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Effects of A Nursing Intervention

with Homeless Veterans

A Dissertation

Presented for the Doctor of Philosophy

Degree

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Jane H. Tollett

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DEDICATION

To my daughter Kellye and my sister Dale who died in tragic accidents during my
doctoral studies and who are sorely missed, but whose love for me and belief in
my work continue to sustain me, and

To my grandson, Trevor Tollett Lovingood, who was born during these studies and
whose life inspires me to hope,

I dedicate this work.

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ABSTRACT

The purpose of this quasi-experimental study was to determine if a specific nursing intervention to instill hope would positively influence levels of hope, self-efficacy, self-esteem and depression in homeless veterans. Miller's (1983, 1992) Model of Patient Power Resources served as the conceptual framework from which a middle-range theory of Homelessness-Hopelessness was derived to guide the study.

The sample consisted of 40 homeless veterans from the Homeless Evaluation Unit (HEU) Department of Veterans Affairs Medical Center at Mountain Home, Tennessee. The subjects completed pretests on admission, were randomly assigned to the treatment or waiting control group and completed posttests at the end of four weeks of either specialized nursing intervention or the usual and customary treatment in the HEU. Data were collected with the Miller Hope Scale (Miller & Powers, 1988), the General Self-Efficacy Subscale (Sherer, Maddox, Mercandante, Prentice, Dunn, Jacobs, & Rogers, 1982), the Rosenberg Self-Esteem Scale (Rosenberg, 1965) and the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979). Test-retest reliability was high for each instrument. Qualitative data were recorded in field notes.

Quantitative statistical analyses were performed on the data using correlations, analysis of covariance (ANCOVA) and *t*-tests. The qualitative data were analyzed for patterns and themes. Length of homelessness was inversely related to hope and positively related to depression on admission to the study. There was support for the

Homelessness-Hopelessness theory as evidenced by a high level of depression and low levels of hope, self-efficacy and self-esteem among these homeless veterans. Further support for the theory was seen in the increased levels of hope and self-esteem and decreased depression in veterans who received the nursing intervention. Treatment and control groups differed significantly with regard to hope at posttest. Implications for the nursing profession, public policy and future research were discussed.

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CHAPTER 1

INTRODUCTION

Homeless persons live a life of entrapment, impoverishment and risk (Dennis, Buckner, Lipton, & Levine, 1991; Fischer & Breake, 1991; Marin, 1991; National Institute of Mental Health, [NIMH], 1992). Although it is commonly assumed that many homeless persons choose this state, there is little evidence to support such a notion. The homeless are at high risk for illness, trauma (physical and psychological) and abuse (Goodman, Sake & Harvey, 1991; Kiesler, 1991; Wright, 1987). They suffer losses of relationships, material possessions and society's esteem. These people frequently exhibit symptoms of a loss of hope such as an inability to seek or receive assistance, to set goals or to work toward breaking out of their homeless state (Drake, Osher & Wallach, 1991; Marin, 1991).

Hope is a vital life force in humans (Capps, 1970; Fitzgerald, 1979; Korner, 1970; Miller, 1983). One function of hope is to defend against despair (Korner, 1970; Owen, 1989; Raleigh, 1980). Expectation is a key attribute of hope and is, of course, directed toward the future -- not the past. This expectation can be directed toward relief from a difficult situation (Dufault & Martocchio, 1985; Korner, 1970), but a person must have a basic sense of control over his environment and a belief that there is a "way out" to be able to hope for relief from present difficulties (Bandura, Adams, & Beyer, 1977; Lynch, 1974; Raleigh, 1980). A sense of entrapment, multiple losses, illness, impoverishment and life-threatening situations leads to a loss

of hope or an inability to hope (Barnfather & Erickson, 1989; Korner, 1970; Miller, 1985; Raleigh, 1980). When hope is lost there is no reason to act, to set goals or to work toward freedom from adverse situations, because there is no way out (Lynch, 1974; Schneider, 1980).

STATEMENT OF THE PROBLEM

When homeless persons enter health-care settings they do not readily set goals, participate in programs or use available resources in a constructive way. Their behavior is seen by health care professionals as reflective of apathy and indifference, giving the impression that these individuals are lazy and choose homelessness as a way of life. In fact, this behavior may be a natural consequence of homelessness and the concomitant loss of hope, which creates a self-perpetuating cycle of hopelessness, low self-efficacy, low self-esteem, and depression. Therefore, there is a need to study this group to better understand the dynamics of this human response. Caring professionals must develop a way to instill hope in these persons to enable them to move on with the process of reestablishing themselves in society.

Purpose of the Study

The purpose of the study is to determine if a specific nursing intervention to instill hope will positively influence a population of homeless veterans with regard to their levels of hope, self-efficacy, self-esteem and depression.

Research Questions

The following research questions have been formulated to guide the study:

1. What are the levels of hope, self-efficacy, self-esteem and depression of homeless veterans?
2. Will a specific nursing intervention instill hope, increase self-efficacy increase self-esteem and lessen depression in these individuals?

Miller's Conceptual Framework

Miller's (1992) Model of Patient Power Resources (Figure 1) was selected as the conceptual framework for this study. Miller's interest in the nursing care of the chronically ill and personal family experiences led to her work in human power resources. Her belief is that power is a resource for living that is present in all individuals and is "the ability to influence what happens to oneself" (p. 3). Miller identified the prevalent theme throughout patients' reactions to chronic illness as loss of control or power. She agrees with Turk (1979) that one's sense of personal mastery, as evidenced by confidence in individual ability and a sense of control and self-efficacy to handle situations related to an illness, are important factors influencing positive adjustment to chronic illness. Miller's Patient Resource Model (1988, 1992) contains seven patient power resources. These are (a) physical strength and reserve, (b) psychological stamina and social support, (c) positive self-concept (self-esteem), (d) energy, (e) knowledge, (f) motivation and (g) belief system (hope) (see Figure 1).

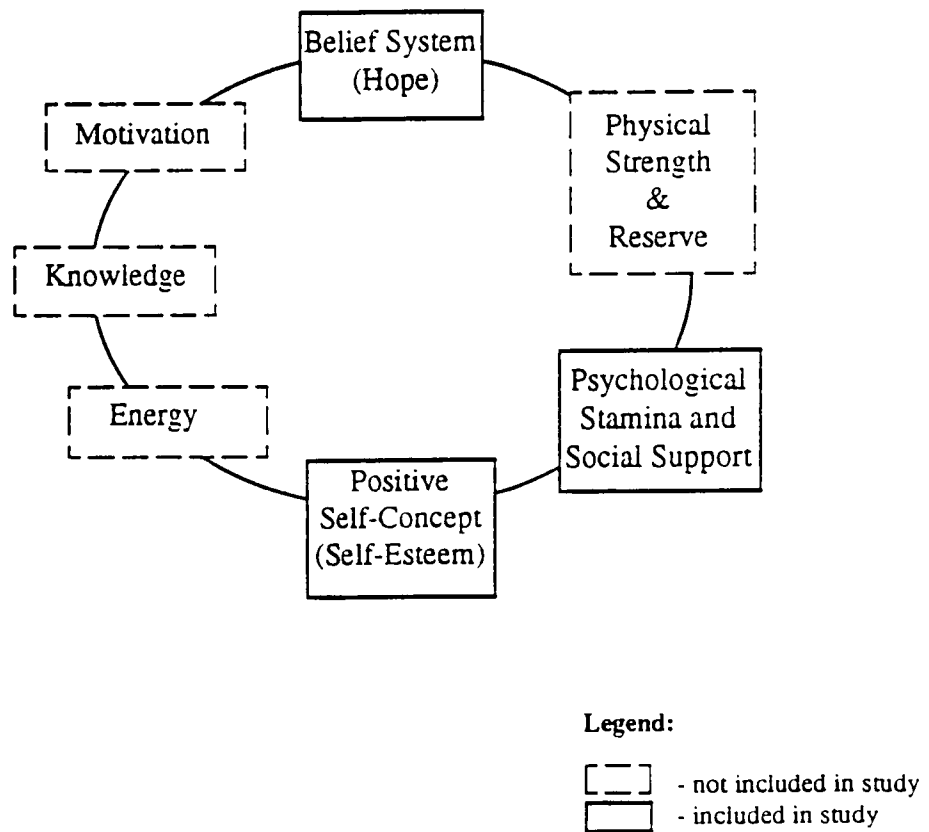


Figure 1. Miller's Patient Power Resources Model (Miller, 1983, 1992). Used by permission.

Miller's Theory of Powerlessness-Hopelessness

Miller (1992) asserts that the ultimate goal of nursing care is to maintain and enhance quality of life in clients and family. Further, she believes that quality of life includes playing roles that are important to the individual, giving and receiving love, balancing dependence with independence, being satisfied with self, being at peace, having a sense of self-worth, having energy to enjoy life's special pleasures, coping effectively and having hope. Miller says that chronically ill persons have goals similar to well persons, including the goals to live life fully and to function optimally in all aspects of life (i.e., quality of life). According to Miller's theory a perception of lack of control interferes with achieving quality of life. Therefore, maximizing the patient's power resources facilitates the patient's ability to cope.

The Patient Power Resource model posits that individuals may have deficits in several power resources. Chronic illness, because of its unpredictability and concomitant losses, leads to powerlessness. "When powerlessness is not contained, hopelessness can result" (Miller, 1992, p. 415). In this situation, a cycle of powerlessness-hopelessness can develop in the individual in which "powerlessness leads to depression and low self-esteem, causing hopelessness that in turn immobilizes the individual" (p. 415). In the chronically ill this cycle of prolonged hopelessness with no relief in sight continues until the patient gives up and falls into despair. This cycle can lead to self-harm or hasten death in these individuals. According to Miller, coping with perceived powerlessness is a major concern throughout chronic illness.

Effective nursing care of these patients will promote the development and support of the patient's power resources (see Figure 2).

Parallel Theory of Homelessness-Hopelessness

This study proposes that Miller's Model of Patient Power Resources and her theory of the powerlessness-hopelessness cycle have utility for understanding another group of patients, homeless persons, and that a parallel exists between the chronically ill and the homeless. This proposed parallel is supported by clinical observation and clinical reasoning. A comparative review of the characteristics of the chronically ill set forth by Miller and the characteristics of homeless from the literature support this proposal.

Comparison of Chronically ill and Homeless

Miller sets forth that individuals who are chronically ill suffer the loss of their accustomed roles and relationships in the family and community as well as the loss of independence and control over their environment. This characteristic has been documented in the homeless literature as well (National Institute of Mental Health [NIMH], 1992; Sergi, Murray, & Gotanch, 1989). Like the chronically ill, homeless persons experience a poor quality of life that includes the loss of family and community standing and relationships, as well as the ability to give and receive love (Leidy, Ozbolt, & Swain, 1990; NIMH, 1992; Segal & Baumohl, 1980). Furthermore, the imbalance of dependence and independence observed in the chronically ill is present in the homeless population and influences the low

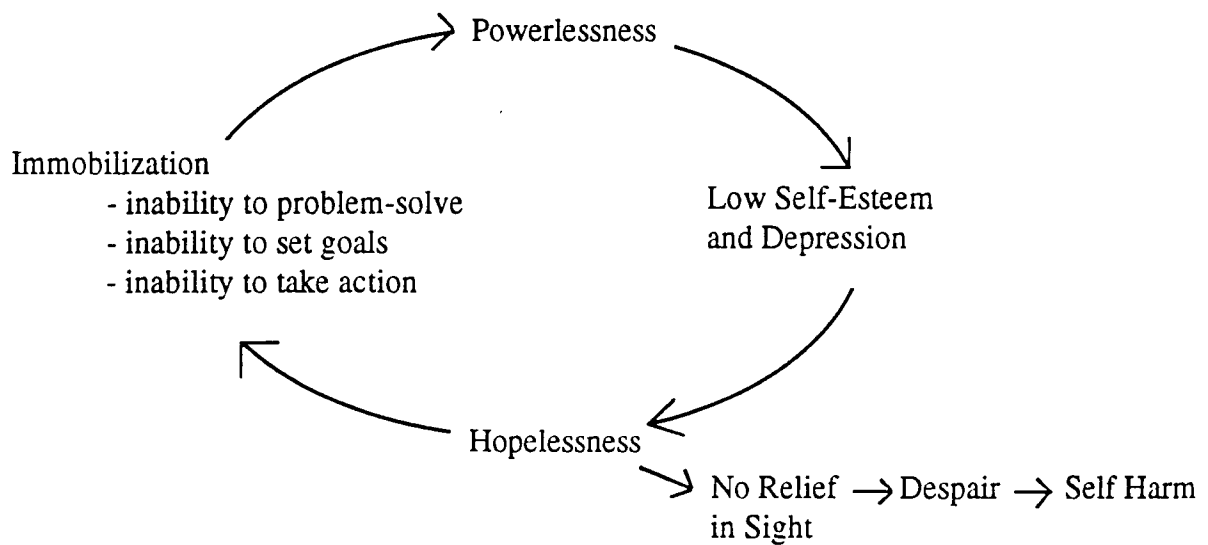


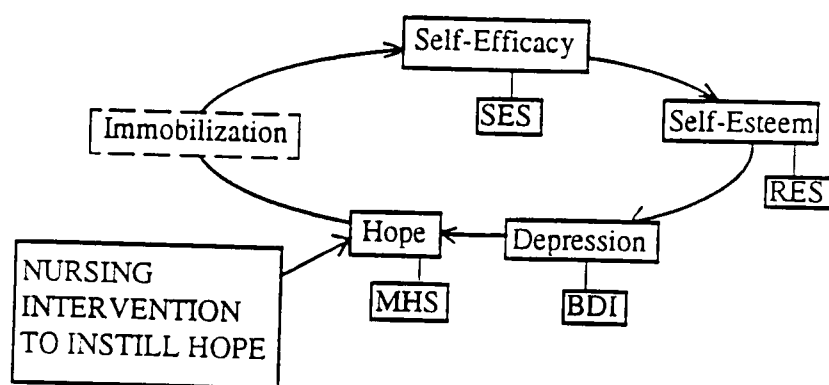
Figure 2. Miller's Theory of the Powerlessness-Hopelessness Cycle (Miller, 1992). Used by permission.

quality of life experienced by these people (NIMH, 1992). Just as the chronically ill become dependent on the care of others for basic needs, the homeless also are dependent on the benevolence of others for essential needs. As the chronically ill lose control over their environment when they are hospitalized or unable to care for themselves, the homeless experience the loss of control over their environment and, in addition, the loss of material possessions, safety and security (Ball & Gavassy, 1984; Hartman, 1989; Surber, Dwyer, Ryan, Goldfinger, & Kelly, 1988).

Miller points out that the episodic nature of chronic illness leads to feelings of powerlessness. The episodic nature of homelessness has been documented (Arce, Tadlock, Vergare, & Shapiro, 1983; NIMH, 1992). Many of the homeless have had several episodes of homelessness interspersed with periods of having a place to stay. Therefore their homelessness parallels the episodic nature of chronic illness. Repetitions of the homeless-not homeless sequence lead to the perception that they have no control over events that happen to them (Kozol, 1988; Leidy et al., 1990). They begin to believe that nothing really works and feelings of powerlessness ensue. This powerlessness is like that described by Miller as characteristics of the chronically ill. Specifically, this feeling of powerlessness is a loss of confidence in their ability to positively influence their personal lives (i.e., a loss of self-efficacy); they do not believe that they can do what is needed to change their situation which, according to Miller, leads to immobilization. Negotiating the maze of disparate federal, state, and local services and understanding the regulations, policies and criteria for services with

which the homeless are faced many times requires more patience, tolerance and/or coordination than these individuals possess (NIMH, 1992), thus increasing their feelings of powerlessness. Therefore, attempting to find help can be a frustrating experience that further disrupts the power resources of the homeless person. When the homeless come for help they exhibit characteristics and behaviors indicative of immobilization, just as Miller described in the cycle of powerlessness-hopelessness among chronically ill patients. Homeless persons often miss scheduled appointments, fail to set goals or work toward those they do set; fail to follow up on leads for employment, training or housing; are non-compliant with therapy and medication and in general present a picture of apathy and indifference (Drake et al., 1991; Fischer & Breakey, 1991).

The homelessness-hopelessness theory being proposed here posits that lethargy, apathy and indifference exhibited by homeless persons result from deficits in their power resources, namely in self-concept (leading to low self-esteem), psychological stamina (leading to depression) and the belief system (leading to hopelessness), which creates powerlessness (a sense of low self-efficacy). This cycle was established by the loss of control over most aspects of their lives and the situation in which they find themselves (see Figure 3).



Legend:

- not included in study
- included in study
- MHS - Miller Hope Scale
- SES - Self-Efficacy Scale
- RES - Rosenberg Esteem Scale
- BDI - Beck Depression Inventory

Figure 3. Tollett's Theory of Homelessness-Hopelessness.

THEORETICAL FRAMEWORK FOR THIS STUDY

A homelessness-hopelessness theory that derives from Miller's conceptual framework was developed for this study. The homelessness-hopelessness theory posits that the self-esteem of the homeless person is damaged from the feelings of failure and powerlessness. Following the erosion of self-esteem, depression of mood becomes a problem. If there is no relief from the situation of homelessness at this point, an overwhelming despair and loss of hope is imminent. The homeless person becomes immobilized and the cycle perpetuates itself. It is somewhere in this cycle that health-care professionals often encounter these individuals.

Miller's powerlessness-hopelessness cycle is a description of the chronically ill. However, this cycle also describes the homeless population, as has been demonstrated. In addition, the present study takes the cycle beyond the descriptive level to the prescriptive level providing the target for the nursing intervention and predicting a positive patient outcome. The homelessness-hopelessness theory holds that intervening in the cycle at the belief system by instilling hope will aid in restoring the perception of power (self-efficacy), will raise self-esteem and lessen depression, thus breaking the cycle of homelessness-hopelessness in homeless veterans and allowing mobilization for reintegration into society.

Homelessness-Hopelessness Theory

The homelessness-hopelessness theory being proposed is summarized in the following assumptions and propositions. From this theory a research hypothesis is developed for this study which constitutes testing of middle range theory.

Tollett's Assumptions:

1. Power is a resource for living and is the ability to influence what happens to oneself and,
2. Deficits in power resources result in powerlessness and,
3. When powerlessness is not contained hopelessness results and,
4. Human responses to chronic illnesses and homelessness have similar characteristics and,
5. Homelessness results in deficits in power resources and hopelessness and,
6. In homeless persons, a cycle of homelessness-hopelessness may develop and is comprised of hopelessness, low self-efficacy (powerlessness), low self-esteem and depression which renders the person immobile and unable to take action to break out of the homeless state.

Tollett's Propositions:

1. It is possible to instill hope in individuals and,
2. The instillation of hope is a specific nursing intervention.
3. Effective nursing care of homeless persons will intervene in the homelessness-hopelessness cycle to instill hope.

4. A nursing intervention to instill hope in homeless persons will break the homelessness-hopelessness cycle increasing levels of hope, self-efficacy, self-esteem and decreasing depression and immobilization, allowing reintegration into society.

Hypothesis:

There is greater hope, self-efficacy and self-esteem and less depression in subjects receiving a specific nursing intervention to instill hope than in the subjects who receive the usual and customary treatment.

SIGNIFICANCE OF THE STUDY

This study provides a more precise understanding of the psychosocial characteristics of homeless veterans and advances knowledge of the effect of a specific nursing intervention in instilling hope. Further, it provides useful information to those professionals who work with the homeless veteran population in designing programs to meet their needs and break the cycle of homelessness.

Delimitations and Limitations

The sample of this study was delimited to male homeless veterans who were admitted to the Homeless Evaluation Unit the Department of Veterans Affairs Medical Center at Mountain Home during the data collection period. These veterans sought and were promised help with their homeless situation. This fact may have already influenced their levels of hope prior to the intervention. Therefore, generalizations of the findings of the study to other populations would not be appropriate.

The study was not designed to detect all possible factors influencing levels of hope or homelessness among homeless veterans. Personality characteristics and cognitive abilities were beyond the scope of this study.

This study was conducted using a specific nursing intervention over a short time period. This time-frame (four weeks: twelve treatments) was determined based on time constraints related to the nomadic nature of the homeless population. However, the brevity of the treatment is acknowledged as a limitation.

Nominal Definitions of Terms and Abbreviations

For the purpose of this study the following definitions of terms and abbreviations will be used:

1. Homeless--any adult who lacks a fixed, regular, adequate nighttime residence; or any adult who has a primary nighttime residence that is
 - a. a publicly or privately operated supervised shelter designed to provide temporary living accommodations or
 - b. a place (public or private) not designed for, or ordinarily used as a regular sleeping accommodation for human beings (Public Law 100-77-July 22, 1987, section 103).
2. Veteran. A male who meets the criteria set by the Department of Veterans Affairs to determine veteran status. These criteria are: 1. honorable discharge from the military and, 2. twenty-four consecutive months in the military if the service time was after September, 1980. In the event that

the service time was after September, 1980, and the veteran does not have twenty-four months consecutive service but has a service-connected disability, he may receive care for that disability. Veteran status is determined by clerical personnel prior to admission to any VA facility, including Mountain Home VAMC.

3. VA. The Department of Veterans Affairs is a cabinet level program of the United States whose mission is two-pronged: medical care and benefits for veterans.
4. Department of Veterans Affairs Medical Center (VAMC) at Mountain Home. The Mountain Home VAMC is a medical center at Mountain Home, Tennessee that is funded, operated and controlled by the Department of Veterans Affairs and whose services are restricted to veterans.
5. Homeless Evaluation Unit (HEU). The homeless evaluation unit is an interdisciplinary program of the Mountain Home VAMC whose mission is to break the cycle of homelessness in homeless veterans. The interdisciplinary team consists of a nurse-coordinator, clinical psychologist, and a clinical social worker. "Usual and customary treatment" provided in the unit is described in Chapter 3.

6. Hope. Hope is "an anticipation for a continued good state, an improved state, or a release from a perceived entrapment" (Miller & Powers, 1988, p. 6).
7. Powerlessness. Powerlessness is "The perception of the individual that one's own actions will not significantly affect an outcome" (Miller, 1983, p.38).
8. Self-esteem. Self-esteem is a multidimensional concept referring to a global attitude about one's self-worth (Rosenberg, 1965).
10. Depression. Depression is defined as distorted negative perceptions about the self, the world, and the future (Beck, Rush, Shaw, & Emery, 1979).

Operational definitions of these and other terms appear in chapter 3.

SUMMARY

Hope is an intrinsic component of life and is necessary for the mobilization of the self to take action. The ability to hope can be lost or destroyed by entrapment in a difficult situation, a lack of control over the environment, loss of resources including supportive relationships, and illness. The homeless are, in fact, in a difficult situation with no immediate or simple way out. This absence of any apparent escape route leads to a feeling of entrapment. They experience losses of resources, both material and non-material, and intrinsic as well as extrinsic. They suffer from a variety of chronic and acute mental and physical illnesses which their homeless state exacerbates.

When the homeless are received in the health care system they are frequently unable to optimally use the resources available to them. This phenomenon may be due to an immobilization which is a natural consequence of being homeless. This study uses a middle-range theory derived from the work of Judith Miller (1983; 1992) to examine the level of hope, self-efficacy, self-esteem, and depression, and the ability to modify these factors in homeless veterans through a nursing intervention.

Chapter 2

REVIEW OF LITERATURE

This chapter contains a review of the literature on homelessness, hope, self-efficacy, self-esteem and depression. Additionally, the theoretical basis for the specific nursing intervention used in the present study will be delineated. Because the literature on hope, self-efficacy, self-esteem and depression is quite extensive, only the most pertinent studies will be cited in this literature review.

HOMELESSNESS

A thorough search of the literature leads to the conclusion that there is not a consensus on the definition of "homeless" (Allen, Chapman, & Ketron, 1988; Patton, 1988; Sergi, Murray, & Gotanch, 1989; Smoyak, 1989). Most authorities agree that homelessness is the condition of being without a regular dwelling place or mailing address. However, a major problem with this definition is that it omits those homeless persons who receive mail at a friend's house or a post office box but live in a tent, cave or under a bridge. This definition also excludes the people who periodically move from relative to relative, to friends or to chance acquaintances but who are essentially homeless. Berman-Rossi and Cohen (1989) talk about the "precariously housed" who are at great risk to become homeless, and Boondas (1988) contends that persons living in single-room occupancy situations should be included in the homeless count. Other people on the fringe of homelessness are the large numbers of working poor and the near poor (Moccia & Mason, 1986; Weis, 1987b).

Apparently, one does not have to be visibly on the streets to be homeless (Moccia & Mason, 1986; Weis, 1987a). Studies show that the homeless population is dynamic with persons moving among shelters, streets, and the homes of others (Arce, Tadlock, Vergare, & Shapiro, 1983; Dennis, 1990; Hartman, 1989). Homelessness is not confined to urban areas as in the past; we now see increasing numbers of homeless surfacing in rural America (Patton, 1988).

Scope of the Problem

Although there is not agreement on the definition of homelessness, there is consensus that the homeless population is growing and that this growth is likely to continue (cf. Allen et al., 1988; Boondas, 1988; Cohen, First, Roth & Arewa, 1988; Gibbs, 1988; Hartman, 1989; Institute of Medicine, 1988; Leda, Rosenheck, Medak, & Olson, 1989; Marin, 1988; Rosenheck & Leda, 1990b; Sergi et al., 1989). Estimates of the size of the homeless population range from 250,000 to 3,000,000 (Bowdler, 1989; Lindsey, 1989; Moccia & Mason, 1986; Nyamathi & Shuler, 1989; Rosenheck, Leda, Gallup, Astrachan, Milstein, Leaf, Thompson, & Errera, 1989; Sergi et al., 1989) depending on who is doing the counting and reporting. Whatever the actual size of the population, the problem is one that requires attention. The enormity of the homeless phenomenon has been described as a national disgrace (Hartman, 1989) and as a national crisis (Gullberg, 1989).

The History of Homelessness in the U. S.

There have been four major periods of homelessness in the United States (Robertson, 1987). The first followed the Civil War and was comprised largely of laid-off railroad workers. The early hobos were unemployed because of fluctuating post-war business cycles and the depression of 1873-79 swelled their ranks. The reduction in demand for seasonal workers and unskilled labor due to the mechanization of farms and industry at the turn of the century increased the homeless population. These homeless people migrated to the cities and drifted between labor jobs, living in rooming houses designed for single, transient males, thus the "skid row" homeless were created (Burnette, Covington, Falcone, Manda, Peterson, Poag, Wallin & Washington, 1990; Schneider, 1986).

The second period of homelessness was created by the second Great Depression which caused unemployment for hundreds of thousands and evictions of tens of thousands. This growing problem was curtailed by the start of World War II when the homeless population essentially vanished (Burnette, et al., 1990).

The economic recession of the early 1950s as well as a large number of unemployed veterans following World War II created the third wave of homelessness in this country. Missions, welfare hotels and bars in run-down sections of large inner cities became the "homes" for these homeless persons during this time. The new skid row homeless people were less numerous, older and more alcohol and

welfare dependent than the previous skid row population (Burnette, et al., 1990; Hopper, 1984; Schneider, 1986).

The fourth period of homelessness is the present one (Burnette, et al., 1990). This period reflects some of the same patterns as the previous homeless eras, namely, unemployment, poverty, lack of affordable housing, and large numbers of veterans on its rolls. However, this period differs from the previous ones in significant ways; the group is younger and more ethnically diverse (Burnette, et al., 1990; Robertson, 1987).

The Current Situation

The current homeless population is a changing one. Depiction of the homeless as the skid-row alcoholic, the "hobo," or the "bag lady" is outdated (Boondas, 1988). Although these people are part of the homeless population, they are a distinct minority. Homelessness is now a problem of the young as well as the elderly (Bean, Stefl, & Howe, 1987; Boondas, 1988; Bowdler, 1989; Institute of Medicine, 1988; Johnson & Kreuger, 1989; Weis, 1987a), with children under eighteen years of age and their mothers comprising the fastest growing segment of the population (Ayers, 1989; Breton, 1989; Edelman, 1989; Hodgkinson, 1989; Jennings, 1988, 1989; Lindsey, 1989; Mills & Ota, 1989; Morrisette & McIntyre, 1989; Popp, 1988; Taylor, 1989). Families have become a large subgroup of the homeless population (Institute of Medicine, 1988; Kozol, 1988) with some researchers reporting that

families constitute at least twenty percent of the total homeless population in America (Bowdler, 1989; Hutchison, Searight, & Stretch, 1986; Mills & Ota, 1989).

The current homeless population includes a variety of people representing a diverse cross-section of society (Damrosch & Strasser, 1988; Johnson & Kreuger, 1989). Families, run-aways (minors), street-people, chronically mentally-ill, situationally distressed, elderly poor, chronic substance abusers, veterans, battered spouses, immigrants, migrants and students are some of the subgroups of the homeless (Damrosch & Strasser, 1988; Davidson & Jenkins, 1989; Dennis, 1990; Hagen, 1987; McNichol, 1988; Monk, 1989; Smoyak, 1989). Although the homeless population is diverse, studies have shown that there are few significant differences in terms of demographics and background variables among the population sub-groups (Dennis, 1990). Current research identifies the following characteristics of the homeless population: the average age is 35-40 years, one-fourth is female, one-third to one-half has at least a high school education, one-fifth is family units and minorities are over-represented. Among the homeless, one-third suffer from severe mental illness with five to seven percent of the single adults in need of acute inpatient psychiatric care. Approximately 30 to 40 percent are alcoholics (Berman-Rossi & Cohen, 1989; Bowdler, 1989; Dennis, 1990; Koroloff & Anderson, 1989; Morrissey & Dennis, 1990; Sargent, 1989; Salem, 1990). Although categorization of the homeless in terms of length of time in that status (i.e., acute vs. chronic) would be useful, researchers have not begun to make such distinctions. Many who write on the

subject of homelessness deplore the scarcity of research and agree on the need for more information about the subgroups of the population (Allen et al., 1988; Dennis, 1991; Nyamathi & Shuler, 1989; Sargent, 1989; Sergi et al., 1989).

Homeless Veterans

One subgroup of the homeless population that has been studied in-depth is the veteran group. Between thirty and fifty percent of the homeless are veterans (Gonzales-Osler, 1989; Helzer, Robins, McEvoy, 1987). Of these, nearly 50 percent are Vietnam era veterans with a median age of 40 years (Leda, Rosenheck et al., 1989; Rosenblum & Garte, 1990; Rosenheck, Leda, Gallup, Astrachan, Milstein, Leaf, Thompson, & Errera, 1989; Stevens, 1990; Stone, 1990). The Department of Veterans Affairs has set up two types of multi-site homeless treatment programs; one type is an outpatient program for the chronically mentally ill and the other type is a domiciliary-based program for all diagnoses. These programs have provided assessment and treatment to a large cross-section of veterans. The programs have also contributed a body of data about the veterans served. However, these data mainly deal with the demographics, health histories, and homeless states of the veterans rather than with social, psychologic and physical reactions to homelessness.

A brief overview of the data on homeless veterans shows them to be male (97.9%) and white (62.5%). They have alcohol problems (59.1%), non-substance abuse psychiatric illnesses (35.1%), are dually diagnosed (15.6%) or have chronic medical illnesses (54.2%). Veterans of the Vietnam War are heavily represented in

this population (30-50%) (Leda, Rosenheck et al., 1989; Rosenblum & Garte, 1990; Rosenheck & Leda, 1990a; Rosenheck, Leda, Gallup et al., 1989; Stevens, 1990; Stone, 1990).

Vietnam Veterans

There are several factors related to a high representation of Vietnam veterans among the homeless population. During the Vietnam era, the United States was involved in a race for space exploration and strategic arms. Both of these priorities placed a heavy emphasis on education. Nearly one million draft-eligible men were deferred from the war because of their occupation or student status (Surrey, 1982). This deferment removed a large number of people from higher socioeconomic groups so that the burden of the Vietnam draft fell to members of lower socioeconomic groups (Baskir & Strauss, 1978). These factors contributed to the lower average age (19.6 years) of the Vietnam soldier and may explain the extreme vulnerability of these soldiers to war trauma (Burnette, et al., 1990).

The circumstances in which Vietnam veterans returned to civilian life have also been blamed for contributing to the difficulties they experienced in readjustment (Burnette, et al., 1990). Although World War II veterans returned to a burgeoning economy with offers of education, vocational training and housing assistance, Vietnam veterans returned to a disadvantaged position. They were behind their contemporaries who had not served and who had begun to establish themselves in their careers and with families. The economy was in the midst of a recession and was shifting from a

blue-collar to a service orientation. These veterans found themselves relegated to low-pay work with little chance of advancement and salaries inadequate for the high-cost society in which they lived. Their opportunities for educational benefits were limited and were usually not adequate for leverage to better paying jobs (Burnette, et al., 1990).

Causes of Homelessness

According to Hartman (1989), a major contributor to the increase in the homeless population is the lack of affordable low-cost housing. The Reagan administration was responsible for reducing support for low-income housing by 76 percent. The abuse and mismanagement of the remaining funds by the Department of Housing and Urban Development further reduced the availability of low-cost housing (Hartman, 1989).

A reduction in the Medicaid/Medicare budget by 13 billion dollars, cuts in nutrition funding, health care rationing, the decline of social programs and the reduction of the real value of public assistance are other contributing factors perpetuated by the Reagan administration (Allen et al., 1988; Bowdler, 1989; Curtin, 1986; Hartman, 1989; Institute of Medicine, 1988; Popp, 1988). An increase in unemployment rates, a breakdown of family systems, and deinstitutionalization of mental patients from inpatient facilities are also contributing factors of homelessness (Aiken, 1987; Appleby & Desai, 1985; Belcher, 1988; Bowdler, 1989; Cohen, 1989; French, 1987, 1989; Institute of Medicine, 1988; Jones, 1983; Lamb, 1984; Martin &

Nayowith, 1989; Maurin, Russell, & Hitchcock, 1989; Riesdorph-Ostrow, 1989; Salem, 1990; Segal & Baumohl, 1980). A recent study indicates that events of childhood such as foster care, group home placement and running away are also frequent antecedents to homelessness (Susser, Lin, Conover, & Struening, 1991).

Health Care of the Homeless

Problems of access to care, including health care, plague the homeless. Many programs are not open to homeless persons because of policy restrictions, and the homeless do not take full advantage of the services that are available (Drake, Osher, & Wallach, 1991; Fischer & Breakey, 1991). The reasons for this phenomenon are varied. These include a distrust of the system, lack of transportation, ignorance of their eligibility for services and bureaucratic obstacles (Institute of Medicine, 1988; Weis, 1987a). Homeless persons are at risk for all of the standard illnesses and, in addition, are predisposed to physical and emotional trauma, infestations, communicable diseases, peripheral vascular disease, malnutrition and disorders such as frostbite and burns that are directly related to extremes in the environment (Damrosch & Strasser, 1988; Institute of Medicine, 1988; Weis, 1987a). Many of these conditions, which are easily treated in early stages, become exacerbated by the homeless state and frequently develop into major illnesses and problems (Damrosch & Strasser, 1988; Sergi et al., 1989).

Homelessness and Mental Illness

Reported rates for mental health problems among the homeless vary widely, ranging from 2-90 percent, with estimates of alcohol problems in 4-86 percent and drug abuse in 1-70 percent of the homeless (Fischer, 1989). According to the report of the Task Force on Homelessness and Severe Mental Illness (NIMH, 1992) about one-third of single homeless adults are suffering from severe mental illness. Kiesler (1991) advocates a much lower figure (approximately 10%) for the homeless chronically mentally ill. Whatever the correct figure, it seems evident that homelessness exacerbates mental illness, which sustains the homeless state. Specifically, lack of income, diminished social support, presence of substance abuse, lack of housing, fragmentation of services, community resistance, discrimination and limited resources contribute to an exacerbation of the mental illness and to the continuation of homelessness (NIMH, 1992). Consequently, there is an on-going debate as to whether the problem of the homeless chronically mentally ill population is a mental health or an economic issue (Kiesler, 1991).

Many suggestions for addressing the problem have been offered. These deal largely with (a) the development of a wide range of housing and service options (Arce et al., 1983; Dennis et al., 1991; Drake et al., 1991; NIMH, 1992; McCarty, Argerion, Heubner & Lubran, 1991); (b) consolidation of authority and accountability (Aiken, 1987) use of new service settings and (c) development of diverse, comprehensive and non-traditional approaches (Aiken, 1987; Bachrach, 1984b; Ball &

Havassy, 1984; Connolly, 1984; French, 1989; Gonzales-Osler, 1989; Hogarty, 1989; Lamb, 1984; Lipton, Sabatini, & Katz, 1983; Maurin et al., 1989; Riesdorph-Ostrow, 1989).

Case management (Riesdorph-Ostrow, 1989; Salem, 1990; Sargent, 1989), allowing control over treatment (Cohen, 1989), easier commitment to institutions (Belcher, 1988) and the removal of barriers to successful living for these individuals (Arce, et al., 1983; Aiken, 1987; Appleby, et al., 1985; Bachrach, 1984a; Bachrach, 1984b; Ball & Havassy, 1984; Cohen, et al., 1984; Cohen, 1989; Lipton, et al., 1983; Lamb, 1984; Maurin, et al., 1989; Riesdorph-Ostrow, 1989; Ryan, 1989) are specific suggestions for treatment approaches from mental health professionals including social workers, nurses, psychologists and psychiatrists. Additionally, caregivers must develop flexible, empathic, optimistic and non-blaming attitudes and approaches to their care for these patients if that care is to be successful (Bachrach, 1984a; Bachrach, 1984b; Cohen, 1989; Connolly, 1989).

Special Challenges

Although the homeless person's state is one characterized by deprivation, isolation, losses and victimization (Boondas, 1988; Hartman, 1989; Institute of Medicine, 1988; Kozol, 1988), there is little mention in the literature of the patient's feelings or reactions to the homeless state. Goodman, Sare and Harvey (1991) see homelessness as a psychological trauma that acts as a risk factor for emotional disorders. Accordingly, "depression, anger, anxiety, sleeplessness, listlessness,

acting out, and the like--are directly related to the conditions of being homeless" (Kiesler, 1991, p. 1246).

Hartman (1989) cited a study of homeless women who reported nervousness, low energy, irritability, loneliness, confusion and worry. She then asked if it is strange that a person would experience these feelings when faced with the losses, insecurity and danger of homelessness. It is possible that the behaviors of homeless persons that many social service and health care providers label as apathy and a disinterest in changing the homeless state are a natural consequence of homelessness. Hartman's (1989) rhetorical question was meant to raise an awareness of the gaping hole in the current work with the homeless--an awareness of despair, hopelessness and the special needs of the homeless that compound the problems of access and acceptance of care, consequently frustrating caregivers. Perhaps a better understanding of hope and hopelessness is necessary to deal with the special problems of this challenging population.

HOPE

The Role of Hope

There are several current definitions of hope, many of which encompass multiple themes. Gottschalk (1974) says that hope is not a trait but a psychological state based on self-reliance. Hope denotes an optimism for a favorable outcome in personal earthly activities and in cosmic and spiritual events. Included in the state of hope is a feeling of receiving help, support and confidence from others, as well as

receiving God's blessing. Theoretically and conceptually, hope has been identified as a sense of the possible (Meissner, 1973; Lynch, 1974), a belief that positive things will occur in the future (Kiesler, 1977), a refusal to accept an intolerable situation as final (Marcel, 1962) and as a coping strategy (Henderson & Bostock, 1977). Hope is a spur (Frank, 1968) and a prerequisite to action (Stotland, 1969); it also has an activating effect in the mobilization of energy to achieve an expected outcome (Green, 1977). Raleigh's definition from her 1980 investigation of hope in the physically ill adult is based in goal attainment, expectation and an orientation for the future. Raleigh's study (1980) used six items relating to future orientation and achievement from the Time Opinion Survey (TOS) as a measure of hope in 90 adults who were chronically ill or suffering from life-threatening illnesses. In her study, there was a lack of significant relationship between the TOS and any of the variables including internal locus of control of health, personal factors and category of illness, which led her to doubt whether the instrument actually measured the construct of "hope." She concluded that there was a need for the development of a valid instrument to measure hope in conjunction with additional exploratory research on hope.

Miller (1985) explored the nature and etymology of hope and based her instrument development on a definition of hope that is

...characterized by an anticipation for a continued good state, an improved state or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future which is good and is based upon mutuality (relationships with others), a sense of personal competence,

coping ability, psychological well-being, purpose and meaning in life, as well as a sense of "the possible" (Miller, 1986, p. 52).

Hinds' (1988) grounded theory work with well and ill adolescents generated the belief that "hope is a contributing factor in health maintenance and is especially vital for individuals experiencing life-threatening illness" (p. 79). Her work identifies a dimension of the definition of hope from adolescents with cancer that was not found in other groups. This dimension was a focus on others rather than on self.

There is agreement in the literature that hope is an important factor in sustaining life and is, therefore, a vital life force (Capps, 1970; Fitzgerald, 1979; Korner, 1970; Kubler-Ross, 1969; Miller, 1983; Miller & Powers, 1988; Stotland, 1969). The function of hope in the human experience is to defend against despair (Korner, 1970; Owen, 1989; Raleigh, 1980; Schneider, 1980). Owen's (1989) qualitative work to develop and study the meaning of hope for patients with cancer found that the exchange of energy was a focal point in perceiving hope. Persons who have hope as a coping strategy (Baird, 1989; Herth, 1989; Korner, 1970; Miller, 1983) have an improved mental and physical functioning (Frank, 1968) and an increased healing capacity (Cousins, 1979; Gottschalk, 1985). Hope not only guards against despair but also fortifies the body's defense against attack (McGee, 1985) and promotes health (Cousins, 1979, 1989).

Miller's Theory of Hope

Miller (1983) described three intensities of hope, ranging from hope characterized by shallow optimism to hope at its most intense level. Hope at the intense third level "arises out of suffering, personal trial or state of captivity" (p. 288). At this level, if relief from the suffering, trial or captivity is not imminent, deep despair occurs. It is hope at this intense level that is part of Miller's (1983) powerlessness-hopelessness cycle. Her powerlessness-hopelessness cycle is based on the premise that chronic illness, because of its concomitant losses, leads to powerlessness. The theory says that powerlessness leads to depression and low self-esteem that causes a hopelessness that, in turn immobilizes the individual. This cycle of powerlessness-hopelessness continues until the patient gives up. The giving-up that results from prolonged hopelessness leads to death. When hope is restored, power and mobility are restored (Miller, 1983).

Characteristics of Hope

Hope has an orientation toward the future. One does not hope about the past, but hopes for the future (Melges & Bowlby, 1969; Nowotny, 1989). Expectation is a key attribute of hope (Erickson, Post, & Paige, 1975; Lynch, 1974; Raleigh, 1980; Stotland, 1969; Wright & Shontz, 1968). This expectation can be directed toward a future good, a goal attainment or relief from some difficult situation (Dufault & Martocchio, 1985; Korner, 1970, Nowotny, 1989; Raleigh, 1980; Whall, 1989). Hope is a way of looking at the future in the context of the past and present (Capps,

1970). If the present experience is very difficult, one gets a distorted view of the future (Raleigh, 1980).

The concept of hope involves the basic sense of mastery or control over one's environment. Hope is a feeling that there is a way out of a difficult situation or a way to get relief from pain (Bandura, Adams, & Beyer, 1977; Lynch, 1974; Raleigh, 1980). In its future orientation/expectancy frame of reference, hope serves as a determinant of self-direction. Engel (1964) noted that it is difficult to project one's self into an uncertain future. Therefore, if the future seems impossible, there is no reason to develop long-range goals (Raleigh, 1980).

Hope is not a passive waiting for external forces to bring about the future but is a prerequisite for action. One does not act without hope (Default & Martocchio, 1985; Hickey, 1986; Mayerhoff, 1971; Raleigh, 1980; Stotland, 1969; Weiner, 1985). Neither does one hope without action. Stotland (1969) theorized that if there is expectation of attaining a goal, one is likely to act in order to attain it. In this way, hope is associated with action. On the other hand, hopelessness is an inability to act, a move toward despair, an entrapment in a life that is too difficult to handle (Lynch, 1974; Schneider, 1980).

Loss of Hope--Hopelessness

Hopelessness can be caused by any event that results in feeling a loss of control over one's life (Korner, 1970; Limandri & Boyle, 1978; Miller, 1985). The loss of personal resources, whether in the form of physical energy and health, love of life or

material possessions, can foster a move toward hopelessness. The loss of loved ones, or external social supports (Pokorney, Kaplin, Tsai, 1975) and many other types of loss lead to hopelessness (Limandri & Boyle, 1978; Miller, 1983; Nowotny, 1989; Weiner, 1985). Illness, life-threatening situations, hardships, impoverishment and prolonged stressors each contribute to the development of hopelessness (Barnfather & Erickson, 1989; Erickson & Swain, 1982; Korner, 1970; Nowotny, 1989; Weiner, 1985).

Characteristics of Hopelessness

Persons who experience hopelessness are characterized by apathy, indifference (Lynch, 1974; Korner, 1970; Marcel, 1962; Schneider, 1980; Travelbee, 1971), inability to cope (Schneider, 1980), inaction (Farmer & Sundberg, 1986, 1986), low self-esteem (Beckham, Leber, Watkins, Boyer, & Cook, 1986; Schneider, 1980; Wetzel & Reich, 1989), a sense of futility and giving up (Lynch, 1974; Schneider, 1980), despair (Owen, 1989; Petrie & Chamberlain, 1983), loneliness, rejection (Farmer & Sundberg, 1986; Fry, 1984), inability to problem solve (Schotte & Clum, 1987), depression (Abramson, Metalsky, & Alloy, 1989; Alloy, Abramson, Metalsky & Hartlage, 1988; Coyne, Kesser, Tal, Turnbull, Wortman, Greden, 1987; Erickson & Swain, 1982; Fry, 1984; Garcia & Marks, 1989; Peterson & Seligman, 1984; Tiger, 1979), withdrawal, despondence (Barnfather, Swain, & Erickson, 1989; Miller, 1983), immobilization (Erickson & Swain, 1982; Fromm, 1968; Weiner, 1985), fatigue (Frank, 1968; Mayeroff, 1971), suicidal ideation (Petrie, Chamberlain,

& Clark, 1988; Petrie & Chambelain, 1983), sociopathy and physical illness (Beck, Weissman, Lester, & Trexler, 1974; Cousins, 1979; Greene, O'Mahoney & Rungasamy, 1982).

Hope and hopelessness appear, by all accounts, to be powerful concepts which have major implications in physical, emotional and spiritual health and behaviors. According to the literature, it can be seen that these concepts should be further studied and more attention should be given to moving hopeless individuals toward hope. The present study purports to do both.

POWERLESSNESS

A person without hope sees himself as a failure and has no expectation that anything or anyone can help him out of his present situation (Cox, 1989; Engel, 1964; Schneider, 1980; Seligman, 1973; Weiner, 1985). This hopelessness creates a sense of powerlessness that Miller (1992) describes as the perception that one lacks the ability or capacity to affect an outcome. The powerlessness concept closely relates to others including learned helplessness (Seligman, 1990; Wortman & Brehm, 1975), locus of control (Rotter, 1969) and self-efficacy (Bandura, 1977; Sherer et al., 1982).

Learned helplessness is described as the way individuals react when they are unable to exert control over their environment (Seligman, 1990; Wortman & Brehm, 1975). In the learned helplessness research with animals, lack of control over aversive stimuli resulted in later interference with learning. However, according to

Wortman & Brehm (1975), an examination of the human helplessness literature shows that we know little about what produces helplessness in humans due to the presence of plausible alternative explanations in most of the research. Recently, Seligman (1990) who has done the seminal work on helplessness (Seligman, 1975, 1976), has begun to promote the notion of "learned optimism" as an antidote for helplessness in humans. He believes that (a) individuals can choose the way they think; (b) thoughts are not only reactions to events, but also actually change what ensues; and (c) resilience in the face of defeat can be acquired. Further, Seligman espouses that the key to the process of acquiring resilience in the face of defeat is hope. According to Seligman, people who feel hopeless or have the most pessimistic attitudes are likely, once they fail, to have symptoms of learned helplessness for a long time and across many endeavors. These people then lose self-esteem and become depressed.

SELF-EFFICACY

Personal control, or power (Miller, 1983, 1992) contributes to psychological adjustment and physical health (Bandura, 1986; Lefcourt, 1981, 1982; Taylor & Brown, 1988). Thompson's (1981) typology of control proposes that reactions to stressful events depend on their meaning to the individual and recognizes that control does not have to be real to have effects.

According to Bandura (1977), the concept of self-efficacy is basic to the issue of personal control. Self-efficacy is a belief in one's capabilities to execute required behaviors (Bandura, 1977; Sherer, Maddux, Mercandante, Prentice-Dunn, Jacobs &

Rogers, 1982). Self-efficacy theory describes two types of expectancies that control behaviors: outcome expectancies and self expectancies. Bandura (1977) differentiates between these two expectancies. Individuals who believe that particular behaviors will produce certain outcomes (outcome expectancies) but who doubt their ability to perform these behaviors (efficacy expectancies) will not experience behavior change. According to Bandura (1977), efficacy expectations interact with, but are independent of, outcome expectancies. Self-efficacy theory asserts that expectations of personal mastery are the primary determinants of changes in behavior (Sherer et al., 1982). Expectations of self-efficacy determine the initial decision to perform a behavior and the amount of effort to expend in the behavior, as well as the amount of persistence to use in the face of adversity (Bandura, 1977).

Self-efficacy has a direct influence on the choice of activities; people avoid situations that they believe they cannot cope with and become involved in activities they feel capable of handling (Bandura, 1977). The stronger the perceived efficacy, the more effort is expended in an activity. This action/reaction to perceived efficacy can create a self-determining cycle of events. Those who persist in threatening situations and master the experience gain efficacy reinforcement, whereas those who choose to avoid threatening situations or cease their activities early reinforce negative efficacy expectations (Bandura, 1977). However, mastery experiences enhance self-efficacy only if the ability to perform successfully is attributed to personal skill or effort, not to luck (Bandura, 1977). According to Sherer and his colleagues (1982),

past experiences with success or failure in a variety of situations result in a general set of expectations that the individual carries into new situations.

Efficacy expectations vary on the dimensions of magnitude, generality and strength (Bandura, 1977). Magnitude refers to efficacy expectations based on the level of difficulty of the tasks. Efficacy expectations that differ for specific tasks as opposed to general tasks are said to differ in generality. Expectancies can vary in strength with weak expectancies giving up in the face of adversity and strong expectancies persevering (Bandura, 1977). Bandura's (1977) self-efficacy theory posits that efficacy expectancies are based on four major sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological states. Usual methods to enhance self-efficacy and reduce defensive behaviors operate through these information modes. The performance accomplishments source of efficacy expectancy is based on personal mastery experiences; the vicarious experience source uses observations that others perform threatening activities without adverse consequences; the verbal persuasion source induces through suggestion the belief that a previously overwhelming situation can be coped with successfully; and the diminishing state source is illustrated by a diminishing emotional arousal to stressful situations that leads to greater expectancies of personal efficacy (Bandura, 1977).

Self-efficacy is becoming recognized as an important variable in health behaviors and illness management. A recent study to evaluate the relationship of self-

efficacy and social support to self-management in persons with epilepsy found that self-efficacy was a greater predictor of self-management of epilepsy in adults than was social support (DiIorio, Faherty, & Manteuffel, 1992). This study was limited, however, because of the 24% response rate which was 98 subjects of a possible 404. The ability of this sample to represent the population, and therefore the generalizability of the study, is questionable. Godding and Glasgow (1985) conducted a study of participants in a smoking cessation program and decided that a high confidence in the ability to stop smoking was associated with success. In their study, success was measured by fewer cigarettes smoked, lower nicotine cigarettes smoked, and less of each cigarette smoked. These findings caused them to conclude that self-efficacy is more than "global self-confidence" (p. 589). Ginter and Poret (1988) examined factors associated with relapse and maintenance following a self-management course. A 10-week follow-up showed that self-efficacy and outcome expectancy correctly classified 80% of those who maintained gains in their projects. This study lacks generalizability to other populations, however, due to the predominantly female (F=34, M=1) and professional (e.g. teachers, nurses, counselors and others) sample. The study was further limited by the self-efficacy measurement. The end-of-class response on a 10-point scale to the question, "How confident are you that you can continue to apply the self-management principles to your project?" (Ginter & Poret, 1988, p. 79) was the sole self-efficacy measure. Health status and self-efficacy were the most powerful predictors of health promotive

behaviors in a study of 278 blue-collar employees (Wetzel, 1989). Self-efficacy was measured with the General Self-Efficacy subscale of the Self-Efficacy scale (Sherer et al., 1982). Wetzel's sample was nonrandom but comprised more than 25% of the target population. However, subjects were volunteers so that results must be generalized with caution. The researcher concluded that "the better a person believes his health to be, the more likely he is to act to maintain it; and believing in one's ability to accomplish a behavior acts as a motivator to perform the behavior" (p. 102).

Personal control and perceived efficacy have been found to be related to quality of life. Perception of internal control over health was a direct contributor to quality of life in arthritis patients in Burckhardt's 1985 study. Data for the study were collected from 94 subjects by means of a semi-structured questionnaire. The author concluded from multiple regression and path analysis of the data that

...subjects who believed strongly that control over their health was their responsibility, who attributed physical health to taking good care of themselves and who believed that they had the power to make themselves well had higher quality of life scores than those who did not hold those beliefs as strongly or who disagreed with them (p. 15).

Internal control over health explained 20% of the variance in quality of life in this study. According to the literature, then, the less control and past successes a person perceives, the lower his self-efficacy is likely to be and therefore, his positive

behaviors. Certainly the literature lends support for a study of self-efficacy among homeless subjects and an attempt to increase that level.

SELF-ESTEEM

Coopersmith (1967) describes four components that contribute to self-worth: (1) power, the ability to influence people and events important to the person; (2) significance, a sense of being accepted and valued by others; (3) competence, the ability to reach goals; and, (4) virtue, behaving consistently with our moral values and beliefs. Self-esteem is the most common term given to self-evaluative behavior, attitudes, beliefs or perceptions (Coopersmith, 1967). Self-esteem is defined by Jenny (1990) as representative of the extent to which a person believes himself/herself to be capable, significant, successful, and worthy. Global self-esteem, according to Rosenberg (1979), is the most important aspect of the self-concept and describes a person's feelings regarding adequacy and worth, health, appearance, skills, and sexuality. Furthermore, Rosenberg says that a person with high self-esteem considers himself or herself as a person of worth, although not necessarily superior to others.

According to Sheppard (1984), self-esteem develops during the first five years of life. Zevin (1989) and others (cf. Laing & Bruess, 1989) believe that self-esteem is a lifelong process and an accumulation of events that grows and flourishes in a positive and safe environment. Stanwyck (1983) lists interactions with significant others, social role expectations, psychosocial development crises, and communication and coping styles as important factors in the development of self-esteem. According

to Hayes and Fors (1990), educators believe that higher levels of self-esteem are by-products and expected outcomes of educational experiences. As self-esteem is learned, it can be changed (Neal, 1981), although it may be resistant to change (Guglielmo, Polak, & Sullivan, 1985). That self-esteem can be changed is validated by Gurney (1987) who cites from a review of research studies in which the self-esteem was enhanced either intentionally or coincidentally. However, the subjects in these studies were in their formative years (range 4-17 years) when self-esteem is developing. The same changes may not hold true for adults. Levinson's (1977) research showed that developmental changes do occur in the adult personality and, according to Markus and Wurf (1987), the self-esteem is dynamic, multifaceted and capable of change.

Hubbs-Tait and Blodgett (1989) believe that people with low self-esteem have a negative appraisal of their coping abilities and behave accordingly. In their study (N=64) coronary-prone Type A and noncoronary-prone Type B males were divided into low and high self-esteem groups and their behavior under stress was assessed. As expected, the low self-esteem Type A individuals were more adversely effected by high stress than the high self-esteem Type A group. The researchers concluded that it is the difference in self-esteem that is important and not differences between Type A and Type B behavior in stressful interactions. A flaw in this study, however, was use of the median split to determine high and low esteem.

Self-esteem has been found to be related to feelings of control. Reynolds (1988) reports a study of 589 college students that found strong correlations between grade point average, general self-concept (measured by the academic self concept scale) and locus of control. Subjects with higher internal feelings of control had a higher academic self-concept. In a study of the influence of perceptions of control on reactions to stressful events Gilbert and Mangledorff (1979) used a sample of counseling clients and non-clinical university students. The subjects' reactions were measured by the Stressful Life Experience Inventory and self-esteem was measured by the Texas Social Behavior Inventory (short form). They found that clients reported feeling less control and lower self-esteem than non-clients.

Many persons with low self-esteem are depressed or seem likely to appear depressed. Rosenberg (1965) reports a study with a significant association between low self-esteem and the likelihood of being seen as depressed by nurses. In that study 50 normal volunteers from the National Institute of Health completed the Rosenberg Self-Esteem Scale. Only 4% of the volunteers with high self-esteem were rated as depressed by nurses, whereas eighty percent of those with low self-esteem were seen as depressed.

Foote, Piazza, Holcombe, Paul, and Daffin (1990) found a significant positive relationship between self-esteem and hope in their study of persons with multiple sclerosis. The purpose of their study was to determine interrelationships among hope, social support and self-esteem (using the Miller Hope Scale, Rosenberg Esteem Scale,

and Personal Resources Questionnaire) in a convenience sample. The study determined that self-esteem and social support were related to hope and to each other. Although the researchers concluded that the relationship among the concepts indicates that nurses can plan care for multiple sclerosis patients toward increasing self-esteem and social networks, there was no integration attempted and no delineation of what would be included in such an intervention. In a 1978 study of the relationship between routine nursing activities and patient outcomes, Lum, Chase, and Cole found high self-esteem related to positive health outcomes including lower anxiety, more compliance with therapy, a greater desire to maintain contact with others and a lesser perception of self as a burden to others. Their study was conducted with a small sample (N=57) but encourages the consideration of enhancing self-esteem to promote positive health outcomes. Wetzel and Reich (1989) found that low self-esteem was highly correlated with suicide intent. Their study was conducted with a depressed inpatient sample (N=60) in which daily ratings of self-esteem, hopelessness and suicide intent were made by senior residents. They concluded that self-esteem may account for as much as 25% of the variance in suicide ratings.

Laing and Bruess (1989) describe a self-esteem promoting environment as one that nurtures mutual respect, value, uniqueness, personal power, responsibility, and positive goals. According to Zevin (1989) the components necessary to support self-esteem development include, but are not limited to, the practice of goal orientation. This goal orientation is motivated by dreams of what the individual wants to

accomplish, the recognition of personal strengths and skills and the practice of positive self-talk and affirmation.

Byers and her colleagues (1990) paired alcoholics with nursing home residents in the role of helping companions as a strategy to enhance self-esteem in the alcoholics. The Tennessee Self Concept Scale (TSCS) was administered to all subjects who were assigned either to the paired group or to the library for reading time (N=25 per group). The study showed that the alcoholic subjects' feelings about themselves became more positive as a result of the helping relationship. Analysis of variance yielded the information that the paired group improved in seven of the nine measures of the TSCS. This is an encouraging report that a nursing intervention designed to improve self-esteem did just that.

Self-esteem plays an important role in overall health. Certainly low self-esteem may predispose the individual to psychosocial stress including depression, hopelessness and suicide intent. Miller (1983) asserts that self-esteem is an important variable in developing hopelessness or maintaining hope, in that individuals need to feel good about themselves, their value and worth before they can invest in improving their situations. The previous review of literature would bear out this assertion and support the relevance of a study to measure and enhance self-esteem in homeless individuals.

DEPRESSION

Beck (1979) noted that hopelessness is the central psychological core in depressed patients. In his model of depression, Beck describes cognitive patterns that induce the patient to regard himself, his experiences, and his future negatively (Beck, Rush, Shaw, & Emery, 1979). Negative thoughts, including self-blame, believing that there is no way out or that nothing can improve things move the person into a depressive-hopeless state (Williams & Wells, 1989). Characteristics of depression include (a) a dour picture of the self, the world and the future; (b) negative changes in mood including crying and disinterest; (c) changes in behavior such as passivity, indecisiveness and suicidal actions, and; (d) undesirable physical symptoms such as anorexia or insomnia (Seligman, 1990). There are numerous theories regarding the etiologies of depression. Included in these is the endocrine model which purposes that changes occur in the endocrine system after a prolonged exposure to stress. Further, it is theorized that these endocrine changes precipitate the vegetative signs of depression such as lethargy, anorexia, constipation, insomnia, psychomotor retardation and diminished libido and concentration (McEnony, 1988). Specific hormones of interest in the endocrine model that have been found to be altered in depressed patients are cortisol, growth hormone, thyroid releasing hormone, luteinizing hormone and prolactin. However, a review of those research data are not pertinent to the present study and will not be presented here. Genetic factors are also linked to the development of depression (and other mood disorders). The risk of

depressive disorder in close relatives is 20 percent compared with 5-10 percent for the general population. Studies have been conducted to substantiate this fact, but a cause-and-effect relationship has not been established (Loomis, 1988).

Other theories specific to the development of depression include (a) anger turned inward; (b) object loss; and (c) learned helplessness. The anger turned inward theory is based on Freud's theory which holds that the loss of a significant object or person triggers both an angry and loving response. Since this ambiguous reaction is confusing and difficult to deal with, the anger is turned against the self. According to the anger turned inward theory, this response would lead to depressive symptoms (Loomis, 1988). Object loss is described as the forced separation of a person from a significant object (Loomis, 1988). Bowlby (1960) says that such a loss during the early formative years of infancy and childhood establishes a pattern of anxiety, grief and hopelessness that becomes the coping mechanism for dealing with subsequent losses. Since life is fraught with losses, this coping style leads to a depressed attitude toward existence. Learned helplessness was discussed in conjunction with powerlessness earlier in this chapter and will not be repeated here.

Brown and Harris (1978) concluded that depression is an understandable response to adversity with loss as the common feature; however, in depression, the implications of loss usually extend far beyond the fact of the loss itself. Melges and Bowlby (1969) as well as Greene (1989) believe that hopelessness is the key factor in clinical depression and that loss is probably the most likely cause of hopelessness.

Hopelessness and depression together are considered strong predictors of suicide.

Several research studies have indicated that hopelessness is the link between depression and suicide ideation, attempts and eventual suicide (cf. Beck, Kovacs & Weissman, 1975; Cole, 1988; Wetzel, Margulies, Davis & Karam, 1980).

Although there is evidence supporting various theories of the development of depression, the etiology remains unknown. It is known, however, that depression is expressed in a wide range of biologic, emotional, cognitive, and motor responses (Loomis, 1988). Certainly, the literature leads to the belief that homeless persons are disposed toward depression due to trauma and loss associated with the homeless state as well as early developmental trauma and family history. Therefore, a study such as this one, which looks at the level of depression and attempts to lessen it in homeless veterans, is warranted.

MODIFICATION OF HOPELESSNESS

The present study is predicated on the assumption that it is possible to modify hopelessness. Several writers believe that a primary function of nursing is to inspire hope (Mayerhoff, 1971; Miller, 1983, 1985; Schneider, 1980; Watson, 1979); the importance of inspiring hope has been well documented in the literature (Hinds, 1984, 1988; McGee, 1984; Miller, 1983; Whall, 1989; Wright & Shontz, 1968). The components of the nursing intervention used in this study are based on the literature discussed in this section of the chapter. Each component was selected so that treatment time would be used in an efficacious manner to create in the individual

subjects an anticipation of the future and a belief in their competence. Specifically, the treatment was intended to instill hope, increase self-efficacy and self-esteem and to lessen depression.

Inspiring Hope

The process begins with assessment for the absence or presence of hope (Campbell, 1989; Erickson et al., 1988; Scanlon, 1989) which is possible with reliable instruments that have recently been developed (see Chapter 3 for discussion of advances in concept measurement). According to the literature, the inspiration of hope is needed to prevent susceptibility to mental and physical deterioration (Jourard, 1970), for survival of serious illness (Hinds, 1989; Miller, 1985; McGee, 1986), to maintain, regain or augment health (Dufault & Martocchio, 1985), to reverse regressive passivity (Korner, 1970) and avoid "giving-up" (Schneider, 1980), for a feeling of well-being and to spur to action (Frank, 1968), to hasten healing (Frank, 1968; Mader, 1988) and to rejuvenate (Mader, 1988). These are certainly worthy goals of nursing care for any individual. General guidelines for creating an environment to instill hope include person-to-person interaction between the nurse and patient to renew feelings of value, worth, self-efficacy and self-esteem (Cousins, 1989; Schneider, 1986).

Examples of specific strategies to accomplish the goal of instilling hope are rare. One example is Hickey's (1986) suggestions drawn from her work with cancer patients. Her suggested strategies to enable hope include (a) developing an awareness

of life, (b) identifying a reason for living, (c) establishing support systems, (d) incorporating religion, (e) incorporating humor and (f) setting realistic goals. She gives the nurse suggestions for accomplishing these strategies. A patient's awareness of life includes a realistic appraisal of him/herself, the disease, treatment, support, financial situation, needs of daily living and the probability of living normally. She states that there are several ways to help persons develop an awareness of life but lists only one major skill, active listening. It is not clear how the nurse is to assist the patient in a realistic comprehensive appraisal. Certainly, active listening will not accomplish this task.

To enable patients to identify a reason for living, Hickey urges nurses to recognize when patients are not aware of a reason for living and to help them find one. However, there are no specific strategies given to help the nurse know how to accomplish such a task. Most of Hickey's comments regarding establishing a support system deal with encouraging the family unit to be supportive during the patient's illness. The only suggestion she has for those patients who have no supportive family or friends is to use cancer and community support groups to establish a support system. Hickey continues with her suggestions to nurses for enabling hope by encouraging them to address the spiritual aspect of living and dying, but the only usable suggestion is to refer them to the hospital chaplain. To incorporate humor, Hickey draws on Cousins' (1979) work and suggests humorous videos, joke books and special comedy shows. These are usable suggestions but hardly excite nurses

who are seriously looking for ways to incorporate humor to instill hope. Certainly her idea to help patients and families develop positive attitudes about themselves and their illnesses has merit. She does not offer any real assistance in "how" it is to be done, however. Nurses must help the patients set realistic immediate, short-term and long-term goals. Hickey's (1986) suggestions are, as most of the literature on hope, somewhat vague and non-specific. Others give similar advice.

According to Miller, the hopeful environment is one of informality, interest and friendliness (Miller, 1985; 1991). The hopeless person must be assisted to recognize his unique adaptive resources and must have access to information and knowledge about options available to him (Miller, 1985). Additionally, it is important for the individual to control events in his day-to-day life (Brockopp, et al., 1989). There are little data available for the evaluation of these strategies in producing hope.

Schneider (1980) relates three case studies involving patients in the intensive care setting to illustrate the mechanisms for accomplishing the task of instilling hope. In the first case study the patient died. Schneider believes that he died prematurely because he was given no hope for his condition. In the second case study a chronically depressed patient who felt very hopeless gained hope although he remained helpless and depressed. According to Schneider this was an improved condition, and she credits the nursing care that concentrated in three areas: (1) medicating his discomfort; (2) emphasizing his improvements; and (3) encouraging him to make decisions for his return to hope. The third case study describes a

reversal of hopelessness in an elderly female who had severe arthritis and an acute myocardial infarction. The nursing measures to relieve hopelessness included increasing the patient's feeling of self-worth by talking to her and spending time with her, treating her discomfort, encouraging her activity such as being up in her room and helping her keep abreast of the outside world through news media of newspapers and TV.

It is clear that most of the suggestions offered in the literature to promote hope are vague or open to a wide variance in interpretation. An example of such a suggestion is Korner's (1970) ideas about moving the patient out of immobility and into activity with understanding and companionship. If understanding and companionship fail to achieve mobility, emergency measures such as shouting, physical blows or taking charge in strong and decisive ways are recommended. Another example of a suggestion that is open to interpretation is Mader's (1988) suggestions and examples for inspiring hope with a "focus on the positive" (p. 17) and the recommendation of the establishment of open and honest communication.

Clearly, there is no evidence of inspiring hope on which to base a nursing intervention. Unfortunately, most of the references are theoretical, conceptual or descriptive in nature and offer no empirical evidence of hope actually being inspired through nursing efforts. Much of the literature is so vague and open to interpretation that it offers little practical usefulness. Certain themes such as control and goal setting do appear in the literature, however, and these may be useful in the

development of a treatment strategy for hope. It is apparent, though, that it is up to the nurse or other care provider to develop specific strategies to instill hope. The present study attempts to do that.

Building Hope Through Group Work

Group work is one avenue for creating an environment for hope as evidenced by what we know about hope and relationships. Community and social support are needed for bonding and linkages for good mental health (Martin & Nayowith, 1989). Stotland (1969) asserts that a person cannot hope alone because hope arises out of relationships to others (Hickey, 1986; Miller, 1983; 1985). Discontinuity in relationships weakens the capacity for personal integration of behavior which spirals the sense of alienation and isolation (Abel & Abel, 1980). Anomie (i.e., the general sense of self-to-others alienation) is inversely related to hope. Loneliness, isolation, and rejection by others leads to hopelessness (Bond & Feathers, 1988). Therefore, it is important to create a sense of community when attempting to instill hope. Gardner (1989) advocates building community because a sense of community confers identity, belonging and security on its members. Glasser and Suroviak (1989) suggest utilizing naturally forming support networks to tap sharing and helping potential. Breton (1989) recommends using the structure of small groups for nurturance, education and challenge. Berman-Rossi and Cohen (1989) describe a group that empowers homeless women by focusing on their strengths rather than their weaknesses. The group existed in a single-room-occupancy hotel and met for five years, using shared

decision-making as a prime component. The study is descriptive, with no formal evaluation of hope or power, but it is reported that the group members became able to handle the difficult issues in their lives through the group work. Theoretically, the supportive structure of small groups can create the environment for hope to thrive in the individual; the group format was used in the present study of homeless veterans.

Building Hope Through Reality Surveillance

Reality surveillance is a strategy in which a person looks for grounds on which to base hope or identifies a reason for living (Hickey, 1986). According to Wright and Shontz (1968), adult hopes are supported by the person's desires and reality considerations. This is a cognitive process of phenomenal grounding in reality; however, it does not have to actually be realistic. As long as the person believes that he has grounds for his hopes, he is reassured.

Miller (1983) says that it is important to focus on the positive aspects of the present to find reasons to hope for the future. Rehabilitationists Wright and Shontz (1968) concluded that despair is a state in which both the future and the present are overwhelmed by negatives; despair does not flourish when either the future or the present is bright. Through reality surveillance one can discover one's own competence and worth and brighten the perception of the present or the future or both (Glasser & Suroviak, 1989). Senge (1990) talks about creating a natural tension to move reality toward the "wished for" future by having a realistic picture of the present and a compelling vision of the future. Assistance with reality surveillance and

the development of a vision of the future can be accomplished through identifying previous successes (Dufault & Martocchio, 1985; Schneider, 1980) and current strengths (Senge, 1990). Wright and Shontz (1968) found reality surveillance an important factor for hope in adults. In their phenomenologic study they examined hoping as a process in the human condition through interviews with a sample of subjects who were dealing with problems of disablement either of themselves, a family member or a patient. A feature that distinguished hoping structures of adults and children in their study was the absence of reality surveillance in the child. Conceptually, then, reality surveillance should be an integral strategy to instill hope in adults.

Building Hope Through Goals

Hope arises from having something to accomplish (Miller, 1985) and by creating optimal challenges (Glasser & Suroviak, 1989). Owen (1989) suggests that incremental step-wise goals are manageable. The sense of attainment as an action plan is accomplished enables the individual to cope with changing conditions and to develop strategies for success. Hinds (1988) asserts that a component of hope is the recognition that a personal effort is needed to effect the desired change. This need for effort gives the impetus to set goals, to devise a plan of action to accomplish goals and to act to achieve the goals. Thus, theoretically, devising and revising goals is an important component in the strategy to instill hope, but there are no studies that have attempted to instill hope with these strategies.

SUMMARY

The literature on homelessness describes the plight of the homeless as one of losses, hardships, impoverishment and as trapped in a state that is more than the absence of a home. Homelessness is also being without bonds, without a set of linkages and without a network (Martin & Nayowith, 1989). Hopelessness develops in response to losses, hardships, impoverishment, entrapment and isolation and results in apathy and despair, a lowered sense of ability, low self-esteem and depression. The homeless are viewed as apathetic and indifferent by many health care professionals (Bachrach, 1984a; Bachrach, 1984b; Ball & Havassy, 1984; Belcher, 1988; Maurin et al., 1989). Unchecked hopelessness can proceed to natural or suicidal death. There is little indication in the literature that anyone has begun to look at relationships among the concepts of homelessness, hopelessness, self-efficacy, self-esteem and depression, although the literature makes the case for the presumed relationships among these concepts quite clearly. Nor has anyone reported an empirical attempt to instill hope through a specific treatment intervention. The study of the homelessness-hopelessness cycle and the effects of an intervention to instill hope, self-efficacy and self-esteem and lessen depression may be long overdue.

Chapter 3

METHODOLOGY

INTRODUCTION

The purpose of this study was to (a) measure the extent to which a specific sample of the homeless population, homeless veterans, displayed depression and low levels of hope, self-efficacy and self-esteem and (b) ascertain if a specific nursing intervention could lessen depression and instill hope, self-efficacy and self-esteem in these individuals.

This research project was reviewed and approved by the Veterans Affairs-East Tennessee State University Institutional Review Board, the Mountain Home VAMC Research and Developmental Committee and the University of Tennessee Institutional Review Board. Participation in the project was completely voluntary and subjects were free to withdraw at any time without penalty or loss of benefits. Appendix A contains the Patient Information Sheet and consent forms that were used.

THE DESIGN OF THE STUDY

This study employed a quasi-experimental pretest, posttest 1, posttest 2 design with random assignment of subjects to a treatment or waiting control group (usual treatment for four weeks and then the specific nursing intervention).

Assumptions

The following assumptions were made about the study:

1. The veterans are aware of their own feelings and will report them accurately.
2. Any unknown variables affecting the feelings and perceptions of veterans in the study will equally affect all veterans in the study.

The Population, Sample, and Setting

The population of the study was comprised of all male homeless veterans admitted to the Homeless Evaluation Unit (HEU) at Mountain Home VAMC from May to October 1992. The accessible sample was composed of those in the population who agreed to participate in the study.

The veterans admitted to the HEU become inpatients in a domiciliary barracks-type setting. In the HEU each man is assigned to a bed with a locker and bedside table in a two- or three-man cubicle. The veterans share a community bathroom, TV room and separate large group sitting area. The veterans' housing facilities adjoin the area containing the offices of the HEU team members. Meals are served in another building a block away.

The HEU has an interdisciplinary treatment approach with the mission to break the pattern of homelessness through the development of a caring evaluation and treatment program. The HEU program is aimed toward promoting positive life changes and enhancing abilities for independent living in homeless veterans. Each veteran's physical, emotional, social and vocational functioning is evaluated and a specific individual treatment plan is formulated. Specific treatment that occurs in the

evaluation unit includes individual and group counseling and therapy. Additionally, there is a crisis support group led by the psychologist, a social development and social skills group led by the social worker and a lifestyle and health group led by the nurse. Each veteran receives opportunities for education and specific treatment.

Four hundred sixty veterans were served in this treatment unit between November, 1988 and November, 1990. These veterans were males with a mean age of 50 years. They were primarily of the Caucasian race (92.3%) and stayed on the unit an average of forty-two days. Further, they had serious medical problems (86.2%), current or past alcohol dependence/abuse (66.2%), current or past drug dependence/abuse (19.0%), and psychiatric diagnoses (54.8%) (Department of Veterans Affairs, 1991). The accessible sample closely resembled this population.

Research Questions

The following research questions were investigated:

1. What are the levels of hope, self-efficacy, self-esteem and depression of homeless veterans?
2. Do the levels of hope, self-efficacy, self-esteem or depression in veterans in the treatment group change significantly after receiving the nursing intervention to instill hope?
3. Are there significant differences in levels of hope, self-efficacy, self-esteem or depression between the waiting control and treatment groups after the

treatment group has completed their treatment and the waiting control group has received only the usual HEU treatment?

4. Are there significant differences in levels of hope, self-efficacy, self-esteem and depression between the waiting control and the treatment group after each one has completed the treatment phase?
5. Are there significant changes in the levels of hope, self-efficacy, self-esteem or depression in the waiting control group veterans between pretest, posttest 1 and posttest 2?

INSTRUMENTS

To answer the research questions, data were collected using the Miller Hope Scale, the Self-efficacy Scale, the Rosenberg Self-esteem Scale and the Beck Depression Inventory. Information about the reliability and validity of these instruments follows.

Miller Hope Scale

There are several instruments available that purport to measure the concept of hope. Three such instruments were designed by nurses. Hinds (1984) developed the Hopelessness Scale for Adolescents using grounded theory methods including interviews with well and ill adolescents. This scale was based on a careful conceptualization of hope but its development and intended use with adolescents renders it inappropriate for the present study.

The Herth Hope Scale (HHS) (Herth, 1991) was based on Dufault and Martacchio's (1985) model of hope which combined perspectives from philosophy, theology, sociology, psychology and nursing. The HHS was designed for use with adults in the clinical setting with items based on three dimensions of hope: (a) cognitive-temporal; (b) affective-temporal; (c) affiliative-contextual. The cognitive-temporal dimension is based on the "...perception that a positive, desired outcome is realistically probable in the near or distant future" (Herth, 1992, p. 41). A feeling of confidence and the initiation of plans to reach a desired outcome is characteristic of the affective-temporal dimension. The affiliative-contextual dimension is the recognition of interdependence and interconnectedness between self and others and self and spirit (Herth, 1991). The HHS has evolved through revisions, a content validation process, a pretest and a pilot test with acceptable validity and reliability. The development of this scale has expanded the knowledge of hope and potentially offers an additional reliable instrument to measure the construct of hope. According to the author the HHS is not ready for use as a clinical diagnostic aid but its development continues.

The Miller Hope Scale (MHS) (Miller & Powers, 1988) was selected for use in this study since it was authored by the theorist who developed the conceptual/theoretical ideas which guided the study. The MHS was developed for research with Miller's conceptual-theoretical system to capture multiple dimensions of hope. The MHS was based on a thorough exploration of the nature and etymology of hope. The

development and refinement of the scale included (a) "a comprehensive review of the literature including the etymology of hope, theology, philosophy, sociology, anthropology, psychology, biology, nursing and health perspectives" (Miller, 1992, p. 417); (b) a qualitative research study to determine valid indicators of hope; (c) an exploratory study of persons who had survived threatened hope states; and (d) psychometric evaluation. Critical elements of hope which provided the framework for item generation were (a) mutuality-affiliation, which is described as caring, sharing, belonging, feeling needed, trust in another and experiencing unconditional love; (b) sense of the possible, which involves avoidance of a futile attitude and a global impression that all of life is hopeless; (c) avoidance of absolutizing, (i.e. imposing all or nothing standards); (d) anticipation of a future that is good; (e) achieving goals or a sense of life satisfaction; (f) psychological well-being; (g) purpose and meaning in life or a sense of life satisfaction; (h) freedom which is the opposite of a feeling of entrapment; (i) reality surveillance which confirms that there is reason to hope; (j) optimism and (k) mental and physical activation to combat the apathy of despair (Miller, 1992).

To establish content validity, the scale was critiqued by measurement and content experts, and then it was pretested and refined. Norms were established using 522 healthy individuals. There are 40 items on the 6 point Likert scale with a scoring range of 40-240. Typical items include "I feel trapped, pinned down," "I do not have any inner strengths," "I make plans for my own future," and "my life has meaning"

with choices ranges from strongly disagree to strongly agree. The higher the score, the higher the level of hope. The internal consistency alpha coefficient was .93, and 2-week test-retest reliability .82. Criterion related construct validity was established by correlating the MHS to the Psychological Well-Being Scale, $r = .71$, the Existential Well-Being Scale, $r = .82$ and a 1-item Hope Self Assessment, $r = .69$. Discriminant validity with the Hopelessness Scale was established, $r = -.54$. Maximum likelihood factor analysis resulted in a three-factor solution: (a) I Satisfaction with Self, Others and Life; (b) II Avoidance of Hope Threats; and (c) III Anticipation of a Future (Miller & Powers, 1988). The MHS is a recent development (1988) and has not yet been widely used. According to Miller (1992b) other psychometric reviews of the scale have been done with reports of good internal consistency. However, the process of reanalysis and summarization has not been completed. Studies in progress include: (a) subjects who are HIV positive; (b) subjects who have diagnoses of diabetes, multiple sclerosis or arthritis; and (3) subjects who are critically ill (Miller, personal communication, August, 1992). Permission was obtained from Judith Fitzgerald Miller to use the Miller Hope Scale (MHS) (Miller & Powers, 1988) to collect data for the study.

Self-Efficacy Scale

Self-efficacy refers to expectations of personal mastery or convictions of personal effectiveness (Bandura, 1977). According to Bandura, a person can believe that certain behaviors lead to a specific outcome, but if the person doubts his/her

ability to perform those activities, they will never be attempted. In the present study, one subscale of the Self-Efficacy Scale (SES) (Sherer et al., 1982) was selected to approximate the concept of powerlessness, which Miller (1983) defines as the "perception of the individual that one's own actions will not significantly affect an outcome" (p. 38). The similarity of powerlessness and self-efficacy was discussed more fully in Chapter 2. Observed behaviors such as apathy, in homeless veterans, seem to reflect the belief that nothing they can do will help the situation.

Sherer and his colleagues (1982) developed the Self-Efficacy Scale (SES) to measure self-efficacy that is not tied to specific situations or behaviors. The scale was based on the belief that self-efficacy expectations are power determinants of self-changes. SES contains two subscales, the General Self-Efficacy Scale (GSES) and the Social Self-Efficacy Scale (SSES). The scale was developed through factor analysis with the items focused on three areas: (a) willingness to initiate behaviors; (b) willingness to expend effort in completing the behavior; and (c) persistence in the face of adversity. Twenty-three items of an original 36 loaded at or above the .40 level and were retained in the scale.

Seventeen of the items measure self-efficacy without reference to any specific behavioral domain. These 17 items accounted for 26.5% of the total variance in preliminary studies (N=376 college students, Cronbach alpha .86). These items became the General Self-efficacy subscale. The remaining six items accounted for 8.5% of total variance and reflected efficacy expectations in social situations and were

named the Social Self-efficacy subscale. The Cronbach alpha for this subscale was .71. Factor analysis of the 23-item scale with a new sample of 298 college students replicated the original two-factor (general and social) solution. Responses range from "strongly disagree" to "strongly agree" options on a 5-point scale with the middle option for "neither agree nor disagree." The range of possible scores is 17 to 85 for general self-efficacy and 6 to 30 for social self-efficacy. Examples of the questions are, "I give up on things before completing them" and, "I am a self-reliant person."

Scores of the instrument were correlated with several other measures of personality characteristics to establish construct validity. The results of the correlations were moderate and in the appropriate direction which confirmed the predicted conceptual relationships with the self-efficacy scale. Criterion validity was established through two studies (N=150 veterans; N=101 college students) which demonstrated that past success experiences were positively correlated with scores on the SES. For these studies the internal consistency coefficient was .86 for general self-efficacy, the range was 17-85, the mean was 64.31 and the standard deviation (SD) was 8.58. The internal consistency coefficient for the SSES was .71, the mean was 21.20 and the SD was 3.63.

Eden and Kinnar (1991) used the General Self-Efficacy scale to measure self-efficacy in their project designed to increase volunteering by boosting self-efficacy. In their Hebrew version of the GSE (a 7-item scale) the Cronbach's alpha was .86. This study dichotomized the subjects into high and low general efficacy groups based

on the GSE scores. This fact, as well as the translation into another language, limited the generalizability of the findings but represents evidence that the scale has validity. Hays and Buckle (1992) used the Self-Efficacy Scale with psychiatric patients (N=105) to compare with the college students scores from the initial studies using the scale. The psychiatric inpatients scored significantly lower than the healthy normative sample. The mean score for general efficacy was 57.5 (SD=12.1) for psychiatric subjects and 62.3 (SD=9.8) for students. Social self-efficacy mean for psychiatric subjects was 19.4 (SD=4.9) and for students 20.25 (SD=4.2). The authors concluded that the scale appears to have usefulness in assessment of the capacity of individuals to become agents of change in their lives.

Some tools have been developed to measure self-efficacy in specific groups. For example, the Epilepsy Self-efficacy Scale (ESES) (Dilorio et al., 1992) was designed to measure the degree of confidence epileptic individuals have in their abilities to perform the specific tasks of medication-taking, seizure control and general epilepsy management. Another scale to measure perceived self-efficacy in a select population is the Arthritis Self-efficacy Scale (Lorig, Chastain, Ung, Shoor, & Holman, 1989). Although these scales demonstrated good validity and reliability, they are too narrowly focused to be useful in general populations. For this study of the homelessness-hopelessness theory, the General Self-Efficacy Subscale of the Self Efficacy Scale (Sherer et al., 1982) was selected to measure a cognitive aspect of

generalized self-efficacy. Permission to use the scale was obtained from the author, Mark Sherer.

Rosenberg Self-esteem Scale

The Rosenberg Self-esteem Scale (RES) was used to measure global self-esteem, a basic feeling of worth (Rosenberg, 1965). This 10-item scale has a range of scores from 10-40 with higher scores indicating higher self-esteem. Questions on the scale inquire primarily into feelings about the self and include "All-in-all, I am inclined to feel that I am a failure," "I am able to do things as well as most other people" and "I certainly feel useless at times." The respondent chooses from a 4-point Likert scale ranging from "strongly disagree" to "strongly agree." The scale was designed for "ease of administration, economy of time, unidimensionality and face validity" (Wylie, 1989, p. 25).

The RES was designed to measure global feelings of self-worth or self-acceptance among adolescents (Rosenberg, 1965). Originally, the scale was tested on a sample of 5024 high school juniors and seniors from New York high schools but since that time it has been used with a range of ages, socioeconomic levels, ethnic groups, nationalities and psychiatric conditions (Wylie, 1989).

Internal consistency was established with a Cronbach alpha of .77 for the original New York student subjects. Studies with adults report similar alpha coefficients: for example, civil servants (N=873) alpha=.83 (Schmitt & Bedeian, 1982) and parents (N=116) alpha=.80 (Orme, Reis, & Herz, 1986). A suitable test-

retest reliability of .85 has been reported with a 2-week interval for 28 college students (Silber & Tippet, 1965). Numerous studies have supported the idea that the Rosenberg Self-Esteem scale represents a unidimensional construct. One such study was O'Brien's, whose factor analysis resulted in a single factor accounting for 52.8% of the variance. Demo (1985) used a sample of 61 ninth graders in his attempt to find validation evidence for a range of methods for measuring self-esteem and found that confirmatory factor analysis substantiated the validity of the RSE as a measure of global self-esteem. The RSE has become the standard by which new measures are evaluated (Blascovich & Tomaka, 1991).

Foote and her colleagues (1990) used the RSE in their study of the relationship between hope, self-esteem and social support in multiple sclerosis patients. For this sample, the mean score was 29.68 (SD=5.95) which the authors equated to a moderate level of self-esteem. The RSE has been used in a study of stability and level of self-esteem as predictors of anger arousal and hostility (Kernis et al., 1989). However, the scoring system for that study was modified, making comparisons of scores inappropriate. The RSE was chosen for this study based on its long and successful history of usefulness and its validity for measuring global self-esteem. Permission to use the scale in this study was obtained from the authors.

Beck Depression Inventory

Depression involves negative perceptions about the self, the world and the future (Beck et al., 1961). The Beck Depression Inventory (BDI) (Beck et al., 1961)

was used to measure depression in this study. This inventory has been widely used to detect depression in normal as well as in psychiatric patients. The BDI was designed by Beck, Ward, Mendelson, Mock & Erbaugh (1961) to measure the behavioral manifestations of depression. Items were clinically derived from observations and records of the characteristic attitudes and symptoms of depressed patients. Twenty-one categories of symptoms and attitudes were selected from those that appeared to be specific for depressed patients and which were consistent with the description of depression in the psychiatric literature. The BDI was developed with self-evaluative statements that were constructed to represent each of the 21 categories of symptoms and attitudes and which were ranked from neutral to maximum severity of symptoms. Scoring consists of adding the values of the responses. Scores range from 0-63, with higher scores indicating higher levels of depression. An example of the range of response options for an item is "I do not feel like a failure"; "I feel I have failed more than the average person"; "As I look back on my life, all I can see is a lot of failures"; or, "I feel I am a complete failure as a human being." The respondent circles the statement (or statements if they apply equally well) that best describes the way he or she has been feeling during the past week (Beck et al., 1961).

The inventory was tested and replicated with two psychiatric inpatient samples, which included a depth of depression rating by a psychiatrist on the basis of a clinical interview. Other measures to determine validity and reliability included agreement of a panel of psychiatrists on criteria to make clinical judgments of depression. This

was accomplished through a series of observed independent interviews in which two of the psychiatrists interviewed each patient and a discussion of disagreements in the ratings (Beck et al., 1962).

Internal consistency of the inventory was obtained. The split-half reliability was also performed and the Pearson r yielded a reliability coefficient of 0.86 (with corrections the coefficient was 0.93). The stability of the instrument was determined using a variation on the test-retest method which showed a consistent relationship of the instrument to the patient's clinical state (Beck et al., 1962). The inventory was validated using several different procedures. The results indicated that the BDI is valid for the determination of the depth of depression ($p < 0.001$) and it has the power to discriminate between specific depth of depression categories ($p < 0.0004$) (Beck, Steer, & Garbin, 1988).

Beck, Steer, and Garbin (1988) reviewed twenty-five years of research on the psychometric properties of the tool. A meta-analysis of internal consistency estimates produced a mean coefficient alpha of .86 for psychiatric patients and .81 for non-psychiatric subjects. The inventory appears to be stable in that the ten studies using a pretest and posttest format had a range of correlation coefficients for psychiatric subjects from .48 to .86 and for non-psychiatric subjects from .60 to .83 (Beck et al., 1988). The meta-analysis for content validity indicates that the inventory reflects 6 of the 9 DSM-III criteria appropriately. The three DSM-III criteria that are not fully addressed by the inventory had been deliberately omitted to prevent false positives (in

the case of appetite and sleep) or because the criterion was inappropriate for a self-report instrument (in the case of agitation).

Concurrent validity has been well established over the last 25 years. The BDI correlates with several concurrent measures of depression with a range of mean coefficients from .59 to .76. Discriminant validity has remained high in that the BDI differentiated normals from psychiatric patients, differentiated between different types of depression and detected major depressions. Construct validity of the BDI has been determined by its ability to detect variations between selected attitudes and behaviors. The BDI was chosen for this study based on its long and successful history of usefulness with a wide range of subjects (Beck et al., 1988). Permission for its use with this study of the hopelessness-homelessness theory was obtained from the author, Aaron T. Beck.

Demographic Data Collection

Demographic data such as age, education, income, marital status, combat experience and length of homelessness are obtained as a part of routine HEU admission data collection and were available to the study through chart review.

Qualitative Data Collection

Field notes were kept from the group meetings conducted by the investigator. These notes included observations about the group process as well as about group members' participation. Direct quotes and paraphrases from patients' comments during and about the group were recorded by the group leader. These descriptive

data were used to highlight, illustrate and clarify the quantitative portion of the study and appear in Chapter 5. The fieldnote data were analyzed by a qualitative researcher and the group leader independently to identify themes and patterns to present a picture of the lived experience of the group work. This method of analysis is in keeping with Knafl and Howard's suggestions (1986) for data collected for illustration with an emphasis on the research problem being addressed. In this case, the psychosocial variables of hope, self-efficacy, self-esteem and depression in homeless veterans were the problems being addressed in the larger project.

PROCEDURES

Random Assignment

On the day of admission to the HEU the veteran was offered the opportunity to participate in the study. Of the 44 veterans admitted during the data collection period, 40 agreed to participate in the study (91% of the potential sample). After receiving information and signing the informed consent, the veteran was randomly assigned to the waiting control group (usual treatment of four weeks and then the specific nursing intervention) or the treatment group (nursing intervention).

Randomization was obtained using a table of random numbers. The first 25 numbers encountered went in the treatment group, the second 25 became the control group.

Pretest

Each veteran responded to the Miller Hope Scale (MHS), Self-efficacy Scale (SES), Rosenberg Self-esteem Scale (RES) and the Beck Depression Inventory (BDI)

at the time of admission to the study (pretest scores). Ideally, the person performing the intervention is not the same person as the researcher, or is in ignorance of the specific research questions. Neither of these options was feasible for this study. In an effort to minimize the possibility of introducing biases into the study due to the researcher and the intervener being the same person, the instruments (both pretest and posttest) were administered by a research assistant (RA). The RA was another member of the HEU team who had research experience. Using an RA for the administration of the scales helped reduce the possibility of the patients giving socially desirable answers, in that participants did not see the connection between the answers on the scales and pleasing the group leader. The completed scales were coded without patient identification. The scales (MHS, SES, RES, BDI) used in this study require responses about specific attitudes, beliefs or feelings which are not highly conducive to response set by the responder. There are no right or wrong answers, and the answers could change from day to day with the feelings of the patient.

Posttest

At the end of the treatment period, both groups, the treatment and the waiting control, were administered the scales to obtain posttest (post treatment for treatment group, post-control for waiting control group) scores (Posttest 1).

Waiting Control Group Intervention

At that time, the waiting control group then began a treatment phase with the nursing intervention as described for the treatment group. At the end of the treatment

period this group had the scales administered again to obtain post-treatment scores Posttest 2).

The following section of the chapter provides details about the design and the delivery of the nursing intervention.

DESIGN OF NURSING INTERVENTION

The treatment (a specific nursing intervention) was designed to instill hope, increase levels of self-efficacy and self-esteem and to lower depression based on the incorporation of strategies that are suggested in the literature. Pertinent research using these strategies is described in Chapter 2. Because many of these elements overlap (i.e., the same general strategy is suggested for more than one element), the suggested strategies are summarized here with some statements linking them to the nursing intervention followed by a description of the nursing intervention. It is assumed that the linkages of the specific nursing intervention components to the suggested strategies will be apparent.

Strategies to Instill Hope

Included in a general listing of components that inspire hope are the (a) identification of positive aspects of life (Hickey, 1986; Mader, 1988); (b) renewal or the reformulation of feelings of value, worth, self-efficacy and self-esteem (Cousins, 1989; Schneider, 1986); (c) establishment of support systems; (d) establishment of realistic short-term and long-term goals (Hickey, 1986); (e) recognition of internal strengths and adaptive resources; (f) increased knowledge of

options (Miller, 1985); and (g) control of day-to-day life events (Brockopp et al., 1989). The structure of the nursing intervention set in the small group vehicle promotes each of these strategies through one or more of the specific components that are included in various exercises.

Strategies to Increase Self-Efficacy

Personal mastery expectations are primary determinants of behavioral change (Sherer et al., 1982) and past success or failure shapes an individual's perception of self-efficacy (Ewart et al., 1988); therefore, an important factor in increasing perceived self-efficacy is success or the accomplishment of a task. Perceived personal control and choices over plans and events in daily life are also valuable in increasing self-efficacy (Bandura, 1977; Gilbert & Mangelodorf, 1979; Thompson, 1981). Encouragement by a respected authority figure reinforces changes in self-efficacy (Ewart et al., 1983). Additionally, success in a situation that requires skill enhances self-efficacy more than success in a situation that could be attributed to chance (Rotter, 1954).

The structure of the "success mapping" exercise in the nursing intervention incorporates these general strategies. The subjects are given the encouragement to develop their own plans and realistic goals and are also given the opportunity and support to experience successes with these plans as they accomplish small tasks. Examples include attending Alcoholics Anonymous (AA) meeting and receiving chips for periods of sobriety.

Strategies to Increase Self-esteem

Byers and her colleagues (1990) assert that it is important for persons with low self-esteem to have the opportunity to engage in meaningful behaviors that have an opportunity for success. Unconditional positive regard for the individual by the therapist in the form of "prizing," which is based on the work of Carl Rogers, has been suggested (Williams-Barnard & Lindell, 1992). High prizing has been found to produce an increase in self-esteem and includes showing a genuine interest and concern for the individual's welfare with no value judgements on behaviors. High prizing includes an attitude of responsibility to the client. This is contrasted to low prizing which is related to lowered self-esteem that consists of offering advice, placing positive or negative value on behaviors and an attitude of responsibility for the client (Williams-Barnard & Lindell, 1992). Laing and Bruess (1989) also speak to the value of a positive attitude and a safe environment that nurtures respect and enhances personal power, responsibility and goals for growth of self-esteem. Others have recommended environments that promote the opportunity to be self-motivated, to increase knowledge, to increase communication skills and to improve decision-making skills (Read & Greene, 1989; Watson & Bell, 1990). Zevin (1989) listed specific behaviors to accomplish an increase in self-esteem. These behaviors are (a) setting and achieving goals, (b) recognizing personal strengths, (c) responding to challenges and problems and (d) practicing positive thinking in the form of self-talk and affirmations. Further, he says that because self-esteem is influenced by many factors,

the attitudes and behaviors of those working with individuals are important in the development of self-esteem. He says that the leader (teacher) needs to (a) gain an understanding of the needs, interests and concerns of the students, (b) provide individuals with an opportunity to become actively involved in planning (their curricula) and (c) view individuals as real people with personal needs and interests.

The nursing intervention was set in the environment described. The group and the leader created a warm, accepting and caring atmosphere. The structure of the group work offered the subjects opportunities to improve their communication skills, to develop sustaining relationships and to make their own decisions. The specific behaviors that were recommended (e.g., goal-setting, identifying personal strengths and skills, and positive thinking) were incorporated as well.

Strategies to Decrease Depression

Depression has long been known as a major form of psychopathology (Alloy et al., 1988). According to Hollon and Beck (1978), there is evidence that behavioral or cognitive interventions are effective in treating depression. Although space constraints preclude full review of the research in this area, a few examples follow. Outpatient cognitive therapy was found to be a more effective intervention than tricyclic medications in a study of unipolar depression in men and women (N=41) (Rush, Beck, Kovac, & Hollon, 1977). Treatment lasted an average of 12 weeks with a maximum of 20 psychotherapy visits (1 hour duration) and 12 weekly drug visits. Subjects completed the BDI and were rated by clinicians using the Hamilton

Rating Scale for Depression (Hamilton, 1960), and for anxiety (Hamilton, 1959).

Cognitive therapy produced a significantly greater reduction of depressive symptomatology than did the drug. Drop out rates were lower in the cognitive treatment group (5.7% compared to 36%) as well. The internal validity of the study was deemed adequate although the clinical judges were not blind to the intent of the study. According to Hollon and Beck, "clinician ratings and the self-report measures of depressive symptomatology supported the superiority of cognitive therapy" (Hollon & Beck, 1978, p. 464).

A study combining drugs and psychotherapy versus drug therapy alone among married individuals diagnosed with a bipolar affective illness, manic type (N=65) produced interesting results (Davenport, Ebert, Adland, & Goodwin, 1975). Subjects were assigned to a drug plus a couple's psychotherapy group or to a drug only group. A third group was created for control, but subjects were not randomly assigned nor were they followed closely. The couples group met weekly for one hour for 12 to 14 months. No information is reported regarding drug dosages. The drug plus psychotherapy group reported no rehospitalizations or marital failures, while the drug only group reported two rehospitalizations and 5 marital failures during treatment. The findings suggest that a variety of psychotherapies may have an impact on bipolar patients; however, results cannot be broadly interpreted due to the possible lack of randomization to the third group and the lack of uniformity in follow-up times (Hollon & Beck, 1978).

Hopelessness predisposes one to develop depression (Abramson, Melalsky & Alloy, 1989; Beck, Steer, & McEelroy, 1982, Coyne et al., 1987; Greene, 1989; Ivanoff & Jang, 1991; Weiner, 1985) as does experiencing uncontrollable negative events (Peterson & Seligman, 1984; Rose & Mirowsky, 1989; Weiner, 1985). It is thought that being in control encourages active problem-solving which reduces depression (Ross & Mirowsky, 1989). Low self-esteem (Greene, 1989) and the absence of supportive persons to talk to (Pokorny et al., 1975; Ross & Mirowsky, 1989) are included in components of depressive conditions. Distorted negative perceptions about personal self, world and future lead to feelings of depression (Beckham, Leher, Watkins, Boyer, & Cook, 1986). Therefore, strategies to reduce depression might reasonably include those designed to instill hope, to increase self-esteem, to promote personal control and to identify a process for making sense of the future. The small group structure and the specific work of the nursing intervention includes these principles. It provides for supportive encouragement, taking control in the form of reasonable planning for the future and identification of personal strengths and attributes.

DELIVERY OF NURSING INTERVENTION (TREATMENT)

The nursing intervention was conducted through twelve 60 minute small group sessions, led by the nurse-researcher and conducted three times a week during the first four weeks of the veteran's stay in the HEU. The nurse-researcher was well qualified to conduct this intervention. She has twenty-nine years experience as a

registered professional nurse with work experience in a variety of settings. Currently, she conducts small group sessions as a part of her duties on the HEU. She has worked in this setting since the inception of the homeless program and has extensive experience in dealing successfully with this kind of patient. The small group format was chosen to ensure efficient use of limited time available to achieve the goals of the intervention (Yalom, 1985).

Small Group Design

The structure of small groups was used for the nursing intervention in an effort to create an environment conducive to hope (Miller, 1985). Small groups are recommended to build community (Gardner, 1989) and social support networks (Bond & Feathers, 1989; Miller, 1985; Ross & Mirowsky, 1989) and to reduce anomic loneliness (Bond & Feather, 1988), and isolation (Fry, 1984). Small groups are also used to tap the sharing and helping potential which naturally occurs in this setting (Glasser & Suroviak, 1989), to promote team work and cooperation (Meeker, 1990) and to nurture, educate and challenge the group members (Breton, 1989; Kinney, 1990) .

According to Yalom (1985), group therapy aids in therapeutic change through eleven primary factors. Included in these factors are (a) instillation of hope, (b) universality (realization that one's problems are not entirely unique), (c) imparting information, (d) altruism, (e) the corrective recapitulation of the primary family group, (f) development of socializing techniques, (g) imitative behavior,

(h) interpersonal learning, (i) group cohesiveness, (j) catharsis and (k) existential factors. Essentially, the nursing intervention used the group design to enhance the attributes of the small group process for increasing hope, self-efficacy and self-esteem and reducing depression.

The pre-determined length of the group work of four weeks may seem short for the purpose of therapeutic change in hope, self-efficacy, self-esteem and depression. This period of time was chosen primarily due to the nomadic nature of the subjects. In addition, there are precedents for the time, frequency and size of the group design. According to Yalom (1985) at least 60 minutes is required for adequate warm-up, unfolding and working through the themes of the session. The group tends to suffer if too much time elapses between group sessions. Meeting more than once a week increases the intensity as well as the continuity of the work as "the entire process takes on the character of a continuous meeting" (Yalom, 1985, p. 278). Further, groups that continue to function over a long period of time offer certain advantages such as allowing time for the patient to work through complex issues, but there is evidence that the group with a pre-determined life span encourages intense commitment to work and serves the purpose very well in a shorter period of time. Gurney (1987) reports significant positive effects on self-esteem in students aged 4-17 years in just 10 weeks when curricula focused on self-esteem. Others have had similar success with short time frames. Byers et al. (1990) demonstrated an increase in self-esteem among alcoholics after a 14 day intervention. An increase in self-

concept was noted after eight weeks of two 60-minute sessions using prizing as an intervention (Williams-Barnard & Lindell, 1992). Connell et al (1985) posits that a minimum of 50 hours is required for results in the affective domain. The life span, frequency and duration of the group intervention used in this study falls within these parameters.

An open group, where members are replaced as they leave the group (as designed for this study), is a viable therapeutic option (Yalom, 1985). Ideal group size, according to Yalom's experience, is seven or eight members, with a range of five to ten. Thus, the design of the group was open with five to ten members and a pre-determined duration (60 minute sessions), frequency (three times a week) and life span (4 weeks). The themes of the nursing intervention were reality surveillance and defining and refining goals. Elements of the treatment are summarized in Figure 4 and operationalized in Appendix C.

Reality Surveillance

Reality surveillance (Wright & Shontz, 1968) was conducted by assisting each veteran to search for reasons to hope (Miller, 1985; Wright & Shontz, 1968; Fry, 1984; Hickey, 1986). Each veteran identified strengths (Fry, 1984; Glasser & Suroviak, 1989), assets (internal and external), and something in his life in which he felt pride as described in Appendix C, page 159, Session 1. Orientation). The leader of the group (nurse-researcher) and the group members affirmed each veteran during and between the group meetings by reminding each other of these strengths, assets

Summary of Treatment

- A. Setting for the nursing intervention
 - 1. Small group format
 - 2. Three 60 minute sessions per week
 - 3. Four week duration
- B. Reality surveillance
 - 1. Identification of strengths, assets and sources of pride
 - 2. Affirmations by group leader and group members
 - 3. Development of a creative tension
 - a. Record an accurate picture of the present
 - b. Formulate a vision of a compelling future
- C. Defining and Refining goals
 - 1. Development of passion for something to be or to do
 - 2. Development of a success map
 - a. Key characteristics
 - b. Mentors and support persons
 - c. Obstacles
 - d. Resources
 - e. Success indicators
 - 3. Training partners
 - 4. Affirmations
 - 5. Contracts

Figure 4. Summary of Tollett's Treatment Elements used in the Nursing Intervention

and reasons to be hopeful and by encouraging a focus on the positives in life as Mader (1988) suggests.

Since hope arises from having a purpose in life (Bond & Feather, 1988), and having something to accomplish (Hickey, 1986; Miller, 1985; Wright & Shontz, 1968), an accurate picture of the present and the formulation of a vision of the future (Scanlon, 1989; Senge, 1989) were the next steps in reality surveillance. This was accomplished by each veteran drawing a picture of himself and his world as it is now with discussion about how he would like for this picture to change (See p. 159, Session 2. Vision). In the researcher's experience, a common feature among homeless veterans is a desire for the future to be different from the past. Group discussion centered around the development of a realistic picture of the present and a vision of the future. This task was intended to develop the creative tension described by Senge (1990) which can move the present condition toward a compelling vision of the future. The veteran then drew a picture of his world with the change/s accomplished. Each veteran shared with the group his perception of his world and his vision of the future (Example pictures are in Appendix D).

Defining and Refining Goals

The next part of the nursing intervention used an adaptation of "success mapping" (King, 1991) to define and refine goals and establish an action plan. Williams and Long (1979) point out the importance of goals in their model for self-control. Their model proposes that the selection of the goal is the first and possibly,

the most critical step in self-management. Further, it is essential that the goal be something that is cared about and important to the individual. The veterans used their work from the earlier sessions to identify something in their vision of the future that they really wanted to be or to do. King (1991) believes that successful people have three things in common: (a) passion, (b) vision and (c) action. In her Olympian Thinking theory, King posits that ordinary people can accomplish extraordinary things when they align these three elements. Because these tasks are germane for increasing hope, self-esteem and self-efficacy and lessening depression and because of the practical nature of success mapping, this technique was adapted to accomplish the tasks of this component of the nursing intervention. In the nursing intervention, the veterans began the visioning process in the steps of reality surveillance. They then used this work to identify something in their vision of the future for which they could develop a passion. Each veteran imagined himself in the role he envisioned for the future. If he could not imagine himself actually being that person or doing that task, a more realistic picture was sought. Whall (1989) recommends this defining and refining goals to foster success. The tasks of developing a passion and defining and refining goals are described more fully in Appendix C, p. 159 under Session 3.

Success mapping began by placing the desired goal at the end of a road drawn on their map. This became the finish-line (King, 1991). The success map was completed in subsequent group sessions and included features identified by King (1991). These consisted of the following: (a) key characteristics of the person the

veteran wanted to be, (b) a list of mentors and support persons, (c) potential obstacles to reaching the goal and strategies for avoiding or overcoming those obstacles (called insurance policies), (d) resources that were necessary to reach the goal, (e) indicators that progress was being made toward the goal, (f) identification of a partner to work with on common tasks, (g) small-concrete tasks ("to dos"), (h) affirmations ("I want," "I will," "I am" statements) and, (i) contracts with the group and themselves to accomplish the tasks and reach the larger goal at the end of the road. Success mapping is described under the heading, Session 4 in Appendix C, p. 160.

To identify key characteristics the veterans described the person in the position or in the setting they had placed at the end of the road. These included behaviors, attributes, character traits, beliefs and values. This was a significant step because it forced the veteran to look at life realistically and to determine which, if any, of these characteristics he already possessed and to begin to accept the idea that he could develop or adopt some new and/or different characteristics. Williams and Long (1979) recommend setting the goal only slightly higher than the present level of operation to strengthen the chance of success. Identifying mentors and support persons was the next step. As described in Chapter 2, homeless persons rarely have significant others in their lives. This part of the process was not meant to be a negative step, although it pointed out the absence of these types of persons in the veterans' lives; it was intended to encourage them to seek quality friendships with persons who would be positive and encouraging to them. Mentors were meant to be persons who knew more about what was required to become the person at the end of

the road than the veteran did. In the mentor capacity, a person could assist, guide, give advice and perhaps help the veteran overcome or avoid some of the obstacles in the road. Sessions 5 and 6 in Appendix C, p. 160 describe these activities more fully.

The obstacles were known or perceived events, items, people, thoughts, feelings, behaviors or anything that would alter the progress toward the goal. For every obstacle that was identified, the veteran formulated a three-pronged plan for avoiding the obstacle. For instance, if returning to substance use such as alcohol was seen as a potential obstacle, the plan might include attending AA meetings regularly, taking along a sober buddy on trips to town and staying out of establishments that sell alcoholic beverages. Every goal requires resources. These were identified and placed on the map. Common items listed were transportation, housing and money.

According to Williams and Long (1979) goals should be measurable, and as progress is measured success becomes more likely. Indicators to mark progress were placed along the road and served as incremental goals. Examples are an AA chip for a period of sobriety and receiving the high school General Equivalency Diploma (GED). Training partners were considered an important part of this process since it is easier to attempt change with someone who is also attempting change and who will serve as an alter ego (King, 1991). Sessions 8 and 9 in Appendix C, p. 161 contain an operational discussion of these steps.

The action steps encourage initiating behaviors toward the goal. Homeless individuals have difficulty setting goals and working toward them, as described in

Chapter 2. These steps are purposefully very small, concrete and accomplishable tasks. Affirmations consist of positive self-talk to establish the idea that the goal is realistic and that the person is efficacious (Williams & Long, 1979). These take the form of "I" statements, "I want to be/do...", "I will be/do..." and "I am ..." (King, 1991). The contracts are used to further encourage action toward the goal. The veteran makes three contracts; with himself, the group and his training partner to establish a deeper commitment to the action. When the success map was completed, the veteran had a comprehensive individualized action plan to accomplish his desired goal. In the process of completion of the map, each veteran had accomplished at least one small task (goal) which is important for self-esteem, self-efficacy and hope. Sessions 9 through 12 in Appendix C describe these elements of the nursing intervention. See Appendix D for examples of Success Maps.

STATISTICAL ANALYSES OF THE DATA

Descriptive statistics were used to describe the veteran subjects in regard to the demographic characteristics. Research questions were answered in the following way:

- Question 1. Mean scores on hope, self-efficacy, self-esteem and depression of homeless veterans were compared to the means reported for various samples in the literature.
- Question 2. The paired t test was performed to determine significant changes between the pretest and the posttest of the treatment group for each variable.

- Question 3. An analysis of covariance (ANCOVA) was used to compare the two groups on the posttest scores to determine if there was a significant difference at the time when the treatment group had completed the treatment and the waiting control group had received only the usual HEU treatment. The pretest score served as the covariate. The ANCOVA tested the significance of differences between the group means after adjusting the posttest scores to eliminate the effects of the covariate.
- Question 4. An analysis of covariance (ANCOVA) was intended to be used to determine if there was a significant difference in the two groups' posttest scores at the completion of the waiting control treatment phase. However, the attrition rate was such that the size of the group completing this phase was too small for statistical analysis.
- Question 5. It was intended that repeated-measures analysis of variance (ANOVA) would be performed to determine if there was a significant difference between the control group pretest, Posttest 1 and Posttest 2 scores. This procedure was not used because there was not a large enough sample completing Posttest 2. A paired t test was used to determine if there was significant difference between Pretest and Posttest 1 for the control group.

Chapter 4

RESULTS

This chapter contains a presentation of univariate descriptive statistics for the variables of interest and an examination of these data for the presence of outliers and skewness. Correlational analyses of the variables are presented next, in order to examine relationships among the variables. Finally, results of paired t tests and ANCOVA procedures are presented to determine intra- and intergroup differences. A summary of the findings concludes this chapter.

DESCRIPTIVE STATISTICS FOR THE TOTAL SAMPLE

The waiting control group design of the study was modified to a simple treatment-control group format due to the high attrition rate of subjects in the waiting control group. A total of four subjects remained in the study long enough to complete the treatment phase following the waiting period. Forty veterans were admitted to the study. Thirty-three of these stayed in the study and completed at least one posttest. The posttest sample size was 33 with 13 in the control group and 20 in the treatment group. The low n (33) is directly related to the low census of the HEU and a low number of homeless veterans seeking admission during the summer of 1992, the time of data collection for this study. The mild weather was probably a factor in this situation. The fact that 91% (40 of 44) of the veterans who were admitted agreed to participate in the study may reflect the fact that they were eager for treatment.

Table 1 includes the distribution of the numeric sociodemographic variables.

Table 2 contains the distribution of categorical sociodemographic variables. Table 3 includes means, standard deviations, variances and ranges of scores for all continuous variables (tables appear in Appendix E). Initial examination of the univariate descriptive statistics established the presence of outliers for hope, self-esteem and depression. The data analyses were performed with the outliers removed and also with the outliers remaining in the data set. There was no change in the results with the outliers removed and the decision was made to use the entire data set to keep the sample size as large as possible.

Because attrition is always of concern to researchers, characteristics of program dropouts were examined carefully. As shown in Table 4, the early attrition group was a little younger (mean age 42.6 and 47 years respectively), they were poorer (\$0 average income compared to \$196.68), and they had been homeless a shorter time (average 33 months compared to 40 months) than the original sample. Even though this group was slightly different on these demographic variables, they were not different on the scores for the dependent variables. The mean score on the pretests of the early attrition group (N=7) compared to the original sample was: Hope, 139.55 to 138.55; Self-Efficacy, 50.86 to 50.23; Self-esteem, 22 to 24.15; and Depression, 25.71 to 25.40.

COMPARISON OF MEANS TO NORMATIVE SAMPLES

Miller Hope Scale

Although the MHS is a fairly recent development and has not been widely used in research, there are data available from its development process. In a study of 522 healthy young college students (mean age 21.45) the overall mean for the MHS was 164.46 (SD=16.31) and the range was 105 to 198 (Miller & Powers, 1988). Foote (1990) and her colleagues used the MHS in a descriptive study of 40 individuals with multiple sclerosis (mean age = 48.2). The mean MHS score for this study was 157.9, the SD was 24.61 and the range was 108-200. The homeless veterans who participated in this study scored lower on the MHS (mean = 138.55) than the healthy college or chronically ill samples but evidenced more variability in these scores (SD = 30.32) than either sample.

General Self-Efficacy Scale

The General Self-Efficacy Scale (GSES) has been used with a variety of samples. The mean score for 376 college psychology students was 172.65 (SD = 27.31) on the 14-point Likert general self-efficacy subscale (Sherer et al., 1982). Further validation studies using a sample of 101 college psychology students found the mean to be 64.31 (SD = 8.58) on the adjusted 5-point Likert scale, which the researchers interpreted as a comparable score to the previous study (Sherer & Adams, 1983). Wetzel (1989) used the GSES in a study of 179 blue-collar workers (age 20-60 years of age). The GSES mean for this group was 63.0 (SD = 8.0). Sherman's

(1989) study of the impact of gender on the relationship of locus of control to mental health indicators reports a mean score on the GSES of 62.3 (SD = 9.59) for male subjects. Hays and Buckle (1992) report a mean GSES score of 57.5 (SD = 12.1) in a study of adult in-patient psychiatric subjects. The homeless veterans in the present study scored lower than any of the previously tested groups on this variable (mean 50.23), and the variability of their scores was higher (SD = 15.70).

Rosenberg Self-Esteem Scale

The RES (Rosenberg, 1965) has been used with a wide variety of studies and subjects. However, there are not reports of its use with homeless veterans. The original sample consisted of 5024 New York high school students. The early version of the scale yielded a range from 0-16 compared to the later 10-item 4-point Likert scale version which ranges from 10 to 40 that was used in this study. Foote and her colleagues (1990) used this scale with individuals aged 32-70 who were diagnosed with multiple sclerosis and reported a mean of 29.68 (SD = 5.95). The homeless veterans in this study reported lower self-esteem but comparable variance to the chronically ill multiple sclerosis group (mean 24.15, SD 5.43).

Beck Depression Inventory

The veterans in this study had a BDI mean score of 25.40, which is higher than that reported for 54 mental health outpatients (mean age = 36) for whom depression was a problem (BDI = 21.8) (Beckham, Leher, Watkins, Boyer, & Cook, 1986). The categories of depression currently used by Beck and his colleagues (Beck,

personal communication, August, 1992) were used in the analysis of the BDI scores in this study. The depression scores of the homeless veterans in this study are very high with 53% in the combined moderate to severe and severe depression categories. The category of severe depression was the largest ($n=13$) with 33% of the subjects scores within this range. The moderate to severe category contained 20% ($n=8$), mild to moderate contains 17% ($n=7$) and there were 15% ($n=6$) in the mild depression range and another 15% ($n=6$) in the normal range. Table 5 displays the distribution of these and the posttest scores.

RESULTS OF CORRELATIONAL ANALYSES

Correlations Among Variables

Correlation coefficients for all of the dependent variables are depicted in Table 6. Examination of the correlation matrix for multicollinearity shows that there were correlations among most of the dependent variables both pretest and posttest. The results of this study suggest that the constructs of hope, self-efficacy, self-esteem and depression are quite strongly related. The demographic variables were not significantly correlated to the other variables for the most part. Length of homelessness was inversely correlated to hope (MHS1 pretest - $r = -.57$; $p = .0005$) and positively related to depression (BDI1 pretest $r = .40$; $p = .01$). There was one other significant correlation, that of income and age, ($r = .53$, $p = .001$), predominantly because of the Social Security benefits the older veterans receive.

Test-Retest Reliability

Correlations between pretest and posttest scores of the dependent variables were examined to determine test-retest reliability. The instruments showed high test-retest reliability. The Miller Hope Scale produced $r=.82$ ($p=.0001$), the General Self-Efficacy scale reliability was $r=.77$ ($p=.0001$), the Rosenberg Self-Esteem Scale $r=.80$ ($p=.0001$) and the Beck Depression Inventory $r=.80$ ($p=.0001$). These data are presented in Table 7.

TEST OF HYPOTHESIS

The hypothesis that there is greater hope, self-efficacy and self-esteem and less depression in subjects receiving a specific nursing intervention to instill hope than in subjects who receive the usual and customary treatment was tested using an analysis of covariance procedure (ANCOVA). The results of these analyses are displayed in Table 8 and show a significant difference in levels of hope between the control and treatment groups ($F=8.93$, $p=.006$). There were no other significant differences between the groups on the dependent variables; however, the scores on each of the other variables changed in the hypothesized direction. Specifically, the treatment group distribution of depression scores changed pretest to posttest from 35% to 20% severely depressed, and 15% to 40% normal (no depression) as can be seen in Table 9. Although these data were not statistically significant, they may have clinical significance. Changes in the other scores were not quite as dramatic as those on the

depression scale; the mean for self-efficacy changed from 48.28 to 53.60 pretest to posttest and for self-esteem from 23.40 to 25.25 (Table 10).

Additional Analyses

The specific research questions were answered with a variety of analyses. The results of these analyses are presented in the following section.

Question 1. *What are the levels of hope, self-efficacy, self-esteem and depression of homeless veterans?*

Means and standard deviations were used to answer this question. The results indicate that the homeless veterans in this study were lower on hope, self-efficacy and self-esteem and were higher in depression than normative samples, as well as selected research samples.

Question 2. *Does the level of hope, self-efficacy, self-esteem or depression in veterans in the treatment group change significantly after receiving the nursing intervention to instill hope?*

Paired t tests were performed for each variable to answer question 2 to determine significant changes between the pretest and posttest of the treatment group. There were significant differences in levels of hope ($t = 5.41$, $p = .0001$); self-esteem ($t = .2.45$, $p = .02$); and depression ($t = -3.40$, $p = .003$). There was not a significant change in self-efficacy ($t = 1.89$, $p = .07$). These data are displayed in Table 11.

Question 3. *Is there a significant difference in levels of hope, self-efficacy, self-esteem or depression between the waiting control and treatment groups after the treatment group has completed treatment and the waiting control group has received only the usual HEU treatment?*

The third research question was answered with the ANCOVA reported in the Test of Hypothesis section of this chapter.

Question 4. *Is there a significant difference in levels of hope, self-efficacy, self-esteem or depression between the waiting control and the treatment group after each one has completed the treatment phase?*

Question 4 was not answered because the waiting control phase of the study did not come to fruition. Only four subjects who completed the waiting phase also completed the treatment phase and the second posttest. These data are summarized in Table 12; there were no statistical analyses performed on these data due to the small number of subjects. It is interesting to note that hope and self-esteem dropped for each of the four subjects from pretest to posttest 1 (during the control period) but increased at posttest 2 (following treatment) to exceed pretest scores. Self-efficacy increased from pretest to posttest 1 and 2 and depression dropped over the course of the three testings.

Question 5. *Is there a significant change in the levels of hope, self-efficacy, self-esteem or depression in the waiting control group between pretest, posttest 1 and posttest 2?*

Research question 5 was not answered because of the failure of the waiting control treatment phase. In Table 4 there is a summary of scores of the subjects who prematurely terminated treatment ($N=7$). These did not greatly differ from the pretest scores of the entire sample (see Table 3 for comparison). Paired t tests were performed to determine if significant changes occurred between pretest and posttest for the control group. These data are presented in Table 13. There were no significant differences for the control group pretest and posttest on any of the variables.

The fieldnotes were analyzed by a qualitative researcher. These data were used for illustration. There were specific themes and patterns identified among these data with a desire for help as the primary theme. Secondary divisions of the data were made for the beginning and the ending of the group work. Themes at the beginning included being disconnected, depressed, hopeless and afraid. Included in these patterns were: (a) no future orientation, (b) no pride, (c) aloneness, (d) substance abuse and (e) altered thinking processes. Toward the end of the treatment group, the main theme was more connection with life, which was divided into (a) increased belief in God, (b) interest in the future, (c) more connected with others and (d) improved thinking abilities.

SUMMARY OF FINDINGS

The findings support the theory of the homelessness-hopelessness cycle consisting of low levels of hope, self-efficacy, self-esteem and high levels of

depression among homeless veterans. Further, the findings lend credence to the theory that nursing can intervene in this cycle at the level of hope to effect significant changes as seen by the statistically significant difference in hope, self-esteem and depression after treatment. Lastly, this study provides support for the practical usefulness of this particular nursing intervention as evidenced by the therapeutic changes in self-efficacy, self-esteem and depression among those subjects who received the treatment and through the analysis of the fieldnotes. Implications of these findings will be discussed in Chapter 5.

Chapter 5

DISCUSSION

OVERVIEW

This study represents an initial investigation into psychosocial variables among homeless veterans. Specifically, the concepts of hope, self-efficacy, self-esteem and depression were studied using a mid-range theory about the homelessness-hopelessness cycle in homeless veterans. Further, nursing intervention into the homelessness-hopelessness cycle was attempted at the belief system (hope) level. Discussion of the results of the statistical analyses is presented in this chapter, along with strengths, limitations and implications of the study and recommendations for future research.

DISCUSSION OF THE HOMELESSNESS-HOPELESSNESS THEORY

The pretest scores for the sample (N=40) support the proposition that homeless veterans experience hopelessness, low self-efficacy, low self-esteem and high levels of depression. The correlations indicate that these variables are related and lend credence to the homelessness-hopelessness cycle. Further, the study supports the notion that an appropriate place for intervention is at the level of hope. This is evidenced by statistically significant difference in hope between the treatment and control groups and the significant changes in hope, self-esteem and depression within the treatment group following the nursing intervention. These findings are important for the nursing profession because they support Miller's nursing theory of the

powerless-hopelessness cycle and its usefulness with a patient group other than the chronically ill.

The levels of hope, self-efficacy and self-esteem were lower in this sample than the normative samples used in development of the instruments. Additionally, self-esteem was lower in homeless veterans than in a chronically ill sample. Self-efficacy was also lower in this sample than in a psychiatric sample and, finally, depression was higher than in a depressed mental health outpatient sample. Quotes from the field notes support the accuracy of the measurement of these variables. An example of a recorded statement is, "There is no hope for me," and another was, "This place (HEU) is my last hope." It is important to note that the word "hope" was never used by the group leader during the group work. Others indicated that they had no strengths or past successes. These results are indicative of the tremendous psychosocial stress homelessness imposes on the individual. Further, these data and the review of previous research that relates depression and/or hopelessness to suicide inform us that homeless veterans are extremely vulnerable for negative mental health outcomes.

DISCUSSION OF RESULTS OF HYPOTHESIS TESTING

It was hypothesized that levels of hope, self-efficacy and self-esteem would be greater and the level of depression would be lesser in the subjects who received a specific nursing intervention to instill hope than in subjects who received the usual and customary treatment in the HEU. There was partial support for this hypothesis,

as evidenced by the statistically significant difference between the treatment and the control group found by the ANCOVA procedure for hope. That the other variables, self-efficacy, self-esteem and depression did not show statistical significance may be explained by the fact that the intervention was designed to enter the homelessness-hopelessness cycle at the level of hope. According to the literature, hope should come first since it is necessary for action (cf. Miller, 1987; Stotland, 1969). The variables other than hope, though not statistically significant between groups with ANCOVA, moved in the desirable direction following the nursing intervention. One of the veterans stated, "I had thought of all of this before but I never thought I could accomplish it. Now I believe that it's possible." Perhaps the intervention should be continued for a longer time period for these other variables to show significant change. One subject's remark shows the need for a longer time to put the needed elements for success in place. He said, "I feel confident while I'm here but when I leave here, I'm on my own." Perhaps this intervention has begun the process of interrupting the cycle and the subjects should move into other specific treatment modalities to continue the change process. These modalities might include halfway houses or other specialized treatments.

DISCUSSION OF OTHER FINDINGS

The significant inverse correlation of length of homelessness to hope ($-.57, p = .0005$) and the positive relationship of length of homelessness to depression ($.40, p = .07$) may be an important cue that intervention into the cycle of homelessness-

hopelessness early in the homeless state might be more successful than waiting until hope has reached a very low level. This finding has important policy implications that will be introduced in a later section.

STRENGTHS AND LIMITATIONS

Strengths of the study include replicability, random assignment to treatment or control groups, and the practical utility of the nursing intervention. Most important, though, is the fact that this study represents an initial attempt to design a theory-driven nursing intervention to instill hope. Additionally, it successfully used the instrument to measure hope that was designed to test the theory that formed the framework for the study.

One major limitation of this study was the size of the sample. Although the study was designed with a built-in replication in the nature of a waiting control group, this tactic was unsuccessful due to the high attrition rate of that group. The attrition was not totally unexpected, because the nomadic nature of these individuals is well-known. There were 44 veterans admitted to the HEU during the five months of this study. Of these, 40 agreed to participate in the study (91% of the potential sample) and were randomly assigned to the treatment or the waiting control group (Treatment $n=25$ and waiting control $n=15$). Subsequently, seven of these 40 left the program before completing the first posttest (18%). Of these seven, five were from the treatment group, but only three of these had actually begun the small group work (nursing intervention). This left a total of 33 in the entire study (20 treatment and 13

waiting control) who completed at least one posttest. Only four of the 13 in the waiting control group remained with the study long enough (8 weeks) to complete the treatment phase and second posttest (see Table 10). The decision was made, based on dissertation committee guidance, to drop the waiting control feature and use the simple treatment and control group design to ensure a large enough sample of subjects to complete the project. As discussed previously, there did not appear to be an attrition bias since the subjects who failed to complete the study ($N=7$) were not very different from those who did (see Table 4). The fact that only three subjects dropped out after beginning treatment suggests that the small group work was a positive and useful experience. This is reflected in comments recorded in the field notes such as, "this is the kind of practical help I've been needing." Another subject, long after completion of the group work, brought his success map to the group leader to show the progress he had made and to get affirmation that his proposed extensions were appropriate to his progress. This indicates that, for some, the work was useful. The low attrition from the group work does not lend support for the myth that homeless persons do not really want help or that they want everything done for them. In fact, the subjects worked very diligently and consistently in the group process.

Another limitation is the fact that this study did not take medication treatment into account. This was a variable that could not be controlled; medication is a part of the therapeutic treatment regimen of the HEU. Approximately 50% of the subjects were medicated during the study. This would be a more remarkable limitation if the

results had showed dramatic changes in the level of depression. As it is, the results may indicate that a more extensive use of antidepressants is warranted. Other limitations include the fact that the data were collected during the summer months when jobs tend to be more plentiful and living on the streets may not be as uncomfortable as in other seasons. This fact probably accounts for the low admission rate to the HEU during this study and the high attrition rate, as well. It may also be possible that the levels of hope, self-efficacy, self-esteem and depression were more positive during the summer months and because these individuals had been admitted to a program to receive help. If this is an accurate speculation, the vulnerability of those veterans on the streets during the winter months should be considered a crisis state.

IMPLICATIONS OF THE STUDY

Professional Implications

There is evidence that the homelessness-hopelessness cycle exists as posited in the theory. More significant, though, is the implication for nursing's ability to create an intervention and intervene at a meaningful level to instill hope. Given the importance of this variable for physical and mental health and quality of life, this is an important implication. The fact that this study successfully implemented a theory-driven nursing intervention lends support for theory-driven research. Mishel (1992) advocates theory-driven intervention to give control over the intervention and a more powerful study which results in a greater ability to detect treatment effects. This is

advantageous for nursing in building and developing its knowledge base. Another implication for nursing knowledge development is that this study used the instrument (MHS) that was developed to test a nursing theory and found significance.

Societal Implications

Given that (a) depression is a known predictor of suicide (Arsanow, & Carlson, 1988; Cole, 1989) and (b) hopelessness is frequently an even better predictor of suicide than depression (Arsanow, Carlson & Guthrie, 1987; Beck et al., 1990; Greene, 1981; Petrie et al., 1985; Wetzel et al., 1982), the very high levels of depression and hopelessness among the homeless veterans in this study mandates public and VA policy development and action. It is imperative that homeless veterans be aggressively treated to avoid the fatal results of hopelessness and depression. This idea is highlighted by the significant inverse relationship between length of homelessness and level of hope and the positive relationship with depression. Obviously, there is a need to seek innovative ways to prevent homelessness and to intervene very early in the homeless state. Government policy makers and the Department of Veterans Affairs share a moral obligation to the men who have given a portion of their lives to their country in military service to assist them to reenter the society they worked to preserve.

Future Research

As demographic, military, psychiatric and medical data are collected in various VA homeless programs, attention should also be given to collection of data that is

meaningful for program and intervention design to determine which program elements are effective in the rehabilitation of homeless veterans. The fact that the simple, practical intervention used in this study made an appreciable difference in the levels of the psychosocial variables under investigation leads to the belief that there are probably vast possibilities for successful meaningful interventions. Nurses need to be involved in designing these because they (a) already recognize the import of these variables to health, and (b) they tend to use a holistic approach which is necessary when working with individuals with multiple complex problems.

Because this was the initial empirical attempt to support the theory and to instill hope, the study should be replicated with a larger sample; in another geographic area; during other seasons of the year; with females and with the general homeless population. Similar studies should be designed using a longer period of time for the group or using this intervention as one modality among many. Clearly, these psychosocial variables have import for efforts to assist homeless individuals out of homelessness and other efforts should be made to understand their relationship to the homeless state and their significance in designing interventions.

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APPENDICES

APPENDIX A

INFORMATION SHEET AND

INFORMED CONSENT FORM

Information Sheet

We invite you to participate in a study we are doing at the Homeless Evaluation Unit (HEU) here at the VA domiciliary on homeless veterans and their therapeutic response to nursing care. Although there have been a lot of studies done that describe homeless veterans, no one has focused on how they respond to care.

If you agree to be in our study, all that is required is that you fill out some questionnaires and attend some group sessions while you are a patient in the HEU. The time needed to complete the questionnaires varies but should not take more than 25-45 minutes of your time. The group sessions last only an hour three times a week for four weeks.

Your answers to the questionnaires will be held in confidence by the researchers, with code numbers instead of names identifying the completed questionnaires. These questionnaires will be stored in a locked cabinet in a locked office of the HEU with only the researchers having access to them. (Please make up a four-digit code number and use it on each questionnaire).

We do plan to share our findings with the scientific, VA and education communities. When results are shared through publication in professional journals, educational dissertations, or VA reports, we will only use group data. No individual responses could be identified by a reader.

Participation in this study is entirely voluntary, and you may withdraw from participation at any time and/or refuse to answer specific questions without incurring any penalty.

We would be happy for you to contact us at any time if you have further questions about the project or your participation in it.

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Informed Consent Form

Information about: A nursing intervention with homeless veterans: Effects
on therapeutic progress.

Principal Investigator: Jane Tollett, RN, MSN, doctoral candidate

I understand that this is a research experiment.

I understand that the purpose of this experiment is as follows:

To provide information to improve our efforts to help homeless veterans break
the cycle of homelessness.

I understand that the procedures to be followed are:

1. Completion of a questionnaire on admission to the study.
2. Completion of a questionnaire four weeks after admission to the study.
3. Participation in a small group three (3) times a week for four (4)
weeks.
4. Completion of a questionnaire at the end of the 12 small group
sessions.

Date _____

Signature of Volunteer _____

Information about: A nursing intervention with homeless veterans: Effects on therapeutic progress.

I understand that the possible risks and/or discomforts associated with this experiment include:

1. Inconvenience of completing questionnaires.
2. Inconvenience of attending twelve (12) small group sessions during a four (4) week period.

The questionnaire takes approximately 25 to 45 minutes to complete. The small group sessions will last one hour each. The room for the group meetings will be comfortable and refreshments will be served.

I understand that the possible benefits to me as a participant in this experiment are as follows:

1. I will be able to identify options available to me.
2. I will recognize my strengths and how to use them to my advantage.
3. I will make progress toward reaching my goals.

Date _____

Signature of Volunteer

Information about: A nursing intervention with homeless veterans: Effects on
therapeutic progress.

I understand that participation in this research experiment is voluntary and that I am free to withdraw from the experiment at any time without penalty or loss of benefits or treatment to which I am entitled. I also realize that refusal to participate in this experiment will in no way jeopardize benefits or treatments to which I am otherwise entitled. I understand that I may withdraw from the experiment by notifying Jane Tollett, whose phone number is 7871 and whose office is located in building 2 of the domiciliary in the HEU, Room 302. I understand that I will be notified immediately if any of the results of the experiment might affect my willingness to continue to participate in the experiment.

I understand that I may be withdrawn from the experiment at any time (without regard to my consent) by Jane Tollett, if, in her opinion, it would be inadvisable for me to continue to participate or if the experiment is ended.

Date _____

Signature of Volunteer

Information about: A nursing intervention with homeless veterans: Effects on
therapeutic progress.

I understand that if there are any questions or research related problems at any time during this experiment, I may contact Jane Tollett, RN at phone 7871 (VA) or Sandra Thomas, PhD, RN at phone (615) 974-4151. In the event of a research-related medical problem, I may call Jane Tollett, RN or Dr. Thomas at the above numbers or at 245-3054 during nights or weekends.

I understand that in the event I sustain physical injury as a result of participation in this experiment, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided by the VA Medical Center, if I so desire. If I am not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.

Date_____

Signature of Volunteer_____

Information about: A nursing intervention with homeless veterans: Effects on
therapeutic progress.

I understand that a copy of the results of the experiment will be kept on file in the Homeless Evaluation Unit for a period of at least ten (10) years after completion of the research. I understand that all medical information gained in this study will be treated confidentially, and any publications resulting from this study will not use my name or release any information about my specific medical condition.

I also understand that while my rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the FDA, and the IRB, have free access to any information obtained in this study should it become necessary.

By signing below, I certify that I have read or had this document read to me and I have been given a copy. I have been given the opportunity to ask questions and to discuss my participation with the investigator. I freely and voluntarily choose to participate in this research experiment.

Date _____

Signature of Volunteer(Subject)

Date _____

Signature of Investigator

Date _____

Signature of Witness

APPENDIX B

INSTRUMENTS

MHS

Circle one number for each statement which best describes how much you agree with that statement right now. The numbers refer to:

	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
There are no right or wrong answers	1	2	3	4	5	6
1. When I ask for help I usually receive it.	1	2	3	4	5	6
2. I am positive about most aspects of my life.	1	2	3	4	5	6
3. I look forward to an enjoyable future.	1	2	3	4	5	6
4. I am flexible in facing life's challenges.	1	2	3	4	5	6
5. There are things I want to do in life.	1	2	3	4	5	6
6. I am able to set goals I want to achieve.	1	2	3	4	5	6
7. My life has meaning.	1	2	3	4	5	6
8. I make plans for my own future.	1	2	3	4	5	6
9. I am able to imagine a positive outcome to most challenges.	1	2	3	4	5	6
*10. Time seems to be closing in on me.	1	2	3	4	5	6
11. I have energy to do what is important to me.	1	2	3	4	5	6
*12. I find myself becoming passive toward most things in life.	1	2	3	4	5	6
13. I intend to make the most out of life.	1	2	3	4	5	6

There are no right or wrong answers	Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
	1	2	3	4	5	6
14. I am positive about the future.	1	2	3	4	5	6
*15. I am apathetic toward life.	1	2	3	4	5	6
16. I have the ability to handle problems.	1	2	3	4	5	6
*17. I feel trapped, pinned down.	1	2	3	4	5	6
18. My personal beliefs help me feel hopeful.	1	2	3	4	5	6
19. I value my freedom.	1	2	3	4	5	6
20. I spend time planning for the future.	1	2	3	4	5	6
21. I am able to accomplish my goals in life.	1	2	3	4	5	6
22. I am valued for what I am.	1	2	3	4	5	6
23. I have someone who shares my concerns.	1	2	3	4	5	6
*24. I am hopeless about some parts of my life.	1	2	3	4	5	6
25. I look forward to doing things I enjoy.	1	2	3	4	5	6
*26. It is hard for me to keep up my interest in previously enjoyable activities.	1	2	3	4	5	6
*27. It seems as though all my support has been withdrawn.	1	2	3	4	5	6
28. I am satisfied with my life.	1	2	3	4	5	6

There are no right or wrong answers	Very Strongly Disagree 1	Strongly Disagree 2	Disagree 3	Agree 4	Strongly Agree 5	Very Strongly Agree 6
29. I am needed by others.	1	2	3	4	5	6
*30. I do not have any inner strengths.	1	2	3	4	5	6
31. I know I can get through difficulties.	1	2	3	4	5	6
*32. I will not have good luck in life.	1	2	3	4	5	6
33. I am so overwhelmed, nothing I do will help.	1	2	3	4	5	6
34. I am motivated to do things that are important to me.	1	2	3	4	5	6
35. I feel loved.	1	2	3	4	5	6
36. I try to find meaning in life events.	1	2	3	4	5	6
37. I am preoccupied with troubles that prevent my planning for the future.	1	2	3	4	5	6
38. I feel uninvolved with life.	1	2	3	4	5	6
39. I trust that things will work out.	1	2	3	4	5	6
40. I can find reasons to keep positive about my health.	1	2	3	4	5	6

* = reverse score these items

SES

Instructions: This questionnaire is a series of statements about your personal attitudes and traits. Each statement represents a commonly held belief. Read each statement and decide to what extent it describes you. There are no right or wrong answers. You will probably agree with some of the statements and disagree with others. Please indicate your own personal feelings about each statement below by marking the letter that best describes your attitude or feeling. Please be very truthful and describe yourself as you really are, not as you would like to be.

Mark:A if you **DISAGREE STRONGLY** with the statementB if you **DISAGREE MODERATELY** with the statement

C if you neither agree nor disagree with the statement.

D if you **AGREE MODERATELY** with the statementE if you **AGREE STRONGLY** with the statement

A B C D E	1. I like to grow house plants.
A B C D E	2. When I make plans, I am certain I can make them work.
A B C D E	3. One of my problems is that I cannot get down to work when I should. *
A B C D E	4. If I can't do a job the first time, I keep trying until I can.
A B C D E	5. Heredity plays the major role in determining one's personality.
A B C D E	6. It is difficult for me to make new friends. *
A B C D E	7. When I set important goals for myself, I rarely achieve them.
A B C D E	8. I give up on things before completing them. *
A B C D E	9. I like to cook.
A B C D E	10. If I see someone I would like to meet, I go to that person instead of waiting for him or her to come to me.
A B C D E	11. I avoid facing difficulties. *
A B C D E	12. If something looks too complicated, I will not even bother to try it. *
A B C D E	13. There is some good in everybody.
A B C D E	14. If I meet someone interesting who is very hard to make friends with, I'll stop trying to make friends with that person.
A B C D E	15. When I have something unpleasant to do, I stick to it until I finish it.
A B C D E	16. When I decide to do something, I go right to work on it.
A B C D E	17. I like science.
A B C D E	18. When trying to learn something new, I soon give up if I am not initially successful. *

Mark:

A if you **DISAGREE STRONGLY** with the statement
 B if you **DISAGREE MODERATELY** with the statement
 C if you neither agree nor disagree with the statement.
 D if you **AGREE MODERATELY** with the statement
 E if you **AGREE STRONGLY** with the statement

A B C D E	19. When I'm trying to become friends with someone who seems uninterested at first, I don't give up very easily.
A B C D E	20. When unexpected problems occur, I don't handle them well. *
A B C D E	21. If I were an artist, I would like to draw children.
A B C D E	22. I avoid trying to learn new things when they look too difficult for me. *
A B C D E	23. Failure just makes me try harder.
A B C D E	24. I do not handle myself well in social gatherings. *
A B C D E	25. I very much like to ride horses.
A B C D E	26. I feel insecure about my ability to do things.
A B C D E	27. I am a self-reliant person.
A B C D E	28. I have acquired my friends through my personal abilities at making friends.
A B C D E	29. I give up easily. *
A B C D E	30. I do not seem capable of dealing with most problems that come up in my life. *

General Self-Efficacy Subscale Items:

2, 3, 4, 7, 8, 11, 12, 15, 16, 18, 20, 22, 23, 26, 27, 29, and 30.

Social Self-Efficacy Subscale Items:

6, 10, 14, 19, 24 and 28.

Filler Items:

1, 5, 9, 13, 17, 21, 25, and 26

Scoring procedure:

Convert item responses to numerical data:

A = 1 point

B = 2 points

C = 3 points

D = 4 points

E = 5 points

* Reverse Score

RES

The following is a list of statements of how you feel about yourself. Please circle the number that best corresponds with what you feel.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. I take a positive attitude towards myself.	1	2	3	4
2. I feel that I have a number of good qualities.	1	2	3	4
3. I wish I could have more respect for myself.	1	2	3	4
4. All in all, I am inclined to feel that I am a failure.	1	2	3	4
5. I feel that I'm a person of worth, at least on an equal basis with others.	1	2	3	4
6. I feel I do not have much to be proud of.	1	2	3	4
7. At times I think I am no good at all.	1	2	3	4
8. I am able to do things as well as most other people.	1	2	3	4
9. I certainly feel useless at times.	1	2	3	4
10. On the whole, I am satisfied with myself.	1	2	3	4

BECK INVENTORY

ID# _____

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

1. 0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
 - 1 I feel I may be punished.
 - 2 I expect to be punished.
 - 3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.
 - 1 I am disappointed in myself.
 - 2 I am disgusted with myself.
 - 3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
 - 1 I cry more now than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever am.
 - 1 I get annoyed or irritated more easily than I used to.
 - 2 I feel irritated all the time now.
 - 3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
 - 1 I am less interested in other people than I used to be.
 - 2 I have lost most of my interest in other people.
 - 3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
 - 1 I put off making decisions more than I used to.
 - 2 I have greater difficulty in making decisions than before.
 - 3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance.
3 I believe that I look ugly.
15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any lately.
1 I have lost more than 5 pounds. I am purposely trying to lose weight.
2 I have lost more than 10 pounds by eating less
Yes ___ No ___
3 I have lost more than 15 pounds.
20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 I am very worried about my physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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APPENDIX C
NURSING INTERVENTION

Nursing Intervention to Instill Hope

Group size

The nursing intervention to instill hope will use a small group format as described by Yalom (1985) with an acceptable size range of five to ten members. As attrition occurs new members will be added to the group to maintain at least five members.

Replacement of members:

New members will be added as necessary to maintain appropriate group size. These members will be oriented and absorbed into the group using the schedule of activities outlined in the intervention protocols. The group will be able to function with members working on various steps simultaneously. The discussion surrounding the work should be helpful to the new members as they work steps that others have accomplished.

Group session protocol:

Each group session will contain four essential sequential components to ensure efficient use of a limited number of sessions (Yalom, 1985).

These components are:

1. orientation and preparation (5 to 10 minutes)

This segment includes discussion of any group structure problems such as tardiness or absenteeism. It also recaps the purpose of the group. A general review of work that has been accomplished and a review of the work still to be done by the group. Finally, this segment sets the stage for the specific tasks to be accomplished in this particular session.

2. Member "Go-round" (10-15 minutes)

Each member will be asked to share his experiences (positive and negative), his thoughts and feelings about the previous group work and his assignment for today's session.

3. "Filling" (30 minutes)

This segment of the group consists of interaction among the members as they work on their specific assignment for the day.

4. Review, evaluation and plans for next session (5 minutes)

During this period, the veterans will offer their feed-back about the session and decide how they will prepare for the next session. According to Yalom (1985), this phase can include discussion around how they feel about what they did today, their disappointments in today's work, how they would spend their time if there were more time, and what they would like to have said or done that they did not.

Intervention protocols (for the "filling" segments of each session)

Session 1. Orientation

The relevance of the group to the group members' plans will open this session. Next, the group members will be introduced and become acquainted with each other. The group structure will be explained, including the work that is expected of the group, as well as the mechanisms such as the frequency and duration of meetings, where and when the meetings will occur and attendance and punctuality expectations.

The main task for this session is the identification of strengths, assets, past successes and areas of pride. If an individual has difficulty identifying strengths, the group leader and other members will assist. These can be as simple as a high school education, or a month of sobriety. At the end of this session each veteran will have identified and listed at least two strengths, assets, successes, or items of pride. Lastly, the group members will agree to be supportive to each other by affirming them in their interactions and reminding them of their reasons to feel good about themselves.

Session 2. Vision

The task of this session is visioning which begins with an accurate picture of the present (Senge, 1990). Each veteran will draw a picture of himself in his world as it is now. He will discuss this picture with the group as he feels comfortable doing so. Discussion will center around how he would like for this picture to change. Drawing the picture of the future with the desired changes in place will complete the work of this session.

For the next session, each group member will continue to contemplate the desired changes and to vision himself in the future as he wants to be or doing what he wants to do.

Session 3. Passion

During this session the group members will use the work from Session 1 to identify something that really matters to them; something they really want to do or to be (King, 1991). The emergence of something that really matters and that they can feel passionate about may be a slow process. As the leader and the group interact, the individual group members should be able to identify one thing which will become a goal. The work of the leader will focus on assisting the subjects to let a reasonable idea (goal) emerge from their thinking and feeling.

To prepare for the next session, the group members will be asked to ponder their goals to see if they can develop a passion for them.

Session 4. Success Map

This session will center around the new vision of the future. If the veteran is not able to "see himself" in the desired future, the visioning process will be repeated. A more realistic future will be envisioned so that the veteran can begin to "see himself" in that future. When a veteran can see a goal clearly, even if it seems impossible he can begin to see the little "how to" steps that lead to that goal (King, 1991).

Next, each member will begin the creation of a success map (King, 1991). This map is drawn with the veteran pictured at one end of a road (starting line) and an image of him as he wants to be in his vision of the future at the other end of the road (finish line). The "how-to" steps will be added later.

The individual's work that is to be done before the next session is to identify key characteristics of a person who has reached the finish line and has become that image on his success map.

Session 5. Key Characteristics

During this session each veteran will discuss and determine key characteristics of the person at the finish line on his success map. These key characteristics will then be placed along the road. These will include strengths that the veteran has presently as well as strengths that he will need to acquire such as education, social skills or sobriety to accomplish his goal.

Session 6. Mentors and Cheerleaders

Because creating a plan for change requires knowledge and expertise about what is necessary for the change to occur, the individual will identify and place on the map someone who knows more than he does about what he is hoping to accomplish that he can go to for information and advice. Also, someone who is "on-his-side" to share victories or to encourage him when he is discouraged will be placed on this map as a "cheerleader."

Session 7. Obstacles and Insurance

No road to success is unobstructed. During this session the veterans will identify hurdles, roadblocks and fears. These will be placed along the road with the biggest obstacles or fears in the middle of the road. Discussion will proceed to the means of preventing them from keeping the veteran from reaching the goal. Three insurance policies will be included for each obstacle. For example, if becoming intoxicated is an obstacle, the insurance policies might be attending AA, staying busy, and avoiding places where alcohol is served.

Session 8. Resources and Yardsticks and Partners

The group members will focus on other things that will be necessary to accomplish their goals. Examples of these may include money, equipment, or basic necessities. Whatever the veteran identifies will be placed in a box as necessities to help him on his way down the road to success. Discussion will include ways and means of getting these needs met. The ways and means will be placed on the map.

During this session the group members will also place measuring sticks on their maps. These will be appropriate to the individual maps and may include items like the GED or a month of sobriety. The measuring sticks will be placed along the map at appropriate and strategic places to measure progress. The next step in creating the success map will be to secure training partners. A training partner will be someone from the group who is also working a plan of change and seeking success and who will agree to serve as a support person.

Session 9. To-Dos and Contracts

This session will be spent determining steps based on the vision and the success map that can be taken now to start down the road toward the finish line. From these steps that are determined to be essential to success, one is selected to work on now. If sobriety has been identified as a key characteristic and a breach of sobriety as an obstacle, then sobriety would be a reasonable step to work on now. The veterans will each contract to stay substance free until the next group session. His plan for attaining that goal could include such things as attending AA or seeing his training partner every day for affirmation and encouragement.

Session 10. Contracts

The group members will discuss the obstacles, problems or things that went right with keeping the contract that was made last week. Ideas and suggestions about these activities will be part of this discussion. Next, an extension of the contract is indicated. The substance-free contract might be extended to the next week, a contract to be involved in social interaction with one person might be enlarged to three persons, or a contract to begin the process for GED classes might be expanded to complete the class by a certain date.

Session 11. Affirmations

This session will be similar to session 10 with a discussion of contracts kept and not kept and the reasons why. New contracts will be established based on the natural progression along the success map and step-wise goals that need to be attained.

During this session the veteran will write an affirmation to help him internalize a picture of himself in his vision of the future (King, 1991). This

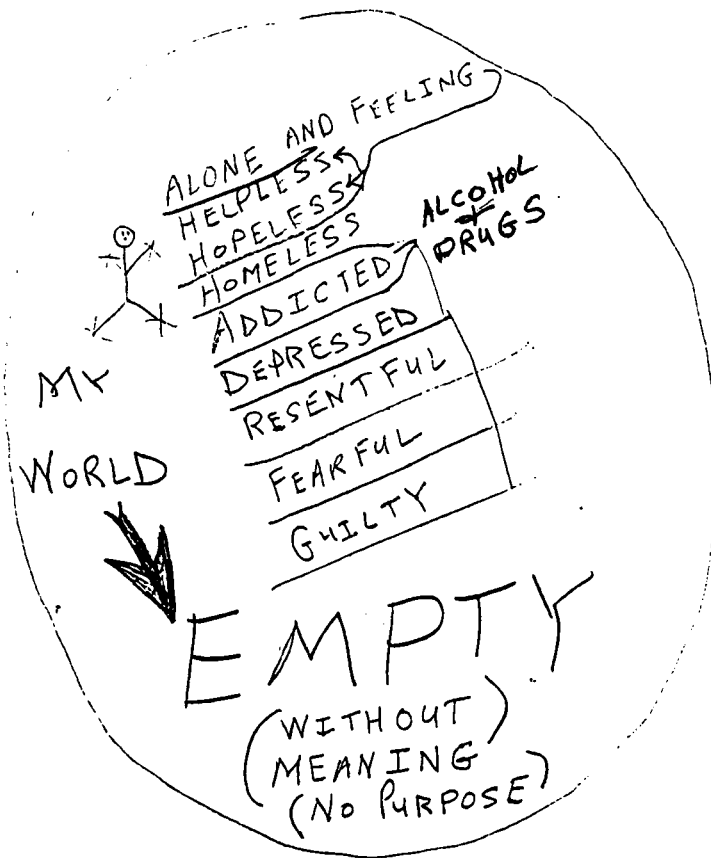
affirmation will take the form of three statements of "I wish", "I will be", and "I am". An example of this for the sobriety goal is "I wish I was substance free," "I will be substance free," and "I am substance free." These affirmations will be stated verbally each morning by the veteran.

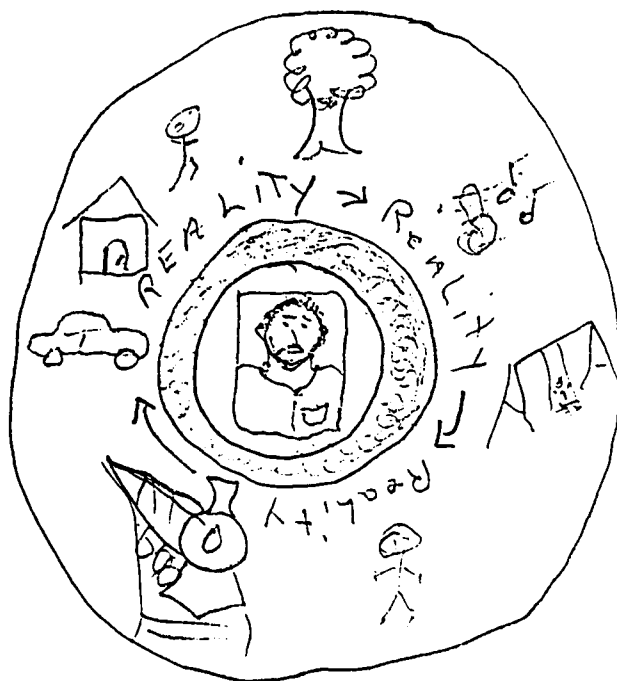
Session 12. New Contracts

This is the final session but it will be stressed that it should not be the end of the work on the success map. Each veteran will agree to see his regular counselor on the HEU and his training partner at least weekly to continue the work on goals contained in the success map. During this session each veteran will talk about what the group has meant to him--both positively and negatively--and articulate his ideas about how he will continue to attain his goals.

Old contracts will be discussed and new contracts made during this session. The new contracts will be made with the training partners since the group will not meet again.

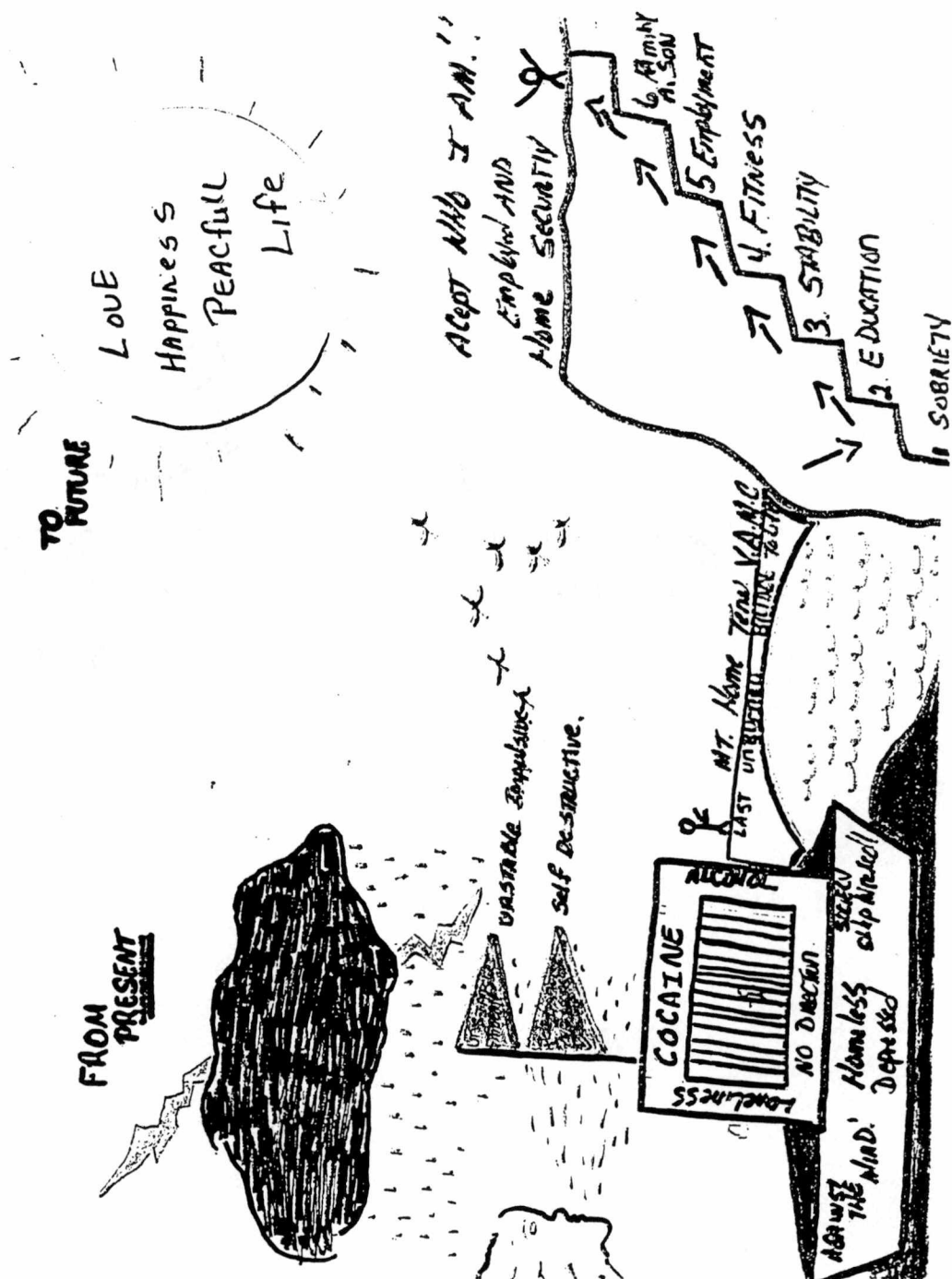
APPENDIX D
Examples of Pictures and Success Maps

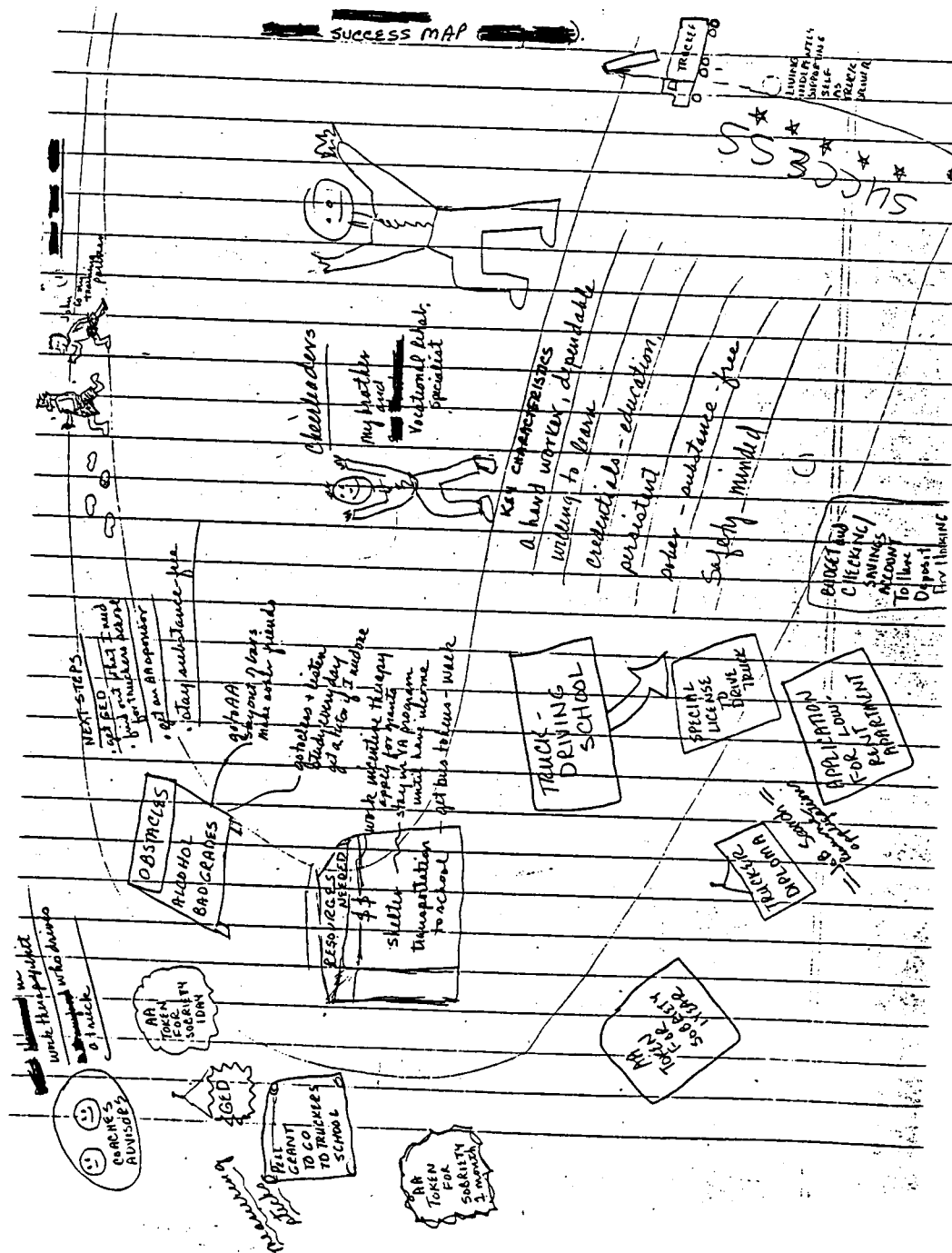


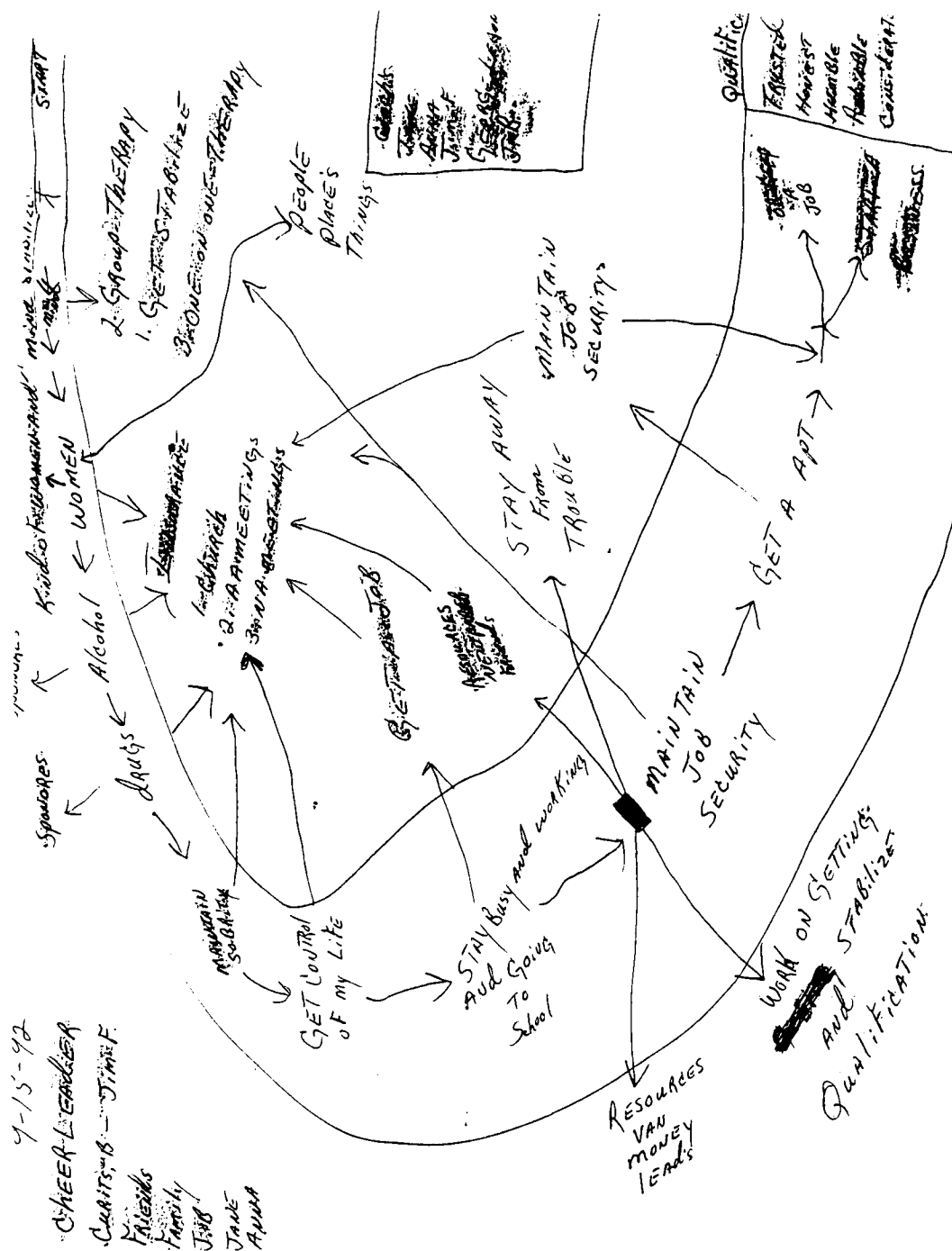


How I Feel NOW!

"Trapped with no way to reality and the good things in life."







APPENDIX E

TABLES

Table 1. Distribution of Numeric Sociodemographic Variables (N=40)

Variable	Mean	SD	Range
Age	47	10.17	31-68
Education (in years)	11.94	1.81	8-16
Income (per month)	\$196.68	\$263.74	0-\$828
Length of Homelessness (in months)	40.38	56.22	1-240

Table 2. Distribution of Categorical Sociodemographic Variables (N=40)

Variable	<u>n</u>	%
Marital Status		
Never married	5	13
Married	0	0
Divorced	27	68
Separated	7	18
Widowed	1	1
Military Status		
Combat	19	48
Non-combat	21	52

Table 3. Means, Standard Deviations, Variances and Ranges of Variables for Entire Sample

Variable	N	Mean	SD	Variance	Range
Hope					
Pretest	40	138.55	30.32	919.07	61-197
Posttest	33	149.97	26.25	689.09	93-217
Self-Efficacy					
Pretest	40	50.23	15.70	246.38	19-89
Posttest	33	52.79	14.14	199.80	29-83
Self-Esteem					
Pretest	40	24.15	5.43	29.52	11-37
Posttest	33	24.91	5.47	29.90	13-39
Depression					
Pretest	40	25.40	16.40	268.86	1-63
Posttest	33	18.91	14.97	224.21	0-55

Table 4. Means, Medians, Standard Deviations and Variance for Subjects Who Prematurely Terminated Treatment (n=7)

Variable	Mean	Median	SD	Variance
MHS1	139.55	155	35.27	1243.91
GSES1	50.86	50	17.90	320.48
RES1	22	25	7.26	52.67
BDI1	25.71	23	12.11	146.57
AGE	42.6	40	7.02	49.3
EDUCATION	12	12	2	4
INCOME	0	0	0	0
LOH	33.33	40	18.90	357.33

Table 5. Distribution of BDI Scores

Categories of Depression	BDI (Pretest n=40)		BDI (Posttest n=33)	
	n	%	n	%
0-9 normal	6	15	12	36
10-15 mild	6	15	2	6
16-19 mild-moderate	7	17	6	18
20-29 moderate-severe	8	20	6	18
30-63 severe	13	33	7	21

NOTE: The number of subjects at posttest was reduced by premature program termination of 7 veterans.

Table 6. Intercorrelation Matrix for Demographic and Dependent Variables

Variable Scale	1 MHS1	2 GSES1	3 RES1	4 BDI1	5 AGE	6 EDUC	7 INC	8 LOH
1. Hope [MHS1] (pretest)	--							
2. Gen Self- efficacy (GSES) (pretest)	.48**	—						
3. Self-Esteem (RES1) (pretest)	.68**	.81**	--					
4. Depression (BDI1) (pretest)	-.72**	-.52**	-.64**	--				
5. Age	.18	.26	.30	-.23	--			
6. Education	.20	.21	.30	-.28	.12	--		
7. Income	.06	.37	.40	.21	.53**	.18	--	
8. Length of Homeless	-.57**	-.02	-.21	.40*	-.20	-.02	.16	--

* $p < .05$ ** $p < .01$

Table 7. Test-Retest Reliability of Instruments

Instrument	1 MHS2	2 GSES2	3 RES2	4 BDI2
1. MHS1	.82*			
2. GSES1	---	.77*		
3. RES1	---	---	.80*	
4. BDI1	---	---	---	.80*

* $p = .0001$ Table 8. ANCOVA* Comparison of Groups on Dependent Variables

Variable	F	p
Hope	8.93	.006
Self-Efficacy	.97	.33
Self-Esteem	1.73	.20
Depression	.33	.57

*Pretest scores = covariate

Table 9. Distribution of BDI Scores of Treatment Group

Categories of Depression	n	Pretest %	n	Posttest %
0-9 normal	3	15	8	40
10-15 mild	4	20	0	0
16-19 mild-moderate	2	10	6	30
20-29 moderate-severe	4	20	2	10
30-63 severe	7	35	4	20

Table 10. Comparison of Group Means and SD on Dependent Variables

Control Group					Treatment Group			
Variable	Pretest		Posttest		Pretest		Posttest	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
MHS	147.87	26.67	146.38	28.62	132.9 6	31.49	152.30	25.07
GSES	53.47	15.58	51.54	13.19	48.28	15.75	53.60	14.90
RES	25.40	4.24	24.38	3.88	23.40	5.99	25.25	6.36
BDI	23.73	17.99	19.92	13.04	26.40	15.67	18.25	16.40

Table 11. Paired t Test Comparison of Pre and Posttest Scores Within Treatment Group

Variable	t	p
Hope (MHS)	5.41	.0001
Self-Efficacy (GSES)	1.89	.07
Self-Esteem (RES)	2.45	.02
Depression (BDI)	-3.40	.003

Table 12. Pretest, Posttest 1, Posttest 2 and Mean Scores for Each Variable for Subjects who Completed the Treatment Phase of the Waiting Control Group

Variable	Subject 1	Subject 2	Subject 3	Subject 4	Mean
Hope Pretest	125	140	161	160	146.5
Posttest 1	116	137	155	158	141.5
Posttest 2	131	145	161	178	153.75
Self-Efficacy Pretest	41	35	65	61	50.5
Posttest 1	47	43	69	55	53.5
Posttest 2	50	42	63	64	54.75
Self-Esteem Pretest	21	24	29	28	25.5
Posttest 1	20	21	31	27	24.75
Posttest 2	22	21	31	29	25.75
Depression Pretest	63	35	17	10	31.25
Posttest 1	34	37	15	03	22.25
Posttest 2	37	20	13	06	19

Table 13. Paired t Test Comparison of Pre and Posttest Scores Within Control Group

Variable	t	p
Hope (MHS)	.24	.81
Self-Efficacy (GSES)	.16	.88
Self-Esteem (RES)	-.81	.44
Depression (BDI)	-1.57	.14

Vita

During the course of her lifetime, Jane Tollett has come to believe that it is in relationships that life has value and meaning. Jane's journey of relationships began October 7, 1942 on a farm in the Appalachian Mountains of Tennessee when she was born to Troy and Estelle Hammons, the second of three daughters. During the first 50 years of her life Jane developed learning and loving relationships with God, family, friends, co-workers, fellow students, professional colleagues, patients and most individuals with whom she made contact.

She married Charles Tollett December 25, 1963 and together they created a caring and supportive family unit with three daughters, Kara (b. 1965), Rachel (b. 1967) and Kellye (b. 1970). The Tolletts welcomed many others into the family, and through the years Jane's sister, Charles' nephews and a Japanese college student made their homes with them.

Jane's personal and professional growth continued as she developed a yen for life-long and life-wide learning and pursued formal education, which included earning a diploma in nursing and degrees in Education (B.S., 1974) and Nursing (M.S.N., 1981; Ph.D., 1992). She has shared her love for people and her expertise and knowledge of nursing through a variety of professional activities and in career positions. Her professional career has included nursing in traditional staff, public health and management roles and with non-traditional clients as clinical specialist and coordinator of a VA Homeless Unit. Jane has participated in the opportunity to learn

with and of her colleagues in professional organizations at the local and state levels, holding various elected offices and committee appointments. Her commitment is also visible in her involvement in community and civic organizations as an advocate for human caring, nursing and for disenfranchised populations.

Jane's work with homeless veterans has strengthened her belief in the key role that relationships hold in quality of life. She has come to believe that it is through inclusion rather than exclusion, collaboration rather than cooperation, and by being impelled from what is within rather than being compelled by what is without, that hope thrives. Living out these beliefs and exercising her leadership and commitment to humanity, Jane has accepted the challenge offered by the VA's Collaborative Homeless Initiative to become the Chief of the Domiciliary for Homeless Veterans in Anchorage, Alaska. Along with Emily Dickinson, Jane says,

*Hope is the thing with feathers
that perches in the soul,
And sings the tune without the words,
And never stops at all,*