given the conditions that prohibit random sampling to achieve the desired 86 participants (Shieh, 2005).

Procedures for Recruitment, Participation, and Data Collection A sample of 39-43 individuals in each group was needed to ensure that the findings have not occurred merely by chance (Shieh, 2005). There was a total of 88 female veterans recruited. I dispensed leaflets/flyers to recruit participants located in various parks, libraries, homeless shelters, and veterans-only lodges in the northern region of New York for 4 weeks to acquire the necessary participants for the study. In each area that I distributed the consent forms, the participant was able to take the surveys with her and return later that day**.**

Included in the female veterans' categories were marital status and ethnicity. Assessments did not take place on any government property. The three testing instruments took approximately 30 minutes. The instruments were administered in isolated areas of various New York parks, discrete sitting room in libraries, outer areas of homeless shelters, and in private sections in veterans-only lodges. I asked the participants outside the libraries, parks, homeless shelters, and veterans-only lodges to complete the inventories and return them to me at a later time the same day. No letter of cooperation was needed due to my not obtaining a room. All research participants partook in the research without prearrangements. Provided to each participant wasan explanation regarding the confidentiality of her demographic information, survey results, and forms. The application provided information describing the method used for the protection of personal assessment data, and an explanation of how the data were used solely for scientific and research purposes. Collected from each participant was the following demographic information: age, the number of deployments, and homeless/nonhomeless status. Ihad rules regarding approval of human studies and recruitment of human subjects from the VA's Associate Chief of Staff for Research and Development that gave me permission to involve female veterans in the present research (Appendix D).

I gave a brief introduction explaining why it is essential for participants to understand the purpose of, why, and what the research will involve. All consent forms were signed. My professional role does not involve mandated reporting; all participants were adults ages 22 to 65. No disabled or clients lacking capacity to give informed consent were included. Also, there were not any clients who resided in nursing homes or

hospitals.

All participants were informed that research participation was voluntary. I described where the assessments will take place: a park, library, outside of a shelter, or veterans-only lodges. All instruments were administered individually. Participants were informed when their information was destroyed. All participants were informed that there are no benefits to partake in the study. All data were distinguished solely by a code, with personal details stored in a locked file or secured computer with access only by me. Participants were informed of the results of the study if requested.

In the consent form, I also included referrals with names and telephone numbers of mental health organizations to assist the responders if they become distraught in general or as a result of study participation. Individuals not willing to participate were asked to return the letter of consent and the demographic form. Forms that were not completed by the participants were collected and destroyed. I employed nonintrusive methods to prompt applicants to return the testing instruments. Also, I provided clarification that there will not be any correspondence in the future that pertains to the study, unless requested. The debriefing took place as soon as possible and to ensure that the responders understood the reason for the information session. I described what the current research states regarding female veteran homelessness and asked the responder if she had any questions.

Instrumentation

I used three instruments. The PCL-M (Weathers et al., 1994) is a self-report measure of the 17 *DSM-V* symptoms of PTSD. The PCL-M is a rating scale that explores

the characteristics of PTSD. The BDI-II (Beck et al., 1996) is a multiple-choice test of 21 items. The test is a self-administering version of the original 1961 test. The BHS (Beck, 1988) is a self-report 20-item true/false test; possible scores range from 0 to 20, with higher scores indicating greater hopelessness. Permission from the developer regarding two of the instruments is required; no permission was needed to use the third tool.

PTSD PCL-M Checklist

PTSD checklist (military version) is a military version, and it includes questions that relate to a stressful military experience that operationalizes the characteristics of PTSD (Conybeare, Behar, Solomon, Newman, &Borkovec, 2012). The PCL-M is a U.S. Government checklist; all have the authority to use the instrument because the device is open source. The PCL-M is a 17-item self-report measure of the 17 *DSM-V* symptoms of PTSD. The PCL-M is regularly used with active service affiliates and veterans (Grieger et al., 2006). The PCL-M is one of the symptom assessments most frequently used by clinicians for active duty members and veterans because the instrument assesses symptoms regarding stressful military occurrences.

The PCL-M consists of items such as whether the individual has repeated, disturbing memories, thoughts, or images of a stressful military experience. The approximate time to complete the PCL-M is 5-10 minutes. The instrument includes a 5point, Likert-type scale where 1=*not at all* and 5=*extremely* (Weathers et al., 1994). In the PTSD-M (military version), each question presented in the test indicates a level that points out more or less severe PTSD evidence (Bryan & Corso, 2011; Keen, Kutter,

Niles, &Krinsley, 2008). Overall severity ratings range from 17 to 85. Scores of 50 or greater indicate the presence of clinically significant PTSD (Owens, Herrera, & Whitesell, 2009).

Weathers et al. (1994) confirmed test-retest reliability for the PCL-M to be 0.96 with an interval of 2-3 days between testing. Estimate of internal reliability values for Cronbach's alpha was0.92for the *DSM*-A symptoms, 0.92 for B symptoms, 0 .92 for C symptoms, and 0.97 for all 17symptoms. The validity of the PCL-M is retained using significant positive correlations with other confirmed PTSD measures (r =0.64 to 0.93), general measures of pathology, and clinician-administered controlled interviews for PTSD (Blanchard, Jones-Alexander, Buckley, &Forneris, 1996; Weathers et al., 1994). Hatzenbuehler, Parpal, and Matthews (1983) showed that the overall test-retest reliability coefficients were acceptable to assess the consistency. The PCL-M has convergent validity when compared with other measures such as the Mississippi Scale for PTDS, the Minnesota Multiphasic Personality Inventory-2, the Impact of Event Scale, and the Combat Exposure Scale. Keen et al. (2008) reported that research had demonstrated sufficient psychometric properties for the PCL-M.

The objective of the Weathers et al. (1994)study was to develop more precise and reliable psychological evaluations for life-time stressor. The psychometric properties of the PTSD Checklist (PCL) were investigated in a sample of treatment-seeking and community-dwelling male veterans(Hall et al., 2012).Keen et al. (2008) showed that the PCL possesses strong, robust psychometric properties. Participants were not allowed to

participate in the study if they experienced mental disorders orwereunable to avoid using a substance for 24 hours before and throughout the study. Participants varied in age from 29 to 65 years (mean ± standard deviation [*SD*] = 47.4 ± 7.1; (Keen et al., 2008). Twenty-five participants (21.9%) met the diagnostic criteria for PTSD (Keen et al., 2008).

Hatzenbuehler et al. (1983) showed that the overall test-retest reliability coefficients were acceptable to assess the consistency. The PCL-M (Weathers et al., 1994), a self-report measure of the 17 *DSM-IV* symptoms of PTSD, is a rating scale operationalization the characteristics of the PTSD. Hall et al. (2012) showed that the PCL-M instrument revealed a gender difference between the two models of male and female soldiers. Hall et al. showed higher PTSD scores among women. The PCL-M is a U.S. Government checklist; all have the authority to use the instrument because the device is open source.

Beck Depression Inventory

The BDI-II (Beck et al., 1996) is one of the most widely used depression measurement tools because of the instrument's versatility in inpatient and outpatient settings. The BDI-II is a self-administered, 21-item,multiple-choice test that is used to measure depression in adults and adolescents. The BDI is a regularly used instrument for quantifying levels of depression. Assessment of depressive psychological indications are in the first division of the test, whereas the second part evaluates physical symptoms. The BDI-II is an appropriate test for individuals aged 13-80 years (Beck et al., 1988). The test is scored on a scale from 0-63, with a higher score indicating a greater severity of depression. A score of 0-99 indicates minimal depression, the norm of the general population. A score of

10-16 indicates mild depression, a score of 17-29 indicates moderate depression, and a score of 30-63 indicates severe depression. The approximate time to complete the BDI-II is 5 to 10 minutes (Beck et al., 1996). Individuals with high scores on the BDI-II are prone to reporting high scores of depression or anxieties. The BDI-II has been tested for reliability and validity and has been used for decades. The reliability of the BDI-II (Beck et al., 1996) is considered good, with item-total correlations that range from .39 to .70 in an outpatient population. Testretest reliability over a week's interval was found to be .93 for outpatients, and the validity scores are also considered reliable (Dozois, Dobson, &Ahnberg, 1998). There have been more than 2,000 studies of the BDI-II and multiple language translations of the test (Barroso &Sandelowski, 2001). Scores on the BDI-II are related adequately to measures used to screen for depression severity and suicide risk. Test-retest reliability was studied using the responses of 26 outpatients who were tested at first and second therapy sessions 1 week apart(Beck, 1996). There was a correlation of .93, which was significant at $p < .001$ (Beck, 1996).The mean scores of the first and second total scores were compared with a paired t (25) =1.08, which was not significant (Beck et al., 1996). The convergent validity of the BDI-II was assessed by administration of the BDI-1A and the BDI-II to two subsamples of outpatients (N=191). The order of presentation was counterbalanced.

One other measure was administered between these two versions of the BDI, yielding a correlation of .93 (p<.001) and means of 18.92 (SD=11.32) and 21.888 (SD=12.69) the mean BDI-II score being 2.96 points higher than the BDI-1A (Beck et al., 1996). Osman, Kopper, Gutierrez, and Frank (2004) performed three studies. In the first research, expert raters (N=7) and adolescent psychiatric inpatients (N=13) evaluated the

BDI-II items to assess content validity (Osman et al., 2014). In the second study, confirmatory factor analyses of several first-order solutions neglected to provide sufficiently adequate measures for 205 boys, 203 girls and the merged sample (Osman et al., 2014).

Reliability estimates were sufficiently high (range=0.72 to 0.91) for the BDI-II total and scale scores(Beck et al., 1996). The data from the following admissions were linked because there were no significant differences between youths on demographic variables of age, gender composition, ethnicity, and diagnostic groups (all $p>.05$; chisquare analyses; (Beck et al., 1996) For the combined participants, the mean age was 15.67 years (*SD* =0.95). The mean age of 15.65 years (*SD*=0.92) for the boys and the mean age of 15.68 years (*SD*=0.98) for the girls did not differ significantly, $t(317) = 0.29$, $p = .77$(Beck et al., 1996). The ethnic population of the sample included 84.6% European American, 5.0% African American, 3.5% Latino American, 1.3% Asian American, and 5.6% mixed or other ethnicities(Beck et al., 1996). The mean period of stay of the sample was approximately 46 days (range=14–220 days; (Beck et al., 1996). The mean Shipley Institute of Living Scale (Zachary, 1986) IQ of the sample was 103.29 (*SD*=9.28), suggesting normal intellectual levels of functioning (Osman et al., 2004). The approximate time to complete the BDI-II is 5 to 10 minutes (Beck et al., 1996). Regarding construct validity, the convergent validity of the BDI-II was reviewed using two subsamples of outpatients (*N*=191). The order of presentation showed an offset, and at least one other measure conducted between these two versions of the BDI. Generating

a correlation of .93 (p<.001) and means of 18.92 (SD=11.32) and 21.888 (SD=12.69) the mean BDI-II score is 2.96 points higher than the BDI-1A (Beck, 1996).

The outcomes of the BDI-II are available in the BDI-II manual (Beck et al., 1996). Regarding validity and reliability, various research scholars have found the BDIII to be consistently valid. The BDI-II demonstrates equivalent results when compared to the MMPI Depression Scale and other depression measures. Beck et al. (1996) noted that the reliability of the BDI-II is considered excellent, with item-total correlations that range from 0.39 to 0 .70 in an outpatient population. Test-retest reliability over a week's interval was found to be 0 .93 for outpatients (Beck et al., 1996). The BDI-II is regularly used among active service affiliates and veterans (Beck et al., 1996).

Beck Hopelessness Scale

The BHS (Beck, 1988)was used to assess the hopelessness of the female veteran participants. The approximate time to complete the BHS survey is 10-15 minutes (Beck, 1998). The BHS measures subjects' views and beliefs concerning their degree of pessimism involving their futures. The BHS is a self-report instrument containing 20 true/false items. Scores range from 0 to 20, with higher scores indicating higher levels of hopelessness (Beck, 1998). The BHS significantly correlates with the BDI.

Steer, Rissmiller, Ranieri, and Beck (1994) investigated the psychometric properties of the computer-administered versions of the revised BDI and BHS, using 330 inpatients diagnosed with different psychiatric disorders. All the corrected-item correlations for both the BDI and BHS were significant, and the pre- and posttest correlations for the BDI and BHS scores over an average of 9 days were also highly

significant (Steer et al., 1994). The coefficient alpha for the BDI was .92, and the Kuder Richardson-20 (KR-20) for the BHS was .91 (Steer et al., 1994). All of the corrected-item correlations for both the BDI and BHS were significant ($p < .001$), and the pre- and posttest correlations for the BDI (r=.56) and BHS (r=.53) scores over an average of 9 days were also highly significant ($p < .001$; (Steer et al., 1994).The internal reliability coefficients are reasonably high (Pearson r=0.82 to .93 in seven norm groups), but the BHS test-retest reliability coefficients are average .69 after 1 week and .66 after 6 weeks (Dowd & Owen, 1992). The BHS has high internal consistency among nonclinical and clinical samples with an alpha of .93 (Beck, 1976). The BHS has excellent internal consistency (α=.93-.83) in clinical populations (Beck et al., 1974). Pompili et al. (2013) with (N=169), university (N=577) and community (N=976) presented good internal consistency and a check on data quality (Kuder-Richardson) coefficients were 0 .75, 0.78, and .89, respectively. When adding the Spearman-Brown formula, if the scale included 20 items, as in the original version, the reliability would increase to around 0.87 (Ilioceto & Fino, 2015). Dowd and Owen (1992) reported that the BHS was capable, well created, and validated, with enough reliability. Furthermore, the BDI-II (Beck et al., 1996; Becket al., 1979) moderately correlates with the BHS, and the BDI is better suited to predicting suicidal ideation behavior.

Neufelda, O'Rourke, and Donnelly (2010) found that hopelessness has been identified as the significant predictor of suicide-related ideation and behavior to a greater degree than the severity of depressive symptoms. Most participants were female (76 out

of 117; Neufelda et al., 2010). These analyses provide support for the concurrent reliability and validity of responses to the BHS.

Data Analysis Plan

An MANOVA was used to the three hypotheses. The analysis was carried out using the Statistical Package for the Social Sciences (SPSS) software program, Student Version 21.0. This data analysis included descriptive statistics, means, standard deviation, and frequency where appropriate. Also, histograms were not offered, as well as *z*-scores and normal Q-Q plots to support assumptions of normality if needed. Furthermore, not provided was regression tables and supporting figures if an effect of the condition is determined. For these analyses, an alpha would have been set at p=.05, meaning the confidence level associated with the results will meet or exceed 95%.

The MANOVA was used to determine if there is a significant mean difference in the dependent variables as a result of varying levels of the independent variable. Not included were potential covariates and confounding variables. Confounding variables are unexpected variables that diminish the internal validity of the research findings. I evaluated the relationship between variables. There were not any covariate variables in this study because no other variables in the study were measurable or had a statistical connection with the dependent variables.

Broeck, Cunningham, Eeckels, and Herbst (2005) stated that data cleaning has three phases that involve repetitive cycles of screening, diagnosing, and editing of suspected data abnormalities. Data cleaning involves understanding the causes and categories of errors at all stages of the study, throughout as well as after measurements.

Screening data consists of four basic types of peculiarities: lack or excess of data, outliers and inconsistencies, unusual patterns in (combined) distributions, and unanticipated analysis results and additional types of inferences and abstractions (Broeck et al., 2005). The purpose of diagnosing is to explain the nature of the troublesome data points, designs, and statistics. In this study, I administered the data cleaning at the time of data entry or data reentry

The three research questions and corresponding hypotheses were

1. Is there a difference in frequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat?

$H_0$1: Homeless female veterans will not have a significant difference in the occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

$H_1$1: Homeless female veterans will have a significant difference in the occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

2. Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat?

$H_0$2: Homeless female veterans will not have a significant difference in the occurrence depression from nonhomeless female veterans who have experience combat, as measured by the Beck Depression Inventory BDI-II.

$H_1$2: Homeless female veterans will have a significant difference in the occurrence of depression from nonhomeless female veterans who have experienced combat, as measured by the BDI-II.

3. Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat?

$H_0$3: Homeless female veterans will not have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat, as measured by the BHS.

$H_1$3: Homeless female veterans will have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat as measured by the BHS.

Dataset Information

The dataset incorporated information about the homeless and nonhomeless female veteran participants. Descriptive statistics were employed to present summaries of respondents' characteristics, including homelessness/nonhomelessness, age, and number of deployments. Gravetter and Wallnau (2006) identified descriptive statistics as "statistical procedures that are employed, to summarize, organize, and simplify data" (p. 5).

I examined, screened, and cleaned all data; all invalid data were eliminated. Each decision was objective; all data were considered, and no significant information was disregarded. Also, all datasets such as the syntax or log that automatically documents the conclusions of the SPSS 21.1 program was used. The collected data from the self-report

instruments were described by descriptive and inferential statistics, including the entire sample number, mean, median, and standard deviation.

Threats to Validity

External Validity

External validity denotes how well results can be representative or generalizable to the population of study (Carlson & Morrison, 2009). External validity is the degree to which the conclusions in a study would coincide with the results obtained from various persons in other places and at different times (Trochim, 2009). A threat to external validity may occur when respondents in the study are not from different areas, and the generalization of other participants cannot be represented. I attempted to minimize this external threat by selecting eligible participants from various areas, such as selecting responders from different regional areas of New York. The study's external validity will determine the extent to which the outcome can be generalized to other locations and other women veterans at different places and periods of time.

Internal Validity

Internal validity refers to whether the effects detected in a study are due to the manipulation of the independent variable and not some other element. Any research that allows researchers to choose one explanation over another has a high level of internal validity with confidence because it avoids numerous probable confounds (Trochim & Donnelly, 2008). Creswell (2009) stated that potential threats to internal validity could stem from the experimental procedures, treatments, or experiences with participants who threaten the researcher's capacity to make correct inferences from the data regarding the sampling. Also,

a responder who does not believe the survey is confidential may either intentionally or inadvertently fill out a survey with mistruths. Individuals participating in research might present dishonest responses on any assigned survey. Experimenters may impede internal validity by erroneously interpreting participants' performance based on expectations, or by making errors while recording data based on their anticipation of participants' responses. I attempted to ensure internal validity by managing all the experimental methods while gathering data and not prejudging any research outcome.

Construct Validity

Construct validity relates to the capability of a measurement tool, such as a survey or test, to measure the psychological theory of the study (Field, 2009). An example of a threat to construct validity is a participant not being truthful but rather providing answers based on his/her guess at the actual purpose of the study. In this study, the participants had a full understanding of the research's topic. Also, as Trochim and Donnelly (2008) explained, responders may exhibit the human tendency to want to look good or look smart.A possible threat to construct validity is if, for example, the participant's responses are not truthful, butprimality to appear upstanding and not for the candid results of the research.

Ethical Procedures

In social science research, there can be no omitting of ethical factors. Barke (2009) found that all research ethics committees "must identify and assess the potential risks to human research subjects and balance those risks against the possible benefits of the research" (p. 337). The study was given to the IRB to ensure and observe the rights

of the participants. I obtained Walden University's IRB approval before initiating the research. The task of the IRB is to determine that all ethical requirements are satisfied and in agreement with all regulations that concern the research. I maintained the confidentiality of participants, the data collected, and the outlined procedures. The responders' names, additional identifying characteristics, and data collected from external access before and after the entire study period remained secure. According to the IRB, all researchers who will recruit participants for a study are compelled to permit the IRB to review and approve the scripts, audio or videotapes, and websites. Also, the final copy of printed advertisements was reviewed and accepted by the IRB before usage. The requirements were (a) the researcher will ensure no endangerment to the participants in the research study, (b) the researcher will obey all the U.S. federal regulations and university standards for ethical research, (c) the researcher will at all times follow the ethical principles linked to utilizing human subjects, and (d) the researcher will follow all the prerequisites of informed consent before and throughout the study. In this study, no participants were coerced to participate in the research. Each participant received a synopsis of what the research encompassed and read and signed an informed consent before beginning the study. Each informed consent had a designated identification number. Also, the informed consent letter included a message ensuring respondents that research participation is voluntary and that the surveys are confidential as described by the (American Psychological Association, 2002). The study was comprehensible to the participants so that they could rescind their consent at any point. Each participant learned

that refusal to take part in the study did not involve any penalties or loss. If the responder became emotionally upset or experienced any adverse consequences due to participation, she as allowed to discontinue the study, and the responder was offered the information to seek assistance. I ensured that individual/s were safe and had information that will aid in their remaining safe such as telephone numbers to the nearest VA. I ensured that the participant/s were not devoid of care by providing connections to care when it was needed.Contained in the informed consent was information about procedures, benefits, purpose, privacy, and the right to withdraw from the study at any time.

The testing instruments were handed out in the equivalent orders and were collected from each respondent immediately after completion to ensure confidentiality of the assessment results. All participants were capable of giving consent to take part in the study. My contact information, as well as a description of the instruments, was in the responders' packet (to be found in Appendix C). The collection of all data occurred over a 4-week period in anticipation of achieving the appropriate number of respondents for the study. All data were in a locked in a file drawer, and no one butme had access to the data. Furthermore, data were maintained by me at all times. All data will be securely stored for a 5-year period and then destroyed. Handling of all data gathered during the study complied with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). There were no conflicts of interest, power differentials, or research prepared in my employment environment. There was no use of incentives.

Summary

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in posttraumatic stress, depression, and hopelessness in homeless versus nonhomeless female veterans who have experienced at least one U.S. military deployment. The variables were measured using the PCL-M (PTDS) total score (Weathers et al., 1994), the II BDI-II total score (Beck et al., 1996), and the BHS total score (Beck, 1988).I used quantitative analysis, and I provided a statistical explanation of trends or attitudes of the study's sample. An MANOVA was used to determine if there is a significant mean difference in the dependent variables as a result of varying levels of the independent variable. The threats to validity were mitigated, and the ethical principles including participant informed consent and data confidentiality were outlined.

Chapter 4 will include an introduction, data collection, and results.

Chapter 4: Results

The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who had experienced at least one U.S. military deployment. I used the quantitative approach in this study tofind the differences in the variables of the research.

Included in this chapter is the following: the timeframe, methods for data collection, what was employed for recruiting participants, response rates of implied participants, any withdrawals from data collection methods discussed in Chapter 3, the demographic characteristics of the sample, and representativeness of the sample. I next

describe the results of the data in detail, including a report of the descriptive statistics that characterize the sample, an evaluation of whether the sample data met statistical assumptions for a one-way MANOVA, and a detailed report of statistical analytical findings (formulated by research questions and hypotheses). I outline statistics and probability findings, confidence intervals as appropriate, and effect sizes as fitting. The results of multivariate testsarereported, when appropriate, and I provide several tables to represent results. A summary is presented at the end of the chapter with the answers of the research questions and a transitional presentation of the findings into an introduction to the next chapter.

Quantitative Research Questions and Hypothesis

The research questions and hypotheses that were tested in this study were

1. Is there a difference in frequency of the occurrence of PTSD between homeless and nonhomeless female veterans who have experienced combat?

$H_0$1: Homeless female veterans will not have a significant difference in the occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

$H_1$1: Homeless female veterans will have a significant difference in the occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTSD PCL-M scale.

2. Is there a difference in frequency of the occurrence of depression between homeless and nonhomeless female veterans who have experienced combat?

$H_0$2: Homeless female veterans will not have a significant difference in the occurrence depression from nonhomeless female veterans who have experience combat, as measured by the Beck Depression Inventory BDI-II.

$H_1$2: Homeless female veterans will have a significant difference in the occurrence of depression from nonhomeless female veterans who have experienced combat, as measured by the BDI-II.

3. Is there a difference in the frequency of hopelessness between homeless and nonhomeless female veterans who have experienced combat?

$H_0$3: Homeless female veterans will not have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat, as measured by the BHS.

$H_1$3: Homeless female veterans will have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat as measured by the BHS.

Data Collection

Time Frame

The Walden IRB approved this study on July 11, 2018. I also requested permission to handout preapproved fliers to recruit participants for my study into several veterans-only lodges, female homeless shelters, female veteran shelters, and libraries.Mydatacollection and recruitment required 75 days to be completed. Flyers were distributed requestingfemale soldiers to volunteer to be in this study (see Appendix A).I used the PCL-M to collect data for the dependent variable PTSD. I used the BDI-II

for the dependent variable depression. I employed the BHS for the dependent variable hopelessness. A convenience and snowball sample of participants was collected from homeless shelters, veterans'-only legions, libraries, and areas away from the properties of several VA hospitals.

Response Rate

Data collection is a systematic method that permits the researchers to answer research queries, test hypotheses, and analyze results (Frankfort Nachmias & Nachmias, 2008). I asked 91 participants to partake in the study, and 88replied; the response rate was 96%. Raw scores from the three instruments were downloaded in a SPSS file. Frequencies were used to confirm the integrity of the data and to address and identify any missing data concerns. The participants included female veterans who had at least one deployment and who were 22 to 65 years of age. The participants were recruited from homeless shelters, veterans'-only legions, parks, and female-only veteran shelters. The participants anonymously confirmed consent by completing three surveys. Response deletion accounted for three incomplete surveys from participants who did not hand in all three instruments necessary to analyze the data. The final dataset consisted of responses from a total of 88 female veteran women. There were no discrepancies that existed in the data collection from the plan presented in Chapter 3.

Demographic Characteristics of Samples

Data for this study were coded, compiled, and analyzed with the application of SPSS 21.0. The data collected included scores of the surveys PCL-M, BDI-II, and the

BHS for women veteran soldiers. I calculated descriptive statistics for the demographic variables. The data source did not present information concerning marital status or ethnicity. Ninety-one informed consents, as well as the three survey instruments regarding the study, were distributed to each of the female veterans. Of the 91original participants, three participants refused to complete all three tools and returned their informed consents and each of their three surveys. There were 43 nonhomeless and 45 homeless participants. Concerning the length of homeless participants' deployment, 19 maintained 3 years, 22 were 3 to 5 years, and four were between 6 to 10 years. In regard to the nonhomeless, 18 were deployed for 3 years, 17 served 3 to 5 years, and seven served between 6 to 10 years. For the homeless participants, there were 19 within the ages of 25-35, 20 among the ages of 36-45, and one over the age of 55. Of the nonhomeless participants, 19 were 25-35 years of age, 15 were between the ages of 3645, eight were among the ages of 46 to 55 year of age, and one was over the age of 55. Twenty-nine homeless participants served 4 to 5 years, 10 served 6 to 10 years, and 12 served over 10 years. Among the nonhomeless, 28 served 4 to 5 years, nine served 6 to 10 years, and six served beyond 10 years. Thirty-four homeless women veteran responders participated in combat, and 11 were not involved in a conflict. Twenty-five nonhomeless were engaged in warfare, and 18 nonhomeless women veterans did not fight in battle. The assumption of sample size, normality, outliners, linearity, multicollinearity and singularity, and homogeneity of variance-covariance matrices were examined with no severe violations noted. The study's sample showed the characteristics of the population so that the sample findings can be generalized to the population. There were no primary

univariate analyses that justify the addition of covariates in the model. Means, standard deviations, and distribution statistics were calculated for the continuous variables in the dataset. As measured by the PTDS PCL-M scale, the means score of the homeless female veteran were (*M*=58.13, *SD*=12.75); the means of the nonhomeless female veteran were (*M*=52.43, *SD*=12.36). As measured by the BDI-II, the means of the homeless female were (*M*=36.53, *SD*=8.75)depression differences (p <.01) between homeless (M = 36.53, SD = 8.75) and non-homeless (M= 27.81, SD = 6.72).The BHS between the homeless and nonhomeless the means (*M*= 9.24, *SD*=3.74) showed no significant differences. Tables 1 and 2 show the descriptive statistics.

Table 1

	Homeless	Non-Homeless

Homeless status	45	43

Descriptive Statistics for Nominal Variables (*N* = 88)

Years deployed		
0	0	1
< 3 years	19	18
3-5 years	22	17
6-10 years	4	7
Age	19	19
25-35	20	15
36-45		
46-55	5	8
55+	1	1
Length of military service		
4-5 years	29	28
6-10 years	10	9
>10 years	12	6
Participation in combat Yes	34	25
No	11	18

Table 2

Descriptive Statistics for Means, Standard Deviations and Distribution Statistics

	Homeless Status	Mean	Std. Deviation
Depression	Not Homeless	27.81	6.762
	Homeless	36.53	8.751
	Total	32.32	8.955

Hopelessness			9.7143	3.78885
	Not Homeless			
Homeless		9.2444	3.74260	
	Total		9.4713	3.75047
PTSD			52.43	12.361
	Not Homeless	Homeless		
58.13	12.752			
	Total		55.38	12.816

Tables 3, 4, and 5 shows the multivariate analyses that exhibits the relationships between variables and their significance to the question studied. The statistic measured was Wilks's lambda, which is the most common test statics used when there are more than two categories of independent variables and examination of the *p*-value is linked with the statistic and the multivariate test..

Table 3

Descriptive Statistics for Scale Dependent Variables (*N* = 88)

Variable	*M*	*SD*
PTSD		
Homeless	58.13	12.75
Nonhomeless	52.60	12.27
Depression		
Homeless	36.53	8.75
Nonhomeless	27.30	7.46
Hopelessness		

Homeless	9.24	3.74
Nonhomeless	9.71	3.79

Table 4

MANOVA Test of Between Subjects Effects

Variable	*F*	Sig. (*p*)	Partial eta squared
PTSD	4.48	0.37	.050
Depression	26.8	< .01	.240
Homelessness	.338	.562	.004

Table 5

Pillai's Trace, Wilks' Lambda, Hotellings's Trace, and Roy's Largest Root

		.963	711.001 b	3.000	83.000	.000
Intercept	Pillai's Trace	.037	711.001 b	3.000	83.000	.000
	Wilks' Lambda					
	Hotelling's Trace	25.699	711.001b	3.000	83.000	.000
	Roy's Largest Root	25.699	711.001b	3.000	83.000	.000
Homeless Status	Pillai's Trace	.260	9.745b	3.000	83.000	.000
	Wilks' Lambda	.740	9.745b	3.000	83.000	.000
	Hotelling's Trace	.352	9.745b	3.000	83.000	.000

Results

I conducted a one-way MANOVA to determine the scores of PTSD, depression, and hopelessnessthat both the homeless and nonhomeless female veterans may experience.I used G*Power analysis(version 3.1.9.2) to calculate the desired sample size to determine the minimum number of participants appropriate for this study.An *F* test of a MANOVA repeated measures between factors was performed. Based on a medium effect size effect size *f*= 0.25 and standard alpha and power (*f*2=.05, alpha=. 05, power=.80), the study required a minimum sample of 86.Theconfidence intervals around the statistics would meet or exceed 95%.

The mean score of the homeless female veteran (*M*=58.13, *SD*=12.75) had a substantial difference in the occurrence of PTSD from nonhomeless female veterans who had experienced combat, as measured by the PTSD (PCL-M) scale. The mean of the nonhomeless female veteran (*M*=52.43, *SD*=12.36) was significantly different. There were higher reported levels of PTSD for the homeless female veteran who had at least one deployment; this hypothesis was supported. There were significant depression differences ($p < .01$) between homeless and nonhomeless veterans. The mean of the homeless female (*M*=36.53, *SD*=8.75) was significantly different from the mean of the nonhomeless (*M*=27.81, *SD*=6.72). There were higher reported levels of depression for the homeless female veterans who had at least one deployment; the hypothesis was also supported. There were no significant differences ($p=.562$) between homeless (*M*=9.24, *SD*=3.74) hopelessness.

Evaluation of Assumptions

Four primary assumptions with the use of MANOVA were considered in this study. These statistical analyses were performed to ensure the data met the assumptions of the MANOVA analysis.

- Assumption # 1: I had two or more dependent variables that are measured at the continuous level. When analyzing data using a one-way MANOVA, a significant part of the method includes inspecting to make confident that the data can be analyzed using this test. The one-way MANOVA has 10 assumptions to consider; seven of them by using SPSS Statistics can be observed.
- Assumption # 2:The data consisted of one independent variable (female veterans) with two categorical independent groups (homeless and nonhomeless female veteran).
- Assumption # 3: The data consisted of independent observations. There was no correlation between the observations in each group(Laerd Statistics, 2016). There was no relationship between the groups themselves. Each female veteran group was independent of the other female veteran group.
- Assumption #4: There is an adequate sample size for analysis. A one-way MANOVA must also meet seven assumptions. They must link to how the data fits the one-way MANOVA model. There cannot be any univariate or multivariate outliers. There should be multivariate normality, and there should not be any multicollinearity. There should exist a linear association between the dependent variables for each group of the independent variable(Laerd Statistics).Also, there should be a sufficient sample size such as a total of 88 participants 43 nonhomeless and 45 homeless. Further, there should be the homogeneity of variance-covariance

matrices, and there should be the homogeneity of variances. I stopped reviewing here. Please go through the rest of your chapter and look for the patterns I pointed out to you. I will now look at Chapter 5.

Hypotheses

Hypothesis 1indicated significant statistical differences between the homeless and nonhomeless female veterans. As measured by the PTDS PCL-M scale, the means score of the homeless female veteran were significant for PTSD differences (p=.037) between homeless (M=58.13, SD=12.75) and nonhomeless veterans (M=52.43, SD=12.36). The occurrence of PTSD from nonhomeless female veterans who have experienced combat, as measured by the PTDS PCL-M, showed noteworthy statistical differences between the homeless and nonhomeless female veterans.

Hypothesis 2indicated significant statistical differences between the homeless and nonhomeless female veterans. The homeless female veteran did have a substantial higher level of depression as measured by the BDI-II scale and significant depression differences ($p < .01$) between homeless (M=36.53, SD=8.75) and non-homeless (M=27.81, SD=6.72).

Hypothesis 3indicated that homeless female veterans will not have a significant difference in the occurrence of hopelessness from nonhomeless female veterans who have experienced combat, as measured by the BHS. There were no significant differences (p=.562) between homeless (M=9.24, SD=3.74) hopelessness. Hypothesis 3was supported. Hypothesis 3 (i.e. There were significant differences in hopelessness between homeless and nonhomeless female veterans who have experienced at least one U.S. military deployment) was accepted. The results of the one-way MANOVA indicated that there was a statistically significant difference between homeless and nonhomeless female

veterans who had experienced at least one U.S. military deployment on the linear combination of posttraumatic stress, depression, and hopelessness, F (3, 83)=9.75, p<.01, Wilks' Lambda=.74, partial eta squared=.26. A Wilks's lambda test was run to test which variable contribute significance in discriminant function. The closer Wilks's lambda is to 0, the more the variable contributes to the discriminant function. The p-value was less than 0.05, so I concluded that the corresponding function explained the group membership well and was a good fit for the data. The Wilks's lambda was significant, Λ = .74, X 2 (4, N=8,720) = 251.93, p< .01.Pillar's Trace was also interpreted, although Pillai's Trace is less sensitive to violations of assumptions.

I examined the assumptions of sample size, normality, outliers, linearity multicollinearity, singularity, and homogeneity of variance-covariance matrices with no severe violations. I found that hopelessness was not consistent with previous research regarding the groups (NCHV, 2012; Ready et al., 2012; Tsai et al., 2014; Whipple et al., 2011). The demographic and descriptive data were essential in explaining the subcategories of information concerning the participants because knowledge of whether the participants qualified to partake in the study was essential.

Summary

In this chapter, I presented the data collection, data analysis, and results for this research. I offered an insight into the homeless female veterans who experience PTSD, depression, and hopelessness. A one-way MANOVA was used to determine whether there are group homeless vs. nonhomeless female veterans who have experienced at least one U.S. military deployment) mean differences on the linear combination of three dependent variables: posttraumatic stress, depression, and homelessness. The results of

the one-way MANOVA indicated there was a statistically significant difference between homeless and nonhomeless female veterans who have experienced at least one U.S. military deployment on the linear combination of posttraumatic stress and depression. There were no significant differences in hopelessness. The null hypothesis of hopelessness is rejected and the alternative hypothesis that there were differences in posttraumatic stress and depression between homeless and nonhomeless female veterans who have experienced at least one U.S. military deployment was accepted.

Chapter 5 presents a discussion, interpretation of findings, and implications for social change. I provide conclusions and the limitations of the study. Also, I proposed recommendations for development and future research.

Chapter 5: Discussion, Conclusions, and Recommendations The purpose of this quantitative, quasi-experimental study was to determine whether there are differences in PTSD, depression, and hopelessness in homeless versus nonhomeless female veterans who have participated in at least one U.S. military deployment. This study was a quantitative quasi-experimental design. The study will add to the literature regarding the necessary shelter and healthcare needs of the women veterans who served in or proximity or in combat. Male veterans have adequate assessments and shelter, particularly male soldiers who may experience various symptoms resulting from trauma after returning from conflict. Since January 2013, the Combat Exclusion Policy ended, and women soldiers will now assist on equal ground with their counterparts. Increased services and housing needs for women veterans who served in combat are required. Assistance and support must be extended to female veterans, especially those women veterans with children. In this chapter, I will review the findings of this study,

introduction, interpretations, limitations of the study, recommendations, implications, and conclusion.

Interpretation of the Findings

I found that the data supported the hypotheses that the homeless female veterans did experience higher levels of PTSD and depression, but not that they underwent more elevated levels of hopelessness. I found that hopelessness was endured at similar levels for both the homeless and nonhomeless. Moreover, I found that there were much higher levels of depression experienced by the homeless veterans. Both the homeless and nonhomeless female veterans who were deployed/in combat endured levels of both PTSD, depression, and hopelessness. The results of this study may expand the knowledge of the lack of shelter and the prevalent mental disorders that the reintegrating women veterans experience.

Scholars (Fargo et al., 2012; Kane, 2013; NCHV, 2012; Tucker & Hall, 2012; VISN, 2012)have stated that the VA acknowledges that, without intervention, mental health concerns can put women veterans at higher risk of homelessness. I also found that the homeless female veteran does experience higher levels of PTSD and depression. Because there was limited research regarding hopelessness experienced by female veterans, there were no comparative studies to review about my finding of no significant difference between homeless and nonhomeless female veterans. Although I did not include suicide in this research, hopelessness is an emotional precursor that leads to this severe mental disorder (Thomas et al., 2014).Iliceto and Fino (2015) determined that there is a need to increase the research of female veterans and their experience of hopelessness.

Mattocks et al. (2012) explored the female veterans' stressful military experiences and postdeployment reintegration problems as the main stressors that these women face. Mattocks et al. showed that women veterans were struggling with significant mental health disorders such as PTSD and depression. My research included female veterans deployed at least once. Other researchers have indicated that many women in combat experience PTSD, depression, and different stressors than men that are related to combat and their multiple deployments (Kane, 2013). Jacobson, Donoho, Crum-Cianfione, and

Maguen (2015) discovered that the women experienced PTSD more than male veterans. Also, women in the war zone experienced continued periods of stress, and the continuation of exposure to combat intensifies PTSD gender disparities (Fontana et al., 2010; Vogt et al., 2011).

My results aligned with other studies (James et al., 2013; Schell et al., 2011; Wells et al., 2010) who found that there is a substantial frequency of depression experienced by female veterans who experienced at least one deployment. Comparable to the findings of my study, Pittman et al. (2012) also found that PTSD and depression are comorbid conditions; PTSD and depression had comparable severity relating to a health-related quality of life concerns.

Consideration of the Findings in Data of Existing Studies

Haskell et al. (2010) determined that because the VA previously has rendered care for the mostly male veterans, the significant proportion of female veterans who have served in various wars, with different healthcare requirements, have not received the equivalent high-quality care as the men veterans. The VA renders much-needed medical preventive services for women veterans, but additional assistance is needed (Tsai et al.,

2014).

There are new role developments for women in the military, and they are undertaking conflicts at greater rates than in prior cohorts of veterans. The results of this study revealed the importance of expanding housing and mental healthcare for returning home female veterans. Miller and Engdahl (2013) stated that the homeless veteran does experience higher levels of PTSD and depression than the nonhomeless. Further, there is an abundance of deficiencies regarding the veteran females' housing and mental health services when they return from deployments. Mattocks et al. (2012) determined thatlack of shelter and the experience of mental health disorders are confronted by female veterans after leaving the military. The participants (N = 88) demonstrated that there are new role developments for women in the military, and they are undertaking conflicts at higher rates than in prior cohorts of veterans; many are returning home experiencing mental health illnesses as well as enduring homelessness.

Tech, Kilbourne, McCarthy, Welsh, and Blow (2008) confirmed that 25% of female veterans experience mental health concerns after combat exposure. Tech et al. established that homeless female veterans were more likely than the housed female veteran to screen as having higher levels for PTDS and depression. Also, the nonhomeless female veteran and homeless female had no significant differences when experiencing hopelessness (Tech et al., 2008). This is in line with what I found. However, few scholars have examined female veterans' involvements in conflict and to what degree. When they return to the United States and reintegrate into civilian life, the female veteran may experience mental health disorders.

The Increased Enlistment of Women Soldiers and Their Needs

Positioned around the world, there are 1.5 million women on active duty who will someday need shelter and mental health support(USDVA-NCVAS, 2012a). Presently, there are 1.8 million women who have returned home, and to date, the total number that is in need of shelter and mental services are increasing (USDVA-NCVAS, 2012a).Furthermore, more women are enlisting and serving in the military than ever before in history. Now there is more shelter necessary as homelessness continues to increase (Montgomery & Burns, 2014; Thompson &Bridier, 2013). Hamilton et al. (2011) determined that the increased homelessness of the women veterans could be partially due to their experiencing further trauma during their military terms or being in proximity to conflict. Researchers came to these findings before these women soldiers were discharged and reentering civilian life.

Most scholars on the subject of the mental health disorders in the military have been primarily focused on the male veterans who experienced PTSD, depression, and hopelessness as well as homelessness. Research regarding hopelessness is also a form of study regarding the female veteran that should be a separate study from depression. Thomas et al.'s (2014) study is considered an emotional precursor to the suicide events for all patients. Scholars (Montgomery & Byrne, 2014; Thompson &Bridier, 2013) reported that female veterans returning home have a range of severity of homelessness; yet, there is little literature on this issue.

Female veterans who have not been exposed to conflicts because of exposure to any form of traumatic ordeals of war likewise experience PTSD. In this research, I sought to attempt to fill a gap in the literature concerning gender-specific homelessness and nonhomeless female veterans. The female soldier is in need of additional studies

concerning her comorbid vulnerability of mental health disorders such as PTSD and depression after their reentry to civilian life. I attempted to bridge the gap. The PTSD and depression instrument assessment outcomes for the homeless female veteran participants in my study revealed that these participants had higher levels of these mental health illnesses. I found that women veterans are in need of mental health hospitalization due to experiencing comorbid mental health disorders; several scholars have established that hopelessness and depression are sometimes correlated (lliceto & Fino, 2015;

Marsiglia et al., 2011). Because women are joining the military at a ratio of 4 to 1, more research is needed to begin to bridge the gap in the literature concerning the women veterans. The VA provided fewer services for the female veteran because their mental health and medical needs are likely to be different from those of the male veteran upon which the VA has traditionally focused (Tsai et al., 2012).

Relationship of the Findings to the Theoretical Framework

There were four theoretical frameworks in the study. The four theories used in this study have significant theoretical implications. The conditioning theory developed by Pavlov (1902) and used by Orr et al. (2000) explains the process of negative reinforcement that the fear conditioning of the female veteran may experience while exposed during combat. The conditioning theory connects to PTSD considering that behaviors are learned by conditioning. The cognitive theory of depression(Beck, 1967)is used to explain how depression can be the root of despair moods that can be counterproductive in every phase of life, particularly the homeless female veteran. The ecological theory (Bronfenbrenner, 1977) was used to interpret the consequences of risk factors that determine an individual's environment and socioeconomic circumstances.

The ecological theory was essential to this study because homelessness can be understood, not by assessing the characteristics of the individual, but by understanding the environmental and social circumstances of that individual. The hopelessness theory of depression (Abramson et al., 1989) is used to illustrate how negative thoughts affect a person's emotional state of mind and self-worth; hence, it was chosen as part of the framework for this study. Also, hopelessness expectation is a cause and not a symptom of depression. The hopelessness theory is relevant because veterans struggling with hopelessness were more likely to commit suicide than the general population (Thomas et al., 2014).The conditioning theory (Pavlov, 1902) that is used by Orr et al. (2000)is based on the view that people may respond to conflicting events, and this can create conditioned responses such as flashbacks or nightmares that are symptoms of PTSD. Orr et al. provided an account of several prominent aspects of PTSD. Moreover, the restraint of these triggers is notable for those experiencing PTSD (Brewin & Holmes, 2003).The ecological theory (Bronfenbrenner, 1977)links individuals in the environments with their perception of their surroundings (Sallis et al., 2009).The focus is not just on the characteristics of homeless individuals, such as the female veterans, but preferably on how and in what way their everyday environments may contribute to the cycle of the female soldier's homelessness. The cognitive theory of depression(Beck, 1967) is based on the development of dysfunctional beliefs that create negative self-views and lead to depression. The theory is used to explain how the female veteran experiences can develop dysfunctional beliefs; these assumptions result in negative self-views, which lead to depression (Beck et al., 1975).

The hopelessness theory of depression is grounded on the mechanism by which people can experience negative foresight for their future and their self-esteem.

Proponents of the hopelessness theory emphasize the importance of cognitive processes in the maintenance and treatment of depression. Events confronted by female veterans may show hopelessness that may impact their homeless status. The hopelessness that the female veteran may feel brings about responses such as low self-esteem, loss of goals and self-respect, lack of ambition, despair, despondency, and several other mood dispositions

(Haeffel, 2010).

Limitations of the Study

There were several elements that may have affected the study's results. The strength of the study wasinachieving better knowledge of the predictability for which female veterans, homeless or nonhomeless, experience PTSD, depression, and hopelessness. Montgomery and Byrne (2014) found that the female veteran has different military experience and that there is a connection with the scarcity of postmilitary shelter and health services. In addition, scholars have discussed homelessness and the mental health disorders experienced by female veterans after deployments and then reintegrating into a noncombatant life. Scholars (NCHV, 2012; Rukmana, 2010; USDHHS-SAMHSA, 2012) found that women veterans who are homeless stems from the scarcity of environmental resources. The results from the sample population make it difficult to form conclusions about the larger society. Having only acquired female veterans from the New York area, dissimilar results may have occurred. Other states that may have added orhave fewer types of housing, medical, mental health assistance may have had an effect on the scores of the study's dependent variables. Another limitation was that the sample resided in one state. Also, the limitation in this study was the self-report nature of the testing instruments; the participants might over or underreport, therefore creating the

possibility of deceptive answering. There may be a possibility that homeless female veterans with children may have higher levels of hopelessness.

Recommendations

There are various types of recommendations regarding this study that can be performed, such as decreasing restrictions to VA treatments for female veterans and training clinicians to medically and psychologically assist and assess the deployed female who was in proximity to combat. Because there will be many more female veterans returning home, the opportunity for researchers to conduct extended research of this study's data concerning the scarcity of shelter and healthcare deficiencies that female veterans face is also recommended. I did determine that these homeless female veterans did experience higher levels of PTSD and depression than the nonhomeless. Furthermore, I found that nonhomeless experienced various levels of both mental disorders. Also, I found that hopelessness was experienced by both homeless and nonhomeless female veterans.This type of research should be followed up on so that additional information for the literature of psychology is provided. Prospective research into what mental health concerns exist particular to female veterans is required. Some form of outreach after their discharge must investigate women veterans' requirements. Two notable Examples not included in this study but are recommended for future research is the study of women who endured military sexual trauma (MST) as well as the prevalence of substance abuse among women soldiers.

Implications

Now that women in the U.S. military are joining the services and their combat participation has been permitted, the numbers of homeless female soldier continue to increase (Burmile r& Shanker, 2013). There is a lack of literature concerning their

needs when reintegrating into nonmilitary life. I learned that the branches of the military are not offering adequate housing and mental health resources for the female veterans as they have the male veterans. The findings of this study may help the V, A. and other veterans' organizations acquire the additional housing necessary for the homeless female soldiers. The various organizations that advocate for the female women, VA, clinicians, and communities can read the results of the study and take action to make positive changes in regard to all that is needed for these women soldiers. Possibly, the many communities that these soldiers reintegrate to will begin the building of homes and/or shelters for these soldiers, with the advocacy of the churches and nonprofit organizations in various areas. The findings may motivate the development of strategies or support for women veterans and aid in their homelessness; this research may prompt others to develop additional construction of community housing, primarily just for the female soldiers. Also, healthcare services can be better organized to assist the female soldiers with the mental disorders of PTSD, depression, and hopelessness once they are discharged from the military. Numerous community-based organizations might consider coordination with post assessments with clinicians and other mental health professionals to support these soldiers with their health needs. The study may promote positive social change by adding to the limited research on homelessness and the mental health disorders experienced by female veterans after deployments and then transitioning to civilian life. The constructing of suitable housing and gender-specific health needs of the female veteran will hopefully bring about a social change.

Diminishing the restrictions and changing the criteria for the female veterans to acquire mental health services will increase their seeking of services once these soldiers have returned home. The constructing of more housing to match the number of women

serving in the military who will need a shelter would be excellent support. All decisions regarding accommodation should apply to female veterans with and without children because many are single parents.

Conclusion

The purpose of this study was to determine the scores of PTSD, depression, and hopelessness both the homeless and nonhomeless female veterans may experience. The female veterans merit the same shelter accommodations and mental healthcare as men veterans. Hopefully, more community supports that specialized in the construction of housing will be implemented. Research is related to studies of the men veterans and both before and after reintegration of civilian life. Female veterans are now in need of the same categories of research, especially after their discharge from the military services. The appropriate government organizations, such as the VA and DoD, lack a transitioning strategy for female veterans. Female veterans require added support for their genderspecific needs that will sustain them immediately once they are discharged. There should be a collaborative understanding of what housing and mental health requirements each woman veteran might need once released from active duty. I hope that this research will produce a satisfactory outcome on supporting this population to have a more attainable and productive reintegration in civilian life. Now that the women are involved in ground warfare and joining the military in high numbers as well as returning home in vast amounts from deployment, it is paramount to make more significant efforts to ensure females that are transitioning from the military have the increased resources.

I found showed that homeless female veterans did have higher scores on PTSD and depression and that the hopelessness scores had no significant differences. I found

although the VA has assisted the women soldiers in both the areas of mental health and housing, additional support is needed. New medical advancement services need to be created to promptly examine the women veterans for PTSD, depression and hopelessness immediately after their deployment.

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Appendix A: Leaflet/flyer to Recruit Participants

RESEARCH FOR ALL FORMERLY DEPLOYED FEMALE SOLDIERS

I am asking female veterans homeless and nonhomeless to join in a study. The reason of this study is to see if the three surveys' results are different. There was a survey on "post-traumatic Stress Disorder," depression, and hopelessness. The questions about post-traumatic stress disorder, has 17 questions that takes 10 minutes. The study about depression has 21 questions and takes about 10 minutes. The study about hopelessness has 20 questions and takes about 10 minutes. Those in the study will have to be deployed one or more times. If you were in the **Army, Navy, Airforce, Marine or Coast Guard**, and are homeless or not homeless and want to take part in the study, please let me know. All answers was private. The surveys will take an half an hour.

Appendix B: Military Demographic Questionnaire

This survey was designed to collect information pertaining to information about female veterans in civilian life. Data collected from this survey was used for dissertation research purposes only. Please review and complete all questions listed on the survey. Once you have completed the survey, please follow the instructions of the researcher. Thank you for your help and support.

1. How many years do you have you served in the armed services?

a) Less than three years
b) 3 to 5 years
c) 6-10 years
d) More than 10 years

2. How many years were you deployed?

a) Less than three years
b) 3 to 5 years
c) 6-10 years

3. Indicate your age range.

a) 25-35
b) 36-45
c) 46-55d)
d) 56-+65

4. What was your length of military service?

a) 4 to 5 years
b) 6 to 10 years
c) 10 or more

5 Have you participated in combat?
a) yes

b). No Appendix C: Letter from the Veteran's Administration

Associate Chief of Staff for Research & Development

Subject : RE: needed Permission

Date : Thu, Jun 06, 2013 09:49 PM CDT
From : **"Kaufman, James - MD/ACOS/R&D" <James.Kaufman@va.gov>**
To : "'Shorrelle Kennedy'" <shorrelle.kennedy@waldenu.edu>

Shorrelle,

The VA has specific rules regarding approval of human studies and recruitment of human subjects, but these rules only apply to studies physically conducted at the VA or those using VA resources. The studies we discussed use neither, so the VA has no jurisdiction. You are not going on to military property or using military resources, so the US military has no jurisdiction. It appears that Walden has an IRB. They would be the ones to oversee your research. If they have an FWA then you will need to abide by HHS regulations regarding human subjects' research. If you are going to homeless shelters to recruit participants, you likely would need their permission but not because of human subjects protection, but because you would be trespassing. I don't quite understand whether your IRB is asking about these permissions because of regulatory concerns, which I do not believe are relevant, or because they just want to make sure that the entities from which you recruit agree, which is more a courtesy and to keep you out of the trespassing mode. Bottom line, recruiting veterans on private property does not require approve of VA or US military.

James Kaufman, MD

Associate Chief of Staff for Research & Development

Appendix D: Instructions

Thank you for your willingness to take part in this study. In the packet, you will find the following:

A letter from the from the Veteran's Administration Associate Chief of Staff for Research & Development

Two copies of an informed consent form

A Demographic Questionnaire

The Posttraumatic Checklist–Military

The Beck Depression Inventory-II

Hopelessness Scale

Two number 2 pencils

Prior to completing any forms please read, sign and date one of the informed consent forms. The additional consent form is for you to retain for your records. Once you have signed the consent form please give the form to me (the researcher) to be placed in the locked in a metal container and retained by me (the researcher) for five years.

Appendix E: Permission Granted

From: licensing pas.licensing@pearson.com
Sent from: bill schryverpearson.com
To: "Shorrelle.kennedy@waldenu.edu" <Shorrelle.kennedy@waldenu.edu>
date: Mon, May 19, 2014 at 11:16 A.M. subject: Permission request mailed by: Pearson.com important mainly because it was sent directly to you

Dear Ms. Kennedy,

Permission to use a Pearson assessment is inherent in the qualified purchase of the test materials in sufficient quantity to meet your research goals. In any event, Pearson has no objection to you using the Beck Hopelessness Scale®(BHS) and **you may take this email response as formal permission from Pearson to use the test in its as-published formats in your student research.**

The (BHS) is a sensitive clinical assessment that requires a high degree (B Level) to purchase, administer, score and interpret. It also represents Pearson copyright and trade secret material. As such, Pearson **does not permit photocopying or other reproduction of our test materials by any means and for any purpose when they are readily available in our catalog. Consequently, you may not simply reproduce the (BHS) test forms**.

Long term license agreements with our Test Authors prohibit Pearson from providing or licensing our test materials at no charge/gratis for any purpose.

The (BHS) is available in both English and Spanish in our online catalog and the forms are quite reasonable. To qualify for and purchase a (BHS) Kit or other test materials, please visit the following link to the product page in our online catalog: http://www.pearsonclinical.com/psychology/products/100000105/beck-hopelessnessscale(BHS).html

If you do not yet meet the qualification level to purchase the test forms, your professor or faculty supervisor may be able to assist you by lending their qualifications.

One (BHS) Kit (Manual and 25 Record Forms/Questionnaires and one Scoring Key) is priced at125.00 plus shipping/handling and any applicable taxes. You can test 25 subjects with just the Kit. An additional package of 25 Record Forms/Questionnaires sells for $55.00 plus s/h/t.
Finally, because of test security concerns, permission is not granted for appending tests to theses, dissertations, or reports of any kind. You may not include any actual assessment test items, discussion of any actual test items or inclusion of the actual assessment product in the body or appendix of your dissertation or thesis. You are only permitted to describe the test, its function and how it is administered and discuss the fact that you used the Test, your analysis, summary statistics, and the results.

That said, we do have a few sample items that you may include in your research results, and I have attached them herein.

Regards,

William H. Schryver
Senior Licensing Specialist Please respond only to pas.licensing@pearson.com
Appendix E: Privacy and Confidentiality

Section 4: Privacy and Confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality

(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.

(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

4.03 Recording

Before recording the voices or images of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives.

4.04 Minimizing Intrusions on Privacy

(a) Psychologists include in written and oral reports and consultations, only information germane to the purpose for which the communication is made.

(b) Psychologists discuss confidential information obtained in their work only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.

4.05 Disclosures

(a) Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient, or another legally authorized person on behalf of the client/patient unless prohibited by law.

(b) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

4.06 Consultations
When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant, or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation. (See also Standard

4.07 Use of Confidential Information for Didactic or Other Purposes Psychologists do not disclose in their writings, lectures, or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients, or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.

Appendix G: Permission Granted

From: licensing pas.licensing@pearson.com
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To: "Shorrelle.kennedy@waldenu.edu" <Shorrelle.kennedy@waldenu.edu>
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Finally, because of test security concerns, permission is not granted for appending tests to theses, dissertations, or reports of any kind. You may not include any actual assessment test items, discussion of any actual test items or inclusion of the actual assessment product in the body or appendix of your dissertation or thesis. You are only permitted to describe the test, its function and how it is administered and discuss the fact that you used the Test, your analysis, summary statistics, and the results.

That said, we do have a few sample items that you may include in your research results, and I have attached them herein.

Regards,

William H. Schryver