

***Examining the Relationship Between Youth Homelessness and Aggression
Poverty Studies Capstone Project***

Faculty Advisors:

Jay Brandenberger, Center for Social Concerns and Psychology
Benedict Giamo, American Studies

Introduction

Youth Homelessness

Teen homelessness has recently begun to gain recognition as a rapidly escalating problem in American society. It is estimated that between 1 and 1.5 million American teens—about 6 percent of the U.S. adolescent population—currently experience one or more periods of homelessness each year (Cohen, 2009). Part of the emergence of a substantial homeless adolescent population can be attributed to the rise in youth separating from their family. The Justice Department conducted a study in 1989 that suggested that about 500,000 youth run away or are thrown out of their homes each year (Robertson, 1991). This is especially alarming given that an estimated 75 percent of cases in which youth separate from the family go unreported (“National Youth Homelessness Awareness Month”, 2009). Many youth who separate from their family are unable to secure stable housing, leading them to be absorbed into the growing homeless adolescent population (MacLean, Embry, & Cauce, 1999). The 2004 Conference of Mayors Study found that about 5% of the homeless in the United States are unaccompanied youth (CRS Report for Congress, 2005).

This separation of adolescents from their birth families can be the result of the adolescent running away, being kicked out, or being removed from the home. Factors that commonly motivate such a separation include family poverty, lack of affordable housing, abuse of the child by his or her parents, maltreatment due to sexual orientation, substance abuse, coming of age in the foster care system, and/or being born to homeless parents (Cohen, 2009). These problems are being exacerbated by the economic crisis that is causing many families to be under the additional stress of unemployment and food instability (“National Youth Homelessness Awareness Month”, 2009). However, it is important to note that these conditions are also experienced at high rates by teens who do not separate from the family. Thus, there is a large population of adolescents who lack a sense of home and belonging who are entirely overlooked by the aforementioned estimates of homeless youth.

In conducting the present study, it is essential to move beyond the traditional, purely physical concept of homelessness and to establish a working definition that encompasses homelessness as a social state as well as a physical state of non-belonging. Homelessness will be defined for the purposes of this study as lacking a place of belonging where one can safely and reliably receive shelter. This definition requires a complex analysis that must combine information about the stability of one’s physical residency with the social support and belongingness inherent to a true sense of home.

In light of this definition, the Interpersonal Support Evaluation List (ISEL) was incorporated into the present study as a measure of homelessness. The ISEL measures functional and perceived social support and has often been applied to homeless and impoverished populations. It is a four-part questionnaire measuring four specific aspects of social support and belonging: 1) tangible support, the perceived availability of material aid, 2) appraisal support, the perceived availability of someone with whom to discuss personal issues, 3) self-esteem support, and 4) belonging support, the perception that there is a group with which one can identify and socialize (Brookings and Bolton, 1988).

Those adolescents who can be classified as homeless based on lack of social support and/or a stable physical residence often suffer life-long repercussions and poorer outcomes than their counterparts with stable home environments. For example, homeless adolescents suffer from health problems and psychological symptoms, including conduct disorders, at significantly higher frequencies as compared to their non-homeless peers (Feitel, Margetson, Chamas, & Lipman, 1992; Robertson, 1991; Wright, 1991). This trend has been found to hold true for the particular conduct disorder in question in this study: chronic aggression (Robertson, 1991).

Adolescent Aggression

Aggression can be defined for the purposes of this study as behavior intended to cause harm to another, regardless of whether there is a violent outcome. Adolescent aggression is a daunting societal problem in the United States. The National Youth Risk Behavior Survey, issued by the Center for Disease Control and Prevention, is administered each year to samples ranging from 10,904 to 16,296 American youth in order to track trends in youth aggression. The large sample size and random selection of this study allow the American public to presume the results to be highly representative of national trends. The findings of the National Youth Risk Behavior Survey from 1993 into the early 21st century pointed to a hopeful decline in youth aggression, but that trend began to turn around in 2005. The survey data collected since then shows a steady increase in youth aggression rates. The results of the most recent 2009 survey indicated that 17.5% of students had carried a weapon and 5.9% had carried a gun in the last 30 days before the survey was administered. Furthermore, 31.5% of students had been in a physical fight at least once in the past year (CDC, 2009). In other recent studies, these results have been reinforced by complementary findings estimating that 42% of males and 28% of females ages 14-18 have participated in a physical fight in the past year (Marcus, 2008).

It can prove hard to accurately assess the prevalence of adolescent aggression using records other than self-reported survey data because the overwhelming majority of aggressive incidents are never reported. According to the National Center for Juvenile Justice, juvenile arrest rates for violent crime averaged 670 for every 100,000 males and 118 for every 100,000 females between 1990 and 2003 (Marcus, 2008). However, self-report studies conducted by Snyder and Sickmund (1995) found that 80-90% of adolescents reported having participated in some kind of delinquent behavior by the age of 18. Even more shockingly, 30% of males and 10% of females reported committing at least three violent offenses in the year before their 18th birthday (Snyder and Sickmund, 1995). The only crime that is almost always discovered is homicide, and the fact that homicide has been consistently ranked as the second leading cause of death in the age category of 12-19 years by the NCHS speaks to the concerning prevalence of this violent crime among American youth as well (Marcus, 2008).

There are numerous theories that have developed in response to public concern about adolescent aggression. A popular, culture-specific theory suggests a decline in the emotional

intelligence of American children as a result of rapid cultural and societal changes (Goleman, 1995), leading to a reduced ability to monitor and regulate emotional states such as anger. In contrast, the social-learning theory argues that aggression is learned, sustained, and unlearned by way of observation and classical and operant conditioning (Moeller, 2001). This model suggests that aggression is internalized by youth through modeling, imitation, and then a reward that encourages the youth to use aggression again. A more individualized perspective is provided by the frustration-aggression hypothesis, which states that aggression is the inevitable reaction to a situation in which a youth is blocked from a goal-directed behavior (Moeller, 2001). The most integrated approach is the General Aggression Model. This model suggests that it is the interaction of personal identity/stable personality traits and environmental triggers of anger that produce aggression. Psychologically salient situational factors trigger anger, which reduces inhibition, fixates attention, primes aggressive scripts, and increases arousal, which then produces an effect that is dependent on an individual's predisposition (Marcus, 2008).

Personality risk factors for aggressive behavior have been determined to include sensation-seeking tendencies, negative affect, anger, depression or mood disorders, and an underdeveloped concept of empathy (Marcus, 2008). There are also a variety of situational risk factors that are essentially universally correlated with aggressive behavior, including provocation, frustration, deprivation, pain, incentives to participate in aggressive behavior, and modeling of aggressive behavior.

Longitudinal studies of aggression have found that early childhood aggression has a relatively high likelihood of persisting over time in the absence of a pro-active intervention to counter aggressive impulses (Vance et. al. 2002). A study at the University of North Carolina at Chapel Hill examined thirty-seven high-risk adolescents who demonstrated aggression to identify predictors of their behavioral outcomes (Vance, J.E., Bowen, N. K., Fernandez, G., & Thompson, S., 2002). Psychosocial risk factors and psychiatric symptom severity were the two factors tested as possible predictors of the stability of aggressive tendencies over time. Psychiatric symptom severity was found to be a less important predictor of behavioral outcomes than psychosocial risk factors such as poor parent-child relationships, low family support, and minimal prosocial interaction with peers (Vance, J.E., Bowen, N. K., Fernandez, G., & Thompson, S., 2002).

Interaction Between Youth Homelessness and Aggression

This study is being conducted to examine the possible relationship between adolescent homelessness and aggressive behavior. This is an important area of study because the traumatic experience of homelessness and/or family instability has been found to cause youth to act out feelings of distress and victimization (MacLean, Embry, & Cauce, 1999). Psychologist Linda J. Anooshian interviewed 93 sets of mothers and children and found that family instability consistently contributed to problematic aggressive behaviors among children (2005). A study that directly assessed the prevalence of severe aggressive behavior and conduct disorders similarly found that in a population of 219 runaway and homeless adolescents ages 12–19, 55% suffered from conduct disorders and 62% exhibited severe aggression (Booth & Zhang, 1996). These findings are further supported by a study conducted by Baron, Forde, & Kennedy (2007), which examined the conflict management of homeless as compared to non-homeless male youth ages 18–30 years. The data collected indicated that homeless youth are more likely to demand reparation from those they perceive to have caused them harm and are more likely to use aggression to settle conflict regardless of the magnitude of the conflict. The present study is

designed in response to these findings as well as the possible relevance of these findings to the Getting Over Angry Lives (GOAL) Program, run by Individuals and Families in Transition in Elkhart, Indiana.

The GOAL Program is an aggression management intervention that is deeply integrated into the disciplinary system of Elkhart public schools and the Elkhart County juvenile court system. Students are enrolled in the GOAL Program based on recommendations by school, parents, counselors, probation officers and/or juvenile court due to aggressive behavior. The GOAL Program seeks to guide students through a 7-week process of reflecting and realizing both the effects and the alternatives to living an angry life. The program aims to incorporate discussion and community building into five crucial lessons on goal setting, hot buttons and anger signals, physical aspects of anger, self-talk, and accepting personal responsibility.

The GOAL Program has developed amidst the rise of hundreds of similar aggression prevention and/or rehabilitation programs over the last 30 years (Marcus, 131). These programs have enjoyed varying degrees of success and have motivated the development of a growing body of academic theories about interventions. The American Psychological Association (1993), Surgeon General's Report (2009), and National Institute of Health (2006) have all attempted to outline the key components of a successful youth aggression intervention. Criteria determined to be crucial across these sources include addressing associated risk factors, using a clinical approach, early and sustained intervention, working on social competence, and designing an intervention across social contexts (Marcus, 135).

The suggestions of the American Psychological Association, Surgeon General's Report, and National Institute of Health have been supported by extensive evidence regarding the success rates of various programs. One particularly crucial, common finding was that focused treatment programs are less effective than comprehensive interventions that extend across multiple areas of adolescents' lives (Vance et. al., 2002). One of the most salient studies to examine aggression and related interventions is a meta-analysis of 221 studies conducted since 1960 on school-based anti-aggression programs. This study has included a total of 56,000 youth from age five through high school and has consistently measured progress using pre- and post-testing. When considered as a whole, all programs compiled had a significant effect when compared to the control that received no intervention. Ages five and under and 14 and over were the age brackets that responded most successfully. When different intervention styles were compared, behavioral and classroom management as well as therapy and counseling were most effective in decreasing aggressive behavior. Statistically significant improvements were also produced by social competence training, which teaches resolution of interpersonal conflicts via improved communication and conflict resolution skills. Learning anger control techniques, such as practice, relaxation and self-talk, is a central component of this intervention style (Marcus, 136). This last model seems to be most closely embodied by the GOAL Program involved in the present study.

There are also a variety of risk factors that have emerged as areas of concern that the majority of interventions are failing to address. For example, many programs are making insufficient efforts to redirect the adventure-seeking tendencies often exemplified by chronically aggressive youth. Also, media exposure to violence is a risk factor rarely addressed in programming. Perhaps most significantly, early drug and alcohol use is often interrelated with aggressive behavior but rarely confronted. These are areas that youth continue to struggle with after interventions, and these unaddressed areas inevitably impede the ability of the adolescents to make permanent behavioral changes (Marcus, 156). This suggests that interventions need to

be more conscious of the ways that these problems can be tackled simultaneously within the lesson plans of aggression interventions. The present study will examine whether homelessness status may be another similar factor interfering with the success of anti-aggression programming.

The current study will be conducted in order to investigate the relationship between homelessness and teen aggression in the context of Individuals and Families in Transition (iFIT) community programming. The purpose of this investigation is to help improve iFIT's responsiveness to the specific needs of the population served by its anti-aggression programming. This study will assess the degree to which homelessness needs to be addressed more proactively. It will furthermore attempt to address a gap in literature to date by finding out the extent to which homelessness is an issue that interferes with aggressive teens' ability to make positive behavioral changes during an intervention.

There are two specific goals in this investigation. The first is to explore whether homelessness is a condition faced more frequently by those teens with aggression issues than those without. The second is to assess whether home instability is a predictor of low achievement for aggressive teens participating in an anti-aggression intervention. The participants involved in this study will be aggressive and non-aggressive teens involved in community programming offered by iFIT.

The first part of this project will be a demographic study using survey data to assess whether aggressive and non-aggressive teens suffer from homelessness at differing rates. Thus, the independent variable will be aggression status. Teens enrolled in a goal settings class, who are not currently in trouble with the law, will function as the non-aggressive comparison group while teens enrolled in the Getting Over Angry Lives (GOAL) anti-aggression program will function as the aggressive target group. The dependent variable being assessed will be homelessness status. I predict that I will find a higher degree of homelessness among teens with aggression management problems as compared to the non-aggressive group of teens from the same area.

The second part of the project will be a program effectiveness study that uses self-assessment data to gauge the extent to which homelessness affects the ability of aggressive teens to respond successfully to an anti-aggression intervention. Homelessness status will now become the independent variable while the dependent variable will be the amount of improvement made during an anti-aggression intervention. The comparison group will be the teens in the GOAL Program who are determined not to be homeless ("low homelessness") based on part one of this study. The target group will be the teens in the GOAL Program who are determined to be homeless ("high homelessness") based on part one of this study. Self-assessment data will be used to compare the degree to which each group improves their aggressive tendencies over the course of the 7-week GOAL program. My hypothesis for this part of the study is that the anti-aggression intervention will be less effective for homelessness teens, meaning that they will show less improvement from the beginning to the end of the intervention than those aggressive teens with a stable home environment.

Method

Participants

The first part of the study, which used survey data to contrast the homelessness rates of aggressive as compared to non-aggressive teens in the Elkhart area, included a comparison group of 30-35 non-aggressive teens ages 14-18 recruited from a goal settings class run by iFIT.

Enrollment in this class was based on need for assistance with time management, goal setting, and academic commitment. The students participating are not currently in trouble with the law and can be classified as non-aggressive.

The target group was 30-35 aggressive teens ages 14-18 recruited from the Getting Over Angry Lives (GOAL) anti-aggression program run by iFIT. Students are enrolled in the GOAL Program based on recommendations by school, parents, counselors, probation officers and/or juvenile courts due to aggressive behavior. The ethnic composition of each class is usually about 1/3 Hispanic, 1/3 white, and 1/3 black, and both males and females are included.

The second part of the study, which evaluated the GOAL Program to see if it is less effective for homeless teens, used as the comparison group those teens in the GOAL Program determined not to be homeless ("low homelessness") based on part one of this study. The target group was teens in the GOAL Program determined to be homeless ("high homelessness") based on part one of this study. Self-assessment data was used to compare the degree to which each group improved their aggressive tendencies over the course of the 7-week GOAL program.

Recruitment

All participants in the GOAL and goal settings classes that fell within the 2010 Fall Semester were eligible to participate in this study. I did not interfere with iFIT's recruitment of participants for these two classes due to the importance of having a sample typical of those that participate in the class under non-testing conditions.

To recruit from the goal settings and GOAL classes once students enrolled, I spoke in front of the class at the first session. Subjects were recruited at the first session because both students and parents were required to attend. I explained what participation in the study would entail and how it would benefit iFIT programming. I passed out separate consent forms to parents and assent forms to teens. I gave the parent-child pairs a few minutes to read, discuss together, and ask questions. I then stayed after class so parents or teens could ask questions privately if they preferred. At the end of the class, parent consent and student assent forms were collected at the door. Only those students for whom I received both student assent and parent consent were included in the study.

Compensation and benefits

There were no individual benefits provided to the participants by way of monetary compensation or increased chances of graduation from the program. However, there are communal benefits to participation because this study will enable iFIT to improve its programming, particularly its GOAL intervention. The wider Elkhart community will benefit because teen aggression will be more effectively addressed and rehabilitated. The institution will also be able to better address the issues underlying youth aggression and work towards prevention, thereby making the community a safer place. A safer community is advantageous to all participants.

Special precautions

To account for the fact that age and emotional maturity level may have affected the ability of the GOAL student participants to give informed consent, I walked through a very thorough explanation of what the teens would be asked to do with their parents present so that both students and parents could make informed decisions about whether the teen could handle

participation. I was sure to specify that participation was not mandatory and would have no bearing on an individual's graduation from the program. I also explained that I would maintain confidentiality except in the event that abuse was discovered. I delineated the procedures for reporting abuse so that teens would be informed prior to any self-disclosure (see "Confidentiality"). Participants were also informed that they could choose to skip items or withdraw at any time if the study caused emotional or psychological harm.

Both the primary investigator and the usual class teachers, who are trained to perceive and respond to the particular needs of their students, proctored the administration of the questionnaires in this study. At the sign of significant distress, the principal investigators and proctors intervened.

Confidentiality

The control group of teens in the goal setting class submitted their questionnaires anonymously. The experimental group of GOAL students, however, were assigned numbers because their questionnaire responses had to be matched with their aggression self-assessments before and after the GOAL Program in order to accomplish the second part of the study.

Numbered stickers were randomly placed on the inside covers of the participants' GOAL Program notebooks. They were asked to write this number on the front of their questionnaires and each of their aggression self-assessments (before and after). I made copies, then blacked out the names on my copies and the numbers on the teacher copies. This way, I could match up the questionnaire responses with the self-assessments but would not know to whom the numbered sets belong. The teachers, on the other hand, were able to assess the progress of individual students but not able to match up those assessments with the questionnaire responses, so they could not know the homelessness status of any particular students. The students were asked to remove the stickers from their notebooks at the end of the class. The iFIT Program and GOAL Program teachers were provided with the cumulative results of the study when the project was complete.

When responses to supplementary interviews with GOAL participants were recorded, names were stripped so that recordings were identified by numbers only. The recorded interviews were not released for use of any kind outside of the study. They were kept in a secure, unmarked location.

Prior to the study, I informed participants of my obligation to break confidentiality should illegal activity or abuse come to my attention. I was required to notify an iFIT staff member and defer to them due to their superior training in handling such issues. The standard iFIT procedures for reporting abuse would then be followed. An iFIT staff member would first interview the youth to assess the situation and devise a plan of action. The youth would be encouraged to inform and obtain cooperation of their parent or guardian. The staff member(s) involved would then plan and facilitate interventions with the potential to unite families. However, where required by law, the iFIT staff would act to protect the youth. In instances where children and parents or guardians could not be re-united, the staff would consult with the Executive Director and pursue an alternate plan. Teens and parents were forewarned both verbally and in writing of this mandatory exception to confidentiality.

Design

The first part of this study used an independent groups design with natural groups assignment. The independent variable being manipulated was aggression level. The two levels of the independent variable were high aggression, represented by the GOAL students with a history of aggressive behavior, and low aggression, represented by the students in the goal setting class without a history of aggressive behavior. The dependent variable was the degree of homelessness that students experience.

The second part of this study used a pre-test, post-test design with the dependent variable of part one of the study—level of homelessness—becoming the independent variable. GOAL students who were found to be experiencing a high degree of homelessness in part one of the study were assigned to the target group while GOAL students determined in part one to be experiencing a low degree of homelessness were assigned to the comparison group. Self-evaluations were administered at the beginning and end of the GOAL course as a measurement of the dependent variable: improvement in aggression management. This improvement was quantified using the differences between pre-test and post-test scores. The improvement in the aggression management of the target group was compared to the improvement of the comparison group.

Measures

The Interpersonal Support Evaluation List (ISEL) was designed by Cohen and Hoberman (1983) to measure the perceived availability of social support resources. It measures functional and perceived social support and is frequently applied to homeless and impoverished populations. This questionnaire is comprised of 40 dichotomous items, half phrased negatively and half phrased positively, which are scored such that a higher score reflects a higher degree of perceived social support. This measure is well established; it has been used in similar research and has been experimentally validated by a number of studies. Brookings and Bolton (1988) published the Confirmatory Factor Analysis of the Interpersonal Support Evaluation List, which studied 133 college students (45 male, 88 female) who completed the ISEL in order to evaluate the appropriateness of the questionnaire as a measure of social support. Large correlations were found among the four primary factors used to assess social support (namely, tangible support, appraisal support, self-esteem support, and belonging support), suggesting that the ISEL is a useful, congruous measure. Furthermore, reliability coefficients over a one-week interval for the ISEL were found to range from 0.62 to 0.85 (Bates & Toro, 1999).

I selected 31 of the 40 ISEL items based on their relevance to adolescents and presented the questions in the same, randomized order to each participant (Appendix A). For each item, the teen chose true or false according to which better represents how they feel most of the time. Their score based on their responses was the sum of answers that aligned with the desired, i.e. socially desirable, response. The mean scores for a normal population have been found to range from 32.9-34.4 out of 40 total questions with a standard deviation of 4.96-5.98 (Cohen et. al, 1985). For the purposes of this study, these values will be scaled down to their equivalents out of 31 total questions, which makes the mean and standard deviation for a normal population 25.5-26.7 and 3.84-4.63, respectively

The second questionnaire used was a short True/False homelessness survey devised particularly for this study (Appendix B). There were 10 items and scores were the sum of the socially desirable responses provided. This questionnaire was devised in order to complement

the indirect measure of homelessness provided by the ISEL with a direct measurement of homelessness. Because this measure more directly measured homelessness, the results of this questionnaire were used to divide participants into “low homelessness” and “high homelessness” groups for the second part of the study. Ideally, GOAL students with scores falling one standard deviation or more below the expected or normal mean would be considered “low homelessness” and those beyond one standard deviation above the mean would be considered “high homelessness.” However, due to the small sample size available, it was not feasible to exclude participants in the middle of the spectrum. Therefore, participants were divided into groups purely based on whether their questionnaire scores fell above or below the mean.

The self-evaluation given as a pre-test and post-test for the second part of the study has been used by iFIT since the development of the program. It is a 10-item True/False questionnaire gauging aggression and aggression management skills. Items include: “I can back down from a fight” and “My anger is under control.” Ten points are awarded for each item answered “True” for a total score out of one hundred.

Three independent t-tests were run using SPSS to assess the results produced by these measures. The first t-test was run to test for a significant difference between the ISEL scores of the comparison and target groups. The second was run to test for a significant difference between the homelessness questionnaire scores of the comparison and target groups. The third was run to test for a significant difference between the improvement in aggression achieved by participants facing high versus low levels of homelessness as assessed by pre-test and post-test scores. The standard for significance was $p < 0.05$.

Procedure

On the first day of each class (the GOAL Program and the goal settings class), I gave an oral debriefing to both parents and teens describing what participation in the study entailed and how it could benefit iFIT. Parent consent and student assent forms were then distributed. Time was provided to ask questions. At the end of class, I collected the consent and assent forms from those willing to participate.

At a subsequent class, when parents were no longer present, I administered the ISEL questionnaire as well as the True/False questionnaire used to directly assess homelessness, which together took between 15 and 20 minutes to complete. The questionnaires were taken in the students’ usual desks. This procedure provided the data for the first part of the study.

For the program effectiveness part of the study, the aggression self-assessment typically used by the GOAL Program was administered as usual. The usual procedures are that GOAL Program teachers administer the self-assessment on the second day and the last day of the class. Each administration takes between 10 and 15 minutes. This provides the data used for the second part of the study. In effect, nothing was altered from the pre-existing GOAL Program to conduct the second part of the study. The self-assessments were simply released to the primary investigator to be analyzed in conjunction with the data from part one of the study, which allowed evaluation of whether the program is effective for homeless teens.

I attended each GOAL class to discuss additional, related interview questions with a few randomly selected students (Appendix C). These questions took 10-30 minutes to discuss. They enabled a more comprehensive analysis of the possible mediating factors between homelessness and youth aggression by providing qualitative data to supplement the questionnaires.

Results

For the first part of this study, I hypothesized that I would find a higher rate of homelessness among teens with aggression management problems as compared to a non-aggressive group of teens from the same area. The data collected from each of the two measures used was evaluated with an independent samples t-test to determine whether there was a significant difference between the scores of the group of teenagers with aggression problems and those without.

Social support scores were calculated on a scale of 0-31 points using True/False items from the ISEL (Appendix A). Higher scores indicate strong social support. The mean social support score for teenagers participating in the GOAL Program because of a history of aggressive behavior was 22.25 ($SD = 5.59$, range=4-30). The mean score for teenagers participating in iFIT programming but not exhibiting aggression was 24.04 ($SD = 4.33$, range=15-29). While there was a trend of aggressive teens having less social support, the difference between the two groups was not found to be significant ($p=0.187$). Thus, these results cannot be used definitively to substantiate the hypothesis.

Direct homelessness scores were also derived based on a 10-question questionnaire designed specifically for this study (Appendix B). On this measure, higher scores correlate with a higher degree of homelessness (previously defined as lack of belonging). The mean homelessness score for GOAL participants was 5.23 ($SD = 2.28$, range=1-9) while the mean homelessness score for non-aggressive iFIT participants was 3.81 ($SD = 2.40$, range=0-10). When compared using an independent samples t-test, the GOAL teens with aggression problems had significantly higher rates of homelessness than the comparison group ($p=0.027$). Thus, these results support the hypothesis that teens with chronic aggression report higher rates of homelessness.

My hypothesis upon designing the second part of the study was that the GOAL anti-aggression intervention would be less effective for homelessness teens, meaning that they would report less improvement from the beginning to the end of the intervention than aggressive teens with a stable home environment. The results obtained were inconclusive. The mean improvement shown by teens reporting low homelessness was 25.6 as compared to 28.3 for teens reporting high homelessness. However, these results were essentially negligible due to the standard deviation of 17.4 for the low homelessness group and 17.0 for the high homelessness group. There was no significant difference found between the improvements made by the two groups ($p=0.719$), indicating that the hypothesis cannot be confirmed by these results.

Discussion

The purpose of this study was to first assess whether those teens exhibiting aggression were experiencing higher rates of homelessness compared to other teens participating in iFIT programming. Then, aggressive teens experiencing a low level of homelessness were compared to those experiencing a high level of homelessness to determine whether the former teens were able to make lifestyle changes in response to an intervention more successfully than the latter. Based on previous findings that the traumatic experience of homelessness and/or family instability causes youth to act out feelings of distress and victimization in the form of aggressive behavior (Anooshian, 2005; Booth & Zhang, 1996; Boron, Forde, & Kennedy, 2001; MacLean, Embry, & Cauce, 1999), I hypothesized that aggressive teens would report higher rates of homelessness than non-aggressive teens. Furthermore, I hypothesized that the aggressive teens

experiencing homelessness would be less able to make positive life changes due to lack of social support and stability. The first hypothesis was, overall, supported by the results of the study. The aggression-prone students participating in the GOAL Program reported a significantly higher degree of homelessness than nonaggressive teens based on anonymous, self-reported homelessness questionnaire data. They also demonstrated a non-significant but consistent trend toward lower social support scores based on the ISEL social support questionnaire. The second hypothesis, however, could not be substantiated because the improvements shown by teens experiencing both high and low degrees of homelessness were extremely variable and not significantly different.

Many items of interest emerged from both the ISEL and homelessness questionnaires as stand-alone evidence that lack of home stability and support is a problem that needs to be addressed for GOAL students. In particular, three ISEL items fundamentally indicated lack of social support. The first was “There are several people that I trust to help solve my problems,” which was answered false by 56.3% of students (18 out of 32). Similarly, on an item stating “I feel that there is no one I can share my most private worries and fears with,” 46.8% answered true (15 out of 32). Perhaps the single most telling item on the ISEL was item 30: “I am more satisfied with my life than most people are with theirs,” to which 57% responded false (16 out of 28).

The homelessness questionnaire produced similarly noteworthy results. The last three items in particular provided results relevant to iFIT. The statement “I have thought about leaving the place where I live” produced the most extreme, troubling results in that 85.7% responded true (24 out of 28). Furthermore, in response to the item “My life would be better if I could leave the place where I stay and the people I currently live with,” a majority of 53.6% chose true (15 out of 28). The last item, “If I knew that there was a safe place to go that would take me in, I would strongly consider leaving the place that I stay now” is perhaps the single most important indicator of whether the youth shelter that was recently closed is a necessity to this particular population. A clear majority of 64.3% agreed with this statement (18 out of 28), which indicates that the majority of GOAL students are in need of a safe alternative to staying in unhealthy homes.

In this study, the covariance of homelessness and aggression found was consistent with previous researchers’ conclusions that homelessness is a strong predictor of aggressive behavior. There is a range of possible explanations for why this relationship exists. The interview data collected in conjunction with this study exposed some of these explanations. In considering interview feedback, however, it is important to remember that homelessness is defined for the purposes of this study as lacking a place of belonging where one can safely and reliably receive shelter.

Participants reported a wide variety of factors connecting feelings of homelessness to acting out aggressively. Most reported a complete absence of positive communication and expression of affection among their family members. Constant put-downs and physical, aggressive expression of frustration and anger were the most commonly reported forms of familial interactions. In many cases, there was clear modeling of uncontrolled anger and illegal stress response techniques by parents and siblings. From these accounts, it seems likely that these teens are more prone to interacting with others aggressively because they have grown up without a model of positive self-expression.

Participants also consistently reported that some of their strongest feelings of anger stem from lack of control in their home lives. They described the stress of dreading going home every

day and feeling unsafe once there. Many students cited alcoholism, parental conflict, and participation of parents in illegal activity as reasons that they felt unsafe in their home. Multiple students gave account of the very visceral reaction of their heart rate rising and their breathing getting heavier upon entering their house or seeing the person that they associate with conflict and instability. A particular teen explained to me that never being able to relax, have space to get away, or let one's guard down puts a person on edge and makes him or her infinitely more likely to snap, even in contexts completely unrelated to the source of the stress.

A great number of teens directly or indirectly expressed that feeling unsafe, not valued, and/or a lack of belonging in their home life has led to a detrimental lack of self-worth. Many referenced trying a variety of other outlets besides aggression as a means of release for their negative emotions. There were repeated references to histories of drinking, drug use, and cutting, with at least one interviewee having previously attempted suicide. This lack of self-worth can, in itself, make teens more likely to feel defensive and overly-sensitive to criticism.

Although this feedback helps to explain the GOAL participants' aggressive behavior in response to home stability, these family experiences cannot be assumed to contrast with the experiences of the nonaggressive control group. In the design of the first part of this study, an inherent limitation was that iFIT programming does not have available a true comparison group of teens with a "normal" life situation. While it is true that the goal settings class students used as the nonaggressive comparison group have enrolled in their iFIT program for purely academic reasons and do not have a history of aggression, there are often risk factors in their lives that are making them prone to academic underachievement. For these students, nonconformity with academic expectations may in fact be their outlet instead of aggressive behavior.

The instability of even the comparison population is evident in that the mean social support score was 24.04, which is notably lower than the mean of 25.5-26.7 expected for a normal population (Cohen et. al, 1985). Furthermore, the mean homelessness score among the goal settings comparison group was 3.81, which is much higher than would be expected for a normal, stable population (which would be expected to score close to zero). In the design of this study, I had to choose between using a comparison group of teens who were possibly also troubled but who were more comparable due to participation in the same community and iFIT programming or a sample of students who would have normal life situations but would be from a more prosperous and/or stable area and have incomparable life experiences. I chose the former, but results may have been more significant—although arguably less useful to iFIT—had I chosen the latter option.

Upon close examination of ISEL responses, it is apparent that social support may also have been confounded with socioeconomic status for the comparison group. Items such as "If I needed an emergency loan of \$100, there is someone I could get it from," "It would be difficult to find someone who would lend me their car for a few hours," and "If for some reason I were put in jail, there is someone I could call who would bail me out" caused the great majority of goal settings comparison group students to lose points. The lower ISEL scores that resulted may not have truly represented lack of social support, but rather lack of financial resources, which this study did not intend to assess. The comparison group sample may have been biased toward students of low socioeconomic status because enrollment in the goal settings course suggests that students may have been unable to obtain tutoring services or other, more costly means of improving academic performance.

In the design of the second part of this study, there were also inherent limitations that may have factored into the inconclusive results. First, the pre and post-tests used a non-

continuous scale, with possible scores limited to multiples of 10%. This produced outrageous standard deviations of 17.4 and 17.0 for the low and high homelessness groups, respectively. Also, the sample size was smaller than I could have foreseen because I had not anticipated such a high rate of failure from the course and, thus, attrition from the study. Many of the students failed to attend the necessary number of classes or disappeared and were unreachable using their contact information. Although this trend speaks to the very transience with which this study is concerned, it was not very conducive to collecting results. There still may be an effect of homelessness on teens' ability to make positive life changes, but it could not be detected in this study. The possibility, however, is supported by the ISEL item "Most of my friends are more successful at making changes in their lives than I am," for which a majority of 51.7% GOAL students answered true (15 out of 29).

Despite the limitations of this study, the results collected contribute significantly to the information currently known about the homelessness status of the teens served by iFIT. This study substantiated the suspicion of iFIT staff that homelessness is a prevalent problem among GOAL students. It also provided concrete evidence that homelessness is an area that needs to be addressed proactively in the content of the course itself. Students were exceedingly vocal when providing feedback on the GOAL course and how it can best respond to their needs during their interviews. These students are facing a profound lack of belonging and an absence of modeling of healthy interaction, which is a significant underlying cause of their aggressive behavior. They repeatedly expressed the desire for more frequent GOAL classes and more constant support with a focus on self-expression. Students specifically suggested getting everyone talking, even if that means going around a circle during discussion. Many hoped that this would build trust and make class more personal and experience-based. They also vocalized that peer feedback is uniquely helpful and can help to build a sense of community. I was surprised by the majority assertion that discussion with one another is the most important aspect of the GOAL course because it makes students feel that their voices and experiences are valued and that they are not alone. This widely-shared sentiment suggests that the GOAL classroom may in fact be where belonging and positive modeling can begin.

By supplying insights and statistics as well as revealing particular questionnaire items that highlight the social support insufficiencies faced by students, I am hopeful that this study will improve iFIT's understanding of and responsiveness to the population it serves. Furthermore, insight into the high degree of homelessness experienced by aggressive youth has the potential to motivate further research regarding the demand for a youth homeless shelter in the Elkhart community. It is possible that this study can serve as a starting point for the collection of evidence to appeal for restored funding for the youth homeless shelter that was formerly located in Elkhart County.

In the future, the findings from this study might be further explored by collecting data from a greater number of GOAL participants over substantially longer than one academic semester. Furthermore, it would be helpful to include a second comparison group of students from the public school system that have never sought iFIT services in order to understand the degree to which the homelessness experienced by GOAL students deviates from the norms of the larger community. This was not a reasonable option for an independent project but would be feasible for a larger-scale, longer-term investigation. Also, a larger sample and continuous scales would enable more effective assessment of the degree to which homelessness affects teen performance in an aggression intervention. This still has great relevance to iFIT's understanding of the degree to which their program is effective for homeless GOAL participants.

The findings of this study also have the potential to contribute meaningfully to the field by substantiating existing theories on teen homelessness and aggressive behavior. The statistical results of this study in conjunction with interview feedback support existing evidence that the traumatic experience of homelessness and/or family instability often causes youth to act out their feelings of distress and helplessness (MacLean, Embry, & Cauce, 1999). Interview feedback also provided evidence that the social-learning theory that aggression is learned, sustained, and unlearned by way of observational learning (Moeller, 2001) is supported by the experiences of many Elkhart youth. Furthermore, the stories articulated by many GOAL participants confirm the validity of the frustration-aggression hypothesis, which states that aggression is the inevitable reaction to a situation in which a youth is blocked from a goal (Moeller, 2001). For many students, their family lives are blocking them from their goal to achieve belonging, stability, and self-worth, and their stress and frustration over being blocked leads them to act out aggressively. It is vitally important to continue to test these theories and to open dialogue in order to better understand youth exhibiting aggression. Those teens who can be classified as homeless based on lack of social support and/or a stable physical residence have been found to suffer life-long repercussions and exhibit life-long chronic aggression (Feitel, Margetson, Chamas, & Lipman, 1992; Robertson, 1991; Wright, 1991). I hope that this study serves to stimulate both awareness among academics and continued community-based investigation.

References

- Anooshian, L. G. (2005). Violence and aggression in the lives of homeless children. *Journal of Family Violence, 20*, 373-387. doi: 10.1007/s10896-005-7799-3.
- Baron, S.W., Forde, D.R., & Kennedy, L.W. (2007). Disputatiousness, aggressiveness, and victimization among street youths. *Youth Violence and Juvenile Justice, 5*, 411-425. doi: 10.1177/1541204077299582.
- Bates, D. S., & Toro, P.A. (1999). Developing measures to assess social support among homeless and poor people. *Journal of Community Psychology, 27*, 137-156.
- Booth, R. E., & Zhang, Y. (1996). Severe aggression and related conduct problems among runaway and homeless adolescents. *Psychiatric Services, 47*, 75-80.
- Cohen, S., & Hoberman, H. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology, 13*, 99-125.
- Feitel, B., Margetson, N., Chamas, J., & Lipman, C. (1992). Psychosocial background and behavioral and emotional disorders of homeless and runaway youth. *Hosp Community Psychiatry, 43*, 155-159.
- Goleman, D. (1995). *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam Books.
- MacLean, M. G., Embry, L. F., & Cauce, A. M. (1999). Homeless adolescents' paths to separation from family: Comparison of family characteristics, psychological adjustment, and victimization. *Journal of Community Psychology, 27*, 179-188.
- Marcus, R.F. (2008). Cross-sectional study of violence in emerging adulthood. *Aggressive behavior, 35*, 188-202. doi: 10.1002/ab.20293.
- Moeller, T.G. (2001). *Youth aggression and violence: A psychological approach*. New Jersey: Lawrence Erlbaum Associates, Inc.
- National Center for Chronic Disease Prevention and Health Promotion (2009). National youth risk behavior survey. <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>.
- National youth homelessness awareness month: Ways to get involved. (2009). *Huffington Post*. <http://www.huffingtonpost.com>.
- North, C. S., Smith, E. M., & Spitznagel, E. L. (1994). Violence and the homeless: An epidemiologic study of victimization and aggression. *Journal of Traumatic Stress, 7*, 95-110.
- Robertson, M.J. (1991). Homeless youth: An overview of recent literature. In J.H. Kryder-Coe,

L.M. Salamon, & J.M. Molnar (Eds.), *Homeless children and youth: A new American dilemma* (pp. 33-69). New Brunswick, NJ: Transaction Publishers.

Snyder, H.N., & Sickmund M. (1995). Juvenile offenders and victims: A focus on violence. *U.S. Department of Justice*. <http://www.ncjrs.gov>.

Wright, J.D. (1991). Is homelessness a housing problem? *Understanding homelessness: New policy and research perspectives*, 205-244.

Vance, J.E., Bowen, N.K., Fernandez, G., & Thompson, S. (2002). Risk and protective factors as predictors of outcome in adolescents with psychiatric disorder and aggression. *American Academy of Child Adolescent Psychiatry*, 41, 36-43.

Appendix A
Interpersonal Support Evaluation List (ISEL)

Instructions

This scale is made up of a list of statements each of which may or may not be true about you. You may find that many of the statements are neither clearly true nor clearly false. For each statement you are asked to circle probably true (T) or probably false (F). Please try to choose the one that is most descriptive of you. If a question is causing you distress, however, you may skip it and move onto the next question. If the subject matter of this questionnaire is altogether distressing to you, you have the right to exit. This study has no bearing on your graduation from the iFIT program in which you are participating.

Please remember that this is not a test and there are no right or wrong answers. Also, the answers you provide in this questionnaire will remain confidential and anonymous.

1. There are several people that I trust to help solve my problems.
T F
2. If I were sick and needed someone to take me to the doctor, I would have trouble finding someone.
T F
3. There is someone who takes pride in my accomplishments.
T F
4. I feel that there is no one I can share my most private worries and fears with.
T F
5. Most people I know don't enjoy the same things that I do.
T F
6. If I was stranded 10 miles from home, there is someone I could call who would come and get me.
T F
7. There really is no one who can give me an objective view of how I'm handling my problems.
T F
8. I feel that I'm on the fringe of my circle of friends.
T F
9. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.
T F

10. If for some reason I were put in jail, there is someone I could call who would bail me out.

T F

11. I am able to do things as well as most other people.

T F

12. There is someone I can turn to for advice about handling hassles over household responsibilities.

T F

13. If I needed a place to stay, I could easily find someone who would put me up.

T F

14. When I feel lonely, there are several people I can talk to.

T F

15. In general, people don't have much confidence in me.

T F

1. I often meet or talk with family or friends.

T F

2. If I needed an emergency loan of \$100, there is someone I could get it from.

T F

3. I am closer to my friends than most other people are to theirs.

T F

4. There is someone I could turn to for advice about making career plans or changing my job.

T F

5. No one I know would throw a birthday party for me.

T F

6. If I wanted to have lunch with someone, I could easily find someone to join me.

T F

7. I think that my friends feel that I'm not very good at helping them solve problems.

T F

8. It would be difficult to find someone who would lend me their car for a few hours.

T F

9. If I wanted to go on a trip for a day (e.g., to the mountains, beach, etc), I would have a hard time finding someone to go with me.

T F

10. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.
T F
11. Most of my friends are more successful at making changes in their lives than I am.
T F
12. There are several different people I enjoy spending time with.
T F
13. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.
T F
14. I don't often get invited to do things with others.
T F
15. I am more satisfied with my life than most people are with theirs.
T F
16. If I were sick, there would be almost no one I could find to help me with my daily chores/responsibilities.
T F

Appendix B
True/False Supplemental Survey

- | | | |
|---|---|---|
| T | F | I sleep under the same roof every night. |
| T | F | I sleep in the same bed every night. |
| T | F | My address and phone number have changed many times during my life. |
| T | F | I personally have been or my family has been homeless at one time. |
| T | F | I have lived with friends or relatives outside of my immediate family for an extended period of time. |
| T | F | I stay at a place where I feel safe. |
| T | F | I stay at a place that I feel is my home. |
| T | F | I can enter and leave the place that I sleep whenever I want to. |
| T | F | I have been kicked out of the place where I stay before. |
| T | F | I have thought about leaving the place where I live. |
| T | F | My life would be better if I could leave the place where I stay and the people I currently live with. |
| T | F | If I knew that there was a safe place to go that would take me in, I would strongly consider leaving the place that I stay now. |

Appendix C

Interview Questions

1. What does “home” mean to you? What are things that you feel make a good home?
→What would you want your home to look like?
2. How does the place you stay compare to that?
→If you could change your home or the place that you stay in any ways you wanted, what would you change?
3. Do you feel that your home or the place that you stay is part of what makes you angry? (Why?/Why not?)
 - a. What are your triggers when you’re at home?
 - b. How well do the people you live with control their anger?
4. If you had a safe place to go where you felt wanted, would you leave your home?
 - a. What would that look like?
 - b. Do you know of safe places that you could go?
5. If you did truly make a change after this class and learn to control your anger, would that make your home life better? Do you feel like it would make a difference?
6. What do you need from this program to start getting past feeling angry? Do you have ideas of what would be helpful? What more could iFIT be doing?

Appendix D

PARENT PERMISSION FORM

Your son or daughter is invited to participate in a study about how social support and belonging affect teen anger. The study is a collaborative effort between iFIT and a Psychology student from the University of Notre Dame. We hope to gain a better understanding of the challenges faced by youth participating in iFIT programs. This may help iFIT to understand their students better and adjust the programs to better fit their students' needs. Your son or daughter was selected as a possible participant in this study because of their enrollment in an iFIT program.

This study will take a total of at most 30 minutes of your child's time. The only risk is that they may feel some discomfort because the questions are somewhat personal.

_____ If you provide consent by signing your initials here, your son or daughter will be asked to fill out a series of True/False questionnaires at the beginning and end of their iFIT course. This will take about 10-15 minutes of class time.

_____ Additionally, if you provide your initials to the left, your child will participate in a short, approximately 10-minute interview that will be recorded (voice only) and used to help explain the data collected. The recordings will be kept locked up at all times. They will be deleted when the study and all related analysis is completed.

Information that is provided during this study will remain confidential. Participants will be assigned numbers that will be used to identify all questionnaires and voice recordings. Names will not be used. The anonymous data collected in this study will be released only to the student investigator and iFIT. An exception to confidentiality will be made, however, if the investigator has reason to believe that your son or daughter is experiencing an immediately threatening or abusive situation. In this case, the appropriate iFIT personnel will be notified. The iFIT staff will then hold an interview to assess need and establish a plan of action. If necessary, the staff will facilitate and enable activities that have the potential to unite families. Where required by law, the staff will act to protect your son or daughter.

Your decision whether or not to allow your child to participate will not prejudice your future relations with iFIT. If you decide to consent to participation, you or your child are free to end their participation at any time without penalty. If you choose not to consent to your child participating in the study, they will be asked to sit quietly in their seat while their classmates fill out their questionnaires.

Your child will only directly benefit from this study by improving the quality of the programming that they receive from iFIT. They will not receive any individual rewards.

STUDENT ASSENT FORM

You are invited to participate in a study about how young people respond to challenges. Specifically, this study will look at how social support and belonging affect youth aggression. The study is a collaborative effort between iFIT and a Psychology student from the University of Notre Dame. We hope to gain a better understanding of the challenges faced by youth participating in iFIT programs. This will help iFIT to understand their students better and adjust the programs to better fit their students' needs. You were selected as a possible participant in this study because of your enrollment in an iFIT program.

_____ If you provide consent, which you may indicate by signing your initials on the line provided at the start of this paragraph, you will be asked to fill out additional questionnaires at the beginning and end of your iFIT course. Each will take about 10 minutes. The questionnaires will be given during class time. This study will take a total of at most 30 minutes of your time. The only risk is that you may feel some discomfort because the questions are somewhat personal.

_____ Also, with your consent, also indicated by placing your initials on the line, participants who are part of the GOAL Program may be randomly selected to participate in a short, approximately 10-minute interview that will be recorded (voice only) and used to help explain the data collected. The recordings will be kept locked up at all times and will be deleted when the study and related analysis is completed.

Information that you provide during this study will remain confidential. All questionnaires and voice recordings will be identified by numbers alone. Names will not be used. Numbered stickers will be placed on the inside covers of the participants' course notebooks. Participants will be required to write this number on the front of their questionnaires. The anonymous data collected in this study will be released only to the student investigator and iFIT. An exception will be made, however, if the investigator has reason to believe that you are experiencing physical or emotional abuse. In this case, the appropriate iFIT personnel will be notified. The iFIT staff will then hold an interview to assess need and establish a plan of action. If necessary, the staff will facilitate and enable activities that have the potential to unite families. Where required by law, the staff will act to protect you.

Your decision whether or not to participate will not prejudice your future relations with iFIT. If you decide to participate, you are free to end your participation at any time without penalty. If you do choose to participate, participating in the study will not progress your release from the program and is not related. If you choose not to participate, you will be asked to sit quietly in your seat while your classmates fill out their questionnaires.

Appendix D

Descriptive Statistics for Homelessness and Social Support Scores

Independent Samples T-Test: ISEL

Group Statistics

Testing Group		N	Mean	Std. Deviation	Std. Error Mean
Homelessness Scores	Comparison Group	28	24.0357	4.33318	.81889
	GOAL Students	28	22.2500	5.58851	1.05613

	Levene's Test for Equality of Variances		t-test for Equality of Means				
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Equal variances assumed	.416	.522	1.336	54	.187	1.78571	1.33641
Equal variances not assumed			1.336	50.846	.187	1.78571	1.33641

Independent Samples T-Test: Homelessness Questionnaire

Group Statistics

Testing Group		N	Mean	Std. Deviation	Std. Error Mean
Homelessness Scores	Comparison Group	27	3.8148	2.40252	.46236
	GOAL Students	30	5.2333	2.28463	.41711

	Levene's Test for Equality of Variances		t-test for Equality of Means				
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Equal variances assumed	.001	.971	-2.284	55	.026	-1.41852	.62103
Equal variances not assumed			-2.278	53.670	.027	-1.41852	.62271

Independent Samples T-Test: Self-Reported Improvement of Aggressive Behavior

Group Statistics

Testing Group		N	Mean	Std. Deviation	Std. Error Mean
Aggression Scores	Low Homelessness	9	25.5556	17.40051	5.80017

Group Statistics

Testing Group		N	Mean	Std. Deviation	Std. Error Mean
Aggression Scores	Low Homelessness	9	25.5556	17.40051	5.80017
	High Homelessness	12	28.3333	16.96699	4.89795

	Levene's Test for Equality of Variances		t-test for Equality of Means				
	F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
Equal variances assumed	.193	.666	-.367	19	.717	-2.77778	7.56282
Equal variances not assumed			-.366	17.139	.719	-2.77778	7.59157