June 2018

A Longitudinal Analysis of the Effect of the Starting Right, Now Program on Unaccompanied Homeless Adolescents' Well-Being

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A Longitudinal Analysis of the Effect of the *Starting Right, Now* Program on Unaccompanied Homeless Adolescents’ Well-Being

by

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
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Date of Approval:
March 29, 2018

Keywords: life satisfaction, hope, coping

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Acknowledgements

I would like to thank those individuals who have provided their expertise, guidance, support, and encouragement during my dissertation research. First, I would like to thank my Major Professor, Dr. Linda Raffaele Mendez, for her invaluable contributions to my professional and personal growth during my graduate school experience. I have learned so much about school psychology and life from you, and I am incredibly grateful to have been able to work closely with someone so talented, caring, and authentic. I would next like to thank my committee members, Dr. John Ferron, Dr. Shannon Suldo, and Dr. Janise Parker, for their feedback and guidance over the course of this project. I would also like to thank my cohort in the School Psychology program, especially Sarah Dickinson and Elizabeth Storey, for their friendship, humor, and love of tacos. Finally, I would like to thank my mom, Karen Esposito, and my boyfriend, Thomas deHaas, for their never-ending supply of love, laughter, patience, and encouragement throughout the course of my graduate studies. Thank you for being my biggest cheerleaders—I could never have done this without you.
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Abstract

To date, few multicomponent interventions focused on meeting the complex needs of unaccompanied homeless youth (UHY) have been developed. One intervention, called Starting Right, Now (SRN), provides unaccompanied homeless adolescents with a broad range of home-, school-, and community-based services and supports to meet the unique needs of each individual. Previous qualitative research has supported the effectiveness of SRN on student outcomes; there has not yet been an examination of the program using quantitative methods. Thus, the current study investigated the impact of Starting Right, Now on students’ well-being through the examination of longitudinal data collected over a 12-month period. Specifically, changes in students’ life satisfaction, hope, and use of coping strategies at three time points were examined. A dataset including ten unique participants was analyzed using the Wilcoxon Signed-Rank Test to evaluate whether statistically significant changes in participants’ (1) life satisfaction, (2) hope agency, (3) hope pathways, (4) maladaptive coping strategies, and (5) adaptive coping strategies occurred between baseline (Time 1), six months of participation (Time 2), and twelve months of participation (Time 3; available for a subset of the sample). Results indicated a statistically significant increase in life satisfaction, hope agency, and hope pathways after six months of participation in SRN. There were no additional statistically significant changes in life satisfaction, hope agency, or hope pathways after one year of participation, and there were no statistically significant changes in adaptive coping or maladaptive coping at any time point. Findings from the current study support the implementation and future expansion of the SRN model in order to positively impact life satisfaction and hope among UHY.
Chapter One:

Introduction

The National Center for Homeless Education (2014) defines a homeless student as any student who lacks a fixed, regular, and adequate nighttime residence. During the 2014-2015 academic year, 1,263,323 children and adolescents enrolled in U.S. public schools were identified as homeless (NCHE, 2016). Of those 1.26 million students, 95,032 were identified as being unaccompanied homeless youth (UHY). UHY are individuals under the age of 18 who are separated from their families and are no longer in the custody of a parent or legal guardian (NCHE, 2014). Of note, the NCHE (2016) has suggested that the number of UHY in schools is under-reported in some states. Overall, the population of UHY has increased by 21% over the last three academic years (NCHE, 2016).

Children and adolescents are at increased risk for many negative outcomes after becoming homeless. When compared to their housed peers, homeless youth have been found to experience increased rates of internalizing symptoms (Buckner et al., 1999) and disorders such as posttraumatic stress disorder (PTSD), major depressive disorder, and substance abuse disorders (Whitbeck et al., 2007). The homeless population also is at risk for experiencing low levels of life satisfaction and low perceived quality of life compared to the housed population (Bearsley & Cummins, 1999; Biswas-Diener & Diener, 2006). In regard to educational outcomes, UHY exhibit poor school attendance (Murphy, 2011), poor standardized test scores (NCHE, 2016), and high drop-out rates (Aratani & Cooper, 2015) compared to same-age peers who have never been homeless. Research on homeless and unaccompanied youth also has
investigated the specific coping strategies used by this population. Specifically, homeless youth have been found to use a variety of positive and negative coping strategies, including religiosity/spirituality, finding a purpose in life, aggressive behavior, and substance use (Carlson et al., 2012; Lindsey, Kurtz, Jarvis, Williams & Nackerud, 2000; Williams, Lindsey, Kurtz, & Jarvis, 2001).

The literature on homeless youth overall suggests that this is a highly vulnerable population. At this time, there is limited research on effective interventions to support their complex needs. Many of the interventions studied might be referred to as traditional interventions, focusing solely on one aspect of care (e.g., mentorship, provision of basic needs, mental health services, substance use). Unfortunately, research has not supported the efficacy of traditional interventions (e.g., Baer, Garrett, Beadnell, Wells & Peterson, 2007; Cauce et al., 1994; Thompson, Pollio, Constantine, & Von Nebbitt, 2002), which have been compared to treatment as usual or a waitlist control. In fact, the literature to date has supported the effectiveness of few traditional interventions. Stable housing has been found to promote increased general health and decreased substance use (Kisely, Parker, Campbell, Karabanow, Hughes & Gahagan, 2008). Similarly, mentoring has been associated with lower problem consequences of substance use among homeless youth (Bartle-Haring, Slesnick, Collins, Erdem & Beuttner, 2012).

Given that single component interventions have not proven to be particularly effective in meeting the complex needs of homeless youth, researchers have begun more recently to examine the impact of multi-component interventions for this population. One intervention, the Social Enterprise Intervention (SEI), provides homeless youth with mentoring, vocational training, and mental health services over ten months. SEI was found to significantly increase participants’ life
satisfaction scores compared to treatment as usual (Ferguson & Xie, 2007). Another multi-component intervention, the Community Reinforcement Approach (CRA), is an ecological intervention that provides housing supports, medical care, job skills, social support, mental health services, and legal services to meet the needs of each homeless adolescent involved in the program. Participants in CRA were found to engage in less drug use and exhibited fewer depressive and internalizing symptoms after the intervention, as compared to treatment as usual (Slesnick, Prestopnik, Meyers, & Glassman, 2007).

A third multi-component intervention, Starting Right Now (SRN), provides UHY with a broad range of home-, school-, and community-based services and supports based on the unique needs of each student. Services include housing, mental and physical health care, mentoring, leadership training, mindfulness training, academic tutoring, and other individualized supports. The effectiveness of SRN has been supported through qualitative research (Randle, 2016) but has not yet been studied using quantitative methods.

**Definition of Key Terms**

**Unaccompanied homeless youth (UHY).** In this study, unaccompanied homeless youth are defined as individuals under the age of 18 who have separated from their families, are no longer in the physical custody of a parent or legal guardian, and who lack a fixed, regular, and adequate nighttime residence (NCHE, 2014).

**Life satisfaction.** Life satisfaction is defined in this study using Diener’s (1984) definition, namely that life satisfaction is a positive, global evaluation of one’s life. Life satisfaction is subjective, as it is based on each individual’s own conceptualization of what makes up a good life (Diener, 1984). According to Suldo, Riley and Shaffer (2006), life
satisfaction is the most frequently used indicator of well-being in studies of youths’ perceived quality of life.

**Hope.** The current study utilizes Snyder and colleagues’ (1991) definition of hope. These researchers defined hope as an overall perception that goals can be met and includes two components: a sense of agency and successful pathways. Agency is conceptualized as a sense of determination in regard to achieving personal goals, while pathways are conceptualized as a sense of having the ability to plan specific ways to meet personal goals (Snyder et al., 1991). While these two components of hope are closely related, they are independent in that high (or low) levels of one component do not necessarily indicate high (or low) levels of the second component.

**Coping strategies.** In this study, coping is defined as an individual’s response to a threatening or stressful situation (Carver, Scheier, & Weintraub, 1989). Coping is typically separated into two general types: 1) problem-focused coping, which aims to alter the source of distress, and 2) emotion-focused coping, which aims to manage the emotional distress elicited by the situation (Carver et al., 1989). Coping can also be separated into adaptive and maladaptive coping strategies. Coping strategies such as substance use, denial, avoidance, and self-blame are conceptualized as maladaptive, while coping strategies such as acceptance, humor, religion, and positive reframing are conceptualized as adaptive coping strategies (Carver, 1997).

**Adverse childhood experiences (ACEs).** In the current study, an adverse childhood experience (ACE) is defined as a negative life experience prior to the age of 18, such as physical or sexual abuse, inadequate parental care, parental incarceration, or familial mental illness (Felitti et al., 1998). ACEs have been found to be predictive of multiple negative adult outcomes, including episodes of homelessness (Felitti et al., 1998; Herman et al., 1997).
**Purpose of the Current Study**

The purpose of the current study was to ascertain whether participation in Starting Right, Now was associated with significant changes in student mental health. In particular, the current study examined longitudinal data collected over a 12-month period to determine whether changes in participants’ life satisfaction, hope, and use of coping strategies occur. To date, there has been no quantitative analysis of the impact of SRN on student outcomes, although previous research (Randle, 2016) has investigated student perceptions of the impact of SRN utilizing qualitative methods. Thus, the current study contributes to the existing literature by providing the first examination of the impact of SRN on various indicators of student well-being.

**Research Questions**

The specific research questions answered in this study are as follows:

1) Do students participating in Starting Right, Now experience changes in life satisfaction after six months? After one year?

2) Do students participating in Starting Right, Now experience changes in hope after six months? After one year?

3) Do students participating in Starting Right, Now experience changes in use of coping strategies after six months? After one year?

It was hypothesized that statistically significant increases in life satisfaction, hope, and use of positive coping strategies would be supported by findings from the analyses conducted in the current study. This hypothesis was based on the goal of Starting Right, Now: to end the cycle of homelessness by providing unaccompanied homeless adolescents with wraparound services to meet their physical, emotional, and academic needs. The hypothesis that increases in life satisfaction would be seen is also supported by previous research on another multi-component
intervention for homeless youth, which was found to significantly increase life satisfaction among participants in the program (Ferguson & Xie, 2007).

**Contributions to the Literature**

The current study makes several important contributions to the literature. First, the current study is the first to examine if and how Starting Right, Now impacts student wellness over a one-year period using quantitative methods. To date, only one researcher (Randle, 2016) has investigated the perceived impact of SRN through unstructured qualitative interviews with participants. The current study adds to this literature by conducting a more targeted examination of the impacts of SRN on students’ life satisfaction, hope, and coping strategies. The current study also utilized longitudinal data collected at three time points over a one-year period, which provides a more comprehensive understanding of if and when Starting Right, Now impacts participants’ well-being. Furthermore, as noted by Moore (2005), UHY remain an understudied population, and the results of the current study contributes to the limited existing body of research on interventions to serve these youth.

The current study also has implications for practicing school psychologists and other educators. For example, if SRN is found to significantly improve participants’ well-being, it would increase educator’s knowledge of how to support UHY who remain in school despite the challenges associated with their life circumstances. In conjunction with community-based organizations, school personnel could work to implement a similar system of support for unaccompanied homeless youth in their own communities.
Chapter Two:
Review of the Literature

This chapter summarizes the relevant educational and psychological literature that provides the foundation for the current study. First, an overview of the prevalence of unaccompanied homeless youth will be provided, followed by a description of the most common pathways to homelessness. Next, information about the risks faced by youth after becoming homeless will be discussed, including academic performance, mental illness, and mental wellness. Then, legislature related to homeless youth in schools will be reviewed. Traditional interventions for homeless youth will also be described, including community-based and school-based interventions. Finally, multicomponent interventions for unaccompanied homeless adolescents, including Starting Right, Now, will be described.

Prevalence of Unaccompanied Homeless Youth

As defined by the National Center for Homeless Education (NCHE, 2014) a homeless student is any student who lacks a fixed, regular, and adequate nighttime residence. This includes sharing housing with others (being “doubled-up”), staying in a homeless shelter, and living in public places, campgrounds, or cars. Although most youth who are homeless remain with their families, some homeless youth are separated from their families and are no longer in the physical custody of a parent or legal guardian (NCHE, 2014); these youth are known as unaccompanied homeless youth (UHY). As reported by the NCHE (2016), approximately 1,263,323 homeless children and adolescents were enrolled in public schools during the 2014-2015 academic year. Of these homeless youth, 95,032 were classified as UHY. This number represents a 21%
increase in the number of UHY over the past three academic years, with the possibility that the number of UHY is under-reported in some states (NCHE, 2016).

**Pathways to Homelessness**

UHY may become homeless for a variety of reasons. The NCHE (2002) noted that the primary causes of homelessness for UHY are: physical or sexual abuse by a caregiver, neglect, family discord, and parental mental health concerns (including substance abuse). Similarly, Moore (2005) reported that homelessness among unaccompanied youth is most often due to family conflict or financial problems. Due to these factors, youth may choose to run away from home to escape the distress caused by their living environment (Tyler & Schmitz, 2013). In other cases, parents or guardians may encourage the adolescent to leave the home, lock the adolescent out of the home, or abandon the adolescent; these youth are known as “throwaways” (Aratani, 2009).

Martijn and Sharpe (2006) investigated the specific causes of homelessness among Australian youth. Participants were homeless youth between the ages of 14 and 25 (mean age = 19.9 years), and the total sample included 33 youth. The sample was 36% female; 90% of the sample reported experiencing at least one traumatic event during their lifetime. During an in-depth, semi-structured interview, participants were asked to provide a chronological description of their life experiences in regard to family, mental health, housing, trauma, and substance use. Qualitative analysis of the interviews revealed five common pathways to homelessness.

The first pathway of “drug and alcohol trauma” was characterized by an experience of trauma related to the use of alcohol or drugs. In some cases, the traumatic event preceded the substance abuse, while in others the substance abuse preceded the traumatic event. The second pathway, “trauma and psychological problems,” was characterized by the experience of a
traumatic event, followed by psychological problems such as posttraumatic stress disorder or major depressive disorder. The third pathway of “drug/alcohol and family problems” was characterized by the combination of substance abuse and family discord, including emotional abuse, neglect, and conflict with family members. The fourth pathway, “family problems” consisted of family discord (e.g., neglect, domestic violence, foster care placement) without the presence of substance abuse. The final pathway, “trauma,” was characterized by sexual abuse during childhood, with all participants in this pathway reporting that the abuse began around age five. Martijn and Sharpe (2006) noted that taken together, these pathways suggest that early traumatic childhood experiences, including neglect, substance use, sexual abuse, and physical abuse, can lead to homelessness in adolescence. However, because this research was conducted with Australian youth, cultural factors may limit the generalizability of these pathways to homeless youth in America.

Herman, Susser, Struening, and Link (1997) similarly investigated causes of homelessness among homeless adults. Participants were 487 adults in the United States between the ages of 25 and 54. The sample was reported to be 85% white, with 53% of the sample having completed at least some college education and 4% of the sample reporting a history of homelessness. Based on the results of a phone survey administration of the Adverse Childhood Experiences (ACE) questionnaire, Herman and colleagues used odds ratios to determine whether adverse childhood experiences were risk factors for adult homelessness. Results indicated that adults who reported ever being homeless endorsed significantly more adverse childhood experiences than those adults who were never homeless (p<.005). In regard to specific adverse childhood experiences, neglect by a caregiver resulted in an odds ratio for homelessness of 12.7; physical abuse resulted in an odds ratio for homelessness of 15.8; experiencing both neglect and
any type of abuse resulted in an odds ratio for homelessness of 26.0; and the experience of any adverse childhood experience resulted in an odds ratio for homelessness of 8.0. Thus, the authors concluded that adverse childhood experiences, particularly neglect and physical abuse, are significant risk factors for later episodes of homelessness in adulthood. However, it is unclear whether these results generalize to adolescents who are homeless, as all of the adults who reported an experience of homelessness were homeless during adulthood.

Raffaele Mendez, Dickinson, Esposito, Connolly, and Bonilla (2017) utilized a qualitative methodology to explore causes of homelessness among unaccompanied youth who remained in school despite their life circumstances. Participants were nine students between the ages of 17 and 20 who were recruited from a community-based organization providing wrap-around services to unaccompanied homeless youth. The sample was 56% male, 22% African American, 44% European American, 11% Hispanic American, and 22% Caribbean American. Based on participants’ unstructured interviews, nine themes were identified to describe common factors in participants’ lives that were related to their experience of homelessness. The first theme, “shuffled,” represented that all participants described frequently mobility in regard to both home and school. The second theme, “abused,” indicated the frequency of physical, emotional, and/or sexual abuse experienced by participants before separating from their families. “Suppressed,” the third theme, detailed how participants expressed they felt they could not speak up about the abuse for various reasons. The fourth theme, “what is normal?”, represented how many participants did not understand that the situations they were experiencing in their home lives were not typical. Theme five, “not the priority,” indicated that participants felt their parents prioritized other people or their own desires over the needs of their children. “Unmet basic needs,” theme six, represented that all participants described living conditions that included
overcrowded housing, lack of food, and lack of reliable transportation. Theme seven, “shouldering responsibility,” indicated that many participants took on adult-like responsibilities such as caring for younger siblings or earning money for the family because their parents or caregivers were unable or unwilling to do so. The eighth theme, “saving graces,” detailed that in spite of their challenging life circumstances, all participants had a person or an activity in their life that provided respite from their difficulties in some way. Finally, theme nine was “unexpected wisdom,” which represented that participants demonstrated remarkable resilience and wisdom in the face of such adversity. Overall, Raffaele Mendez and colleagues concluded that while participants had many common life and family factors that contributed to their becoming homeless, these unaccompanied homeless youth also displayed resilience, wisdom, and strength to overcome their life circumstances with support from others.

Outcomes After Becoming Homeless

School performance. Youth who are unaccompanied and homeless are considered to be underrepresented in the school population due to the fact that their challenging life circumstances often prohibit them from attending school regularly (Murphy, 2011; NCHE, 2016). Although homeless students indicate that they value school, they tend to be absent for 6-8% of the school year due to mobility and exclusionary punishment (e.g., suspensions and expulsions; Murphy, 2011).

Homeless youth who are able to remain in school are at increased risk for poor academic performance, particularly on state assessments. The NCHE (2016) reported that during the 2014-2015 academic year, approximately 30% of all homeless youth received a proficient score on state reading/language arts assessments. Less than 25% and 39% of all homeless youth received a proficient score on state mathematics assessments and state science assessments, respectively,
during the same academic year. Additionally, Murphy (2011) noted that homeless students are overrepresented in the special education population but also tend to receive fewer and lower quality services for which they are eligible.

Homeless youth also are at increased risk for dropping out of high school compared to same-age youth who are housed. Among a sample of one-time homeless youth \((n = 183)\) and youth with repeated homeless episodes \((n = 122)\), Aratani and Cooper (2015) found that youth who had experienced homelessness at least once were significantly more likely to have dropped out of high school compared to youth who were not homeless \((n = 2,305)\). Specifically, approximately 25% of youth with one episode of homelessness failed to complete high school, and 35% of youth with repeated episodes of homelessness failed to complete high school. In comparison, approximately 16% of never-homeless youth dropped out of high school. Aratani and Cooper (2015) concluded that repeated episodes of homelessness more than double the likelihood that a given student will drop out of high school.

**Psychopathology.** In addition to difficulties in school, UHY are at increased risk for psychopathology compared to youth who are not homeless. In conducting a review of the literature regarding the prevalence of psychiatric disorders among homeless youth, Hodgson, Shelton, van den Bree, and Los (2013) sought to clarify relationships between homelessness and mental illness. After reviewing 46 cross-sectional and longitudinal research studies from the United States, Canada, and Australia, the authors concluded that in most studies, psychopathology was found to precede homelessness, although in some cases homelessness increased the risk of psychopathology (e.g., substance abuse, PTSD, and depression). The presence of psychopathology was also found to prolong the episode of homelessness, with substance abuse and externalizing disorders leading to the highest risk of lengthy episodes of
homelessness. However, none of the studies included in this review of the literature included UHY, and it is unclear whether this general pattern is representative of homeless youth who do not remain with their families.

Buckner, Bassuk, Weinreb, and Brooks (1999) sought to determine how youth homelessness impacts mental health status. Participants were 80 homeless school-age children (mean age = 9 years) and 148 housed children in a comparison group. The homeless sample was 49% female, with 26% of participants identifying as white, 21% African American, 45% Hispanic/Puerto Rican, and 8% other race/ethnicity. Using an unmatched case-control design, the authors compared sheltered homeless youth who remained with their families and housed, low-income youth. The Child Behavior Checklist (CBCL) was used to measure emotional and behavioral problems; the Children’s Depression Inventory (CDI) was used to assess self-reported depressive symptoms; and the Revised Children’s Manifest Anxiety Scale (RCMAS) was used to assess self-reported anxiety symptoms. Results indicated that homeless children had significantly higher CBCL internalizing scores compared to housed children ($t[208]=3.41$, $p<.001$), with 47% of homeless children scoring above the clinical cutoff score compared to 21% of housed children ($z=5.82$, $p<.001$). There were no statistically significant differences between homeless and housed children on the CDI or RCMAS, and the authors reported that the length of time that children were homeless did not have an impact on mental health problems. However, it is important to note that the control group of housed youth included in this study was unmatched, and participants were from one urban area only. Additionally, due to the relatively young age of participants, it is unclear whether these results can be generalized to an adolescent homeless population, particularly adolescents that do not remain with their families.
Whitbeck, Hoyt, Johnson, and Chen (2007) similarly investigated psychopathology among homeless youth, focusing on the prevalence of posttraumatic stress disorder (PTSD). Participants were 428 homeless and runaway adolescents between the ages of 16 and 19 (mean age = 17.4 years). The sample was 56% female; 15% of the sample identified as being in the LGBTQ population. In regard to ethnicity, the sample was 59% European American, 22% African American, 5% Hispanic, and 14% other racial/ethnic group. The University of Michigan Composite International Diagnostic Interview (UM-CIDI) structured interview protocol was used to indicate the presence of a major depressive episode, PTSD, and substance abuse based on diagnostic criteria from the DSM-III. Results indicated that 35% of the sample met lifetime criteria for PTSD, with 16% of the sample meeting 12-month criteria for the same disorder. PTSD was found to be comorbid with major depressive disorder and substance abuse for 48% and 44% of the sample, respectively. Whitbeck and colleagues (2007) concluded that homeless adolescents are at high risk for experiencing PTSD and other mental health disorders after becoming homeless. However, because the authors did not compare the homeless youth to housed youth, it cannot be determined how much greater the risk for PTSD is for homeless youth compared to those who are not homeless.

Felitti and colleagues (1998) sought to determine the relationship between childhood abuse and trauma and later functioning. Specifically, the authors administered the ACE questionnaire to 8,506 individuals between the ages of 19 and 92. The sample was 52% female and 79% white, with no other demographic information provided. Using adjusted odds ratios, Felitti et al. (1998) reported that individuals who reported experiencing four or more adverse childhood experiences were at 12 times the risk for suicide, 4.6 times the risk for depression, and 4.7 times the risk for substance use compared to individuals who had not experienced any ACEs.
Thus, the authors conclude that experiencing trauma, abuse, or neglect in childhood places an individual at a significantly higher risk of psychopathology later in life. Although this study did not focus on the experiences of homeless adolescents, Herman et al. (1997) noted that homeless individuals have often experienced a number of ACEs prior to becoming homeless. Thus, these results are likely still applicable to many homeless youth due to their history of abuse and trauma during childhood.

Although research on the relationship between adolescent homelessness and psychopathology is still limited, the existing literature suggests that individuals who are homeless are at increased risk of psychopathology compared to those who are housed. Specifically, homeless youth are at increased risk of internalizing symptomology (Buckner et al., 1999) and mental health disorders including PTSD, major depressive disorder, and substance abuse (Whitbeck et al., 2007). Furthermore, individuals who have been exposed to trauma, abuse, and neglect are at increased risk for negative outcomes including suicidality, depression, and substance abuse (Felitti et al., 1999). Overall, homeless youth are at increased risk for psychopathology compared to youth who are housed, although which comes first is not always clear.

**Mental wellness.** In comparison to a psychopathology-focused model of mental health, the dual factor model of mental health conceptualizes mental wellness and mental illness as two separate but related constructs, rather than opposite ends of a spectrum (Greenspoon & Saklofske, 2001). Children’s mental wellness deserves consideration due to its tendency to buffer youth from potentially harmful stressors (Huebner, Suldo, Smith & McKnight, 2004) and its ability to build positive qualities in individuals and improve overall quality of life (Seligman &
Csikszentmihalyi, 2000). In addition to outcomes related to mental illness, homelessness can also impact mental wellness outcomes such as life satisfaction, hope/optimism, and coping skills.

**Life satisfaction.** One indicator of mental wellness is life satisfaction, which is defined as a positive, global evaluation of one’s life and is based on each individual’s personal conceptualization of what a good life is (Diener, 1984). Life satisfaction is a commonly-used indicator of well-being, particularly within the dual-factor model of mental health, due to its relative stability over time (Suldo, Riley & Shaffer, 2006). Among youth, life satisfaction is associated with a variety of positive outcomes, including experiencing fewer externalizing and internalizing behavior problems as well as high emotional, social, and academic self-efficacy (Suldo & Heubner, 2006).

As noted by Altena, Brilleslijper-Kater, and Wolf (2010), there are few studies to date that have investigated quality of life among homeless adults, children, and adolescents. One research project conducted by Biswas-Diener & Diener (2006) studied subjective well-being and life satisfaction among homeless individuals living on the west coast of the United States. Participants were homeless adults in California and Oregon with a mean age of 40.7 years. The sample was 24% female and 49% Caucasian. The Satisfaction with Life Scale (SWLS) was used to assess life satisfaction. Scores on the SWLS range from 5-35, with a score of 5-19 being negative, 20 being neutral, and 21-35 being positive. On average, homeless adults in Oregon had an average life satisfaction score of 17.27, and homeless adults in California had an average life satisfaction score of 14.12. Both of these average scores are considered to be low levels of life satisfaction. The authors thus concluded that homeless adults experience low life satisfaction and hypothesized this may be due to a lack of material resources such as food and housing. However, because this study included homeless adults only, it is unclear whether homeless adolescents,
and specifically unaccompanied homeless adolescents, also experience relatively low life satisfaction.

To date, the only study of quality of life among homeless youth was conducted by Bearsley and Cummins (1999). Participants in this study were 524 adolescents between the ages of 14 and 17 (mean age = 15.8 years). The sample was 57% female, with no other demographic information reported. These researchers divided their sample into four categories: homeless youth, at-risk youth (youth who leave home but subsequently return several times), non-homeless public school students, and non-homeless private school students. For analyses, homeless youth and at-risk youth were combined into one group, with non-homeless public and private school students similarly grouped together. The 16-item Comprehensive Quality of Life Scale for Adolescents was used to assess quality of life. ANOVA results indicated that among homeless youth, the overall quality of life score was significantly lower than the quality of life scores of non-homeless youth (F[2,280]=10.689, p<.001). Thus, the authors concluded that homelessness, as well as being at risk for homelessness, has a significant and negative impact on youth’s perceived quality of life. However, it has yet to be determined whether these results are also representative of unaccompanied homeless adolescents, due to the fact that homeless youth in the study remained with their families.

**Hope/optimism.** Another indicator of mental wellness is hope. Hope, or optimism, is defined as the perception of an individual that he or she is able to meet his or her goals (Snyder et al., 1991). Hope includes two components: having a sense of determination related to meeting the goal, which is known as agency, and having a sense of the ability to plan specific methods for meeting that goal, which is known as pathways (Snyder et al., 1991). Agency and pathways are closely related but are independent. Thus, high or low levels of one aspect of hope does not
necessarily lead to high or low levels of the second aspect. Low levels of hope have been associated with somatic complaints and general psychopathology, as well as increased anxiety (Erickson, Post, & Paige, 1975).

In Canada, Miller, Donahue, Este, and Hofer (2004) studied how hope played a role in coping among homeless youth. The sample included 41 homeless Canadian youth between the ages of 15 and 19; no other demographic information was provided by the authors. In-depth, semi-structured interviews were conducted with each participant, with thematic analysis used to examine the findings. Results showed that themes of optimism and hope for the future, as well as beliefs that their situations would change, were present in most youth’s interviews. Specifically, youth viewed their homelessness as a learning experience that would help them be successful in the future. Many youth also reported having concrete goals about education, career, or family life that they were currently working towards and that provided them with hope for a better future. The authors concluded that because hope and optimism were present among these homeless youth, it is important for interventions for this population to build upon and facilitate these strengths to help youth find employment and educational opportunities. However, because participants in the study were Canadian, it is unclear whether the findings of this study generalize to the lives of homeless youth in America.

In the only study of hope among homeless youth in America, Herth (1998) aimed to identify the role hope plays in the lives of homeless youth and how that hope is maintained. Participants in the study were 60 homeless youth between the ages of 6 and 16 who resided in homeless shelters with their families. The sample was 38% female, and all participants were currently enrolled in school. In regard to ethnicity, the sample was 37% African American, 27% Caucasian, 23% Hispanic, 8% Asian, and 5% American Indian. The researcher conducted semi-
structured interviews and collected drawings from each participant, using methodological triangulation to analyze the data. Results found that the youth described hope as being very important to them. Methods used to maintain hope included feeling connected to others; having a “hope object;” engaging in positive thinking; and experiencing accomplishments, particularly at school. Among adolescents (ages 13-16) specifically, hope tended to focus on a specific goal and what the adolescent was doing to achieve that goal. For adolescents, past accomplishments tended to be the most important way that hope was facilitated and maintained. Although the youth in this sample described the importance of hope in their lives, all participants remained with their families. Thus, these findings cannot be generalized to unaccompanied homeless adolescents who are no longer with their families.

**Coping skills.** Coping is another indicator of mental wellness and is defined as an individual’s response to a threatening, stressful, or otherwise harmful situation (Carver et al., 1989). Coping may be either problem-focused (i.e., directed at changing the source of distress), or emotion-focused (i.e., targeting the emotional response elicited by the situation; Carver et al., 1989). Coping also is typically separated into adaptive strategies such as humor, religion, and positive reframing, and maladaptive strategies such as substance use, denial, and self-blame. The coping strategies used by an individual are thought to influence that person’s growth and development, with positive coping strategies associated with positive growth and development (Phelps & Jarvis, 1994). Successful coping in children and adolescents also is associated with positive outcomes including low levels of stress, high levels of resiliency, and less frequent emotional and behavioral problems (Compas, Malcarne, & Fondacaro, 1988).

Using a case study approach, Carlson, Cacciatore, and Klimek (2012) sought to identify strengths and coping strategies of an unaccompanied refugee minor. The participant was one
male who arrived in the United States at the age of 16 without his family and lived in a foster care placement after arriving in America. Through interviews with the participant, the authors found that religiosity contributed to this individual’s positive attitude and resiliency in the face of the trauma he experienced in his home country. Carlson and colleagues (2012) also found that having a purpose in life was beneficial for this youth and provided him with the motivation to overcome setbacks he faced after arriving in the United States. Thus, the positive coping strategies of meaning in life and spirituality were particularly important for this youth. However, given that this youth was a refugee placed in foster care rather than an UHY, these findings may not be applicable to unsheltered UHY from the United States.

Also outside of the United States, Raghallaigh and Gilligan (2010) studied the coping strategies of unaccompanied, sheltered minors in Ireland. Participants in the research were 32 adolescents between the ages of 14 and 19, with the sample being 56% female. No other demographic information was provided by the authors. Qualitative interviews with each participant were analyzed using open coding methodology. The authors reported a variety of positive coping strategies used by the unaccompanied minors. These included: having a positive outlook and focusing on the positive aspects of a situation, focusing on hope for the future, finding meaning in their current and past circumstances, distracting themselves from negative emotions or distress, and using religion as a way to make meaning and feel connected to others. However, given that the participants of this study were Irish, cultural factors may have influenced the coping strategies identified by these youth and thus limit the applicability of these findings to unaccompanied youth in the United States.

Coping strategies have also been studied among youth in the United States. For example, in order to better understand how UHY successfully transition to adulthood, Lindsey, Kurtz,
Jarvis, Williams, and Nackerud (2000) held focus groups with a small sample of homeless young adults. Participants were 12 unaccompanied homeless individuals from two states between the ages of 18 and 25. The sample was 75% female, 75% Caucasian, and 25% African American. Using an interview protocol and a focus group methodology, researchers asked participants to share the resources and coping strategies that helped them transition to adulthood. The authors reported the following coping strategies: 1) learning new attitudes and behaviors to cope with difficult times; 2) developing self-confidence and learning self-care; 3) identifying goals; 4) learning how to have healthy relationships with others; 5) learning from mistakes and past experiences; and 6) spirituality. Overall, these homeless adolescents used a variety of positive coping strategies in order to overcome the challenges of their circumstances. However, the sample in this study was predominantly female and relatively small, which may limit the generalizability of these results.

Williams, Lindsey, Kurtz, and Jarvis (2001) were similarly interested in learning more about the development of resiliency among homeless youth. Five formerly homeless youth from a larger study were interviewed using semi-structured interviews lasting 50-90 minutes. Participants were two 21-year-old African American women, one 22-year-old Caucasian woman, and two 19-year-old Caucasian women. Interview transcripts were analyzed using open coding methodology, and a multiple case study design was employed. In regard to coping, participants reported engaging in the following negative coping strategies: violence/physical aggression, substance abuse, withdrawing from sources of social support, and suicidal ideation. In regard to positive coping strategies, participants reported the following: religion and spirituality, gratitude, hope for the future, and finding a meaning or purpose in life. The authors noted that participants who reported higher numbers of positive coping strategies tended to be more successful (e.g.,
employed, not arrested) compared to individuals who used more negative coping strategies. However, given the small sample size and lack of male perspectives in this study, it is unclear whether these findings about coping strategies are generalizable to a broader population of homeless adolescents.

Although research on coping strategies among homeless or unaccompanied youth is still limited, the existing literature has identified several common coping strategies used by these populations. Among unaccompanied youth, common coping strategies include hope for the future, religion, distraction, and finding meaning or a purpose in life (Carlson et al., 2012; Raghallaigh & Gilligan, 2010). Among homeless youth, coping strategies include religion/spirituality, a meaning or purpose in life, using social support, engaging in aggressive behavior, using substances, and suicidality (Lindsey et al., 2000; Williams et al., 2001).

In sum, youth who become homeless are at increased risk for many negative outcomes compared to youth who remain housed. Homeless youth are more likely to experience negative school outcomes such as poor attendance (Murphy, 2011), poor standardized test scores (NCHE, 2016), and high drop-out rates (Aratani & Cooper, 2015). In regard to mental illness, when compared to housed youth, homeless youth are at increased risk of psychopathology, including post-traumatic stress disorder, depression, substance abuse, and suicidality (Buckner et al., 1999; Felitti et al., 1999; Whitbeck et al., 2007). The homeless population also tends to have lower life satisfaction compared to housed individuals (Bearsley & Cummins, 1999; Biswas-Diener & Diener, 2006). In regard to coping, homeless youth use a variety of positive and negative coping strategies, including religion, finding a purpose in life, substance abuse, and aggressive behavior (Carlson et al., 2012; Lindsey et al., 2000; Williams et al., 2001). Finally, in spite of their
challenging circumstances, youth who are homeless remain hopeful regarding the future and seek to change their circumstances through their own efforts (Herth, 1998; Miller et al., 2004).

Legislation and Interventions for Homeless Youth

**McKinney-Vento Homeless Assistance Act.** The McKinney-Vento Homeless Assistance Act (42 U.S.C. § 11431 et seq.) was initially created in 1987 as the first and only federal legislation regarding homelessness. It was reauthorized in 2001 as part of the No Child Left Behind Act and amended most recently in 2009 as part of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The McKinney-Vento Act provides several protections for homeless youth in regard to education. Specifically, it requires that homeless students are provided free transportation to and from their school of origin (defined as the school the student attended when they become homeless) regardless of subsequent housing transitions. It further requires that each state identifies a “coordinator” who will review policies and procedures related to homeless students in order to ensure these youth are able to attend school. Each school district is also mandated to appoint a “local education liaison” to educate staff, families, and students of the rights and protections provided by the McKinney Vento Act. Although the Act also requires that schools provide homeless students with referrals to community service providers, it does not make provisions for financial resources to pay for such outside care. This is particularly important given that many homeless youth, and particularly UHY, have limited financial resources.

In spite of the protections provided by the McKinney-Vento Homeless Assistance Act, unaccompanied youth remain particularly vulnerable. This is because many UHY may not realize that they are in fact legally homeless (Aviles de Bradley, 2011; NCHE, 2002; Wynne & Ausikaitis, 2013), particularly if they are living with a friend or in temporary facilities like
motels or campgrounds. Although youth in these situations have a place to stay and thus may not self-identify as homeless, their housing is neither “fixed” nor “regular,” making them legally homeless (Aviles de Bradley, 2011). Furthermore, UHY typically do not understand the rights and protections granted to them under the McKinney-Vento Act (Aviles de Bradley, 2011), and if they are aware of their rights, they may feel too embarrassed or ashamed to seek assistance (Wynne & Ausikaitis, 2013).

**Traditional interventions.** In addition to legislation aimed at protecting homeless youth, there are a variety of traditional interventions that seek to meet their needs. These interventions typically focus on one aspect of care (e.g., mentorship, provision of basic needs, mental health services) rather than taking a multi-component approach to treatment. These interventions are typically provided to youth through community-based agencies and schools, and include drop-in centers, homeless shelters, housing programs, school-based mental health services, and mentoring programs.

**Community-based agencies.** Community-based shelters are one source of interventions for homeless youth. Thompson, Pollio, Constanstine, and Von Nebbitt (2002) examined the effectiveness of short-term shelter services for UHY compared to long-term services. Participants were 421 homeless youth from four states, 368 of whom used short-term shelters and 54 of whom used long-term services. Long-term services were not described by the authors. Youth using short-term shelters were on average 14.7 years old, with the sample being 61% female and 73% white. Youth using long-term services were on average 15.3 years old, with the sample being 11% female and 60% white. A quasi-experimental design with an active control group was employed, with pre-intervention and six-week post-intervention data collected from both groups. Data were collected through brief outcome interviews developed by the researchers.
for the purpose of the study. Outcomes of interest included school suspension rates, employment, sexual activity, and self-esteem. Chi-squared tests and $t$-tests did not indicate any significant differences between short-term shelter services and long-term services on any of the outcome variables, with both groups improving compared to baseline (effect sizes = .28-.42). Thus, the authors concluded that short-term shelters are as effective as long-term treatment, although the characteristics of long-term treatment were not described. Additionally, the authors noted that there were significant gender and age differences between the shelter sample and the long-term services sample, which impacts generalizability of these findings. Finally, because shelter services were not compared to a no-treatment control group, it is not clear how shelter services, either short-term or long-term, compare to a lack of treatment.

In addition to short-term shelters, drop-in centers may also be used to provide community-based services to homeless youth. Research conducted by Baer, Garrett, Beadnell, Wells, and Peterson (2007) examined the effect of services provided at a drop-in center for homeless youth. Specifically, the authors were interested in whether a brief motivational intervention provided at the center was effective in reducing substance use and increasing service utilization among homeless adolescents using the center’s services. The intervention was provided for four sessions over four weeks, with sessions lasting between 17-32 minutes. Youth chose from 13 possible topics related to substance use, and counselors provided them with feedback regarding how their behaviors aligned with local and national norms while guiding the youth through the exercises prescribed in the intervention workbook. Participants were 117 homeless adolescents aged 14-19 (mean age = 17.9 years), with 56% of the sample being female. In regard to ethnicity, the sample was 58% Caucasian, 19% multiracial, 9% Native American, 8% African American, 4% Hispanic/Latino, and 2% Asian. All participants reported a history of
alcohol and/or drug use prior to beginning the intervention. Participants were randomly assigned to the brief motivational intervention or treatment-as-usual at the drop-in center. Substance use data were collected from participants’ self-report of substance use over the last 30 days, and sign-in sheets from the drop-in center were used to assess service utilization. Data were collected at baseline, one month after treatment, and three months after treatment.

Results indicated that there were no significant treatment effects in regard to drug or alcohol use. However, the treatment group was found to experience increased service utilization compared to the control group at one-month follow-up only (Cohen’s $f^2 = .03$). Thus, the authors concluded that after three months there were no significant, lasting effects of the intervention on homeless adolescents’ substance use or service utilization. It is important to note, however, that not all youth who participated in the study completed all four intervention sessions, with 40% of the sample completing only one or two sessions. Additionally, it is unclear whether participants in this study were unaccompanied. Overall, it may be that greater treatment exposure or a longer intervention period would have a different impact on homeless adolescent’s service utilization and substance use.

Another community-based service that may be provided to homeless youth is housing. Kisely, Parker, Campbell, Karabanow, Hughes, and Gahagan (2008) investigated the impact of stable housing on the health of homeless adolescents in Canada. Participants were 45 Canadian adolescents between the ages of 16-25 (mean age = 19.8 years). The sample was 68% female; no information regarding the race/ethnicity of the sample was provided. Adolescents in the control condition ($n = 20$) received case management services focused on education and job placement, while adolescents in the intervention condition ($n = 15$) received the same case management services and were also provided with stable, semi-independent housing. The Mini International
Neuropsychiatric Interview (MINI), the General Health Questionnaire 12, the Alcohol Use Disorders Identification Test (AUDIT), and the Medical Outcomes Survey Short Form were used to assess participants’ health. Results of chi-squared tests indicated that adolescents receiving the stable housing intervention reported higher general health levels on the Medical Outcomes Survey Short Form ($\chi^2 = 13.70, p<.001$). Participants in the intervention condition also reported fewer substance use disorders as indicated by the MINI ($\chi^2 = 4.32, p<.05$). There were no significant differences between groups on the AUDIT or the General Health Questionnaire 12.

The authors concluded that stable housing has a positive impact on homeless adolescents’ health over and above case management services; however, because a control group receiving no services was not included, it is unclear whether stable housing is the most important component of an intervention for homeless adolescents. Additionally, given that all participants resided in Canada, cultural factors may limit the generalizability of these findings to homeless adolescents in the United States.

**School-based services and mentoring.** Schools are another setting in which homeless adolescents are provided with services. In a review of the literature, Toro, Dworsky, and Fowler (2007) noted the lack of empirical research on school-based interventions for homeless youth. These authors suggested that school-based interventions should include mental health interventions and, for homeless youth who remain with their families, intervention supports for parents as well. Additional, Toro et al. (2007) recommended the use of positive behavioral supports in schools as a means for engaging and supporting homeless students who remain in schools.

Mentoring, which may take place in the school environment, is another intervention that has been used with homeless children and adolescents. Mentoring is often identified by homeless
youth as being meaningful and beneficial for their success. For instance, Kurtz, Lindsey, Jarvis, and Nackerud (2000) sought to determine how runaway and homeless youth successfully transitioned into adulthood. Participants in their study included homeless youth aged 18-25 from two states who participated in phenomenological interviews. The sample was 75% female, 75% Caucasian, and 25% African American. Results indicated that homeless youth perceived that help received from others was crucial in facilitating their success. Specifically, they described that contact with caring adults who set boundaries and held the youth accountable were especially important to them. They identified adults within their families as helpful but noted that professionals, such as social workers and teachers, also played a meaningful role in their success. Although these relationships with caring adults were not formal mentoring relationships, the findings described by Kurtz and colleagues (2000) highlight the role educators can play in helping homeless adolescents find success.

Similarly, Aviles de Bradley (2011) conducted qualitative interviews with unaccompanied homeless high school students in order to better understand their experiences in school. Participants in the study were six African-American high school students in Chicago; no information regarding participants’ age or gender was provided. After analyzing interview transcripts, one theme identified by the researcher was the importance of caring adults in the lives of these homeless adolescents. Youth in this study noted that they lacked consistent, supportive adults in their lives, although they all indicated a desire to have close, meaningful relationships with adults. Although the generalizability of these results is limited given the lack of diversity in the sample, these findings also suggest the importance of formal and informal mentoring relationships between adults and homeless youth.
In comparison to the studies described above, to date, only one formal study has been conducted to examine the impact of a mentoring program on homeless adolescents. Bartle-Haring, Slesnick, Collins, Erdem, and Beuttnner (2012) were interested in whether the mentoring program they studied impacted homeless youths’ substance abuse and internalizing behaviors. Participants were 90 homeless adolescents accessing a drop-in center for services, all of whom were receiving treatment for substance abuse. Participants were aged 14-22 (mean age = 17.5 years), with 48 participants in the treatment group and 42 participants in the control group. The sample was 48% female, 54% white, 29% Hispanic, and 17% Native American, African American, or other racial group. Participants were randomly assigned to the treatment or control group by researchers. The mentoring intervention consisted of 12 sessions (lasting for at least one hour) that focused on setting goals and identifying alternative behaviors to drug use. The Beck Depression Inventory II (BDI-2) was used to assess depressive symptoms; the Youth Self Report (YSR) was used to assess internalizing behaviors; and the Problem Oriented Screening Instrument for Teenagers (POSIT) was used to assess problem consequences associated with substance use. Data were collected at baseline, three-month follow-up, and six-month follow-up. Multi-level modeling was used to analyze the data, and researchers controlled for the number of sessions attended by participants and demographic information including age, race, and gender. Results indicated that mentoring was associated with lower problem consequences of substance use (coefficient = .029, p<.05). However, results also indicated that mentoring was associated with higher levels of internalizing symptoms as measured by the YSR (coefficient = -.059, p<.05). It should be noted that this mentoring intervention consisted of only 12 sessions rather than an ongoing relationship, and session lengths differed across participants. Additionally, researchers did not determine the impact of the mentoring intervention on outcomes such as
quality of life or school performance. However, this intervention provides conditional support for
the use of mentoring with homeless adolescents, particularly those who are experiencing
substance use problems.

In sum, there is limited empirical support for the effectiveness of traditional community-
based and school-based interventions to support homeless youth. Of the interventions studied to
date, only two have been found to improve at least one outcome for homeless youth. Stable
housing has been shown to promote increased general health and decreased substance use
disorders (Kisely et al., 2008). Mentoring has also been supported through qualitative research
(Aviles de Bradley, 2011; Kurtz et al., 2000) and has been found to lower problem consequences
associated with drug use (Bartle-Haring et al., 2012), but mentoring has also been found to
increase internalizing symptomology among homeless adolescents (Bartle-Haring et al., 2012).

Multi-component interventions. In comparison to traditional interventions for homeless
youth provided at school or in the community, multi-component interventions attempt to address
multiple needs common to this population. Multi-component interventions do not focus solely on
one issue, such as substance abuse; rather, these interventions attempt to address basic needs
(e.g., shelter, food), mental health concerns, physical health problems, social/emotional issues,
and substance abuse through a coordinated system of care. As described below, there are several
suggested models for multi-component care for homeless youth and a handful of such
interventions that have been empirically studied.

Proposed models. Proposed models of care for homeless youth are those multi-
component interventions that have been described by researchers but have not yet been
empirically studied. One such model was proposed by McManus and Thompson (2008). These
researchers described the importance of taking a trauma-informed approach when working with
UHY because many UHY have been exposed to trauma either before or since becoming homeless. These authors argued that interventions for homeless youth should target trauma directly because trauma symptoms can inhibit these youth from seeking the necessary supports and gaining the skills needed to successfully transition out of homelessness. McManus and Thompson emphasized that a multi-component intervention for UHY must be culturally component and take into account the unique culture among homeless youth. Their intervention model also promotes the development of self-efficacy and feelings of safety among UHY by developing trust, allowing youth to gain and exercise control over their lives, and increase self-esteem. This model of care is strengths-based and promotes emotional well-being in addition to providing physical safety and meeting basic needs. Of note, the authors do not identify specific evidence-based intervention strategies that would accomplish the goals described above.

Another proposed community-based intervention model was described by McKenzie-Mohr, Coates, and McLeod (2012). Like the model described in McManus and Thompson (2008), this intervention also focuses on providing trauma-informed supports for homeless youth. McKenzie-Mohr and colleagues (2012) stated that interventions for homeless youth will not be effective unless these interventions do more than simply meet youths’ basic needs. Specifically, these authors emphasized that traditional interventions for homeless youth focus on reintegrating youth into society by meeting basic needs and providing job skills and education. However, trauma-informed care goes beyond these services and also focuses on addressing the traumatic experiences of homeless youth in order to empower them and reestablish their sense of control. By receiving a multi-component system of care that includes education, mental health services, shelter, and food security, McKenzie-Mohr and colleagues believe that homeless youth will be better equipped to achieve success.
In comparison to the two community-based models of care described above, Julianelle (2009) described a school-based multi-component intervention for UHY. This author stated that most homeless youth express a desire to go to school and see the value in education, and thus schools must provide supports to enable UHY to attend school and be successful. Julianelle identified seven key principles for supporting UHY in schools. These principles are: 1) ensure that basic needs are met first by coordinating health care, housing, and social services; 2) provide a safe and supportive environment in schools and offer consistent mentorship for students; 3) ensure that the McKinney-Vento Homeless Assistance Act is consistently and fully implemented and that students are aware of their rights; 4) adopt policies and programs that directly support homeless youth, such as waiving fees and offering creative credit recovery options; 5) actively work to re-engage youth in school through dropout prevention programs; 6) improve child welfare policies and practices to prevent youth from becoming unaccompanied; and 7) work in collaboration with community partners to serve these youth. Julianelle’s proposed model focuses on prevention and intervention strategies and highlights the importance of individualizing services based on the needs of each student rather than providing “one size fits all” programs.

**Intervention programs.** Although there have been several proposed multi-component interventions to serve homeless youth, to date few of these interventions have been empirically studied. One such intervention is case management, which involves connecting youth with resources and services based on their needs. Cauce and colleagues (1994) aimed to determine the effectiveness of an intensive case management program called Project Passage on homeless adolescents. Project Passage provided youth with case management services focused on increasing coping skills, reducing risk-taking behavior, and increasing access to needed resources such as housing, vocational training, health care, and mental health services. The
program included assessment, collaborative treatment planning with the adolescent, connecting
the adolescent to services, monitoring progress, assisting with self-advocacy, and building a
therapeutic alliance between the case manager and each adolescent. The authors did not indicate
how much contact between case managers and adolescents occurred each week. Participants
were 115 unaccompanied homeless adolescents (mean age = 16.5 years). The sample was 59%
white, 22% African American, 8% Hispanic, 7% Native American, and 4% Asian/other ethnic
group. The gender of the sample was not described. Random assignment was used to assign
participants to the intervention (n = 55) or care as usual at a community agency (n = 60). Using a
pre-post control group design, data were collected every three months. Measures used were the
YSR to assess internalizing and externalizing behaviors; the Reynolds Adolescent Depression
Scale to assess depressive symptoms; the Problem Behavior Scale to assess antisocial behaviors;
the Personal Experience Screening Questionnaire to assess substance use; the Rosenberg Self-
Esteem Scale to assess self-esteem; and the Life Domains Scale to assess quality of life. Results
from ANOVA and MANOVA analyses indicated that participants saw improvement on all
outcome measures after three months, with no significant differences between the intervention
and control groups. The authors noted a trend toward significance, and it may be that a larger
sample size would have resulted in a significant effect of the intervention compared to care as
usual. Additionally, the authors also detailed how case managers who provided care as usual
interacted with case managers who provided the intervention, and it is possible that diffusion of
the intervention led to the control group’s comparable improvement.

Another multi-component intervention for homeless youth is the Social Enterprise
Intervention (SEI) developed by Ferguson and Xie (2007). This intervention provides homeless
youth with vocational training, mentoring, and clinical mental health services in order to improve
mental health outcomes, provide social support, and increase service utilization while decreasing engagement in risky behaviors. The program consists of five stages lasting approximately ten months total. Participants in the study were 28 homeless youth aged 18-24 (mean age = 21.4 years) who were recruited from a local homeless agency. Sixteen youth received the SEI program while 12 youth were included in the control group and received treatment as usual. The sample was 19% female, 38% African American, 25% Hispanic, 19% Caucasian, 6% Asian, and 13% other racial/ethnic group. Data were collected at baseline and at one-month follow-up. Measures used were the Reynolds Depression Screening Inventory to assess depressive symptoms; the Rosenberg Self-Esteem Scale to assess self-esteem; the SWLS to assess life satisfaction; and the Adult Self Report to assess internalizing and externalizing behaviors. A structured interview developed by the research team was used to assess mental health and engagement in risky behaviors. Results indicated that the intervention had a significant impact on participants’ life satisfaction (Cohen’s $d = 0.95$, $p<.05$). There were borderline significant improvements in peer support (Cohen’s $d = 0.72$, $p<.10$) and depressive symptoms (Cohen’s $d = 0.59$, $p<.10$). No significant improvements seen in the intervention group on any other outcome variables. Of note, this study used a small sample size and did not randomly assign participants to conditions, which impacts the generalizability of these findings. However, as the authors note, the SEI program highlights the importance of providing multi-component interventions to homeless youth in order to influence a variety of outcomes, including life satisfaction.

A third multi-component intervention for homeless youth was studied by Slesnick, Prestopnik, Meyers, and Glassman (2007). The Community Reinforcement Approach (CRA) intervention is a behaviorally-focused ecological intervention consisting of 12 sessions. The intervention addresses housing, medical care, employment, social support, mental health, and
legal services as determined by a collaboratively developed treatment plan for each youth. CRA uses role play, homework, and skills practice to meet each youth’s goals. Participants in a study examining the effect of CRA were 180 homeless adolescents living on the street aged 14-22 (mean age = 19.2 years). The sample was 34% female and 41% Anglo, 30% Hispanic, 12% multiracial, 3% African American, 13% Native American, and 1% Asian. Random assignment was used to assign participants to the intervention (n = 96) or treatment as usual at a drop-in center (n = 84). Data were collected at baseline and at six-month follow-up. Form 90 was used to assess the quantity and frequency of drug and alcohol use; the National Youth Survey Delinquency scale was used to assess delinquent behavior; the YSR was used to assess internalizing and externalizing behaviors; the Coping Inventory for Stressful Situations was used to assess coping strategies; the BDI-2 was used to assess depressive symptoms; the Health Risk Questionnaire was used to assess HIV knowledge and status; and Shaffer’s Computerized Diagnostic Interview Schedule for Children was used to assess for DSM-IV diagnoses. Results indicated that youth who received the CRA intervention had a statistically significant decrease in drug use compared to treatment as usual [F(1,153)=5.39, p<.05]. The intervention group also had a statistically significant decrease in depressive symptoms [F(1,153)=6.89, p<.05] and in internalizing symptoms [F(1,153)=5.73, p<.05] compared to the control group. There were no significant differences between groups in regard to any other outcomes. Although the intervention did have a statistically significant impact compared to treatment as usual for homeless youth, it should be noted that participants completed a mean of 6.8 intervention sessions out of a total of 12 sessions. Thus, it may be that increased treatment adherence would lead to different results. Nonetheless, CRA has been demonstrated to be an effective multi-component intervention to meet the unique needs of homeless youth.
**Starting Right, Now.** Starting Right, Now (SRN) is another multi-component intervention aimed at meeting the needs of UHY in a large city in the southeastern United States. As described by Randle (2016), SRN provides a broad range of care and support for youth by connecting home-, school-, and community-based services. The program is funded entirely through private and public grants as well as private donations. Students are referred to the SRN program by school personnel and undergo an interview process at their schools before being accepted into the program. Students are accepted to the program based on the decision of the program director regarding whether she feels the students would be successful in SRN, with less than half of all applicants accepted into the program. Another factor impacting a student’s acceptance into SRN is whether they have other housing options available to them, such as living with another family member. Once accepted into SRN, each student is provided with housing (shared with other students in the program), access to mental and physical health care services, and other individualized support services based on their unique needs. Each SRN participant is also matched with a trained adult mentor, with whom they are in frequent contact. The program provides additional supports as well, including social events, personal computers, emotional intelligence training, leadership skills programs (e.g., Dale Carnegie training), public speaking training, mindfulness training, academic tutoring, and assistance applying to and obtaining financial support for college. Students are assisted in finding a part-time job through various community businesses and organizations that support the work of SRN. Students who contract with SRN must meet the following requirements to remain in the program: attending school regularly, working a 20-hour per week part time job, contributing a portion of their earnings to the SRN household, earning grades of C or above in all classes, submitting to random drug
testing, and attending all mandatory SRN meetings and trainings. The program has served approximately 100 youth since its inception in 2009.

To date, SRN staff members have analyzed pre-post data on students’ GPA and absenteeism, both of which support the effectiveness of the program (Randle, 2016). Additionally, Randle (2016) conducted a qualitative analysis to determine how participants perceive that their lives changed as a result of being in the SRN program. Participants in the study were nine SRN students aged 17-20. The sample was 44% female and 44% European American, 33% Hispanic/Latino, and 22% African American. All participants had been involved in the SRN program for at least one year prior to participating in the study. Using unstructured interviews and thematic analysis, Randle (2016) identified several main themes representing the effect of SRN on participants’ lives. The first theme, “always there on my side,” described the importance of the support and mentorship students received from SRN staff and their mentors. The second theme, “now my goals seem a lot more achievable,” noted participants’ increased hope and direction in regard to achieving their personal goals. Theme three, “didn’t have to worry as much,” showed that participants were less worried about having their basic needs met, and theme four, “you learn to trust,” showed that participants felt able to trust adults and ask for help when they needed it. Theme five, “better ways to deal,” noted that SRN taught participants new coping strategies and provided them with the ability to overcome setbacks and obstacles, as demonstrated by theme six, “the point is getting back up.” Theme seven, “better friends,” represented participants’ feelings that they had built stronger friendships through SRN, and theme eight, “pay it forward,” represented the students’ desire to give back to others because of the impact SRN had on their lives. Randle also described an essence of participants’ interviews, which was “lifted.” This essence was identified from participants’ descriptions of how the SRN
program provided them with a higher quality of life and helped them move to a higher personal and educational level as a result of the supports they received. Overall, the author concluded that SRN has a positive impact on many aspects of unaccompanied homeless adolescents’ lives. To date, however, there have been no quantitative studies investigating the impact of SRN on the mental health outcomes of unaccompanied homeless youth.

There are few multi-component interventions that have been empirically studied and shown to positively impact the lives of homeless youth. One such intervention is SEI, which was found to increase life satisfaction compared to treatment as usual at a homeless agency (Ferguson & Xie, 2007). CRA is another effective multi-component intervention for homeless youth and has been shown to decrease drug use, depressive symptoms, and internalizing symptoms among homeless youth compared to treatment as usual at a drop-in center (Slesnick et al., 2007). The SRN program is a third multi-component intervention specifically designed for UHY. Although the intervention’s effectiveness has been supported through qualitative research with participants (Randle, 2016), to date there have been no quantitative examinations of SRN’s impact on participants’ well-being or other outcomes.

**Conclusion**

In general, there is a lack of existing research on homeless youth and in particular on UHY. In regard to school outcomes, UHY are at risk for low academic achievement (NCHE, 2016), poor attendance (Murphy, 2011), and dropping out of high school (Aratani & Cooper, 2015). Homeless individuals have also been found to be at increased risk for psychopathology, with homeless youth experiencing a greater risk of internalizing symptomology (Buckner et al., 1999) and a variety of mental health disorders (Whitbeck et al., 2007). There is also little research on the impact of homelessness on mental wellness outcomes. In regard to quality of life,
homeless youth have been found to have lower scores compared to housed youth (Bearsley & Cummins, 1999). Although hope has been found to be an important influence in the lives of homeless youth, there have been no quantitative or longitudinal investigations regarding how homelessness influences levels of hope and optimism among this population. Similarly, although there have been multiple qualitative studies investigating the use of various coping strategies among homeless and/or unaccompanied youth, there have been no quantitative or longitudinal examinations of how homelessness influences coping strategies used by youth.

There is a similar dearth of research on interventions that can be used to support homeless youth. Traditional interventions provided by schools and community agencies that focus on one specific need or concern have limited effectiveness (Bartle-Haring et al., 2012; Kisely et al., 2008). There are also few existing multi-component interventions for homeless youth that are effective in addressing the broad range of needs present in this population (Ferguson & Xie, 2007; Slesnick et al., 2007). Furthermore, although qualitative research (Randle, 2016) has supported a positive impact of Starting Right, Now, there have been no quantitative or longitudinal examinations of the impact of SRN on student outcomes. Thus, further examination of promising programs like SRN is needed to determine the most effective ways to provide intervention to UHY. The current study contributes to the limited intervention research for this population by examining the longitudinal impact of the SRN program on participants’ well-being. The current study also contributes to the currently limited understanding of life satisfaction, hope, and coping strategies among homeless youth, and specifically unaccompanied homeless youth.
Chapter Three: Method

This study involved analyses of an existing longitudinal dataset to investigate the impact of Starting Right, Now (SRN) on participants’ well-being. This chapter provides an overview of the study’s participants and the process used to identify and recruit participants. Next, data collection procedures, including information regarding the measures utilized, are delineated. Finally, statistical analyses of the current study are discussed.

Participants

The dataset analyzed in the current study was existing data from a larger research study examining the impact of SRN on students’ psychopathology, well-being, and school engagement. Specifically, two subsets of the larger dataset were analyzed in the current study to focus on the program’s impact on student well-being. The first dataset (Sample A) consists of two waves of data, with Time 1 (baseline) data collected when students entered the SRN program and Time 2 data collected six months later. A total of ten students with complete data at Time 1 and Time 2 were included in Sample A. Sample A was 70% female, with an average age of 17.7 years at the time of entry into SRN. In regard to ethnicity, the final Time 2 sample was 30% Black/African American, 20% White, 30% Hispanic/Latino, and 20% multiracial. Of note, the participants included in the current study were not included in any other study of SRN (e.g., Randle, 2016).

The second dataset (Sample B) consists of three waves of data, with Time 1 (baseline) data collected when students entered the SRN program, Time 2 data collected six months later,
and Time 3 data collected one year after students entered SRN. A total of five students with complete data at Time 1, Time 2, and Time 3 were included in the final dataset to be analyzed in this study. All of the students in Sample B were also included in Sample A. Sample B was 40% female, with an average age of 17.6 years at the time of entry into SRN. In regard to ethnicity, the final Time 3 sample was 20% Black/African American, 20% White, 40% Hispanic/Latino, and 20% multiracial.

All students who were selected to participate in the SRN program were included in recruitment procedures for the current study. Students were excluded from participation if they were not accepted into SRN or if they refused to sign the SRN contract that is required for them to participate in the SRN program. No other exclusionary criteria were used.

In order to recruit students to participate in the current study, potential participants were identified based on their acceptance into the SRN program. At the time of a student’s admission into the program, each potential participant signed a contract with SRN agreeing to the program’s requirements. Immediately following the student’s signature of the contract, the SRN director provided the student with a recruitment flyer (Appendix A) and provided the student with a telephone with which to contact the primary investigator, Dr. Linda Raffaele Mendez, if they wished to participate. The student was then provided with information about the study and was read informed consent (Appendix B) and/or assent documents (Appendix C) according to the script developed by the research team. After all student questions were answered, each student then verbally indicated to the PI whether he or she was willing to participate in the current study.

Overall, a total of sixteen students were recruited for participation in the current study. Of those students, fourteen provided verbal consent/assent to participate. Complete Time 1 data
were collected from all fourteen participants. The final Time 1 sample was 79% female, with an average age of 17.6 years at time of entry into the program. In regard to ethnicity, the final Time 1 sample was 50% Black/African American, 14% White, 21% Hispanic/Latino, and 14% multiracial.

Six months after his/her entry into SRN, at Time 2, all fourteen students who participated in Time 1 data collection were sought out for participation. Of those students, four left the SRN program for various reasons (e.g., moving out of the area served by SRN, choosing not to continue with the program in college) and therefore do not have complete Time 2 or Time 3 data. The final Time 2 sample \((n = 10)\) was 70% female, with an average age of 17.7 years at the time of entry into the program. In regard to ethnicity, the final Time 2 sample was 30% Black/African American, 20% White, 30% Hispanic/Latino, and 20% multiracial. The final Time 2 sample will be referred to as Sample A in the current study. The demographic features of the sample are shown in Table 1.
Table 1

Sample A Demographic Features

<table>
<thead>
<tr>
<th>Demographics Variable</th>
<th>Total Sample (N = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
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<tr>
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<td>African-American</td>
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<tr>
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<tr>
<td>Multi-racial</td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

Note: *Grade reported is at time of entry into the Starting Right, Now program.

One year after baseline data were collected, at Time 3, ten students in Sample A who participated in Time 1 and Time 2 data collection were sought out for participation. Of those ten students, five left the SRN program after graduating from high school and therefore do not have complete Time 3 data. A total of five students with complete data at Time 1, Time 2, and Time 3 were included in Sample B to be analyzed in this study. Sample B was 40% female, with an average age of 17.6 years at the time of entry into the program. In regard to ethnicity, the final sample was 20% Black/African American, 20% White, 40% Hispanic/Latino, and 20% multiracial. The demographic features of this sample are displayed in Table 2.
Table 2

*Sample B Demographic Features*

<table>
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</tr>
</thead>
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<td>Grade*</td>
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<tr>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
<td></td>
<td>African-American</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
</tr>
<tr>
<td></td>
<td>Multi-racial</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Note: *Grade reported is at time of entry into the Starting Right, Now program.*

Participant 1 is a multiracial female who entered SRN at age 18 (grade 12). She reported experiencing six Adverse Childhood Experiences (ACEs) prior to age 18: emotional abuse, physical abuse, sexual abuse, physical neglect, parental divorce, family substance abuse, and family mental illness.

Participant 2 is a Hispanic/Latino male who entered SRN at age 16 (grade 11). He reported experiencing two ACEs prior to age 18: emotional abuse and parental divorce.

Participant 3 is a Hispanic/Latino male who entered SRN at age 18 (grade 12). He reported experiencing seven ACEs prior to age 18: emotional abuse, physical abuse, emotional neglect, parental divorce, family substance abuse, family mental illness, and family incarceration.
Participant 4 is an African American male who entered SRN at age 19 (grade 12). He reported experiencing seven ACEs prior to age 18: emotional abuse, physical abuse, emotional neglect, physical neglect, parental divorce, family substance abuse, and family incarceration.

Participant 5 is a white female who entered SRN at age 17 (grade 12). She reported experiencing seven ACEs prior to age 18: emotional abuse, emotional neglect, physical neglect, parental divorce, domestic violence, family substance abuse, and family mental illness.

Participant 6 is a multiracial female who entered SRN at age 17 (grade 12). She reported experiencing five ACEs prior to age 18: emotional neglect, physical neglect, family substance abuse, family mental illness, and family incarceration.

Participant 7 is a white female who entered SRN at age 17 (grade 12). She reported experiencing eight ACEs prior to age 18: emotional abuse, physical abuse, emotional neglect, physical neglect, parental divorce, family substance abuse, family mental illness, and family incarceration.

Participant 8 is a Hispanic/Latino female who entered SRN at age 18 (grade 12). She reported experiencing four ACEs prior to age 18: sexual abuse, parental divorce, domestic violence, and family substance abuse.

Participant 9 is an African American female who entered SRN at age 19 (grade 12). She reported experiencing one ACE prior to age 18: parental divorce.

Participant 10 is an African American female who entered SRN at age 18 (grade 12). She reported experiencing nine ACEs prior to age 18: emotional abuse, physical abuse, emotional neglect, physical neglect, parental divorce, domestic violence, family substance abuse, family mental illness, and family incarceration.
The following participants were not included in Sample B analyses due to their decision to exit SRN after graduating high school: Participant 5, Participant 6, Participant 8, Participant 9, and Participant 10. All participants who did not remain in the study were females who entered SRN in grade 12. They did not report any common ACEs.

**Data Collection Procedures**

Data were collected from all participants at three separate time points. Time 1 data were collected on the day that participants were accepted into the SRN program but before they had entered the SRN house for the first time. Time 2 data were collected approximately six months after each participant entered the program, and Time 3 data were collected approximately one year after each participant entered the program. Time 1 data were collected from December 2015 to January 2017; Time 2 data were collected from June 2016 to July 2017; and Time 3 data were collected from January to June 2017.

Approval from the USF Institutional Review Board was obtained prior to data collection (Pro00023832; Appendix D). Verbal consent was utilized for this study, due to time limitations. Specifically, Time 1 data were to be collected after participants were accepted into SRN but before they entered the SRN house for the first time, which occurred on the same day. Therefore, students interested in participating in the current study called the primary investigator to learn more about the study and gave verbal consent if they chose to participate. For participants under the age of 18, parental consent was waived due to the research team’s inability to identify and locate the parents or legal guardians of these students who are UHY and therefore were not in the custody of a legal guardian at the time of their acceptance into SRN.

At Time 1, data were collected from students utilizing pen-and-paper surveys due to limited internet access at the participants’ schools, where surveys were taken. After consent was
obtained by the primary investigator, the SRN director provided the student with a questionnaire packet. When the student completed the packet, the SRN director placed the packet in a sealed envelope and notified the primary investigator. The author of this dissertation collected the data packet and then scored and entered the data into the database.

At Time 2, data were collected using an online survey administered through the Survey Monkey platform. Each student completed the online survey at the SRN office on a private computer while being monitored by an SRN staff member. Measures were presented in a counterbalanced order to limit any possible order effects. Data were then scored and entered into the database by the author of this dissertation and another member of the graduate student research team.

At Time 3, data were similarly collected using an online survey administered through Survey Monkey. Again, each student completed the online survey at the SRN office on a private computer while being monitored by an SRN staff member. Measures were presented in a counterbalanced order to limit any possible order effects. Data were then scored and entered into the database by the author of this dissertation or another member of the graduate student research team. The author of this dissertation was directly involved in data collection and coordinated all online data collection procedures.

**Measures**

**Demographics form.** The demographics questionnaire administered at Time 1 (Appendix E) included items regarding participant age, grade level, gender, and race/ethnicity.

**Adult Hope Scale** (AHS; Snyder et al., 1991). The AHS (Appendix F) is a twelve-item measure of hope among adults. Specifically, the measure is appropriate for individuals aged 15 and older. The measure consists of two subscales: agency, which assesses an individual’s
determination in regard to goals, and pathways, which assesses an individual’s appraisal of their ability to overcome obstacles and reach those goals. Each subscale contains four items; the remaining four items on the scale are filler items that are not scored. The AHS asks individuals to indicate the extent to which they agree with each statement (e.g., “I energetically pursue my goals.” “I can think of many ways to get out of a jam.”) on an eight-point Likert scale ranging from 1 (definitely false) to 8 (definitely true). An individual’s score is calculated by summing all eight scored items. Subscale scores are calculated by summing the four items included on a given subscale. Higher scores on the AHS indicate higher levels of hope.

With regard to internal consistency, Cronbach’s alpha for the total score ranged from .74 to .84 (Snyder et al., 1991). For the agency subscale, Cronbach’s alpha ranged from .71 to .76, and Cronbach’s alphas for the pathways subscale ranged from .63 to .80 (Snyder et al., 1991). Further, Snyder and colleagues (1991) reported a three-week test-retest reliability coefficient of \( r = .85 \), an eight-week test-retest reliability coefficient of \( r = .73 \), and a ten-week test retest reliability coefficient of \( r = .76 \), all of which are considered acceptable.

The AHS has adequate construct validity \( (r = .60; \) Snyder et al., 1991) when compared to another measure of optimism (Life Orientation Test; Scheier & Carver, 1985). As reported by Snyder and colleagues, the AHS also has adequate convergent validity with the Hopelessness Scale \( (r = -.51; \) Beck, Weissman, Lester, and Trexler, 1974). The AHS was completed by participants in the current study at Time 1, Time 2, and Time 3. Cronbach’s alpha was calculated for all participants’ AHS scores from each wave of the study to determine the reliability of the data collected.

**Brief COPE** (B-COPE; Carver, 1997). The B-COPE (Appendix G) is a 28-item measure of coping that was developed as a brief form of the 60-item COPE inventory (Carver, Scheier, &
Weintraub, 1989). The COPE inventory is appropriate for use with adolescents (Phelps & Jarvis, 1994) and adults (Carver et al., 1989). The B-COPE asks individuals to indicate the extent to which they utilize various positive and negative coping strategies when faced with a stressful event. Specifically, for each item presented, individuals indicate the extent to which they utilize a given strategy on a four-point Likert scale ranging from 1 (I don’t do this at all) to 4 (I do this a lot). The B-COPE consists of 14 subgroups that include two items each; each subgroup represents a specific coping strategy (e.g., positive reframing, humor, denial, substance use). Because the B-COPE is intended to be modified for research purposes (Carver, 1997), for the purposes of the current study these subgroups were organized more broadly into an adaptive coping subscale and a maladaptive coping subscale, which include 16 and 12 items, respectively. An individual’s score on each subscale is calculated by summing responses to each item on that subscale. Higher scores on the B-COPE indicate more frequent use of that type of coping strategy.

In regard to reliability, Carver (1997) reported that for each subscale, Cronbach’s alpha ranged from .50 to .90, indicating adequate internal consistency. Factor analysis revealed similar factor loadings with the COPE inventory (Carver, 1997), which separates coping strategies into maladaptive and adaptive groups. When used with adults, one-year test-retest reliability coefficients for the B-COPE were adequate (r = .58 to r = .72; Cooper, Katona, & Livingston, 2008). The B-COPE was completed by participants in the current study at Time 1, Time 2, and Time 3. Cronbach’s alpha was calculated for all participants’ B-COPE subscale scores from each wave of the study to determine the reliability of the data collected.

Students’ Life Satisfaction Scale (SLSS; Huebner, 1991). The SLSS (Appendix H) is a seven-item measure of students’ global life satisfaction intended to be used with students in
grades three and above. The SLSS asks students to rate their agreement with statements about their life (e.g., “My life is going well.” “I have what I want in life.”) on a six-point Likert scale from 1 (strongly disagree) to 6 (strongly agree). Two of the items on the SLSS must be reverse-scored before a mean score can be obtained. A student’s mean score is calculated by adding all responses and dividing the sum by the number of items to determine an average overall life satisfaction score. Higher average scores are indicative of higher levels of life satisfaction.

Item-total correlations on the SLSS are adequate and range from $r = .46$ to $r = .72$ (Huebner, 1991). Huebner (1991) reported a two-week test-retest reliability coefficient of $r = .74$, and Gilman and Huebner (1997) reported a test-retest reliability coefficient of $r = .64$ over a four-week period, both of which are considered acceptable. Additionally, Huebner, Funk and Gilman (2000) found that the SLSS had a one-year test-retest reliability of $r = .53$. The SLSS has adequate internal consistency as identified by Huebner (1991; alpha = .82) and Gilman and Huebner (1997; alpha = .84). According to Dew and Huebner (1994), the SLSS has adequate internal consistency (alpha = .86) when used with adolescents. As reported by Huebner (1991), the SLSS has appropriate construct validity with the Piers-Harris happiness subscale ($r = .52$) and the Andrews-Withey life satisfaction item ($r = .62$). Among adolescents, the SLSS also has acceptable construct validity ($r = .58$) when compared to the Perceived Life Satisfaction Scale (Dew & Huebner, 1994). The SLSS was completed by students in the current study at Time 1, Time 2, and Time 3. Cronbach’s alpha was calculated using participants’ SLSS scores from each wave of the study to determine the reliability of the data collected.

**Data Analysis**

The longitudinal samples examined in the current study included ten unique participants, with ten participants in Sample A and five participants in Sample B. Prior to all analyses,
Cronbach’s alpha was calculated for participants’ scores on the AHS, B-COPE, and SLSS at each time point to determine the reliability of the data collected.

Due to the limited number of data points available for each participant, visual analysis utilizing graphical displays was not utilized in the current study. Rather, descriptive analysis were conducted using tables displaying data for each participant at each time point.

In order to answer the research questions of the current study, a Wilcoxon Signed-Rank Test was used to obtain inferential statistics. The Wilcoxon Signed-Rank Test is a nonparametric statistical test utilized with small sample sizes that does not assume normality of data. Nonparametric tests do, however, assume that data are continuous and independent. This test was used to determine if there was a statistically significant difference between baseline (Time 1) data and Time 2 data for all participants in Sample A, on a given outcome. The test was based on data from participants who showed either a positive or a negative change, meaning that those with no change over time were not included in the analyses. The Wilcoxon Signed-Rank Test statistic \((W^+, W^-)\) was calculated as follows. First, Time 1 scores were subtracted from Time 2 scores on a given outcome measure in order to calculate a difference score. Second, the absolute values of the difference scores were ordered from lowest to highest. Then each absolute value was assigned a rank from 1 to \(n\), with 1 indicating the lowest score and \(n\) indicated the highest score. Each rank was then assigned either a positive or a negative sign matching the sign of the difference score. \(W^+\) was calculated by summing all positive ranks and \(W^-\) was calculated by summing all negative ranks. Finally, \(W^+\) and \(W^-\) scores were compared to critical values in order to determine statistical significance.

In order to obtain an effect size estimate for this difference, the matched-pairs rank-biserial correlation was utilized. The matched-pairs rank-biserial correlation is described by
Kerby (2014) as the appropriate effect size estimate for use with the Wilcoxon Signed-Rank Test. The correlation was calculated as followed. First, the total rank sum was calculated by adding together all ranks assigned. Then, the proportion of positive ranks (e.g., from 0 to 1) was calculated by dividing $W_+$ by the total rank sum. Next, the proportion of negative ranks (e.g., from 0 to 1) was calculated by dividing $W_-$ by the total rank sum. Finally, the correlation value was calculated by subtracting the proportion of negative ranks from the proportion of positive ranks. The resulting correlation provides an effect size estimate for the difference, which can be interpreted as the difference between the proportion of positive change evidence and the proportion of negative change evidence, such that a value of 1 would indicate all change was positive, a value of -1 would indicate all change was negative, and a value of 0 would indicate no tendency for positive or negative change.

The test was also used to determine if there is a statistically significant difference between Time 2 and Time 3 data for all participants in Sample B, on a given outcome. Similarly, the Wilcoxon Signed-Rank Test was calculated by first subtracting Time 2 scores from Time 3 scores on a given outcome measure. The absolute values of these difference scores were then ordered from lowest to highest. Each absolute value was assigned a rank of 1 to $n$, with 1 indicating the lowest score and $n$ indicated the highest score. Each rank was assigned either a positive or a negative sign matching the sign of the difference score. $W_+$ was calculated by summing all positive ranks and $W_-$ was calculated by summing all negative ranks. Finally, $W_+$ and $W_-$ scores were compared to critical values in order to determine statistical significance. It should be noted that in order to obtain statistical significant at the .05 level for Sample B analyses, all five participants needed to experience a change in the given outcome variable in the same direction.
In order to obtain an effect size estimate for this difference, the matched-pairs rank-biserial correlation was utilized. The matched-pairs rank-biserial correlation is described by Kerby (2014) as the appropriate effect size estimate for use with the Wilcoxon Signed-Rank Test. The correlation was calculated as followed. First, the total rank sum was calculated by adding together all ranks assigned. Then, the proportion of positive ranks (e.g., from 0 to 1) was calculated by dividing $W_+$ by the total rank sum. Next, the proportion of negative ranks (e.g., from 0 to 1) was calculated by dividing $W_-$ by the total rank sum. Finally, the correlation value was calculated by subtracting the proportion of negative ranks from the proportion of positive ranks. The resulting correlation provides an effect size estimate for the difference.
Chapter Four:

Results

This chapter provides the results of the analyses conducted to address the research questions in the current study. First, reliability statistics are provided for the data utilized in the current study. Then, descriptive analyses of the data are delineated. Finally, results from the nonparametric statistical analyses are summarized and effect sizes of observed differences are described.

Data Screening

The dataset was screened for errors and accuracy by examining the minimum and maximum scores of each variable. No irregular scores were noted during data screening.

Scale Reliability

Prior to analyses, all scales utilized within the study (i.e., AHS, B-COPE, SLSS) were analyzed to determine the internal reliability of each within the sample of students at each time point.

Time 1. At Time 1, for ten participants, the internal consistency (as measured by coefficient alpha) for the AHS agency subscale was 0.62 and for the AHS pathways subscale was 0.66. Coefficient alpha values at Time 1 for the B-COPE subscales were 0.83 and 0.76 for adaptive and maladaptive coping, respectively. The internal consistency of the SLSS at Time 1 was 0.41.

Time 2. At Time 2, for ten participants, the internal consistency (as measured by coefficient alpha) for the AHS agency subscale was 0.68 and for the AHS pathways subscale was
0.88. Coefficient alpha values at Time 2 for the B-COPE subscales were 0.85 and 0.86 for adaptive and maladaptive coping, respectively. The internal consistency of the SLSS at Time 2 was 0.81.

**Time 3.** At Time 3, for five participants, the internal consistency (as measured by coefficient alpha) for the AHS agency subscale was 0.60 and for the AHS pathways subscale was 0.76. Coefficient alpha values at Time 2 for the B-COPE subscales were 0.52 and 0.92 for adaptive and maladaptive coping, respectively. The internal consistency of the SLSS at Time 2 was 0.64.

**Descriptive Analyses**

Due to the limited number of data points available for each participant, visual analysis utilizing graphical displays was not used in the current study. Rather, descriptive analysis were conducted using tables displaying data for each participant at each time point. Table 3 displays each participant’s life satisfaction score at each time point; Table 4 displays each participant’s hope agency score at each time point; Table 5 displays each participant’s hope pathways score at each time point; Table 6 displays each participant’s maladaptive coping score at each time point; and Table 7 displays each participant’s adaptive coping score at each time point.
### Table 3

**Participants’ Life Satisfaction Scores**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.43</td>
<td>3.14</td>
<td>5.00</td>
</tr>
<tr>
<td>2</td>
<td>3.29</td>
<td>4.14</td>
<td>3.29</td>
</tr>
<tr>
<td>3</td>
<td>2.57</td>
<td>5.14</td>
<td>4.00</td>
</tr>
<tr>
<td>4</td>
<td>3.00</td>
<td>4.29</td>
<td>3.71</td>
</tr>
<tr>
<td>5</td>
<td>2.43</td>
<td>2.00</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>3.71</td>
<td>4.00</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>2.29</td>
<td>5.43</td>
<td>3.57</td>
</tr>
<tr>
<td>8</td>
<td>2.71</td>
<td>4.57</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>3.71</td>
<td>3.00</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>3.86</td>
<td>6.00</td>
<td>X</td>
</tr>
</tbody>
</table>

*Note:* X indicates no data available at that time point due to participants exiting the study. Life satisfaction was measured using the Students’ Life Satisfaction Scale and ranges from 1-6, with higher scores indicating higher life satisfaction.

### Table 4

**Participants’ Hope Agency Scores**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
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<td>28</td>
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<td>4</td>
<td>21</td>
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<tr>
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<td>X</td>
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<tr>
<td>6</td>
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<td>27</td>
<td>X</td>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
<td>26</td>
<td>29</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>24</td>
<td>31</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>31</td>
<td>32</td>
<td>X</td>
</tr>
</tbody>
</table>

*Note:* X indicates no data available at that time point due to participants exiting the study. Hope Agency was measured using the Adult Hope Scale and ranges from 4-32, with higher scores indicating higher hope agency.
Table 5

Participants’ Hope Pathways Scores

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>25</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
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<td>32</td>
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<tr>
<td>4</td>
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<td>28</td>
<td>22</td>
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<tr>
<td>5</td>
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<td>25</td>
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<tr>
<td>6</td>
<td>20</td>
<td>21</td>
<td>X</td>
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<tr>
<td>7</td>
<td>24</td>
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<tr>
<td>8</td>
<td>27</td>
<td>32</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>19</td>
<td>28</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>32</td>
<td>32</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: X indicates no data available at that time point due to participants exiting the study. Hope Pathways was measured using the Adult Hope Scale and ranges from 4-32, with higher scores indicating higher hope pathways.
Table 6

Participants’ Maladaptive Coping Scores

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
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<td>23</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>39</td>
<td>36</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>22</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>28</td>
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<td>26</td>
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<tr>
<td>8</td>
<td>30</td>
<td>12</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>24</td>
<td>18</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>24</td>
<td>19</td>
<td>X</td>
</tr>
</tbody>
</table>

*Note:* X indicates no data available at that time point due to participants exiting the study. Maladaptive coping was measured using the Brief COPE and ranges from 12-48, with higher scores indicating higher use of maladaptive coping strategies.
Table 7

Participants’ Adaptive Coping Scores

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1 (Baseline)</th>
<th>Time 2</th>
<th>Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>43</td>
<td>38</td>
<td>43</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>35</td>
<td>49</td>
</tr>
<tr>
<td>3</td>
<td>57</td>
<td>61</td>
<td>38</td>
</tr>
<tr>
<td>4</td>
<td>44</td>
<td>51</td>
<td>40</td>
</tr>
<tr>
<td>5</td>
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<td>X</td>
</tr>
<tr>
<td>6</td>
<td>34</td>
<td>33</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>44</td>
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<tr>
<td>8</td>
<td>46</td>
<td>49</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>48</td>
<td>37</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>52</td>
<td>56</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: X indicates no data available at that time point due to participants exiting the study. Adaptive coping was measured using the Brief COPE and ranges from 16-64, with higher scores indicating higher use of adaptive coping strategies.

As indicated in Table 3 above, almost all participants’ life satisfaction scores were noted to increase from Time 1 to Time 2. Between Time 2 and Time 3, only one participant experienced an increase in life satisfaction scores, with the remaining participants experiencing a decrease in life satisfaction scores.

In regard to hope agency, scores appeared to increase from Time 1 to Time 2; however, hope agency scores appeared to decrease from Time 2 to Time 3, with only one participant experiencing an increase between Time 2 and Time 3. In regard to hope pathways, scores appeared to increase from Time 1 to Time 2. However, hope pathways scores appeared to decrease from Time 2 to Time 3, as no participants experienced a score increase between Time 2 and Time 3.
In regard to maladaptive coping, participants’ scores did not appear to follow a clear trend from Time 1 to Time 2, as some participants experienced an increase in the use of maladaptive coping strategies while others experienced a decrease in the use of maladaptive coping strategies. A similar pattern to scores was noted between Time 2 and Time 3.

Similarly, in regard to adaptive coping, participants’ scores did not appear to follow a clear trend from Time 1 to Time 2, as some participants experienced an increase in the use of adaptive coping strategies while others experienced a decrease in the use of adaptive coping strategies. A similar pattern to scores was noted between Time 2 and Time 3.

**Nonparametric Analyses**

**Sample A.** In order to answer the research questions of the current study, a Wilcoxon Signed-Rank Test was used to obtain inferential statistics. Calculations for each test statistic utilizing Sample A for life satisfaction, hope agency, hope pathways, maladaptive coping, and adaptive coping are presented in Tables 8, 9, 10, 11, and 12, respectively.
Table 8

Wilcoxon Signed-Rank Test for Life Satisfaction (Sample A)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>2.43</td>
<td>3.14</td>
<td>0.71</td>
</tr>
<tr>
<td>2</td>
<td>3.29</td>
<td>4.14</td>
<td>0.85</td>
</tr>
<tr>
<td>3</td>
<td>2.57</td>
<td>5.14</td>
<td>2.57</td>
</tr>
<tr>
<td>4</td>
<td>3.00</td>
<td>4.29</td>
<td>1.29</td>
</tr>
<tr>
<td>5</td>
<td>2.43</td>
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<tr>
<td>6</td>
<td>3.71</td>
<td>4.00</td>
<td>0.29</td>
</tr>
<tr>
<td>7</td>
<td>2.29</td>
<td>5.43</td>
<td>3.14</td>
</tr>
<tr>
<td>8</td>
<td>2.71</td>
<td>4.57</td>
<td>1.86</td>
</tr>
<tr>
<td>9</td>
<td>3.71</td>
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<td>-0.71</td>
</tr>
<tr>
<td>10</td>
<td>3.86</td>
<td>6.00</td>
<td>2.14</td>
</tr>
</tbody>
</table>

Rank Sums: 49.5, 5.5

Note: Total rank sum = 55. \( W_{\text{critical}} = 10 \) at \( \alpha = .05 \)

In regard to life satisfaction, results of the signed-rank test indicated a statistically significant increase in life satisfaction (\( |W_{\text{obtained}}| = 5.5 < |W_{\text{critical}}| = 10, n = 10, p < .05 \)) after six months of participation in SRN. The matched-pairs rank-biserial correlation for life satisfaction is \( r = .80 \).
Table 9

<table>
<thead>
<tr>
<th>Participant</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
<td>26</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>25</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>3</td>
<td>28</td>
<td>32</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
<td>27</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>5</td>
<td>26</td>
<td>25</td>
<td>-1</td>
<td>1.5</td>
</tr>
<tr>
<td>6</td>
<td>22</td>
<td>27</td>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>7</td>
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<tr>
<td>10</td>
<td>31</td>
<td>32</td>
<td>1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Rank Sums: 43.5 1.5

Note: Total rank sum = 45. $W_{critical} = 8$ at $\alpha = .05$

In regard to hope agency, results of the signed-rank test indicated a statistically significant increase in hope agency ($|W_{obtained}| = 1.5 < |W_{critical}| = 8, n = 9, p < .05$) after six months of participation in SRN. The matched-pairs rank-biserial correlation for hope agency is $r = .93$. 
Table 10

Wilcoxon Signed-Rank Test for Hope Pathways (Sample A)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>25</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>21</td>
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<td>5</td>
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<td>31</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>27</td>
<td>32</td>
<td>5</td>
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<tr>
<td>9</td>
<td>19</td>
<td>28</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
</tbody>
</table>

Rank Sums: 36

Note: Total rank sum = 36. $W_{critical} = 5$ at $\alpha=.05$

In regard to hope pathways, results of the signed-rank test indicated a statistically significant increase in hope pathways ($|W_{obtained}| = 0 < |W_{critical}| = 5, n = 8, p <.05$) after six months of participation in SRN. The matched-pairs rank-biserial correlation for hope pathways is $r = 1.0$. 

Table 11

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>19</td>
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<td>18</td>
<td>0</td>
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<tr>
<td>3</td>
<td>15</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>24</td>
<td>23</td>
<td>-1</td>
</tr>
<tr>
<td>5</td>
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<td>18</td>
<td>-6</td>
</tr>
<tr>
<td>10</td>
<td>24</td>
<td>19</td>
<td>-5</td>
</tr>
</tbody>
</table>

Rank Sums: 10 35

Note: Total rank sum = 45. \( W_{\text{critical}} = 8 \) at \( \alpha = .05 \)

In regard to maladaptive coping, results of the signed-rank test indicated no statistically significant change in maladaptive coping (\( |W_{\text{obtained}}| = 10 > |W_{\text{critical}}| = 8, n = 9, p > .05 \) after six months of participation in SRN. The matched-pairs rank-biserial correlation for maladaptive coping is \( r = -0.56 \).
Table 12

Wilcoxon Signed-Rank Test for Adaptive Coping (Sample A)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Time 1</td>
<td>Time 2</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>43</td>
<td>38</td>
<td>-5</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>35</td>
<td>0</td>
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<tr>
<td>3</td>
<td>57</td>
<td>61</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>44</td>
<td>51</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>53</td>
<td>46</td>
<td>-7</td>
</tr>
<tr>
<td>6</td>
<td>34</td>
<td>33</td>
<td>-1</td>
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<tr>
<td>7</td>
<td>44</td>
<td>51</td>
<td>7</td>
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<tr>
<td>8</td>
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<td>37</td>
<td>-9</td>
</tr>
<tr>
<td>10</td>
<td>52</td>
<td>56</td>
<td>4</td>
</tr>
</tbody>
</table>

Rank Sums: 23 22

Note: Total rank sum = 45. \(|W_{critical}| = 8\) at \(\alpha = .05\)

In regard to adaptive coping, results of the signed-rank test indicated no statistically significant change in adaptive coping (\(|W_{obtained}| = 22 > |W_{critical}| = 8, n = 9, p > .05\) after six months of participation in SRN. The matched-pairs rank-biserial correlation for adaptive coping is \(r = 0.03\).

**Sample B.** In order to answer the research questions of the current study, a Wilcoxon Signed-Rank Test was used to obtain inferential statistics. Calculations for each test statistic utilizing Sample B for life satisfaction, hope agency, hope pathways, maladaptive coping, and adaptive coping are presented in Tables 13, 14, 15, 16, and 17, respectively.
Table 13

**Wilcoxon Signed-Rank Test for Life Satisfaction (Sample B)**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 2</td>
<td>Time 3</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>3.14</td>
<td>5.00</td>
<td>1.86</td>
</tr>
<tr>
<td>2</td>
<td>4.14</td>
<td>3.29</td>
<td>-0.85</td>
</tr>
<tr>
<td>3</td>
<td>5.14</td>
<td>4.00</td>
<td>-1.14</td>
</tr>
<tr>
<td>4</td>
<td>4.29</td>
<td>3.71</td>
<td>-0.58</td>
</tr>
<tr>
<td>7</td>
<td>5.43</td>
<td>3.57</td>
<td>-1.86</td>
</tr>
</tbody>
</table>

**Rank Sums:**

| Rank Sums | 4.5       | 10.5     |

**Note:** Total rank sum = 15. \(W_{critical} = 1\) at \(\alpha = .05\)

In regard to life satisfaction, results of the signed-rank test indicated no statistically significant change in life satisfaction (\(|W_{obtained}| = 4.5 > |W_{critical}| = 1, n = 5, p > .05\) from six months to one year of participation in SRN. The matched-pairs rank-biserial correlation for life satisfaction is \(r = -.40\).

Table 14

**Wilcoxon Signed-Rank Test for Hope Agency (Sample B)**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 2</td>
<td>Time 3</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>26</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>19</td>
<td>-6</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>23</td>
<td>-5</td>
</tr>
<tr>
<td>4</td>
<td>27</td>
<td>22</td>
<td>-5</td>
</tr>
<tr>
<td>7</td>
<td>29</td>
<td>27</td>
<td>-2</td>
</tr>
</tbody>
</table>

**Rank Sums:**

| Rank Sums | 1.5       | 13.5     |

**Note:** Total rank sum = 15. \(W_{critical} = 1\) at \(\alpha = .05\)
In regard to hope agency, results of the signed-rank test indicated no statistically significant change in hope agency (\(|W_{obtained}| = 1.5 > |W_{critical}| = 1, n = 5, p > .05\)) from six months to one year of participation in SRN. The matched-pairs rank-biserial correlation for hope agency is \(r = -0.80\).

Table 15

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score Time 2</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 3</td>
<td>Positive</td>
<td>Negative</td>
</tr>
<tr>
<td>1</td>
<td>29</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>23</td>
<td>21</td>
<td>-2</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>16</td>
<td>-16</td>
</tr>
<tr>
<td>4</td>
<td>28</td>
<td>22</td>
<td>-6</td>
</tr>
<tr>
<td>7</td>
<td>31</td>
<td>30</td>
<td>-1</td>
</tr>
</tbody>
</table>

Rank Sums: 10

Note: Total rank sum = 10. \(W_{critical} = 0\) at \(\alpha = .0625\)

In regard to hope pathways, results of the signed-rank test indicated no statistically significant change in hope pathways (\(|W_{obtained}| = 0 < |W_{critical}| = 0, n = 4, p > .05\)) from six months to one year of participation in SRN. The matched-pairs rank-biserial correlation for hope pathways is \(r = -1.0\).
Table 16

**Wilcoxon Signed-Rank Test for Maladaptive Coping (Sample B)**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 2</td>
<td>Time 3</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>20</td>
<td>21</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>16</td>
<td>-14</td>
</tr>
<tr>
<td>4</td>
<td>23</td>
<td>18</td>
<td>-5</td>
</tr>
<tr>
<td>7</td>
<td>27</td>
<td>26</td>
<td>-1</td>
</tr>
</tbody>
</table>

**Rank Sums:** 5.5 6.5

*Note:* Total rank sum = 15. $W_{\text{critical}} = 1$ at $\alpha=.05$

In regard to maladaptive coping, results of the signed-rank test indicated no statistically significant change in maladaptive coping ($|W_{\text{obtained}}| = 5.5 > |W_{\text{critical}}| = 1$, $n = 5$, $p >.05$) from six months to one year of participation in SRN. The matched-pairs rank-biserial correlation for maladaptive coping is $r = -.33$.

Table 17

**Wilcoxon Signed-Rank Test for Adaptive Coping (Sample B)**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Score</th>
<th>Change</th>
<th>Rank of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 2</td>
<td>Time 3</td>
<td>Positive</td>
</tr>
<tr>
<td>1</td>
<td>38</td>
<td>43</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>49</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>61</td>
<td>38</td>
<td>-23</td>
</tr>
<tr>
<td>4</td>
<td>51</td>
<td>40</td>
<td>-9</td>
</tr>
<tr>
<td>7</td>
<td>51</td>
<td>38</td>
<td>-13</td>
</tr>
</tbody>
</table>

**Rank Sums:** 5 10

*Note:* Total rank sum = 15. $W_{\text{critical}} = 1$ at $\alpha=.05$
In regard to adaptive coping, results of the signed-rank test indicated no statistically significant change in adaptive coping ($|W_{obtained}| = 5 > |W_{critical}| = 1, n = 5, p > .05$) from six months to one year of participation in SRN. The matched-pairs rank-biserial correlation for adaptive coping is $r = -.33$. 
Chapter Five: Discussion

The current study examined the longitudinal impact of Starting Right, Now on participants’ well-being, as indicated by life satisfaction, hope agency, hope pathways, maladaptive coping, and adaptive coping. Specifically, research questions evaluated: (1) the impact of Starting Right, Now on participants’ life satisfaction after six months and one year of participation in the program; (2) the impact of Starting Right, Now on participants’ hope after six months and one year of participation in the program; and (3) the impact of Starting Right, Now on participants’ use of coping strategies after six months and one year of participation in the program. The following discussion explores the findings of this study as they relate to the above research questions, as well as in relation to the existing literature on the topic. Next, implications of the current study for school psychologists and contributions to the literature are presented. Limitations of the current study are also discussed. Finally, directions for future research are identified.

Impact of SRN on Participants’ Well-Being

Table 18 presents a summary of the results of each statistical test for each outcome at each time point.
Table 18

Summary of Findings

<table>
<thead>
<tr>
<th></th>
<th>Change from Time 1 to Time 2</th>
<th>Change from Time 2 to Time 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Satisfaction</strong></td>
<td>Significant, positive increase $(r = .80)$</td>
<td>No significant change $(r = -.40)$</td>
</tr>
<tr>
<td><strong>Hope Agency</strong></td>
<td>Significant, positive increase $(r = .93)$</td>
<td>No significant change $(r = -.80)$</td>
</tr>
<tr>
<td><strong>Hope Pathways</strong></td>
<td>Significant, positive increase $(r = 1.0)$</td>
<td>No significant change $(r = -1.0)$</td>
</tr>
<tr>
<td><strong>Maladaptive Coping</strong></td>
<td>No significant change $(r = -.56)$</td>
<td>No significant change $(r = -.33)$</td>
</tr>
<tr>
<td><strong>Adaptive Coping</strong></td>
<td>No significant change $(r = .03)$</td>
<td>No significant change $(r = -.33)$</td>
</tr>
</tbody>
</table>

*Note. α = .05*

**Research Question One.** The first research question of the current study was: “Do students participating in Starting Right, Now experience changes in life satisfaction after six months? After one year?”

**Six months of participation.** Based on visual analyses, almost all participants’ life satisfaction scores were observed to increase from Time 1 to Time 2. Analysis of participant demographics did not reveal any common factors that might explain the two decreased scores present in the data.

Results from the Wilcoxon Signed-Rank Test indicated a statistically significant increase in life satisfaction from Time 1 to Time 2, with a matched-pairs rank-biserial correlation of $r = .80$. Thus, it can be concluded that participation in Starting Right, Now is associated with a large increase in life satisfaction after six months of participation. Although the size of this increase was large, it should be noted that not all participants were above the clinical cut-off score of four for life satisfaction at Time 2, with approximately 30% of the sample below four. These
participants were still in need of further intervention in order to boost their life satisfaction scores from the dissatisfied range into the satisfied range of four and above.

The finding that SRN is associated with increases participants’ life satisfaction after six months of participation aligns with previous research conducted by Ferguson and Xie (2007). This study found that after ten months, another multicomponent intervention, Social Enterprise Intervention, increased life satisfaction of participants when compared to treatment as usual. This finding also aligns with SRN’s goal to provide wraparound services in order to meet participants’ physical, emotional and academic needs.

One year of participation. Based on visual analyses, only one participant experienced an increase in life satisfaction scores from Time 2 to Time 3, with the remaining participants experiencing a decrease in life satisfaction. Analysis of participant demographics did not reveal any unique factor that might explain why only one participant experienced an increase in life satisfaction.

Results from the Wilcoxon Signed-Rank Test indicated no statistically significant change in life satisfaction from Time 2 to Time 3, with a matched-pairs rank-biserial correlation of $r = - .40$. Thus, another six months of participation in SRN does not seem to be associated with any additional statistically significant changes in life satisfaction.

The finding that further participation in SRN is not associated with changes in life satisfaction may be explained by the fact that all participants were attending college, not high school, at the time of Time 3 data collection. Thus, their life satisfaction may not have increased further due to the additional life stressors and changing circumstances experienced as part of the transition to college. As reviewed by Hurst, Baranik, and Daniel (2012), new college students report stressors related to transitioning to college, such as the challenges associated with
adjusting to a new environment, independence from family, and separation from previous sources of social support, like friends and family. Additionally, the lack of statistically significant finding may be due to the extremely small sample size utilized in the analyses, which required that all five participants in Sample B experience a change in the same direction in order to achieve statistical significance. Finally, these results may be explained by the hedonic treadmill theory (Brickman & Campbell, 1971). This theory proposes that people briefly react to positive or negative events or life circumstances, but then automatically habituate to these circumstances and return to a neutral emotional state. Thus, the students in SRN may have habituated to their new life circumstances after one year in the program.

**Research Question Two.** The second research question of the current study was: “Do students participating in Starting Right, Now experience changes in hope after six months? After one year?”

**Six months of participation.** Based on visual analyses, participants’ hope agency and hope pathways scores appeared to increase from Time 1 to Time 2. Analysis of participant demographics did not reveal any unique factors that might explain the one decreased score present in the data.

Results from the Wilcoxon Signed-Rank Test indicated a statistically significant increase in hope agency from Time 1 to Time 2, with a matched-pairs rank-biserial correlation of $r = .93$. Thus, it can be concluded that participation in Starting Right, Now is associated with a large increase in hope agency after six months of participants.

Results from the Wilcoxon Signed-Rank Test also indicated a statistically significant increase in hope pathways from Time 1 to Time 2, with a matched-pairs rank-biserial correlation
of \( r = 1.0 \). Thus, it can be concluded that participation in Starting Right, Now is associated with a large increase in hope pathways after six months of participation.

The finding that SRN is associated with increases in participants’ hope agency and hope pathways after six months of participation cannot be compared to previous research, as the current study is the first to investigate the impact of a multicomponent intervention for UHY on participants’ hope. This finding does, however, align with SRN’s goal to provide wraparound services in order to meet participants’ physical, emotional and academic needs.

**One year of participation.** Based on visual analyses, participants’ hope agency and hope pathways scores appeared to decrease from Time 2 to Time 3. Analysis of participant demographics did not reveal any unique factor that might explain why only one participant experienced an increase in hope agency.

Results from the Wilcoxon Signed-Rank Test indicated no statistically significant change in hope agency from Time 2 to Time 3, with a matched-pairs rank-biserial correlation of \( r = -.80 \). Based on these results, another six months of participation in SRN does not seem to be associated with any additional statistically significant changes in hope agency.

Results from the Wilcoxon Signed-Rank Test also indicated no statistically significant change in hope pathways from Time 2 to Time 3, with a matched-pairs rank-biserial correlation of \( r = -1.0 \). Based on these results, another six months of participation in SRN does not seem to be associated with any additional statistically significant changes in hope pathways.

The finding that further participation in SRN is not associated with changes in hope agency and hope pathways may be explained by the fact that all participants were attending college, not high school, at the time of Time 3 data collection. Thus, their hope agency and hope pathways may not have increased further due to the additional life stressors and changing
circumstances experienced as part of the transition to college. Additionally, the lack of statistically significant finding may be due to the extremely small sample size utilized in the analyses, particularly in regard to the hope pathways analyses. Finally, these results may be explained by the hedonic treadmill theory, with the students in SRN habituating to their new life circumstances after one year in the program.

**Research Question Three.** The third research question of the current study was: “Do students participating in Starting Right, Now experience changes in use of coping strategies after six months? After one year?”

**Six months of participation.** Based on visual analyses, participants’ maladaptive coping scores did not appear to follow a clear trend from Time 1 to Time 2, as some participants experienced an increase in the use of maladaptive coping strategies while others experienced a decrease in the use of maladaptive coping strategies. In regard to adaptive coping, participants’ scores from Time 1 to Time 2 similarly did not follow a clear trend, with some participants experiencing an increase in the use of adaptive coping strategies and other participants experiencing a decrease in the use of adaptive coping strategies. Analysis of participant demographics revealed that all male participants experienced an increase in the use of adaptive coping strategies, while there was no clear trend among female participants.

Results from the Wilcoxon Signed-Rank Test indicated no statistically significant change in the use of maladaptive coping strategies from Time 1 to Time 2, with a matched-pairs rank-biserial correlation of \( r = -.56 \). Thus, participation in Starting Right, Now does not appear to be associated with any changes in the use of maladaptive coping strategies after six months of participation.
Results from the Wilcoxon Signed-Rank Test indicated no statistically significant change in the use of adaptive coping strategies from Time 1 to Time 2, with a matched-pairs rank-biserial correlation of $r = .03$. Thus, participation in Starting Right, Now does not appear to be associated with any changes in the use of adaptive coping strategies after six months of participation.

The finding that SRN is not associated with changes in the use of maladaptive or adaptive coping strategies aligns with research by Slesnick and colleagues (2007), who reported that Community Reinforcement Approach did not have a statistically significant impact on participants’ use of coping strategies as measured by the Coping Inventory for Stressful Situations. Thus, it may be particularly difficult to positively impact UHY’s use of adaptive coping strategies such as social support, religion, humor, positive reframing, and acceptance, as no multicomponent interventions to date have positively impacted coping in this population.

This finding does not, however, align with other previous research in this area. For example, two individual components of SRN, stable housing (Kisely et al., 2008) and mentoring (Aviles de Bradley, 2011; Kurtz et al., 2000) have been found to reduce substance abuse—a maladaptive coping strategy—among homeless youth. Additionally, the multicomponent intervention Community Reinforcement Approach (Slesnick et al., 2007), has also been found to decrease drug use among participants when compared to treatment as usual. This lack of findings might be attributed to participants’ reluctance to honestly report their use of specific coping strategies as several items on the B-COPE (i.e., items asking about substance use) assess the use of strategies prohibited by the SRN contract, despite participants being told the information was confidential.
One year of participation. Based on visual analyses, participants’ maladaptive coping scores did not appear to follow a clear trend from Time 2 to Time 3, as some participants experienced an increase in the use of maladaptive coping strategies while others experienced a decrease in the use of maladaptive coping strategies. In regard to adaptive coping, participants’ scores from Time 2 to Time 3 similarly did not follow a clear trend, with some participants experiencing an increase in the use of adaptive coping strategies and other participants experiencing a decrease in the use of adaptive coping strategies. Participants 1 and 2 were noted to experience increases in the use of both adaptive and maladaptive coping strategies, while Participants 3, 4, and 7 were noted to experience decreases in the use of both adaptive and maladaptive coping strategies. Further analysis of participant demographics did not reveal any common factors that might explain why some participants experienced increases in the use of coping strategies while others experienced decreases.

Results from the Wilcoxon Signed-Rank Test indicated no statistically significant change in maladaptive coping from Time 2 to Time 3, with a matched-pairs rank-biserial correlation of $r = -.33$. Thus, another six months of participation in SRN does not seem to be associated with any additional statistically significant changes in the use of maladaptive coping strategies.

Results from the Wilcoxon Signed-Rank Test also indicated no statistically significant change in adaptive coping from Time 2 to Time 3, with a matched-pairs rank-biserial correlation of $r = -.33$. Thus, another six months of participation in SRN does not seem to be associated with any additional statistically significant changes in the use of adaptive coping strategies.

The finding that further participation in SRN is not associated with changes in the use of adaptive or maladaptive coping strategies may be explained by the fact that all participants were attending college, not high school, at the time of Time 3 data collection. Thus, their coping
strategies may not have changed further due to the additional life stressors and changing circumstances experienced as part of the transition to college. Additionally, the lack of statistically significant finding may be due to the extremely small sample size utilized in the analyses. Finally, these results may be explained by the hedonic treadmill theory, with the students in SRN habituating to their new life circumstances after one year in the program.

**Implications for School Psychologists**

The current study has implications for practicing school psychologists and other educators. First, because SRN was found to significantly improve aspects of participants’ well-being, the current study increases educator’s knowledge of how to support UHY who remain in school despite the challenges associated with their life circumstances. In conjunction with community-based organizations, school personnel could work to implement a similar system of support for unaccompanied homeless youth in their own communities. Specifically, unaccompanied homeless adolescents would benefit from a multicomponent system of care that includes home-, school-, and community-based supports focusing on all aspects of these youths’ lives in order to improve their well-being. This improvement in well-being is important for this population because previous researchers have noted the connections between various indicators of well-being and outcomes including higher emotional, social, and academic self-efficacy (Suldo & Huebner, 2006); fewer symptoms of psychopathology (Erickson, Post, & Page, 1975; Suldo & Huebner, 2006); and lower stress and higher resiliency (Compas, Malcarne, & Gondacaro, 1988). Similarly, the current study supports the expansion of the Starting Right, Now model to other communities, given its positive impact on participants in the program.
Limitations of the Current Study

There are several limitations of the current study that should be noted. First, there was no control group included in this study. This is due to the fact that it was not possible to identify and track students who applied to but were not accepted into SRN for the purposes of establishing a control group. Similarly, it would not have been ethical to randomly assign unaccompanied homeless youth to a waitlist control condition and withhold needed services and treatments, particularly because participants were accepted into SRN partially on the basis of having no alternative housing options. Thus, the design of the current study was not experimental and a causal relationship between the SRN program and student outcomes cannot be identified. It also was not possible to determine which specific components of the SRN program were most effective.

Another limitation of the current study was that participants did not enter the SRN program at the same time due to the program’s ongoing acceptance of new students throughout each academic year. Thus, data collection for Time 2 overlapped with data collection for Time 1; similarly, data collection for Time 3 overlapped with data collection for Time 2. It may be that the time of the year in which students enter SRN impacts their experience in the program, and it was not possible to control for that variable.

An additional limitation of the current study involves the use of the B-COPE. This measure included items (e.g., regarding substance abuse) to which participants may not have responded honestly due to these coping strategies being prohibited by the SRN contract. Also of note, analysis of participants’ life satisfaction scores at Time 1 indicated these data were not reliable (Cronbach’s alpha = 0.41), which may be partially explained by the small sample size utilized in this study.
Finally, due to the small size of the SRN program, the current study utilized small sample sizes (\(n=10\) for Sample A; \(n=5\) for Sample B). Thus, it was difficult to identify any statistical effects of the program on student well-being, particularly after one year of participation. For example, even though there were strong correlations present in Sample B analyses (e.g., a matched-pairs rank-biserial correlation for hope agency of \(r = -0.80\)), there was not a statistically significant change associated with those variables due to the small sample size. The small sample sizes of the current study also limit generalizability of the findings to other unaccompanied homeless adolescents. Similarly, it should be noted that the current study utilized a select group of unaccompanied homeless youth, given that these youth were chosen to participate in the SRN program by the program director based on the potential she believed each student possessed. Thus, this sample may not be representative of all unaccompanied homeless youth and generalizability of the findings is limited.

**Contributions to the Literature**

Despite the limitations noted above, the current study makes several important contributions to the literature. The current study was the first to examine if and how Starting Right, Now impacts student wellness over up to a one-year period using quantitative methods. To date, only one researcher (Randle, 2016) has investigated the perceived impact of SRN through unstructured qualitative interviews with participants. The current study adds to this literature by conducting a more targeted examination of the impacts of SRN on students’ life satisfaction, hope, and coping strategies. The current study also utilized longitudinal data collected at two or three time points over a six-month to one-year period, respectively, which provides a more comprehensive understanding of if and when the Starting Right, Now program impacts participants’ well-being. Furthermore, as noted by Moore (2005), UHY remain an
understudied population, and the results of the current study contribute to the limited existing body of research on interventions to serve these youth. Specifically, providing UHY with access to the wide range of supports and services such as those available through SRN (e.g., job placement, tutoring, mental health care, medical care, mentoring, housing) was found in the current study to improve participants’ life satisfaction, hope agency, and hope pathways after six months of participation in the program. These findings also support the implementation of programs similar to SRN in other communities in order to serve this vulnerable population of youth, as well as the expansion of SRN into other areas.

Summary and Future Directions.

The current study has contributed to the literature by providing the first examination of the longitudinal impact of Starting Right, Now on participants’ well-being, specifically in regard to life satisfaction, hope, and use of coping strategies. The current study also contributed to the currently limited understanding of efficacious interventions for vulnerable unaccompanied homeless youth. The results of this study indicate that participation in Starting Right, Now was associated with statistically significant increases in life satisfaction, hope agency, and hope pathways after six months of participation in the program. Participation for an additional six months (one year total) was not associated with any further statistically significant changes. These findings add support to previous qualitative research that suggested Starting Right, Now has a positive impact on the lives of participants (Randle, 2016). These findings are also meaningful when compared to the expected trajectories of life satisfaction and hope variables over time. Previous research indicates that life satisfaction tends to decrease over the course of adolescence regardless of gender or race (Goldbeck, Schmitz, Besier, Herschbach, & Henrich, 2007). Additionally, hope has been found to be a moderately stable construct over the course of
adolescence (Valle, Huebner, & Suldo, 2006). These findings strengthen the association between participation in SRN and the demonstrated increases in life satisfaction and hope after six months because these increases cannot be explained by maturation effects or normal change experienced over time.

In order to gain a more complete understanding of the impact of Starting Right, Now on participants’ well-being, future research should aim to replicate the current study with a larger sample of participants. Because the current study used small sample sizes for all analyses, it was difficult to determine statistical effects of the program, particularly after one year of participation. Additionally, future research efforts would also be enhanced by collecting data from participants more frequently, given that the current study included data collected from participants every six months. This would allow researchers to further examine when the program has the greatest impact on participant well-being, as well as if and how that impact changes or fluctuates over time.

Another goal of future research should be to determine which specific aspects of Starting Right, Now (e.g., mentoring, academic tutoring, leadership training) have the most impact on participants’ well-being, as the current study was not able to separate individual intervention components for further analyses. For example, it is not known whether coping strategies are specifically taught to students as part of mental health services provided, and this information may help to explain the results of the current study in regard to use of coping strategies. Grouping students based on time of entry would be one method of exploring the impact of various intervention components, because students who enter the program at different points in the year experience a different sequence of components. This would enable future researchers to evaluate whether a specific component provides added benefits in regard to student well-being.
References


Appendices
Appendix A: Recruitment Flyer

UNIVERSITY OF SOUTH FLORIDA

STARTING RIGHT, NOW (SRN) RESEARCH STUDY

Principal Investigator:
Dr. Linda Raffaele Mendez
University of South Florida

PURPOSE OF THE STUDY
To learn more about the impact of SRN on the lives of students involved in the program (including changes in attitudes, beliefs, health and experiences as a result of participating in SRN).

TIME COMMITMENT:
15-30 minutes every 6 months for the next 18 months

YOU ARE ELIGIBLE TO PARTICIPATE IF:
*You have been accepted into SRN
*You have signed the SRN contract

POTENTIAL BENEFITS:
Having the opportunity to share your experiences, beliefs and attitudes with researchers who are interested in learning more about your experiences

You will not be compensated for your participation in this study.

TO LEARN MORE ABOUT THE STUDY AND PARTICIPATE, PLEASE CALL DR. RAFFAELE MENDEZ AT [REDACTED]

USF IRB Study: Pro00023832
Appendix B: Informed Consent Script

Script for Obtaining Verbal Informed Consent

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: Starting Right, Now Longitudinal Study

The person who is in charge of this research study is Dr. Linda Raffaele Mendez. This person is called the Principal Investigator.

You are being asked to participate because you may be accepted into the Starting Right, Now program. The purpose of this study is to learn more about the impact of SRN on the lives of students involved in the program. Specifically, we are interested in learning more about how your attitudes, beliefs, health, and experiences change as a result of your participation in SRN. This information will add to the research on programs that help homeless youth achieve their goals and break the cycle of poverty.

If you take part in this study, you will be asked to complete a packet of surveys every six months for the next 18 months. Survey questions will ask you about your health, attitudes, beliefs, and experiences. Each survey packet will take approximately 15-30 minutes to complete. The first packet of surveys will be completed using paper and pencil. You will take the surveys at your school in the room where you meet with SRN staff. These surveys will be administered immediately after you sign your contract with SRN. The remaining three survey packets will be completed using a computer-based survey program. You will take these surveys at the SRN office in [insert location]. SRN staff will remind you when it is time for you to take these surveys. You have the alternative to choose not to participate in this research study.

You should only take part in this study if you want to volunteer and should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not will not affect your enrollment in SRN. Your decision to participate will not affect your potential enrollment and future success as a student at the University of South Florida if you ultimately choose to apply for admission to the university.

This research is considered to be minimal risk.

We will not pay you for the time you volunteer while being in this study.
We must keep your study records as confidential as possible. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.) These include:
  - The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  - The Department of Health and Human Services (DHHS).

A federal law called Title IX protects your right to be free from sexual discrimination, including sexual harassment and sexual violence. USF’s Title IX policy requires certain USF employees to report sexual harassment or sexual violence against any USF employee, student or group, but does not require researchers to report sexual harassment or sexual violence when they learn about it as part of conducting an IRB-approved study. If, as part of this study, you tell us about any sexual harassment or sexual violence that has happened to you, including rape or sexual assault, we are not required to report it to the University. If you have questions about Title IX or USF’s Title IX policy, please call USF’s Office of Diversity, Inclusion & Equal Opportunity at (813) 974-4373.

If you have any questions about this study, you can contact the investigator, Dr. Linda Raffaele Mendez at 813-974-1255. If you have question about your rights as a research participant please contact the USF IRB at 813-974-5638.

Would you like to participate in this study?

*PI will record if verbal consent is given.
Appendix C: Verbal Assent Script

Script for Obtaining Verbal Assent

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: Starting Right, Now Longitudinal Study

The person who is in charge of this research study is Dr. Linda Raffaele Mendez. This person is called the Principal Investigator.

You are being asked to participate because you may be accepted into the Starting Right, Now program. The purpose of this study is to learn more about the impact of SRN on the lives of students involved in the program. Specifically, we are interested in learning more about how your attitudes, beliefs, health, and experiences change as a result of your participation in SRN. This information will add to the research on programs that help homeless youth achieve their goals and break the cycle of poverty.

If you take part in this study, you will be asked to complete a packet of surveys every six months for the next 18 months. Survey questions will ask you about your health, attitudes, beliefs, and experiences. Each survey packet will take approximately 15-30 minutes to complete. The first packet of surveys will be completed using paper and pencil. You will take the surveys at your school in the room where you meet with SRN staff. These surveys will be administered immediately after you sign your contract with SRN. The remaining three survey packets will be completed using a computer-based survey program. You will take these surveys at the SRN office in Tampa, Florida. SRN staff will remind you when it is time for you to take these surveys. You have the alternative to choose not to participate in this research study.

If you do not want to take part in this study, that is your decision. You should only take part in this study because you want to volunteer. If you decide to take part in this study, you still have the right to change your mind later. No one will think badly of you if you decide to stop participating. Your decision to participate or not will not affect your enrollment in SRN. Your decision to participate will not affect your potential enrollment and future success as a student at the University of South Florida if you ultimately choose to apply for admission to the university.

To the best of our knowledge, your participation in this study will not harm you.

We will not pay you for the time you volunteer while being in this study.
We must keep your study records as confidential as possible. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.) These include:

  - The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  - The Department of Health and Human Services (DHHS).

A federal law called Title IX protects your right to be free from sexual discrimination, including sexual harassment and sexual violence. USF’s Title IX policy requires certain USF employees to report sexual harassment or sexual violence against any USF employee, student or group, but does not require researchers to report sexual harassment or sexual violence when they learn about it as part of conducting an IRB-approved study. If, as part of this study, you tell us about any sexual harassment or sexual violence that has happened to you, including rape or sexual assault, we are not required to report it to the University. If you have questions about Title IX or USF’s Title IX policy, please call USF’s Office of Diversity, Inclusion & Equal Opportunity at (813) 974-4373.

You can ask questions about this study at any time. You can talk with your parent(s)/guardian or other adults about this study. You can talk with the person who is asking you to volunteer by calling Dr. Linda Raffaele Mendez at 813-974-1255. If you think of other questions later, you can them. If you have question about your rights as a research participant please contact the USF IRB at 813-974-5638.

Would you like to participate in this study? *PI will record if verbal consent is given.*
11/16/2015

Linda Raffaele Mendez, Ph.D.
USF Department of Educational and Psychological Studies
4202 E. Fowler Avenue, EDU 162
Tampa, FL  33620

RE:  Expedited Approval for Initial Review
IRB#:  Pro00023832
Title:  A Longitudinal Study of Students in Starting Right, Now

Study Approval Period: 11/14/2015 to 11/14/2016

Dear Dr. Raffaele Mendez:

On 11/14/2015, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
SRN IRB Protocol.docx

Consent/Assent Document(s):
Child Verbal Assent Form.docx
Adult Verbal Consent Form.docx

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:
(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the informed consent process as outlined in the federal regulations at 45CFR46.116(d) which states that an IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the IRB finds and documents that (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practically be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject’s wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

This study involving data pertaining to children falls under 45 CFR 46.404 – Research not involving greater than minimal risk.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board
Appendix E: Demographics Form

ID Number________________       Birthdate: _____-_____-____
(month)       (day)       (year)

PLEASE READ EACH QUESTION AND CIRCLE ONE ANSWER PER QUESTION:

1. I am in grade:               9  10  11  12

2. My gender is:                Male   Female

3. My race/ethnic identity is:
   a. American Indian or Alaska Native  e. Native Hawaiian or Other Pacific Islander
   b. Asian                                f. White
   c. Black or African American           g. Multi-racial (please specify):____________________
   d. Hispanic or Latino                  h. Other (please specify):____________________
Appendix F: Adult Hope Scale
This measure is available in the public domain from:


Please indicate how closely each statement matches your feelings.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Definitely False</th>
<th>Mostly False</th>
<th>Somewhat False</th>
<th>Slightly False</th>
<th>Slightly True</th>
<th>Somewhat True</th>
<th>Mostly True</th>
<th>Definitely True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can think of many ways to get out of a jam.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>2. I energetically pursue my goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>3. I feel tired most of the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>4. There are lots of ways around any problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>5. I am easily downed in an argument.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>6. I can think of many ways to get the things in life that are important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>7. I worry about my health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>8. Even when others get discouraged, I know I can find a way to solve the problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9. My past experiences have prepared me well for my future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>10. I’ve been pretty successful in life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>11. I usually find myself worrying about something.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>12. I meet the goals that I set for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

*note: items 2, 9, 10, and 12 are included in the agency subscale. Items 1, 4, 6, and 8 are included in the pathways subscale. Items 3, 5, 7 and 11 are filler items and are not scored.*
Appendix G: Brief COPE
This measure is available in the public domain from:


<table>
<thead>
<tr>
<th>Think of a difficult situation you have faced in the past six months. How did you cope with that difficult situation?</th>
<th>I didn’t do this at all</th>
<th>I did this a little bit</th>
<th>I did this a medium amount</th>
<th>I did this a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I’ve been turning to work or other activities to take my mind off things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I’ve been concentrating my efforts on doing something about the situation I’m in.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I’ve been saying to myself “This isn’t real.”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I’ve been using alcohol or other drugs to make myself feel better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I’ve been getting emotional support from others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I’ve been giving up trying to deal with it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I’ve been taking action to try to make the situation better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I’ve been refusing to believe that it has happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I’ve been saying things to let my unpleasant feelings escape.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I’ve been getting help and advice from other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I’ve been using alcohol or other drugs to help me get through it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I’ve been trying to see it in a different light, to make it seem more positive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I’ve been criticizing myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I’ve been trying to come up with a strategy about what to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I’ve been getting comfort and understanding from someone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I’ve been giving up the attempt to cope.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I’ve been looking for something good in what is happening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. I’ve been making jokes about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I’ve been doing something to think about it less, such as going to the movies, watching TV, daydreaming, sleeping or shopping.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. I’ve been accepting the reality of the fact that it has happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. I’ve been expressing my negative feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Item</td>
<td>Statement</td>
<td>Items 1, 3, 4, 6, 8, 9, 11, 13, 16, 19, 21, and 26 are included in the maladaptive coping subscale. Items 2, 5, 7, 10, 12, 14, 15, 17, 18, 20, 22, 23, 24, 25, 27, and 28 are included in the adaptive coping subscale.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I’ve been trying to find comfort in my religion or spiritual beliefs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23</td>
<td>I’ve been trying to get advice or help from other people about what to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>I’ve been learning to live with it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25</td>
<td>I’ve been thinking hard about what steps to take.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26</td>
<td>I’ve been blaming myself for things that happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27</td>
<td>I’ve been praying or meditating.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>I’ve been making fun of the situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix H: Students’ Life Satisfaction Scale
This measure is available in the public domain from:


Please indicate how closely each statement matches your feelings.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My life is going well</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>2. My life is just right</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>3. I would like to change many things in my life</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>4. I wish I had a different kind of life</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>5. I have a good life</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>6. I have what I want in life</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>7. My life is better than most kids’</td>
<td>Strongly Disagree</td>
<td>Mostly Disagree</td>
<td>Mildly Disagree</td>
<td>Mildly Agree</td>
<td>Mostly Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

*note: items 3 and 4 are reverse-scored items.*