THE RELATIONSHIP BETWEEN LEVEL OF EMOTIONAL INTELLIGENCE, EMOTIONAL AWARENESS, AND SYMPTOMS OF PSYCHOLOGICAL STRESS AMONG HOMELESS PARENTS

by

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ABSTRACT

The Relationship Between Level of Emotional Intelligence, Emotional Awareness, and Symptoms of Psychological Stress Among Homeless Parents

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This study examined the relationship between symptoms of psychological stress and levels of emotional intelligence and awareness among parents living in a homeless shelter. The literature indicates that homeless parents are exposed to a large number of stressors and traumata, but that their level of emotional intelligence and awareness may affect the degree to which they are affected by those stressors. This study is designed to explore the extent to which their emotional intelligence and level of emotional awareness is associated with their ability to exist in a traumatic environment with lower likelihood of psychological symptomatology, pathological dissociation, and demoralization. Although the study does not directly measure the relationship between emotional intelligence/emotional awareness and interpersonal coping methods, psychological symptoms, dissociation, and demoralization are symptoms of poorer psychological coping. Emotional intelligence was assessed using the Mayer/Salovey Caruso Emotional Intelligence Test (MSCEIT) and Emotional Awareness was assessed using the Levels of Emotional Awareness Scale (LEAS). Levels of psychological stress were assessed with the Brief Symptom Inventory (BSI), the Dissociative Experiences Scale (DES), and the

Psychiatric Epidemiology and Research Interview for Demoralization (PERI-D). A negative relationship was hypothesized to exist between the measures of emotional intelligence and awareness and the measures of psychological stress. The results of this study indicate partial support for its' hypotheses. As predicted, participants in the study are contending with a greater degree of symptomatology, dissociation, and demoralization than the general population. Additionally, their affect regulatory capacity as measured by the MSCEIT and the LEAS is limited compared to the general population. A significant negative relationship between psychological stress and affect regulatory capacity was not found. However, this pattern was evident for participants who engaged in pathological forms of dissociation. The statistical power of this study was limited by the small sample size (n=42), which may have obscured small but significant correlations that were consistent with the studies' hypotheses. Therefore, future research with larger samples is needed to ascertain more precisely the nature of the relationships that may exist between these variables. Future research is needed to develop sound typologies of homeless families in order to better direct policy and intervention with this population. Additionally, longitudinal research that can ascertain the extent to which affect regulatory capacity predicts good outcomes for this population is necessary in order to further the efficacy of clinical work with these families. Finally, evaluations of programmatic interventions designed to increase emotional knowledge and general affect regulatory capacity are needed.

Dedicated to the memory of Dr. Leonard B. Kruk, Jr.

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TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

CHAPTER I

LITERATURE REVIEW

Introduction

This chapter will describe the significance of and literature supporting a study that examined the relationship between symptoms of psychological stress and levels of emotional intelligence and awareness among parents living in a homeless shelter for families. First, I will briefly describe the clinical encounters that inspired the research. The research describing the characteristics of homeless families will then be discussed with a particular focus on the traumatic aspects of the homeless experience. The literature on resilience will be then reviewed with a focus on emotion regulation capacity. Finally, a review of the literature on emotional intelligence and awareness will be presented with a focus on the definition, measurement, and acquisition of these capacities. Emotion regulation capacity as a central protective mechanism in resilience among at-risk populations will be presented.

Overview and Significance of the Study

While many studies have explored the impact of homelessness on individual well-being (Bassuk, Weinreb, Buckner, Browne, Salomon, & Bassuk, 1996; Paquette & Bassuk, 2009), few have looked at the role that emotion regulation plays in protecting a person from the psychological consequences of prolonged exposure to homelessness. While this study does not directly assess resilience as an outcome variable, establishing a link between emotional intelligence, emotional awareness

and psychological distress may have theoretical and clinical implications. Finding that higher levels of emotional intelligence and awareness may be related to lower levels of psychological stress and symptomatology could help those who work with homeless parents to identify and foster these abilities with this population. Additionally, it would help establish emotional intelligence and awareness as potential protective mechanisms for those undergoing chronic environmental stress.

Clinical Inspirations for the Study

The idea for this study emerged from work I had been doing with homeless families over a 6-year period. This work consisted of interviewing families and conducting multiple family groups and, on a few occasions, psychotherapy with individual families, parents, and their children living in a homeless shelter in the Bronx. As I did this work I became curious regarding the differences I saw among the parents in their parenting styles and general coping skills while living under what amounts to, at best, very difficult, and, at worst, traumatic circumstances. The broad questions I wanted to explore centered on understanding the source of the remarkable strengths and resilience that some parents possessed despite living under such adverse circumstances. What I noticed from the interviews with parents and their children was that for some of these families there was a remarkable amount of reflectivity and meaning-making regarding their experiences of the shelter and significant insight regarding their own and their children's emotional experience. Teens in families with parents who seemed to have higher levels of reflectiveness also appeared more attuned to their own and their parents' emotions than teens from families with less reflectiveness. These parents also presented themselves

differently than others, that is, they possessed an emotional vitality that was at times infectious. This impact of this kind of family on the interviewers was often expressed through conversations about the great affection and admiration of their strengths this particular family engendered. In contrast, other families expressed a huge degree of chaos and trauma; for them as well as for the interviewers, the interviews were a much more difficult experience. I left these interviews feeling tired, slightly irritated, at times confused and guilty for feeling this way about these families who were obviously suffering so much.

These responses are common countertransference reactions evoked when working with traumatized people (Boss, 2006; Messler-Davies & Frawley, 1994). However, from the content of the interviews it did not seem as if these families had experienced more trauma than the more emotionally reflective families. In fact, my experience interviewing these families mirrors findings in the research literature (Bassuk et al., 1997) demonstrating that the vast majority of parents in homeless families have survived numerous traumatic experiences throughout their lives, including childhood physical and sexual abuse, and, for women, domestic violence as adults. I don't want to give the impression that these parents were so clearly demarcated into "good" parents and "bad" ones. In fact, almost all of the parents that I encountered possessed remarkable strengths for coping with all of their significant struggles. Rather, the experience of being with some parents was markedly different from others and that seemed to correlate with their ability to think about themselves and their children in an open and reflective manner. Given

that all of these families had experienced traumatic situations I wondered what factor or factors might differentiate among them.

Applied Clinical Aspects of the Research

Clinically, this study aims to discover information that might be of utility to those working with at-risk populations. Specifically, this study aims to provide support for the idea that maintaining a therapeutic focus on the emotional consequences of becoming and being homeless, with an understanding that the particular manifestation of those emotional consequences (might be) connected to a person's level of emotional intelligence and awareness, may be important in achieving lasting therapeutic impact. This study seeks to provide support for a blended psychodynamic/family systems approach to working with homeless families in particular, and at-risk populations in general. Specifically, this study may provide data suggesting that clinicians working in these settings would benefit their clients by thinking about, assessing, and intervening with parents and families through the lens of emotion regulation capacity. For example, it would likely benefit families for shelter staff to consider the implications for families of some shelter policies that tend to infantilize the parent subsystem thus leaving the children feeling that their parents are not the ones in control of the situation. Additionally, an affect regulation focus would result in case workers receiving training in active and empathic listening when communicating with homeless parents. Finally, clinicians coming from a purely behavioral background might be encouraged to take a greater interest in the emotional experiences of the family in this situation and work with them to discover constructive ways of coping with the situation.

Applied Programmatic Aspects of the Research

The findings about parent emotion regulatory capacity and symptoms of psychological stress will also help to refine a preventive, psychoeducational intervention for homeless families that is affiliated with the larger study. The intervention is conducted in homeless shelters as a Multiple Family Discussion Group (MFDG) which brings together between four and seven families for six sessions. This program is currently implemented by the Ackerman Institute for the Family, City College, and HELP USA. Many of the participants in the present study took part in this program following participation in the research. The aim of this group is to strengthen families emotional functioning through increasing their attention to the struggles that they are facing and the strengths they possess. A recent function of the group that came about through this new focus on affect regulation and attachment is to also attempt to increase the families' attention to the emotions connected to the struggles that they face, their knowledge of each other's feelings regarding these struggles and their ability to communicate with one another about these feelings.

Characteristics of Homeless Families

When people think of homelessness they commonly think of older men suffering from drug or alcohol addiction and mental illness roaming the streets. This stereotype has been prevalent in American society since the days of the Great Depression when the train hopping hobos and bowery bums characterized the homeless condition. For a number of reasons, (Rossi, 1990) the face of

homelessness in America has changed radically since the 1970's.[1] Now instead of a 50-year-old alcoholic, one is more likely to encounter a 28-year-old mother with two young children, 50% of whom are under the age of 5, at the homeless shelters. These families make up the fastest growing segment of the homeless population (US Conference of Mayors, 2009).

In 1983, the first year data were collected on homeless families, they made up 28% of the nations homeless. The most recent HUD report (U.S. Department of Housing and Urban Development, 2009) found that 38% of the 664,000 people who were homeless on one night in January of 2008 consisted of families, a 9% increase from the previous year and a more than 30% increase in 25 years. In urban areas such as New York City, that number is as high as 75% of all homeless persons. On any given night in New York City, close to 9,000 families will be sleeping in shelters. This number doesn't include those precariously housed families who are "doubling up" in friends' and families' apartments. This conservatively estimated number is thought to be much higher than the number of families staying at shelters (da Costa Nunez, 1996).

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[1] The literature on the impact and correlates of homelessness is vast and presented in a wide range of journals and websites. Some excellent current sources for facts and references include the National Center on Family Homelessness (www.familyhomelessness.org), the National Child Traumatic Stress Network Homelessness and Extreme Poverty Working Group (www.NCTSNet.org), the Columbia Center for Homelessness Prevention Studies (www.cchps.columbia.edu), the Coalition for the Homeless (www.coalitionforthehomeless.org), the National Alliance to End Homelessness (www.endhomelessness.org), the Institute for Children and Poverty (www.icpny.org), and the National Center for Children *in* Poverty (www.nccp.org). A brief review is also to be found in Fraenkel, Hameline, and Shannon (2009).

Most researchers now agree that the primary causes for the surge in homeless families over the past two decades are economic and material: the lack of affordable housing, the move to a service economy, the extreme decrease in TANF (Temporary Assistance to Needy Families) payments, the increased number of poor households, and the increased gentrification of the inner cities (Bray et al., 2009; Buckner, 2008; Rossi, 1990; Shinn & Gillespie 1994). Likewise, the findings regarding which poor families actually become homeless, has shown homelessness to be associated with the presence of certain risk factors that are more due to the multiplicative effects of difficult circumstances than distinct personal or psychological characteristics (McChesney, 1992).

Stressful Conditions of Homeless Shelters

Kozol (1988) describes one difficulty that families have in the homeless shelters:

> "Annie says her husband has to live with her illegally. Because of her asthma she cannot go down each night to sign him in. He has to sneak in past the guards.... Because the jobs available to men like Annie's husband are unlikely to be permanent, rarely offer health insurance, and could not support a family in New York, the forfeiture of benefits... poses unacceptable risks. Thus, loyal fatherhood becomes a fiscal liability. The father becomes extinct within his family. If he wants to see his children he must sign in as a stranger ." (p. 58)

For most families, the process of entering and existing within the shelter system is just one more traumatic situation with which they must cope. One of the

first things that many homeless families face upon entering the shelter system is the dismantling of the primary social network in their lives. According to recent data, 55% of the nation's shelters do not admit men and many do not allow any males over the age of 10[2] (US Conference of Mayors, 2009). In certain instances, there are good reasons for this exclusion. One particularly important one is that in many cities the general family shelters include women who are escaping from domestic violence. Indeed, according to the Institute for Children and Poverty (1995), close to half of all homeless women have been battered and only a percentage of these make their way to a specialized domestic violence shelter.

Nevertheless, for families in which violence has not occurred, these general policies act as a barrier to remaining together, often contributing to anxiety and depression among their members. For a family in dire need of shelter, the choice is to split up or risk being turned away. For two parent families, the separation from the father may leave homeless family members with a feeling of social isolation, mistrust, and helplessness. "...we have three kids and they miss their daddy because he's not here. They are going through something, but I am too. We are a very close family and it's hard. I cry too sometimes. I feel very depressed" (Choi & Snyder, 1999). Beyond separating family members from each other due to the exigencies of shelter policy, the system in many states removes children from their families entirely and places them in foster care solely because of the family's homelessness.

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[2] Publicly funded shelters in New York City such as the one used in this study do admit men. Many privately run shelters do not admit males due to the prevalence of problem behaviors (ie. substance abuse, violence) in males (T. Hameline, personal communication, January 8, 2011 personal communication).

Kozol (1988) eloquently illustrates how the system of homelessness and the shelterization process progressively isolates family members by stripping them of their social roles, and rewarding them for dismantling their existing family system. "Homeless people can lose faith in their ability to care for themselves and in the willingness of others to help them, and may develop an abiding sense of distrust of others" (Goodman, Saxe, & Harvey, 1991, p. 1221). In 1990, the U.S. House of Representatives estimated that as many as 30% of foster care cases originate because of the parents' lack of adequate housing (as cited in Choi & Snyder, 1999). Ironically, having been in foster care as a child is one of the major risk factors for future homelessness as an adult (Van Ry, 1993).

The forfeiting of vital family ties in order to secure stable shelter in the present likely has damaging consequences for many families. Indeed, the breaking up of the family leads to the kind of social disaffiliation that many researchers identify as one of the prime characteristics of homeless families. While there is no research presently that conclusively demonstrates that the condition of being homeless causes this disaffiliation, there is a significant amount of anecdotal evidence (Choi & Snyder, 1999; Kozol, 1988; Van Ry, 1993) that points in this direction.

Separation, however, is not all that these families have to bear. Upon entering the shelter system, families are subjected to the rules and regulations of a complex bureaucracy and their lives are directly affected by the decisions of the shelter staff. "Here they say that the staff is the boss and my children listen to staff, not me, saying they are the boss" (Choi & Snyder, 1999, p. 72). The shelter staff

makes many decisions regarding the regulation of the lives of children and mother that under normal conditions the mothers would make for themselves. These include when and what food needs to be in the refrigerator, what time to come home at night (curfew), when to get up in the morning, what behavior is acceptable for children, and what method of discipline is acceptable. Most shelters ban physical forms of discipline of any kind (even though limited corporal punishment is allowed in many states, including New York). Parents who disregard this ban are given demerits, which jeopardizes their chances of remaining in the shelter. Many of the shelter's inhabitants, however, come from a culture that accepts corporal punishment as a valid method of disciplining children. They view this ban as an unwarranted intrusion into their life. Moreover, most shelters enact this ban without offering to teach the parents alternative methods of discipline for their children. This further exacerbates the parents' feeling of helplessness when it comes to controlling their lives. [3]

> "My older daughter, since we have been here, she doesn't get too many spankings, because we're not allowed to spank them here, and her mouth is extra spunky. They don't let you discipline your kids. They'll give you blue slips, and you get three blue slips, you get kicked out. I can pass up the spanking to have a roof over my head." (Choi & Snyder, 1999, p. 89)

Having to defer to the shelter rules on issues such as curfew and discipline may result in a disempowering of the parents in both their own, and in their

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[3] Hameline (personal communication, January, 8, 2011), emphasizes the larger political context surrounding the provision of social services generally in order to contextualize policies of homeless shelters. A degree of social regulation has consistently accompanied public assistance programs in America.

children's eyes. "You can't raise your child being homeless, because you got this person helping you, this person hindering you, and you got other rules you have to abide by... and kids see that. Kids are smarter than we realize" (Choi & Snyder, 1999, p. 92).

The qualitative evidence cited above serves to illustrate how the process of entering and then existing in a typical homeless shelter can damage the individual and collective well-being of homeless families. Shelters tend to have somewhat inflexible rules and regulations that create what many residents describe as a "prison-like" atmosphere. The ironic consequences of these actions are that they serve to perpetuate the qualities that increase the likelihood of remaining homeless. For many families, the shelterization process exacerbates and/or creates experiences of social disaffiliation and learned helplessness. These conditions are considered the prime ingredients of psychological trauma (Goodman, Saxe, & Harvey, 1991).

While the process of shelterization is but one facet of the multi-faceted experience of being homeless, it is one factor that all homeless families share. It also largely shapes the families' experience of what it means to be homeless. In Baumann's (1993) study on the meaning of homelessness for mothers with children, they described a 'downward spiral' filled with frustration, depression, anxiety, and lowered self-esteem. The evidence suggests that the shelterization process leads homeless families to begin to internalize society's prejudices about what it means to be homeless. This negative transformation of self leads, ironically, to a greater likelihood of remaining homeless.

There is a significant body of research that addresses the question of whether the experience of homelessness itself is more deleterious than the experience of poverty generally. To answer this question, researchers have compared homeless children with those that are impoverished but not homeless on measures of mental health and cognitive ability (Bassuk, et al.,1996; Buckner, 2008; Culhane, Metraux, Park, Schretzman, & Valente, 2007; Masten, Miliotis, Graham-Bermann, Ramirez, & Neemann, 1993). Some of the data show differences on measures of mental health and cognitive ability between the two populations while others do not, however, all of the studies show significant differences between these two groups and the general population on measures of exposure to stressful life events, behavior problems in children and psychopathology.

Masten et al. (1993) compared 159 homeless children with 62 poor housed children. They found homeless children had more recent stress, more disrupted schooling and friendships, and higher levels of antisocial behavior. Problems for both housed and homeless children were more related to other risk factors, such as parental distress, than to housing status or income. They suggested that the deleterious impact of homelessness be viewed as the extreme end of the "continuum of risk" due to poverty generally. That is, homeless and poor housed children face many of the same stressors but homeless children have the additional stressor of living in a shelter.

In a study comparing childhood and adult risk and protective factors of homeless and low-income housed women, Bassuk et al. (1997) identified two major differences between them. In childhood, the homeless mothers were more likely to

have had a primary caretaker who abused drugs and to have been placed in foster care than were the low-income housed women. The researchers speculated that the placement in foster care could impair the social and emotional development of the child. Interestingly, the experience of childhood trauma and loss did not differentiate between the two groups, with both groups reporting high rates of trauma and loss. In adulthood, homeless mothers were more likely to have mental health and substance abuse problems and more likely to have poor or eroded social support networks than low-income housed mothers. In addition to the challenges described earlier, the majority of homeless parents enter this situation as trauma survivors. In particular, a staggering 92% of homeless mothers have experienced severe physical and/or sexual assault at some point in their lives compared to 82% of matched low-income housed mothers (Bassuk et al., 1996). Sixty percent of both groups had been sexually and/or physically abused at least once, but often more than once, before the age of 12.

These findings suggest that the childhood risk factors identified both likely impaired the attachment status and subsequent affect regulatory capacity of the individual. The process of becoming and then being homeless is yet another in a series of traumatic experiences that these parents and their children must endure.

Traumatic Stress

Traumatic stress results from the interaction of extreme external events that place a demand on the individual to change in some way and that are perceived by the individual as threatening. This perception results in increasing levels of physiological and psychological distress. Green (1990) helped to clarify this

definition by emphasizing the interaction of three events in the development of traumatic stress. First there is an event in the external world, then this event is perceived as threatening or undesired in some way, finally the interaction of the event with the appraisal creates a psychological response such as distress.

People who have been exposed to traumatic stress tend to experience persistent intrusions related to the trauma (Laub & Auerhan, 1993); a compulsion to repeat situations that are similar to the trauma (van der Kolk, 1989); avoidance and withdrawal, including engaging the defense of dissociation (Litz, 1992; van der Kolk, Greenberg, Boyd, & Krystal, 1985); reduced or decreased ability to modulate arousal (Shalev, 1996); problems with executive function capacities such as focus, distractibility, and stimulus discrimination (McFarlane, Weber, & Clark,1993); and alterations in utilization of defenses and shifts in personal identity (Herman, 1992; Rieker & Carmen, 1986). Additionally, they suffer long-term consequences of the exposure such as deficits in self-regulation capacity, generalized hyperarousal, a shattering of meaning, and social avoidance (van der Kolk, 1996). Finally, exposure to traumatic stress has a significant psychobiological impact consisting of hyperactivation of the sympathetic nervous system, impairment in the regulation of stress hormones and mood related neurotransmitters such as serotonin and norepinephrine, decreased hippocampal volume (responsible for the consolidation of events in long-term memory), increased amygdala activity (responsible for fear response), and increased right-hemispheric lateralization (van der Kolk, 1996).

As described earlier, homeless parents contend with a significant amount of acute and chronic stress, in addition to the vast majority having survived one or

more instances of physical and/or sexual abuse. Goodman et al. (1991) argue that the experience of losing one's home, going through the often dehumanizing and stressful process of determining eligibility for shelter, and living in a shelter, with the attendant loss of "safety, predictability and control" (p. 1219), is a form of traumatic stress. The experience of becoming and being homeless can also exacerbate traumatic symptomatology among those who have been previously victimized, creating a significant barrier to recovery. According to these authors, the experience of homelessness causes social disaffiliation, which involves a withdrawal from the world of supportive others and a retreat into oneself due to the judgment of others and their own withering self-esteem. They write, "Trauma victims' sense of being without sanctuary in a world filled with malevolent forces is often compounded by actual failures of social support networks and by the social withdrawal of those on whom the victims have relied for support" (p. 1220). Additionally, the experience of homelessness can engender a sense of learned helplessness (e.g. Seligman, 1975) where people feel that they have lost control over the course of their lives and eventually give up hope.

Kiser and Black (2005) reviewed the past 15 years of research on the traumatic conditions of urban family poverty. They argued that families living in poverty experience a high number of traumatic events along with experiencing the chronic stress of the inability to control future exposure to traumatic events due to the instability and unpredictability of the communities they inhabit. The impact of this exposure varies from positive psychological growth to debilitating disorder

based on the complex interaction of biological, familial, psychological, and social factors.

Kiser and Black's (2005) review found ample evidence that adults and children living in poverty experience increased distress and manifest trauma symptoms such as irritability, detachment, and problems with emotional regulation. Persons who experienced prior victimization exhibited higher levels of distress than those who did not. They found that parental distress associated with poverty can have a significantly negative impact on their parenting behaviors and subsequent relationships. Finally, living in poverty has been found to negatively impact family structure, relations, and coping. Specifically, family structure in poor urban families tends to lack routine and organization (Brody & Flor, 1997; Clark, Barrett, & Kolvin, 2000). Family relations in these families tends to be negative, punitive, lacking nurturance, and at-risk for violence. Coping styles in families living under the harsh conditions of poverty tend to be characterized by increased agitation and vigilance followed by hopelessness and avoidance.

In general, although some research has documented the traumatic effects of poverty and homelessness, little research has examined individual differences on psychological variables that may be associated with differences in the ability to cope successfully with the trauma of homelessness (Goodman et al., 1991).

Resilience

Not all families are equally affected by the traumatic conditions of poverty (Kiser & Black, 2005). Some parents respond to the chaos of their outside world by paying more attention to their family and its needs. They work to establish regular

routines and schedules for the family members, they use the adversity of the environment as something to bring them closer together as they fight against it, and they are able to establish and maintain flexible and effective coping strategies. These are families who exhibit resilience that buffers them from the deleterious impact of their traumatic circumstances.

Numerous studies (Freitas & Downey, 1998; Werner & Smith, 2001) document a wide variety of responses to the same traumatic event. The impact of trauma depends to some extent on each individual's particular combination of biological, intrapsychic, interpersonal, and cultural factors. The study of resilience centers on understanding the variables that enable a person to survive and, in some cases, actually thrive when exposed to circumstances that would result in most people experiencing a cascade of negative consequences. Rutter (1999) defines resilience as:

> "the phenomenon of overcoming stress or adversity. That is, put in more operational terms, it means that there has been a relatively good outcome for someone despite their experience of situations that have been shown to carry a major risk for the development of psychopathology (p. 119)."

Several studies indicate that perceived social support is a factor that enhances resilience in response to PTSD (Brewin, Andrews, & Valentine, 2000; Schumm, Briggs-Phillips, & Hobfoll, 2006). Interestingly, this research indicates that perception of support may be more important in predicting resilience than are differences in the amount and type of support received. That is, believing that help

will be available might be a greater predictor of resilience than actually receiving help.

Humphreys (2003) investigated the relationship between resilience and symptomatology among battered sheltered women. She found a significant negative correlation between resilience and symptomatology. Although this population reported higher levels of physical and psychological distress than a normative sample, those who were more resilient reported experiencing significantly less physical and psychological distress.

Rutter's (1987, 1999) seminal work on resilience in children helped to increase understanding of the mechanisms through which high-risk individuals may be protected from the development of psychopathology. He identified four resilience-enhancing mechanisms: the reduction of the negative impact of the event, the reduction of negative chain reactions, the promotion of self-efficacy, and the opening up of new opportunities. Rutter emphasizes the role of the processing of cognitive and affective experiences as a major factor underlying an individual's capacity to utilize these protective mechanisms.

Buckner, Mezzacappa, and Beardslee (2003) examined the relationship between self-regulatory processes and resilience among 155 homeless youth between the ages of 8 and 17. They cited Karoly (1993) who defined self-regulation as referring to

> "those processes, internal and or transactional, that enable an individual to guide his/her goal-directed activities over time and across changing circumstances… impl[ying] modulation of thought, affect, behavior, or

attention via deliberate or automated use of specific mechanisms and supportive metaskills (p. 25)."

They utilized a "person-focused" as opposed to a "variable-focused" definition of resilience, meaning that they grouped the study participants as resilient, non-resilient, or neither based upon a pattern of functioning across numerous measures. In defining resilience they looked for both the relative absence of factors such as behavior problems and psychopatholoy and the presence of good adaptation and competence in managing the challenges of daily living. After controlling for exposure to prior adversity and existing psychological resources, the authors found that self-regulation capacity was more predictive of membership in the resilient group than any other variable.

The capacity to modulate one's affective experience to obtain an optimal level of emotional arousal is essential to psychological growth and when impaired may contribute to the development of psychopathology. In fact, the defining characteristics of many types of psychopathology involve deficits in emotion regulatory capacity either through the under- or over-regulation of emotional experience (Calkins & Fox, 2002; Cicchetti, Ackerman, & Izard, 1995; Gross, 1998). Gross (1998) defines emotion regulation as "the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (p. 275). Although there are not yet well-validated measures of adult emotion regulation, emotion regulation is a component of the concept of emotional intelligence and emotional awareness, for which there are strong measures. These concepts are discussed below.

Emotional Intelligence

The concept of emotional intelligence first appeared in the literature in 1990 and brought together two aspects of human functioning that have long been viewed as being at odds with each other -- emotion and reason. Salovey and Mayer (1990) initially offered a definition of emotional intelligence as "the ability to monitor one's own and others' feelings, to discriminate among them, and to use this information to guide one's thinking and action" (p. 189). Their research (Mayer, Caruso, & Salovey, 1998, 1999; Mayer, DiPaolo, & Salovey, 1990; Mayer, Gaschke, Braverman, & Evans, 1992) resulted in a "four-branch" model of emotional intelligence (Mayer & Salovey, 1997). These branches are hierarchically arranged from the most basic to the most complex emotional skills and consist of *emotional perception*, *emotional integration*, *emotional understanding*, and *emotional management*, with emotional perception as the basic level and emotional management as the higher order ability. The four branches of emotional intelligence and their definitions are presented in Table 1 (excerpted from Salovey, Mayer, Caruso, & Lopes, 2003, p. 252).

Emotional perception is defined as the ability to perceive and to express feelings. Particularly important to this branch is the ability to perceive and identify emotion not only in oneself but in others and in the environment. Salovey et al. (2003) identify this branch as similar to Lane and Schwarz's (1987) construct of emotional awareness and as negatively related to the development of alexithymia.

The second branch involves using emotions to influence thinking. It emphasizes emotional experiencing as enhancing cognition, as opposed to using

cognition to alter affect. The authors discuss how cognition will change depending on one's affective state and how the alteration of affective state may aid thinking through, enabling one to entertain multiple points of view. Success in this area involves knowing and being able to access appropriate emotions for the task at hand. Therefore, someone who suffers from emotional lability without the capacity to utilize it to accomplish a specific task may not experience enhanced thinking capacity. However, someone who knows how to apply what they learn from their emotional life towards the accomplishment of desired ends may experience enhanced coping.

The third branch involves the degree to which a person has a nuanced understanding of his or her emotions, their progression, how they blend together, and how they progress over time. Salovey et al. (2003) define it as "one's intelligence about the emotional system" (p. 253). Someone who is proficient in this area possesses declarative knowledge about the workings of emotion. They understand how emotions change over time and how particular situations occasion multiple and sometimes conflicting emotional states. They understand how and why moments of emotional turmoil resolve and how and why they accelerate.

The fourth branch involves the capacity to regulate and manage emotions in oneself and in others. Salovey et al. (2003) define it as involving a persons' ability to "monitor, discriminate and label their feelings accurately, believe that they can improve or otherwise modify these feelings, use strategies that will alter their feelings, assess the effectiveness of these strategies" (p. 253). This is the most advanced capacity and requires proficiency in the other three branches. The

definition of this branch sounds very much like the tasks involved in cognitive-behavioral therapy except applied to feelings instead of thoughts.

Measuring Emotional Intelligence

Since Goleman's (1995) popularization of the construct of emotional intelligence (EI), interest in the topic has grown. However, there are disagreements about how to define and measure emotional intelligence. Some researchers view emotional intelligence as a trait and assess it with self-report measures (Bar-On, 1997; Schutte et al., 1998). Others (Mayer, Salovey, & Caruso, 2000, 2008) contend that this approach lacks construct validity due to overlap with other personality traits. Grewal, Brackett, and Salovey (2006) cite research that demonstrates that these measures do not properly discriminate between emotional intelligence and the Big Five personality variables, and note the small correlations between self-report and ability measures of emotional intelligence (Brackett & Mayer, 2003).

The first ability-based measure of emotional intelligence was called the Multifactor Emotional Intelligence Test (MEIS; Mayer et al., 1999) which led to the eventual development of the Mayer Salovey Caruso Emotional Intelligence Test (MSCEIT; Mayer, Salovey, & Caruso, 2002). The MSCEIT employs eight separate tasks to measure the four branches of emotional intelligence. These tasks and the psychometric properties of the MSCEIT will be discussed in the methods section.

There are a large number of studies on emotional intelligence and its correlates, conducted on numerous different populations, including CEOs, teachers, nurses, mid-level corporate executives, university students, customer service teams,

couples, abusive partners, substance abusers, and those with clinically significant mental illnesses. However, a review of the literature revealed no studies to date looking at the correlates of emotional intelligence in homeless or poor housed families. Given the above-cited literature indicating the role that understanding and modulating one's cognitive and affective responses play in mediating the effects of trauma and stress, it seems important to assess the role that emotional intelligence might play in homeless adults' responses to their particular stressors.

Emotional intelligence as measured by the MSCEIT has been found to exhibit a moderately strong positive correlations with the big five traits of agreeableness (r =.33) and conscientiousness (r = .25) (Mayer et al., 2002). After reviewing the studies of the relationship between EI and personality characteristics, Mayer et al. (2002) concluded that "The high EI person is somewhat more agreeable and emotionally sensitive and empathic than others, and the individual perceives him or herself as undergoing personal growth" (p. 42).

Higher emotional intelligence quotients (EIQ) also have shown a moderately positive correlation with secure attachment as measured by Bartholemew and Horowitz's (1991) relationship questionnaire (r = .28) and a small negative correlation with anxious/preoccupied attachment (r = -.14) (Kafetsios, 2004). In addition, parents who exhibit higher EIQs tend to exhibit greater levels of parental warmth than those with lower scores (Mayer et al., 1999).

Those higher in EIQ tend to perceive higher levels of social support from their immediate social network than those with lower scores. They were also found to be more likely to own and display pictures of significant others in their homes, to

keep scrapbooks, and to be involved in a caretaking profession (Brackett, 2001; Formica, 1998).

In couples, higher levels of emotional intelligence have been found to increase relationship satisfaction. Couples with lower EIQ report experiencing less emotional depth in relationships, more overall conflict, and rate their experience in relationships more negatively than those with higher total EIQ scores (Brackett, Warner, & Bosco, 2005).

Grewal et al. (2006) emphasize the relationship between the managing emotions subscale on the MSCEIT and emotion regulation capacity. They argue that the managing emotions (ME) subscale measures a person's ability to obtain "the optimal regulation of emotions in both intra- and interpersonal situations" (p. 45). Therefore, people who have high scores on this subscale should have better social interactions and perceptions of social support generally. Lopes, Salovey, and Strauss (2003) found that those with higher ME scores tended to perceive interactions with friends more positively than those who scored lower. They also perceived greater levels of parental support. Those with high ME scores are more likely to be describes as supportive and caring by close friends (Lopes et al., 2004). High ME scorers also report better relationship quality than low scorers. College students with high scores on the ME subscale are more likely to provide emotional support to their roommates and less likely to exit when there is a conflict in the relationship. Additionally, they tend to be more popular than those who score lower on this subscale (Lopes, Salovey, Cote, & Beers, 2005).

There have been few studies evaluating the clinical utility of the emotional intelligence construct. Of those conducted, one study found that emotional intelligence acts as a moderator between stress and mental health (Ciarrochi, Deane, & Anderson, 2002). In this cross-sectional survey of 302 university students, high scores on the subscales measuring emotional perception and managing others' emotions had different effects on the experience of depression, hopelessness, and suicidal ideation. Specifically, students who scored higher in emotional perception experienced greater levels of depression, hopelessness, and suicidal ideation when confronted with life stress than those who scored lower. Students who scored lower on measures of managing others' emotions reported higher levels of suicidal ideation when confronted with life stress. These findings suggest that higher emotional perception skills may function as a liability for those who don't have similarly high skills in managing emotional states in themselves and others.

Herterl, Schutz, and Lammers (2009) compared the MSCEIT scores of patients diagnosed with Major Depressive Disorder (MDD), Borderline Personality Disorder (BPD), and Substance Abuse Disorder (SAD) with non-clinical controls in order to ascertain whether there were differences in emotional ability between them. Patients with MDD were found to have a lower total EIQ than controls and to exhibit deficits in the subscales measuring understanding emotional information and using emotions to facilitate thought. Of note, and counter to the authors' expectations, patients with MDD did not show significant differences from controls on the perceiving and managing emotion subscales. Patients with BPD also exhibited a lower total EIQ than controls and exhibited deficits in the higher level

branches of emotional intelligence of understanding and managing emotions. Finally, patients with SAD also exhibited a lower total EIQ than controls, and exhibited deficits in the using, understanding, and managing emotions branches, but not in emotional perception. According to the authors, this was the first study to utilize ability-based emotional intelligence measures to understand the emotional functioning of people with severe mental health issues.

Levels of Emotional Awareness

Writing just a few years before the emergence of the emotional intelligence construct, Lane and Schwartz (1987) developed a distinct but related construct designed to emphasize the role of emotions in clinical disorders. They defined *emotional awareness* as "an individual's ability to recognize and describe emotion in oneself and others" (Lane, 2000, p. 173). Influenced by Piaget's stages of cognitive development, they developed a cognitive-developmental model of the emergence of emotional awareness which has five sequential levels of integration and differentiation. They specified five increasing levels of emotional awareness, from physical sensations, to action tendencies, single emotions, blends of emotion, and blends of blends of emotional experience ("the capacity to appreciate complexity in the experiences of self and others" [Lane, 2000, p. 173]).

In developing a theoretical basis for the construct of emotional awareness, they cite a number of psychoanalytic theorists, including Mahler, Pine, and Bergman (1975) and Blatt (1974), who implicitly linked the nature of emotional experiencing and the quality of object representations without providing a framework for understanding exactly how the two influence each other.

Lane and Schwartz's Five Levels of Emotional Awareness

Level 1: **Sensorimotor reflexive.** People at this level of emotional awareness have no or only a very slight awareness of emotional experience. Instead, they are aware only of undifferentiated bodily sensations. Observers, however, could detect differentiated affective experiencing through behaviors like facial expressions. These people would have no conscious awareness of these affective experiences and would deny them if pointed out to them. Additionally, they have little if any awareness of their own or others' sense of self.

Level 2: Sensorimotor enactive. People at this level of emotional awareness still have no, or only a very slight, awareness of emotional experience. They are aware of bodily sensations and the impulse to enact them along the lines of the hedonic or pleasure principle. They are able to describe their state only in bodily or action-oriented terms but would not be able to refer to the possession of feelings. They possess minimal awareness of others' feelings except through imitation.

Level 3: Preoperational. People at this level of emotional awareness become aware of having emotional experience but in undifferentiated either/or terms. Their emotional range, depth, and complexity are quite limited. They have limited ability to modulate the expression of emotional experience, and require another to help them in doing so. They are able to recognize the other, but that recognition is largely stereotypic and they unable to appreciate the uniqueness of the other person.

Level 4: Concrete operational. People at this level of emotional awareness possess an increased understanding of the ebb and flow of emotional experience. They achieve a more differentiated sense of the nature of their emotional experience, and begin to articulate the experience of multiple emotional responses to a particular event. They see the existence of seemingly contradictory emotional experiences as complementary. They commence with the ability to tolerate and modulate extreme affective experiences based on expectations about how others will respond. They see others as unique for both internal and external attributes, but still in a relatively gross manner.

Level 5: Formal operational. People at this level of emotional awareness continue to differentiate the qualities of their internal emotional experiencing and make strides towards further differentiating the emotional experiencing of others. They also possess a complex capacity to use and experience subtle blends of emotions even if they haven't been modeled by others. They begin to employ metaphor to describe experience. They develop the ability to see themselves through the eyes of others. Their achievement of this level of emotional awareness creates a desirable feedback loop, making it likely that the person will achieve their goals in the world.

Lane and Schwartz's model integrates the development of well-differentiated and integrated self and object representations with the development of optimal levels of emotional awareness. In this sense, they help us to identify the developmental conditions that would give rise to this ability and the developmental obstacles that might impede it.

As demonstrated earlier, homeless families face a number of obstacles that may make the attainment of emotional awareness beyond the level of pre-operational unlikely, such as a high likelihood of having experienced neglectful or abusive parenting, a history of poverty, and significant current life stressors. However, for those who do attain higher levels of emotional awareness, this may provide them with an important resilience-strengthening resource in responding to stressors.

The Level of Emotional Awareness Scale (LEAS; Lane, Quinlan, Schwartz, Walker, & Zeitlin, 1990) was developed to assess persons' level of emotional awareness. Specifically, the LEAS measures the ability to verbalize emotions. It presents a person with either 10 or 20 (depending on the version used) scenarios involving two people. The scenarios are designed to evoke emotional responses. The person is asked to write down how they would feel in that situation and how they think the other person would feel. Lane (2000) argues that the ability to verbalize experience is related to the ability to manage it. The LEAS evidences a moderately strong positive correlation ($r = .38$) with the verbal subsection of the Wechsler Adult Intelligence Scale – Revised (Lane et al., 1990), suggesting that verbal ability does impact a persons' performance on the LEAS. However, Rau (1993) found that high LEAS scorers were better able to recognize emotion in photos (a nonverbal task) than low scorers, indicating that while better verbal ability is related to better performance on the LEAS, the LEAS is not simply another measure of verbal ability. The LEAS and its psychometric properties will be discussed in greater depth in the methods section.

The LEAS has been found to correlate positively with level of ego development and capacity for cognitive complexity (Lane, Kevley, Dubois, Shamsundara, & Schwartz, 1995) and self-restraint and impulse control (Barrett, Lane, Sechrest, & Schwartz, 2000). Low scores on the LEAS have been found in patients with substance abuse disorder (Carton et al., 2010), eating disorders (Bydlowski, et al., 2005), and in smokers (Carton, Bayard, Jouanne, & Lagrue, 2008). Ciarrochi, Caputi, and Mayer (2003) found that those with higher levels of emotional awareness are less likely to have their cognitive judgments biased by high levels of positive or negative mood states.

Baslet, Termini, and Herbener (2009) gave the LEAS to 21 individuals with schizophrenia spectrum disorder and found that they had lower levels of emotional awareness for the emotions of others, but normal levels of awareness of their own emotions. They also found that higher LEAS scores were associated with a better quality of life. Donges et al. (2005) reported a similar finding of a lower level of emotional awareness for others' emotions in patients with unipolar depression. Subic-Wrana, Bruder, Thomas, Lane, & Köhle, (2005) showed an increase in LEAS scores for patients on a psychosomatic ward as a function of treatment.

High LEAS scorers have shown greater activity in the anterior cingulate cortex when thinking about emotional experience (Lane et al., 1998). The dorsal and ventral anterior cingulate cortex has been found to be related to a persons' awareness of affective experience (Bush, Luu, & Posner, 2000; Ochsner & Gross, 2005). In a further study of this relationship (Frewen et al., 2008), researchers examined differences between trauma-exposed individuals with and without PTSD.

Individuals with PTSD had lower LEAS scores than those exposed to trauma but who had not developed PTSD. They also found an interaction between these groups and the activity of the anterior cingulate cortex. The non-PTSD group evidenced a positive correlation between LEAS scores and activity of the ventral anterior cingulate cortex while the PTSD group evidenced a negative correlation between these variables. In other words, as the LEAS score increased so did the level of activity in the anterior cingulate cortex for the non-PTSD group, while the opposite was true in the group that had developed PTSD.

Conclusion and Hypotheses of the Current Study

The above review suggests that homeless parents are exposed to a large number of stressors and traumata, but that their level of emotional intelligence and awareness may affect the degree to which they are affected by these stressors. The parents in this study are struggling to survive a difficult situation. While they cannot control the environmental factors that contribute to their difficulties they can exert some influence on their affective responses to it. This study is designed to explore the extent to which their emotional intelligence and level of emotional awareness is associated with their ability to exist in a traumatic environment with lower likelihood of psychological symptomatology, pathological dissociation, and demoralization. Although the study does not directly measure the relationship between emotional intelligence/emotional awareness and interpersonal coping methods, psychological symptoms, dissociation, and demoralization are symptoms of poorer psychological coping.

The studies of emotional intelligence and emotional awareness reviewed earlier indicate that those with higher scores on these measures are likely to perceive greater social support, to engage in constructive coping, to be more conscientious and open-minded, and less likely to exhibit symptomatology or PTSD even after having been exposed to traumatic situations. These findings indicate that emotional intelligence and emotional awareness may serve as protective factors for people undergoing stressful situations. Therefore, the primary hypothesis of this study is that homeless parents with higher emotional intelligence quotients and higher levels of emotional awareness will evidence lower scores on measures of symptomatology and psychological stress. The inferential hypotheses and exploratory questions are listed below.

Hypothesis 1: Homeless parents will have psychological distress at levels that are similar to clinical samples and greater than community samples. Research on similar populations cited earlier indicates that they are significantly distressed and look more similar to clinical populations than to the general public.

Hypothesis 2: Homeless parents will engage in more dissociation than the general population. Specifically differences in the frequency of item endorsement on the Dissociative Experiences Scale (described below) between study participants and the general population is expected.

Hypothesis 3: Homeless parents will experience demoralization as measured by the PERI-D (Dohenrend, Shrout, Egri, & Mendelsohn, 1980). The PERI-D is a comprehensive measure of demoralization (discussed in the Methods section). Although there are no available normative statistics on this instrument, comparison

will be made to a representative sample of 209 randomly sampled adults living in Washington Heights, NYC (Shrout et al., 1988).

Hypothesis 4: According to the literature reviewed, this sample is likely to have experienced more early trauma and is currently undergoing a significant amount of chronic stress. Therefore, this study hypothesizes that participants will evidence lower emotional intelligence and lower levels of emotional awareness than the general population.

Hypothesis 5: This study hypothesizes that affect regulatory capacity serves as a protective, resilience-enhancing factor. Therefore it is hypothesized that emotional intelligence and level of emotional awareness will be negatively associated with measures of psychological distress.

CHAPTER II

METHODS

Participants

The participants for this study were parents living in a transitional housing shelter in the South Bronx. Data were collected from June 2006 through June 2007. The data were collected as part of a larger study (Principal Investigator: Peter Fraenkel, Ph.D.), on the challenges and coping approaches of homeless families, and on the effectiveness of a family-based intervention in fostering individual and family functioning. Both the larger study and the present study, which analyses a portion of the data collected in the larger study, have ongoing approval from the CCNY Institutional Review Board (IRB).

The shelter typically accommodates up to 210 families on a given night and provides them with studio or one-bedroom efficiency style units depending on the size of the family. The shelter is designed to provide temporary housing as residents transition into government subsidized long-term housing. The average general length of stay for families is 8 months, and for the present sample of families, at the time that they participated in the research, 51.9% of the sample had been homeless 9 months or less (see Figure 1). All of the families residing in the shelter were eligible to participate in the study (participant recruitment is described under Procedures). After participating in the research portion of the larger study, the families were invited to take part in an 8-week, manualized, multiple-family

discussion group that focused on discussing challenges of shelter life and of the transition from welfare to work, trading coping ideas, and various activities designed to strengthen family communication and cohesion.

Characteristics of Study Participants

The sample consisted of 42 homeless parents ranging in age from 19 to 53 with a mean age of 34.24 (*SD* = 9.97). Eighty-one percent of the sample was female and 64.3% (of the 28 participants who provided this data) were single parents. The sample's race/ethnicity was primarily split between African/African-American (*n* = 19, 45.2%) and Latino (*n* = 21, 50.0%), with the remaining 4.8% (*n* = 2) Caucasian. Data on length of time being homeless, reason for homelessness, and level of education were also collected. These demographic and homeless history data are presented in Figures 1 and 2, and Table 2. Approximately 50% of this subset of the sample had been homeless for 9 months or less. (Because all the families immediately entered the shelter system upon becoming homeless, "length of time in shelter" and "length time being homeless" are essentially the same.) For those who answered the question, the two most frequent reasons for becoming homeless were eviction for inability to pay the rent (*n* = 14, 33.3%) and overcrowding due to "doubling up" with in-laws (*n* = 11, 26.2%). The majority of the sample (*n* = 26, 61.9%) had obtained a high school diploma, GED, or better, while 38.1% (*n* = 16) had dropped out of high school.

Procedure

Families were invited to participate in the study in the following manner. The shelter director's administrative assistant provided the research coordinator with a monthly census, which listed all of the families in the shelter in the order of their arrival to the shelter. Families were contacted either by the doctoral student research

coordinator (the present author) or a project staff member (a masters or doctoral student in clinical psychology) who told them briefly about the study and the group, and invited the families to meet with a research staff member to learn more about the study. They were told that they were under no obligation to meet with the research staff, or to participate in the research or the family group. If a family elected to meet with the research staff, they were told that if they decided to participate after hearing more about the study, they would be interviewed that afternoon if at all possible and then be given a packet of questionnaires, and so an appointment of four hours was set in the event they agreed to participate (usually from 3 p.m. until 7 p.m.). When families arrived for the research meeting, the staff members first read the informed consent forms aloud and answered any of the family's questions. If the family agreed to participate, they signed the informed consent forms. There was an informed consent form for parents (see Appendix A), who gave permission for themselves as well as their children to participate; a written informed assent for children and teens 12 and older; and an oral assent script for children 11 and younger. Part of the informed consent process was informing families that the interviews would be videotaped to allow for review and coding. The families were informed that the videotape would be seen only by staff members

for research and professional training purposes. The present study does not make use of the videotapes, or any of the data from or about the children and teens.

Participating families were then interviewed. Parents and teens were interviewed separately and then conjointly. The total time in interviews was 1½ to 2 hours. After a snack break, the family was then given a packet of questionnaires to complete with a project staff member present to answer any questions they might have regarding the instruments. Each parent, teen, or child worked individually with assistance from a research assistant. In addition to written questionnaires, the parents were asked to complete the Mayer-Salovey-Caruso emotional intelligence test (MSCEIT) on the computer. If they were not able to complete the interview and the questionnaires on the same day, another appointment was scheduled within the week to complete the questionnaires. The whole process occurred on one or two afternoons depending on the size and needs of the particular family and took approximately 4 hours to complete. The family received dinner (which consisted of either pizza or Chinese food) during the primary evening of their participation and received a stipend of $50 upon completion of this portion of the study. They were then debriefed and invited to the next family group cycle. There were no incidents of upset about either the interview or questionnaires: to the contrary, families appeared to enjoy both research procedures.

Instruments

Measures of Psychological Distress

The Brief Symptom Inventory. The Brief Symptom Inventory (BSI, Derogatis, 1993) is a 53-item self-report measure of psychological distress. It is a

simplified version of the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1983) and measures general psychological distress as well as specific types of symptomatology. Completion of the BSI requires the participant to report on the presence of particular symptoms (e.g. "trouble falling asleep") in the past week on a 5-point Likert scale of severity from 0 (*not at all*) to 4 (*extremely*).

General distress is measured using three scales: the Global Symptom Index (GSI) which is the average severity score of all 53 items and ranges from 0 to 4, the Positive Symptom Total (PST) which is the number of items endorsed as present (i.e. greater than 0) and ranges from 0 to 53, and the Positive Symptom Dimension Index (PSDI) which is the average severity of only those items endorsed as problematic and ranges from 0 to 4. The BSI assesses specific types of psychopathological symptoms with subscales that tap the following nine symptom clusters: somatization, obsessive–compulsive problems, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. These scores are the average severity of all the items assigned to that subscale.

The BSI shows high test-retest reliability (r = .90) and concurrent validity with the SCL-90-R and the MMPI (Derogatis, 1993). The current sample demonstrated excellent internal consistency (alpha = .97). There is some controversy regarding the nine factor scale as proposed by Derogatis, and evidence for the exact number of dimensions measured is equivocal (Hayes, 1997). However, most researchers generally agree that the BSI is a valid and reliable measure of psychological distress, and is one of the most frequently used scales in research and clinical contexts.

The Dissociative Experiences Scale. The Dissociative Experiences Scale (DES; Bernstein & Putnam 1986; Carlson & Putnam, 1993) is a 28-item self-report measure designed to assess experiences of dissociation. A typical DES question is "Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you." The respondent then slashes the line, which is anchored at 0% on the left and 100% on the right, to show how often he or she has this experience. The DES contains items describing a variety of dissociative experiences, many of which are normal experiences (e.g. "Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear all or part of what was said.")

Psychometric evaluations of the DES have found test-retest reliability coefficients ranging from .79 to .86 and split-half reliability coefficients of .83 and .93 (Bernstein & Putnam, 1986; Frischolz et al., 1990). The current sample demonstrated excellent internal consistency (alpha = .95). Bernstein and Putnam (1993) reviewed numerous studies that provide support for the establishment of construct and criterion validity for this measure.

Factor analytic studies (Carlson, Putnam, Ross, Anderson, Clark, Torem, et al., 1991; Ross, Joshi, & Currie, 1991) suggest that the DES taps both dimensional and categorical components of dissociative experience. The subscales of the DES represent three categories of the dissociative experiences: Amnesia; Absorption and Imaginative Involvement; and Derealization/Depersonalization. Of note, Carlson and Putnam (1993) caution against overreliance on use of the subscales due to the

positive skew that characterizes most DES data (i.e. scores tend to be on the low end of the scale) which may distort the correlations relied upon to establish the factors. Additionally, it has not yet been established whether the factors indicate different categories of dissociation or simply different rates of endorsement. For example, the Absorption and Imaginative Involvement factor consists of items that tend to be highly endorsed whereas the Amnesia factor consists of items that tend not to be highly endorsed. However, these factors do represent categorically different behavioral responses to trauma and may be viewed as representing a hierarchy of coping from the more to less adaptive.

Waller, Putnam, and Carlson (1996) culled eight items from the Amnesia and Depersonalization subscales on the DES that they believed to be markers of pathological dissociation and that are categorically different from non-pathological forms of dissociation that the rest of the measure taps into. They established the DES-Taxon (DES-T) subscale to represent these items. While both clinical and non-clinical populations may endorse items outside of the DES-T to varying degrees, most non-clinical participants will not endorse the eight items that make up the DES-T at all. Utilizing a cutoff score of 30 on the DES-T correctly identifies members of the taxon 87% of the time.

The construct validity of the DES-Taxon has not been established and recent studies support the hypothesis that apparent categorical differences on the DES may be an artifact of response frequency. Merrit and You (2008) compared the MMPI scores of college students who had high DES-T scores with college students who had high scores of non-pathological dissociation. They found no significant

difference between the two groups on MMPI performance; moreover they found strong positive correlations between the two subscales. However, Allen, Funtz, Huntoon, and Brethour (2002) found that DES-T membership discriminated members of an inpatient sample who reported experiences of childhood sexual abuse. Waller, Ohanian, Meyer, Everill, and Rouse, (2001) found that DES-T scores differentiated women with the most severe form of eating disorder (Binge-Purge Anorexia) from women with less severe forms of eating disorder and from normal controls. Of note, the women with less severe forms of eating disorders exhibited elevated DES-II scores compared to normal controls but did not differ on their DES-T scores.

The Psychiatric Epidemiology Research Interview. The Psychiatric Epidemiology Research Interview (PERI; Dohenrend et al., 1980) is a 27-item, self-report measure of non-specific, non-psychiatric stress. It is different from the BSI in it that it attempts to measure more specifically the impact of stress and adversity on a person's functioning, in addition to assessing standard symptomatology. It is a widely used measure in community psychology. Dohrenwend et al. (1980) developed the PERI in order to better assist researchers in providing an overall sense of level of distress of particular populations. The PERI operationalizes Frank's (1973) construct of *demoralization* which is conceived as a composite of anxiety, depression, feelings of helplessness, feelings of hopelessness, and low self-esteem. The PERI can be answered about symptoms experienced either within a time frame of the past year or the past month. Setting the time frame as the past month is thought to assess the impact of recent environmental changes on

participants' psychological state. In contrast, the time frame of a year is thought to assess more chronic, internally-driven demoralization, although it could be argued that long-term social context conditions such as poverty and joblessness could be responsible for year-long levels of demoralization. In any case, the current study used the past month time frame in order to assess participants' state since becoming homeless.

While it is expected that there will be a positive association between the BSI and the PERI, the PERI was included because it allows assessment of gradations of psychological distress that do not necessarily reach a clinical level. PERI scores may also be more indicative of the impact of homelessness, while the BSI will provide more information regarding existing symptomatology.

The PERI has demonstrated high internal consistency reliability and construct validity (Dohrenwend et al., 1980; Roberts & Vernon, 1981) as well as criterion validity by showing that mean scores on the PERI are higher for patient samples than those in the general community (Stokes, 1976; Tesler, 1977). The current sample demonstrated excellent internal consistency (alpha = .96).

Measures of Emotional Intelligence and Awareness

The Mayer-Salovey-Caruso Emotional Intelligence Scale (MSCEIT). As described in the literature review, the MSCEIT is an ability-based measure of emotional intelligence in that it assesses "how well people perform tasks and solve emotional problems" (Mayer et al., 2002, p. 1). It is a 141-item measure that is administered by computer. It consists of eight subtests, two for each branch of EI. The subtests consist of the following eight tasks: (a) perceiving emotion in faces;

(b) perceiving emotion in ambiguous pictures; (c) knowing what emotions are most useful to experience for the completion of a particular task; (d) knowing how different emotions are related to other sensations (such as color, light, and temperature); (e) understanding emotional blends; (f) the general transition of emotional responses in response to a particular event; (g) knowing how to use one's emotional reactions in certain situations to achieve a particular result; and (h) knowing how to act in response to certain situation in order to impact how another person might feel and respond.

The MSCEIT is a standardized instrument that yields an overall emotional intelligence quotient (Total EIQ) that is indexed to traditional intelligence quotient measures and so has a mean of 100 and a standard deviation of 15. It also yields two Area scores called Experiential and Strategic. The Experiential Area score is a measure of a persons' ability to "perceive emotional information, to relate it to other sensations such as color and taste, and to use it to facilitate thought" (Mayer et al., 2002, p. 17). The Strategic Area score measures a person's ability to understand and use emotional information for planning and self-management. The MSCEIT also yields four branch scores and scores for each of the eight subtests.

There are two scoring options for the instrument: general and expert. In the general scoring method, an answer is considered correct to the extent that it is similar to the answers offered by the normative sample. In the expert scoring method, an answer is considered correct to the extent that it concurs with the consensus of 21 international emotional experts regarding the correct answer to a particular question. The authors recommend using the general scoring method

because it accesses the total normative sample whereas the expert method accesses a subset of that sample. They add that there is little difference between the two methods and report intercorrelations between the two methods of .98 on the Total EIQ and ranging from .93 to .98 on the subscales. Therefore, the general scoring method was employed with the sample in this study.

The MSCEIT has been normed on over 5,000 participants and has established a full scale reliability of .91. The Strategic and Experiential area scores have reliabilities of .85 and .90 respectively. The four branch score reliabilities range from .74 to .89. The MSCEIT has established content (Mayer & Salovey, 1997) and factorial (Ciarrochi, Chan, & Caputti, 2000; Mayer et al., 1999) validity. A number of studies have evaluated the discriminant validity of the MSCEIT. Of particular importance, it has established discriminant validity from general intelligence as it yields a non-significant positive correlation of .05 with Ravens matrices (Ciarocchi et al. 2000) and a non-significant positive correlation of .15 (Salovey et al., 2003) with the vocabulary score of the WAIS-III. Interestingly, Ciarrochi et al. (2003) found a non-significant correlation of .00 to .21 with the Level of Emotional Awareness Scale which will be described below.

The Level of Emotional Awareness Scale (LEAS). The LEAS is a measure of the degree of integration and differentiation of an individual's awareness of emotional states in themselves and others. Similar to the MSCEIT, it is an ability measure in that it asks the participant to complete a task and then rates his or her performance based on the five levels of emotional awareness detailed in the previous chapter. Administration of the LEAS consists of having participants read

dyadic scenarios that involve the interaction of the participant with another person in situations involving frustration, pleasure, or some combination of these experiences, after which the participant writes down what they imagine they would be feeling in these situations and what the other person would be feeling. The LEAS evidences good construct and criterion validity as well as high inter-rater reliability (Lane, 2000; Lane et al., 1990; Lane et al., 1998). The LEAS can be administered in either a 10- or 20-scenario version. We administered the 10-scenario version at the beginning of the study and used the remaining 10 scenarios as a post-group outcome measure for the larger study.

Scoring the LEAS involves evaluating the participant's response for the level of integration and differentiation of emotional awareness. Participants are given a score between 0 and 5 for their emotional awareness of themselves and their emotional awareness of the other person in the scenario. Total scores are obtained by the adding together the highest scores for each scenario. Table 3 shows a sample question with examples of responses at each level of emotional awareness.

For this study, masters- and doctoral-level psychology research assistants were trained in LEAS scoring through reviewing the scoring manual and studying the glossary of words that were typical of different levels that were provided in the manual (Lane, 1991). Raters were considered reliable to score after achieving 80% agreement on 40 scenarios scored by the scale's authors. All responses were independently scored by two research assistants. When there was disagreement on a score, the scorers discussed the disagreement and consulted the manual to arrive at an agreement.

Data Analysis

The quantitative analyses proceeded in two steps. First, descriptive analyses were performed to describe the sample and analyses were performed to determine whether demographic or background variables were associated with the criterion or predictor variables. Then hypothesis testing was conducted and, finally, analyses were performed to address the exploratory questions.

Hypotheses 1, 2, 3, and 4 predicted the current sample would show more pathological scores on the BSI, DES, PERI-D, MSCEIT, and LEAS than the general public, and these hypotheses were tested using one-sample *t*-tests comparing the current sample's means to established norms or data from representative studies.

Hypothesis 5, predicting associations between measures of emotional intelligence and awareness and measures psychological distress, was tested first using a series of Pearson product moment correlations. It was believed that emotional intelligence and awareness as measured by the MSCEIT and the LEAS act as a protective factor for homeless parents and effectively buffer them from the deleterious impact of residing in the chronically stressful situation of homelessness. Statistically, this would be demonstrated by a negative correlation between the emotion skills measures (MSCEIT and LEAS) and measures of symptomatology (BSI, DES, and the PERI-D). Specifically, it was predicted that (a) the MSCEIT would be negatively associated with the BSI, the DES, and the PERI-D, and (b) the LEAS would be negatively associated with the BSI, the DES, and the PERI-D.

This hypothesis was also tested using multiple linear regression to combine the effects of all three psychological stress scales and determine whether they, as a group, were associated with emotional intelligence or emotional awareness.

Exploratory Question 1 asked whether particular DES items would be endorsed more by the current sample of homeless parents as compared to the general public. This was examined by comparing the current data to findings reported by Ross et al. (1991) using one sample *t*-tests.

Exploratory Question 2 was explored using a descriptive item-by-item analysis of the PERI-D to determine which items were the most and least distressing. Items were split into those that were above and those that were below the mean, and ordered by difference from the mean. These were then compared descriptively.

CHAPTER III

RESULTS

Descriptive Data

Means, standard deviations, medians, and skew and kurtosis statistics for the criterion and predictor measures were computed to describe the sample and to assess normality of the data prior to conducting hypothesis tests. Results for the criterion measures (BSI, DES, and PERI) are presented in Table 4. Many of the BSI scores are slightly positively skewed (between 1 and 2), meaning that the scores tend to cluster at the low end of the scale. A few scores are somewhat kurtotic, meaning that the distribution of scores is somewhat more pointed than a perfectly normal distribution. However the primary BSI measure, the GSI score, is only mildly kurtotic and skewed. The DES subscale scores show some skew but the DES total is normally distributed and the DES Taxon scale is mildly kurtotic and skewed. The PERI scores show no skew or kurtosis. However, *t*-tests (which will be used to evaluate hypotheses 1 through 4) have been shown to be quite robust in the face of moderate skew or kurtosis for samples the size of the current one (Sawilowsky & Blair, 1992). Correlation and regression (to be used for hypotheses 5 and 6) are also robust in the face of the current mild level of skew and kurtosis (Fowler, 1987; Garson, 2010).

The interrelationship of the DES subscales was analyzed using Pearson product moment correlations and are reported in Table 5. Since the subscales of Amnesia and Absorption were very highly correlated with the DES total score, and

the Depersonalization subscale was very highly correlated with the DES-Taxon scale, only the DES total and DES Taxon will be used for hypothesis testing.

Descriptive statistics for the predictor variables, the LEAS and MSCEIT, are presented in Table 6. The data appear to be sufficiently normally distributed. Intercorrelations of the MSCEIT scales (see Table 7) show that the three scores were strongly and positively intercorrelated. The relationship was stronger than reported in the normative data. The correlation matrix presented in Table 7 shows an *r* of .78 between the experiential and strategic area scores whereas the normative data shows an *r* of .51.

Relationships Between the Measures of Emotional Abilities

There was a small, nonsignificant, positive correlation of $r = .10$ between the LEAS and Total EIQ scores which indicates the two variables are not significantly related to each other, consistent with previous studies (Ciarocchi et al., 2003). In addition, there were no significant correlations between the LEAS and any MSCEIT subscale scores.

Relationship of Measures to Demographic Variables

In order to determine whether background or demographic variables were associated with the dependent or independent variables, and therefore should be considered as covariates, a series of analyses were conducted. The demographic variables of ethnicity, gender, and age were tested for associations with the dependent and independent variables. The background variable of length of time homeless was also examined.

Ethnicity

To determine whether there were any significant differences between the two prominent ethnic groups in the sample, Hispanic/Latino and African/African-American, on the criterion or predictor variables, independent samples *t*-tests were computed (see Table 8). Since there was only one Caucasian subject, s/he could not be included in this analysis. Hispanic participants showed significantly higher scores than African-American participants on DES Taxon and DES-Depersonalization. African-American participants showed significantly higher scores than Hispanic participants on MSCEIT scores of Emotional Experiencing, Emotional Reasoning, and Overall Emotional Intelligence. None of the other scales showed significant differences between the two ethnic groups.

Gender

Independent samples *t*-tests were conducted comparing male *(n* = 8) and female (*n* = 34) scores on the criterion and predictor variables (see Table 9). Significant differences were found for Emotional Experiencing and Overall Emotional Intelligence, with males showing significantly higher scores than females on these two scales. In addition, a trend toward significantly higher scores for men was seen on the Emotional Reasoning. No gender differences were seen on any of the other scales.

Age

To determine whether age was associated with scores on the criterion or predictor variables, Pearson correlations were conducted. Results are presented in

Table 10. Aside from a trend toward a significant relationship between age and scores on the emotional experiencing scale, no significant associations with age were found.

Length of Time Homeless

To determine whether there were any significant associations between the length of time a family had been homeless and the criterion and predictor variables, spearman rho correlations were conducted (see Table 11). This correlation was chosen because the variable of time homeless is ordinal, having been collapsed into 6 month intervals. None of the scales showed a significant association to length of time homeless.

Hypothesis Tests

Hypothesis 1: Psychological Distress

Participants' BSI scores were compared to normative data gathered by Derogatis (1993). Derogatis presents norms based on samples of (a) 341 non-patient members, (b) 1002 adult psychiatric outpatients, and (c) 423 adult psychiatric inpatients. All three norms and the current sample's data are presented visually in Figure 3. One-sample *t*-tests were performed to test this hypothesis and these are presented in Tables 13, 14, and 15.

Table 12 shows that the current sample's scores on the BSI are significantly higher on all subscales than the non-patient normative sample. Table 13 shows that the current sample is similar (i.e. not significantly different) to the outpatient sample on scores of PSDI and Somatization. On all other scales they are lower than the outpatient sample (but still higher than the non-patient sample). The *t*-tests presented in Table 14, comparing the current sample to the impatient norms, show no significant differences on the GSI, PST, Somatization, Obsessive Compulsive, Hostility, and Paranoid Ideation scales. It should be noted that Derogatis' (1993) inpatient norms are often lower than the outpatient norms, and thus the *t*-tests in Table 14 show more similarity to the inpatient normative sample. Figure 4 combines these means into one chart, demonstrating the relationship of all four samples to each other.

These analyses support Hypothesis 1 that predicted that participants would be more similar to psychiatric samples than community samples. These findings indicate that these participants are significantly stressed and struggling with multiple

psychological difficulties. This replicates the findings of Weinreb et al. (1993, 2003) who used the Global Severity Index of the BSI as a measure of general distress. However, the present sample had significantly lower GSI's than Weinreb et al.'s 2003 sample (t (41) = -2.09, $p < .05$).

Hypothesis 2: Dissociation

Participants mean score on the DES was 17.57 (SD = 16.01). This score indicates slightly elevated levels of dissociation compared to some normative data but not all.

DES-Taxon: Pathological dissociation. Of note, a greater percentage of this sample (9.5%) had DES-T scores above 30 than was found by Ross et al. (1991) in non-clinical samples (3.3%). This indicates that there is a greater degree of pathological dissociation in this population than in the general public.

Ross et al. (1991) administered the DES to a stratified cluster sample of 1055 non-psychiatric adults in Winnipeg, Canada. He found a mean total score of 10.80, which is significantly lower than the present sample mean of 17.57 (SD = 16.01) (t (41) = 2.74, $p < .009$). The comparison sample showed no major demographic differences from the current sample, with the exception of age.

Exploratory Question: Comparison of Participant Item Endorsement on the DES to Norms

Ross et al. (1991) presents data on means and prevalence (percentage of respondents who had a score greater than 0) for each item of the DES. For the purposes of addressing this exploratory question, these means were used as norms and were compared to study participants' data to ascertain whether and how this

sample's report of dissociation differs from the normative data. Table 15 presents a comparison of means and prevalence on items of the DES. The items are organized in order of the mean difference between the sample and the population. The items do not cluster around any one subscale of the DES.

Hypothesis 3: Demoralization

Participants were given the PERI-D to measure experiences of demoralization. Participants mean score of 2.53 (SD = .89) was compared to data collected on 209 randomly sampled adults living in Washington Heights, NYC (Shrout et al., 1988). A one-sample *t*-test was conducted and indicated that study participants exhibit significantly greater levels of demoralization than the comparison group, whose mean was 0.93, (t [41] = 11.70, $p < .001$). This supports Hypothesis 3.

Exploratory Question 2: Most and Least Distressing Items on the PERI-D

An item-by-item analysis of the PERI-D was conducted to determine which were the most and least distressing. Table 16 shows means and standard deviations for items whose means fell above the overall sample mean (M = 2.53, SD = .89). Table 17 shows means and standard deviations for items whose means fell below the overall sample mean.

Highly endorsed items are indicative of common responses to experience of extremely stressful situations and cluster around themes of worry, hopelessness, loneliness, and despair. Items that are not highly endorsed represent themes of severe panic and low self-esteem. While it is true that even lightly endorsed items indicate greater distress than the comparison sample, this finding indicates that as a

group, the participants in this study are least likely to endorse items that indicate a low perception of self-worth.

Hypothesis 4: Emotional Intelligence and Emotional Awareness

This hypothesis predicted that the current sample would exhibit lower levels of emotional intelligence (EIQ) and awareness (LEAS) than the general population.

Participants' MSCEIT scores were compared to normative values of 100 (since this scale is scaled to a mean of 100) using one-sample *t*-tests. Results showed that the current sample's scores on the overall Emotional Intelligence Quotient and Strategic Area scores were significantly lower than the population means and the Experience scores trended in that direction. The one-sample *t*-tests results are presented in Table 18.

Participants' mean score on the LEAS was 53.62 with a standard deviation of 8.75. This is significantly lower (t (41) = -6.13, $p < .001$) than data obtained from the general population by Lane et al. (1996) who conducted the LEAS with an age-stratified sample of 380 community members who ranged in age from 18 – 80. They found no differences as a function of age or gender in their sample. They reported a mean score of 61.9 with a standard deviation of 10.7. They also reported mean scores of 51 participants who met criteria for alexithymia as measured by the Toronto Alexithymia Scale. These participants mean LEAS score was 56.9 with a standard deviation of 10.8 which was still significantly higher (t (41) = -2.43, $p < .02$) than the scores of the current study's participants.

Results indicate that participants scored significantly lower on measures of emotional intelligence and awareness, which supports this hypothesis.

Hypothesis 5

A major hypothesis of this study was that there would be a negative relationship between measures of psychological stress and measures of emotional abilities. In other words, it was expected that participants who scored higher on measures of emotional intelligence and awareness would score lower on measures of psychological distress.. Pearson correlations were conducted to test this hypothesis (see Table 19).

Contrary to the hypothesis, there were no significant correlations between the total BSI, DES, and PERI scores and scores on the MSCEIT or the LEAS. This suggests that psychological stress is not related to emotional abilities. However, scores on the DES Taxon did show a moderately strong negative correlation (r = -.3, $p < .05$) with the emotional reasoning score on the MSCEIT and trended in that direction with the total and experiencing scores, which lends partial support to the validity of the hypothesis.

This hypothesis was also tested using multiple linear regression analysis to combine the effects of all three psychological stress scales and determine whether they, as a group, were associated with emotional intelligence or emotional awareness. The first regression, predicting emotional awareness, was not significant (R = .051, F[3, 38] = 0.03, p = .99), with the three distress scores only predicting 0.3% of the variability in emotional awareness. The second regression, predicting emotional intelligence, was also not significant (R = .119, F [3,38] = 0.18, p = .91), with the three distress variables predicting only 1.4% of the variability in emotional intelligence.

The results indicate that the more likely a study participant was to report engaging in more pathological forms of dissociation, the lower their performance was on the MSCEIT. There were no significant correlations between measures of psychological stress and the LEAS.

CHAPTER IV

DISCUSSION

The results of this study indicate partial support for its hypotheses. As predicted, participants in the study are contending with a greater degree of symptomatology, dissociation, and demoralization than the general population. This is consistent with other studies conducted with homeless families. Additionally, their affect regulatory capacity as measured by the MSCEIT and the LEAS is limited compared to the general population. An overall negative relationship between psychological stress and affect regulatory capacity was not found. However, this pattern was evident for participants who engaged in pathological forms of dissociation.

Symptoms of Psychological Stress

Psychiatric Symptomatology

As expected, participants' responses to the BSI indicate that they are significantly stressed and struggling with multiple psychological difficulties. This replicates the findings of Weinreb et al. (1993, 2003), who used the Global Severity Index of the BSI as a measure of general distress. As was noted earlier, this sample had significantly lower GSI scores than Weinreb's 2003 sample (t (41) = -2.09, $p <$ .05).

The participants in this study were similar to a clinical population on measures of overall severity of symptoms and on subscales measuring somatization and paranoid ideation. However, they performed better than clinical populations, although worse than non-clinical ones, on the remaining subscales (i.e. obsessive

compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, and psychoticism). This may mean that this particular sample is not struggling with significant symptomatology but that the elevated scores are more indicative of the significant stress they were undergoing when this study was conducted. Alternatively, the wide range and high kurtosis of many of the subscale distributions may indicate that a percentage of the sample is experiencing clinical levels of symptomatology, while the rest is more similar to a non-clinical population.

Dissociative Experiences

The homeless parents in this study spent a greater percentage of their time in dissociative activities than the general population, however, their mean score for dissociation (M = 17.57, SD = 16.01) was within normal limits. Ross (1991) reports that most samples find mean scores that vary somewhere between 10 and 20 which indicates a relatively normative level of dissociation. Additionally, the level of dissociation seen in this population is lower than normative data would suggest when adjusted for ethnicity. For example, Douglass (2009) conducted a study demonstrating that non-clinical ethnic minority populations tend to report higher levels of dissociation than Whites and that levels of dissociation in these communities bear a different relationship to psychological adjustment than they do for Whites. She found mean levels on the DES of 20.94 for African-American participants and 23.07 for Latino/a participants. The ethnic differences in dissociation found in this study replicate Douglass's findings. Douglas discussed the limits of the DES mean score in distinguishing pathological from non-pathological dissociation. She referred to studies demonstrating that racial/ethnic

minorities are more likely to have an external locus of control as compared to whites as a coping mechanism when confronted with events over which they could not exert much control such as racism. She cited Dunn et al. (1993) who proposed that "dissociation may be a coping mechanism for racial discrimination" (p. 34). For this reason, the greater prevalence of pathological dissociation in this sample should be interpreted cautiously, as the sample was primarily non-White.

Some of the item differences found between study participants and normative data may be due to the actual experience of being homeless. For example, the item that represents the greatest mean difference (being accused of lying when one is telling the truth) represents a common experience of this population and likely does not indicate a dissociative perception but rather a realistic one. Additionally, item difference numbers 6, 5, and 16 ("being approached by people one doesn't know who call one by a different name", "finding unfamiliar things among one's belongings", and being in a familiar place but finding it unfamiliar") may be less dissociative and more representative of the profound dislocation that people experience when they are no longer in familiar surroundings. The ecological validity of this scale for the homeless population may be weakened by these differences. If these mean differences result from normal behaviors of homeless people, then this scale may not be the best measure of dissociation for this population. A structured clinical interview such as the SCID-D may provide a more valid and reliable measure of dissociation among homeless families.

Demoralization

Participants reported greater levels of demoralization than a sample living in a working class upper Manhattan neighborhood. This is expected given the considerable stress of entering the homeless system. They were most distressed by feeling of sadness, worry, hopelessness, and bodily symptoms. Despite this, they were able to maintain personal pride and general self-esteem, a significant coping mechanism. Additionally, they were less distressed by symptoms of panic and dread.

Affect Regulatory Capacity

This is the first study to assess levels of emotional intelligence and awareness in an at-risk poverty sample. Results indicate that this sample evidences lower overall emotional intelligence than the community at large. Participants' average emotional experiencing area score was higher than the average strategic area score indicating that the results may be negatively impacted due to deficiencies in adult literacy (because the strategic area subtests relied heavily on verbal reasoning while the experiential subtests did not) and therefore the results should be interpreted cautiously. Anecdotally, experimenters reported that participants made statements such as "I feel like I'm back in school taking a test" and at times had to ask experimenters for the meaning of a particular word. A number of studies (Ciarrochi et al., 2000; Mayer et al., 1999; Salovey et al., 2003) have found mild correlations ranging from .05 to .38 between EIQ score and tests of verbal and cognitive ability. Therefore, it may be that the experiential score is a more valid representation of the emotional intelligence of this group. However, the strong correlation between the experiencing and reasoning subscales ($r = .73$) lends

support to the validity of the discrepancy. Therefore, while adult literacy issues may account for some of the variance in participants' EIQ scores, it is not likely that this alone explains the difference between the area scores.

The ethnic differences in emotional intelligence found in this sample is not supported by the literature, which has not found reliable overall ethnic differences in emotional intelligence. It may be that the differences in this sample are due to a quirk in the data (or to small subsamples) and do not represent reliable differences in the population at large. However, further research is necessary to answer this question. If ethnic differences are found to be stable then it may have to do with issues of test construction and different tests may need to be devised that are sensitive to cultural differences.

Participants in this study evidenced lower levels of emotional awareness than the general population as well. As a group, on average, they were at the pre-operational stage of emotional awareness. Normative data indicates that most people are at the concrete operational stage. This means that for this sample, emotions are likely to be experienced more as actions or bodily sensations. The elevated reports of somatization and distress caused by physical symptoms in this sample would be expected for people at this level of emotional awareness. These participants might therefore have greater difficulty in finding words for feelings for themselves and even greater difficulty in hypothesizing about the intentional states of others. An alternative hypothesis regarding this populations poor performance may call into question the validity of this measure. Strictly speaking, the LEAS measures a persons capacity to put emotions into words and assumes that this ability

correlates with a persons overall level of awareness of their own emotions. Whether this ability to verbalize emotions in a specific manner is necessary for emotional awareness and whether it relates to the hypothesized feeling states mentioned above is an empirical question that has not yet been approached in the literature.

Relationship Between Symptoms of Psychological Stress and Affect Regulatory Capacity

The results do not support the central hypothesis of the study: that overall symptoms of psychological stress are related to emotion regulatory capacity. A negative association between the total scores on the measures of psychological stress and the measures of affect regulatory capacity was not found. However, a significant, moderately strong negative relationship was found between pathological dissociative symptoms as measured by the DES-Taxon and the emotional reasoning subscale of the MSCEIT. Similar associations between the DES-T and the total EIQ and experiencing subscale that trended toward significance were also present. These findings offer limited support for the hypothesis and indicate that individual differences in emotional intelligence may be related to levels of pathological dissociation.

Implications of Findings

Study participants reported experiencing a greater degree of stress and symptomatology than the general population but not as high on most measures as clinical populations. Additionally, the wide range of scores and high levels of skewness and kurtosis on some measures indicate that there may be a subgroup of this sample that looks more similar to psychiatric populations than others. Almost

10% of this sample scores above the clinical cutoff for pathological levels of dissociation, which is a good predictor of dissociative disorders and other psychopathology (Ross, 1991). Similar findings of subgroups or types of homeless families have led researchers to propose developing typologies of homeless families to aid treatment decisions (Danseco & Holden, 1998; Kuhn & Culhane, 1998). For example, families that are transitionally homeless and have never been homeless before are less likely to present with serious mental health issues while the chronically homeless (in either frequency or duration) are more likely to have mental health problems and warrant a different type of treatment. Clinicians working with this population would do well to identify these different types of homeless families through thorough assessment and through familiarizing themselves with these typologies.

Study participants' low levels of emotional intelligence and awareness might mean that it will be harder for them than the average person to cope with a stressful environment. They are more likely to experience somaticizing disorders and engage in maladaptive coping efforts such as withdrawal or substance abuse when confronting stressful situations. Additionally, it might be harder for them to help their children to represent and understand their emotional experiences during such a stressful time, which could contribute to the development of symptomatology and maladaptive behaviors in their children. Clinically, it is important to focus on participants' emotional experiences of becoming and being homeless in order to help them develop an emotional language for themselves and their children that may attenuate their symptoms of psychological stress. Results indicate that a substantial

portion of therapeutic efforts should focus on building emotional knowledge of oneself and others in order better cope with this situation. The negative relationship between pathological dissociation and emotional reasoning further supports the implementation of therapeutic efforts to increase emotional knowledge and reasoning skills in this population.

Limitations of the Present Study and Suggestions for Future Research

This study has several limitations. First, due to the difficulties inherent in community research and recruitment of participants, randomization of the sample was not possible. Therefore, the participants were self-selecting and the interpretations of the data are limited by that bias. Second the findings are limited by the correlational nature of the study, which makes it impossible to ascertain whether or not the link between pathological dissociation and emotional intelligence is causal. Third, the small sample size of this study resulted in weakened statistical power that may obscure small but significant correlations that may be consistent with the studies hypotheses. Given a sample size of 42, a correlation of .30 or larger is necessary to reach statistical significance. Additionally, only large effect sizes of .7 sd or larger would achieve statistical significance given this sample size. Therefore, small correlations and small to moderate effect sizes may be obscured by this data. Further research with a larger sample size would help to ascertain the validity of this studies hypotheses. Fourth, this study lacked prospective data and observational/behavioral measures. The case for the influence of emotional intelligence on the lives of homeless families could be more clearly made by looking at the outcomes of homeless families of high and low emotional

intelligence, assessing and then tracking the families from their entry into the homeless shelter and assessing various behavioral measures over time (e.g. staff ratings of interpersonal functioning in the shelter, including getting along with other residents and with staff, adhering to shelter policies such as curfews, as well as reliability in making and keeping social service, employment, and housing appointments). Also, measures of resilience would have helped to further understand what role, if any, affect regulatory capacity played in protecting homeless families from the stressful effects of the homeless experience. Fifth, the validity of the measures of affect regulatory capacity, particularly the LEAS, may be limited. That is, while level of emotional awareness may be related to a person's capacity to actually regulate their emotional experience, a causal link between the two has not yet been established. Therefore, the lack of a relationship between the LEAS and the measures of psychological symptomatology may be the result of the limited validity of the LEAS to answer the questions of this study. Further research with instruments that more directly measure the behaviors associated with emotional regulation would be helpful in this regard. Finally, due to external limitations, this study lacked a comparison group of poor but housed individuals which would have provided a control group for the deleterious impact of poverty generally and provided information about the unique impact of homelessness on these families.

Future research is needed to develop sound typologies of homeless families in order to better direct policy and intervention with this population. Additionally, longitudinal research that can ascertain the extent to which affect regulatory capacity predicts good outcomes for this population is necessary in order to further

the efficacy of clinical work with these families. Finally, evaluations of programmatic interventions designed to increase emotional knowledge and general affect regulatory capacity are needed.

APPENDIX A

CONSENT FORM: Part I and Part II

Informed Consent to Participate in Research
Study on Employment and the Family: Part One

Principal Investigator: Peter Fraenkel, Ph.D.,
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General Introduction

HELP USA is working together with The City College of New York and the Ackerman Institute for the Family to learn more about families that are homeless and that have to move from welfare to work. In Part One of this study, we interview families and give them a packet of questionnaires to find out more about their psychological, emotional, and basic material needs as well as about their personal beliefs, strengths, and abilities. The interview asks about the kinds of difficulties homeless families face, the positive things as well as the difficult things that can occur when a parent attempts to gain employment, and how families cope with all these challenges. In the interviews, we will ask you and your children your thoughts about work and employment, and what kinds of changes (both positive and negative) you expect once you (the parent) begin job training and when you obtain employment. We will also ask you questions about how you interact as a family. Your participation in this part of the study will help us learn more about what homeless families go through, what they need, and what their strengths and abilities are.

In Part Two of this study, we are testing the usefulness of a program created to support families as they deal with the challenges of living in a shelter and as they attempt to move from welfare to work. The program is called Fresh Start for Families, and it was developed in part from what we learned from families in a previous similar study done by the Ackerman Institute and HELP USA. The program is described in a second, separate Informed Consent Form. After you complete Part One of the study, we will ask you if you would like to participate in Part Two, and you will receive this second Informed Consent Form.

Steps in the Study

There are five steps in Part One of the study. It is up to you and your family how many steps you choose to do, and you are free to discontinue participating at any point, even after starting a step. After we describe the steps, we will describe the different ways you can choose to participate in the study.

Steps 1 and 2: Describing the Study to You and Your Family. The first two steps were our first conversation about the study, and our meeting right now to go over the details of it. If you and your children agree to participate and sign

this Informed Consent Form and the Children's Assent Form, you go to the third step.

Step 3: Interview. In the third step, you and your children will be interviewed for one hour and 20 minutes). Part of the interview (about 40 minutes) will be with you (the adult or adults in the family) alone, and part with the kids joining you (about 40 minutes). If there's a pre-teen or teen aged 10 to 19 in your family, he or she will have a separate interview while you're being interviewed alone. We find that pre-teens and teenagers often feel more comfortable talking about personal things apart from their parents. You can have a copy of the interview questions we ask you or your pre-teen or teenager. You and your kids can choose not to answer any questions that you don't feel comfortable answering. There will be breaks and snacks provided during the interview, and a pizza dinner so you don't have to worry about cooking that night. You will also be paid $25.00 for your time completing the interview.

Step 4: Questionnaires. In the fourth step, which occurs right after the interview, one of our Research Assistants will give you and the kids who are age 8 or over a set of questionnaires. The questionnaires we give you will ask questions about your backgrounds, your feelings and moods, how you think and feel about yourself, how you see your kids' emotions and behaviors, your family beliefs and ways of coping, and how the family gets along. We will give you some questionnaires to fill out right after the interview. Those questionnaires will take about 1½ hours to fill out. You can fill them out while the kids are filling out their questionnaires. The other questionnaires for you take about another hour to fill out. You can fill them out in your unit and bring them back the following week.

Here are some more details about the questionnaires we will give your kids. They will take about 1½ hours to fill out. One of the questionnaires, which is called Feelings about Being in the Shelter, will be read to your child by the research assistant, who will record your child's answers on the form. That will take about 12 minutes. Another one, called the TAT, is a set of 9 cards with pictures of people on them doing different things. Your child will be asked to tell a story about the pictures, and the research assistant will ask your child some questions about his or her stories and tape record his or her answers so that they can write them down and read them carefully later. This procedure helps us learn about how kids think about emotions. The TAT will take about 24 minutes. The tape of your child's answers to the TAT is erased immediately after the research assistant writes down what he or she said. If there is time and if the child is not too tired, he or she will then be asked to fill out the other 5 questionnaires. Two of them ask about different kinds of feelings and how the child handles them; each one takes 10 minutes to finish. Another one asks the child to read some short stories about other people and think about what they might be feeling. That one takes about 15 minutes to do. Then, there is one more questionnaire that asks how the child feels about the family: that one takes about 15 minutes to do.

If you or your child are too tired to do any or all of the questionnaires after the interview, we will set up another time when you can come back on another day to meet with the research assistant and do those questionnaires.

Step 5: Meeting to Go Over the Questionnaires. In the fifth step, you will meet again with the Research Assistant one week later for no longer than 1 hour, to return and go over any questionnaires that you completed in your unit. The Research Assistant will go over the questionnaires with you and the kids to make sure you didn't miss any items that you wanted to answer. You are free to skip any items or whole questionnaires that you do not want to answer. At the end of this meeting you will be paid $25.00 for your time in filling out the questionnaires.

HELP Files. From the beginning of the study we will also ask your written permission to check your HELP files to see what kinds of work, education, or training opportunities you had.

Confidentiality. In order to learn more from your responses, we will videotape or audiotape the interviews. The entire tapes will be viewed or listened to only by the family support project staff to help us better develop the program. The family support project staff include Peter Fraenkel, PhD, who is the Principal Investigator of this study and Co-Director of the Fresh Start for Families Program; two Program Coordinators, who are either social workers or psychology graduate students from the City College of New York; as well as 2 Research Coordinators and 6 Research Assistants who assist in identifying important information from the tapes. The Research Coordinators are graduate students in clinical psychology at City College; the Research Assistants are social workers in postgraduate training at the Ackerman Institute for the Family, and psychology graduate and upper-level undergraduates (juniors and seniors) at the City College of New York. All of these family support project staff have completed training in the importance of maintaining confidentiality and a respectful attitude towards all information that families provide, whether on videotapes, audiotapes, or in writing on questionnaires. All staff work directly under the supervision of Dr. Fraenkel, who is a Professor at City College.

Portions of the tapes on which you appear may be used to create a short (10 – 20 minute) tape that combines short clips from many different families. This tape will be shown only to mental health and social service professionals, and to persons in charge of giving financial support to research and programs, so that they can learn about the needs and coping abilities of families who are homeless, and to demonstrate the Fresh Start for Families group program. Your identity will be protected because your last name will not be mentioned by you or by us on any original tape, and all first names mentioned on the edited tape will be beeped out. These tapes will be shown only by Dr. Fraenkel and will remain in his possession.

The original tapes of family interviews and groups will be labeled only with code numbers – no names go on any labels. After any interview or group, you may choose to watch the tape and ask that we not use part or all of it.

Just like the tapes, all questionnaires and information from HELP files about your work opportunities will be labeled with code numbers -- your names do not go on anything except for this consent form, a form called the Family Information Form, and one sheet that links your name to the code numbers. This sheet is important so that we make sure we give the

same code numbers to you each time we give you questionnaires. All tapes, questionnaires, and summaries of work records will be locked in cabinets that are stored in a locked room inside another locked room at the City College of New York. The consent forms and sheet linking names to code numbers will be kept in a separate file cabinet from the ones that contain the tapes, questionnaires, and summaries of work records. Only project staff members have access for the purposes of scoring and analyzing the information. There is a risk of breach of confidentiality.

Your information will be kept totally confidential, to the extent permitted by law. The only time that we are required to break confidentiality is if you or your child make a statement or provide information in an interview, on a questionnaire, in a group, or in passing that you, he or she (1) is in danger or (2) may hurt yourself/themselves or someone else. In this case, we would discuss this with you and then report it to the Director of Clinical Services at HELP, who would then take the appropriate steps to safeguard the persons in danger. In the same way, if your child tells us that he or she has been sexually, physically, or emotionally abused, or if we strongly suspect this might be the case, we are mandated (required) to report this. We would first immediately talk with you, then with the Director of Clinical Services, and then make the report to the State Central Registry.

Risks and Benefits. No physical risks or discomforts are anticipated to occur for you or your children by participating in this study. You and your children may experience some degree of emotional discomfort in talking about the experience of being homeless or in answering some of the questionnaire questions. There is a possibility that you or your children may experience some symptoms of distress, such as anxiety, upset, or sadness after doing the interview, doing the TAT story-telling task, or filling out the questionnaires. If you or your child experience distress, we will discuss with you whether you would like to see a staff clinician of the shelter for psychological counseling. However, no lasting negative effects are expected from participating in this research. Please ask us if you have questions or concerns about particular questions asked in the interviews or questionnaires.

You may experience a number of positive benefits from participating in the study. From the interview, you and your family may feel positively about having an opportunity to talk to people who are interested in your experiences becoming homeless and trying to move from welfare to work. In previous similar research done by the Principal Investigator, families indicated that they found it a positive experience to have a chance to talk about their feelings, what they'd been through, and their coping abilities, even though this research interview is not therapy. From completing the questionnaire packet, you and your family may find that you become more aware both of the problems you are facing currently and the coping skills and other strengths you already have.

Just to review the stipends offered. Families will be given a stipend of $25.00 for completing the interview, and $25.00 for the completed questionnaires, for a total of $50.00. "Completed" questionnaires includes having the meeting with the research assistant to make sure all questionnaires are filled in (except for items that you specifically do not wish to answer).

If you have any questions regarding this research, you can call Professor Fraenkel, who is the Principal Investigator, at (212) 650-5671. If you have any questions concerning your rights as a participant in this study, you can call the City College IRB Office IRB Administrator, Ms. Lissy Wassaff, at (212) 650-7902. You can write to her at:

Ms. Lissy Wassaff
IRB Office IRB Administrator
The City College/City University of New York Medical School Institutional Review Board
Convent Avenue at 138th Street, Room S-16
New York, NY 10031

Please sign this Informed Consent form to indicate that you understand the purpose of this study, and that you have agreed to participate in it. In addition, your signature indicates that you give consent to the City College and Ackerman Institute project staff to review your HELP case file and employment case file at HELP Works. The case file review will focus on basic demographic data, employment history and current employment status, as well as employment and training opportunities you are offered and/or take part in over the year. A copy of this form will be provided to you for your records.

SEE NEXT PAGE FOR SIGNATURES

Informed Consent to Participate in Research
Study on Employment and the Family: Part One

I understand the purpose and procedures of the research. I have been given sufficient time to consider whether I wish to participate in the study. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I give my full consent to participate and to allow my children to participate. (These signature lines for adults and teens, ages 13-18).

_____ _____
Signature Date

_____ _____
Print your name Your Age

_____ _____
Signature Date

_____ _____
Print your name Your Age

_____ _____
Signature Date

_____ _____
Print your name Your age

For participating children under 12 years of age:

Name of Child:_____ _____
Age
Name of Child:_____ _____
Age
Name of Child:_____ _____
Age

_____ _____
Signature of Adult Guardian Date

_____ _____
Print your name Relation to Children

_____ _____
Principal Investigator Date

Informed Consent to Participate in Research
Study on Employment and the Family: Part Two

Principal Investigator: Peter Fraenkel, Ph.D.,
Associate Professor, Department of Psychology, City College of New York
Room 7/120, NAC Building, 138th & Convent Avenue
New York, New York 10031
(212) 650-5671

General Introduction

In this second part of the study, we are testing the usefulness of a program created to support families living in homeless shelters and as they attempt to move from welfare to work. The program is called Fresh Start for Families, and it was developed in part from what we learned from families in a previous similar study done by the Ackerman Institute and HELP USA. Your participation in this family support program will allow us to make the program even better by helping us to see if the program helps families cope better as a family, feel better emotionally, and helps the adult members get and keep jobs.

Different Ways to Participate in Part Two of the Study. There are a few ways that you and your family may participate in this part of the study. You can decide to participate in the Fresh Start for Families support program (Step 1a) and the HELP Works employment program (Step 1b); only the Fresh Start for Families program; only the HELP Works employment program; or neither program. If you choose to participate in neither program, you can still participate in the rest of the study by completing the questionnaires in Steps 2-5. And as mentioned before, you can withdraw from the study at any point. In order to receive payment for a particular step, you must complete that step. Your decision to participate or not participate in this study or in any particular step of the study will in no way affect the usual services you receive here at HELP.

Steps in the Study

Step 1a: Six Weeks of the Fresh Start for Families Group. In the first step, after you and your family complete the interview and the questionnaires, you will be invited to join the six-week Fresh Start for Families group. In the Fresh Start for Families group, 6 to 8 families meet together once a week, from 5:30 p.m. – 7:30 p.m. on Wednesdays. The purpose of the Fresh Start for Families group is to help families deal with the challenges of living in a homeless shelter, including the strong negative emotions that family members may feel, especially as the adult members deal with the challenges of moving back to work or go to work for the first time. Groups will be co-led by psychology graduate students from the City College of New York, psychologists and social workers from the Ackerman Institute, and social workers and employment specialists from HELP. Your family interview will help us know what you would most like to get out of being in the group. At the end

of each weekly group session, all family members will complete a short evaluation of the group. The evaluation is anonymous – your name does not go on it. The evaluation takes 3-5 minutes to complete. This will help us know how useful the group is for you and your family, and will give us ideas about what to change.

Step 1b: The HELP Works Employment Program. At the same time that you are invited to join the Fresh Start multiple family discussion group, you will be invited to enroll in HELP Works. HELP Works provides training in writing resumes, job interviews, searching for jobs, and other employment skills. The program also has staff members that help you find a job or internship towards a job.

Step 2: Questionnaires at the End of the 6-Week Family Group Program. In the second step, you will be asked to come the week after group ends to complete another set of questionnaires – the same ones you completed after the interview and before the group. As before, the questionnaires ask you about your feelings and moods, how you think and feel about yourself, how you see your kids' emotions and behaviors, your family beliefs and ways of coping, and how the family gets along. The set of questionnaires for adults takes 2 hours to complete; for kids and teens about 1½ hours. At the end of this meeting you will be paid $25.00 for your time in filling out the questionnaires.

Here are some more details about the questionnaires we will give your kids. They will take about 1½ hours to fill out. One of the questionnaires, which is called Feelings about Being in the Shelter, will be read to your child by the research assistant, who will record your child's answers on the form. That will take about 12 minutes. Another one, called the TAT, is a set of 9 cards with pictures of people on them doing different things. Your child will be asked to tell a story about the pictures, and the research assistant will ask your child some questions about his or her stories and tape record his or her answers so that they can write them down and read them carefully later. This procedure helps us learn about how kids think about emotions. The TAT will take about 24 minutes. The tape of your child's answers to the TAT is erased immediately after the research assistant writes down what he or she said. If there is time and if the child is not too tired, he or she will then be asked to fill out the other 5 questionnaires. Two of them ask about different kinds of feelings and how the child handles them; each one takes 10 minutes to finish. Another one asks the child to read some short stories about other people and think about what they might be feeling. That one takes about 15 minutes to do. Then, there is one more questionnaire that asks how the child feels about the family: that one takes about 15 minutes to do.

If you and your family decided not to participate in the Fresh Start program but decided to continue participating in the study, you will receive this set of questionnaires at this time as well. (The option of participating in the study but not in Fresh Start is discussed below).

Step 3: Monthly Work Report Form. In the fourth step, we will ask you to fill out each month a 2-page work report form to tell us what kind of jobs, educational activities, or other training you did during the month. The form takes about 5 to 10 minutes to complete.

Step 4: Questionnaires One Year Later. The fourth and final step comes 1 year after you completed the previous set of questionnaires (see Step 2). We will give you or send you another set of questionnaires and ask for your final work report form. This is a shorter set of questionnaires takes about 1½ hours for adults to complete, 1 hour for kids and teens. You will be paid $25.00 for your time in filling out the questionnaires.

HELP Files. As in Part One, we will also ask your written permission to check your HELP files to see what kinds of work, education, or training opportunities you had.

Confidentiality. In order to learn more from your responses, we will videotape the groups. The entire tapes will be viewed only by the family support project staff to help us better develop the program. The family support project staff include Peter Fraenkel, PhD, who is the Principal Investigator of this study and Co-Director of the Fresh Start for Families Program; two Program Coordinators, who are either social workers or psychology graduate students from the City College of New York; as well as 2 Research Coordinators and 6 Research Assistants who assist in identifying important information from the tapes. The Research Coordinators are graduate students in clinical psychology at City College; the Research Assistants are social workers in postgraduate training at the Ackerman Institute for the Family, and psychology graduate and upper-level undergraduates (juniors and seniors) at the City College of New York. All of these family support project staff have completed training in the importance of maintaining confidentiality and a respectful attitude towards all information that families provide, whether on videotapes, audiotapes, or in writing on questionnaires. All staff work directly under the supervision of Dr. Fraenkel, who is a Professor at City College.

Portions of the tapes on which you appear may be used to create a short (10 – 20 minute) tape that combines short clips from many different families. This tape will be shown only to mental health and social service professionals, and to persons in charge of giving financial support to research and programs, to demonstrate the Fresh Start for Families group program. Your identity will be protected because your last name will not be mentioned by you or by us on any original tape, and all first names mentioned on the edited tape will be beeped out. These tapes will be shown only by Dr. Fraenkel and will remain in his possession.

The original tapes of family interviews and groups will be labeled only with code numbers – no names go on any labels. After any interview or group, you may choose to watch the tape and ask that we not use part or all of it.

Just like the tapes, all questionnaires and information from HELP files about your work opportunities will be labeled with code numbers -- your names do not go on anything except for this consent form, a form called the Family Information Form, and one sheet that links your name to the code numbers. This sheet is important so that we make sure we give the same code numbers to you each time we give you questionnaires. All tapes, questionnaires, and summaries of work records will be locked in cabinets that are stored in a locked room inside another locked room at the City College of New York. The consent forms and sheet linking names to code numbers will be kept in a separate file cabinet from the ones that contain the tapes, questionnaires, and summaries of work records. Only project staff members have access for the purposes of scoring and analyzing the information. There is a risk of breach of confidentiality.

Your information will be kept totally confidential, to the extent permitted by law. The only time that we are required to break confidentiality is if you or your child make a statement or provide information in an interview, on a questionnaire, in a group, or in passing that you, he or she (1) is in danger or (2) may hurt yourself/themselves or someone else. In this case, we would discuss this with you and then report it to the Director of Clinical Services at HELP, who would then take the appropriate steps to safeguard the persons in danger. In the same way, if your child tells us that he or she has been sexually, physically, or emotionally abused, or if we strongly suspect this might be the case, we are mandated (required) to report this. We would first immediately talk with you, then with the Director of Clinical Services, and then make the report to the State Central Registry.

Risks and Benefits. No physical risks or discomforts are anticipated to occur for you or your children by participating in this study. There is a possibility that you or your children may experience some symptoms of distress, such as anxiety, upset, or sadness after filling out the questionnaires, or for your child, during or after telling stories to the TAT cards. If you or your child experience distress, we will discuss with you whether you would like to see a staff clinician of the shelter for psychological counseling. However, no lasting negative effects are expected from participating in this research. Please ask us if you have questions or concerns about particular questions asked in the interviews or questionnaires.

From participating in the Fresh Start Program, you and your family may get a sense of support from other families and from the co-leaders. You may feel comforted to know that others have been through similar experiences to yours. You also may have the opportunity to share ideas and specific tips about how to cope with being homeless and moving from welfare to work. From participating in the HELP Works program, you may learn the skills taught in the program, such as how to write a resume, how to do a job interview, and how to do a job search. You will also be helped to find an internship or a job, and/or an educational or training program that furthers your employment goals. Of course, the potential benefits listed above cannot be guaranteed.

Just to review the stipends offered. Families will be given a stipend of $25.00 for each set of questionnaires, for a total of $50.00. "Completed" questionnaires includes having the meeting with the research assistant to make sure all questionnaires are filled in (except for items that you specifically do not wish to answer).

If you have any questions regarding this research, you can call Professor Fraenkel, who is the Principal Investigator, at (212) 650-5671. If you have any questions concerning your rights as a participant in this study, you can call the City College IRB Office IRB Administrator, Ms. Lissy Wassaff, at (212) 650-7902. You can write to her at:

Ms. Lissy Wassaff
IRB Office IRB Administrator
The City College/City University of New York Medical School Institutional Review Board
Convent Avenue at 138th Street, Room S-16
New York, NY 10031

Please sign this Informed Consent form to indicate that you understand the purpose of this study, and that you have agreed to participate in it. In addition, your signature indicates that you give consent to the City College and Ackerman Institute project staff to review your HELP case file and employment case file at HELP Works. The case file review will focus on basic demographic data, employment history and current employment status, as well as employment and training opportunities you are offered and/or take part in over the year. A copy of this form will be provided for your records.

Informed Consent to Participate in Research
Study on Employment and the Family: Part Two

I understand the purpose and procedures of the research and the group program. I have been given sufficient time to consider whether I wish to participate in the study. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I give my full consent to participate and to allow my children to participate. (These signature lines for adults and teens, ages 13-18).

_____ _____
Signature Date

_____ _____
Print your name Your Age

_____ _____
Signature Date

_____ _____

Print your name Your Age

For participating children under 12 years of age:

Name of Child:_____ _____
Age

Name of Child:_____ _____
Age

Name of Child:_____ _____
Age

_____ _____
Signature of Adult Guardian Date

_____ _____
Print your name Relation to Children

_____ _____
Principal Investigator Date

APPENDIX B

TABLES AND FIGURES

Table 1

The four-branch model of emotional intelligence

Branch Name	Brief Description of Skills Involved
Perceiving Emotions	The ability to identify emotions in oneself and others, as well as in objects, art, stories, music, and other stimuli.
Using Emotion to Facilitate Thought	The ability to generate, use, and feel emotion as necessary to communicate feelings, or use them in other cognitive processes.
Understanding Emotion	The ability to comprehend emotional information, how emotions combine and progress through relationship transitions, and to appreciate such emotional meanings.
Managing Emotion	The ability to be open to feelings, to regulate them in oneself and others to promote personal understanding and growth.

Adapted from Salovey, Mayer, Caruso, & Lopes (2003), p. 252

Figure 1

Length of Time Homeless

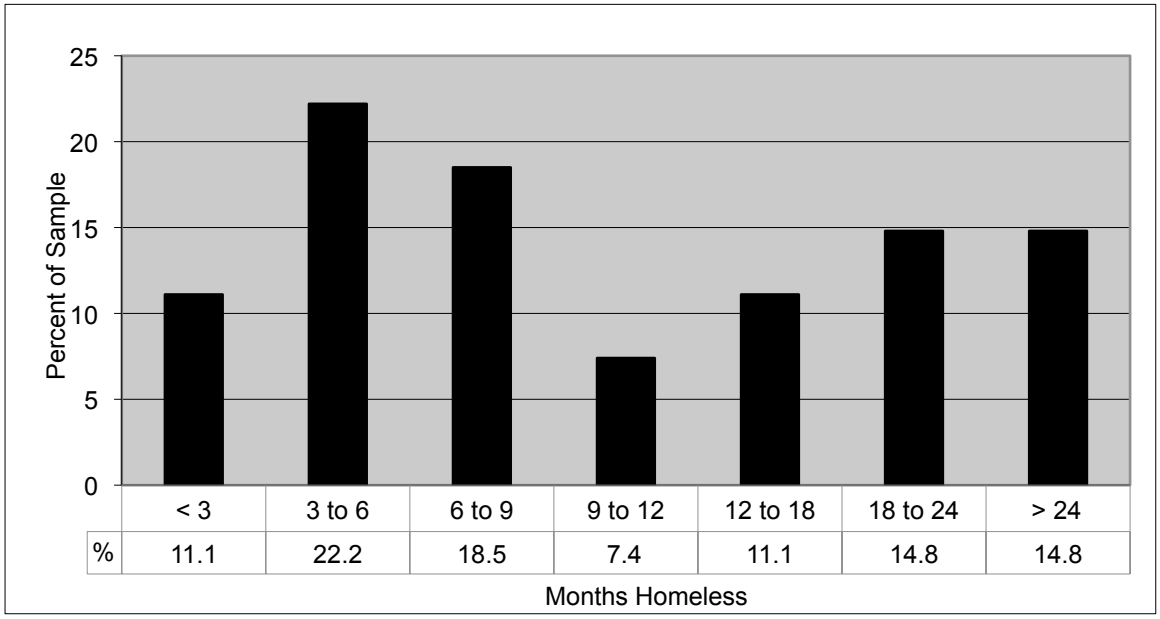

Figure 2

Reasons for Homelessness Reported.

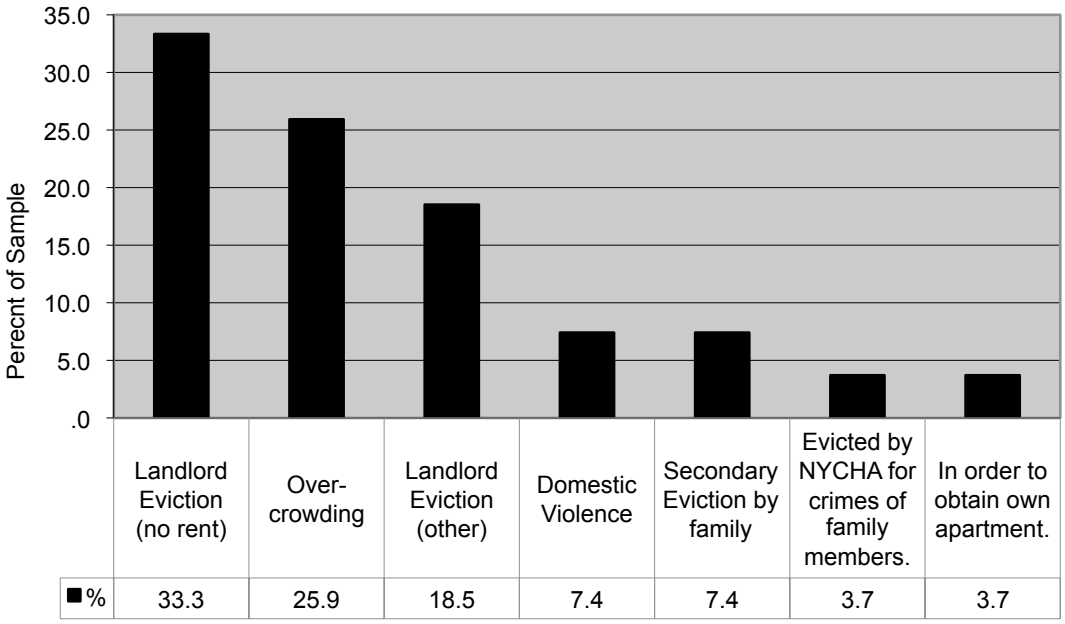

Table 2

Participants' Education Level

Education Level	*n*	%
Some High School	16	38.1
High School Graduate or GED	21	50.0
Some College	5	11.9
Total	42	100.0

Table 3

Sample LEAS Question with Scored Responses at Each Level of Emotional Awareness

Scenario: "You and your best friend are in the same line of work. There is a prize given annually to the best performance of the year. The two of you work hard to win the prize. One night the winner is announced: your friend. How would you feel? How would your friend feel?"

Score	Level of Emotional Awareness	Sample Response
0	Sensorimotor Reflexive	I don't work hard to win "prizes." My friend would probably feel that judges knew what they were doing.
1	Sensorimotor Enactive	I'd feel sick about it. It's hard for me to say what my friend would feel – it would all depend on what our relationship was like and what the prize meant to her.
2	Preoperational	I'd probably feel bad about it for a few days and try to figure out what went wrong. I'm sure my friend would be feeling really good.
3	Concrete Operational	We would both feel happy. Hey, you can't win 'em all!
4	Formal Operational	I would feel depressed – the friend in this light is just like any other competitor. I would also begrudgingly feel happy for my friend and rationalize that the judges had erred. My friend would feel very gratified but would take the prize in stride to save the friendship.
5	A more complex form of Formal Operational	I'd feel disappointed that I didn't win but glad that if someone else did, that person was my friend. My friend probably deserved it! My friend would feel happy and proud but slightly worried that my feelings might be hurt.

Adapted from Lane (2000) p. 187.

Table 4

Brief Symptom Index Subscale Scores (n = 42)

Scale	Subscale	Low	High	Mean	(SD)	Skew	(SE)	Kurtosis	(SE)
BSI	GSI	.00	3.62	0.82	(0.78)	1.420	(.365)	2.876	(.717)
	PST	.00	52.00	20.86	(15.58)	.261	(.365)	-1.018	(.717)
	PSDI	.00	4.00	1.71	(0.96)	-.097	(.365)	.325	(.717)
	Somatization	.00	3.86	0.70	(0.91)	1.658	(.365)	2.520	(.717)
	Obsessive Compulsive	.00	3.83	1.07	(1.04)	.993	(.365)	.619	(.717)
	Interpersonal Sensitivity	.00	4.00	0.79	(0.81)	1.539	(.365)	4.453	(.717)
	Depression	.00	4.00	0.91	(1.00)	1.332	(.365)	1.264	(.717)
	Anxiety	.00	3.83	0.66	(0.76)	1.946	(.365)	5.981	(.717)
	Hostility	.00	4.00	0.78	(0.97)	1.470	(.365)	1.988	(.717)
	Phobic Anxiety	.00	2.80	0.53	(0.80)	1.615	(.365)	1.437	(.717)
	Paranoid	.00	3.20	1.08	(0.92)	.771	(.365)	-.044	(.717)
	Psychotic	.00	3.60	0.63	(0.76)	1.938	(.365)	4.968	(.717)
DES	Total	.00	67.14	17.57	(16.01)	1.138	(.365)	.787	(.717)
	Absorption	.00	72.22	24.42	(20.43)	.852	(.365)	- .272	(.717)
	Amnesia	.00	67.50	13.75	(16.18)	1.546	(.365)	2.127	(.717)
	Depersonalization/ Derealization	.00	61.67	10.00	(14.85)	1.784	(.365)	3.020	(.717)
	DES-Taxon	.00	53.75	10.65	(14.16)	1.703	(.365)	2.425	(.717)
PERI		1.26	4.52	2.53	(0.89)	.465	.365	-.544	.717

Note: GSI: Global Severity Index, PST: Positive Symptom Total, PSDI: Positive Symptom Dimension Index; DES: Dissociative Experiences Scale; PERI: Psychiatric Epidemiology Research Interview.

Table 5

Intercorrelation of DES Subscales

	Total	Taxon	Amnesia	Absorption	Depresonalization
Total	1.00				
Taxon	.84 *	1.00			
Amnesia	.91 *	.83 *	1.00		
Absorption	.95 *	.68 *	.76 *	1.00	
Depersonalization	.84 *	.94 *	.81 *	.69*	1.00

* $p < .001$

Table 6

Descriptive Statistics for the Predictor Variables: MSCEIT and LEAS

Scale	Low	High	M (SD)	Skew (SE)	Kurtosis (SE)
MSCEIT					
Overall Emotional Intelligence	54.11	123.19	79.45 (16.84)	.619 (.365)	.140 (.717)
Emotional Experiencing	59.74	150.70	94.72 (19.88)	.345 (.365)	.114 (.717)
Emotional Reasoning	52.43	113.26	74.86 (12.80)	.827 (.365)	1.752 (.717)
LEAS	34.00	68.00	53.62 (8.75)	-.506 (.365)	-.185 (.717)

Table 7

Intercorrelations of MSCEIT Subscales

	r (p)		
	Experiencing	Reasoning	Overall EIQ
Experiencing	--		
Reasoning	.73 (< .001)	--	
Overall EIQ	.93 (< .001)	.91 (< .001)	--

Table 8

Independent Samples t-*Test Results Comparing African Americans and Hispanics on Dependent and Independent Variables*.

	African-American (n = 19)		Hispanic (n = 21)				
Scale	*M*	(SD)	*M*	(SD)	*t*	df	*p*
DES	14.60	(11.75)	19.47	(18.75)	-0.99	34.00	0.33
DES Taxon	4.61	(5.74)	15.12	(16.40)	-2.76	25.27	0.01 *
DES Amnesia	9.87	(12.36)	16.73	(18.75)	-1.35	38	0.19
DES Absorption	23.22	(17.04)	24.71	(23.31)	-0.22	38	0.82
DES Depersonalization	3.68	(7.32)	14.05	(16.58)	-2.60	28.10	0.02 *
LEAS	52.84	(8.06)	54.19	(9.82)	-0.47	38	0.64
PERI	64.74	(26.86)	69.10	(18.99)	-0.60	38	0.55
Emotional Experiencing	99.00	(20.63)	90.15	(18.72)	1.42	38	0.16
Emotional Reasoning	79.22	(14.44)	71.07	(10.27)	2.07	38	0.05 *
Overall Emotional Intelligence	84.26	(18.36)	74.84	(14.51)	1.81	38	0.08 †
BSI GSI	.60	(.65)	.89	(.65)	-1.44	38	0.16
BSI PSDI	1.78	(.83)	2.09	(.39)	-1.38	20.81	0.18
BSI PST	17.79	(15.55)	22.38	(15.07)	-0.95	38	0.35

Note: DES: Dissociative Experiences Scale; LEAS: Level of Emotional Awareness Scale; PERI: Psychiatric Epidemiology Research Interview; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; PSDI: Positive Symptom Dimension Index; PST: Positive Symptom Total

* $p \leq .05$,

† $p < .10$

Table 9

Independent Samples t-*Test Results Comparing Men and Women on Predictor and Criterion Variables*

	Female (n = 34)		Male (n = 8)				
Scale	*M*	(SD)	*M*	(SD)	*t*	df	*p*
DES	17.12	(16.54)	19.46	(14.36)	-0.37	40	0.71
DES Taxon	10.33	(14.09)	12.03	(15.32)	-0.30	40	0.76
DES Amnesia	13.38	(16.82)	15.31	(13.98)	-0.30	40	0.77
DES Absorption	23.73	(20.67)	27.36	(20.46)	-0.45	40	0.66
DES Depersonalization	9.36	(14.44)	12.71	(17.27)	-0.57	40	0.57
LEAS	53.53	(8.22)	54.00	(11.36)	-0.14	40	0.89
PERI	70.09	(23.05)	61.75	(27.72)	0.89	40	0.38
Emotional Experiencing	91.59	(19.51)	108.02	(16.41)	-2.20	40	0.03 *
Emotional Reasoning	73.14	(12.10)	82.16	(13.92)	-1.84	40	0.07 †
Overall Emotional Intelligence	76.85	(16.23)	90.51	(15.71)	-2.15	40	0.04 *
BSI GSI	.83	(.66)	.78	(1.22)	0.19	40	0.85
BSI PSDI	1.98	(.65)	2.13	(1.05)	-0.43	34	0.67
BSI PST	22.24	(15.06)	15.38	(17.44)	1.13	40	0.27

Note: DES: Dissociative Experiences Scale; LEAS: Level of Emotional Awareness Scale; PERI: Psychiatric Epidemiology Research Interview; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; PSDI: Positive Symptom Dimension Index; PST: Positive Symptom Total

* $p < .05$,
† $p < .10$

Table 10

*Pearson Correlations Between Age and Predictor and Criterion Variables (*n *= 42)*

Scale	*r*	*p*
DES	-.17	0.28
DES Taxon	-.02	0.93
DES Amnesia	-.23	0.15
DES Absorption	-.16	0.30
DES Depersonalization	-.08	0.63
LEAS	-.29	0.06
PERI	-.03	0.85
Emotional Experiencing	-.28	0.08 †
Emotional Reasoning	-.19	0.22
Overall Emotional Intelligence	-.21	0.17
BSI GSI	.01	0.96
BSI PSDT	.14	0.43
BSI PST	.01	0.97

Note: DES: Dissociative Experiences Scale; LEAS: Level of Emotional Awareness Scale; PERI: Psychiatric Epidemiology Research Interview; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; PSDI: Positive Symptom Dimension Index; PST: Positive Symptom Total

† $p < .10$

Table 11

Relationship of Predictor and Criterion Variables to Length of Time Homeless

Variable	Spearman's Rho	*p*	*N*
DES	.183	.35	28
DES-Taxon	.196	.32	28
DES Amnesia	.210	.28	28
DES Absorption	.185	.35	28
DES Depersonalization	.125	.53	28
LEAS	.244	.21	28
PERI	-.109	.58	28
Overall Emotional Intelligence	.221	.26	28
BSI GSI	.219	.26	28
BSI PSDI	.129	.57	22
BSI PST	.266	.17	28

Note: DES: Dissociative Experiences Scale; LEAS: Level of Emotional Awareness Scale; PERI: Psychiatric Epidemiology Research Interview; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; PSDI: Positive Symptom Dimension Index; PST: Positive Symptom Total

Table 12

One Sample t-*Tests Comparing BSI Subscale Means to Non-patient Norms*

Subscale	*M*	(SD)	Norm	*t* (df = 41)	*p*
GSI	0.82	(0.78)	.30	4.35	<.001
PST	20.92	(15.56)	11.45	3.95	<.001
PSDI	2.00	(0.70)	1.29	6.05	<.001
Somatization	0.70	(0.91)	.29	2.93	.005
Obsessive Compulsive	1.10	(1.05)	.43	4.14	<.001
Interpersonal Sensitivity	0.84	(0.86)	.32	3.90	<.001
Depression	0.91	(1.00)	.28	4.08	<.001
Anxiety	0.66	(0.76)	.35	2.63	.012
Hostility	0.81	(0.97)	.35	3.06	.004
Phobic Anxiety	0.50	(0.77)	.17	2.75	.009
Paranoid Ideation	1.11	(0.93)	.34	5.39	<.001
Psychoticism	0.61	(0.76)	.15	3.91	<.001

Note: GSI: Global Severity Index, PST: Positive Symptom Total, PSDI: Positive Symptom Dimension Index

Table 13

One Sample t-*Tests Comparing BSI Subscale Means to Outpatient Norms*

Subscale	*M*	(SD)	Norm	*t* (df = 41)	*p*
GSI	0.82	(0.78)	1.32	-4.14	<.001
PST	20.92	(15.56)	30.80	-4.11	<.001
PSDI	2.00	(0.70)	2.14	-1.22	.232
Somatization	0.70	(0.91)	0.83	-0.92	.361
Obsessive Compulsive	1.10	(1.05)	1.57	-2.87	.006
Interpersonal Sensitivity	0.84	(0.86)	1.58	-5.57	<.001
Depression	0.91	(1.00)	1.80	-5.74	<.001
Anxiety	0.66	(0.76)	1.70	-8.88	<.001
Hostility	0.81	(0.97)	1.16	-2.38	.022
Phobic Anxiety	0.50	(0.77)	0.86	-3.08	.004
Paranoid Ideation	1.11	(0.93)	1.14	-0.21	.839
Psychoticism	0.61	(0.76)	1.19	-4.93	<.001

Note: GSI: Global Severity Index, PST: Positive Symptom Total, PSDI: Positive Symptom Dimension Index

Table 14

One Sample t-*Tests Comparing BSI Subscale Means to Inpatient Norms*

Subscale	*M*	(SD)	Norm	*t* (df = 41)	*p*
GSI	0.82	(0.78)	0.83	-0.05	.963
PST	20.92	(15.56)	24.81	-1.62	.114
PSDI	2.00	(0.70)	1.66	2.89	.007
Somatization	0.70	(0.91)	.90	-1.42	.162
Obsessive Compulsive	1.10	(1.05)	1.32	-1.33	.190
Interpersonal Sensitivity	0.84	(0.86)	1.29	-3.39	.002
Depression	0.91	(1.00)	1.52	-3.93	<.001
Anxiety	0.66	(0.76)	1.49	-7.09	<.001
Hostility	0.81	(0.97)	0.87	-0.43	.670
Phobic Anxiety	0.50	(0.77)	0.92	-3.59	.001
Paranoid Ideation	1.11	(0.93)	1.10	0.08	.941
Psychoticism	0.61	(0.76)	1.09	-4.08	<.001

Note: GSI: Global Severity Index, PST: Positive Symptom Total, PSDI: Positive Symptom Dimension Index

Figure 4

Participants BSI Scores Compared to Non-Patient, Outpatient, and Inpatient Norms

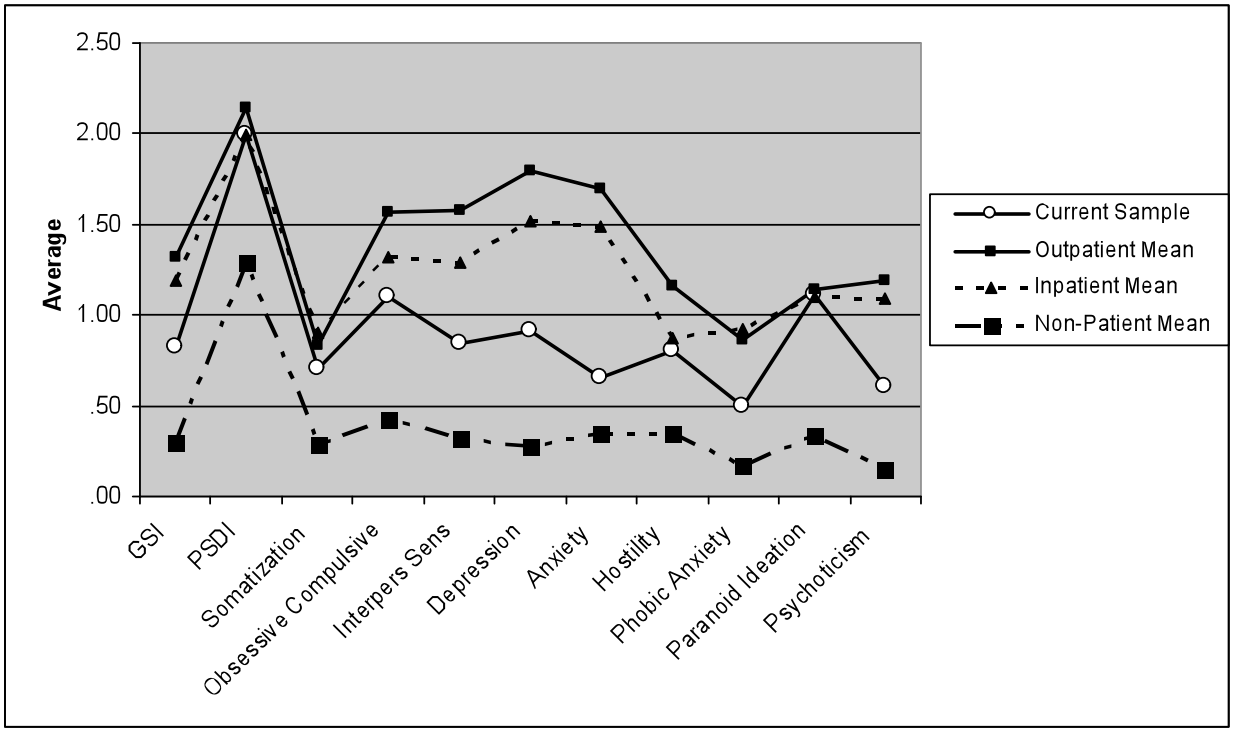

Table 15

Significantly Different DES-II Items at the .05 Level of Significance

	Mean			Prevalence	
DES Item	Sample	Norm[a]	Difference	Sample	Norm[a]
10. Being accused of lying when one is telling the truth.	25.2	7.3	17.9	62	41
14. Remembering past so vividly one seems to be reliving it.	33.6	17.4	16.2	64	60
6. Being approached by people one doesn't know who call one by a different name.	27.6	12.2	15.4	64	52
18. So involved in fantasy that it seems real.	22.4	10.0	12.4	50	45
21. Talking out loud to oneself when alone.	26.0	15.2	10.8	52	56
2. Missing part of a conversation.	33.8	24.3	9.5	76	83
5. Finding unfamiliar things among ones belongings.	13.8	4.5	9.3	33	22
16. Being in a familiar place but finding it unfamiliar.	17.6	8.6	9.0	43	40
7. Seeing oneself as if looking at another person.	13.1	5.3	7.8	36	29

[a] obtained from Ross et al. (1991)

Table 16

*Average Scores for Individual PERI-D Items That Fell Above the Overall Mean of the Sample (*M *=2.53, SD =.89), in Descending Order*

Item # and content	*M* (SD)
2. How often have you been bothered by feelings of sadness of depression – feeling blue?	3.36 (1.16)
14. How often have you felt that nothing turns out for you the way you want it?	3.24 (1.23)
1. How often have you felt you were bothered by all different kinds of ailments in different parts of your body?	3.17 (1.21)
6. How often have you felt lonely?	3.07 (1.42)
7. How often have you been bothered by feelings of restlessness?	3.02 (1.39)
23. You are the kind of person who is the worrying type, you know, a worrier. [c]	3.02 (1.55)
19. During the past month, how often have you had trouble with headaches or pains in the head?	2.83 (1.32)
20. During the past month, how often has your appetite been poor?	2.81 (1.35)
13. During the past month, how often have you had trouble concentrating or keeping your mind on what you were doing?	2.71 (1.29)
12. During the past month, how often have you felt confused and had trouble thinking?	2.69 (1.33)
25. When you have gotten angry in the last month, how often have you felt uncomfortable, like getting headaches, stomach pains, cold sweats, and things like that?	2.60 (1.45)
10. During the past month, how often have you felt anxious?	2.60 (1.31)
27. During the past month, how often have you been bothered by nervousness, being fidgety or tense?	2.55 (1.43)

[c] reversed values

Table 17

*Average Scores for Individual PERI-D Items that Fell Below the Overall Mean of the Sample (*M *= 2.53, SD = .89) in Descending Order*

Item # and content	*M* (SD)
16. During the past month, how often have you felt completely helpless?	2.50 (1.45)
21. In general, if you had to compare yourself with the average (male/female) your age, what grade would you give yourself for the past month?	2.45 (1.09)
15. During the past month, how often have you felt completely hopeless about everything?	2.36 (1.38)
11. During the past month, how often have you feared that something terrible would happen to you?	2.33 (1.24)
3. In general, how satisfied have you been with yourself in the last month?	2.31 (1.22)
9. During the past month, how often have you feared going crazy, losing your mind?	2.29 (1.38)
17. During the past month, how often have you had times when you couldn't help wondering if anything was worthwhile anymore?	2.26 (1.25)
26. During the past month, how often have you feared being left alone or abandoned?	2.24 (1.39)
5. During the past month, how often have you felt confident?	2.24 (1.14)
8. During the past month, how often have you felt useless?	2.17 (1.31)
4. How often have you had attacks of sudden fear and panic?	1.95 (1.01)
22. You are the kind of person who feels he has much to be proud of. (Lower score = more pride)	1.95 (1.25)
24. You are the kind of person who feels that he is a failure generally in life. (Lower score = less of a failure) [c]	1.95 (1.32)
18. How often have you been bothered by cold sweats?	1.67 (1.12)

[c] reversed values

Table 18

One-Sample t-*Test Comparing Participants' Emotional Intelligence Scores with the Population Norms (*M *=100)*

Scale	*M*	(SD)	*t*	df	*p*
Total EIQ	79.45	(16.84)	-7.91	41	< .001
Strategic Area Score	74.86	(12.80)	-12.73	41	< .001
Experiencing Area Score	94.72	(19.88)	-1.72	41	.093

Table 19

Pearson Correlations Between Measures of Psychological Distress and Measures of Emotional Intelligence

		r (*p*)			
		MSCEIT			
Scale	Subscale	Overall EIQ	Experiencing	Reasoning	LEAS
BSI	GSI	-.10 (.51)	-.11 (.50)	-.16 (.32)	.03 (.85)
	PST	-.14 (.37)	-.19 (.22)	-.16 (.33)	-.01 (.96)
	PSDI	-.04 (.81)	.08 (65)	-.16 (.34)	.10 (.57)
DES	Total	-.06 (.70)	-.08 (.61)	-.07 (.67)	.05 (.75)
	Taxon	-.25 (.11)	-.22 (.16)	-.30 (.05) *	.04 (.82)
PERI	Total	-.12 (46)	-.19 (.24)	-.10 (.54)	.03 (.87)

Note: EIQ: Emotional Intelligence Quotient; LEAS: Level of Emotional Awareness Scale; BSI: Brief Symptom Inventory; GSI: Global Symptom Index; PSDI: Positive Symptom Dimension Index; PST: Positive Symptom Total; DES: Dissociative Experiences Scale; PERI: Psychiatric Epidemiology Research Interview

* $p \leq .05$

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