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**Impact of Coping Style, Negative Life-Events,
Self-Esteem, and Social Support on the
Psychological Adjustment of Homeless Adolescent Males**

by

Elizabeth Anne Votta, M.Sc.

**A thesis examination submitted to
the Faculty of Graduate Studies and Research
in partial fulfilment of
the requirements for the degree of**

Doctor of Philosophy

**Department of Psychology
Carleton University
Ottawa, Ontario
September, 2001**

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Elizabeth Votta

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the degree of Doctor of Philosophy

Chair

External Examiner

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September, 2001

Abstract

Evaluated in this study was the extent to which coping style, together with the roles of negative life-events, self-esteem, and perceived social support were associated with depressive symptomatology, internalizing behaviour problems, and externalizing behaviour problems in homeless adolescent males. Data were obtained from 100 youth accessing an emergency shelter in Ottawa, Ontario. Youth accessing local Ottawa drop-in centres but living with their parents (n = 70), and youth from a local high school who had never stayed in a shelter or accessed a drop-in centre (n = 54) served as comparison groups. Results indicated that homeless youth reported a greater use of the disengagement coping style than non-homeless youth. Homeless youth also reported a higher negative life-events index, lower self-worth, less perceived parental support, as well as higher levels of depressive symptomatology and both internalizing and externalizing behaviour problems, than non-homeless youth. Hierarchical regression analyses indicated that disengagement coping and low self-worth were significant predictors of depressive symptomatology, internalizing behaviour problems, and externalizing behaviour problems. Results indicated that homeless youth with a disengaging coping style, high negative life-events index, low self-worth, and low perceived parental support were at high risk for depressive symptomatology, as well as internalizing and externalizing behaviour problems.

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**Impact of Coping Style, Negative Life-Events,
Self-Esteem, and Social Support on the
Psychological Adjustment of Homeless Adolescent Males**

Stress and coping studies indicate that adolescents with high levels of stress may be at risk for physical illness, hospitalization, suicide, eating disorders, depression, delinquent conduct, poor school performance, and low self-esteem (Adams, Overholser, & Spirito, 1994; Barnet, Joffe, Duggan, Wilson, & Repke, 1996; Barron & Yoest, 1994; Compas, Orosan, & Grant, 1993). This literature also indicates that the impact of stressful events on adolescents' psychological development is dependent in part on the ways adolescents cope with stress (Compas et al., 1993). Adaptive coping responses may reduce some stressors to the level of momentary disruptions, while less adaptive coping patterns may exacerbate stress and contribute to long-term negative outcomes (Compas et al., 1993). It has recently been proposed that one can better address whether coping is adaptive or maladaptive if the initial focus is on the engaging or disengaging nature of one's coping style (Compas, Connor, Osowiecki, & Welch, 1997). Within this model, adolescents with high levels of stress, few social supports, and a disengaging coping style are at risk for depression and poor physical health (Compas et al., 1993).

Similar outcomes have been demonstrated in studies assessing adolescents' self-esteem. Among normative and clinical samples of adolescents, those with low self-esteem exhibit high levels of depression and hostility, low affect, and impaired daily functioning (Harter, 1983, 1992; Harter & Jackson, 1993). Powerful determinants of self-esteem include perceived competence in domains where success or approval is important, level of

perceived support received from parents and peers, and whether the support is perceived as basic or conditional (Harter, 1992).

Despite numerous studies assessing adolescents' psychological development, homeless youth, as a subgroup, have been evaluated primarily through epidemiological and descriptive studies. Demographic studies indicate that many homeless youth run away from family and home environment situations which are characterized by stress, conflict, and/or dysfunction (Rotheram-Borus, Parra, Cantwell, Gwadz, & Murphy, 1996; Rotheram-Borus, Rosario, & Koopman, 1991; Unger et al., 1998). On the street, many youth may live without a consistent source of shelter, food, or money, in an environment where crime and violence are a frequent occurrence. Low self-esteem, lack of social support, and high rates of depression, hostility, and substance abuse further characterize many homeless youth (Perkins, Tryssenaar, & Moland, 1998; Smart & Walsh, 1993; Unger et al., 1998). These findings highlight that homeless youth are at high-risk for poor psychological and physical outcomes, and also reflect the importance of extending research into the psychological aspects of youth homelessness.

Studies on homeless youth are limited by several methodological shortcomings. Consequently, the association between homeless adolescents' self-esteem and their psychological adjustment warrants further research. Given the poor psychological outcomes associated with high levels of stress, lack of social support, and poor coping skills reported in other adolescent-based studies, the nature and impact of the stressors encountered by homeless youth, their perceived support systems, and the ways in which they cope also warrants further research. The purpose of this study was thus to examine

the extent to which coping style, negative life-events, self-esteem, and perceived social support were associated with the psychological adjustment of homeless adolescent males.

Homelessness among Youth

Homeless youth comprise a subgroup of adolescents who are increasing in number throughout Canada on a daily basis. Once on the street, homeless youth are at risk for sexual and/or physical assault, lack of safe shelter and food, physical illness, HIV infection, involvement in criminal activity, and suicide (Greene & Ringwalt, 1996; Perkins et al., 1998; Rotheram-Borus, 1993; Rotheram-Borus, Koopman, & Ehrhardt, 1991; Rotheram-Borus et al., 1996; Smart & Walsh, 1993; Unger et al., 1998). From a perspective which collectively considers individual, familial, and societal factors, researchers from various fields have increased their efforts to understand both the antecedents and outcomes of youth homelessness.

Definitional Problems

Defining youth homelessness is an issue which has political, sociological, epidemiological, clinical, and practical implications. Broad definitions encompass all youth who have been abandoned, cast out, or rejected by their families, do not have a fixed address, find themselves frequently moving from one place to another, and lack basic shelter provisions; narrow definitions refer to those youth who have no roof over their head and sleep every night on the street (Caputo, Weiler, & Anderson, 1997; van der Ploeg & Scholte, 1997). Due to this lack of consensus in definition, critical questions such as the total number of homeless youth, who they are, who are the most in need, and why they are homeless remain unanswered.

Given the heterogeneous nature of youth seen in shelters and on the street, difficulties doing research on homeless youth include developing an operational definition, and identifying and gaining access to the youth (Caputo et al., 1997). Homeless youth are now generally described as those who have left home with or without parental/guardian knowledge, have been thrown out of their homes, left social service placements, and/or lack basic shelter provisions (Rotheram-Borus et al., 1996; Unger et al., 1998; van der Ploeg & Scholte, 1997). Although all homelessness studies have identified youth as homeless by the location in which they were living at the time of study (e.g., street, shelter, abandoned building, park), few studies have specified a time-frame during which youth had been living in one of these locations in order to be considered homeless (e.g., living on the streets for 2 or more consecutive months) (Kipke, O'Connor, Palmer, & MacKenzie, 1995). In this study, a time-frame of 7 consecutive days was thus selected in order to operationalize its' "homeless" definition. The time-frame also served the dual purpose of distinguishing between those youth truly in need of the shelter's emergency housing services, and those using the shelter for an isolated incident and who could return home (e.g., missed last bus home, out partying). Consequently, the present study used the term "homeless youth" to refer to male youth between the ages of 16 to 19, who were currently without a fixed address, and who, independent of their parent(s)/guardian, stayed in a shelter, service agency, makeshift street dwelling, or partner's/friend's dwelling, for at least 7 consecutive days.

Demographic Issues of Youth Homelessness

Population Estimates. Worldwide, conservative estimates suggest that 100 million youth are homeless (United National Children's Fund, 1989). Two million adolescents are estimated to be homeless in the United States (Janus, McCormack, Burgess, & Hartman, 1987). City-estimates range from 2,000 in New York (Shaffer & Caton, 1984), to 5,000 in San Francisco (Luna, 1987), to 35,000 in Los Angeles (Unger et al., 1998). In Canada, epidemiological studies of youth homelessness are scarce. Throughout Canada, approximately 150,000 youth are estimated to be runaways (Radford, King, & Warren, 1989), while 5,000 to 12,000 youth are estimated to comprise Toronto's street youth population (McCarthy & Hagan, 1992). Similar prevalence figures are estimated for other Canadian cities (e.g., Vancouver, Calgary, Edmonton). Variability in population estimates likely reflects the lack of an operational definition and central reporting mechanism, as well as difficulties accessing the youth.

Classification Systems. To better understand the homeless phenomenon, researchers have examined patterns of differentiating behaviours among homeless youth. Consequently, a number of studies report typologies based on primary motives for leaving, such as dysfunctional family dynamics or intolerable home situations, adolescent pregnancy, parental financial difficulties, school difficulties, criminal or delinquent acts, and physical and/or sexual abuse (Adams, Gullotta, & Clancy, 1985; Brennan, 1980; Hier, Karboot, & Schweitzer, 1990; Rotheram-Borus, Rosario et al., 1991; Shane, 1989). Classifying homeless youth by such demographic variables as gender or services utilized is relatively straightforward. However, problems may arise when more subjective questions

are used for classification purposes. Youth may avoid answering direct questions or deliberately give incorrect answers.

Given these potential classification problems, empirically-defined typologies of homeless youth have been developed for use in youth-homelessness studies. Zide and Cherry (1992) developed a four-group typology of homeless youth. "Running to" youth do not leave home in response to family dysfunction, but rather because they seek pleasure, instant gratification, and freedom from parental attempts to set limits. "Running away" youth leave without parental consent, and are typically running from dysfunctional families or home situations in which they are exposed to potential harm (e.g., abuse, alcoholic parent). "Thrown out" or "Throwaway" youth have left their homes with the full knowledge of their parents/guardians, and tend to be strongly alienated from their families. "Forsaken" youth come from families who can no longer support them and thus leave home to support themselves. Brannigan and Caputo (1993) also developed a model of youth homelessness which was based on the intersection of 2 continua: the first measured involvement in the street lifestyle; the second measured time spent on the street. Using these continua, homeless youth were identified as "Curbsiders" (i.e., involved in socially acceptable behaviours), "Throwaways" (i.e., victimized youth), "Delinquents", and "Entrenched Street Youth".

Psychological Adjustment of Homeless Youth: Empirical Investigations

Initial studies of youth homelessness were epidemiological and descriptive. In the last two decades, homeless youth have been the focus of research designed to assess such constructs as self-esteem, depression, hostility, suicidality, and stress. Key studies which

have assessed these constructs are presented in this section. A synopsis of additional studies which have examined homeless youths' psychological adjustment is detailed in Appendix A.

Mental Health. Studies conducted to assess the association between mental health and homelessness indicate that depression, depressive symptoms, and other psychiatric problems are prevalent among homeless youth. In their assessment of depression, mood, and conduct disorders in a sample of 118 New York homeless youth, Shaffer and Caton (1984) reported that depression was common in both males and females; males exhibited higher levels of conduct disorder symptoms, specifically school suspensions and expulsions (71%). In a study of 52 youth accessing an emergency shelter in Australia, Hier et al. (1990) reported that “runaway” and “throwaway” youth, both male and female, scored in the clinical range on the Depression sub-scale of the MMPI, as compared to American adolescent norms. Differences across gender were not significant. Both males and females also scored high on social isolation, hostility, and antisocial tendencies (Hier et al., 1990). A study of 45 homeless male youth in Ottawa indicated that 27% reported experiencing mental health problems in the year prior to the study and 18% reported being diagnosed with a psychiatric illness in the year prior to the study (Farrell, Aubry, Klodawsky, and Pettey, 2000).

The association between depressive symptoms and substance use, social support, self-esteem, and parental substance abuse among homeless youth have also been examined. Smart and Walsh (1993) reported that one-third of 145 youth reported feelings of depression often or always in the three months preceding their study, as measured by

the Centre for Epidemiological Studies of Depression Scale. Self-esteem, perceived social support, length of time spent in a hostel, and parents' drug-use were the best predictors of depression. Most recently, Litrownik, Taussig, Landsverk, and Garland (1999) conducted a study in which they examined the prevalence of prior involvement with the mental health system in youth accessing an emergency shelter. Of the 295 youth interviewed, 10.5% reported a prior psychiatric hospital admission, 57.7% had been admitted to a psychiatric hospital in the year prior to their use of the shelter, and 43.1% had received counselling.

Few studies of youth homelessness have included comparison groups and/or differentiated between clinical depression and depressive symptoms. Using the Centre for Epidemiological Studies Depression Scale, a Kitchener-Waterloo study reported that street youth had a higher mean level of depression than a sample of high school youth (Ayerst, 1999). In comparison to a prevalence rate of 7% among community and high-school adolescents (Peterson et al., 1993), 26% of homeless youth in Hollywood (N = 93) (Robertson, Koegel, & Ferguson, 1989) and 64% of homeless youth in Los Angeles (N = 432) (Unger et al., 1998), met DSM-III criteria for clinical depression. In Unger et al.'s study, depressive symptoms were also associated negatively with instrumental social support and positively with social isolation.

Although the clinical implications of these findings are important in the study of youth homelessness, a discussion of depressive phenomena among homeless adolescents is complicated by several factors. First, few studies have included comparison groups or compared their results to those of standardized norms. Second, few studies have distinguished between clinical depression and depressive symptoms. Third, as no reported

study has followed youth at risk longitudinally, or measured depression both before and after a homeless episode, it is difficult to determine if the reported levels of depression were precipitants or the result of youths' homelessness. Fourth, adolescents rarely experience depressed mood in the absence of other negative emotions (Compas & Hammen, 1994), and are often diagnosed with a depressive disorder and one or more co-morbid conditions (Rhode, Lewinsohn, & Seeley, 1991), which contributes to the complexity underlying studies of adolescent depression.

Suicidality. The prevalence of suicidal ideation and suicide attempts among homeless youth has also been examined. In a study based on interviews with 712 street youth from 10 Canadian cities (e.g., Montreal, Ottawa, Vancouver), Radford et al. (1989) reported that 25% of respondents had suicidal thoughts. In Toronto, 27% of street and shelter youth (N = 390) reported at least one prior suicide attempt (McCarthy & Hagan, 1992). One year later, in another study involving Toronto's homeless youth (N = 145), this number had risen to 42% (Smart & Walsh, 1993). In a study of youth attending various substance-abuse treatment programs in Ontario (Smart & Ogborne, 1994), 53% of the youth identified as "street youth" had attempted suicide (n = 261), compared to 30% of the youth identified as "non-street youth" (n = 586).

A number of studies conducted in the United States report findings consistent with data reported of homeless youth in Canada and youth in the general population. In an epidemiological survey conducted over a 2-week period, Shaffer and Caton (1984) found that 16% and 33% of male and female runaways, respectively, had attempted suicide. In a series of interviews conducted with 576 runaway youth over a 2-year period, Rotheram-

Borus (1993) reported that 37% of the youth had previously attempted suicide; 44% had made an attempt within the previous month. Other studies involving homeless youth also cite reports of prior suicide attempts ranging from 30 - 50% (Smart & Adlaf, 1991; Stiffman, 1989; Unger, Kipke, Simon, Montgomery, & Johnson, 1997; Unger et al., 1998). These rates were higher than those reported from high school samples (e.g., 3 - 13%) (Andrews & Lewinsohn, 1992; Garland & Zigler, 1993; Garrison, 1989; Smith & Crawford, 1986), community samples (e.g., 2%) (Earls, 1989; Velez & Cohen, 1988), and adolescent clinic patients (e.g., 12.2%) (Joffe, Offord, & Boyle, 1988).

Although homeless males tend to report fewer suicidal behaviours than females, similar rates of suicidal ideation are reported across gender (e.g., 62%) (Shaffer & Caton, 1984; Rotheram-Borus, 1993; Unger, Kipke, Simon, Montgomery, & Johnson, 1997; Unger et al., 1998). Among both male and female runaways and homeless adolescents, life-time suicide attempts has also been positively associated with substance abuse, negative life-events, running away, mental health and behaviour problems, low self-esteem, family instability, sexual and physical abuse, and having a friend who attempted suicide (Stiffman, 1989; Greene & Ringwalt, 1996; Yoder, 1999).

Substance Use. Numerous studies conducted in Canada and the United States indicate that engagement in criminal acts (e.g., prostitution, robbery), delinquency (e.g., shoplifting, trespassing, loitering), and exposure to violence and violent victimization is widespread among homeless youth (Kipke, O'Connor, Palmer, & MacKenzie, 1995; Kipke, Montgomery, Simon, & Iversen, 1997; Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Koopman, Rosario, & Rotheram-Borus, 1994; Smart & Walsh, 1993;

Unger et al., 1997, 1998). Numerous studies also indicate that substance use/abuse and criminal acts related to drug use (e.g., drug possession and trafficking) are widespread among homeless youth (Baron, 1999; Farrell et al., 2000; McCarthy & Hagan, 1992; Smart & Adlaf, 1991; Unger et al., 1997, 1998).

McCarthy and Hagan (1992) reported that 80% of a sample of Toronto's homeless youth smoked marijuana, 42% reported cocaine use, 55% used hallucinogens, and 34% used amphetamines. Similar rates were reported by Kipke et al. (1995) in their study of Hollywood's homeless youth; 79% had used alcohol, 77% had used marijuana, 68% had used methamphetamine, 67% had used LSD, 54% had used cocaine, and 30% had injected drugs. These rates exceeded those found in high school and community samples, which reported that 38% of high school seniors had tried marijuana, 16% had tried stimulants, 11% had used LSD, and 6% had tried cocaine (Unger et al., 1997).

Relative to a sample of non-homeless youth, Smart and Adlaf (1991) reported that alcohol and drug consumption were three times greater among Toronto's street youth. Smart and Adlaf also reported a positive association between the amount of alcohol and drugs consumed by street youth one week before their study and increased time on the street; youth also self-identified alcohol consumption as a coping strategy. Findings obtained from a sample of 200 male street youth in Edmonton indicated that exposure to parental substance abuse increased street youths' risk of alcohol and hard-drug use (Baron, 1999). Histories of physical abuse and the presence of substance-using peers were related to the use of alcohol, marijuana and psychedelic drugs, while long-term homelessness was positively associated with hard-drug use (Baron, 1999).

Typically, most youth homelessness studies have reported substance use patterns based on youths' responses to non-standardized measures. Farrell et al. (2000) reported that 36% and 57% of Ottawa's homeless youth self-reported problems due to current or past alcohol and drug use, respectively. Only a few studies have employed DSM-III criteria to examine the prevalence of substance abuse disorders among homeless youth (Robertson et al., 1989; Kipke et al., 1997). In their assessment of the relationship between alcohol use and youth homelessness, Robertson et al. reported that 48.4% of youth met criteria for a diagnosis of either alcohol abuse or dependence; 23.7% met criteria for abuse only, 3.2% met criteria for dependence only, and 21.5% met criteria for both abuse and dependence. Although 66% of the youth reported alcohol consumption prior to their first homeless episode, only 15% perceived alcohol as a factor in their homelessness; 5% identified alcohol use as the precipitant to their homelessness (Robertson et al., 1989). Similar findings were reported by Kipke et al. in their assessment of drug and alcohol abuse disorders among homeless youth. DSM-III criteria indicated that 43% of youth met criteria for both an alcohol and drug abuse disorder; 32% met criteria for alcohol abuse and dependence, while 39% met criteria for drug abuse and dependence. Length of time homeless was positively associated with both the risk of "alcohol abuse" disorder and the risk of "drug abuse" disorder (Kipke et al., 1997).

Physical Health. Given the transient lifestyle associated with homelessness, homeless youths' physical health has also been considered to be at risk. Findings from a study of Toronto's runaway and street youth indicate that in comparison to 2% of non-runaway youth, 16% of runaway and 38% of street youth rated their physical health as

poor (Smart, Adlaf, Walsh, & Zdanowicz, 1994). Unger et al. (1998) reported that length of time from home was a factor in youths' subjective ratings of their physical health; youth who had been homeless for more than one year reported poorer physical health than did youth who had been homeless for less time.

Homeless youth are also at high-risk for HIV infection, sexually transmitted diseases, teenage pregnancy, and unsafe sexual behaviours. Compared to 7% of national samples in the United States, 50% of homeless adolescent males have had more than 10 sexual partners in their life; homeless youth also have higher prevalence rates of sexually transmitted diseases (50 - 70%), pregnancy, and teenage motherhood, than non-homeless youth (Booth, Zhang, & Kwiatkowski, 1999; Kipke et al., 1995; Robertson et al., 1989; Rotheram-Borus, Koopman, et al., 1991; Sweeney, Lindegren, Buehler, Onorato, & Janssen, 1995). A recent Washington, DC study indicated that youth without social networks, consisting of strong, affective, and supportive bonds between a few friends, were more likely to report illicit drug use, multiple sex partners, and survival sex than youth with a social network (Ennett, Bailey, & Federman, 1999). Radford et al. (1989) reported similar findings of Canadian street youth. Of 712 youth interviewed, two-thirds reported having had five or more sexual partners in their lifetime, compared to 17% of college/university students; 32% of street youth also reported that they never used a condom when engaging in sexual intercourse.

Limitations of Youth Homelessness Investigations

Despite the increasing number of studies which have been conducted to evaluate youth homelessness in the last two decades, several methodological limitations hamper the

utility and generalizability of the results obtained. First, in the absence of an operational definition of youth homelessness, one cannot discount the great variability in both the degree and intensity of youth homelessness (e.g., duration, frequency, time of year) in any given study. Previous studies are also characterized by great variance in participants' age range (e.g., 12 to 25 years), thus making it difficult to generalize findings to specific age groups or conclude if there were differences as a function of age (i.e., young, middle, older adolescents).

Sampling is also an issue, as studies which focussed on only one group (e.g., emergency shelters, abused youth, street youth) are limited in terms of to whom one can generalize. Studies consisting of shelter youth only may not represent street youth who fail to use agency-services. Furthermore, the size and proportion of youth who do not use agency-services are not well known. Gender and season may be influential factors in the number of street or agency youth at any time, thereby affecting the findings' external validity. Other studies have been more heterogeneous in their samples by recruiting youth from shelters, drop-in centres, and street sites. Typically, these studies treated youth from shelters and drop-in centres as one group, and then made comparisons to street youth. While definitions of the shelter and street youth are provided in these studies, definitional information is not provided on the drop-in centre youth. In the absence of data to support the assumption that shelter and drop-in youth do not differ, significant differences between the groups may have gone undetected.

The studies are also characterized by great variance in sample size, as well as a lack of comparison groups and/or normative standards. With respect to sample size,

studies have ranged from 27 to 455 participants. In the absence of reported power analyses, it is possible that studies with smaller samples lacked sufficient power to detect true differences. The lack of comparison groups and/or normative standards makes it difficult to determine if the findings reported on homeless youth differed from non-homeless youth. That all studies were comprised of convenience samples and not randomly selected samples also limited the findings' generalizability.

In the absence of longitudinal studies to prospectively examine the direction of causality, caution should be used in inferring causation from the various results. For example, it is possible that depressive symptoms, poor health, and/or substance abuse may be a cause, rather than the effect, of being homeless. In the absence of follow-up data, studies have also been unable to determine if there were changes in youths' psychological status throughout the duration of their homeless period.

Another limitation is the reliability and validity of the measures used. In order to compare and replicate findings across studies and populations, some studies employed standardized measures in their entirety, while others employed standardized questionnaires, but selected subsets of items. Studies selecting subsets of items have not addressed the potential effects on the measures' psychometric properties. Other studies sought to be sensitive to the needs of this population by designing study-specific measures, while others used measures designed for specific adolescent-groups. In the latter studies, the validity of using adolescent-specific measures (e.g., for in-school youth) with street youth who are not in school has rarely been discussed.

Summary

In summary, homeless adolescents comprise a subgroup of adolescents who are increasing in number throughout Canada on a daily basis. Adolescents leave home for various reasons. Some seek adventure, while others are lured away by friends or lovers. Some have been forced to leave by parents with whom they have difficult relationships, while some seek to escape homes where drugs, crime, or abuse is prevalent. Whatever their underlying reason for leaving home, once “on the street”, homeless youth face numerous stressors, placing them at risk for such mental and physical health problems as depression, suicide, HIV infection, and substance abuse.

Stress and Coping

Initial models conceptualized stress as a discrete event that was manifested by measurable changes in the environment (Coddington, 1972; Holmes & Rahe, 1967). Later approaches defined stress as a consequence of environmental events as they were cognitively appraised by an individual (Lazarus & Folkman, 1984). Others differentiated between ongoing daily transactions with the environment and the occurrence of major changes in one’s life situation that involved significant levels of social readjustment (Compas, Davis, Forsythe, & Wagner, 1987; Kanner & Feldman, 1991). Recently, researchers have adopted a comprehensive model which proposes that major and minor stressors are interrelated aspects of stress, but which also reflects both the objective nature and cognitive appraisal of events. Current models recognize that neither subjective or objective elements alone are sufficient to understand what is stressful to different individuals, who is vulnerable to what types of stressors, and how they will cope with

different stressors.

Coping has been defined as the cognitions and behaviours individuals use to modify adverse aspects of their environment and minimize internal threat induced by stress (Cohen & Lazarus, 1979; Lazarus & Folkman, 1984). In times of stress, coping mechanisms are enlisted. The ability to withstand stress depends on the coping mechanisms' adaptability, or effectiveness at reducing the impact of a stressor or its associated negative emotion. Coping is said to include instinctive or reflexive reactions to threat, as well as an array of learned responses to aversive stimuli (Lazarus & Folkman, 1984). For a review of the conceptualization of coping, see Lazarus and Folkman (1984).

For the purposes of this study, this section will review current findings regarding stress and coping in adolescents, discuss the theoretical and clinical implications for psychopathology associated with current theories of coping style and strategies, and present the limited research conducted to assess stress and coping among homeless adolescents.

Stress and Coping in Adolescents

Stress and coping are important concepts in understanding the developmental phase of adolescence. The ability to effectively cope with stress is a skill which differentiates adolescents at low- and high-risk for maladjustment (Jeffries McWhirter, McWhirter, & Hawley McWhirter, 1994). To better understand the impact of various stressors on adolescents, researchers have examined the effects of singular stressful events on adolescents as a subgroup and as related to the developmental period of adolescence (Compas, Davis, & Forsythe, 1985; Compas, Wagner, Slavin, & Vannatta,

1986; Compas, Banez, Malcarne, & Worsham, 1991; Simmons, 1987; Simmons, Burgeson, Carleton-Ford, & Blyth, 1987). See Compas (1987a) for a review of the studies conducted to assess stress and life-events during adolescence. Although key studies assessing the effects of stress on adolescents are presented in this section, a synopsis of additional adolescent stress and coping studies conducted since Compas' (1987a) review is presented in Appendix B.

Cross-sectional and prospective studies indicate that, throughout adolescence, potential stressors may include major life events (e.g., death of loved one), transitional events (e.g., move to new home, school), daily hassles (e.g., peer or parent conflict), developmental/maturational stressors (e.g., autonomy issues, peer acceptance, physical image and sexuality concerns), and chronic stressors (e.g., school issues) (Comerci & MacDonald, 1990; Compas, 1987a, 1987b; de Man, Leduc, & Labreche-Gauthier, 1993; Simmons, 1987; Simmons et al., 1987; Unger et al., 1998). Most recently, Compas et al. (1985, 1986, 1991) sought to identify the types of stressors with which adolescents were trying to cope and the levels of stress they experienced. Results indicated that adolescents perceived daily events (e.g., caring for siblings, arguments with boyfriend/girlfriend, parental punishment) differently than major life events (e.g., graduation, moving), both in terms of frequency and valence. Across age and gender, more positive than negative major life events were reported. Daily events were reported as negative more frequently than were major events, and increased in number with age. Females reported more negative than positive daily events, while males reported the opposite pattern.

Before proceeding to a discussion of the relationship between stress and psychopathology, it is important to discuss current limitations associated with the measurement of stress and coping in adolescents (Compas et al., 1985). First, many existing measures of life events are comprised of events generated by adults, not adolescents. Second, existing measures have assessed only a limited portion of the types of events encountered by adolescents, focussing on “major life events” to the exclusion of “daily hassles”. Lastly, the mechanisms through which life events exert their impact, particularly whether it is the “objective” or “subjective” aspects of events that influence well-being, are not well understood.

Further complicating the measurement of stress and coping during adolescence is the problem of circularity inherent in this research area. A first issue is whether stress functions as a cause, correlate, or consequence of psychological distress and psychopathology. Prospective designs and follow-up studies are essential to determine whether stress predicts increases in symptoms of psychopathology, and vice versa, and whether stressful events are predictive of later behaviour problems. A second issue pertains to the perception of stress as a function of one’s coping style. Do individuals with different coping styles differ in their perception of the type, intensity, and frequency of perceived stressors in their lives? Does an individual who copes well report fewer stressors because they actually have fewer stressors, or because they are not stressed by the same stressors as someone with coping skills which are less adaptive?

Stress and Coping in Adolescents: Implications for Psychopathology

Studies examining the effects of stress on adolescents indicate that high levels of stress are associated with a wide range of physical and psycho-social problems, including physical illness, delinquent conduct, poor school performance, hospitalization, low self-esteem, eating disorders, and depressive symptoms (Adams et al., 1994; Barnett et al., 1996; Compas, 1987a, 1987b; Compas et al., 1993). To explain the association between stress, coping, and psychopathology in adolescents, researchers have focussed on two theoretical frameworks. The first framework is the traditional differentiation between cognitive (emotion-focussed) and behavioural (problem-focussed) coping strategies (Folkman & Lazarus, 1980, 1985; Lazarus & Folkman, 1984). The second framework is the recently proposed differentiation between engagement and disengagement coping styles (Carver, Scheier, & Weintraub, 1989; Compas et al., 1985, 1997).

Cognitive and Behavioural Coping Strategies. Coping strategies refer to the cognitive or behavioural actions taken in the course of a particular stressful episode. These may vary across time and situation depending on the nature of the stressor, one's perception of one's available coping resources, and the stressor's magnitude (Folkman & Lazarus, 1980, 1985; Lazarus & Folkman, 1984). Through avoidance, cognitive-reframing, or selective attendance to positive aspects of the self or situation, emotion-focussed coping strategies are defined as efforts to regulate emotional states that are associated with exposure to stress. One may also respond to stress behaviourally by acting on the stressor. Problem-focussed coping strategies include problem-solving, seeking information, direct action, and seeking social support.

Although previous research suggests that problem-focussed coping is generally more effective and adaptive than emotion-focussed coping (Unger et al., 1998), the problem-emotion focussed coping strategy model is not without its' limitations. First, problem- and emotion-focussed coping strategies may be implemented simultaneously or separately, they may be incompatible (e.g., intense studying, but taking tranquilizers to reduce anxiety), and they may have both positive and negative effects (e.g., social support may enhance or interfere). Second, the selection and effectiveness of a coping strategy is influenced by various person (e.g., age, values) and situation (e.g., type of stress) variables and both must be available and acceptable to a person. Third, stress and coping should not be conceived as a linear stimulus-response process, but rather as a bi-directional and ongoing process. While emotion-focussed strategies may deal directly with the stressor, emotions are often distressing and may themselves be a stressor. Emotional arousal may thus effect cognitive and behavioural efforts to deal with a problem.

An additional limitation of the emotion- and problem-focussed coping strategy model is its measurement. Coping processes may change from one situation to another depending on how one appraises stressful events, or as a singular stressful event unfolds. To address the multi-dimensional nature of coping, Folkman and Lazarus (1980) developed the Ways of Coping Checklist to describe adults' coping. Initial respondents reported using both problem-focussed and emotion-focussed coping strategies. Furthermore, there was considerable variability for most respondents in their preference for one type of coping strategy over the other. Respondents tended to emphasize separate problem- and emotion-focussed strategies for different stressors. Folkman and Lazarus

concluded that the way a given problem was appraised or defined was significantly related to one's coping strategy. Problem- and emotion-focussed coping strategies were favoured for dealing with work- and health-related stressors, respectively; men also used problem-focussed strategies more often than women (Folkman & Lazarus, 1980).

Engagement and Disengagement Coping Styles. While type of stress, age, gender, and other personal characteristics may influence one's vulnerability to stress, proponents of the engagement-disengagement model of coping style suggest that one's vulnerability and resiliency to stress may be better understood by first examining one's overall coping style (Compas, 1995). Supporters of this framework do not discount the clinical implications associated with determining if one is employing problem- or emotion-focussed coping strategies. Instead, they assert that emphasis must first be placed on whether one's coping style is one of engagement or disengagement with a stressor or negative emotion (Compas et al., 1997). By knowing whether one's tendency toward stress is one of engagement or disengagement, one can then identify and make inferences about the nature and potential effectiveness of one's coping strategies.

Underlying the engagement-disengagement coping dimension is the assumption that cognitive and behavioural responses to stress are directed either toward or away from the source of the stress or negative emotions (Compas et al., 1997), thereby affecting the impact of a stressor on an individual. The target of one's engagement or disengagement may be a negative component of the person-environment relationship (e.g., stressor, negative emotions) or may involve a positive focus (e.g., avoidance through pleasant thoughts or activities) (Compas et al., 1997; Repetti, 1992). Engagement coping includes

planned problem solving (e.g., making/following a plan of action), cognitive restructuring (e.g., focus on situation's positive aspects), and seeking social support (Compas et al., 1997). Each of these responses involves psychological contact with the source of the stressful interaction with the environment or the negative emotions that resulted from the stressful event. In contrast, disengagement coping includes problem avoidance (e.g., staying away from reminders), wishful thinking (e.g., wishing problem had not occurred), avoidance of negative emotions and thoughts (e.g., trying not to think about problem), and social withdrawal (e.g., avoiding contact with others) (Compas et al., 1997).

Among the measures designed to evaluate the engagement and disengagement coping style are the Responses to Stress Questionnaire (RSQ) (Compas et al., 1997; Compas, 1999, Personal Communication) and the COPE Inventory (Carver et al., 1989). The RSQ characterizes responses to specific stressful events or specified domains of stress along the dimensions of voluntary/involuntary, engagement/disengagement, and primary/secondary control. The COPE Inventory assesses a broad range of dysfunctional and functional coping responses, in three different formats: "dispositional" or trait-like version; the degree to which they actually had a response during a particular period in the past; and the degree to which respondents had each response during a period up to the present. Although validity studies of the engagement/disengagement coping style model are ongoing, current findings indicate that the disengaging coping style is associated with poor psychological and physical outcomes in adult cancer patients (Carver & Scheier, 1994). Other studies indicate that stressful experiences and the ways in which adolescents cope with stress play important roles in the onset and maintenance of a wide range of

psychological distress and psychopathology (i.e., diagnostic disorders). The beneficial effects of engagement coping appear to be greatest in response to stressors which are objectively controllable, or which adolescents perceive as controllable (e.g., academic stressors) (Compas, Malcarne, & Fondacaro, 1988). In contrast, adolescents with a disengaging coping style, high levels of stress, and/or low social support are at greater risk for depression, poor physical health, and substance abuse (Compas et al., 1993).

Although homeless youth have not served as a subgroup of study for the engagement-disengagement model, they may be a population for whom this model is most applicable. As previously discussed, adolescents with high levels of stress, poor coping skills, and low social support may be at risk for mental and physical health problems. Homeless youth specifically, are at high-risk for these outcomes. Their risk status and potential for negative outcomes have been associated with their perceived reasons for leaving home and the transient nature of life on the street. Their coping style, of which running away from home may exemplify disengagement coping, has not been considered theoretically or clinically. Given both the high-risk status of homeless youth and current data supporting the association between coping style and adolescent psychopathology, this model served as the theoretical framework for the present study.

Stress and Coping in Homeless Youth

With the increased prevalence of youth homelessness, researchers have begun to examine homeless adolescents' stressors (past and current) and coping skills, and the impact on homeless adolescents' adjustment. Recent studies indicate that many homeless youth left family and home environments, in which they often experienced poverty, family

conflict, physical and sexual abuse, parental absence, and/or parental substance abuse (Teare et al., 1995; Unger et al., 1997; van der Ploeg, 1989). During their homeless period, youth may be out of school, unemployed, involved in gang activity, drug dealing, substance use, and prostitution. Homeless youth also tend to live without a consistent source of shelter, food, and money, and may be at risk for substance abuse, behaviour problems, physical illness, and violence (McCarthy & Hagan, 1992; Teare et al., 1995; Unger et al., 1997, 1998).

In Amsterdam, homeless adolescents' (n = 86) prior experiences were examined along five dimensions: family background, history of professional help, school experiences, number of friends, and self-perception (van der Ploeg, 1989). More than 70% of youths' parents were divorced. More than 60% of youth reported rare contact with their parents. Many youth had a history of receiving professional help; 79% had been in residential institutions and 21% in foster families. Thirty-six percent rated their school experiences as negative, 22% were regularly truant, 70% had changed schools at least once, and 40% had repeated one or more classes. Few youth (15%) reported friendships lasting one year, while 11% reported having no friends at all.

Physical or sexual abuse was cited by half of the youth in Miner's (1991) study of homeless adolescents' self-concept, as their reason for leaving home; 23% left because of home conflicts. Involvement in at least one delinquent or illegal activity (e.g., theft, prostitution, etc.) was reported by two-thirds of the youth. Although finding shelter was not rated as difficult, 44% reported moderate to severe difficulties with police, 37% reported being thrown out of accommodations, and 30% reported problems with

illness and hunger. Consistent with these findings, McCarthy and Hagan's (1992) study of homeless adolescents' street experiences indicated that the majority of youth had been on the street for at least six months, during which time they were without permanent shelter, a stable source of food, consistent employment, close friendships, or a regular income. Although many youth reported heavy drug use, engagement in criminal activity, and a history of suicide attempts, males reported a greater involvement in theft and incidence of incarceration than females.

In considering the findings of these studies, it is important to recognize that standardized measures of stress were not employed in any of the studies. In van der Ploeg's (1989) study, respondents participated in a comprehensive interview, whereas in Miner's (1991) study participants were asked to rate their experiences with family relationships, school achievement, friendships, family discipline, and juvenile convictions on investigator-designed 6-point scales. McCarthy and Hagan's (1992) study consisted of an author-designed questionnaire comprised of questions from measures used in previous investigations of homelessness.

Studies specifically designed to assess stress and coping among street youth are limited. Ayerst (1999) explored stress and depression levels in Canadian street youth, as well as the methods they used to cope. In comparison to high school youth, street youth reported a higher number of stressors during the past year. As methods of coping, street youth were more likely to engage in drug use, alcohol use, and self-harm, whereas high school youth more frequently resorted to productive problem solving and discussion with someone they trusted. Another Canadian-based study reported that the most prominent

stressful life-events experienced by homeless male youth in the previous year included an inability to find work, inability to find decent housing, loss of contact with family members and friends, and being the victim of a violent crime (Farrell et al., 2000). In a study of homeless youth recruited from both fixed and natural street sites in Los Angeles, Unger et al. (1998) examined stress, coping, and social support. Stressful life events were associated positively with symptoms of depression, poor physical health, and substance use. Youths' most frequent stressors were falling in love or gaining a close friend, conflicts with family members, lovers or close friends, and losing a lover or close friend. The latter stressor was rated as the most severe. In keeping with previous findings that social support may lessen the negative effects of stress on mental and physical health (Daniels & Moos, 1990; DeLongis, Folkman, & Lazarus, 1988), Unger et al. reported that social support decreased the risk of depressive symptoms and poor health, but was not related to the risk of substance abuse. Emotion-focussed coping strategies increased the risk of depressive symptoms, poor health and substance abuse disorders, whereas problem-focussed coping strategies decreased the risk of alcohol use disorder and poor health (Unger et al., 1998).

Summary

Whether due to the numerous stressors reportedly experienced by homeless youth both during childhood (e.g., poverty, family conflict, physical and sexual abuse) and during the homeless experience (e.g., out of school, unemployment, gang and criminal activity, substance use, lack of shelter/food/clothing), recent studies indicate that homeless youth are at risk for psychological maladjustment, physical illness, and maladaptive

behaviours. While much attention has been given to the apparent impact of these stressors and their association with psychological maladjustment, little attention has been given to the manner in which adolescents have coped with their stressors, and continue to cope as a homeless youth.

Self-Esteem

Recent findings indicate that self-esteem, or negative self-evaluation, plays a role in individuals' daily lives, cognitive functioning, and overall affect (Harter & Jackson, 1993). Among adolescents, low self-esteem has been associated with high levels of depression, hostility and delinquency (Maxwell, 1992). As a subgroup of adolescents who are at high-risk for both depression and delinquency, h depression and delinquency, onh have or are at risk for low self-esteem. Given previous findings that homeless youth do exhibit lower levels of global and domain-specific self-esteem than non-homeless youth (Adams et al., 1985; Maxwell, 1992; Simmons & Weinman, 1991; Unger et al., 1997), the continued evaluation of the determinants and effects of homeless youths' self-esteem is warranted.

Self-Esteem in Adolescents

Adolescence is often portrayed as a period of rebellion and turbulence, during which adolescents are disengaging from parents and seeking new attachments. As such, it is also a time during which the role of global and domain-specific self-esteem in psychosocial development has been extensively evaluated. For a review of the self-system, see Harter (1983).

Conceptualization of Self-Esteem. Initial studies conceptualized and assessed self-esteem as a uni-dimensional construct, global self-esteem, referring to personal feelings of

self-respect, acceptance, goodness, and worthiness (Crocker & Major, 1989). Later studies demonstrated that global self-esteem could be distinguished from such concepts as self-confidence (i.e., appraisal of one's competence or ability, either in general or in a specific domain), collective self-esteem (i.e., evaluation of worthiness of one's own social group), and domain-specific self-evaluation (e.g., athletic ability, academics, physical appearance) (Crocker & Major, 1989).

The potential discrepancy between one's global and one's domain-specific self-evaluations led researchers to conclude that self-esteem would be more effectively measured if conceptualized as a multi-dimensional construct. Subsequent studies supported this conclusion, demonstrating that one tends to evaluate one's functioning in different areas of life differently, and that one's judgement of self-esteem may be independent of one's judgement of self-concept (Harter, 1983, 1986, 1988). Given these findings, a measure which evaluates the multi-dimensional nature of self-esteem was administered in the current study.

Effects of Low Self-Esteem in Adolescents. Among adolescents, the roles of global and domain-specific self-esteem in psycho-social development have been extensively evaluated. Assessments of the multi-dimensional nature of self-esteem indicate that adolescents will experience lower self-esteem when there is a negative discrepancy between perceived self-concept in a domain and the importance of that domain. Determinants of adolescents' level of self-esteem include perceived competence in domains where success is considered important, level of perceived support received from parents and peers, and whether the support is perceived as basic or conditional (Harter,

1983, 1992).

Numerous findings indicate that adolescents' self-esteem is highly related to affect, along a continuum of cheerful to depressed, with correlations ranging from .72 to .80 (Harter, 1992; Kaslow, Rehm, & Siegel, 1984; Renouf & Harter, 1990). Among normative samples, adolescents with low self-esteem consistently reported depressed affect; 80% reported that their depression represented a mix of sadness and anger, where anger was directed toward others or in conjunction with anger directed toward the self (Renouf & Harter, 1990). These findings are also consistent in clinical samples of adolescents. In a study of adolescents with psychiatric diagnoses of depression, the vast majority reported low self-esteem (Harter, 1992). In comparison to normative adolescent samples, samples of both delinquent adolescents and adolescents abused as children exhibit lower self-esteem, more depression, and greater psychological distress (Gold, 1986; Kazdin, Moser, Colbus, & Bell, 1985; Maxwell, 1992).

Other studies have demonstrated associations between self-esteem and school achievement, as well as between self-esteem, stressful life events, and perceived level of support from parents and peers. Studies of in-school adolescents indicate low school achievement is not the result of low self-esteem, but rather that low school achievement contributes to low self-esteem; deficiency in self-concept is said to be a critical predictor of school drop-out (Harter & Connel, 1982). Positive associations between levels of self-esteem and maternal support, as well as peers' aid when maternal support was absent, have also been demonstrated in a study of in-school adolescents (Hoffman, Ushpiz, & Levy-Shiff, 1988).

Self-Esteem in Homeless Youth

Concurring with previous studies involving normative and clinical samples of adolescents, studies assessing the self-esteem of homeless youth demonstrate a positive association between self-esteem and mental health status. As homeless youth are at risk for many outcomes associated with low self-esteem, particularly depression and delinquent acts, recent studies have been conducted to evaluate self-esteem in this population.

One of the initial studies to examine self-esteem in homeless adolescents was conducted by Adams et al. (1985). Responding to items on a self-image survey, the majority of homeless youth reported that they were persons of worth and were satisfied with themselves. However, in response to items assessing their feelings of success, usefulness, and self-pride, 80% responded that they saw themselves as a failure, 63% were not proud of themselves, and over 53% reported feeling useless. Consistent with this finding, Smart and Ogborne (1994) reported that in comparison to 66% of non-homeless youth, only 50% of street youth in a study of youth substance-abuse treatment programs reported feeling good about themselves.

In a study of 163 youth who had been placed in an emergency shelter due to child abuse or severe family problems, self-esteem did not differ as a function of gender, age, type of abuse, family characteristics (e.g., family composition, employment), or type of referral (i.e., parents, Children's Protective Services) (Simmons & Weinman, 1991). Standardized measures of self-esteem and adjustment indicated that abused shelter-youth demonstrated poorer self-esteem and adjustment to various life domains relative to normative data (Simmons & Weinman, 1991). Similar findings were obtained in a sample

of adolescents in an emergency shelter of their own volition (Miner, 1991). Scores on the Offer Self-Image Questionnaire, Beck Depression Inventory, Beck's Hopelessness Scale, and Rotter's Internal-External Locus of Control Scale indicated that homeless adolescents exhibited lower self-esteem, and demonstrated more significant deficits in self-concept across areas of personal, social, and family self, than did adolescents living at home.

Consistent with these results, Maxwell (1992) reported that adolescents in an emergency shelter demonstrated lower levels of self-esteem, as well as higher levels of depression and hostility than adolescents in a comparative study. Self-esteem was also found to be a significant predictor of depression in a study of Toronto's street youth. Scores on the Centre for Epidemiological Studies Depression Scale and Rosenberg Self-Esteem Scale indicated that youth with high self-esteem were significantly less depressed than those with moderate and low self-esteem (Smart & Walsh, 1993). Most recently, Unger et al. (1997) reported symptoms of low self-esteem in 16% of 432 homeless youth in Los Angeles. Responses to the Rosenberg Self-Esteem Scale indicated that 55% of youth reported feeling useless and 49% wished for more self-respect. Low self-esteem was significantly correlated with suicidal thoughts, suicide attempts, and self-injurious behaviours; 93% of youth with low self-esteem also reported one or more other mental health problems.

As in most of the homeless literature, methodological factors must be considered in reviewing the results to date on homeless adolescents' self-esteem. First, not all studies have included comparison groups or compared their results to those of standardized norms. As a result, it is difficult to discern if homeless adolescents' self-esteem differs

significantly from that of non-homeless youth. Second, it is difficult to determine if homeless adolescents' self-esteem contributed to their being homeless, or if it was positively or negatively affected, by the homeless experience. For some youth, low self-esteem may be the result of a realistic appraisal of their negative life experiences and continuing failures, rather than the cause of these difficulties. For others, leaving what they perceive to be dysfunctional home environments and becoming involved with other homeless youth, may raise their self-esteem by instilling in them feelings of belonging, acceptance, or friendship. Unfortunately, no known study has followed youth at risk for being homeless longitudinally or measured self-esteem both before and after a homeless episode. Third, co-morbidity, particularly with depressive diagnoses, also underlies issues of self-esteem.

Summary

Concurring with previous studies involving normative and clinical samples of adolescents, studies assessing the self-esteem of homeless youth demonstrate a positive association between self-esteem and mental health status. In comparison to standardized norms and comparison groups, homeless youth exhibit lower scores on global- and domain-specific measures of self-esteem, thereby further supporting the continued evaluation of self-esteem as a multidimensional construct. Despite previous findings that self-esteem is a significant predictor of depression in youth living in shelters and on the street, the relationship between stress, coping, and self-esteem in homeless adolescents has not been examined and thus warrants research.

Rationale for Current Study

Although various subgroups of adolescents have been the focus of numerous psychological studies, research on homeless adolescents has been primarily descriptive and epidemiological with little evaluation of psychological constructs. The impact of negative life-events, social support, and the skills used by adolescents in the general population to cope with stress have been extensively examined, particularly within the theoretical framework of the engagement-disengagement coping style model. However, little is known about these constructs as they relate to the psychological adjustment of homeless youth. Better understanding of the relationship between these constructs could lead to the development of improved outreach programs for homeless youth. The focus of such programs would be to assist such youth to manage their stressors, use adaptive coping styles, and lower their risk of psychological maladjustment.

Homeless youth have not served as a subgroup of study for the engagement-disengagement model. However, they may be a population for whom this model is most applicable. Adolescents with high levels of stress, poor coping skills, and low social support may be at risk for mental and physical health problems. Homeless youth specifically, are at high-risk for these outcomes. Their risk status and potential for negative outcomes have been associated with their perceived reasons for leaving home and the transient nature of life on the street. Their coping style, of which running away from home may exemplify disengagement coping, has not been considered theoretically or clinically. Given both the high-risk status of homeless youth and current data supporting the association between coping style and adolescent psychopathology, this model served

as the theoretical framework for the present study.

The primary objective of this study was to examine the impact of coping style, together with the roles of negative life-events, self-esteem, and perceived social support, on homeless adolescent males' psychological adjustment (i.e., depressive symptomatology, internalizing behaviour problems, externalizing behaviour problems). These variables, which have not been extensively evaluated in this population, were examined through the use of standardized psychological measures and within a theoretical framework that addressed the association between coping style and psychological maladjustment. Comparisons were made to two groups of non-homeless adolescent males: (1) youth accessing local drop-in centres, and living with their parent(s)/guardian(s); and (2) local high school youth who had never accessed an emergency shelter or drop-in centre, and living with their parent(s)/guardian(s).

A secondary objective was to improve upon the methodological limitations associated with previous research involving homeless youth by employing an operational definition of homelessness, differentiating between homeless youth and comparison groups consisting of non-homeless youth, examining within-group differences in the various subgroups of homeless youth, and recruiting a sample size based on power analyses.

Hypotheses

Examined in the current study were the effects of coping style, negative life-events, self-esteem, and perceived social support on the depressive symptomatology and internalizing/externalizing behaviour problems in homeless adolescent males and two comparison groups of non-homeless adolescent males.

The first set of hypotheses examined differences between the groups on the measures. Relative to drop-in and high-school youth, it was hypothesized that homeless youth would exhibit greater use of the disengagement coping style, a higher total negative life-events score, lower self-esteem, less perceived social support, and poorer psychological adjustment (i.e., higher levels of depressive symptomatology, internalizing behaviours, externalizing behaviours).

The second set of hypotheses examined differences within the homeless adolescent population. It was hypothesized that (a) disengagement coping style would be associated with a high negative life-events score, low self-worth, and low perceived support; (b) disengagement coping would be associated with high levels of depressive symptomatology, internalizing behaviours, and externalizing behaviours; and (c) high levels of depressive symptomatology, internalizing behaviours, and externalizing behaviours would be exhibited by adolescents with greater use of the disengagement coping style, high negative life-events score, low self-esteem, and low perceived support.

Method

Participants and Procedures

Three groups of male youth were recruited for this study in order to test the proposed hypotheses. The case group consisted of homeless youth. The two comparison groups of youth living with their parent(s)/guardian(s) included: (1) youth accessing Ottawa drop-in centres; and (2) a normative comparison group recruited at an Ottawa high school.

Interviewers in this study consisted of the author of this paper, a Ph.D. Psychology candidate, and 2 undergraduate students. All interviewers had prior experience working with youth, and participating in research projects involving youth. All interviewers were trained in crisis management and suicide-intervention. Interviewers rotated between the shelter and drop-in centres, and were each present for the data collection sessions at the high school.

Case-Group: Homeless Youth. For the purposes of this study, the term “homeless youth” referred to all male youth between the ages of 16 to 19 years, who were currently without a fixed address, and who, independent of their parent(s)/guardian, stayed in a shelter, service agency, makeshift street dwelling, or partner’s/friend’s dwelling, for at least 7 consecutive days. One hundred adolescents were recruited from the Salvation Army Young Men’s Shelter (SAYMS), an emergency shelter for adolescent males between the ages of 16 to 19 years. Youth accessing the shelter came directly from home, indirectly from home after a few days or weeks of staying with friends or on the street, from children’s services agencies (e.g., Children’s Aid Society, group homes), or from

legal placements (e.g., police, court-orders).

Comparison Group 1: Drop-In Centre Youth. Seventy male adolescents, between the ages of 16 to 19 years, accessing youth drop-in centres throughout Ottawa comprised the first comparison group. To be included in the study, adolescents must have been living with their parent(s)/legal guardian at the time of the study, and never have accessed an emergency shelter.

Comparison Group 2: High School Youth. Fifty-four adolescents, between the ages of 16 to 19 years, recruited at an Ottawa high school comprised the second comparison group. To be included in the study, adolescents must have been living with their parent(s)/legal guardians at the time of the study, and never have accessed an emergency shelter or youth drop-in centre. Teachers distributed and collected parental consent letters provided by the researcher (Appendix C). In this group, only those students for whom parental consent was obtained were permitted to participate in the study.

Exclusion Criteria. As SAYMS provides shelter services to young males between the ages of 16 to 19 years, this study consisted of male participants only. While it is understood that young women and those outside of this age range also comprise Ottawa's homeless population, the homogeneity of this study's sample was increased by focussing solely on adolescent males between the ages of 16 to 19 years, who represent Ottawa's largest single subgroup of homeless youth. Youth were excluded from participation in the study if they were not fluent in English or suffered from a disorder that affected their ability to comprehend the study procedures (e.g., acute psychosis, obvious developmental

delay). Youth who were previously homeless (i.e., stayed in shelter), but were living with their parent/guardian at the time of the study were also excluded from participation.

Literacy was not an exclusion criterion. Although this situation did not occur, interviews would not have proceeded with youth who were under the influence of drugs and/or alcohol. Had this occurred, youth would have been informed that being impaired could affect their responses, and the interview would have been re-scheduled.

Procedures for Homeless and Drop-In Groups. All youth on the shelter's bed register and drop-ins' sign-in rosters who met inclusion criteria were informed of the study by staff and invited to participate. Staff members were aware of the study's purpose and methodological procedures. They booked an appointment for any interested youth and then informed the interview team. In cases where youth did not arrive for their scheduled time, that time slot was used as a drop-in time for other eligible youth who may have been in the shelter or drop-in at the time.

Eligible youth participated in a 60 to 90-minute structured interview, conducted in a private office in the shelter/drop-in centre. Prior to beginning the research protocol and obtaining informed consent (Appendix D), the interviewer described the study and invited questions from the participants. Participants were given the option of completing the questionnaires independently or having the questions read to them by the interviewer. In either case, the interviewer remained with the participant to answer any questions which may have arisen during completion of the questionnaires. Method of administration was recorded on the demographic information sheet. Upon completion of the questionnaires, participants were given the opportunity to ask questions of the interviewer, and were

given a debriefing form (Appendix E) which contained phone numbers for local mental health agencies and distress centres. Participants received gift certificates redeemable at local restaurants for their participation (\$10 maximum value).

Procedures for High School Group. One week prior to the interviewers' arrival at the school, teachers were asked to distribute and collect parental consent letters provided by the interview team. Only those students for whom teachers obtained informed parental consent were permitted to participate in the study. Participating youth were given the option of completing the questionnaires independently or having the questionnaire items read to them, in a private area, by one of the interviewers. As no youth chose to have the items read to them, questionnaires were completed, as a group, during class time. Informed consent was obtained from the participants prior to the interview's initiation, and debriefing forms given upon its completion. Participants received gift certificates redeemable at local restaurants for their participation (\$10 maximum value).

Study Design. The design of this study was a case-comparison design. The coping style, negative life-events, self-esteem, perceived social support, and psychological adjustment of homeless youth were compared to two groups of non-homeless adolescents: (1) youth accessing Ottawa drop-in centres; and (2) youth from an Ottawa high school.

Sample Size Justification. Sample sizes to test the various hypotheses proposed were determined via power analysis. All sample size targets were achieved. To assess differences between the three groups on measures of coping style, negative life-events, self-esteem, perceived social support, and psychological adjustment, the required sample size was calculated based upon analyses of variance procedures. Use of the statistical

program, Gpower (Faul & Erdfelder, 1992) and Cohen's (1977) statistical procedures for analyses of variance, each indicated that a total sample size of 159 adolescents (53 subjects per group) would provide sufficient power (.80) to observe a medium effect size of .25 ($\alpha = .05$).

Preliminary analyses were conducted to determine if the homeless and drop-in groups were significantly different. Had analyses indicated that the two groups differed, they would have been collapsed into one group and compared to the high-school group; in this case, the required total sample size would have been 128 (64/group, power = .80, medium effect size = .25, $\alpha = .05$). However, in the absence of significant group differences between the homeless and drop-in groups, analyses proceeded as a 3-group design, with 53 subjects per group ($N = 159$).

To examine the psychological adjustment of respondents within the homeless adolescents group, the required sample size was calculated based on multiple regression procedures. Use of the statistical program, Gpower (Faul & Erdfelder, 1992), and Cohen's (1977) statistical procedures for multiple regression, each indicated that a total sample size of 97 adolescents would provide sufficient power (.80) to observe a medium effect size of .15 with α set at .05 (6 predictors: disengagement and engagement coping style, negative life-events, self-esteem, perceived parental and friend support). In light of preliminary analyses which indicated that the homeless and drop-in groups were significantly different, the 97 participants required for the within-group analyses consisted solely of youth recruited at the emergency shelter (44 additional participants than required for the between-group analyses).

Measures

The questionnaire package completed by participants included: an author-designed demographic measure, COPE Inventory, Adolescent Perceived Events Scale-Revised, Self-Perception Profile for Adolescents, Social Support Scale for Children and Adolescents, Beck Depression Inventory, and Youth Self-Report Form.

Demographics (Appendices F to H). A demographic questionnaire was developed for this study, and modified accordingly for the specific groups (e.g., homelessness questions removed from demographic forms for non-homeless respondents). In accordance with the School Board Research Ethics Review Committee's conditions of approval, additional modifications were also required of the demographic information form to be completed by the high school participants. Specifically, items pertaining to legal issues, substance use, and suicidality were removed from the measure for the high school participants. Consequently, this data was not available for analyses. Demographic variables assessed included age, citizenship, language preference, living situation (e.g., length of time homeless, reasons for leaving home and accessing shelter), education, employment and income sources, family structure and CAS involvement, physical and mental health status, referral source, and youth services utilization.

Coping Style (Appendix I). The COPE Inventory (Carver et al., 1989) is a 50-item multi-dimensional measure which distinguishes among 15 distinct coping strategies, and two overall coping styles, Disengagement and Engagement. Within the Disengagement Coping style are the following coping strategies: Acceptance, Substance Use, Denial, Humour, Behavioural Disengagement, Mental Disengagement, and Venting

of Emotions. Within the Engagement Coping Style are the following coping strategies: Active Coping, Planning, Positive Reinterpretation and Growth, Religion, Restraint, Emotional Support, Instrumental Support, and Suppression of Competing Activities. For each item, respondents rate the frequency with which the coping strategy is used on a 4-point scale.

Test-retest correlations over 6-weeks among a sample of college students ranged from .56 to .89. Evidence of the reliability and construct validity of the COPE Inventory include adequate convergent and discriminant validity with scales on the Responses to Stress Questionnaire (.33 to .58), and a positive association between dispositional and situational coping tendencies. Correlations indicated that the denial and behavioural disengagement scales were positively correlated with trait anxiety (.35 to .37), and negatively correlated with optimism (-.27 to -.34), the feeling of being able to do something about stressful situations (-.19 to -.20), self-esteem (-.28 to -.31), and hardiness (-.21 to -.29) ($p < .01$).

Negative Life-Events (Appendix J). As a measure of stress, participants completed a modified version of the Adolescent Perceived Events Scale (APES) (Compas et al., 1987). The APES is a checklist comprised of 100 major and minor life events which provides a global measure of negative and positive life-events, as well as frequency/desirability/impact ratings for 9 content-categories: Family, Living Situation, Death/Accident/Illness, Personal Health and Appearance, Recreation, Romance, School, Social/Friendship, and Work. The version used in this study consisted of an additional 38 homeless-specific items (based on refinement of the measure). For each event,

respondents provide ratings of the frequency of occurrence [1 (never happened) to 9 (happened once a day)], perceived impact of the event [1 (no impact at all) to 9 (extremely high impact)], and desirability of the event [-4 (extremely bad) to +4 (extremely good); 0 (neither good or bad)]. Events are categorized as negative if the desirability rating was between -1 to -4, and positive if the desirability rating was +1 to +4. Events are categorized as minor if the frequency rating is at least 5. Major events must not exceed a frequency rating of 4 and the impact rating must be at least 6. Indices of total positive and negative life-events are obtained by summing the product of desirability and impact ratings for all the respective positive and negative-rated events (Compas, 2001, Personal Communication).

Test-retest correlations over two weeks ranged from .74 to .89 for the number of events reported and for weighted positive and negative events. Test-retest for individual items ranged from .83 to .89. Test-retest reliabilities of the appraisal scales were over 90%. Concurrent and construct validity have been demonstrated (Compas et al., 1985), as has support for the differentiation between major and minor life events (Wagner, Compas, & Howell, 1988).

Self-Esteem (Appendix K). The Self-Perception Profile for Adolescents (SPPA; Harter, 1988) assesses Global Self-Worth and self-concept in 8 areas: Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Job Competence, Romantic Appeal, Behavioural Conduct, and Close Friendship. Participants receive an average score of 1 (low) to 4 (high) for each area of self-concept and global self-worth. Internal consistency reliability coefficients for adolescents in Grade 8 to 11

range from .85 to .93 for the 8 sub-scales (Harter, 1988). Inter-correlations among the sub-scales demonstrate that Scholastic Competence is moderately related to Behavioural Conduct, and that Physical Appearance is highly related to Self-Worth (Harter, 1988).

Perceived Social Support (Appendix L). The Social Support Scale for Children and Adolescents (SSSCA; Harter, 1985) is a 24-item questionnaire which assesses the support respondents (8 - 18 years) receive from 4 sources: parents, teachers, close friends, and classmates. Participants receive an average score of 1 (low) to 4 (high) for each support sub-scale.

Harter (1985) reported moderate internal consistency for each of the four sub-scales: Close Friends ($r = .72$ and $.74$), Classmates ($r = .74$ and $.79$), Parent ($r = .78$ and $.82$), and Teacher ($r = .81$ and $.82$). Concurrent validity analyses indicate that elementary school children's perceived social support was correlated with global self-worth for all four sub-scales: Close Friend ($r = .38$), Classmate ($r = .48$), Parent ($r = .43$), and Teacher ($r = .35$) (Harter, 1985).

Psychological Adjustment. As indices of psychological adjustment, respondents completed the Beck Depression Inventory (Appendix M) and Youth Self-Report Form (Appendix N). The Beck Depression Inventory (BDI; Beck, 1967; Beck, Steer, & Garbin, 1988) is a 21-item self-report questionnaire describing cognitive and somatic symptoms of depression. The questionnaire was initially devised as a depression screening instrument and as a method of measuring severity of depressive illness in adults. The BDI has been reported to be a reliable screening device for major depression and a good measure of the severity of depression in adolescent patients with a diagnosis of depression (Kutcher &

Marton, 1989). A cut-off of 16 (moderate to severely depressed) minimizes false positives (9%) while retaining adequate sensitivity (68%) and an overall classification accuracy rate of 75% (Marton, Churchard, Kutcher, & Korenblum, 1991). Internal consistency reliabilities for the BDI range from 0.8 to 0.9 (Kashani et al., 1987). Scores on this routinely administered questionnaire were used as an indicator of the presence of significant depressive symptomatology in this study's participants.

The Youth Self-Report Form (YSR; Achenbach & Edelbrock, 1986, 1991) is a 102-item self-report scale which assess two broad-based dimensions, Internalizing and Externalizing Behaviours. Within the Internalizing Behaviour Dimension are the following syndrome scales: Somatic Complaints, Anxious/Depressed, and Withdrawal. Within the Externalizing Behaviour Dimension are the Delinquent Behaviour and Aggressive Behaviour syndrome scales. Three additional syndromes which do not load on either the Internalizing or Externalizing dimensions are also assessed: Social Problems, Thought Problems, and Attention Problems. The YSR has a test-retest reliability of .89 and is a valid discriminator of maladjusted and poorly achieving children.

Statistical Analyses. Consistent with the power and sample size analyses discussed previously, three phases of data analyses were conducted.

1. Data were presented on the overall recruitment rate and differential recruitment rates for each group. Refusal and participation rates by group and age were reported, as were any reasons cited for refusal. Comparisons by administrative type (i.e., read to participant, completed independently) were done for all youth in the shelter and drop-in groups.

2. Descriptive statistics were calculated for each group of participants for the demographic information. ANOVAs and chi-square analyses were used to assess differences in demographic variables across the groups.
3. The third phase of analyses addressed differences across groups, and differences between respondents within groups. Data were examined for outliers and to verify all assumptions underlying the proposed statistical procedures.
 - 3.A. Prior studies of homeless youth have typically compared “homeless youth” (e.g., emergency shelters, drop-in centres) to “street youth” (e.g., street sites). Although differences have been reported between “homeless” and “street” youth, potential differences within the homeless group (i.e., between shelter and drop-in centre youth) have not been examined. Beginning with the assumption that shelter and drop-in youth were not significantly different, preliminary analyses (t-tests, ANOVAs) were conducted to determine if the shelter and drop-in groups differed on the coping style, negative life-events, self-esteem, social support, and psychological adjustment measures. These analyses were conducted to determine whether the study would proceed as a 3-group design, or if the shelter and drop-in groups would be collapsed into one group and compared to the high-school group in a 2-group design.
 - 3.B. ANOVAs and MANOVAs were conducted to assess differences in coping style, negative life-events, self-esteem, perceived social support, and psychological adjustment between the groups. Age was examined as a potential covariate in both the univariate and multivariate analyses. Bonferroni correction was made

within each hypothesis to control for experiment-wise error rate with multiple comparisons (α set at .05).

- 3.C. To predict differences in the psychological adjustment (i.e., depressive symptomatology, internalizing behaviour problems, externalizing behaviour problems) of respondents within the homeless adolescents group, hierarchical regression analyses were conducted. Predictors included perceived parental and friend support, self-esteem, negative life-events, and disengagement and engagement coping style.

Ethical Considerations. Although there were no anticipated risks associated with participation in this study, all necessary precautions were taken to ensure that psychological support was provided as needed. To assist youth who became distressed or disclosed suicidal ideation during the interview process, interviewers were trained in crisis management and suicide intervention and implemented therapeutic actions as necessary (i.e., assessment of current risk, immediate follow-up, appropriate referrals). Upon completion of the interview, the interviewer screened all suicide-related questionnaire items (i.e., BDI, YSR, APES). If any of the items were endorsed, the interviewer screened for suicidality and risk, and implemented necessary therapeutic action. In cases where youth experienced some discomfort when discussing their experiences or completing the study questionnaires, youth were given the option of speaking to the interviewers or to an outside service-provider; in the latter case, interviewers made appropriate referrals (e.g., CHEO, Youth Net).

For some youth, participation in this study would be beneficial, in that it would provide them with the opportunity to discuss their experiences in a confidential and non-judgmental setting. Given the nature of the measures selected for use in this study, the interview may also have detected adolescents with psychological disorders or behaviour problems who had gone undetected. In case of this occurrence, referrals would have been made to appropriate resources (Youth Net, CHEO, Sandy Hill Community Health Centre, Distress Line) and support provided by the interviewer until youth were in the care of a health professional.

Unfortunately, given the transient nature of the participants in the homeless and drop-in groups, it was difficult to initiate follow-up contact (e.g., telephone follow-up a few days after the interview) to see if participants reacted well to the interview. If the situation arose where participants made contact with the researcher and appeared in crisis, the interviewer would take the appropriate therapeutic measures (i.e., appropriate referrals, crisis management).

Interviews lasted approximately 60 to 90 minutes and were adjusted to meet the needs of the different participants. Given the number of questionnaires participants were asked to complete, short breaks were offered. To address potential literacy difficulties, participants were given the option of completing the questionnaires independently or having the items read to them by the interviewer. Participants were informed the interview would be terminated if they appeared distressed or expressed a desire to stop. Participants were assured that they would experience no sanctions by the agency/school for the interview's termination.

Informed consent was obtained in writing from all participants. Although all necessary measures were taken to assure participants of their confidentiality, participants were informed of the interviewers' responsibility to report significant suicidal risk. Ethical approval was granted by Carleton University's Department of Psychology Ethics Review Committee, the Children's Hospital of Eastern Ontario Research Ethics Committee, and the Ottawa-Carleton District School Board Research Ethics Review C

Results

This study was initiated to examine the association between coping style, negative life events, self-esteem, and perceived social support with the psychological adjustment (i.e., depressive symptomatology, internalizing behaviour problems, externalizing behaviour problems) of homeless adolescent males. Data were collected over a 12-month period, from January 2000 - January 2001, at Ottawa's sole emergency shelter for male youth (case-group), six youth drop-in centres (first comparison group), and one local high school (second comparison group). During this period, 249 youth were approached to participate. Of the 249 youth approached, 18 youth were ineligible to participate due to age, diagnosed psychosis, language barriers, or because they did not meet the criteria for homelessness. No youth were excluded because they were under the influence of drugs/alcohol at the time of the interview. Parental consent was received for all eligible high school participants. Among the 231 eligible participants, 7 refused to participate in the study. The final sample thus consisted of 224 respondents, resulting in a 97% participation rate overall. Total and group-wise recruitment and participation rates are presented in Table 1.

Insert Table 1 about here

Participants completed a 60 to 90 minute questionnaire package developed to assess various demographic factors, coping style, negative life-events, self-esteem, perceived social support, depressive symptomatology, and behaviour problems.

Consistent with the power and sample size analyses discussed previously, three phases of data analyses were conducted.

Table 1

Overall and Differential Rates in Recruitment and Participation: Frequencies and Percentages

Recruitment Rates		Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	Total Sample (N = 224)
Sample Recruited	n	118	74	57	249
Participant Rate	%	98.0	97.2	94.7	96.9
Refusers	n	2	2	3	7
Reasons Cited for Refusal		Length required for interview	Length required for interview	Reasons not disclosed	
Excluded	n	16	2	0	18
Reasons for Exclusion		Age (too young/old) Psychosis Language Insufficient time in shelter	Age (too young)		

Sample Characteristics and Differential Descriptive Analyses

Descriptive statistics were calculated for each group of participants for the demographic information. ANOVAs and chi-square analyses were conducted to assess differences in demographic variables across the groups. As not all questions were applicable to all youth (e.g., homelessness history not applicable to comparison groups), questions which were not asked are denoted in the respective tables with an “N/A”. With the exception of 1 participant in each of the homeless and drop-in groups to whom the questionnaire items were read by the interviewer, all participants completed their questionnaire packages independently; group comparisons by administrative method were thus not conducted. The interview team for this study consisted of 3 interviewers. Inter-rater reliability was 93% (i.e., percentage of agreement on coding demographic information and scoring standardized questionnaires). Group comparisons for the homeless and drop-in groups were not significant as a function of interviewer. The high school group was not included in these analyses as each interviewer was present at the two data collection sessions. For the homeless youth, preliminary analyses of the demographic information indicated no significant differences as a function of seasonal variation. Additional demographic information and descriptives pertaining to homeless youths’ homelessness history are presented in Appendices O and P, respectively.

Demographics (Table 2). Participant age ranged from 16 to 19 ($M = 17.10$ years; $SD = 1.08$). ANOVA indicated a significant group difference in age [$F(2, 221) = 14.02$, $p < .001$; $\eta^2 = .113$]. Bonferroni follow-up comparisons indicated that youth in the homeless group ($M = 17.47$, $SD = 1.10$) were significantly older than youth in the drop-in

($M = 16.96$, $SD = 1.07$) ($p < .01$) and high-school groups ($M = 16.59$, $SD = .77$) ($p < .001$). All participants reported Canadian citizenship status. Questions pertaining to race were not asked. Although 30% of the youth in each group reported residing in Ottawa since birth, significantly more homeless youth (42%) reported residential status of less than 1 year, in comparison to 8.8% and 3.8% of the drop-in and high-school youth, respectively [$F(2, 127) = 11.78$, $p < .001$; $\eta^2 = .159$].

Insert Table 2 about here

Table 2

Demographics: Means, Standard Deviations, and Percentages

Demographics	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F	η^2
<u>Participant Age:</u>					
Overall	M 17.47 (SD = 1.10)	16.96 (SD = 1.07)	16.59 (SD = .77)	F (2,221) = 14.02***	.113
16 years	% 26.0	47.1	57.4		
17 years	22.0	21.4	25.9		
18 years	31.0	20.0	16.7		
19 years	21.0	11.4			
<u>Time in Ottawa:</u>					
Since birth	% 31.0	42.0	34.6	F (2,127) = 11.78***	.159
More than 1 year	27.0	58.8	61.5		
Less than 1 year	42.0	8.8	3.8		
	range 1 - 192 months	1 - 168 months	3 - 168 months		
<u>Language:</u>					
English	% 80.0	79.1	84.6		
French	1.0	1.5			
Bilingual - English first	4.0	7.5	7.7		
Bilingual - French first	15.0	6.0			
Other		6.0	7.7		

*** p < .001

Education and Employment Status. Chi-square analyses indicated significant group differences on the following variables: completed education-level, type of schooling, school status at time of study, educational difficulties, employment status, and primary source of income. Group-wise percentages for the respective education and employment variables assessed are presented in Table 3.

Insert Table 3 about here

Youth in the homeless group reported a higher incidence of alternate-school enrolment [$\chi^2 (12) = 57.51, p < .001$], drop-out status [$\chi^2 (10) = 113.27, p < .001$], and educational difficulties [i.e., grade-failures ($\chi^2 (2) = 15.85, p < .001$), course-failures ($\chi^2 (2) = 10.87, p < .025$)] than did youth in both comparison groups. With regards to employment status, significantly fewer homeless youth reported part- and full-time work status than did youth in both comparison groups [$\chi^2 (6) = 30.02, p < .001$].

Table 3

Education and Employment Status: Percentages

Education and Employment	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	χ^2
<u>Highest Level Completed:</u>				
Grade 7 - 8	%	7.2		
Grade 9		8.7		
Grade 10		24.6	79.2	
Grade 11		23.2	18.9	
Grade 12		21.7	1.9	
Grade 13		11.6		
<u>Type of School:</u>				
Mainstream	%	89.1	100	$\chi^2 (12) = 57.51^{***}$
Alternate		4.7		
Mainstream + Supports		1.6		
Correspondence/Night school		3.2		
<u>School Status:</u>				
Attending - Full-Time	%	76.5	100	
Attending - Part-Time		7.4		
Graduated		5.9		
Dropped out		5.9		$\chi^2 (10) = 113.27^{***}$
Expelled		1.5		
Dropped out + Expelled		2.9		

Table 3 continued

*** p < .001

** p < .025

Table 3 continued

Education and Employment	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	χ^2
<u>Education Difficulties:</u>				
Failed a grade	%	18.8	14.3	$\chi^2(2) = 15.85$ ***
Failed a course		43.9	40.8	$\chi^2(2) = 10.87$ **
<u>Employment Status:</u>				
Unemployed	%	53.0	40.4	$\chi^2(6) = 30.02$ ***
Casual Work		4.5	9.6	
Part-Time		34.8	48.1	
Full-Time		7.6	1.9	

*** p < .001

** p < .025

Familial Factors. Familial factors assessed in the demographic measure included family structure in which participants were raised, parental marital status, parental education status, parental employment status, number and age of siblings, and whether or not youth had experienced the death of one or both of their parents. Group-wise means, standard deviations, and percentages for the respective familial factors are presented in Table 4.

Insert Table 4 about here

Among homeless youth, biological mothers alone or biological mothers and a stepfather/partner were the most frequently cited primary caregivers. In contrast, both biological parents were the most frequently cited primary caregivers by youth in the comparison groups, [$\chi^2 (16) = 62.34, p < .001$]. Significantly more homeless youth reported coming from families in which their parents were separated/divorced or re-married, [$\chi^2 (12) = 37.10, p < .001$]. Drop-in youth reported a significantly higher number of siblings ($\underline{M} = 3.44$; $\underline{SD} = 2.64$) than did youth in both the homeless ($\underline{M} = 1.85$; $\underline{SD} = 1.64$) and high school groups ($\underline{M} = 2.06$; $\underline{SD} = 1.32$) ($\underline{range} = 0-12$) [$F (2, 203) = 12.93, p < .001; \eta^2 = .114$].

Table 4

Familial Factors: Means, Standard Deviations, and Percentages

Familial Factors	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
<u>Childhood Family Structure:</u>					
Both biological parents	%	48.3	67.3	$\chi^2 (16) = 62.34 ***$	
Adoptive parents	7.0	5.0	1.9		
Foster parents	4.0	1.7			
Group home	10.0	1.7	1.9		
Biological mom only	31.0	20.0	21.2		
Biological dad only	12.0	4.3			
Biological mom + step-dad	12.0	6.7	3.8		
Biological dad + step-mom	7.0	1.7	3.8		
Other	3.0	10.0			
<u>Parental Marital Status:</u>					
Married	<u>Mom</u> 23.0 <u>Dad</u> 21.0	<u>Mom</u> 59.6 <u>Dad</u> 56.9	<u>Mom</u> 51.9 <u>Dad</u> 54.0	$\chi^2 (12) = 37.10 ***$	
Separated/Divorced	41.0	31.3	32.7		
Remarried	20.0	1.8	5.8		
Never married	6.0	5.3	3.8		
Other (e.g., widow)	3.0		5.8		
Unknown	2.0		6.0		
Deceased	5.0	1.8	2.0		

*** p < .001

Table 4 continued

Table 4 continued

Familial Factors		Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
<u>Parents Deceased:</u>						
No	%	91.0	86.4	98.1		
Mother		3.0				
Father		6.0	11.9	1.9		
Both			1.7			
<u>Age at Parent's Death:</u>						
	M	10.89	8.00	8.0		
	<u>SD</u>	5.09	6.06	--		

Mental and Physical Health Status. As indices of their mental and physical health, participants were asked about past/present CAS involvement, past/present use of psychological services, physical health problems, mental health problems, and suicidality. Group-wise percentages for the mental and physical health variables are presented in Table 5.

Insert Table 5 about here

Chi-square analyses indicated significant group differences with respect to past CAS involvement, prior use of psychological services, present mental health problems, and suicide attempts. Significantly more homeless youth than drop-in and high-school youth reported prior CAS involvement [$\chi^2 (8) = 33.31, p < .001$], as well as prior involvement with a psychologist/psychiatrist [$\chi^2 (2) = 27.36, p < .001$], social worker [$\chi^2 (2) = 28.26, p < .001$], and counsellor/therapist [$\chi^2 (2) = 53.29, p < .001$]. Youth in the homeless group reported significantly more physical-health (e.g., asthma, diabetes) [$\chi^2 (2) = 6.38, p < .05$] and mental-health problems (e.g., ADD, depression) [$\chi^2 (2) = 31.76, p < .001$].

As indicated in Table 5, suicidal ideation in one's lifetime was reported by 35% and 27% of the youth in the homeless and drop-in groups, respectively. Youth in the homeless group self-reported a greater number of suicide attempts ($M = .31, SD = .69, range = 0 - 3$) than youth in the drop-in group ($M = .10, SD = .51, range = 0 - 3$) [$F (1, 148) = 3.633, p < .05; \eta^2 = .024$]. This difference was confirmed by responses to the suicide-specific items of the Adolescent Perceived Events Scale (APES), [$\chi^2 (2) = 4.773,$

$p < .10$]. Analyses were also conducted on the suicide-specific items of the Beck Depression Inventory (BDI) and the Youth Self-Report Form (YSR). Responses to the BDI indicated that 29% of homeless youth reported suicidal ideation in the week prior to the study. Responses to the YSR indicated that 24.5% of homeless youth reported suicidal ideation while 17.3% reported suicidal behaviours in the six months prior to the study. Suicide-interventions were conducted with 8 youth in the homeless group, and 2 youth in each of the drop-in and high-school groups.

Table 5

Mental and Physical Health Status: Percentages

Mental and Physical Health Factors	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
<u>CAS Involvement</u>				$\chi^2 (8) = 33.31$	***
<u>Past:</u>					
Care by Agreement	%	8.1			
Crown Ward	16.0				
Society Ward	10.0				
Counselling	5.0	1.6			
No	7.0	90.3	100.0		
	62.0				
<u>Present:</u>					
Care by Agreement	%	1.6			
Crown Ward	8.0	6.5			
Society Ward	1.0				
Counselling	91.0	91.9	100.0		
No					
<u>Physical Health Problems</u> (e.g., asthma, diabetes)	%	10.3	18.9	$\chi^2 (2) = 6.38$	*
<u>Mental Health Problems</u> (e.g., ADD, depression)	%	7.7	5.7	$\chi^2 (2) = 31.76$	***

Table 5 continued

*** $p < .001$ * $p < .05$

Table 5 continued

Mental and Physical Health Factors	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
Psychological Services Used					
<u>Past:</u>					
Psychologist/Psychiatrist	49.0	19.1	13.2	$\chi^2(2) = 27.36$	***
Social Worker	43.0	11.8	11.3	$\chi^2(2) = 28.26$	***
Counsellor/Therapist	54.0	10.3	7.5	$\chi^2(2) = 53.29$	***
None	20.0	73.5	75.5		
<u>Present:</u>					
Psychologist/Psychiatrist	5.0	1.5	3.8	$\chi^2(2) = 13.02$	***
Social Worker *	18.0	7.4			
Counsellor/Therapist	9.0	7.4			
None	76.0	86.8	96.2		
Suicide History					
<u>Suicidal Ideation:</u>					
Never	57.0	66.1	N/A		
In lifetime	35.0	27.4	N/A		
In last 3 months	8.0	6.5	N/A		
<u>Number of Past Attempts:</u>	<u>M</u>	<u>(SD = .69)</u>	<u>.10</u>	<u>(SD = .51)</u>	<u>F (1,148) = 3.63*</u>
0	.31	79.0	96.0	N/A	.024
1		14.0		N/A	
2		4.0	2.0	N/A	
3		3.0	2.0	N/A	
***	$p < .001$				
*	$p < .05$				

Legal Issues and Substance-Use Patterns. Comparisons between participants' legal issues and substance-use patterns were only made between the homeless and drop-in groups. Group-wise means, standard deviations, and percentages for the legal and substance-use variables are presented in Table 6.

Insert Table 6 about here

Analyses indicated a significantly higher prevalence of legal issues/problems [i.e., probation status ($\chi^2 (1) = 14.08, p < .001$), impending court dates ($\chi^2 (1) = 18.99, p < .001$), prior arrests ($\chi^2 (1) = 50.41, p < .001$), and number of arrests, $F (1, 164) = 17.75, p < .001; \eta^2 = .098$].

Analyses also indicated a significantly higher prevalence of cigarette use [$\chi^2 (2) = 98.67, p < .001$], alcohol use, [$\chi^2 (5) = 54.37, p < .001$], and drug use [$\chi^2 (4) = 68.90, p < .001$] among homeless youth than drop-in youth. Among the homeless youth, 77% reported smoking marijuana, 10% used acid, 4% used cocaine, 5% used hash, and 4% used ecstasy.

Table 6

Legal Issues and Substance-Use Patterns: Means, Standard Deviations, and Percentages

Legal Issues and Substance-Use Patterns	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
<u>Legal Issues</u>					
Current legal problems	%	40.0	16.2	N/A	$\chi^2(1) = 10.86$ ***
On probation	%	27.0	4.4	N/A	$\chi^2(1) = 14.08$ ***
Impending court dates	%	27.0	1.5	N/A	$\chi^2(1) = 18.99$ ***
Prior Arrests	%	62.0	7.4	N/A	$\chi^2(1) = 50.41$ ***
# of prior arrests	M	3.19 (<u>SD</u> = 5.89)	.12 (<u>SD</u> = .57)	N/A	F(1,164) = 17.75 *** .098
0		38.0	93.9		
1	%	15.0	3.0		
2		20.0	1.5		
3 - 5		11.0			
6 - 10		9.0	1.5		
11 - 15		2.0			
15 +		5.0			

*** p < .001

Table 6 continued

Table 6 continued

Legal Issues and Substance Use Patterns	Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	F or χ^2	η^2
$\chi^2 (5) = 54.37 ***$					
<u>Alcohol Use</u>					
Daily	%	2.0			N/A
Few times/week		25.0	1.8		N/A
Once/week		20.0	5.4		N/A
Several times/month		21.0	17.9		N/A
Occasional		6.0			N/A
No / Never		26.0	75.0		N/A
$\chi^2 (4) = 68.90 ***$					
<u>Drug Use</u>					
Daily	%	35.0			N/A
Few times/week		34.0	6.6		N/A
Once/week			4.9		N/A
Several times/month					N/A
Occasional		5.0	1.6		N/A
No / Never		22.0	86.9		N/A
$\chi^2 (2) = 98.67 ***$					
<u>Cigarette Use</u>					
$\geq$ than 1/2 pack/day	%	27.0	5.4		N/A
$\leq$ than 1/2 pack/day		64.0	5.4		N/A
No / Never		9.0	89.3		N/A

*** p < .001

Between Group Differences: Assumptions Underlying Statistical Analyses

ANOVA / ANCOVA. The second phase of analyses addressed between-group differences, with age examined as a covariate. Prior to conducting the proposed univariate analyses, descriptive analyses were conducted to assess missing data, measures of central tendency, frequency distributions, skewness, kurtosis, and outliers in the data sets of the BDI, APES, and Self-Perception Profile. Data screening procedures were also conducted to verify all assumptions underlying the proposed statistical procedures. The assumptions of ANOVA pertaining to independence of scores and additivity of effects were not violated. The assumptions pertaining to normality and homogeneity of variance were violated, but the appropriate measures (i.e., square-root transformation, examination of $F_{\max}$ values) were implemented to correct for the violations (Stevens, 1996).

In terms of the assumption relating to the normal distribution of scores, frequency histograms, as well as skew and kurtosis values, demonstrated a significant positive skew in the BDI data ($S_k = 1.20$, $SE = .16$; $K_p = 1.01$, $SE = .33$). Measures of central tendency showed that the majority of scores fell at the low end of the scale. Overall mean BDI score was 13.25 ($SD = 11.67$; range = 0 - 56) with a median of 9.0, further indicating a positive skew. Outliers were present in each of the homeless and high-school box-plot distributions. Univariate analyses conducted with and without the outliers did not differ, thus indicating the outliers were not influential data points and could remain in subsequent analyses in their original form.

Inspection of the Self-Worth frequency histogram indicated a relatively normal distribution in the data. Measures of central tendency indicated that the majority of scores

fell in the middle of the scale. Overall skew and kurtosis values were not significant, ($S_k = -.37$, $SE = .17$; $K_p = -.39$, $SE = .33$). Overall mean for Self-Worth was 2.72 ($SD = .68$, $range = 1.0 - 4.0$) with a median of 2.80. Examination of the box-plot distributions revealed the presence of 2 outliers. Univariate analyses conducted with and without the outliers did not differ, thus indicating the outliers were not influential data points and could remain in subsequent analyses in their original form.

The Adolescent Perceived Events Scale provides global measures of positive and negative life-events. As an index of negative life-events, this study examined the overall score for all negative-rated events (i.e., sum of product of desirability and impact ratings for all negative events) (Compas, 2001, Personal Communication). Inspection of the frequency histogram indicated a significant negative skew in the Total Negative Events data for the entire sample, ($S_k = -1.33$, $SE = .18$). Overall mean score was -318.21 ($SD = 315.49$, $range = -1735.0$ to 0.0), with a median of -251.0. Outliers were evident in the box-plot distribution. Univariate analyses conducted with and without the outliers did not differ, thus indicating the outliers were not influential data points and could remain in subsequent analyses in their original form.

The assumption pertaining to homogeneity of variance assumes that variances are virtually the same for the samples. Heterogeneity among the groups produces a demonstrable increase in Type I error when the ratio of the largest to smallest standard deviation (F_{max}) exceeds 3; with heterogeneous variances, the nature of the effect depends on whether the larger variances are associated with the groups with the smallest sample sizes or with the largest sample sizes (Keppel, 1991; Tabachnick & Fidell, 1996). In this

study, Levene's test indicated a violation of the assumption of homogeneity of variance for the BDI, [$F(2, 214) = 5.546, p < .025$] and the Total Negative Events Score, [$F(2, 190) = 4.77, p < .01$]. Levene's test for Self-Worth indicated no violation of homogeneity of variance, [$F(2, 204) = .946, ns$].

Violations of the normal distribution and homogeneity of variance assumptions indicated that transformation of the BDI and Total Negative Events Scores was appropriate. Following application of the square-root transformation, BDI data for both the entire sample and the group distributions appeared relatively symmetrically distributed; outliers were no longer present, and skew and kurtosis values were no longer significant. Levene's test for homogeneity of variance also indicated the groups were no longer heterogeneous, [$F(2, 214) = 1.913, ns$]. Application of both the square-root and log transformation to the Total Negative Events Score did not successfully correct for either the significant skew or the homogeneity of variance violation. As the F_{max} value associated with the Total Negative Events Score did not exceed 3, the Total Negative Events Score was deemed robust to the homogeneity of variance violation and subsequently analysed in its original form.

ANCOVA rests on the same 4 assumptions underlying ANOVA, as well as 2 additional assumptions pertaining to the nature of the regression between the covariate and the dependent variable: (1) significant relationship between the covariate and dependent variable; and (2) homogeneity of regression coefficients. Data screening procedures revealed a non-significant relationship between the covariate, Age, and the dependent variables, BDI [$F(1, 213) = .362, ns; \eta^2 = .037, ns$], Total Negative Events

Score [$F(1,189) = .365$, ns], and Self-Worth [$F(1,207) = .803$; $r = -.001$, ns]. Given the absence of a significant covariate-dependent variable relationship for these measures, analyses of variance procedures proceeded without the covariate.

MANOVA / MANCOVA. In order to proceed with the proposed multivariate analyses of covariance for the YSR, COPE Inventory, and Social Support Questionnaire variables, data screening procedures were conducted to verify all assumptions underlying the proposed statistical analyses. In this study, the assumptions of MANOVA pertaining to independence of scores, multivariate normal distribution of dependent-variable scores in each group, and equality of population covariance matrices for the dependent variables were not violated (Stevens, 1996).

For MANOVA it is assumed that observations on the dependent variable(s) follow a multivariate distribution in each group. As this assumption cannot generally be tested directly, normality on each variable is tested separately. Univariate normality tends to be taken as a necessary but not sufficient condition for multivariate normality (Stevens, 1996). Inspection of frequency histograms, as well as examination of skew and kurtosis values, indicated normal distributions in both the Externalizing (YSR-Ext) ($S_k = -.102$, $SE = .17$; $K_p = -.05$, $SE = .34$) and Internalizing (YSR-Int) ($S_k = .11$, $SE = .17$; $K_p = -.54$, $SE = .34$) Behaviour Problem dimensions. Measures of central tendency indicated that the majority of scores fell in the middle of the scale for both the YSR-Ext and YSR-Int distributions. Mean scores for the entire sample were 58.87 ($SD = 11.74$; range = 25 - 86; median = 59.0) for the YSR-Ext and 56.14 ($SD = 13.13$; range = 26 - 91; median = 55.0) for the YSR-Int. One outlier was noted in the box-plot distribution of the YSR-Ext. As

multivariate analyses did not differ with and without the outlier, the outlier was not deemed an influential data point. Box's M test indicated no violation of homogeneity of variance-covariance, $[F(6, 275516) = 1.88, ns]$.

Examination of frequency histograms revealed a normal distribution in the overall data sets for both the Engagement ($S_k = .049$, $SE = .166$; $K_p = .013$, $SE = .330$) and Disengagement ($S_k = .054$, $SE = .166$; $K_p = -.065$, $SE = .330$) Coping Styles. Measures of central tendency indicated that the majority of the scores fell in the middle of the scale for both scores. Mean scores for the entire sample were 2.33 for Engagement ($SD = .475$; $range = 1.09$ to 3.69 ; $median = 2.34$) and 2.183 for Disengagement ($SD = .415$; $range = 1.11$ - 3.43 ; $median = 2.178$). Box-plots indicated the presence of 3 outliers in the Engagement data and 1 outlier in the Disengagement data. Multivariate analyses conducted with and without the outliers did not differ, thus indicating that the outliers were not influential data points. Box's M test indicated no violation of homogeneity of variance-covariance, $[F(6, 306973) = 2.959, ns]$.

The Social Support Scale for Adolescents measures perceived support provided by Parents, Friends, Teachers, and Classmates. As 44% of the youth in the homeless group had not been enrolled in school during the school year of the study period, Teachers and Classmates could not be accurately assessed as support providers for this group; group-wise comparisons were thus conducted on only the Parents and Friends sub-scales. Inspection of frequency histograms indicated a relatively normal distribution in the entire data sample of the Parents Scale ($S_k = .047$, $SE = .169$; $K_p = -.489$, $SE = .336$). Although there appeared to be a positive skew in the distribution of the Friends Scale, skew and

kurtosis values were not significant ($S_k = -.476$, $SE = .169$; $K_p = -.337$, $SE = .336$).

Measures of central tendency indicated that the mean score on the Parents scale for the entire sample was 2.62 ($SD = .716$; $range = 1-4$; $median = 2.60$). Mean score for the Friends scale was 3.10 ($SD = .745$; $range = 1-4$; $median = 3.00$). No outliers were detected in either of the Parents or Friends box-plot distributions. Box's M test indicated no violation of homogeneity of variance-covariance, [$F(6, 236474) = 2.327$, ns].

MANCOVA rests on the same assumptions underlying MANOVA, plus 2 additional assumptions regarding the nature of the regression between the covariate and the dependent variable: (1) significant relationship between the covariate and dependent variables; and (2) homogeneity of regression slopes. Data screening procedures revealed a non-significant relationship between the covariate, Age, and the dependent variables: Disengagement Coping Style, [$F(1,212) = .219$, ns; $r = .037$, ns]; Engagement Coping Style, [$F(1,212) = .005$, ns; $r = .003$, ns]; Internalizing Behaviour Problems, [$F(1,204) = .144$, ns; $r = .059$, ns]; Externalizing Behaviour Problems, [$F(1,204) = 1.50$, ns; $r = .019$, ns]; Parental Support, [$F(1,204) = .1548$, ns; $r = .059$, ns]; and Friend Support, [$F(1,204) = .173$, ns; $r = .059$, ns]. Given the absence of a significant covariate-dependent variable relationship for these measures, multivariate analyses of variance procedures proceeded without the covariate.

Between-Group Differences: Statistical Analyses

Before proceeding with the second phase of analyses, in which differences between the case and two comparison groups were examined, differences between the homeless group and drop-in group were assessed. Prior studies of homeless youth have typically

compared “homeless youth” (e.g., emergency shelters, drop-in centres) to “street youth” (e.g., street sites). Although differences have been reported between “homeless” and “street” youth, potential differences within the homeless group (i.e., between shelter and drop-in centre youth) have not been examined. In the absence of data supporting the assumption that shelter and drop-in youth do not differ, preliminary analyses (t-tests, ANOVAs) were conducted to examine potential differences between the shelter and drop-in groups. As demonstrated in the analyses of the demographic information, participants in the homeless and drop-in groups differed significantly on most factors. Given the presence of significant group differences between the shelter and drop-in youth, the groups were not collapsed into one group and compared to the general population in a 2-group comparison design; statistical analyses proceeded according to a 3-group comparison design.

Zero-order correlations were evaluated to assess collinearity and to determine if the predictors (disengagement coping, engagement coping, negative life-events score, self-worth, parental support, friend support) were related to the dependent variables (depressive symptomatology, internalizing behaviours, externalizing behaviours). Collinearity diagnostics indicated no problems with multicollinearity between the predictors. Zero-order correlations, with missing data handled through listwise deletion, are presented in Table 7.

Insert Table 7 about here

Table 7

Zero-Order Correlations between Predictor and Outcome Variables (N = 87)

Predictor/Outcome Variables	1	2	3	4	5	6	7	8
1. Disengagement Coping	---							
2. Engagement Coping	-.003	---						
3. Negative Life-Events	.018	.189	---					
4. Global Self-Worth	-.253**	.184	.089	---				
5. Parental Support	-.117	.104	.174	.239**	---			
6. Peer Support	-.080	.218**	.175	.290**	.362***	---		
7. Depressive Symptoms	.251**	-.315***	-.244**	-.555***	-.155	-.283***	---	
8. Internalizing Behaviours	.276***	-.257**	-.134	-.577***	-.182	-.178	.768***	---
9. Externalizing Behaviours	.435***	-.244**	.008	-.404***	-.081	-.139	.513***	.600***

*** $p < .001$ ** $p < .025$

Univariate analyses were conducted to assess between group differences in negative life-events, self-esteem, and depressive symptomatology. Multivariate analyses were conducted to assess between-group differences in coping style (i.e., disengagement coping, engagement coping), perceived social support (i.e., parental, friend) and behaviour problems (i.e., internalizing behaviour problems, externalizing behaviour problems). Means and standard deviations for each of the construct and outcome measures are presented in Table 8. Bonferroni correction was made within and between each hypothesis to control for experiment-wise error rate with multiple comparisons (α set at .05).

Insert Table 8 about here

Table 8

Construct and Outcome Measures: Means and Standard Deviations

Construct and Outcome Measures	Homeless Group		Drop-In Group		High School Group		F	η^2
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
<u>COPE Inventory</u>								
Disengagement Coping Style	2.29	.38	2.05	.44	2.14	.38	F (2,213) = 7.39***	.065
Engagement Coping Style	2.36	.45	2.28	.55	2.35	.39		
<u>Adolescent Perceived Events Scale</u>								
Total Negative Events Score	-416.23	289.36	-280.15	349.06	-172.48	246.19	F (2,190) = 10.71***	.097
<u>Self-Perception Profile for Adolescents</u>								
Global Self-Worth	2.62	.69	2.74	.61	2.91	.60	F (2,208) = 3.29*	.031
<u>Social Support Scale for Children and Adolescents</u>								
Parental Support	2.40	.76	2.68	.57	3.03	.61	F (2,205) = 13.53***	.117
Friend Support	3.16	.84	2.97	.65	3.15	.63		
<u>Beck Depression Inventory</u>	16.32	12.88	11.23	10.35	9.77	9.21	F (2,214) = 8.16***	.071
<u>Youth Self-Report Form</u>								
Internalizing Behaviours	59.34	12.12	54.55	14.34	51.57	11.90	F (2,205) = 6.49**	.060
Externalizing Behaviours	62.69	9.79	55.27	13.40	55.72	10.72	F (2,205) = 10.81***	.095

*** $p < .001$, ** $p < .01$, * $p < .05$

Coping Style. MANOVA indicated a significant group difference in mean scores for the Disengagement Coping Style, [$F(2,213) = 7.39, p < .001, \eta^2 = .065$]. Bonferroni follow-up comparisons indicated that youth in the homeless group ($M = 2.29, SD = .386$) reported a higher mean score than youth in the drop-in group for the Disengagement Coping Style ($M = 2.05, SD = .44$) ($p < .001$). Group differences for the Engagement Coping Style were not significant.

Negative Life-Events. ANOVA indicated that the groups differed significantly on the global measure of Negative Life-Events, [$F(2,190) = 10.712, p < .001, \eta^2 = .097$]. Bonferroni follow-up comparisons indicated that youth in the homeless group ($M = -416.23, SD = 289.37$) reported a higher Total Negative-Events score than youth in both the drop-in ($M = -280.15, SD = 349.06$) and high school groups ($M = -172.49, SD = 246.18$) ($p < .025$).

Qualitatively, the most negatively rated life-events by homeless adolescents involved Family (i.e., parent getting re-married, parental pressure, parents getting separated/divorced), Death/Accident/Illness (i.e., suicide attempts, death of relative/friend/family member, self-injurious behaviours, and being robbed), Social/Friendship (i.e., being around people who were offensive, not getting along with friends' parents), and School (e.g., getting in trouble or suspended, poor grades). Between-group analyses were not conducted on the qualitative nature of the negative life-events identified.

Self-Esteem. ANOVA indicated a significant group difference in global self-worth, [$F(2,208) = 3.29, p < .05, \eta^2 = .031$]. Bonferroni comparisons indicated that youth in the

homeless group ($M = 2.62$, $SD = .69$) reported a significantly lower self-worth score than did youth in the high-school group ($M = 2.91$, $SD = .60$) ($p < .025$).

Perceived Social-Support. MANOVA indicated a significant group difference in mean scores on the Parents sub-scale of the Social Support Questionnaire, [$F(2,205) = 13.535$, $p < .001$, $\eta^2 = .117$]. Bonferroni comparisons indicated that homeless youth reported significantly less perceived parental support ($M = 2.40$, $SD = .76$) than youth in both the drop-in ($M = 2.67$, $SD = .57$) and high school groups ($M = 3.03$, $SD = .61$) ($p < .025$). The difference in perceived parental support was also significant across the two comparison groups ($p < .025$). Group differences were not significant for scores on the Friends sub-scale.

Depressive Symptomatology. ANOVA indicated a significant group difference in depressive symptomatology, [$F(2,214) = 8.169$, $p < .001$, $\eta^2 = .071$]. Bonferroni follow-up comparisons indicated that homeless youth reported a significantly higher mean score ($M = 16.32$, $SD = 12.88$) than youth in both the drop-in ($M = 11.23$, $SD = 10.38$) and high-school groups ($M = 9.77$, $SD = 9.21$) ($p < .01$). The difference between the two comparison groups in depressive symptomatology was also significant ($p < .01$).

The prevalence of BDI scores in the clinical range (score ≥ 16) was also examined. Chi-square analyses indicated that 39% of the homeless youth reported scores in the clinical range, compared to 28.5% of the drop-in youth and 20.3% of the high-school youth [$\chi^2(2) = 4.34$, $p < .05$]. Relative risk ratios assessing the incidence of BDI scores in the clinical range were also examined. Homeless youth were more likely than high school youth to report BDI scores in the clinical range (odds ratio = 1.25; 95% confidence

interval = 1.013 - 1.551).

Internalizing and Externalizing Behaviour Problems. MANOVA indicated a significant group difference in the YSR-Int scores, [$F(2,205) = 6.491, p < .01, \eta^2 = .060$], with Bonferroni comparisons indicating that youth in the homeless group reported a higher mean score ($M = 58.64, SD = 13.12$) than youth in the high-school group ($M = 51.57, SD = 11.90$) ($p < .01$).

MANOVA also indicated a significant group difference in mean scores on the YSR-Ext, [$F(2,205) = 10.818, p < .001, \eta^2 = .095$]. Bonferroni comparisons indicated that youth in the homeless group reported a higher mean score ($M = 62.69, SD = 9.79$) than youth in both the drop-in ($M = 55.27, SD = 13.40$) and high-school groups ($M = 55.72, SD = 10.72$) ($p < .001$).

Chi-square analyses were conducted to assess the prevalence of scores in the clinical ranges ($T \geq 63$) for both the YSR-Int and YSR-Ext. Results for the YSR-Int indicated that 43.9% of youth in the homeless group were in the clinical range, in comparison to 31.3% of the drop-in youth and 23.9% of the high-school youth [$\chi^2(2) = 6.199, p < .05$]. Results for the YSR-Ext indicated that 48.0% of youth in the homeless group were in the clinical range, in comparison to 26.6% and 28.3% of the drop-in and high-school groups, respectively [$\chi^2(2) = 9.546, p < .01$]. Relative risk ratios assessing the incidence of clinically problematic internalizing and externalizing behaviours were also examined. Homeless youth were more likely than high school youth to report Internalizing Behaviour Problem scores which were in the clinical range (odd-ratio = 1.30; 95% confidence interval = 1.053 - 1.612). Homeless youth were also more likely than both drop-in youth

(odds-ratio = 1.41; 95% confidence interval = 1.110 - 1.795) and high school youth (odds-ratio = 1.29; 95% confidence interval = 1.038 - 1.604) to report Externalizing Behaviour Problem scores which were in the clinical range.

Within-Group Differences: Assumptions Underlying Statistical Analyses

Regression. Hierarchical regression analyses were conducted in the final phase of analyses to determine the predictors of psychological adjustment in homeless youth and of the disengagement coping style. Prior to conducting any of the regression analyses, data screening procedures were conducted to assess missing data, measures of central tendency, frequency distributions, skewness, kurtosis, and outliers, as well as to verify all assumptions underlying the proposed statistical procedures. Missing data was handled through listwise deletion. Regression assumes that the independent variable is measured without error and that the underlying relationship (i.e., regression of Y on X) between the variables is linear. These assumptions were not violated. The remaining assumptions of regression are concerned with the errors: mean of errors for Y, over many replications is expected to be zero; error is independent across levels of Y; error in Ys are the same at each level of X (i.e., homoscedasticity); errors are assumed not to be correlated with the independent variable, X; and errors are normally distributed. These assumptions were not violated. Examination of the scatterplot for homoscedasticity and the Durbin-Watson values indicated no violation of assumptions. Outliers were not present, as indicated by Mahalanobis' Distance and the scatterplot. Collinearity diagnostics indicated no multicollinearity between the predictor variables.

Within-Group Differences: Statistical Analyses

Hierarchical regression analyses were conducted to determine the extent to which Perceived Social Support (Parent, Friend), Global Self-Worth, Negative Life-Events, and Coping Style (Disengagement, Engagement) predicted Depressive Symptomatology, Internalizing Behaviour Problems, and Externalizing Behaviour Problems in the homeless adolescents subgroup. In hierarchical regression, independent variables may be entered into the equation according to logical or theoretical considerations, such that those variables that are presumed to be causally prior are given highest priority of entry (Tabachnick & Fidell, 1996). An alternative order of entry involves entering variables of major importance on the later steps, with lesser variables entered first (Tabachnick & Fidell, 1996). For the purposes of this study, independent variables were entered according to this latter method. In order to determine the contribution of Coping Style to the prediction of psychological maladjustment, over and above all other variables, Coping Style was the final variable entered into the equation. Variables were thus entered into the equation in the following 4 blocks: Perceived Social Support (Parent, Friend), Global Self-Worth, Negative Life-Events, and Coping Style (Disengagement, Engagement). The results for which significant R statistics were obtained for each of the outcome measures are presented in Tables 9 through 11, respectively. The tables also include the unstandardized regression coefficients (*B*), the standardized regression coefficients (β), the squared semi-partial correlations ($\underline{sr}^2$), R^2 , and adjusted R^2 values after each entry of the IVs.

A significant R for regression, with all IVs in the equation, was obtained for Depressive Symptomatology, [$F(6, 81) = 8.76, p < .001$]. After step 1, with Perceived Social Support entered in the equation, $R^2 = .086, F_{cha}(2, 85) = 3.98, p < .05$. After step 2, with the addition of Self-Worth, $R^2 = .324, F_{cha}(1, 84) = 29.64, p < .001$. The addition of Negative Life-Events to the equation did not result in a significant increment in R^2 , [$R^2 = .349; F_{cha}(1, 83) = 3.13, ns$]. The addition of Coping Style in the final step resulted in a significant increment in R^2 , [$R^2 = .394; F_{cha}(2, 81) = 2.998, p < .05$]. Disengagement Coping and Self-Worth made unique contributions to the prediction of Depressive Symptomatology ($\underline{sr}^2 = .032$ and $\underline{sr}^2 = .168$, respectively). The percentage of explained variability in Depressive Symptomatology by all the IVs was 39.4% ($R^2_{adj} = .394; R = .627$).

Insert Table 9 about here

Table 9

Hierarchical Regression of Perceived Support, Self-Worth, Negative Life-Events, and Coping Style on Depressive Symptomatology in Homeless Adolescents Subgroup

	B	β	sr^2 (unique)
Perceived Social Support			
Parent	0.087	.046	.000
Friend	-.184	-.105	.008
			$R^2 = .086$
			$R^2_{adj} = .064$
			$R = .293^{**}$
Global Self-Worth	-0.951	-.451 ***	.168
			$R^2 = .324$
			$R^2_{adj} = .300$
			$R = .569^{***}$
Negative Life-Events	-0.007	-0.15	.020
			$R^2 = .349$
			$R^2_{adj} = .317$
			$R = .591^{***}$
Coping Style			
Disengagement	.698	0.186 *	.032
Engagement	-.404	-0.129	.015
	Intercept =		$R^2 = .394$
	5.582		$R^2_{adj} = .349$
			$R = .627^{***}$

*** $p < .001$

** $p < .025$

* $p < .05$

A significant R for regression, with all IVs in the equation, was obtained for Internalizing Behaviour Problems, [$F(6, 80) = 8.97, p < .001$]. After step 1, with Perceived Social Support entered in the equation, $R^2 = .068, F_{cha}(2, 84) = 3.07, ns$. After step 2, with the addition of Self-Worth, $R^2 = .356, F_{cha}(1, 83) = 37.02, p < .001$. The addition of Negative Life-Events to the equation did not result in a significant increment in R^2 , [$R^2 = .361; F_{cha}(1, 82) = .747, ns$]. The addition of Coping Style in the final step resulted in a significant increment in R^2 , [$R^2 = .402; F_{cha}(2, 80) = 2.723, p < .05$]. Disengagement Coping and Self-Worth made unique contributions to the prediction of Internalizing Behaviour Problems ($\underline{s}r^2 = .032$ and $\underline{s}r^2 = .219$, respectively). The percentage of explained variability in Internalizing Behaviour Problems by all the IVs was 40.2% ($R^2_{adj} = .357; R = .634$).

Insert Table 10 about here

Table 10

Hierarchical Regression of Perceived Support, Self-Worth, Negative Life-Events, and Coping Style on Internalizing Behaviour Problems in Homeless Adolescents Subgroup

	B	β	sr^2 (unique)
Perceived Social Support			
Parent	-0.428	-.027	.000
Friend	0.236	.016	.000
			$R^2 = .068$
			$R^2_{adj} = .046$
			$R = .261$
Global Self-Worth	-9.157	-.525 ***	.219
			$R^2 = .356$
			$R^2_{adj} = .332$
			$R = .596 ***$
Negative Life-Events	-0.002	-0.068	.004
			$R^2 = .361$
			$R^2_{adj} = .330$
			$R = .601 ***$
Coping Style			
Disengagement	5.888	.188 *	.032
Engagement	-2.997	-.112	.012
	Intercept =		$R^2 = .402$
	76.02		$R^2_{adj} = .357$
			$R = .634 ***$

*** $p < .001$

* $p < .05$

A significant R for regression, with all IVs in the equation, was obtained for Externalizing Behaviour Problems, [$F(6, 80) = 6.374, p < .001$]. After step 1, with Perceived Social Support entered in the equation, $R^2 = .020, F_{cha}(2, 84) = .872, ns$. After step 2, with the addition of Self-Worth, $R^2 = .165, F_{cha}(1, 83) = 14.336, p < .001$. The addition of Negative Life-Events to the equation did not result in a significant increment in R^2 , [$R^2 = .167; F_{cha}(1, 82) = .206, ns$]. The addition of Coping Style in the final step resulted in a significant increment in R^2 , [$R^2 = .323; F_{cha}(2, 80) = 9.265, p < .001$]. Unique contributions to the prediction of Externalizing Behaviour Problems were made by Disengagement Coping ($\underline{sr}^2 = .123$), Engagement Coping ($\underline{sr}^2 = .038$), and Self-Worth ($\underline{sr}^2 = .069$). The percentage of explained variability in Externalizing Behaviour Problems by all the IVs was 32.3% ($R^2_{adj} = .273; R = .569$).

Insert Table 11 about here

Table 11

Hierarchical Regression of Perceived Support, Self-Worth, Negative Life-Events, and Coping Style on Externalizing Behaviour Problems in Homeless Adolescents Subgroup

	B	β	sr^2 (unique)
Perceived Social Support			
Parent	.546	.044	.000
Friend	-.088	-.008	.000
			$R^2 = .020$ $R^2_{adj} = -.003$ $R = .143$
Global Self-Worth	-3.91	-.288 **	.069
			$R^2 = .165$ $R^2_{adj} = .134$ $R = .406 **$
Negative Life-Events	0.002	0.059	.003
			$R^2 = .167$ $R^2_{adj} = .126$ $R = .408 **$
Coping Style			
Disengagement	8.882	.365 *	.123
Engagement	-4.156	-.205 ***	.038
Intercept = 61.81			$R^2 = .323$ $R^2_{adj} = .273$ $R = .569 ***$

*** $p < .001$

** $p < .01$

* $p < .05$

Hierarchical regression analysis was also conducted to determine the extent to which Perceived Social Support (Parent, Friend), Global Self-Worth, and Negative Life-Events predicted Disengagement Coping in the homeless adolescent subgroup. The results for which significant R statistics were obtained for Disengagement Coping are presented in Table 11. The table also includes the unstandardized regression coefficients (B), the standardized regression coefficients (β), the squared semi-partial correlations ($\underline{sr}^2$), R^2 , and adjusted R^2 .

A significant R for regression, with all IVs in the equation, was obtained for Disengagement Coping Style, [$F(4, 83) = 2.29, p < .10$]. The percentage of explained variability was 7.9% ($R^2_{adj} = .034$; $R = .281$). Only Self-Worth made a unique contribution to the prediction of the Disengagement Coping Style [$R^2 = .076, F_{cha}(1, 84) = 4.742, p < .05$; $\underline{sr}^2 = .052$]. The addition of Perceived Social Support and Total Negative Life-Events score did not result in significant increments in R^2 .

Insert Table 12 about here

Table 12

Hierarchical Regression of Perceived Support, Self-Worth, and Negative Life-Events on Disengagement Coping in Homeless Adolescents Subgroup

	B	β	sr^2 (unique)
Perceived Social Support			
Parent	-0.057	-.111	.010
Friend	-0.030	.066	.003
			$R^2 = .023$
			$R^2_{adj} = .000$
			$R = .153$
Global Self-Worth	-0.138	-.248 *	.052
			$R^2 = .076$
			$R^2_{adj} = .043$
			$R = .275$
Negative Life-Events	-.000	0.057	.003
	Intercept = 2.73		$R^2 = .079$
			$R^2_{adj} = .034$
			$R = .281 *$

* $p < .05$

Discussion

Examined in the current study were the effects of coping style, negative life-events, self-esteem, and perceived social support on the depressive symptomatology and internalizing/externalizing behaviour problems in homeless adolescent males. Two groups of non-homeless adolescents, drop-in youth and high-school youth, served as comparison groups. A primary limitation of previous research involving homeless youth is the lack of comparison groups and standardized norms by which to determine if homeless youth are reporting scores which are significantly different, statistically, from those of non-homeless youth, as well as clinically significant. Inclusion of comparison groups in this study improved upon prior methodological limitations, and allowed for the subsequent analysis of the first set of hypotheses, which examined between-group differences on the measures. It was proposed that homeless youth would report more problematic scores than both drop-in and high-school youth, while drop-in youth would report more problematic scores than high school youth. Results supported these expected group differences with respect to each psychological construct and outcome measured.

Numerous conclusions can be drawn from the differences obtained between the homeless and non-homeless comparisons. First, differences between the homeless and drop-in groups on the demographic variables indicated that collapsing homeless youth and drop-in youth into one group, as has been done in previous youth-homelessness studies (Greene & Ringwalt, 1996; Kipke et al., 1995, 1997; Robertson et al., 1989; Smart & Walsh, 1993; Smart et al., 1994; Unger et al., 1997, 1998), was not appropriate. Youth recruited from drop-in centres should not be viewed as a subgroup of homeless youth, but

rather as a group to be analysed separately from emergency shelter youth in future studies. Second, relative to non-homeless youth, homeless youth are at higher risk for psychological maladjustment. Third, differences between the comparison groups suggest that drop-in youth are at higher risk for psychological maladjustment than high school youth, and are thus not representative of youth in the general population.

Stress and Coping

Few studies have assessed stress in homeless youth. In their assessment of 25 major life events, Unger et al. (1998) reported that the most severe stressors were losing a lover/friend, conflicts with a lover/friend, worrying about an illness/injury of lover/friend, and conflicts with family members. Ayerst (1999) found that street youth reported experiencing a higher number of stressors than non-homeless youth, but information was not provided on the nature of the stressors. Prominent stressors reported in Farrell et al.'s (2000) study included difficulties finding employment and housing, loss of contact with family and friends, and being the victim of a violent crime. In this study, stressors were examined individually and categorically, as was done by Ayerst, Unger et al., and Farrell et al., but also as a total negative life-events score. Relative to non-homeless youth, homeless youth reported a greater total negative life-events score, which represented the desirability and impact ratings of the 138 negatively-rated major and minor events of the APES. Unlike Unger et al., who reported stressors which were primarily related to conflicts or relationship-issues with friends/lovers, the stressors rated most negatively in this study were related to self-harm, academic difficulties, death, parent marital status, and interpersonal issues. This finding may be a reflection of the greater number of life-events

assessed by the APES, which allowed for the inclusion of numerous and varied types of stressors encountered by adolescents. Although missing data for the APES were substantial in both the drop-in and high school groups, the data were complete for the homeless group, indicating confidence in our within-group analyses.

This study also provided valuable new information about the manner in which homeless youth cope with the stressors in their lives, and the role of coping style in homeless adolescents' psychological adjustment. Although only a few known studies have examined the coping strategies used by homeless youth (Ayerst, 1999; Farrell et al., 2000; Unger et al., 1998), no study has examined the role of overall coping style and its' impact on homeless adolescents' response to stress. Adaptive coping responses may reduce some stressors to the level of momentary disruptions, while less adaptive coping patterns may exacerbate stress and contribute to long-term negative outcomes (Compas et al., 1993). Proponents of the engagement-disengagement model assert that disengagement coping is a maladaptive coping style, thereby indicating that one's coping strategies are ineffective to deal with stress (Compas et al., 1997).

Relative to non-homeless youth, findings of this study demonstrated that homeless youth are characterized by a coping style which is of a disengagement nature, such that cognitive and behavioural responses to stress are directed away from the source of the stress or negative emotion (Compas et al., 1997). Disengagement coping includes such strategies as problem avoidance (e.g., staying away from reminders), wishful thinking (e.g., wishing problem had not occurred), avoidance of negative emotions and thoughts (e.g., trying not to think about problem), and social withdrawal (e.g., avoiding contact

with others) (Compas et al., 1997). That homeless youth are characterized by a disengagement coping style is particularly noteworthy given the nature of the services offered at the emergency shelter in which this study's participating youth resided. The Salvation Army Young Men's Shelter has 24-hour staffing and operates within a case-management system, such that youths' needs are regularly assessed by staff throughout the duration of their shelter stay. The case-management system provides much opportunity for youth to engage with the staff, and for staff to attempt to engage the youth. Staff offer crisis intervention, and make frequent referrals to the numerous outreach workers who work out of the shelter, as well as to nearby youth agencies which service homeless youth. Despite the opportunity for youth to adopt an engagement style or engagement-specific coping strategies while in the shelter, youth continued to endorse a disengagement coping style, thereby suggesting that the coping style of youth accessing emergency shelters is stable and not easily altered. The clinical implications of this will be discussed later in this section.

Complicating the measurement of stress and coping during adolescence is the problem of circularity inherent in this research area. A first issue pertains to the perception of stress as a function of one's coping style. Do individuals with different coping styles differ in their perception of the type, intensity, and frequency of perceived stressors in their lives? Does an individual who copes well report fewer stressors because they actually have fewer stressors, or because they are not stressed by the same stressors as someone with coping skills which are less adaptive? In answer to these questions, this study indicated that individuals with different coping styles differed in their perception of

the desirability and impact associated with the negative events in their lives. Second, this study indicated that youth with a disengaging coping style (i.e., less adaptive coping style) reported more negative stress in their lives. Third, results indicated that disengagement coping was a significant predictor, over and above stress, of psychological maladjustment. Taken together, these results circumvent, at least to some extent, the problem of circularity associated with stress and coping research.

Self-Esteem

Consistent with previous investigations of self-esteem in homeless youth (Adams et al., 1985; Smart & Ogborne, 1994; Simmons & Weinman, 1991; Miner, 1991), results of this study indicated that homeless youth reported lower global self-worth scores than did the non-homeless group of high school youth. As in most of the homeless literature, methodological factors must be considered in reviewing these results. First, it is difficult to determine if homeless adolescents' self-esteem contributed to their being homeless, or if it was positively or negatively affected by the homeless experience. For some youth, low self-esteem may be the result of a realistic appraisal of their negative life experiences and continuing failures, rather than the cause of these difficulties. For others, leaving what they perceive to be dysfunctional home environments and becoming involved with other homeless youth, may raise their self-esteem by instilling feelings of belonging, acceptance, or friendship. No known study has followed youth at risk for being homeless longitudinally or measured self-esteem both before and after a homeless episode. Unfortunately, this study was not longitudinal in design and thus does not allow for such causal inferences to be made.

Second, co-morbidity, particularly with depressive diagnoses, also underlies issues of self-esteem, and must be recognized as an issue in this study. Thirty-nine percent of the homeless youth in this study met criteria for levels of clinical depressive symptomatology. This finding is consistent with Sm finding is consistent with Smarhat homeless youth with high self-esteem were significantly less depressed than those with moderate and low self-esteem.

Perceived Social Support

The Social Support Scale for Children and Adolescents (Harter, 1985) evaluates four sources of support: parental, friend, classmate, and teacher. As nearly half of the respondents in the homeless group reported having dropped out of school at least one school year prior to the study, and thus could not validly rate teachers and classmates as support systems, perceived support from teachers and classmates was excluded from analyses. Given that homeless adolescents tend to be separated from their families, one could have expected that homeless youth would report a greater reliance on their peers for support than non-homeless youth. However, contrary to prior studies involving street youth, which indicated that homeless youth tend to form alliances and peer groups with other homeless youth (Ennett et al., 1999), group differences in peer support were not obtained in this study. This pattern of peer reliance may not be a similar occurrence among homeless youth accessing emergency shelters, due to the high rates of turnover in shelter admissions/discharges and variance in length of stay. The transient nature of the homeless lifestyle may also be a contributing factor in homeless adolescents' reticence to trust and form bonds of friendship.

Analyses of the parental support sub-scale indicated that homeless youth reported less perceived parental support than high school youth. In the absence of parental information to cross-validate this data, interpretations of this finding should proceed cautiously. One explanation for this finding may be the high prevalence rates of single-parent homes and parental separation/divorce reported by homeless youth. In this study, information pertaining to youths' current contact with their parents was not requested. To cross-validate or examine differences in perceptions of support, future studies may seek to include parents of homeless youth. However, in the absence of data indicating how many youth maintain familial contact once in a shelter or on the street, or how many would want and/or consent to their parents' participation, it is difficult to speak to the feasibility of such a study.

Previous research indicated that a lack of social support is associated with depressive symptoms, psychological maladjustment, substance abuse, unsafe sexual behaviours, and poor physical health (Compas et al., 1987; Unger et al., 1998; Ennett et al., 1999). The lack of perceived support reported by this study's homeless youth suggested that they are at risk for these mental and physical health problems. As the measure used in this study did not assess additional supports beyond parent, friends, teachers, and classmates, future studies may also benefit from including or modifying a social support scale which will allow for the assessment of perceived support that homeless youth may receive from service providers, such as shelter staff and outreach workers.

Psychological Adjustment

In addition to self-esteem and social support, studies have also examined the prevalence of depressive symptoms and mental health problems/disorders among homeless youth. Consistent with previous findings which reported rates of 26 to 64% for clinical depression (Robertson et al., 1989; Unger et al., 1998), 39% of the homeless youth in this study reported depressive symptomatology scores which were in the clinical range. Previous studies also reported high levels of antisocial behaviours, specifically school suspensions and expulsions (71%) (Schaffer & Caton, 1984), as well as high levels of social isolation, hostility, and antisocial tendencies (Hier et al., 1990). Concurring with these findings, results of this study indicated that 43% and 48% of homeless youth reported internalizing and externalizing behavior problem scores which were in the clinical range.

The high levels of depressive symptomatology and internalizing behavior problems are of particular concern given previous findings associating depressive symptoms with lifetime suicide attempts, negative life-events, low self-esteem, and mental health problems among homeless youth (Stiffman, 1989; Greene & Ringwalt, 1996). The high prevalence rate of externalizing behavior problems is also of concern given the high incidence of homeless youths' involvement with criminal activity, gangs, aggressive behavior, and substance abuse (Kipke et al., 1995; Koopman et al., 1994; Unger et al., 1997, 1998). In this study, homeless youths' levels of depressive symptoms and internalizing/externalizing behaviours were also higher than levels reported by non-homeless youth. These findings highlight that homeless youth are characterized by poor psychological outcomes and

reflect the importance of extending research into the psychological aspects of youth homelessness in order to reduce their high-risk status.

Predictors of Psychological Adjustment

The second set of hypotheses examined differences within the homeless adolescent population. It was hypothesized that (a) disengaging coping style would be associated with high negative life-events indices, low self-worth, and low perceived support; (b) disengaging coping style would be associated with high levels of depressive symptomatology, internalizing behaviours, and externalizing behaviours; and (c) high levels of depressive symptomatology, internalizing behaviours, and externalizing behaviours would be exhibited by adolescents with greater use of the disengagement coping style, high negative life-events score, low self-esteem, and low perceived support.

Results of regression analyses supported each of these hypotheses. Disengagement coping was associated with high negative life-events scores, low self-worth, and low perceived social support. Disengagement coping and self-worth were also predictors of depressive symptomatology, internalizing behaviours, and externalizing behaviours. In addition to disengagement coping and self-worth, externalizing behaviours was also predicted by the engagement coping style.

These results are consistent with previous findings that adolescents with a disengaging coping style, high levels of stress, and/or low social support are at greater risk for depression, poor physical health, and substance abuse (Carver et al., 1989; Carver & Scheier, 1994; Compas et al., 1993). The association obtained in this study between disengagement coping and psychological maladjustment suggests that homeless

adolescents' coping style was insufficient or ineffective to deal with stressful demands, thus placing them at risk for depressive symptomatology and behaviour problems. The findings reflect the impact of a maladaptive coping style in dealing with stress effectively, and thereby suggest the importance of developing and focusing intervention programs on homeless youth with a disengaging coping style.

Examination of the specific predictors indicated that the combined predictors accounted for a substantial proportion of variability (i.e., 32 to 40%) in psychological adjustment. Further examination of the regression analyses indicated that disengagement coping and self-worth were the primary predictors of externalizing behaviour problems (i.e., 12% and 7%, respectively). This was not surprising given the similarity in strategy- and syndrome- scales comprising both the disengagement coping style (e.g., substance abuse, venting emotions) and externalizing behaviour problems dimension (i.e., delinquent conduct, aggression). With respect to depressive symptomatology and internalizing behaviour problems, disengagement coping was a unique predictor in psychological adjustment (i.e., 3% of the variability), with self-worth accounting for a substantial proportion of additional variability (i.e., 16.8% and 21.9%, respectively). That disengagement was a key predictor is not surprising given the nature of the style, which involves withdrawal from actively coping with a stressor. That self-esteem was a key predictor is also not surprising given Compas et al.'s (1993) finding that individuals with a disengaging coping style and low self-esteem are at risk for psychological maladjustment. Furthermore, prior studies report associations between self-esteem and such factors as depression, hostility, substance use, suicidality, childhood trauma, academic difficulties,

and family dysfunction (Harter, 1992; Kazdin et al., 1985; Maxwell, 1992; Miner, 1991; Smart & Walsh, 1993; Unger et al., 1997). As these factors characterize youth in previous homeless studies as well as this study, this indicates that both disengagement coping and perceptions of self-worth are important factors in the psychological adjustment of homeless youth.

Results also indicated that high levels of depressive symptomatology, internalizing behaviour problems, and externalizing behaviour problems, were exhibited by homeless adolescents who reported high use of the disengagement coping style, negative life-events index, low self-esteem, and low parental support. These findings are consistent with prior studies of suicidality in homeless youth, which report a significant association between suicidality and negative life-events, mental health and behaviour problems, and family instability (Greene & Ringwalt, 1996; Maxwell, 1992; Smart & Walsh, 1993; Stiffman, 1989; Unger et al., 1997). These findings are also consistent with studies of the disengagement coping style model, which indicate that stressful experiences and the ways in which adolescents cope with stress play important roles in the onset and maintenance of a wide range of psychological distress and psychopathology; adolescents with a disengaging coping style, high levels of stress, and/or low social support are at greater risk for depression, poor physical health, and substance abuse (Compas et al., 1993). Significant positive correlations in this study between depressive symptomatology, internalizing behaviour problems, and externalizing behaviour problems were consistent with prior conclusions that adolescents rarely experience depressed mood in the absence of other negative emotions (Compas & Hammen, 1994) or co-morbid conditions (Rhode

et al., 1991). Taken together, these factors indicate that homeless youth, particularly those presenting with a disengagement coping style, low perceived support, high stress, and low self-esteem, are at higher risk for psychopathology than non-homeless youth.

Methodological Limitations

Previous research involving homeless youth is characterized by various methodological limitations which hamper both the generalizability and conclusions which could be drawn. Although this study successfully addressed and improved upon some of these issues, several limitations must nonetheless be considered when drawing conclusions from the results obtained.

First, as the data was cross-sectional in nature, causal relationships cannot be inferred. Longitudinal studies are necessary to clarify the directionality of the associations observed in this study. Unfortunately, given the transient nature of homeless youth, this study, like previous studies, was unable to follow youth at risk longitudinally, or obtain construct- or adjustment-measures before, throughout, and/or after a homeless episode. It is thus not possible to determine if the reported construct- or adjustment-levels were precipitants or the result of youths' homelessness. In the absence of follow-up data, it is also difficult to discern if there were changes in the youths' psychological status throughout the duration of their homeless period (e.g., mental health status may deteriorate with increased time being homeless; increase in suicidal ideation or depressive symptomatology).

Second, the homeless sample used in this study consisted of shelter youth only, and thus may not be representative of those homeless youth who choose not to access youth

service agencies or shelters. However, given the large sample size and period of data collection, it is unlikely that many youth were missed or were unaware of the study. Although the extent to which these findings can be generalized to shelter and street youth populations in other cities is unclear, the prevalence rates of such constructs as suicidality, substance use, legal problems, depressive symptomatology, and self-esteem seen here are consistent with findings reported by other studies of youth homelessness (Unger et al., 1998; Smart & Walsh, 1993; Shaffer & Caton, 1984). Future studies may seek to examine the disengagement coping model with a sample of street youth and/or homeless youth who choose not to access youth service-agencies or a shelter in order to cross-validate the theoretical findings of this study. While a sample of this nature may be difficult to obtain, such a study may offer further information regarding the extent of disengagement in homeless youth. If shelter youth can still endorse a disengagement coping style despite staff efforts to foster engagement coping strategies, one could reasonably expect that street youth would be characterized by a more pronounced use of the disengagement coping style, given their reticence to approach service agencies and an environment in which staff and outreach workers would attempt to engage them.

Given that this study consisted of male adolescents only, findings cannot be generalized to homeless female adolescents. While it is understood that young women and those outside of the 16 - 19 year age range also comprise Ottawa's homeless population, the homogeneity of this study's sample was increased by focussing solely on adolescent males between the ages of 16 - 19 years, who are Ottawa's largest single subgroup of homeless youth. Future research would thus also benefit from the replication of this

study, and particularly the examination of the engagement-disengagement coping style model, with homeless female adolescents. Coping studies indicate that female adolescents use a broader range of coping patterns, as well as more emotionally-attentive and ruminative coping strategies (Compas, 1987a; Compas et al., 1993). Stress studies indicate that female adolescents tend to report more negative daily events (Compas et al., 1985), rate events as more stressful (Lewis, Siegel, & Lewis, 1984), and exhibit a higher association between negative life-events and psychological symptoms (Greenberger, Steinberg, & Vaux, 1982; Johnson & McCutcheon, 1980). These findings suggest that female homeless youth may also be characterized by a disengagement coping style, which contributes to their perception of life-events as negative, and renders their coping strategies ineffective to deal with the events.

Comparison groups were deemed necessary to the design of this study in order to contrast the functioning of homeless youth to that of non-homeless youth. Although future studies would benefit from the continued inclusion of non-homeless comparison groups, selection and recruitment of representative comparison groups for this study was difficult and thus worthy of discussion. For the drop-in youth, staff were initially concerned that youth accessing the downtown drop-in services had been the focus of too many studies, and may have been feeling “over-studied”. To address this, agreements were made with other local drop-in centres to access their youth as well, so as to limit the amount of time spent at one drop-in. This resulted in a very diverse and representative sample of drop-in youth. Gaining access to a high school sample also proved challenging, and unfortunately did not result in as diverse a sample as the drop-in youth. To gain

approval from the school board's review committee, modifications had to be made to the demographic information form (e.g., removal of items pertaining to legal issues, substance use, and suicidality). Unfortunately, this limited comparisons of portions of the demographic variables to two groups rather than three. Although approval had been obtained from the ethics review board, this did not guarantee a school's participation, as that decision rested with the school's principal. While it was originally proposed that the high school sample for this study would be recruited from 3 high schools to ensure the sample's representativeness, permission was only received from one high school. Additional conditions of approval included the testing of youth in one session, during class time, so as to limit any potential disruption to the academic schedule. Studies could not be conducted in September or May, or during breaks and exams. Data were thus collected from 2 classes over 2 days in January/01. The classes from which data were collected were 2 combined Grade 10/11 classes, which explains the lack of age variability in this group.

Third, given that all the measures used in this study were based on self-reports by youth, they were not subjected to cross-validation by such individuals as parents, peers, service providers, and/or teachers. Questionnaire responses may also have been subject to reporting bias, such that participants under-reported their responses in an attempt to please the interviewer, answer in a socially desirable manner, or to avoid the negative consequences of reporting maladaptive or inappropriate behaviours. To address this, participants were given the option of completing the questionnaires independently so as not to have to verbalize their answers to the interviewer. Participants were also assured

that their answers would remain confidential, and would not have any impact on their shelter stay. Examination of the demographic information provided by the homeless youth suggests that they were not answering in a socially biased manner, as they openly provided information on their substance use patterns, legal issues, and suicidality. Their answers were also consistent with prevalence rates reported in other studies of youth-homelessness, further indicating no response-bias.

Fourth, the reliability and validity of the measures used in prior studies of youth homelessness has typically been a fundamental methodological limitation. In order to compare and replicate findings across studies and populations, some studies employed standardized measures in their entirety, while others employed standardized questionnaires, but selected subsets of items. Studies selecting subsets of items have not addressed the potential effects on the measures' psychometric properties. Other studies sought to be sensitive to the needs of this population by designing study-specific measures, while others used measures designed for specific adolescent-groups. In the latter studies, the validity of using adolescent-specific measures (e.g., for in-school youth) with street youth (e.g., who are not in school) has rarely been discussed. In this study, measures for which standardized norms were available and which focussed on the six different constructs of interest were selected (i.e., coping style, negative life-events, self-esteem, social support, depressive symptoms, behaviour problems).

Given the numerous constructs being assessed in this study, the questionnaire package was quite lengthy, presenting us with both advantages and disadvantages. The most prominent advantage was the repetitiveness of some of the items. While many youth

noted that they had already answered an item elsewhere, the repetition served as a check for respondents' thoroughness in answering the items and as a reliability check across items (e.g., suicidal ideation). The homeless and drop-in groups were permitted to take as much time as necessary to complete the questionnaire package, thus resulting in minimal missing data across the measures. In the case of the high school youth, the questionnaire package was completed during class time, which was 75-minutes in length. As the high school group had less time to complete their questionnaire packages, this may have been a contributing factor to the amount of missing data in this group. While future studies may attempt to conduct the interviews over two classes, or after school, this poses recruitment difficulties. In the case of this study, permission was only granted by the School Board Ethics Committee on the condition that the questionnaires be completed in one session, during class time.

To compensate for the length of the package, youth were encouraged to take short breaks as needed. Despite the numerous items of the questionnaires, the diversity of the groups increased the likelihood of missing data. This was particularly relevant with the school-specific items. To address the fact that many youth in the homeless group were not in school, youth were asked to complete the school items if they had been in school in the previous 12-months, a time-frame consistent with other measures. Unfortunately, many youth had not been in school for over a year, thus resulting in much school-specific missing data. In an issue related to the missing data, unequal n's across analyses were evident in this study, particularly in the high-school group. Sample sizes in the homeless and drop-in groups provided sufficient power for the proposed analyses. Furthermore, the

sample size was complete for the case-group, indicating confidence in our internal analyses.

With respect to the measures comprising the questionnaire package, future studies may benefit from the selection of shorter measures, or from the inclusion of youth in the selection of measures which they feel could be completed in their entirety. This is particularly applicable to the stress measure selected for this study. As a 138-item measure, the APES may have been too long for the respondents to complete along with the other measures. With respect to the social support scale, future studies may benefit from including or modifying a social support scale which will allow for the assessment of support that homeless youth may receive from service providers, such as shelter staff and outreach workers. Prior to this study, homeless adolescents had not served as a subgroup of study for the disengagement-engagement coping style model. Although the findings of this study indicated that homeless youth are a subgroup for whom the disengagement-engagement coping style model is applicable, future research would also benefit from the assessment of the model with another disengagement-engagement coping style measure in order to cross-validate the findings obtained in this study.

Fifth, assessing mental health problems in the homeless is problematic (Koegel & Burnam, 1992). Feelings and behaviours reported by homeless youth that appear to be symptomatic of various mental illnesses (e.g., fatigue, inability to concentrate, sleeplessness) may be the result of living on the streets and in shelters rather than indicators of underlying psychopathology. Although one may infer an over-estimation of the prevalence of mental health problems, standardized measures which allow for the self-

reporting of feelings and behaviours were used to attempt to mediate this problem. The measures used in this study assessed symptoms of depression, behaviour problems, low self-esteem, and suicidality. Other psychiatric disorders prevalent in homeless populations were not measured in this study, including schizophrenia, bipolar disorders, and anxiety disorders. Time constraints precluded the intensive interviewing necessary to diagnose these disorders. Had these disorders been assessed, the observed prevalence of mental health problems may have been greater than the 40% found in this study.

Clinical and Research Implications

These limitations notwithstanding, this study makes an important contribution to the literature regarding the clinical and research implications of coping style in the psychological adjustment of homeless adolescent males. Findings demonstrated that homeless youth are characterized by a disengaging coping style, thereby indicating that their coping responses are ineffective to deal with stress. There are two main implications to this finding. The first is that the disengaging coping style may contribute to the chronicity of an existing mental health problem, or exacerbate an existing risk factor. For example, a youth who experienced a childhood trauma (e.g., abuse) may be experiencing post-traumatic stress disorder symptoms, but refrain from seeking out support (i.e., engaging) and choose instead to deny the abuse, mentally disengage, or abuse substances (i.e., disengaging).

Second, the disengagement coping style may serve as a barrier to service utilization. Youth may agree to appointments with mental health professionals or outreach workers, but then not attend the scheduled meeting. Youth may also arrive for scheduled

appointments under the influence of drugs and/or alcohol. Current social assistance programs are not engaging in nature, but rather are very regulatory, mandating that youth attend school, drug-rehabilitation programs, or counselling. As nearly half of the participating homeless youth in this study had dropped out of school, it is unreasonable to assume that their school experiences had been positive. The data in this study suggested that youth have learning/academic difficulties and view school as a negative event. Rather than address their learning difficulties, youth with a tendency to disengage may refuse to register for school, or may register but then not attend. It is imperative that future intervention programs include youth in the development of services, so that they can identify which issues have contributed to their homelessness and what intervention strategies would be most helpful to them (e.g., job skills training, alternate learning modes).

Clinical solutions to this problem include the provision of service in a youth-friendly manner and environment. The context and delivery of services are essential to the development of youth services, particularly in light of current data indicating youths' disengaging nature. The provision of youth-friendly services is accomplished by ensuring that health care professionals are up-to-date and trained to work with homeless youth, that there is a youth-helping-youth component, that youth are included in the decision and planning sessions related to youth services, and that there are a set of established guidelines for minimal standards of health services (Canadian Pediatric Society, 1999; Davidson & Manion, 1996; Virley O'Connor & McDonald, 1999). Ongoing evaluation by youth of their satisfaction with current services would indicate to youth that their input is

valuable and that meeting their needs is important. For service providers, ongoing evaluation would also ensure that youth agencies/workers are aware of current trends among homeless youth (e.g., raves, new hard-drugs), so that services can be modified accordingly.

Youth-friendliness also appears to be an essential component in conducting research studies with homeless youth. The participation rate in this study was 98.0% (n = 100) over a 12-month period. Although this rate is consistent with rates reported in other studies of youth homelessness (e.g., 92% in 1999 Ottawa study) (Farrell, 1999, Personal Communication), such a high participation rate is striking, particularly given the data indicating homeless youths' tendency to disengage from service providers and/or direct involvement with one's stress. Participating youth may have responded to the manner in which the study was implemented. Interviewers presented the study to youth in a manner which was youth-friendly, non-discriminatory, confidential, and as potentially pivotal in the recognition of mental health issues and possible development of intervention-strategies to address homeless youths' needs. Participating youth may also have responded to the interviewers for their caring and non-judgmental attitude, as well as their experience with homeless youth. Approximately half of the participating homeless youth in this study reported prior involvement with a mental health professional. This suggested that despite having a disengaging coping style, homeless youth are not averse to discussing their past/current experiences, provided they can do so in a youth-friendly context. Recent findings indicate that factors such as non-discrimination, acceptance, and confidentiality, are important to homeless youth when participating in research studies or accessing youth-

service-agencies (Canadian Pediatric Society, 1999; Davidson & Manion, 1996; Virley O'Connor & McDonald, 1999). Future studies should therefore continue to incorporate a youth-friendly manner, in 06-Uyouth-friendly manner, in who address homeless youths' needs.

Workshops developed in consultation with youth may be one way in which future studies could connect with disengaged youth, as youth could ensure that the workshops target their needs in a manner which is both effective and interesting (e.g., job skills and role play of employment interviews). Of particular benefit to such workshops would be the involvement of youth who have overcome the focus-issue of a given workshop (e.g., former street youth). Also of benefit may be mobile services, where the initial contact or engagement is made by a service provider (e.g., outreach worker), until such time that youth trust a service or service provider to initiate engagement on their own. For example, outreach teams consisting of nurses, psychiatrists, addiction counsellors, etc., may be more successful at engaging youth initially at a shelter or street site, rather than expecting youth to come to a fixed site. Initial access to free health care services without a valid health card, convenient walk-in services without a scheduled appointment, and free or low-cost medication and medical follow-up should also be considered in order to encourage youth to engage health care providers.

The findings of this study also suggested that future studies should evaluate the stability of one's coping style. Although covariate analyses indicated that age was not a factor in the coping style of this study's participating youth, future studies should assess the coping styles of younger adolescents and monitor its' development through

adolescence. Information on the development of coping style could lead to the subsequent implementation of early intervention programs for pre-adolescents. Proponents of the engagement-disengagement model assert that knowledge of one's coping style allows one to make inferences about the selection and effectiveness of one's coping strategies. This being the case, coping-skills interventions which focus on the use of engaging-specific coping strategies may be effective at reducing one's tendency toward the disengagement coping style, while simultaneously increasing one's tendency toward the engagement style. Such intervention programs would also serve as a possible preventive measure for youth at risk for becoming homeless. Coping-skills interventions of this nature are thus worthy of future evaluation, as is the inclusion of youth in the development of such programs so as to ensure that youth-specific stressors and coping-responses are addressed.

Information on the development and stability of coping style could also lead to the assessment of additional psychological constructs which are positive in nature. Youth homelessness studies have typically assessed problematic constructs such as hostility, depression, poor self-concept, and lack of support. Such constructs as resiliency, adaptability, hardiness, optimism, and locus of control, may reduce the deleterious effects of stress and thereby further distinguish resilient youth from those who respond maladaptively to stress. Therefore, it is reasonable to propose that just as externalizing behaviour problems are positively associated with the disengagement coping style, positive constructs such as resiliency and optimism would be positively associated with the engagement coping style. As factors such as these may play important roles in the onset of an engagement coping style, investigation of these constructs in homeless youth would

be worthwhile. The assessment of these and other constructs through means other than standardized questionnaires would also be worthwhile to future studies of youth homelessness. As this study's findings suggested that homeless youth are not averse to discussing their prior/current experiences, given the right circumstances (i.e., youth-friendly), future studies may seek to report findings based on qualitative analyses of structured interviews or focus groups.

Results of this study also highlighted the prevalence of mental health issues, physical health problems, suicidality, substance abuse, cigarette use, legal problems, academic difficulties, and family dysfunction among homeless youth. Although the rates obtained in this study were consistent with rates obtained in other studies of youth homelessness, the rates were alarmingly high relative to those of non-homeless youth. These rates demonstrated that clinical and outreach interventions must not only address coping style, poor self-esteem, and lack of perceived support, but that they also must include components which target specific problems, such as substance abuse, medication regimens, medical follow-up, involvement in criminal activity, violence, suicidality, gang-activity, and anger.

In conclusion, the findings of this study confirmed that homeless youth are a vulnerable group of young people who are at high risk for poor psychological and physical outcomes (e.g., depression, behaviour problems, suicidality, substance abuse problems). Results also demonstrated that homeless youth tend to endorse a disengagement coping style, thereby indicating that their coping responses may be ineffective to deal with stress. Homeless youth are in need of youth-specific services and intervention-programs that are

designed to foster adaptive coping skills, decrease the incidence of risk-taking behaviours, and reduce the prevalence of psycho-social difficulties. Homeless adolescents' tendency toward a disengagement coping style also reflects the merit of considering overall coping patterns when developing intervention programs for homeless youth. The disengagement-engagement coping style model may provide some insight into our understanding of the high incidence of psychological maladjustment characteristic of homeless youth.

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Appendix A

Summary of Psychological Studies involving Homeless Adolescents

Summary of Psychological Studies involving Homeless Adolescents			
Authors & Year	Sample Descriptives	Constructs & Measures	Results
Adams, Gullotta, & Clancy (1985)	43 homeless youth (YMCA) (22 "runaways; 19 throwaways")	Comprehensive interview constructed from items originally devised for a 1976 national survey of runaway youth	both groups cited extensive parent-child conflict
	11 - 17 years	Assessed: reason for running away; sibling relnp; single-parent homes; birth-order; peer relations; teacher-student relations; self-image	high levels of social isolation both groups perceived themselves as being worthwhile, but showed signs of doubt and insecurity
Ayerst (1999)	27 street youth (12 - 25 years)	Depression: <u>Centre for Epidemiological Studies of Depression Scale</u>	street youth had higher mean level of depression & # of stressors in past year
	27 high school youth ("non-runaways") (16 - 25 years)	Self-esteem: <u>Rosenberg Self-Esteem Scale (portions of)</u> Coping methods - author identified/selected from literature Stress: <u>Adolescent Life Stress Scale</u>	stress and depression were positively correlated street youth used less positive coping strategies

Summary of Psychological Studies Involving Homeless Adolescents

Baron (1999)	200 homeless male street youth under 24 years of age	drug and alcohol use background, street lifestyle, and labour market	<p>exposure to parental substance abuse increased street youths' risk of alcohol and hard-drug use</p> <p>physical abuse history related to psychedelic drugs long-term homelessness influenced hard-drug use drug and alcohol using peers influenced the use of alcohol, marijuana, and psychedelic drugs</p>
Caputo, Weiler, & Anderson (1997)	participating agencies asked to select 10 - 15 former street youth	2 questions: (1) antecedent risk factors that lead to adoption of street lifestyle; and (2) factors influencing youth as make transition off street	various paths lead to street: negative self-image, family and school experiences, involvement with street and delinquent peers
The Street Lifestyle Study	<p>had been on street at least 1 year; off street at least 1 year</p> <p>14 - 29 years old</p> <p>Halifax = 19; Montreal = 12 Ottawa = 15; Calgary = 13 Vancouver = 11</p>	<p>author-designed interview consisting of closed-and open-ended questions</p>	<p>many opportunities for positive interventions: identify risk factors, address youths' personal needs, feelings of isolation and marginalization</p>

Summary of Psychological Studies involving Homeless Adolescents

Ennett, Bailey, & Federman (1999)	runaway & homeless youth (N = 237) 14 - 21 years	demographic characteristics homeless/runaway experiences substance use behaviour sexual behaviour network norms	26% did not report current social relationships youth with no social network were more likely to report current illicit drug use, multiple sex partners, and survival sex
Greene & Ringwalt (1996)	n = 640 shelter youth (12 - 17 years) n = 600 street youth (18 - 21 years) 2-month period	Association between youths' suicide attempts and youth and familial substance use Survey consisting of items adapted from: National Household Survey on Drug Abuse; National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children in America	youth who had used substances were more likely than those who had not to have attempted suicide youth w/ family members who had used substances were twice as likely as those w/o such family members to have attempted suicide
Hier, Korboot, & Schweitzer (1990)	52 shelter youth (10 "runaway"; 17 "throwaway") M = 15.61 years; SD = 0.97 Brisbane, Australia	<u>Depression subscale of MMPI</u> : poor morale, hopelessness, dissatisfaction with one's status <u>Asocial and Autism subscales of Jesness Inventory</u> : social isolation & antisocial tendencies <u>Hostility and Direction of Hostility Questionnaire</u> : aggressive tendencies	clinical levels of depression female throwaways more hostile than male throwaways & female runaways male runaways more hostile than male throwaways; more socially isolated than female runaways

Summary of Psychological Studies involving Homeless Adolescents

Kipke, O'Connor, Palmer, MacKenzie (1995)	N = 432 (84% of eligible youth, 78% screened youth, 74% approached youth)	Social support & social networks: <u>Social Support Questionnaire</u> Stress: <u>Major Life Events Scale</u> Subjective health status: <u>General Health Survey</u> Symptoms of depression: <u>Centre for Epidemiological Studies Depression Scale</u> Alcohol and other drug abuse disorders: <u>Substance Abuse Module</u>	stressful events associated positively w/ depression, substance use, and poor physical health social support decreased risk of depression and poor health 64% met DSM-III criteria for clinical depression
Kipke, Montgomery, Simon, & Iversen (1997)	584 Ss screened of 584, 29 (5%) refused screening 26 (5%) didn't meet age criteria 14 (3%) didn't meet homeless criteria of remaining 515 Ss, 83 (16%) refused	Self-esteem: <u>Rosenberg Self-Esteem Scale</u> ADHD: <u>Adolescent Diagnostic Interview</u> Suicidality: <u>Diagnostic Interview Schedule for Children</u> Self-injurious behaviours: 1 yes/no question exposure to and involvement in violence: structured interview	age associated with depressive symptoms and SIBs; hx of sexual abuse/assault assoc w/ increased risk of suicide, SIB risk factors for substance abuse: on street 1 yr or more, suicide, SIB, depressive symptoms, low self-esteem, and gender
Unger, Kipke, Simon, Montgomery, & Johnson (1997)	13 - 23 years; 73% male recruited from service (70%) and street sites (30%) in Los Angeles, CA paid \$10 for participation	Structured interview entitled: <u>Acquired Immunodeficiency Syndrome Evaluation of Street Outreach Project Street Intercept</u> To assess involvement in HIV risk-related sexual & drug use behaviours,	43% met DSM-III criteria for alcohol abuse disorder and drug abuse disorder, 12% - alcohol abuse disorder, 16% - drug abuse disorder
Unger, Kipke, Simon, Johnson, Montgomery, & Iversen (1998)			

Summary of Psychological Studies involving Homeless Adolescents

Kennedy (1991)	N = 100 (27% male) M = 16.3 years June 1/88 - July 1/89 San Francisco, CA	Descriptive study. Author-designed questions re: school, leaving home, sexuality, substance use, contact w/ social service agencies, familial abuse, mental health issues	youth at risk for emotional and psychological problems 53% reported physical abuse; 30% sexual abuse; 62% multiple abuse; 30% neglect drug use, suicidal ideation
Koopman, Rosario, & Rotheram-Borus (1994)	302 runaway youth in 4 shelters (8 refusals) 154 males; 148 females (11-19 years) recruited 48 hrs after arrival at shelter April/88 - May 91 New York City	Drug and alcohol use: <u>Drug and Alcohol Use Survey for Adolescents</u> Sexual activity: <u>Sexual Risk Behaviour Assessment Schedule - Youth</u>	71% reported alcohol use 46% reported drug use 27% reported either drug or alcohol use during previous week 47% reported substance abuse 17% reported an addiction
Litrownik, Taussig, Landsverk, & Garland (1999)	295 youth entering an emergency shelter care facility 11 - 17 years	Intake interview: current and past history of risk behaviours, involvement with other systems - if endorsed, frequency of occurrence Social service record reviews	25% indicated a prior arrest 10.5% reported a psychiatric hospital admission 43.1% had received counselling
Maxwell (1992)	N = 27 (55% males) 13 - 17 years 2-week shelter for 12 youth St. Louis, MI	<u>Buss Durkee Hostility Inventory</u> <u>Beck Depression Inventory</u> <u>Coopersmith Self-Esteem Inventory</u>	shelter adolescents demonstrated greater hostility, greater depression, and lower self-esteem

Summary of Psychological Studies involving Homeless Adolescents

McCarthy & Hagan (1992)	390 homeless youth (260 male, 130 female) (62% in hostel, 23% on streets, 12% living w/ friends/relatives, 3% in hotel) Toronto, Ontario	author-designed 26-page questionnaire, based on questions and measures used in previous studies of homelessness; assessed demographics, street experiences, behaviour, depression/demoralization, reading level	lack of permanent shelter, stable food source, close friends, regular income, constant employment heavy drug use (53%), criminal activity (43%), incarceration (46%), suicide attempts (27%) females more likely to be depressed or attempted suicided; males more likely to have committed a theft or been jailed
Miner (1991)	N = 30 shelter youth N = 120 Ss living at home (control gp) 13 - 20 years Sydney, Australia	<u>Offer Self-Esteem Inventory</u> <u>Questionnaire</u> <u>Beck Depression Inventory</u> <u>Rotter's Locus of Control</u> <u>Hopelessness Scale</u>	homeless youth exhibited impaired self-esteem & demonstrated significant impairments in self-concept across areas of personal, social, and family self

Summary of Psychological Studies involving Homeless Adolescents

Radford, King, & Warren (1989)	N = 712 street youth (15 - 20 yrs old) From: Toronto, Montreal, Vancouver, Winnipeg, Edmonton, Halifax, Ottawa, St. John's, Saskatoon, Kenora Three comparison groups: Gr. 11 students; Dropouts; and First-year college/university students	Canada Youth and AIDS Study <u>Questionnaire</u> : knowledge, attitudes, and behaviours regarding AIDS and other STDs	Street youth characterized by: high prevalence of substance-use; high-risk sexual behaviours, AIDS; high school drop-out rates; poor relationships with parents; emotional problems; suicidal thoughts/attempts; childhood abuse
Robertson, Koegel, & Ferguson (1989)	N = 93 (4 refusals) recruited from 30 service & street sites 13 - 17 years (61.3% male) May - July/87 Hollywood, CA	<u>Homeless Adolescent Interview Schedule</u> : Author-designed survey designed to assess substance use, mental and physical health, homelessness history, family and social history, criminal history, victimization Alcohol use and abuse: <u>Diagnostic Interview Schedule</u>	48.4% met DSM-III criteria for alcohol abuse disorder 57.1% met DSM-III criteria for both alcohol and drug abuse disorders 26% of sample met DSM-III criteria for clinical depression
Rotheram-Borus (1993)	576 black and Hispanic shelter youth 4 runaway shelters New York City, over 2-years	structured interview format to assess suicidal behaviour and suicide-related risk-factors (6 domains: current suicidality, history of suicidality, depression, conduct problems, alcohol and drug abuse, family and peer suicide	37% had previous suicide attempts 44% had attempted in 1 month before study males less likely to have attempted suicide and be depressed than girls

Summary of Psychological Studies involving Homeless Adolescents

Shaffer & Caton (1984)	N = 118 youth 12 - 17 years New York City	depression, mood and conduct disorders Comprehensive interview to assess demographics, housing status, definitional issues, psychological and social problems, service needs	depression, suicidal thoughts & attempts common females: mood disorder symptoms males: conduct disorder symptoms ½ of youth reported physical abuse 3/5 had parent w/ hx of drug or alcohol abuse, criminality
Simmons & Weinman (1991)	N = 163 (117 girls; 46 boys) 9 - 17 years $\bar{M} = 13.35$; $SD = 1.95$ in shelter due to abuse, family problems Houston, TX	Nowicki-Strickland Locus of Control (to assess degree of external versus internal control) Offer Self-Image Questionnaire (assesses adjustment in 11 domains) Coopersmith's Self-Esteem Inventory (measure of self-esteem)	youth scored below standard norms on all 11 sub-scales of self-image questionnaire below 20 th percentile on self-esteem
Smart & Adlaf (1991)	n = 145 street youth n = 199 students who reported never running away from home or being kicked out of home Feb. - Mar./90; Toronto, Ont.	Author-designed questionnaire to assess: service utilization, life situation/history, well-being (self-esteem, depression, perceived health), alcohol use and problems, drug use and problems, and demographics	alcohol and drug consumption was 3 times greater among street youth one-third showed high levels of depression half reported at least one prior suicide attempt

Summary of Psychological Studies Involving Homeless Adolescents

Smart, Adlaf, Walsh, & Zdanowicz (1994)	217 street youth (152 "agency" youth; 65 street youth) Toronto, Ont,	Drug use: author-designed questions Alcohol use: <u>CAGE Questionnaire</u> Depressive symptoms: <u>Centre for Epidemiological Studies Depression Scale</u> Question on perceived health	street youth: clinical levels of alcohol abuse; high rates of drug use; poor health no difference in depression b/w street & runaway youth
Smart & Ogborne (1994)	N = 11 substance abuse treatment programs throughout Ontario 847 cases between 12 - 24 years (261 cases classified as street youth; 586 cases classified as non-street youth)	study-specific assessment instrument - consisted of substance use section and questions concerning range of psychosocial issues (street characteristics, employment status, welfare, legal situation, service utilization, family/social relationships, referral process, abuse history, psychological problems)	street youth had a larger number of social and drug abuse problems than did non-street youth street youth more likely to be unemployed, on welfare, and have legal problems; more depression, lower self-esteem, more use of alcohol and drugs
Smart & Walsh (1993)	N = 108 (from 11 agencies) N = 37 street youth 13 - 24 years (64% males) (41% from 16-18; 42% from 19 - 21) Toronto, Ont.: 6 week period from Feb. to March	Depressive symptoms: <u>Centre for Epidemiological Studies Depression Scale</u> Social Support: author-designed items Self-esteem: <u>Rosenberg Self-Esteem Inventory</u> Drug use: author-designed items + Drug Abuse Screening Test items Alcohol use: <u>CAGE Questionnaire</u> Family instability: author-designed items	best predictors of depression were self-esteem and length of time spent in a hostel no reln b/w depression and any of alcohol or drug-use variables high depression if parents' drug use caused youth to leave home

Summary of Psychological Studies involving Homeless Adolescents

Stiffman (1989)	291 youth in runaway shelters (84 males, 207 females) 12 - 18 years Sept./85 to Feb./87 St. Louis, MI	Behaviour: <u>Child Behaviour Checklist</u> Depression: <u>Beck Depression Inventory</u> Stressful life events: <u>Adolescent Life Change Event Questionnaire</u> Social skill: <u>Social Anxiety Inventory</u> Mastery: <u>Pearlin Mastery Scale</u> Self-esteem: <u>Rosenberg Self-Esteem Scale</u>	30% reported past suicide attempts suicide attempters had more behavioural and mental health problems than non-attempters
Teare, Smith, Osgood, Peterson, Authier, & Daly (1995)	N = 455 males 10 - 18 years July/91 to Oct./92 Grand Island, Nebraska	Observational data collection schedule: monitored # of youth residing in shelter, average length of stay, & # of behaviour problems occurring on daily basis	# of youth in the shelter and the proportion of youth who had resided longer than 14 days was significantly associated w/ behaviour problems
van der Ploeg (1989)	N = 212 (basic data) of 212, 86 participated in comprehensive interview 13 - 20 years (27% female) Amsterdam, Holland	Author-designed comprehensive interview to assess 5 dimensions/subjects: Negative family backgrounds History of professional help Negative experiences at school Few friends Low self-perception, personality issues	Family: 73% had divorced parents; 70% had rare contact with dads; 60% had rare contact with moms <u>Professional help</u> : 79% had been in residential care; 21% in foster care <u>School</u> : 36% experienced school as negative; 22% regularly truant <u>Friends</u> : 15% had friends lasting 1+ year; 11% had no friends; 66% had 4+ friends

Summary of Psychological Studies involving Homeless Adolescents

Yoder (1999)	N = 527 homeless youth suicide attempts (n = 128) suicide ideators (n = 157) non-suicidal youth (n = 242)	Sociodemographic factors: gender, race, sexual orientation, age Family factors: alcohol/drug problems, physical abuse, emotional problems, sexual abuse Street factors: physical victimization, sexual victimization Peer factors: friend attempted, completed Externalizing behaviour: alcohol & drug abuse, externalization Internalizing behaviour: self-esteem, depression	attempters are more likely than ideators and non-suicidal youth to have been physically or sexually abused, been sexually victimized, had friend who attempted suicide self-esteem, depression, physical abuse, sexual abuse, and a friend who attempted suicide distinguished 3 groups
Zide & Cherry (1992)	N = 262 (63% male) (186 living in shelter, 75 on street) less than 10% refusal rate 11 - 21 years South Florida	To propose a typology of homeless youth testing an empirically based definition of homelessness To distinguish subgroups, use of "social bond" scales (i.e., school bond, mother, father, religion, primary motive, individual, assertion, minor deviance, criminal history, drug use)	4-group typology: "running to" "running away" "thrown out or away" "forsaken"

Appendix B

Summary of Stress and Coping Studies in Adolescents**Studies of Stress and Coping in Adolescents**

Authors & Year	Sample Descriptives	Constructs & Measures	Results
Adams, Overholser, & Spirito (1994)	adolescent inpatients who attempted suicide (n = 91) high school students (n = 155) 12 - 17 years	Adolescent Life Events Survey Reynold's Adolescent Depression Scale Hopelessness Scale for Children Suicide Ideation Questionnaire	adolescents who attempted suicide reported elevated levels of major negative events and exit events chronic strains and discrete stressors were related to an increased severity of depression and suicidal ideation
Ayerst (1999)	27 street youth (12 - 25 years) 27 high school youth ("non-runaways") (16-25 years)	Depression: <u>Centre for Epidemiological Studies of Depression Scale</u> Self-esteem: <u>Rosenberg Self-Esteem Scale (portions of)</u> Coping methods - author identified/selected from literature Stress: <u>Adolescent Life Stress Scale</u>	street youth had higher mean level of depression and higher # of stressors in past year stress and depression were positively correlated street youth used less positive coping strategies

Studies of Stress and Coping in Adolescents

Barron & Yoest (1994)	N = 130 males (81% participation rate) 15 - 19 years	Emotional Distress: <u>Personal Stress Inventory</u> Affective- and Problem-Oriented Coping: <u>Jalowiec Coping Scale</u>	Parent was the most frequently reported stressful relationship, followed by girlfriend Youth used more problem-oriented coping than affective-oriented coping Affective-oriented coping was a better predictor of emotional distress (56% of variance) than problem-oriented coping
Cohen, Burt, & Bjorck (1987)	N = 312 students (153 girls, 159 boys) M = 12.69 years	Life Events - Adolescents: <u>Junior High School Life Experiences Survey</u> Life Events - Parents: <u>Life Experiences Survey</u> Adolescents' Psychological Functioning: <u>State-Trait Anxiety Inventory for Children, Childhood Depression Inventory</u>	initial psychological functioning was significant predictor of youths' subsequent uncontrollable negative events adolescents' positive events served as a life-stress buffer longitudinally for anxiety and for girls' self-esteem
Compas, Howell, Phares, Williams, & Guinta (1989)	N = 309 adolescents (167 girls, 142 boys) 10 - 15 years	Adolescent stress: <u>Adolescent Perceived Events Scale</u> Emotional/behavioural problems: <u>Youth Self-Report Form, Child Behaviour Checklist</u> Parental stress: <u>Hassles Scale</u> Parental symptoms: <u>Symptom Checklist 90 - Revised</u>	youths' self-reported emotional/behavioural problems were predicted by their reports of stressful events and their dads' reports of psychological symptoms moms' reports of childs' problems were predicted by moms' psychological symptoms

Studies of Stress and Coping in Adolescents

Compas, Malcarne, & Fondacaro (1988)	N = 130 children and adolescents 10 - 14 years 73 females; 57 males	Author-designed instrument to assess coping with self-identified recent stressful events Child/Adolescent Behaviour Problems: <u>Child Behaviour Checklist</u> , <u>Youth Self-Report Form</u>	problem-focused strategies negatively related to emotional & behavioural problems; emotion-focused strategies positively related to emotional & behavioural problems problem and emotion focussed coping used in response to both academic & interpersonal stress
Compas, Orosan, & Grant (1993)	summary of authors' previous findings regarding the relation between stressful experiences and psychopathology during adolescence review of studies on developmental patterns in coping during adolescence	Measures cited in studies: <u>Child Behaviour Checklist</u> <u>Youth Self-Report Form</u> <u>Hopkins Symptom Checklist</u> <u>Life Events Questionnaire</u> <u>Symptom Checklist 90 - Revised</u> <u>Social Support Questionnaire</u> <u>Ways of Coping Checklist</u>	stressful events predicted by increase in depressive symptoms, syndromes & disorders over time stressful events (both major and minor magnitude) predictive of subsequent internalizing and externalizing behaviour problems in late childhood and early adolescence during adolescence, emotion-focussed coping is acquired & usage increased females tend to use more emotionally attentive or ruminative strategies; males use emotion-distraction coping

Studies of Stress and Coping in Adolescents

Daniels & Moos (1990)	N = 190 youth 49 youth w/ depression 58 youth w/ conduct disorder 38 healthy youth 12 - 18 years	Author-designed instrument: <u>Life Stressors and Social Resources Inventory - Youth Form</u> (Indices of Stressors, Indices of Resources, Depression)	depressed youth reported more acute and chronic stressors and fewer social resources than did healthy youth indices were associated with individual differences in depressed mood, anxiety, behaviour problems, and self- confidence negative life events, ongoing stressors in different domains, and stable social resources contributed to functioning
D'Elio, O'Brien, Iannotti, Bush, & Galper (1996)	N = 303 4 th and 5 th graders (152 males, 151 females) <u>M</u> = 10.9 years	Author-designed life stress measures Abusable Substance Locus of Control Scale Author-designed substance use measure	Controllable life stress, both the amount of stress experienced and the stressor's reported impact, was positively related to substance use
de Man, Leduc, & Labreche-Gauthier (1993)	Adolescent males (n = 272) Adolescent females (n = 286) (<u>M</u> = 14.0, <u>SD</u> = 1.46)	Scale for Suicidal Ideation Self-Esteem Scale Locus of Control Scale Beck Depression Inventory Life Experiences Survey Autonomy-Control Scale	suicidal ideation was positively related to depression, negative stress, and drug and alcohol use; negatively related to self-esteem, satisfaction with social support, and school absenteeism

Studies of Stress and Coping in Adolescents

Patterson & McCubbin (1987)	Three samples: 1) N = 30 (10 th , 11 th , and 12 th grade males and females) 2) N = 467 junior and senior high school students 185 males; 241 females <u>M</u> = 15.6 years 3) N = 709 adolescents in a study to assess influence of family variables on youths' substance use (11 - 18 years)	Coping: <u>Adolescent Coping Orientation for Problem Experiences</u>	adolescent coping behaviour can be validly assessed from the perspective that adolescent coping is often directed at multiple demands and coping need not only be considered stressor-specific coping behaviours do cluster into patterns of coping females report more frequent use of a broader range of coping patterns than males Social context and family are influential in the learning and use of coping behaviours
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Appendix C

Impact of Stress, Coping Style, Social Support and Self-Esteem on the Psychological Adjustment of Homeless Adolescent Males

Study Description and Parental Consent Form

The purpose of this study is to find out about some of the prior and current life events of adolescents, how they have coped with some of the stressful experiences they have had, and their current adjustment status.

Your son/daughter, _____ (please print), has been invited to participate in an interview which will take approximately 60 - 90 minutes. The interviewer will ask demographic questions about your child's background and will ask him/her to complete questionnaires about their past experiences, how they coped with them, and their current adjustment. Although your child's participation in this study is voluntary, only those students for whom we have obtained parental consent will be permitted to participate. Your child can choose not to answer some questions and/or withdraw at any time during the interview, and will not be sanctioned should he/she choose not to participate in the study. Participating youth will be given the option of completing the questionnaire package independently or having them read to them by the interviewer in a private room at the school. Youth wishing to complete the questionnaires independently will do so in a group setting, during class time. Scheduling of the interview will be at the teacher's convenience to minimize interference with daily routine. A small amount of discomfort may be associated with some of the questions. At the end of the interview, your child will be given a debriefing form with the name and contact numbers of the closest community health centres which provide mental health and crisis services.

All the information collected in the interviews will remain strictly confidential and will be used for research purposes only; data will be used to compare the responses of different groups of adolescents. All of the questionnaires completed will be identified only by a number code and will not appear in any school records. The information will be seen only by members of the research team, and will be kept in a locked filing cabinet belonging to the research team. In reporting findings, the research team will only discuss a summary of the results. Your child's identity will not be revealed without your written consent. However, there are three exceptions for which the law says the research team must share information with others, even if you do not agree. These exceptions are: (1) if your child tells the interviewer that he/she is in danger of harming him/herself or someone else; (2) if your child tells the interviewer about any possible child abuse; and (3) if there is ever a court case and a judge asks for the study's records.

A summary of the results will be available for you and/or your child to pick up at the school where the interview was conducted. Names will not be put on the summaries. The summary of the results is expected to be ready by December 2000.

Your child will be given a gift certificate redeemable at local restaurants for participating in this study (10\$ maximum value).

You may also contact the Chair of the Research Ethics Committee for information regarding participant's rights in research studies at 738-3272 (CHEO). This project has been approved by the Children's Hospital of Eastern Ontario Research Ethics Committee, Carleton University's Psychology Department Ethics Committee, the Ottawa-Carleton Research Advisory Committee, and by the principal of your child's school.

There are two copies of the consent form, one which you keep and one which you sign and return to the researchers to keep. If you have any questions or concerns about the study, you may call Ms. Votta or Dr. Manion at 738-3916 (CHEO).

Elizabeth Votta, M.Sc.
Doctoral Candidate, Psychology
Carleton University

Ian Manion, Ph.D., C.Psych.
Director, Mental Health Research
Children's Hospital of Eastern Ontario

By signing below I, _____ (please print), give my consent for my child to participate in this study.

Parent's Signature: _____

Date: _____

Appendix D

Impact of Stress, Coping Style, Social Support, and Self-Esteem on the Psychological Adjustment of Homeless Adolescent Males

Study Description and Participant Consent Form

The purpose of this study is to find out about some of the experiences that youth accessing emergency shelters and services have had, how they have coped with some of the stressful experiences they have had, and their current adjustment status.

I understand that the interview will take approximately 1 to 1.5 hours, and that I will meet with the research investigator in a private office here at this shelter/agency. I have been told that the interviewer will ask questions about my background and that I will be asked to complete questionnaires about my past experiences, how I coped with them, and my current adjustment. I understand that I can choose not to answer some questions and/or withdraw at any time during the interview. I have been told that my decision about whether or not to participate in the study will have no effect on the services that I receive here, now or in the future. I have been told that a small amount of discomfort may be associated with some of the questions, and that at the end of the interview, I will be given a debriefing form with the name and contact numbers of the closest community health centres which provide mental health and crisis services.

It was explained to me that all the information collected in the interviews will remain strictly confidential and will be used for research purposes only. All of the questionnaires completed will be identified only by a number code. The information will be seen only by members of the research team, and will be kept in a locked filing cabinet belonging to the research team. In reporting findings, I have been told that the research team will only discuss a summary of the results. My identity will not be revealed without my written consent. However, there are three exceptions for which the law says the research team must share information with others, even if I do not agree. These exceptions are: (1) if I tell the interviewer that I am in danger of harming myself or someone else; (2) if I tell the interviewer about any possible child abuse; and (3) if there is ever a court case and a judge asks for the study's records.

I have been told that a summary of the results will be available for me to pick up at the emergency shelters or community agency where I have been interviewed. Names will not be put on the summaries and I am welcome to take one when they are available. We expect the summary of the results will be ready by December 2000.

I will be given a gift certificate redeemable at local restaurants for participating in this study.

You may also contact the Chair of the Research Ethics Committee for information regarding patient's rights in research studies at 738-3272 (CHEO).

There are two copies of the consent form, one which the researchers keep and one which I keep. If I have any questions or concerns about the study, I can call Ms. Votta or Dr. Manion at 738-3916 (CHEO). By signing below, I agree to participate in this study.

Participant's Signature: _____ Date: _____

I have explained this study to the participant and I am satisfied that it is understood.

Researcher's Signature: _____ Date: _____

Appendix E

Impact of Stress, Coping Style, Social Support, and Self-Esteem on the Psychological Adjustment of Homeless Adolescent Males

Debriefing Form

Thank you for taking the time to be a part of our study! We really appreciate your time and effort. We developed this study to look at some of the experiences in youths' lives and to see how they related to the experience of being homeless. We are also interested in finding out more about how youth cope with and adjust to their experiences, so that services can be developed in the future to help youth deal with some of the challenges or problems in their life.

The results will be shared with some of the service directors of the youth agencies, in summary form - your identity will never be revealed. We will have a summary of the results available at the place where you were interviewed, and you can ask the shelter director for a copy of the report. If you have any further questions about the study, please call Elizabeth Votta or Dr. Ian Manion at 737-8916 (CHEO).

If you are feeling distressed, uncomfortable, or like you need to talk to someone about the things that you discussed in the study today, please contact the Sandy Hill Community Health Centre (221 Nelson St., 789-7752 or 239-4006 after hours) or call the Distress Centre (238-3311).

Appendix F

PARTICIPANT DEMOGRAPHIC FORM (Group 1)

NAME: _____ SUBJECT #: _____

INTERVIEWER: _____ DATE: ____/____/____
dd mm yySUBJECT #: _____ GRP: ☐ 1 ADMIN METHOD: ☐ Read
☐ 2 ☐ Independent
☐ 3GENDER: ☐ Male AGE: _____ DOB: ____/____/____
dd mm yy**INTERVIEW RE-SCHEDULED DUE TO SUBSTANCE USE:**☐ Yes 1st Interview Date (dd/mm/yy): ____/____/____
2nd Interview Date (dd/mm/yy): ____/____/____
☐ No**REFERRAL SOURCE TO SHELTER/AGENCY: (1st and 2nd referral source)**☐ Self ☐ CAS worker ☐ School
☐ Parents ☐ YSB worker ☐ Welfare worker
☐ Relatives ☐ YMCA ☐ Social worker
☐ Friends ☐ Police ☐ Other (specify: _____)**DEMOGRAPHIC INFORMATION:****Resident's citizenship status**☐ Canadian citizen ☐ Landed immigrant
☐ Refugee ☐ Other (specify: _____)**Preferred language for communication**☐ English ☐ Bilingual - French first language
☐ French ☐ Bilingual - English first language
☐ Other (specify: _____)**Length of time in Ottawa-Carleton region**☐ Since birth
☐ More than 1 year (specify: _____)
☐ Less than 1 year (specify: _____)

EMPLOYMENT & INCOME SOURCES:

Current employment status

- ☐ Unemployed ☐ Casual work ☐ Working part-time
☐ Working full-time ☐ Other (specify: _____)

If currently employed, type of work: _____

Current source of income

- ☐ GWA ☐ Parent(s) ☐ Employment income
☐ FBA ☐ Relative(s) ☐ Panhandling
☐ CAS ☐ Partner ☐ Prostitution
☐ Friends ☐ Squeegy-ing ☐ None
☐ Other (specify: _____)

EDUCATION:

Highest level of education completed

- ☐ Less than Grade 7 ☐ Grade 9 ☐ Grade 12
☐ Grade 7 ☐ Grade 10 ☐ Grade 13
☐ Grade 8 ☐ Grade 11 ☐ Other (specify: _____)

Current educational status

- ☐ Still attending school - Full-time ☐ Dropped out of school
☐ Still attending school - Part-time ☐ Expelled from school
☐ Graduated ☐ Dropped out + Expelled (mutual)
☐ Other (specify: _____)

Type of schooling

- ☐ Mainstream ☐ Mainstream + supports
☐ Alternative ☐ Night school
☐ Correspondence ☐ Home tutoring
☐ Dropped out ☐ Other (specify: _____)

Educational difficulties

- Failed a grade: ☐ Yes (specify: _____)
 ☐ No

- Failed a course: ☐ Yes (specify #: _____)
 ☐ No

FAMILY STRUCTURE & CAS INVOLVEMENT:

Family structure(s) in which youth raised? (Present or most recent)

☐ Both biological parents	☐ Biological mother only
☐ Adoptive parents	☐ Biological father only
☐ Foster parents	☐ Biological mother and partner/step-father
☐ Group home	☐ Biological father and partner/step-mother
☐ Other (specify: _____)	

If mother (☐) or father (☐) deceased, youth's age at time of parent's death: _____**Parent marital status**

<u>Mother:</u>	☐ Presently married	<u>Father:</u>	☐ Presently married
	☐ Never married		☐ Never married
	☐ Separated / Divorce		☐ Separated / Divorce
	☐ Re-married		☐ Re-married
	☐ Other _____		☐ Other _____

Parent employment status

<u>Mother:</u>	☐ Unemployed	<u>Father:</u>	☐ Unemployed
	☐ Casual work		☐ Casual work
	☐ Working full-time		☐ Working full-time
	☐ Working part-time		☐ Working part-time
	☐ Unknown		☐ Unknown

Parent education status

<u>Mother:</u>	☐ Grade 1 - 8	<u>Father:</u>	☐ Grade 1 - 8
	☐ Grade 9 - 12		☐ Grade 9 - 12
	☐ Graduated high school		☐ Graduated high school
	☐ College or University		☐ College or University
	☐ Vocation/Technical		☐ Vocational/Technical
	☐ Unknown		☐ Unknown

Siblings: Number: _____ Age(s): _____

Services from Children's Aid Society or other Child Welfare Agency?

- ☐ No
- Yes, in the past:**
☐ Care by agreement (temporary)	☐ Crown ward (CAS ward until terminated)
☐ Family Counselling/Counselling	☐ Society ward (CAS ward for specific period)
- Yes, currently:**
☐ Care by agreement (temporary)	☐ Crown ward (CAS ward until terminated)
☐ Family Counselling/Counselling	☐ Society ward (CAS ward for specific period)

HEALTH STATUS:

Physical health issues (e.g., allergies, illnesses - asthma, diabetes)

☐ No☐ Yes (specify: _____)

Mental health issues (e.g., ADHD, depression) identified by health practitioner

☐ No☐ Yes (specify: _____)

Mental health professional involvement (check all that apply)

Past Present☐ ☐ Psychologist/Psychiatrist☐ ☐ Social Worker☐ ☐ Counsellor/Therapist

Suicide history

Thoughts: ☐ never ☐ in lifetime? ☐ in last 3 months?Attempts: ☐ never ☐ yes (#__)

Substance use

☐ Never☐ Drugs Frequency of use: _____
Types: _____☐ Alcohol Frequency of use: _____☐ Cigarettes Frequency of use: _____

Legal problems:

☐ None☐ Currently on probation☐ Impending court dates☐ Prior arrests (specify #: _____)☐ Other: _____**SERVICE UTILIZATION:**

Use of youth services in last 2 months (check as many as apply)

☐ Emergency Shelter☐ Operation Go Home☐ Youth Services Bureau☐ YMCA/YWCA☐ Sandy Hill Community Health Centre☐ Rideau Street Youth Enterprises☐ Children's Hospital of Eastern Ontario☐ Youth Net / Reseau Ado☐ Children's Aid Society☐ Canadian Mental Health Association☐ Royal Ottawa Hospital☐ School Guidance Counsellor☐ Welfare Worker☐ Social Worker☐ Police☐ Rideauwood Addictions Services☐ Pink Triangle☐ Oasis☐ Housing Help☐ Other: _____

LIVING SITUATION:

Length of time away from home _____

Current episode: Length of time away: _____

Reason: _____

Current living arrangement: _____

Past episodes: # (of times away from home): _____

Age (when first left home): _____

Date (mth/yr) of 1st episode: _____

Longest time away: _____

Shelter use: ☐ No☐ Yes: Length of time away: _____

When: _____

Date (mth/yr) of 1st shelter stay: _____

Living environment/arrangement in last 2 months (check as many as apply)

☐ Street	☐ Parental home
☐ Rooming house	☐ Another shelter
☐ Relative's home	☐ Alone in own apartment
☐ Friend's home	☐ CAS home
☐ YMCA/YWCA	☐ Semi-Independent Living Program
☐ YSB Housing Program	☐ Shared a place with friends
☐ Shared a place with partner	

Reasons for leaving home (check all that apply; rank checked items - 1 is main reason)

Y/N Rank

- ☐ _____ Abuse (☐ physical; ☐ verbal/emotional; ☐ sexual)
- ☐ _____ Fights and arguments with parents/guardians
- ☐ _____ Did not agree with family rules
- ☐ _____ Witnessing family violence (e.g., fights between parents/guardians)
- ☐ _____ Witnessing parents'/guardians' substance abuse (☐ drugs; ☐ alcohol)
- ☐ _____ Forced to leave home by parents/guardians
- ☐ _____ Cultural conflict between oneself and parents/guardians
- ☐ _____ Financially, parents could not afford to support youth
- ☐ _____ Resident has left a CAS home
- ☐ _____ Other (specify: _____)

Reasons for coming to shelter

☐ Left home	☐ Home not open (e.g., asked to leave)
☐ Evicted from apartment/room	☐ Travelling
☐ Conflict with roommate	☐ Court referral/placement
☐ CAS placement	☐ Wants to get on GWA
☐ Other (specify: _____)	

Appendix G

PARTICIPANT DEMOGRAPHIC FORM (Group 2)

NAME: _____ SUBJECT #: _____

INTERVIEWER: _____ DATE: ____/____/____
dd mm yySUBJECT #: _____ GRP: ☐ 1 ☐ 2 ☐ 3 ADMIN METHOD: ☐ Read ☐ IndependentGENDER: ☐ Male AGE: _____ DOB: ____/____/____
dd mm yy**INTERVIEW RE-SCHEDULED DUE TO SUBSTANCE USE:**☐ Yes 1st Interview Date (dd/mm/yy): ____/____/____
2nd Interview Date (dd/mm/yy): ____/____/____
☐ No**REFERRAL SOURCE TO SHELTER/AGENCY: (1st and 2nd referral source)**☐ Self ☐ CAS worker ☐ School
☐ Parents ☐ YSB worker ☐ Welfare worker
☐ Relatives ☐ YMCA ☐ Social worker
☐ Friends ☐ Police ☐ Other (specify: _____)**DEMOGRAPHIC INFORMATION:****Resident's citizenship status**☐ Canadian citizen ☐ Landed immigrant
☐ Refugee ☐ Other (specify: _____)**Preferred language for communication**☐ English ☐ Bilingual - French first language
☐ French ☐ Bilingual - English first language
☐ Other (specify: _____)**Length of time in Ottawa-Carleton region**☐ Since birth
☐ More than 1 year (specify: _____)
☐ Less than 1 year (specify: _____)

EMPLOYMENT & INCOME SOURCES:

Current employment status

- ☐ Unemployed ☐ Casual work ☐ Working part-time
☐ Working full-time ☐ Other (specify: _____)

If currently employed, type of work: _____

Current source of income

- ☐ GWA ☐ Parent(s) ☐ Employment income
☐ FBA ☐ Relative(s) ☐ Panhandling
☐ CAS ☐ Partner ☐ Prostitution
☐ Friends ☐ Squeegy-ing ☐ None
☐ Other (specify: _____)

EDUCATION:

Highest level of education completed

- ☐ Less than Grade 7 ☐ Grade 9 ☐ Grade 12
☐ Grade 7 ☐ Grade 10 ☐ Grade 13
☐ Grade 8 ☐ Grade 11 ☐ Other (specify: _____)

Current educational status

- ☐ Still attending school - Full-time ☐ Dropped out of school
☐ Still attending school - Part-time ☐ Expelled from school
☐ Graduated ☐ Dropped out + Expelled (mutual)
☐ Other (specify: _____)

Type of schooling

- ☐ Mainstream ☐ Mainstream + supports
☐ Alternative ☐ Night school
☐ Correspondence ☐ Home tutoring
☐ Dropped out ☐ Other (specify: _____)

Educational difficulties

- Failed a grade: ☐ Yes (specify: _____)
 ☐ No

- Failed a course: ☐ Yes (specify #: _____)
 ☐ No

FAMILY STRUCTURE & CAS INVOLVEMENT:

Family structure(s) in which youth raised? (Present or most recent)

☐ Both biological parents	☐ Biological mother only
☐ Adoptive parents	☐ Biological father only
☐ Foster parents	☐ Biological mother and partner/step-father
☐ Group home	☐ Biological father and partner/step-mother
☐ Other (specify: _____)	

If mother (☐) or father (☐) deceased, youth's age at time of parent's death: _____**Parent marital status**

<u>Mother:</u>	☐ Presently married	<u>Father:</u>	☐ Presently married
	☐ Never married		☐ Never married
	☐ Separated / Divorce		☐ Separated / Divorce
	☐ Re-married		☐ Re-married
	☐ Other _____		☐ Other _____

Parent employment status

<u>Mother:</u>	☐ Unemployed	<u>Father:</u>	☐ Unemployed
	☐ Casual work		☐ Casual work
	☐ Working full-time		☐ Working full-time
	☐ Working part-time		☐ Working part-time
	☐ Unknown		☐ Unknown

Parent education status

<u>Mother:</u>	☐ Grade 1 - 8	<u>Father:</u>	☐ Grade 1 - 8
	☐ Grade 9 - 12		☐ Grade 9 - 12
	☐ Graduated high school		☐ Graduated high school
	☐ College or University		☐ College or University
	☐ Vocation/Technical		☐ Vocational/Technical
	☐ Unknown		☐ Unknown

Siblings: Number: _____ Age(s): _____

Services from Children's Aid Society or other Child Welfare Agency?

- ☐ No
- Yes, in the past:**
☐ Care by agreement (temporary)	☐ Crown ward (CAS ward until terminated)
☐ Family Counselling/Counselling	☐ Society ward (CAS ward for specific period)
- Yes, currently:**
☐ Care by agreement (temporary)	☐ Crown ward (CAS ward until terminated)
☐ Family Counselling/Counselling	☐ Society ward (CAS ward for specific period)

HEALTH STATUS:

Physical health issues (e.g., allergies, illnesses - asthma, diabetes)

- ☐ No
- ☐ Yes (specify: _____)

Mental health issues (e.g., ADHD, depression) identified by health practitioner

- ☐ No
- ☐ Yes (specify: _____)

Mental health professional involvement (check all that apply)

Past Present

- ☐ ☐ Psychologist/Psychiatrist
- ☐ ☐ Social Worker
- ☐ ☐ Counsellor/Therapist

Suicide history

- Thoughts: ☐ never ☐ in lifetime? ☐ in last 3 months?
- Attempts: ☐ never ☐ yes (#__)

Substance use

- ☐ Never
- ☐ Drugs Frequency of use: _____
Types: _____
- ☐ Alcohol Frequency of use: _____
- ☐ Cigarettes Frequency of use: _____

Legal problems:

- ☐ None ☐ Currently on probation
- ☐ Impending court dates ☐ Prior arrests (specify #: _____)
- ☐ Other: _____

SERVICE UTILIZATION:

Use of youth services in last 2 months (check as many as apply)

☐ Emergency Shelter	☐ Operation Go Home
☐ Youth Services Bureau	☐ YMCA/YWCA
☐ Sandy Hill Community Health Centre	☐ Rideau Street Youth Enterprises
☐ Children's Hospital of Eastern Ontario	☐ Youth Net / Reseau Ado
☐ Children's Aid Society	☐ Canadian Mental Health Association
☐ Royal Ottawa Hospital	☐ School Guidance Counsellor
☐ Welfare Worker	☐ Social Worker
☐ Police	☐ Rideauwood Addictions Services
☐ Pink Triangle	☐ Oasis
☐ Housing Help	☐ Other: _____

Appendix H

PARTICIPANT DEMOGRAPHIC FORM (Group 3)

NAME: _____ SUBJECT #: _____

INTERVIEWER: _____ DATE: ____/____/____
dd mm yySUBJECT #: _____ GRP: ☐ 1 ☐ 2 ☐ 3 ADMIN METHOD: ☐ Read ☐ IndependentGENDER: ☐ Male AGE: _____ DOB: ____/____/____
dd mm yy**DEMOGRAPHIC INFORMATION:**

Participant's citizenship status

☐ Canadian citizen ☐ Landed immigrant
☐ Refugee ☐ Other (specify: _____)

Preferred language for communication

☐ English ☐ Bilingual - French first language
☐ French ☐ Bilingual - English first language
☐ Other (specify: _____)

Length of time in Ottawa-Carleton region

☐ Since birth
☐ More than 1 year (specify: _____)
☐ Less than 1 year (specify: _____)**EMPLOYMENT STATUS:**

Current employment status

☐ Unemployed ☐ Casual work ☐ Working part-time
☐ Working full-time ☐ Other (specify: _____)

If currently employed, type of work: _____

EDUCATION:

Participant's current grade: _____

Educational difficultiesFailed a grade: ☐ Yes (specify: _____) ☐ NoFailed a course: ☐ Yes (specify #: _____) ☐ No**FAMILY STRUCTURE & CAS INVOLVEMENT:**

Family structure(s) in which youth raised? (Present or most recent)

☐ Both biological parents	☐ Biological mother only
☐ Adoptive parents	☐ Biological father only
☐ Foster parents	☐ Biological mother and partner/step-father
☐ Group home	☐ Biological father and partner/step-mother
☐ Other (specify: _____)	

If mother (☐) or father (☐) deceased, youth's age at time of parent's death: _____**Parent marital status**

<u>Mother:</u>	☐ Presently married	<u>Father:</u>	☐ Presently married
	☐ Never married		☐ Never married
	☐ Separated / Divorce		☐ Separated / Divorce
	☐ Re-married		☐ Re-married
	☐ Other _____		☐ Other _____

Parent employment status

<u>Mother:</u>	☐ Unemployed	<u>Father:</u>	☐ Unemployed
	☐ Casual work		☐ Casual work
	☐ Working full-time		☐ Working full-time
	☐ Working part-time		☐ Working part-time
	☐ Unknown		☐ Unknown

Parent education status

<u>Mother:</u>	☐ Grade 1 - 8	<u>Father:</u>	☐ Grade 1 - 8
	☐ Grade 9 - 12		☐ Grade 9 - 12
	☐ Graduated high school		☐ Graduated high school
	☐ College or University		☐ College or University
	☐ Vocation/Technical		☐ Vocational/Technical
	☐ Unknown		☐ Unknown

Services from Children's Aid Society or other Child Welfare Agency?

☐ No

Yes, in the past:

☐ Care by agreement (temporary)

☐ Crown ward (CAS ward until terminated)

☐ Family Counselling/Counselling

☐ Society ward (CAS ward for specific period)

Yes, currently:

☐ Care by agreement (temporary)

☐ Crown ward (CAS ward until terminated)

☐ Family Counselling/Counselling

☐ Society ward (CAS ward for specific period)

Siblings: Number: _____ Age(s): _____

HEALTH STATUS:

Physical health issues (e.g., allergies, illnesses - asthma, diabetes) .

☐ No

☐ Yes (specify: _____)

Mental health issues (e.g., ADHD, depression) identified by health practitioner

☐ No

☐ Yes (specify: _____)

Mental health professional involvement (check all that apply)

Past Present

☐ ☐ Psychologist/Psychiatrist

☐ ☐ Social Worker

☐ ☐ Counsellor/Therapist

☐ ☐ Other

SERVICE UTILIZATION:

Use of youth services in last 2 months (check as many as apply)

☐ Emergency Shelter

☐ Operation Go Home

☐ Youth Services Bureau

☐ YMCA/YWCA

☐ Sandy Hill Community Health Centre

☐ Rideau Street Youth Enterprises

☐ Children's Hospital of Eastern Ontario

☐ Youth Net / Reseau Ado

☐ Children's Aid Society

☐ Canadian Mental Health Association

☐ Royal Ottawa Hospital

☐ School Guidance Counsellor

☐ Welfare Worker

☐ Social Worker

☐ Police

☐ Rideauwood Addictions Services

☐ Pink Triangle

☐ Oasis

☐ Housing Help

☐ Other: _____

Appendix I

COPE INVENTORY

Instructions: We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Then respond to each of the following items by placing a number in the blank beside each item, using the response choices listed below. Please try to respond to each item separately in your mind from each other item. Choose your items thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. There are no “right” or “wrong” answers, so choose the most accurate answer for YOU – not what you think “most people” would say or do. Indicate what YOU usually do when YOU experience a stressful event.

**I usually don't
do this at all**

1

**I usually do
this a little bit**

2

**I usually do this
a medium amount**

3

**I usually do
this a lot**

4

- | | I usually don't
do this at all | I usually do
this a little bit | I usually do this
a medium amount | I usually do
this a lot |
|-----|---|---|--|------------------------------------|
| | 1 | 2 | 3 | 4 |
| 1. | _____ | | | |
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| 29. | _____ | | | |
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| 30. | _____ | | | |
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- | | I usually don't
do this at all | I usually do
this a little bit | I usually do this
a medium amount | I usually do
this a lot |
|-----|---|---|--|------------------------------------|
| | 1 | 2 | 3 | 4 |
| 31. | _____ | | | |
| | I sleep more than usual. | | | |
| 32. | _____ | | | |
| | I try to come up with a strategy about what to do. | | | |
| 33. | _____ | | | |
| | I focus on dealing with this problem, and if necessary let other things slide a little. | | | |
| 34. | _____ | | | |
| | I get sympathy and understanding from someone. | | | |
| 35. | _____ | | | |
| | I drink alcohol or take drugs, in order to think about it less. | | | |
| 36. | _____ | | | |
| | I kid around about it. | | | |
| 37. | _____ | | | |
| | I give up the attempt to get what I want. | | | |
| 38. | _____ | | | |
| | I look for something good in what is happening. | | | |
| 39. | _____ | | | |
| | I think about how I might best handle the problem. | | | |
| 40. | _____ | | | |
| | I pretend that it hasn't really happened. | | | |
| 41. | _____ | | | |
| | I make sure not to make matters worse by acting too soon. | | | |
| 42. | _____ | | | |
| | I try hard to prevent other things from interfering with my efforts at dealing with this. | | | |
| 43. | _____ | | | |
| | I go to movies or watch TV, to think about it less. | | | |
| 44. | _____ | | | |
| | I accept the reality of the fact that it happened. | | | |
| 45. | _____ | | | |
| | I ask people who have had similar experiences what they did. | | | |
| 46. | _____ | | | |
| | I feel a lot of emotional distress and I find myself expressing those feelings a lot. | | | |
| 47. | _____ | | | |
| | I take direct action to get around the problem. | | | |
| 48. | _____ | | | |
| | I try to find comfort in my religion. | | | |
| 49. | _____ | | | |
| | I force myself to wait for the right time to do something. | | | |
| 50. | _____ | | | |
| | I make fun of the situation. | | | |
| 51. | _____ | | | |
| | I reduce the amount of effort I'm putting into solving the problem. | | | |
| 52. | _____ | | | |
| | I talk to someone about how I feel. | | | |
| 53. | _____ | | | |
| | I use alcohol or drugs to help me get through it. | | | |
| 54. | _____ | | | |
| | I learn to live with it. | | | |
| 55. | _____ | | | |
| | I put aside other activities in order to concentrate on this. | | | |
| 56. | _____ | | | |
| | I think hard about what steps to take. | | | |
| 57. | _____ | | | |
| | I act as though it hasn't even happened. | | | |
| 58. | _____ | | | |
| | I do what has to be done, one step at a time. | | | |
| 59. | _____ | | | |
| | I learn something from the experience. | | | |
| 60. | _____ | | | |
| | I pray more than usual. | | | |

Appendix J

ADOLESCENT PERCEIVED EVENTS SCALE - REVISED**Instructions**

Frequency Rating: On the following pages is a list of events which may or may not have happened to you. Please read each item carefully. Using the scale below, please indicate how often the **EVENT HAS HAPPENED** to you in the past four months.

Never happened	Happened once in your life	Once a year	Several times per year	Once per month	Several times per month	Once per week	Several times per week	Happened once a day
1	2	3	4	5	6	7	8	9

Desirability Rating: For each event which has happened to you in the last four months, please fill in your rating of the desirability of the event (how good or bad it was when it happened). Good (desirable) events are ones which are pleasant or make us happy, whereas bad (undesirable) events are ones that upset us or make us feel scared, sad, or angry. Using the following numbers write down in the blank space marked **GOOD-BAD RATING** the number which best describes how desirable the event was when it happened to you.

Extremely bad	Very bad	Somewhat bad	Slightly bad	Neither good or bad	Slightly good	Somewhat good	Very good	Extremely good
-4	-3	-2	-1	0	+1	+2	+3	+4

Impact Rating: For each event which has happened to you in the past four months, please fill in your rating of the impact of the event (how much the event affected you). Using the following numbers, write down in the blank space marked **IMPACT** the number (from 0 - 9) which best describes the impact the event had on you.

No impact at all	Very low	Low	Moderately low	Slightly low	Slightly high	Moderately high	Very high	Extremely high impact
1	2	3	4	5	6	7	8	9

***** Note:** The above rating scales are each printed on the last page of this measure. You may tear off the page to assist you in responding to the items

**# of Times Event Has
Happened In Past 4 Months**

**Good-Bad Impact
Rating [1 - 9]**

1.	___	Hobbies or activities (TV, reading, playing an instrument)	___	___
2.	___	Doing things/spending time with family members	___	___
3.	___	Spending time/talking with boyfriend/girlfriend	___	___
4.	___	Marriage or becoming engaged	___	___
5.	___	Dating or doing things with people of opposite sex	___	___
6.	___	Feeling pressured by friends	___	___
7.	___	Family members, relatives, step-parents moving in/out of home...	___	___
8.	___	Helping other people	___	___
9.	___	Fight with or problems with a friend	___	___
10.	___	Restrictions at home (curfew)	___	___
11.	___	Death of a family member	___	___
12.	___	Family member becoming pregnant or having a child	___	___
13.	___	Attending school	___	___
14.	___	Hospitalization of a family member or relative	___	___
15.	___	Falling in love or beginning a relationship with boy/girlfriend	___	___
16.	___	Poor relationship between family members and friends	___	___
17.	___	Doing poorly on an exam or paper	___	___
18.	___	Talking about or sharing feelings with friends	___	___
19.	___	Being around people who are inconsiderate/offensive	___	___
20.	___	Arrest of a family member	___	___
21.	___	Getting in trouble or being suspended from school	___	___
22.	___	Hassles, arguments, or fights with other students or peers	___	___
23.	___	Financial troubles or money worries	___	___
24.	___	Getting bad grades or progress reports	___	___
25.	___	Having bad classes or teachers	___	___
26.	___	Emotional worries (feeling depressed, moody, angry, insecure) ...	___	___
27.	___	Going to church	___	___
28.	___	Meeting new people	___	___
29.	___	Parent getting remarried	___	___
30.	___	Friend getting engaged or married	___	___
31.	___	Friend getting separated or divorced	___	___
32.	___	Having few or no friends	___	___
33.	___	Arguments or fights between parents	___	___
34.	___	Getting good grades or progress reports	___	___
35.	___	Having good classes or teachers	___	___
36.	___	Drinking or drug use	___	___
37.	___	Understanding classes/homework	___	___
38.	___	Change in relationship with boy/girlfriend	___	___
39.	___	Change in relationship with family member(s)	___	___
40.	___	Change in relationship with friend(s)	___	___

**# of Times Event Has
Happened In Past 4 Months**

**Good-Bad Impact
Rating [1 - 9]**

41.	___	Pressures or expectations by parents	___	___
42.	___	Visiting a parent that doesn't live with you	___	___
43.	___	Having plans fall through (not going on a trip, etc.)	___	___
44.	___	Visiting with relatives	___	___
45.	___	Going to parties, dances, concerts	___	___
46.	___	Making love or sexual intercourse	___	___
47.	___	Friends getting drunk or drug use	___	___
48.	___	Not attending your high school prom	___	___
49.	___	Death of a relative	___	___
50.	___	Obligations at home	___	___
51.	___	Spending time alone	___	___
52.	___	Family member or relative having emotional problems	___	___
53.	___	Friend or family member recovering from illness or injury	___	___
54.	___	Arguments or problems with boy/girlfriend	___	___
55.	___	Something bad happens to a friend	___	___
56.	___	Change in privileges or responsibilities at home	___	___
57.	___	Change in health of a family member or relative	___	___
58.	___	Change in health of a friend	___	___
59.	___	Change in number of friends (make new friends or lose friends) ..	___	___
60.	___	Parents discover something you didn't want them to know	___	___
61.	___	Becoming (or making) pregnant or having a child	___	___
62.	___	Brother/sister getting engaged or married	___	___
63.	___	Brother/sister getting separated or divorced	___	___
64.	___	Not spending enough time with family members or friends	___	___
65.	___	School or career change of family member (drops out of school,
gets job, etc.)	___	___
66.	___	Advancing a year in school	___	___
67.	___	Living with only one parent	___	___
68.	___	Talking on the phone	___	___
69.	___	Discussion with parent(s)	___	___
70.	___	Homework or studying	___	___
71.	___	Taking care of younger brother(s)/sister(s)	___	___
72.	___	Change in birth control use	___	___
73.	___	Problems/arguments with parents, siblings, or family members ...	___	___
74.	___	Problems/arguments with teachers or principal	___	___
75.	___	Spending time at home	___	___
76.	___	Changes in alcohol or drug use	___	___
77.	___	Making honour roll or other school achievement	___	___
78.	___	Applying to/waiting to hear from colleges/universities	___	___
79.	___	Negative feelings or worry about appearances	___	___
80.	___	Negative feelings or worry about personal health or fitness	___	___

# of Times Event Has Happened In <u>Past 4 Months</u>		Good-Bad Impact Rating [1 - 9]	
81.	_____ Doing household chores	_____	_____
82.	_____ Something good happens to a friend	_____	_____
83.	_____ Alcohol or drug use of family members/relatives	_____	_____
84.	_____ Breaking up with or being rejected by boy/girlfriend	_____	_____
85.	_____ Death of a friend	_____	_____
86.	_____ Family move	_____	_____
87.	_____ Losing virginity	_____	_____
88.	_____ Parent loses job	_____	_____
89.	_____ Attending your high school prom	_____	_____
90.	_____ Returning to school after time off	_____	_____
91.	_____ Parents getting separated or divorced	_____	_____
92.	_____ Not getting along with parents of friends	_____	_____
93.	_____ Doing well on an exam or paper	_____	_____
94.	_____ Spending time/relaxing/going out with friends	_____	_____
95.	_____ Friend(s) move away or you move away from friends	_____	_____
96.	_____ Getting punished by parents	_____	_____
97.	_____ Being in love or having a relationship	_____	_____
98.	_____ Not having a boyfriend or girlfriend	_____	_____
99.	_____ Friend having emotional problems	_____	_____
100.	_____ Friend becoming pregnant or having a child	_____	_____
101.	_____ Death of significant other (e.g., lover, partner)	_____	_____
102.	_____ Serious illness or injury to self - no hospitalization	_____	_____
103.	_____ Serious illness or injury to significant other (e.g., lover, partner) ..	_____	_____
104.	_____ Hospitalized for physical illness or injury.....	_____	_____
105.	_____ Chronic health condition or disability (past or present)	_____	_____
106.	_____ Limited access to youth-friendly health care services	_____	_____
107.	_____ Attended counselling or therapy sessions	_____	_____
108.	_____ Family member admitted to mental health facility	_____	_____
109.	_____ Friend admitted to mental health facility	_____	_____
110.	_____ Admission to mental health facility	_____	_____
111.	_____ Suicidal thoughts (past or present)	_____	_____
112.	_____ Suicidal attempts	_____	_____
113.	_____ Self-destructive or injurious behaviours (e.g., cutting)	_____	_____
114.	_____ Family member who was victim of violence	_____	_____
115.	_____ Witness of violence or abuse (physical, sexual)	_____	_____

# of Times Event Has Happened In <u>Past 4 Months</u>		Good-Bad Impact Rating [1 - 9]	
116.	_____ Victim of violence or abuse (physical, sexual)	_____	_____
117.	_____ Robbed or burglarized	_____	_____
118.	_____ Victim of discrimination on street	_____	_____
119.	_____ Partner had miscarriage	_____	_____
120.	_____ Partner had abortion	_____	_____
121.	_____ Sexually transmitted disease	_____	_____
122.	_____ Prostitution	_____	_____
123.	_____ Disclosure of homosexual lifestyle to parent(s), sibling(s)	_____	_____
124.	_____ Disclosure of homosexual lifestyle to friend(s)	_____	_____
125.	_____ Being ridiculed because of homosexual lifestyle	_____	_____
126.	_____ Limited employment opportunities for self	_____	_____
127.	_____ Loss of a job	_____	_____
128.	_____ Interactions with law enforcement (e.g., arrested, convicted)	_____	_____
129.	_____ Incarcerated	_____	_____
130.	_____ Lack of housing / safe shelter (i.e., homelessness)	_____	_____
131.	_____ Lack of food	_____	_____
132.	_____ Lack of clothing	_____	_____
133.	_____ Lack of alternative education programs/classes	_____	_____
134.	_____ Learning difficulties	_____	_____
135.	_____ Expelled from school	_____	_____
136.	_____ Dropped out of school	_____	_____
137.	_____ Parent(s) incarcerated	_____	_____
138.	_____ Move (e.g., to new city, community, school, home)	_____	_____

ADOLESCENT PERCEIVED EVENTS SCALE - REVISED

RATING SCALES

Use the following rating scales to answer items 1 to 138.

Frequency:

Never happened	Happened once in your life	Once a year	Several times per year	Once per month	Several times per month	Once per week	Several times per week	Happened once a day
1	2	3	4	5	6	7	8	9

Desirability:

Extremely bad	Very bad	Somewhat bad	Slightly bad	Neither good or bad	Slightly good	Somewhat good	Very good	Extremely good
-4	-3	-2	-1	0	+1	+2	+3	+4

Impact:

No impact at all	Very low	Low	Moderately low	Slightly low	Slightly high	Moderately high	Very high	Extremely high impact
1	2	3	4	5	6	7	8	9

What I Am Like

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Appendix K

Name _____ Age _____ Birthday _____ Month _____ Day _____ Group _____

SAMPLE SENTENCE

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me
a)	☐	☐	Some teenagers like to go to movies in their spare time	BUT	Other teenagers would rather go to sports events.	☐
1.	☐	☐	Some teenagers feel that they are just as smart as others their age	BUT	Other teenagers aren't so sure and wonder if they are as smart.	☐
2.	☐	☐	Some teenagers find it hard to make friends	BUT	For other teenagers it's pretty easy.	☐
3.	☐	☐	Some teenagers do very well at all kinds of sports	BUT	Other teenagers don't feel that they are very good when it comes to sports.	☐
4.	☐	☐	Some teenagers are not happy with the way they look	BUT	Other teenagers are happy with the way they look.	☐
5.	☐	☐	Some teenagers feel that they are ready to do well at a part-time job	BUT	Other teenagers feel that they are not quite ready to handle a part-time job.	☐
6.	☐	☐	Some teenagers feel that if they are romantically interested in someone, that person will like them back	BUT	Other teenagers worry that when they like someone romantically, that person won't like them back.	☐
7.	☐	☐	Some teenagers usually do the right thing	BUT	Other teenagers often don't do what they know is right.	☐
8.	☐	☐	Some teenagers are able to make really close friends	BUT	Other teenagers find it hard to make really close friends.	☐
9.	☐	☐	Some teenagers are often disappointed with themselves	BUT	Other teenagers are pretty pleased with themselves.	☐
10.	☐	☐	Some teenagers are pretty slow in finishing their school work	BUT	Other teenagers can do their school work more quickly.	☐
11.	☐	☐	Some teenagers have a lot of friends	BUT	Other teenagers don't have very many friends.	☐
12.	☐	☐	Some teenagers think they could do well at just about any new athletic activity	BUT	Other teenagers are afraid they might not do well at a new athletic activity.	☐

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me	
13.	☐	☐	Some teenagers wish their body was different	BUT	Other teenagers like their body the way it is.	☐	☐
14.	☐	☐	Some teenagers feel that they don't have enough skills to do well at a job	BUT	Other teenagers feel that they do have enough skills to do a job well.	☐	☐
15.	☐	☐	Some teenagers are <i>not</i> dating the people they are really attracted to	BUT	Other teenagers are dating those people they are attracted to.	☐	☐
16.	☐	☐	Some teenagers often get in trouble for the things they do	BUT	Other teenagers usually <i>don't</i> do things that get them in trouble	☐	☐
17.	☐	☐	Some teenagers do have a close friend they can share secrets with	BUT	Other teenagers do not have a really close friend, they can share secrets with	☐	☐
18.	☐	☐	Some teenagers don't like the way they are leading their life	BUT	Other teenagers do like the way they are leading their life.	☐	☐
19.	☐	☐	Some teenagers do very well at their classwork	BUT	Other teenagers don't do very well at their classwork.	☐	☐
20.	☐	☐	Some teenagers are very hard to like	BUT	Other teenagers are really easy to like.	☐	☐
21.	☐	☐	Some teenagers feel that they are better than others their age at sports	BUT	Other teenagers don't feel they can play as well.	☐	☐
22.	☐	☐	Some teenagers wish their physical appearance was different	BUT	Other teenagers like their physical appearance the way it is.	☐	☐
23.	☐	☐	Some teenagers feel they are old enough to get and keep a paying job	BUT	Other teenagers do <i>not</i> feel they are old enough, yet, to really handle a job well	☐	☐
24.	☐	☐	Some teenagers feel that people their age will be romantically attracted to them	BUT	Other teenagers worry about whether people their age will be attracted to them.	☐	☐
25.	☐	☐	Some teenagers feel really good about the way they act	BUT	Other teenagers <i>don't</i> feel that good about the way they often act	☐	☐
26.	☐	☐	Some teenagers wish they had a really close friend to share things with	BUT	Other teenagers do have a close friend to share things with.	☐	☐
27.	☐	☐	Some teenagers are happy with themselves most of the time	BUT	Other teenagers are often <i>not</i> happy with themselves.	☐	☐
28.	☐	☐	Some teenagers have trouble figuring out the answers in school	BUT	Other teenagers almost always can figure out the answers.	☐	☐

	Really True for Me	Sort of True for Me				Sort of True for Me	Really True for Me
29.	☐	☐	Some teenagers are popular with others their age	BUT	Other teenagers are not very popular.	☐	☐
30.	☐	☐	Some teenagers don't do well at new outdoor games	BUT	Other teenagers are good at new games right away.	☐	☐
31.	☐	☐	Some teenagers think that they are good looking	BUT	Other teenagers think that they are not very good looking.	☐	☐
32.	☐	☐	Some teenagers feel like they could do better at work they do for pay	BUT	Other teenagers feel that they are doing really well at work they do for pay.	☐	☐
33.	☐	☐	Some teenagers feel that they are fun and interesting on a date	BUT	Other teenagers wonder about how fun and interesting they are on a date.	☐	☐
34.	☐	☐	Some teenagers do things they know they shouldn't do	BUT	Other teenagers hardly ever do things they know they shouldn't do.	☐	☐
35.	☐	☐	Some teenagers find it hard to make friends they can really trust	BUT	Other teenagers are able to make close friends they can really trust.	☐	☐
36.	☐	☐	Some teenagers like the kind of person they are	BUT	Other teenagers often wish they were someone else.	☐	☐
37.	☐	☐	Some teenagers feel that they are pretty intelligent	BUT	Other teenagers question whether they are intelligent.	☐	☐
38.	☐	☐	Some teenagers feel that they are socially accepted	BUT	Other teenagers wished that more people their age accepted them.	☐	☐
39.	☐	☐	Some teenagers do not feel that they are very athletic	BUT	Other teenagers feel that they are very athletic.	☐	☐
40.	☐	☐	Some teenagers really like their looks	BUT	Other teenagers wish they looked different.	☐	☐
41.	☐	☐	Some teenagers feel that they are really able to handle the work on a paying job	BUT	Other teenagers wonder if they are really doing as good a job at work as they should be doing	☐	☐
42.	☐	☐	Some teenagers usually don't go out with the people they would really like to date	BUT	Other teenagers do go out with the people they really want to date.	☐	☐
43.	☐	☐	Some teenagers usually act the way they know they are supposed to	BUT	Other teenagers often don't act the way they are supposed to.	☐	☐
44.	☐	☐	Some teenagers don't have a friend that is close enough to share really personal thoughts with	BUT	Other teenagers do have a close friend that they can share personal thoughts and feelings with.	☐	☐
45.	☐	☐	Some teenagers are very happy being the way they are	BUT	Other teenagers wish they were different.	☐	☐

PEOPLE IN MY LIFE

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Name _____

(First)

Appendix *Form*

	Really True for Me	Sort of True for Me	Sample Item		Sort of True for Me	Really True for Me
	☐	☐	Some kids like to do fun things with a lot of other people	BUT	Other kids like to do fun things with just a few people.	☐
1.	☐	☐	Some kids have parents who <i>don't</i> really understand them	BUT	Other kids have parents who really <i>do</i> understand them.	☐
2.	☐	☐	Some kids have classmates who like them the way they are	BUT	Other kids have classmates who wish they were <i>different</i> .	☐
3.	☐	☐	Some kids have a teacher who <i>helps</i> them if they are <i>upset</i> and have a problem	BUT	Other kids <i>don't</i> have a teacher who helps them if they are upset and have a problem.	☐
4.	☐	☐	Some kids have a close friend who they can tell <i>problems</i> to	BUT	Other kids <i>don't</i> have a close friend who they can tell problems to.	☐
5.	☐	☐	Some kids have parents who <i>don't</i> seem to want to hear about their children's problems	BUT	Other kids have parents who <i>do</i> want to <i>listen</i> to their children's problems.	☐
6.	☐	☐	Some kids have classmates that they can become friends with	BUT	Other kids <i>don't</i> have classmates that they can become friends with.	☐
7.	☐	☐	Some kids <i>don't</i> have a teacher who <i>helps</i> them to do their very best	BUT	Other kids <i>do</i> have a teacher who <i>helps</i> them to do their very best.	☐
8.	☐	☐	Some kids have a close friend who really understands them	BUT	Other kids <i>don't</i> have a close friend who understands them.	☐
9.	☐	☐	Some kids have parents who <i>care</i> about their feelings	BUT	Other kids have parents who <i>don't</i> seem to care very much about their children's feelings.	☐
10.	☐	☐	Some kids have classmates who sometimes make fun of them	BUT	Other kids <i>don't</i> have classmates who make fun of them.	☐
11.	☐	☐	Some kids <i>do</i> have a teacher who <i>cares</i> about them	BUT	Other kids <i>don't</i> have a teacher who cares about them.	☐

(OVER)

	Really True for Me	Sort of True for Me			Sort of True for Me	Really True for Me
12.	☐	☐	Some kids have a close friend who they can talk to about things that bother them	BUT	Other kids <i>don't</i> have a close friend who they can talk to about things that bother them.	☐ ☐
13.	☐	☐	Some kids have parents who treat their children like a <i>person</i> who really matters	BUT	Other kids have parents who <i>don't</i> usually treat their children like a person who matters.	☐ ☐
14.	☐	☐	Some kids have class-mates who pay attention to what they say	BUT	Other kids have class-mates who usually <i>don't</i> pay attention to what they say.	☐ ☐
15.	☐	☐	Some kids <i>don't</i> have a teacher who is <i>fair</i> to them	BUT	Other kids <i>do</i> have a teacher who is fair to them.	☐ ☐
16.	☐	☐	Some kids <i>don't</i> have a close friend who they like to spend time with	BUT	Other kids <i>do</i> have a close friend who they like to spend time with.	☐ ☐
17.	☐	☐	Some kids have parents who like them the way <i>they are</i>	BUT	Other kids have parents who wish their children were <i>different</i> .	☐ ☐
18.	☐	☐	Some kids <i>don't</i> get asked to play in games with classmates very often	BUT	Other kids <i>often</i> get asked to play in games by their classmates.	☐ ☐
19.	☐	☐	Some kids <i>don't</i> have a teacher who cares if they feel bad	BUT	Other kids <i>do</i> have a teacher who cares if they feel bad.	☐ ☐
20.	☐	☐	Some kids <i>don't</i> have a close friend who really <i>listens</i> to what they say	BUT	Other kids <i>do</i> have a close friend who really listens to what they say.	☐ ☐
21.	☐	☐	Some kids have parents who <i>don't</i> act like what their children do is <i>important</i>	BUT	Other kids have parents who <i>do</i> act like what their children do is important.	☐ ☐
22.	☐	☐	Some kids often spend recess being <i>alone</i>	BUT	Other kids spend recess playing with their class-mates.	☐ ☐
23.	☐	☐	Some kids have a teacher who treats them like a <i>person</i>	BUT	Other kids <i>don't</i> have a teacher who treats them like a person.	☐ ☐
24.	☐	☐	Some kids <i>don't</i> have a close friend who cares about their feelings	BUT	Other kids <i>do</i> have a close friend who cares about their feelings.	☐ ☐

Appendix Name: _____

Date: _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY**. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
 1 I feel sad.
 2 I feel sad all the time and I can't snap out of it.
 3 I feel so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
 1 I feel discouraged about the future.
 2 I feel I have nothing to look forward to.
 3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
 1 I feel I have failed more than the average person.
 2 As I look back on my life, all I can see is a lot of failures.
 3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
 1 I don't enjoy things the way I used to.
 2 I don't get real satisfaction out of anything anymore.
 3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
 1 I feel guilty a good part of the time.
 2 I feel guilty most of the time.
 3 I feel guilty all the time.

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

7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.
14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.
15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

YOUTH SELF-REPORT FOR AGES 11-18

For office use only
ID #

Please Print

YOUR FULL NAME FIRST MIDDLE LAST

YOUR SEX

☐ Boy ☐ Girl

YOUR AGE

ETHNIC GROUP OR RACE

Appendix N

PARENTS' USUAL TYPE OF WORK, even if not working now (Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, line operator, shoe salesman, army sergeant.)

FATHER'S TYPE OF WORK:

MOTHER'S TYPE OF WORK:

TODAY'S DATE

YOUR BIRTHDATE

Mo. _____ Date _____ Yr. _____

Mo. _____ Date _____ Yr. _____

GRADE IN SCHOOL

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect your views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4.

- I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

a. _____
b. _____
c. _____

Compared to others of your age, about how much time do you spend in each?

Less Than Average Average More Than Average

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

Compared to others of your age, how well do you do each one?

Below Average Average Above Average

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

- II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, crafts, etc. (Do not include listening to radio or TV.)

☐ None

a. _____
b. _____
c. _____

Compared to others of your age, about how much time do you spend in each?

Less Than Average Average More Than Average

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

Compared to others of your age, how well do you do each one?

Below Average Average Above Average

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

- III. Please list any organizations, clubs, teams or groups you belong to.

☐ None

a. _____
b. _____
c. _____

Compared to others of your age, how active are you in each?

Less Active Average More Active

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

- IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

☐ None

a. _____
b. _____
c. _____

Compared to others of your age, how well do you carry them out?

Below Average Average Above Average

☐ ☐ ☐
☐ ☐ ☐
☐ ☐ ☐

Please Print

- V. 1. About how many close friends do you have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more 185
(Do not include brothers & sisters)
2. About how many times a week do you do things with any friends outside of regular school hours?
(Do not include brothers & sisters) ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	About Average	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Get along with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII. Performance in academic subjects. ☐ I do not attend school because _____

Check a box for each subject that you take

	Failing	Below Average	Average	Above Average
a. English or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects — for example: computer courses, foreign language, business. Do not include gym, shop, driver's ed., etc.

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe: _____

Please describe any concerns or problems you have about school: _____

Please describe any other concerns you have: _____

Please describe the best things about yourself: _____

Below is a list of items that describe kids. For each item that describes you *now or within the past 6 months*, please circle the 2 if the item is *very true or often true* of you. Circle the 1 if the item is *somewhat or sometimes true* of you. If the item is *not true* of you, circle the 0.

Please Print 0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1. I act too young for my age	0	1	2	40. I hear sounds or voices that other people think aren't there (describe):
0	1	2	2. I have an allergy (describe):				
0	1	2	3. I argue a lot	0	1	2	41. I act without stopping to think
0	1	2	4. I have asthma	0	1	2	42. I would rather be alone than with others
0	1	2	5. I act like the opposite sex	0	1	2	43. I lie or cheat
0	1	2	6. I like animals	0	1	2	44. I bite my fingernails
0	1	2	7. I brag	0	1	2	45. I am nervous or tense
0	1	2	8. I have trouble concentrating or paying attention	0	1	2	46. Parts of my body twitch or make nervous movements (describe):
0	1	2	9. I can't get my mind off certain thoughts (describe):				
0	1	2	10. I have trouble sitting still	0	1	2	47. I have nightmares
0	1	2	11. I'm too dependent on adults	0	1	2	48. I am not liked by other kids
0	1	2	12. I feel lonely	0	1	2	49. I can do certain things better than most kids
0	1	2	13. I feel confused or in a fog	0	1	2	50. I am too fearful or anxious
0	1	2	14. I cry a lot	0	1	2	51. I feel dizzy
0	1	2	15. I am pretty honest	0	1	2	52. I feel too guilty
0	1	2	16. I am mean to others	0	1	2	53. I eat too much
0	1	2	17. I daydream a lot	0	1	2	54. I feel overtired
0	1	2	18. I deliberately try to hurt or kill myself	0	1	2	55. I am overweight
0	1	2	19. I try to get a lot of attention				56. Physical problems without known medical cause:
0	1	2	20. I destroy my own things	0	1	2	a. Aches or pains (not stomach or headaches)
0	1	2	21. I destroy things belonging to others	0	1	2	b. Headaches
0	1	2	22. I disobey my parents	0	1	2	c. Nausea, feel sick
0	1	2	23. I disobey at school	0	1	2	d. Problems with eyes (not if corrected by glasses) (describe):
0	1	2	24. I don't eat as well as I should				
0	1	2	25. I don't get along with other kids				
0	1	2	26. I don't feel guilty after doing something I shouldn't				
0	1	2	27. I am jealous of others	0	1	2	e. Rashes or other skin problems
0	1	2	28. I am willing to help others when they need help	0	1	2	f. Stomachaches or cramps
0	1	2	29. I am afraid of certain animals, situations, or places, other than school (describe):	0	1	2	g. Vomiting, throwing up
				0	1	2	h. Other (describe):
0	1	2	30. I am afraid of going to school	0	1	2	57. I physically attack people
0	1	2	31. I am afraid I might think or do something bad	0	1	2	58. I pick my skin or other parts of my body (describe):
0	1	2	32. I feel that I have to be perfect				
0	1	2	33. I feel that no one loves me				
0	1	2	34. I feel that others are out to get me	0	1	2	59. I can be pretty friendly
0	1	2	35. I feel worthless or inferior	0	1	2	60. I like to try new things
0	1	2	36. I accidentally get hurt a lot	0	1	2	61. My school work is poor
0	1	2	37. I get in many fights	0	1	2	62. I am poorly coordinated or clumsy
0	1	2	38. I get teased a lot	0	1	2	63. I would rather be with older kids than with kids my own age
0	1	2	39. I hang around with kids who get in trouble				

0	1	2	64. I would rather be with younger kids than with kids my own age	0	1	2	85. I have thoughts that other people would think are strange (describe): _____
0	1	2	65. I refuse to talk				_____
0	1	2	66. I repeat certain acts over and over (describe): _____				_____
			_____				_____

0	1	2	67. I run away from home	0	1	2	86. I am stubborn
0	1	2	68. I scream a lot	0	1	2	87. My moods or feelings change suddenly
0	1	2	69. I am secretive or keep things to myself	0	1	2	88. I enjoy being with other people
0	1	2	70. I see things that other people think aren't there (describe): _____	0	1	2	89. I am suspicious
			_____	0	1	2	90. I swear or use dirty language
			_____	0	1	2	91. I think about killing myself
				0	1	2	92. I like to make others laugh
				0	1	2	93. I talk too much
0	1	2	71. I am self-conscious or easily embarrassed	0	1	2	94. I tease others a lot
0	1	2	72. I set fires	0	1	2	95. I have a hot temper
0	1	2	73. I can work well with my hands	0	1	2	96. I think about sex too much
0	1	2	74. I show off or clown	0	1	2	97. I threaten to hurt people
0	1	2	75. I am shy	0	1	2	98. I like to help others
0	1	2	76. I sleep less than most kids	0	1	2	99. I am too concerned about being neat or clean
0	1	2	77. I sleep more than most kids during day and/or night (describe): _____	0	1	2	100. I have trouble sleeping (describe): _____
			_____				_____
			_____				_____
0	1	2	78. I have a good imagination	0	1	2	101. I cut classes or skip school
0	1	2	79. I have a speech problem (describe): _____	0	1	2	102. I don't have much energy
			_____	0	1	2	103. I am unhappy, sad, or depressed
			_____	0	1	2	104. I am louder than other kids
			_____	0	1	2	105. I use alcohol or drugs for nonmedical purposes (describe): _____
0	1	2	80. I stand up for my rights				_____
0	1	2	81. I steal at home				_____
0	1	2	82. I steal from places other than home				_____
0	1	2	83. I store up things I don't need (describe): _____				_____
			_____				_____

0	1	2	84. I do things other people think are strange (describe): _____	0	1	2	106. I try to be fair to others
			_____	0	1	2	107. I enjoy a good joke
			_____	0	1	2	108. I like to take life easy
			_____	0	1	2	109. I try to help other people when I can
				0	1	2	110. I wish I were of the opposite sex
				0	1	2	111. I keep from getting involved with others
				0	1	2	112. I worry a lot

Please write down anything else that describes your feelings, behavior, or interests

Appendix O

Additional Demographic Information

		Homeless Group (n = 100)	Drop-In Group (n = 70)	High School Group (n = 54)	
Education and Employment					
<u>Youths' Primary Source of Income *</u>					
Ontario Works	%	33.0	3.0	N/A	
Family Benefits		1.0	1.5	N/A	
Children's Aid Society		4.0	1.5	N/A	
Friends		1.0	3.0	N/A	
Parent(s)		4.0	53.0	N/A	
Relative(s)		1.0		N/A	
Squeegying, Panhandling		3.0	3.0	N/A	
Employment		20.0	27.3	N/A	
None		33.0	6.1	N/A	
Familial Factors					
<u>Parental Education Status *</u>					
		<u>Mom</u>	<u>Dad</u>	<u>Mom</u>	<u>Dad</u>
Grade 1-8	%	4.0	3.0	7.0	5.3
Grade 9-12		16.0	9.0	13.0	3.9
High School Graduate		22.0	19.0	29.8	11.1
College/University Graduate		36.0	33.0	42.1	53.7
Vocational/Technical		8.0	1.0		1.9
Unknown		14.0	30.0	14.0	11.1
<u>Parental Employment Status *</u>					
		<u>Mom</u>	<u>Dad</u>	<u>Mom</u>	<u>Dad</u>
Unemployed	%	19.0	8.0	15.5	3.9
Casual Work		2.0		10.3	3.9
Part-Time		5.0	2.0	27.6	27.5
Full-Time		55.0	59.0	41.4	35.3
Unknown		8.0	22.0	3.4	11.8
Deceased				1.7	15.7

		Homeless Group	Drop-In Group	High School Group
Mental and Physical Health Factors				
<u>Services Use in Prior 2 Months</u>				
Youth Services Bureau	%	95.0	37.1	
Police		26.0	7.1	3.7
Operation Go Home		13.0		
Royal Ottawa Hospital		7.0	2.9	5.6
Pink Triangle, OASIS		2.0		
YMCA/YWCA		12.0	20.0	1.9
Housing Help		7.0	8.6	
Rideau Street Youth Enterprises		3.0	1.4	
Canadian Mental Health Association		8.0	1.4	
School Guidance Counsellor		2.0	7.1	9.3
Social Worker		18.0		
Addictions Service		3.0		
Sandy Hill Community Health Centre		28.0	2.9	
Children's Hospital of Eastern Ontario		11.0	5.7	11.1
Children's Aid Society		12.0	2.9	
Ontario Works		65.0	2.9	

* $p < .001$

Appendix P

Homelessness History Descriptives

Homelessness History		Homeless Group (n =100)
Age of 1 st Homeless Episode	<u>M</u>	15.73
	<u>SD</u>	4.93
Longest Homeless Episode (in months)	<u>M</u>	21.50
	<u>SD</u>	31.52
	<u>range</u>	1 - 240 months
Previous Shelter Use	%	36 %
Number of Homeless Episodes	<u>M</u>	1.45
	<u>SD</u>	2.31
	<u>range</u>	0 - 10 episodes
Length of Time Away During Current Episode (in days)	<u>M</u>	457.10
	<u>SD</u>	743.13
	<u>range</u>	7 - 4380 [7 days - 12 years]
Primary Reason for Accessing Shelter		
Left home	%	24.0
Evicted from apartment/room		11.0
Conflict with roommate		3.0
CAS placement		10.0
Home not open		27.0
Travelling		8.0
Court referral/placement		7.0

Homelessness History		Homeless Group (n =100)
Living Environment Prior to Shelter		
Street	%	15.0
Parents		35.0
Friends' house		32.0
Alone in own apartment		14.0
Shared apartment with friends		14.0
With partner		11.0
CAS home		9.0
Semi-Independent Living Program		1.0
Rooming house		5.0
Relatives		9.0
YMCA/YWCA		2.0
Reason for Leaving Home ^a		
Abuse (nature not specified)	%	19.0
Sexual		1.0
Physical		15.0
Verbal/Emotional		18.0
Fights w/ parents		60.0
Disagreed with family rules		26.0
Witnessing family violence		8.0
Parental substance abuse		9.0
Forced to leave by parents		41.0
Parents' financial difficulties		4.0
Left CAS home		9.0
Referral Source to Agency		
Self	%	28.0
Parent(s)		5.0
Relative(s)		4.0
Friend(s)		24.0
Children's Aid Society		7.0
Youth Service Bureau		4.0
YMCA/YWCA		1.0
Police		1.0
Welfare/Social worker		3.0
Other		23.0

^a Total for "Reasons for Leaving Home" surpasses 100% as youth were asked to cite all reasons. Top 3 cited reasons were: "fights with parents", "forced to leave by parents", "disagreed with family rules"