

**DEPARTMENT OF PSYCHOLOGY  
UNIVERSITY OF GHANA**



**PSYCHOSOCIAL CRISES AND COPING AMONG THE HOMELESS IN  
THE GREATER ACCRA REGION, GHANA**

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**THIS THESIS IS SUBMITTED TO THE DEPARTMENT OF  
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## **DECLARATION**

I, Nelly Betty Fosu, do hereby declare that this thesis is the result of my research carried out in the Department of Psychology, University of Ghana, Legon under the effective supervision of Dr. Benjamin Amponsah and Dr. Joana Salifu. I further do declare that all research works cited in this study have been duly acknowledged.

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## **DEDICATION**

I dedicate this thesis to my family.

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## ABSTRACT

Homelessness is a pervasive social problem that has devastating impacts on affected individuals and poses severe challenges to policymakers in developing countries. This study investigated psychosocial distress associated with homelessness and the effectiveness of coping strategies used to manage such distress. Homeless individuals aged 10 years and above in the Greater Accra region of Ghana constituted the research population. An explanatory mixed-method design comprising a cross-sectional survey (study I) and a one-on-one interview (study II) was employed. A sample of 183 participants, consisting of 86 homeless (47.0%) and 97 non-homeless (53.0%) individuals with an age range of 14 – 49 years ( $M=24.95$ ,  $SD=8.75$ ), was drawn for the study. The non-homeless participants served as control only for the assessment of psychosocial distress associated with homelessness. The Revised UCLA Loneliness Scale, the Depression, Anxiety and Stress Scale, the Modified PTSD Symptom Scale-Self Report, the Suicidal Behaviors Questionnaire-Revised, the Somatic Symptom Scale – 8, and the Brief COPE Scale were employed as instruments for data collection in Study I. Semi-structured interview guide was developed for data collection in Study II. Analyses of data in study I revealed significantly higher level of psychosocial distress among homeless participants than non-homeless participants; greater use of adaptive coping strategies than maladaptive coping strategies among the homeless participants; and significant associations between maladaptive coping and psychosocial distress. Thematic analyses of qualitative data in Study II exposed the unique experiences of homeless individuals, their coping behaviors, and the outcomes of such coping behaviors. The findings highlight the need for timely and appropriate interventions to address the psychosocial crises facing the homeless in Ghana.

## CHAPTER ONE

### INTRODUCTION

This chapter lays the background for the study. It defines the major concepts and explains plausible associations among them. It identifies the problem under investigation and articulates the objectives for conducting the study. Finally, it demonstrates the practical and theoretical relevance of the study.

#### **1.1. Background of the Study**

Homelessness is an undesirable life circumstance that unleashes psychosocial distress and disrupts lifestyle. It usually affect individuals with limited access to resources, employment opportunity and social network. It is characterized by economic deprivations, social marginalization, poor mental health and negative self-concept (Biswas-Diener & Diener, 2006; Crane & Warnes, 2005; Tois, 2005; Wilkinson & Marmont, 2003). Homelessness can affect every part of a persons' daily life. Individuals react in different ways to the experience of becoming homeless. While some people seem to react well and take everything in their stride, others are unable to function in any capacity. It is also considered a major social issue in developing countries (de-Graft Aikins & Ofori-Atta, 2007), and more so in developed countries (Toro, 2007).

Research on homelessness and the associated health challenges have received increased attention in developed countries. However, the concept of homelessness appears to be relatively new in developing countries. In Ghana, for example, the term 'homelessness' has no direct local rendition in any Ghanaian language. This suggests that homelessness is an emerging issue in developing countries but an entrenched issue in developed countries.

In the past three decades, homelessness has become a major public health concern that poses severe challenges to policymakers and researchers alike (Byrne, Munley, Fargo, Montgomery, & Culhane, 2013). It is a serious global problem with the situation affecting about 1.6 million people annually and about 650, 000 people sleeping on the streets on daily basis in high income countries such as the United States (Corrigan, Pickett, Kraus, Burks & Schmidt, 2015; Fox et al., 2016). The Centre for Architectural Research and Development Overseas (CARDO) (2003) estimated the total number of homeless people as between 100 million and one billion, depending on counting procedure and adopted definition.

The homelessness situation is worse in low and middle income countries. In Ghana for instance, de-Graft Aikins and Ofori-Atta (2007) have reported that homeless individuals are exposed to elevated levels of mental health challenges that threatens their life and well-being. Past research have focused on examining the risk factors for homelessness, focusing on the relationship between homelessness, criminal justice and mental illness and how the relationship is mediated by risk factors such as victimization and substance use (Chamberlain & Johnson, 2013; Fox et al., 2016). In its current state, as a public health concern, research on homelessness is focused on examining both physical and mental health consequences that homeless individuals deal with on daily basis and how they cope with the challenges (Chondraki, Madianos, Dragioti & Papadimitriou, 2014). Due to the substantial body of literature on risk factors of homelessness, there is an increasing shift to exploring mental health outcomes associated with homeless individuals, especially those in developing countries (Cleverley & Kidd, 2011; de-Graft Aikins & Ofori-Atta, 2007).

The constant rise in the rate of homelessness has compelled countries to define homelessness based on certain criteria such as qualification to welfare assistance, job insecurity,

area of residence, and standard of living in addition to lack of home. Springer (2000) acknowledges the existence of diverse and varying definitions and classifications of the concept of homeless in the literature. Yet, he attributed these variations to differences in viewpoints. Irrespective of perspectives, almost all definitions share certain elements in common among which are lack of housing structure, availability and access to shelter, quality of living, and nature of welfare facilities.

Given the inconsistent manifestation of homelessness across different countries, there is no single definition that is universally acceptable and generally applicable. Various definitions have been proposed, yet each is criticized. This suggests the need for definitions that are context specific and locally applicable. An extensive definition of homelessness, proposed by the United Nations (1982), states that a homeless individual is a person without a home, who resides on the streets or in shelters; or a person with no daily survival necessities such as food, clothing and shelter. Considering its essential elements, the U.N. definition is demonstrative of homelessness in Ghana except the aspect of shelter.

The European Typology on Homelessness and Housing Exclusion (ETHOS), created by the European Federation of National Associations Working with the Homeless (FEANTSA), provided an expanded categorization of homeless (Edgar, 2009). The ETHOS delineated four categories of homelessness namely *rooflessness*, *houselessness*, *insecure housing*, and *inadequate housing*. The category of rooflessness describes literal homelessness where individuals live without any form of housing or shelter. The houselessness category describes individuals living in temporary structures, long-term supported structures, or institutions. Insecure housing category refers to people living temporarily with family or friends, at risk of harm, or risk of eviction, or under threat. Finally, inadequate housing category captures homeless

individuals living in over-crowded settings, condemned buildings, or mobile homes. In broader terms, all four categories are applicable in the Ghanaian context. However, this study focuses on literal homelessness (rooflessness) based on two reasons. First, they exist in significant numbers in the homeless population in Ghana. Second, they are most vulnerable to critical mental health problems.

The most commonly used definition was offered by the United States Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and used by the US Department of Housing and Urban Development (HUD, 2016). Like the ETHOS, this legislation spells out four major categories of homelessness: literally homeless (e.g., sleeping in shelters, in the open, or in areas not appropriate for human dwelling), in impending risk of homelessness, homeless under other US federal statutes, and escaping domestic violence (HUD, 2016). Observably, ‘literally homeless’, as defined by HUD, incorporates the dimensions of ‘rooflessness’ and ‘houselessness’ in the propositions of the ETHOS.

Aside the determination of individuals’ state of homelessness, the duration at which people remain homeless and their unique experiences within the period have also been examined. In this regard, Kuhn and Culhane (1998) classified three temporal groups namely the transitionally homeless, the episodically homeless, and the chronically homeless. The transitionally homeless are individuals who temporarily seek refuge in a shelter at single point in time. The episodically homeless group is made up of individuals with multiple transitions in and out of homelessness. Lastly, the chronically homeless group consists of people who depend on the provision of shelter as a permanent solution to their homelessness. Consequently, this latter group experiences long-term duration of homeless but in shelters.

Cooper (1995) examined the concept of absolute and relative homelessness. The former describes lack of access to shelter and the essentials of a home. The latter describes an individual without a home who dwells in shelter. The Ghanaian situation is more of relative homelessness than absolute homelessness. In Ghana, there are no known state provision of shelters where homeless people can take refuge in times of crisis. In Ghana and many developing countries, there is a public perception that the homeless are individual who are self-inadequate, often unemployed, alcoholics, criminals, or mentally ill (CARDO, 2003). In many developing countries, homelessness is primarily a consequence of economic failure, rural-urban migration, and ineffective housing policies in the context of rapidly growing population and urbanization in bigger cities. In a study of homelessness in nine developing countries including Ghana, CARDO (2003) reported that rural-urban drift was the main cause of homelessness in major cities. The shift in population was largely triggered by individuals' desire to escape rural poverty and to experience the niceties of urban life.

By large, the nature of homelessness in developing countries like Ghana is significantly different from homelessness in developed countries. The Ghana Statistical Service (2002) defined homelessness not only in housing terms but also lack of belongingness to a household. However, it must be noted that while the concept of homelessness is well understood in Ghana, there is no formal definition rendered by any state department. Previous studies on homelessness in Ghana conceptualized homelessness in terms of the quality of residential facilities – primarily identifying people living in slums as homeless (Asante, Meyer-Weitz, & Petersen, 2015; de-Graft Aikins & Ofori-Atta, 2007). It must be pointed out that such conceptualization of homelessness in Ghana is highly superficial and limited in focus. A valid definition of homelessness should take cognizance of lack of settlement structures and enormity of financial

stress. These two defining elements are highly conspicuous in the streets of Accra. It will therefore be erroneous to suggest that there are no literally homeless people in Ghana. Although accessibility to literally homeless individuals in Ghana may be difficult, they exist in significant numbers, especially in the major cities.

### **1.1.1. Causes of Homelessness**

There are considerable research on causes of homelessness and the effectiveness of policy responses (Minnery & Greenhalgh, 2007). Debates on the causes of homelessness have focused on either socio-structural factors (such as fluctuations in labour markets, policies regarding housing , poverty rate, welfare system) or personality characteristics affecting individual agency (such as educational background, intelligence, and self-efficacy), and individual behavioral attitudes (such as substance abuse, criminal behavior and diligence) (Glasser, 1994; Neale, 1997). Individualistic factors and structural factors are both relevant in explaining homelessness (Anderson & Christian, 2003; Sosin, 2003).

### **1.1.2. Consequences of Homelessness**

Homelessness poses consistent challenges to health systems, especially to mental health practitioners, policymakers and researchers (Cleverley & Kidd, 2011). Several studies (e.g. Cleverley & Kidd, 2011; Fox, Mulvey, Katz & Shafer, 2016; Urbanoski et al., 2017) have shown that homeless individuals are at extreme high risk of abuse and victimization, poor physical and mental illness and high mortality rates.

Research evidence shows that homeless individuals are at an elevated risk of mental health problems including depression, substance abuse, health-risk behaviors and delinquency among the youth (Chondraki et al., 2014). Substance abuse, for instance, is cited as one of the most frequently reported behavioral problems among homeless individuals across different socio-cultural and economic contexts. Some studies have identified substance use as normative

of homelessness, with evidence indicating that as high as 69% to 71% of homeless youth reporting problems of alcohol and drug use (Fox et al., 2016; Urbanoski et al., 2017). The high levels of substance use put homeless youth at an increased risk of several other negative health consequences such as risk of disease infection, depression, suicide, physical victimization, and illegal activities (Chondraki et al., 2014).

### **1.1.3. Coping with Homelessness**

Psychosocial resources are crucial to individuals experiencing negative life events. Among these resources is coping. According to Lazarus and Folkman (1980, p. 223) coping refers to “the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them”. Studies on coping and resiliency suggest that vulnerable populations often rely on varied strategies for coping, with each of them drawing on different resources (Kidd & Carroll, 2007). These strategies have received both broad and specific classifications in different perspectives. Emotion-focused and problem-focused coping is a broad categorization made to reflect the goal directed behavior of the individual in a stressful situation. This classification showcases whether the individual makes efforts to solve the problem itself (i.e., problem-focused), or makes efforts to reduce the distress caused by the problem (i.e., emotion-focused). Adaptive and maladaptive coping is another broad classification that focuses on the beneficial outcome of coping strategies. Coping strategies are classified adaptive when they are deemed effective in the management or resolution of the stressful situation. They are classified maladaptive when considered ineffective and sometimes their use leads to an aggravation of the problem.

Aside the broad classifications, there are more specific dimensions of coping behaviors. Examples of these specific categorizations are avoidant coping, denial, social coping, active

coping, substance-use, and self-distraction. Notably, these specific coping strategies are usually reclassified into the broader categories. Given the purview of this study, particularly its focus on mental health outcomes, the conceptualization of coping as adaptive and maladaptive is considered most appropriate and has been adopted accordingly. Adaptive coping involves religion, planning and focusing on task at hand (i.e. task-oriented coping), and the use of emotional support, positive reframing, instrumental support, acceptance, active coping and humour (Ferguson, Bender & Thompson, 2015; Kidd & Carroll, 2007; Zlotnick, Zerger & Wolfe, 2013). Maladaptive coping involves venting, behavioral disengagement, substance use, self-distraction, self-blame and denial (Ferguson et al., 2015; Kidd & Carroll, 2007; Zlotnick et al., 2013).

The way and manner in which homeless individuals manage their difficulties, whether adaptive or maladaptive, can bear serious implications on how they are impacted by homelessness, including their ability to engage in economic activities for their survival. Literature on coping with psychosocial stressors confirm that adaptive coping is negatively associated with substance use behaviors and psychosocial crisis such as depression, delinquency, and health risk behaviors (Ferguson et al., 2015). Conversely, maladaptive coping strategies (such as emotion-focused coping) are positively associated with poor mental health such as elevated risk of depression and poor physical health (Zlotnick et al., 2013). However, the evidence regarding other supposedly maladaptive coping strategies (such as avoidance-oriented coping) has been inconsistent. Some studies have reported that avoidance-oriented coping strategy is negatively associated with poor mental health outcomes such as anxiety, depression and increased use of alcohol (Kidd & Carroll, 2007). Other studies have also reported that avoidance-oriented coping is negatively associated with poor mental health outcomes such as

depression and stress. These direct contradictory findings show that the utility of coping strategies as buffers of mental health is context-dependent and therefore becomes imperative to examine them in the Ghanaian context.

## **1.2. Statement of the Problem**

It is generally desirable for individuals to live in a stable housing condition. However, socioeconomic pressures tend to render a significant number of people homeless, depriving them of shelter, comfort and good mental health. Without a stable housing condition, poor standard of living, and being subjected to the ordeals of the physical environment create a number of unhygienic and mental stress conditions. For some, the only means of coping is through the use of drugs which have its own implications on health.

Studies confirm that homeless people suffer poor mental health compared to non-homeless people (Hwang, 2001; Lippert & Lee, 2015; Public Health Agency of Canada, 2006). Among the mental health conditions frequent in homelessness literature are depression, traumatic symptoms, anxiety, stress, and somatization (Asante, Meyer-Weitz, & Petersen, 2015; Votta & Manion, 2003). Poor mental health may be both a cause and a consequence of homelessness. Homelessness does not only affect health but also self-esteem, income and subsistence (Centre for Addiction and Mental Health, 2003; Frankish et al., 2005). Considering the devastating nature of homelessness, it is necessary to explore the psychosocial resources that could enhance its management.

Consequently, the current study examines the psychosocial crises associated with homeless individuals in Accra, Ghana. Among these psychosocial crises are depression, anxiety, stress, somatization, loneliness, traumatic symptoms, and suicidality. The focus on these variables is primarily due to their revelations in qualitative research on homelessness in the

Ghanaian context (e.g., De-Graft Aikins & Ofori-Atta, 2007). Other psychosocial symptoms such as hyperactivity emotional difficulty, relationship problems, substance abuse, violent behaviors, and conduct disorders have been previously investigated in Ghana (Asante et al., 2015), and, as such, need not be repeated in the meantime. In addition to the selected psychosocial variables, the study examines the nature and effectiveness of coping strategies (adaptive and maladaptive) used by the homeless in dealing with their psychosocial distress.

### **1.3. Aim and Objectives**

#### **1.3.1. Aim of the Study**

The aim is to investigate the crisis level of the psychosocial problems of the homeless in Ghana and the effectiveness of their coping strategies.

#### **1.3.2. Objectives of the Study**

- i. To assess effect of homelessness on psychosocial distress
- ii. To determine gender differences in psychosocial distress among the homeless
- iii. To identify coping strategies frequently employed by the homeless
- iv. To examine the impact of adaptive and maladaptive coping mechanisms on the psychosocial distress of the homeless.

### **1.4. Relevance of the Study**

The study offers knowledge on the psychosocial distress of the homeless in Ghana. Findings from the study will create awareness among readers on the negative consequences of homelessness in Ghana. Among the negative consequences of homelessness revealed in this study are traumatic symptom, depression, anxiety, stress, loneliness, somatization and suicidality. Secondly, this research study will assist homeless people to identify psychosocial resources that serve as buffer for the negative consequences of homelessness. Specifically, it reveals the relative impacts of various coping strategies that are often used by homeless people to

manage their psychosocial crises. Homeless people, therefore, have the opportunity to recognize the crucial factors that can potentially cushion them against the ills of homelessness.

Furthermore, the current study provides useful information that will benefit practitioners in clinical and counseling settings. Findings from the study may aid counsellors and clinicians to perform accurate diagnosis on the psychosocial problems of the homeless and to plan effective interventions for redress. In addition, this research study challenges government and relevant state departments to institute timely interventional measures in housing policies for the purpose of addressing the homelessness situation in Ghana. The compelling evidence gathered on the psychosocial crises and coping among the homeless will serve as a basis for the government of Ghana to devise implementation strategies that will provide homes for the homeless in Ghana.

Finally, the study contributes to the extant literature on homelessness. Even though much has been documented on the psychosocial effects of homelessness, the focus of most past research has primarily been on developed countries, with much less attention to developing countries. It is not surprising that many developing countries have not yet adopted any formal definition of the concept of homelessness. Therefore, the present study becomes significant in validating the psychosocial consequences of homelessness in the Ghanaian context. The study also expands the scope of literature by making an extension of the psychosocial effects of homelessness to suicidality and examining the effectiveness of coping strategies of the homeless.

## CHAPTER TWO

### LITERATURE REVIEW

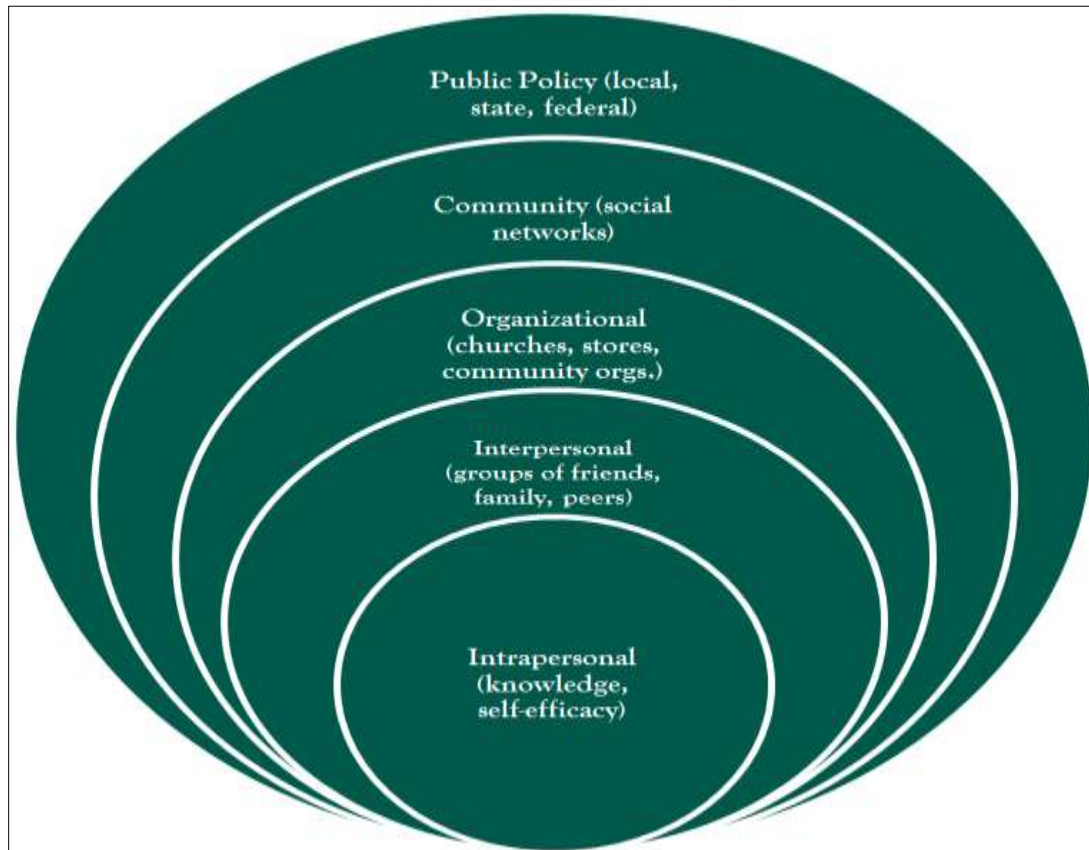
This chapter provides an extensive review of existing literature on homelessness. It begins with a review of theories that explain the causes of homelessness, stress associated with homelessness, and coping process. It continues with a detailed report on empirical research on homelessness encompassing its causes, consequences, coping, and interventions. The chapter also spells out the rationale for the present study. Finally, it outlines the research questions and hypotheses that guided the study.

#### 2.1. Theoretical Framework

##### 2.1.1. Socio-Ecological Model and Homelessness (McLeroy, Bibeau, Steckler, & Glanz, 1988; Nooe & Patterson, 2010)

The Social Ecological Model conceptualizes society as a system whose structural components function together in concentric relationship (McLeroy et al., 1988). It contends that people's behavior is influenced by a number of factors in a multi-layered social environment. The model portrays a system that is composed of five different but interdependent structures (see Figure 1). Central to the system is the *individual* (i.e., intrapersonal structure) whose idiosyncratic elements influence, and are influenced by, other structures. Second to the individual is the micro-structure which comprises interpersonal associations among individuals. It embodies bonds with friends, family, and significant others. *Organizational structure* comes third in the system. This third structure entails individuals' identification with, and membership of, groups or institutions with whom they share common goals and aspirations. Examples of organizations are the church, school, peer groups, corporate organizations, and voluntary organizations.

The fourth structure in the system is the *community* which accommodates the individuals, groups, and institutions. The community exerts significant influence on its members through normative expectations. At the peak of the system is the *macro-structure* which subordinates all other structures. The government, national constitution, the media, and all public policies are macro-structures that dictate and formalize behavior.



**Figure 1.** Illustrative model of relationships among the different SEM levels (McLeroy et al., 1988; Nooe & Patterson, 2010)

According to the socio-ecological model, society functions well when all five major structures are congruent with each other. Harmony between structures is a necessary condition for stability and survival of the individual and society. Disharmony, on the other hand, creates survival problems for the individual - which may be social, psychological, or economic. The

socio-ecological model has been applied in the explanation of homelessness, reflecting a disjuncture in the interplay between intrapersonal variables (such as personality characteristics) and other socio-economic and structural systems (Nooe & Patterson, 2010). To restore harmony between the individual and the environment, homeless people will need opportunities, resources and support from society for their reintegration and adaptation into socio-economic life as well as maintenance of their psychological wellbeing.

In support of the socio-ecological model, Anderson and Christian (2003) reported a shift in perspective on homelessness in the UK from a single-model explanation to a multilateral-model explanation. Originally, exclusive emphasis was placed on structural and individual factors in the explanation of homelessness. However, modern explanations of homelessness rely on sophisticated and interactive models of individual, structural and institutional factors. The socioecological model emphasizes comprehensive explanation of homelessness, prioritizing interactive models over any single-factor model. In this regard, homelessness may be the result of dysfunctions in individual personal character, ineffective institutional structures, and inappropriate housing policies.

### **2.1.2. General Adaptation Syndrome Theory of Stress (Selye, 1936, 1946, 1974)**

The general adaptation syndrome (GAS), proposed by Selye (1936, 1946, 1974), accounts for the mechanisms through which an individual reacts to stressful situations and the resulting physiological consequences. It postulates the possible connection between the adaptation syndrome and various diseases. The GAS contends that most common fatal diseases are due to a breakdown of the hormonal adaptation mechanism. According to Selye (1936, 1946, 1974) when a person experiences a stressful situation, he or she goes through three phases: alarm reaction phase, resistance phase and exhaustion phase. The alarm reaction phase is the first stage

which is characterized by a fight-or-flight response to a stressor. It involves an activation of the sympathetic nervous system which prepares the individual to react to a stressful event. There is significant expenditure of the body's energy at this stage.

Whenever the body is unable to resolve the stressful situation, the resistant phase occurs. Here, the alarm reaction subsides and the body adapts to the stressor through an activation of the parasympathetic system. Although the person outwardly feels normal at this stage, there is exceedingly high pressure on the body's internal organs. As the demand for body resources intensifies while the stressful event persists, the individual enters the exhaustion phase. During this final stage, the signs of the alarm reaction re-appear, resistance to stress decreases, all adaptation energy becomes depleted, and the eventual results may be illness or death.

Unarguably, homelessness is a stressful situation that some individuals have to surmount. Depending on the nature and kind of resources the homeless individual utilizes, he or she may prevail and maintain good physical and psychological health. Drawing from Selye's propositions (1936, 1946, 1974), homeless individuals may effectively manage their stressful situation in the alarm reaction stage when they have abundant body energy and resources. Those who fail at the first stage may adapt to their situation at the second stage – the resistant phase. Individuals at this stage may feel normalized to their situation and accept homelessness as a new way of life. However, long term exposure to this unpleasant circumstance may weaken the individuals' coping ability and make them susceptible to a number of physical and psychological illnesses at the exhaustion phase.

### **2.1.3. Transactional Model of Stress and Coping (Lazarus, 1966; Lazarus & Folkman, 1984)**

One of the most prominent theories of stress is the transactional model of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984). The theory espouses the role of cognitive appraisal in the management of stressful events. According to Lazarus (1966), cognitive appraisal is an internal assessment of the effect that a stressor poses to well-being. On the other hand, coping involves internal and external processes that are used in the management of stressful events in order to minimize their impact on the individual. The transactional model evaluates the level of emotional impacts of daily stressful situations and individuals' cognitive appraisal of such events. Cognitive appraisal involves primary appraisal – where a person assesses the possible harm of the stressful situation, and secondary appraisal – where the individual evaluates his or her ability and personal resources to cope with the stressful situation.

Homelessness, when perceived as a stressful event, can adversely affect wellbeing depending on whether the individual makes a positive appraisal or a negative appraisal (Carver, 1997; Lazarus & Folkman, 1984). An individual makes a positive appraisal when he or she perceives availability of personal resources and the potential to effectively manage a stressful situation. On the other hand, an individual makes a negative appraisal when he or she underestimates personal resources and ability in the management of stressful situation. Homeless individuals with positive cognitive appraisal are likely to explore strategies to minimize the negative impacts of homelessness. On the contrary, homeless individuals with negative cognitive appraisal may have the tendency to retreat in efforts to overcome the homelessness situation.

### **2.1.4. Behavioral Model for Vulnerable Populations (Gelberg, Andersen, & Leake, 2000)**

The Behavioral Model for Vulnerable Populations (Gelberg, Andersen, & Leake, 2000) also serves as a framework for the present study. The model is a modified version the Andersen

Behavioral Model (Andersen, 1968, 1995) which predicts health-seeking behavior of the general population on the basis of assumed relationships among predisposing, enabling and need factors. Characteristics such as health beliefs, age, and race constitute predisposing factors. Enabling factors include health care accessibility, health care affordability, and social support. Need factor comprises an individual's personal assessment of necessity to seek health care services. While the original model focused on the family and the general population as units of analyses, the modified model emphasizes individuals and vulnerable groups as units of analyses.

The Gelberg-Andersen Behavioral Model for Vulnerable Populations has been applied in a wide variety of contexts (Padgett, Struening, & Andrews, 1990; Padgett, Struening, Andrews, & Pittman, 1995; Swanson, Andersen, & Gelberg, 2003). Not only does it integrate predisposing characteristics that exist prior to the perception of illness, enabling resources that aid or hinder utilization of health care services and the need factors relating to physical illness, but more importantly it incorporates specific vulnerabilities common to homeless individuals such as mental health problems, drug and alcohol use, length of homelessness, and lack of access to health care (Kushel, Gupta, Gee, & Haas, 2006). In the presence of these vulnerabilities, the psychosocial wellbeing of the homeless is likely to be undermined.

## **2.2. Review of Related Studies**

Studies examining health outcomes among homeless persons have increased in recent times. Many of the studies focus on prevalence (e.g., Chondraki, Madianos, Dragioti & Papadimitriou, 2014; Cleverley & Kidd, 2011; De-Graft Aikins & Ofori-Atta, 2007; Lippert & Lee, 2015) and, in some cases, risk and protective factors of health outcomes (e.g., Fekadu et al., 2014). A growing number of research reports several risk factors for homelessness for the

purpose of influencing public policy and interventions (e.g., Atherton & Nicholls, 2008; Davies & Allen, 2016; Speak & Tipple, 2006). Across the spectrum of these studies, the mental health of the homeless has received significant attention. Revelations from past studies provide impetus to seek further explanations into theoretically-relevant factors that link homelessness to health outcomes.

The present study makes an extensive review of existing research works on homelessness in six different dimensions. First, the review examines the various ways through which homelessness has been conceptualized. Second, it reports the predisposing factors to homelessness as documented in the literature. The third section of the review conducts a critical account on the social consequences of homelessness. This is followed by an account on mental health consequences of homelessness. A review on the coping strategies commonly adopted by the homeless is presented in the fifth section. In addition, the literature review examines a variety of existing interventions for homelessness. Finally, the study makes a critique of the extant literature with references to shortfalls.

### **2.2.1. Nature of Homelessness**

The concept of homelessness has been variedly defined by different researchers, institutions, and across countries. Among these definitions, the lack of stable housing is central. However, there is much inconsistencies regarding the scope of classifications of homeless individuals based on quality of housing condition, standard of living, and accessibility to shelter. Cognizance of the divergent conceptualization of homelessness, Anderson and Tulloch (2000) conducted a dynamic pathway analysis of homelessness in the UK based on a critical review of the existing research evidence. The authors operated on the assumption that in order to better comprehend the concept of homelessness, it was imperative to adopt a dynamic, process-oriented

approach with a focus on its changing nature across time. Anderson and Tulloch found evidence in support of routes *into* and *out* of homelessness, but not *through* homelessness. They found age, poverty and low income as the most influential characteristics that predict differential pathways into homelessness. Consequently, they reported three fundamental pathways into homelessness that are age-related – youth pathways into homelessness (15–24 years); adult pathways into homelessness (20–50 years); and later life pathways into homelessness (50 plus years).

Similarly, Johnson, Zhu, and Ribar (2017) examined research evidence on homelessness among women in different countries through an extensive review of extant literature. In their review, Johnson et al., observed that although social problems associated with homelessness affect both men and women, the latter suffer exceptional consequences. Generally, the probability for women to become homeless was much greater than men. In situations that women became homeless, they also had the tendency to experience severe mental health outcomes. However, when specific categorizations were considered, such as sheltered homelessness and doubled-up homelessness, differences in the proportions of women and men who were homeless narrowed. In addition, the circumstances of women's homelessness varied from men's homelessness in terms of family structure. Women were highly-overrepresented in family as compared to men who were primarily in single-adult homelessness. This makes the experiences of homeless women even more devastating.

### **2.2.2. Causes of Homelessness**

There are several reasons in the literature that explain why certain individuals become homeless. Key among the causes of homelessness are unemployment, parental neglect, migration, orphanage, divorce, and poverty. In their comparison of causes of homelessness among 114

homeless individuals in Japan, Nishio and colleagues (2017) discovered that most homeless individuals identified economic difficulties as the primary cause of their homelessness. In addition, interpersonal relationship difficulties were also cited as crucial factors. They found that these difficulties were more detrimental to people with mental health challenges. Nishio and colleagues (2017) reasoned that for such individuals, the Housing First model is an appropriate approach. Among other things, the Housing First model seeks to provide housing assistance with no preconditions such as a minimum income requirement (Department of Housing and Urban Development, 2013).

In a comparative research in Australia, the United States and England on the causes of homelessness among adult individuals of 50 years and beyond, Rota-Bartelink and Lipmann (2007) observed that the most frequently reported factors leading to homelessness in Australia were interpersonal problems in households, physical and mental health problems, and difficulties in accessing housing. With regard to social support, Rota-Bartelink and Lipmann revealed that as many as 86% of Australian respondents had contacts with family or friends prior to becoming homeless, yet only 49% benefited from these contacts. More significantly, contact or friendship with colleague homeless persons was most commonly reported. In terms of gender, female homeless individuals were more likely than their male counterparts to seek help from relatives and friends. The majority of respondents did not seek assistance from professional services before becoming homeless.

Anderson and Christian (2003) contended that national statistics on homelessness in the UK focused on the individual in a crisis situation to the exclusion of the wider structural processes that lead to the homelessness situation. In these statistics, households were believed to have become homeless because of rent arrears, relationship breakdown, being discharged from

an institution, an encounter with natural disasters (such as flood, storm or fire), and loss of service tenancy. Inferably, the causes of homelessness portrayed in the official statistics on homelessness in the UK relate to factors that are considerably 'normal' to the life processes of formation and dissolution of households. Anderson and Christian alluded that commentaries and research in the UK have consistently failed to consider structural constraints such as poverty and ineffective housing policies.

Johnson, Zhu, and Ribar (2017) studied the personal, structural, and random causes of homelessness and found evidence on gendered patterns. Particularly, many women reported domestic and intimate partner violence as a precipitating cause of their homelessness. Compared to homeless men, homeless women were vulnerable to negative family experiences such as family breakdown, children's medical problems, and even partner incarceration. Additionally, homeless women were impacted by several of the same challenges facing their men counterparts such as lack of affordable housing, high rents, and childhood abuse, deprivation, or neglect.

Warnes and Crane (2006) compared the causes of homelessness in Boston, Massachusetts, Melbourne, Australia and four English cities. Their participants were homeless individuals who were 50 years old and over. Data in England was obtained from 131 participants on the circumstances and difficulties that influenced homelessness. Two-thirds of the respondents had never been homeless before. Those who had ever been homeless claimed that interactions between personal disadvantages and weaknesses, negative events and inadequate welfare support services were among the various reasons why they ended up homeless. For some, their personal behavior, rather than external factors, led to their homelessness. Others cited the failure of state agencies to timely respond to vulnerabilities, and poor sharing of information

between housing providers and welfare agencies, and deficiencies in administration of services and social security payments as among the causes of homelessness.

Davies and Allen (2016) identified runaway behavior as a major cause of homelessness among the youth, with prevalence estimates of 1 to 1.7 million youth in the U.S. Most homeless youths flee homes in an attempt to escape abuse in the home environment. They end up on the streets and become vulnerable to various forms of victimizations. According to Davies and Allen (2016), the street culture teaches these youths to be tough and makes them become susceptible to violent behaviors and crime. In the view of the authors, not only does childhood abuse predict victimization on the street, but it also makes runaway youth particularly susceptible to trauma-related mental health problems.

In a descriptive study, Phillips (2015) surveyed the views of 115 undergraduate students on homelessness. The participating students responded to questions on perceived causes, solutions, and stigma associated with homelessness. Generally, the respondents viewed unemployment, poor economic circumstances, drug abuse, and mental health problems as influential pathways to homelessness. Although most students reported stigmatizing attitudes on laziness, many did argue for public sympathy toward homeless individuals. Participants were keen on interventional programs for the homeless. They recommended a number of programs as viable interventions for the homeless. These findings suggest that while the public may hold certain stigmatizing views of the homeless, they are highly considerate in their attitudes and concerted in their efforts to find possible solutions.

### **2.2.3. Social Consequences of Homelessness**

Vaughn (2017) examined the narratives of homeless women with the aim of gaining insight into their experiences with interpersonal violence and its connection to their

homelessness. Vaughn acknowledged that previous research had demonstrated the high rates of interpersonal violence that homeless women experience, yet minimal research had focused on closely exploring these narratives to obtain a clearer picture of the complex dynamic processes concerning interpersonal violence and homelessness in women.

Vaughn (2017) presented research findings of six homeless co-researchers residing at a transitional living facility in the Midwest. The co-researchers had completed semi-structured interviews that explored experiences with interpersonal violence and pathways to homelessness. Vaughn identified several key themes from the interviews, including: 1) perspectives on what it means to be homeless, 2) initial pathways to homelessness, 3) adverse childhood experiences, 4) adult trauma, 5) pathways to chronic and/or repeated homelessness, 6) unhealthy coping strategies, 7) healthy coping strategies, 8) relationship between factors that contributed to homelessness, 9) helpful resources received by co-researchers to exit homelessness, and 10) perceived resources needed to exit homelessness.

#### **2.2.4. Mental Health Consequences of Homelessness**

Fekadu et al., (2014) examined the burden and prevalence of psychological disorders and associated unmet care needs among homeless individuals in Addis Ababa, Ethiopia. The psychological disorders of interest were psychological distress, alcohol use disorder and suicidality. Findings from the study showed extremely high levels of prevalence of mental disorders. Out of the sample of 217 homeless adults screened, 90% of them had experienced one form of mental disorder. Specifically, 60.0% of them had hazardous or dependent alcohol use, 41.0% experienced high levels of psychosis and 14.8% experienced attempted suicide in the previous month.

Apart from the high prevalence rates, Fekadu et al., (2014) found out that there was also high level of unmet needs for psychological care. For instance those with high levels of psychosis also had extensive unmet needs. Among these, 80% to 100% reported unmet needs across 26 domains. The findings showed further that less than 10% homeless persons with psychosis had ever received treatment for mental illness. Alcohol use was found to be positively associated with chronicity of homelessness, with those who have been on the street for long, recording higher alcohol abuse. They concluded that prevalence and severity of psychoses and other psychological disorders were high among homeless persons in Addis Ababa compared to the non-homeless population.

Comparatively, chronically homeless individuals are known to have higher rates of mental health problems than episodically homeless people or new-entry homeless people (Lippert & Lee, 2015). Following the cumulative disadvantage theory and drawing from stress research, Lippert and Lee investigated the extent to which current stressors and early life stressors affect this disadvantage. Using data from the US homeless population, Lippert and Lee examined how stressors and coping resources throughout the course of one's life explain observed differences in psychiatric disorders and drug abuse disorders among the homeless. Their findings revealed that new-entry homeless individuals had a greater likelihood to develop current psychiatric disorders compared to the chronically homeless and the episodically homeless. Childhood stressors and coping resources accounted for the observed differences in current psychiatric disorders in adult homeless life. This underscores the relevant role of childhood environment in the mental health of adult homeless individuals.

Cleverley and Kidd (2011) in a qualitative study, examined how personal and street-related factors influenced mental health among a group of 47 homeless youth in Hamilton,

Ontario, Canada. The mental health outcomes examined in the study were psychological distress, resilience, self-esteem and suicidality. Findings from the study showed that long duration of being homeless status virtually eroded self-esteem and resilience among the youth. They found further that the decreased self-esteem predisposed the youth to high levels of psychological stress and also that reduced resilience predisposed them to high levels of suicidal ideation.

In a related study, Chondraki et al., (2014) also examined prevalence of psychosocial stressors among a sample of 254 homeless people in Greece. They reported a prevalence rates of between 20.2% and 70% substance use, psychological stress and psychiatric disorders such as depression and suicidal ideation. Results further showed that older homeless individuals, high education and recognition of psychiatric problem was associated with high intentions of seeking help for psychological problems.

Studies report greater levels of stress among homeless individuals compared to the non-homeless. Several studies have reported that prolonged periods of homelessness affect both risk and protective factors of mental health disorders in different contexts. In Canada, a survey result indicated 24 percent higher level of stress among homeless adults than non-homeless adults (Canadian Institute for Health Information, 2006). In a different survey, homeless Canadian male youth reported twice as high stress level than a comparative non-homeless Canadian male youth (Votta & Manion, 2003). Research on homelessness in the United States of America confirmed higher stress, higher depressive symptoms, poorer health, and greater use of drugs and alcohol among youth who were homeless than those who were not (Unger et al., 1998).

In Ghana, De-Graft Aikins and Ofori-Atta (2007) reported the daily experiences of the homeless. In the context of their study, they defined homelessness as individuals living in squatter settlements. Through an interview with their participants, they assessed causes and

impact of homelessness, most frequently used coping strategies, implications for mental health and interventional measures. Three critical factors reflecting the daily experiences of their participants emerged from their analysis, namely financial, legal and psychosocial. De-Graft Aikins and Ofori-Atta found physical and psychological stresses prevalent among their participants. However physical illnesses were uncommon. Although coping strategies aided adaptation, they were not particularly effective in improving the living conditions of the homeless. This implies that coping strategies were used only as management techniques but not solutions to homelessness.

Asante, Meyer-Weitz, and Petersen (2015) investigated the relationship between risk behaviors and psychosocial problems among the homeless in Ghana. A survey based on an interviewer administered questionnaire was carried out due to higher rate of illiteracy among the participants. Asante et al., found as high as 87% of their participants experiencing severe psychosocial problems. The specific psychosocial problems found were hyperactivity (54%), emotional difficulty (69%), relationship problems (89%) and conduct disorders (74%). Substance abuse, violent behaviors and suicidal ideation were key defining traits of the participants.

There are fewer studies on the relationship between homelessness and suicide. However, qualitative studies provide indication that homelessness is a predictive factor of suicidality through a complex interaction with psychological variables (Kidd, 2004). These preliminary findings need further support.

Johnson et al. (2017) investigated the implications of homelessness on women and their children. Their findings showed that homeless women had greater tendency to report and experience sexual victimization compared to their male counterparts. Additionally, the

relationship between homelessness and physical health was stronger for women than for men. Another consequence of homelessness that Johnson et al. found to be highly gendered was intergenerational impact. Given the indispensable role of women as heads of homeless families, the impacts of homelessness on children were proportionally remarkable. For instance, children under the care of homeless women experienced poorer health outcomes. These findings suggest that policy interventions to homelessness should be tailored more to the needs of homeless women than men, especially when homeless women bear the responsibility of child care in addition to their daily hassles.

The mental health consequences of homelessness is argued to be more serious in older populations compared to the younger population. The reason is attributed to several risk factors that make older people in general and those on streets in particular more vulnerable to adverse mental health outcomes. These risk factors included reduced economic well-being, social isolation and depreciated physical health status (Opalach, Romaszko, Jaracz, Kuchta, Borkowska & Buciński, 2016). Several studies have shown that mental disorders are more prevalent and severe among the aged compared to the young population.

However, in developing countries for instance, research on mental health status among homeless aged population is hardly conducted to understand the issues in this at risk populations. In Ethiopia for instance, Tadesse (2017) argues that mental health literature has not paid the needed attention to the older generation. In a study that described the living conditions of homeless older people in Ethiopia, Tadesse (2017) conducted ethnographic accounts (combining observation, interviews and document reviews) of ten (10) homeless older people and four (4) key informants to understand their coping mechanisms and how that shape their psychological wellbeing. The findings from the study showed that multi-level factors intersect in complex ways

to shape negative mental health among the homeless people. Specifically, the results showed that health problems, extreme poverty, divorce, lack of social and legal protection unavailability of low cost housing and death of close relatives interact to cause negative health consequences on the homeless older people. These factors lead to social isolation, psychological problems and physical health problems.

### **2.2.5. Coping with Homelessness**

The literature on homelessness and mental health provides evidence to suggest that coping strategies may provide valuable psychosocial resource that buffer the stressors associated with homelessness. Studies have examined the stress management strategies of the homeless and have found strong association between coping skills and mental health (Public Health Agency of Canada, 2006). As earlier pointed out, coping skills have been categorized in many ways – both in broad and specific terms. This review assesses the impacts of several of these coping skills on mental health.

Earlier research opined that the use of problem-focused coping strategies improves mental health among homeless youth population, while avoidant or disengagement coping strategies have significant negative impacts on mental health (Ferguson et al., 2015; Votta & Manion, 2003) and sometimes lead to behavioral problems (Votta & Manion, 2003) as well as suicidality (Kidd & Carroll, 2007). In addition, there is evidence to show among non-clinical youth populations that using more emotion-focused coping is associated with higher incidence of anxiety, depression and other poor physical and mental health compared to using problem-focused coping (Nooe & Patterson, 2010).

Research reports that homeless people are likely to adopt distancing coping strategies in their attempt to minimize the effect of stressful events. In Canada, compared with the non-

homeless, homeless young men showed greater tendency toward the use of avoidance and withdrawal strategies in addressing their problems and in their social networks (Votta & Manion, 2003, 2004). These coping mechanisms predicted depression and behavioral problems (Votta & Manion, 2003). Tadesse (2017) also assessed coping strategies among a sample of 10 homeless older people in Ethiopia and reported that these older people used different coping strategies in dealing with the psychosocial stressors of homelessness. Among the coping strategies they employed were begging, spirituality (like use of holy water), building social network within and between themselves and living closer to religious places of worships as means of coping with the psychosocial and economic consequences of homeless.

Kidd and Carroll (2007) examined how coping strategies of the homeless influenced their suicidal behaviors. Their study was conducted among 208 homeless youths in the streets of Toronto and New York cities. The findings from the study showed that the homeless youth employed unproductive coping (e.g. avoidant coping, drug use and social withdrawal) strategies more often and that predisposed them to high risk of suicidal ideation and suicide attempts. Specifically, Kidd and Carroll (2007) reported that the use of avoidant coping, substance use and social withdrawal were associated with high levels of suicidal ideation and suicide attempts. The use of 'belief in a better future' as a coping strategy was found to significantly predict lower levels of suicidal ideation and attempts.

Dashora, Erdem and Slesnick (2011) also investigated how coping style influence behavioral problems among a sample of 268 homeless youth substance abusers in New Mexico. Findings from the study showed that use of high task-oriented coping style was associated with less delinquent behaviors while emotion-focused coping was associated with high levels of

depression, anxiety and delinquency. Contrary to many studies, avoidance coping predicted low levels of anxiety and depressive symptoms as well as less substance use.

Substance use has been identified as one of the maladaptive means in coping with homelessness. Fox et al., (2016) for instance reported that substance is implicated in the negative mental health outcomes in homeless population. In a structural modelling study involving 3,673 recently booked arrested who were homeless, they found that the link between homelessness and mental health was fully mediated by substance use (alcohol and drugs) and violent victimization.

McVicar, Moschion and van Ours (2015) also examined the dynamic relationship that exists between homelessness and substance use in Australia. The study was based on a panel dataset from the 'Journeys Home' project which collected 4 waves of surveys over two year period (between 2011 and 2013). The sample used for the study were 1325 individuals who were either homeless or at the risk of becoming homeless. They found a complex bi-directional relationship between homeless and substance to the effect that substance use among the sample was associated with the risk of becoming homeless and being homeless was also associated with high substance use. However, after controlling for individual characteristics, homelessness was not able to predict substance use but substance use predicting risk of homelessness still maintained significance.

In Merseyside in the U.K., Ross-Houle, Venturas, Bradbury, and Porcellato (2017) explored the role that the use of alcohol plays in the life experiences of homeless people. They discovered that an interaction of several negative life events that happened in a limited time period coupled with a lack of social support resulted in homelessness among many individuals. In addition, the occurrence of other adverse life events such as death of loved ones and relationship breakdowns was also a leading factor to homelessness and a significant predictor of

high levels of alcohol consumption. Among the homeless population, the use of alcohol as a coping mechanism was prevalent. Ross-Houle et al., (2017) identified the availability of support networks as a significant protective factor against homelessness or its debilitating consequences.

Closely in line with research on coping, there is an emerging trend in research studies that focus on resilience in at-risk populations as a product and a significant correlate of coping skills. These studies suggest that the effect of risky environments on individual mental health outcomes are mitigated by individual differences in coping with such environments (Asante et al., 2015; Chondraki et al., 2014). In resilience studies, different forms of coping strategies have been identified, with each of them having differential associations with mental health outcomes. In a systematic review of resilience studies, Cronley and Evans (2017) explored resilience and coping skills among youth experiencing homelessness. They searched eight databases, and 21 articles that fitted the inclusion criteria and represented four methodologies: qualitative, survey and secondary data analysis, quantitative, and mixed-method designs. Their review indicated that youth experiencing homelessness relied on informal social networks for survival, and that spirituality, mental health, and creativity were associated with enhanced coping.

In an empirical study, Fitzpatrick (2017) found optimism as a significant protective factor in mental health. Through an in-depth interview with 168 homeless adults in Northwest Arkansas, Fitzpatrick (2017) examined the extent to which optimism and social support contribute to reducing the adverse effect of homelessness on mental health. The evidence supported the protective role of optimism and social support in reducing the negative impacts of childhood life experiences on depressive symptoms among the homeless. Higher level of optimism among the homeless and greater support predicted lower levels of anxiety and

depressive symptoms. The findings point out the relevance of optimism and social support in preservation of good mental health among the homeless amidst their stressful life experiences.

Several other studies provides evidence to support the relationship between psychopathology and emotion-focused coping with notable gender differences. For instance, Ferguson et al., (2015), in their examination of gender differences in coping strategies among 601 young adults in Los Angeles, Austin and Denver cities of the United States, observed a greater tendency toward the use of drugs and alcohol as a method of coping among homeless women who had experienced both physical and sexual violence, in comparison with those who had experienced only physical abuse. Again, disengagement coping strategies was found a strong significant predictor of post-traumatic stress and depression in women with histories of domestic violence. In the full model, both avoidant coping and problem-focused coping were associated with major depressive symptoms and substance use disorder. Both depressive symptoms and substance use disorder were more pronounced for homeless women than for homeless men (Ferguson et al., 2015).

According to Johnson and colleagues (2017), there are psychological and material coping mechanisms that men and women adopt to enhance their survival when confronted with challenging situations. In a housing crisis situation, women's coping approach differs from their male counterparts in both an advantageous and disadvantageous ways. In beneficial terms, when confronted with the loss of housing, women draw on their social support networks for the provision of temporary or permanent accommodation. In detrimental terms, compared to men, women seem more reluctant to pursue the firm economic strategies once homeless, though some women do engage in highly risky strategies such as prostitution and sexual barter.

Gender differences in coping skills have also been observed among homeless youth. Regarding suicide risk, homeless males and homeless female are known to use different strategies in coping. Kidd and Carroll (2007) noted a significant interactions of gender with social withdrawal and avoidant coping methods. The authors observed that when feeling helpless or trapped, homeless females adopted social withdrawal strategy and avoidant coping while their male counterpart did neither. This may predict greater risk of suicide for female homeless than male homeless individuals.

#### **2.2.6. Interventions for Homelessness**

Housing-first model has been pervasive in policies aimed at addressing the menace of homelessness in many developed countries. Housing-first policy intervention does not only entail provision of housing facilities, but more importantly the provision of essential services that meet the social and health-care needs of the individual. It has been proven that the application of the housing-first model has facilitated the coping abilities of many homeless individuals in managing the myriad of problems associated with homelessness (Atherton & Nicholls, 2008). It should however be acknowledged that housing-first model, though proven effective, maybe expensive and unaffordable in developing countries. Even in the U.S. where the model is implemented, it is applied to only a restricted number of homeless individuals – specifically the chronically homeless with major health complications and/or weak social support. The housing first program is reported to have salubrious effects on health and well-being (Atherton & Nicholls, 2008). In terms of mental health benefits, the housing-first policy reduces psychiatric and emergency admissions. Socially, it insulates individuals from crime and arrests. Given these benefits, it will be necessary for developing countries to create the resources that will support effective

implementation of the housing-first policy, at least for the chronically homeless and vulnerable homeless populations such as women and children.

According to Speak and Tipple (2006), many interventional policies for homelessness in developing countries have been unsuccessful. They are loosely drafted and poorly implemented in an uncritical and unsupervised environment with apathetic attitude towards intended beneficiaries. In many developing countries, the homeless individuals to whom interventions are designed sometimes experience negative and derogatory portrayals from society. They are sometimes labeled or perceived as drunks, unemployed, beggars, and criminals. According to CARDO (2003), this perception is largely false. Speak and Tipple (2006) argued that without correction of this pervasive misconception, even the most well-intentioned interventional policies will yield little or no lasting effect.

Griffith, Seymour, and Goldberg (2015) reasoned that both financial strain and psychosocial challenges may contribute to the incidence of homelessness. On the basis of this reasoning, Griffith et al., probed the impact of financial and psychosocial distress resolution on art therapy for the homeless. At a community resource center, clients participated in an open studio which largely addressed their psychosocial needs (e.g., improved coping skills). They also engaged in an artists' cooperative (i.e., art sales) which addressed their financial needs. Clients' participation in the open studio led to greater life achievements. More impressively, engagement in the cooperative led to even higher life achievements. For non-cooperative members, continuous visit to the open studio led to a steady increase in life achievement. These findings underscore the differential and overlapping benefits of open studio and cooperative interventions for homeless individuals who may be experiencing both financial strain and psychosocial challenges.

In their determination to prevent recurrent homelessness among individuals with severe mental health problems, Herman, Conover, Felix, Nakagawa, and Mills (2007) designed the critical time intervention which focused on promoting continuity of care during the transition from institutional to community living. The major goal of this intervention is to prevent recurrent homelessness and other adverse consequences during the transitional period from institutional centers (such as shelters, and hospitals) into community. It achieves this in two ways: first, by strengthening the long-term ties of the individual to services, family, and friends; and second, by providing practical and emotional support during the transitional period. The intervention focuses on both primary prevention (i.e., preventing non-homeless individuals from becoming homeless), and secondary prevention (i.e., reducing the duration and damaging effects of homelessness once it occurs). Based on its preventive focus, the critical time intervention may be broadly applicable and generally effective in addressing the problem of homelessness.

McKenzie-Mohr, Coates, and McLeod (2011) asserted that trauma among homeless youth may be increasingly pervasive. Through a politicized paradigm of trauma, McKenzie-Mohr and colleagues explored the complex nature of the challenges facing young homeless individuals in social, relational, psychological, and political domains. Their evaluation revealed heightened tension in the needs of the young homeless and trauma in various life domains which existing interventional models failed to effectively address. Given the intensity of trauma, McKenzie-Mohr et al. called for a paradigmatic shift to therapeutic interventions which, they believed, would be helpful in alleviating the adverse effects of trauma on the homeless. They emphasized the incorporation of community services that are responsive to traumatic life experiences of the individual and socially responsible policies that guarantee provision of vital services and ultimately address underlying causes of homelessness among the youth. Although

the authors acknowledged that the existing models of trauma-based services achieve some results, they were skeptical on their long-term effects. For this reason, McKenzie-Mohr and colleagues recommended the adoption of a more radical approach. They introduced a framework that integrates the strengths, prevention, empowerment, and community conditions (SPECs) model (Evans & Prilleltensky, 2007; Prilleltensky, 2005) with trauma-based service provision. In this way, McKenzie-Mohr and colleagues were successful in using both social and political paradigms as a tool for achieving effective resolution of the challenges associated with youth homelessness.

Davies and Allen (2016) maintained that most runaway youth exhibit posttraumatic stress symptoms disorder (PTSD) at significantly higher rates compared to the non-homeless youth. However, there is a notable difference in the manifestation of the PTSD among homeless youth, which is primarily related to the dynamics in street-related cultural life. In spite of the high vulnerabilities of homeless youth population with unusually higher degree of PTSD, there are few empirically tested interventions that are culturally sensitive for traumatized homeless youth. According to Davies and Allen, the existing interventional models have little to no high quality empirical backing. Clinicians therefore have a responsibility to design a uniform, empirically tested and effective trauma intervention suitable for homeless youth population. It is only by such means that the unique challenges facing homeless youths can be effectively resolves.

In semi-structured interviews and focus group discussions, Stona et al., (2015) investigated the life pathways of the homeless, their needs and expectations, and difficulties that confront them on regular basis. The participants in their study included homeless individuals in Caritas housing facilities who had permanently stayed over for a period of 2 years or temporarily over a period of 3 years, as well as Caritas professionals and Luxembourgish psychiatrists.

Focusing on the needs and expectations of the participants regarding their future, the authors identified key areas of concerns among the homeless participants. Among these concerns were (i) desire for freedom and peacefulness, (ii) desire for own space, and (iii) desire to normal lifestyle like all others. These findings spell out the need to develop interventions that focus on respect for freedom and personal choice in housing and support policies.

### **2.2.7. Summary of Literature**

The reviewed literature has highlighted the nature, causes, and consequences of homelessness in the Ghanaian and global contexts. In Ghana, De-Graft Aikins and Ofori-Atta (2007) defined homelessness as individuals living in squatter settlements. This does not suggest that individuals without any form of structures or individuals living on the streets cannot be found in Ghana. Anderson and Tulloch (2000) made a critical review of the existing research that demonstrate dynamic pathway to homelessness in the UK and found evidence in support of routes *into* and *out* of homelessness, but not *through* homelessness. Several causes of homelessness have been identified in the literature with economic factors being key (Nishio et al., 2017). Poverty, low income, and age are significant characteristics that predispose individuals to homelessness (Anderson & Tulloch, 2000; Griffith et al., 2015). Other causes of homelessness are difficulties in accessing housing facilities, physical and mental health problems, and interpersonal problems in households (Rota-Bartelink & Lipmann, 2007).

A number of the reviewed studies have exposed the prevalence of mental health problems among the homeless in developed countries (e.g., Cleverley & Kidd, 2011; Lippert & Lee, 2015) and in Africa (e.g., Chondraki et al., 2014; Fekadu et al., 2014; Tadesse, 2017). Qualitative reports in Ghana have suggested the existence of mental health difficulties among the homeless and their coping efforts (De-Graft Aikins & Ofori-Atta, 2007).

Different coping strategies and their effectiveness on homelessness have been discussed in the literature. For example, the use of problem-focused coping is known to improve mental health among homeless populations, while avoidant or disengagement coping strategies have significant negative impacts on mental health (Ferguson et al., 2015; Votta & Manion, 2003) and sometimes lead to behavioral problems (Votta & Manion, 2003) and suicidality (Kidd & Carroll, 2007). Compared to problem-focused coping, greater use of emotion-focused coping is associated with higher incidence of anxiety, depression and poor physical and mental health outcomes among non-clinical (Nooe & Patterson, 2010).

Finally, the literature review examined existing interventions for homelessness. The critical time intervention was discussed as a means to foster community reintegration and prevent recurrent homelessness among individuals with severe mental health problems (Herman et al., 2007). Housing first model was discussed as a pervasive interventional policy used to address homelessness in many developed countries (Atherton & Nicholls, 2008). In terms of mental health benefits, the housing-first policy intervention was reported to reduce psychiatric and emergency admissions. It was also reported to have the benefit of shielding individuals from crime and arrests.

While housing policy intervention may be promising in terms of its impacts on homelessness, it may be expensive to implement in developing countries like Ghana. Speak and Tipple (2006) attributed the failure of many interventional policies for homelessness in developing countries to poor designs, improper implementation, and lack of supervision coupled with the negative and derogatory portrayals of the homeless in communities. However, CARDO (2003) reacted that the social perception of the homeless as drunks, unemployed, beggars, and criminals are inaccurate portrayals that need to be corrected.

### **2.3. Rationale for the Study**

Studies examining mental health outcomes of homelessness have indicated that homeless individuals experience elevated levels of anxiety, depressive symptoms and suicidality (e.g., Cleverley & Kidd, 2011; Lippert & Lee, 2015). Coping strategies have also been linked to mental health among homeless individuals. These insights notwithstanding, there are still limitations in current state of the literature that need to be addressed.

Even though several studies have examined the association between homelessness and mental health (e.g., Chondraki et al., 2014; Cleverley & Kidd, 2011; Fekadu et al., 2014; Lippert & Lee, 2015; Tadesse, 2017), homelessness still remains an important area for further studies for several reasons. First, majority of the studies have focused on prevalence of mental illnesses among homeless persons. Despite the rich information available, there are limitations in the literature regarding the assessment of the severity of these mental health consequences. Secondly, there is the need to provide robust models that provide explanations of linking mechanisms to informed policy regarding the holistic ways of improving mental health of homeless persons, particularly in developing countries. This calls for multi-level understanding on the complexities of factors operating at different levels of analyses that link homelessness to mental health outcomes. The limitations in the current literature, especially in resource-poor contexts such as Ghana, ought to be addressed with a sense of urgency.

Although the reviewed studies show that homelessness has received much research attention, there is a significant gap in research contexts across countries. Contextual patterns of the reviewed studies reveal that there is much focus on homelessness in developed countries due to availability of reliable data on homeless individuals, clearer definition of the concept, and motivation for designing interventional policies in such countries. The absence of these factors in

developing countries should not undermine the urge to carry out an investigation to provide useful information on this crucial phenomenon that sometimes become life-threatening. Thus, experiences of homeless people in Ghana, their predominant coping strategies and their mental health status deserve similar research attention.

Methodologically, studies on homelessness in Ghana have mostly relied on qualitative design to identify mental health problems associated with homelessness (De-Graft Aikins & Ofori-Atta, 2007). Based on the shortfall of qualitative research, the present study was conducted with mixed method design in an attempt to compensate the shortfalls of both quantitative and qualitative methods. Consequently, the quantitative approach was designed to address essential issues revealed in earlier qualitative studies on homelessness in Ghana. The qualitative approach aimed at providing in-depth understanding into the idiosyncratic experiences of the homeless individuals in Ghana. In other words, the adoption of mixed method allowed the researcher to test earlier qualitative research findings on homelessness in Ghana with quantitative data and subsequently verified the quantitative findings with qualitative interview that laid bare participants' innermost feelings and experiences with homelessness.

#### **2.4. Statement of Hypotheses**

**Hypothesis 1:** There will be significantly higher levels of psychosocial distress among homeless participants than non-homeless participants.

**Hypothesis 2:** Female homeless participants are likely to experience significantly higher levels of psychosocial distress than male homeless participants.

**Hypothesis 3:** The homeless will adopt adaptive coping strategies more frequently than maladaptive coping strategies.

**Hypothesis 4:** Maladaptive coping will predict higher levels of psychosocial distress than adaptive coping.

## 2.5. Research Questions

**Question 1:** How does homelessness affect individuals' personal life?

**Question 2:** By what means do individuals cope with homelessness?

**Question 3:** How effective do individuals perceive their coping behavior?

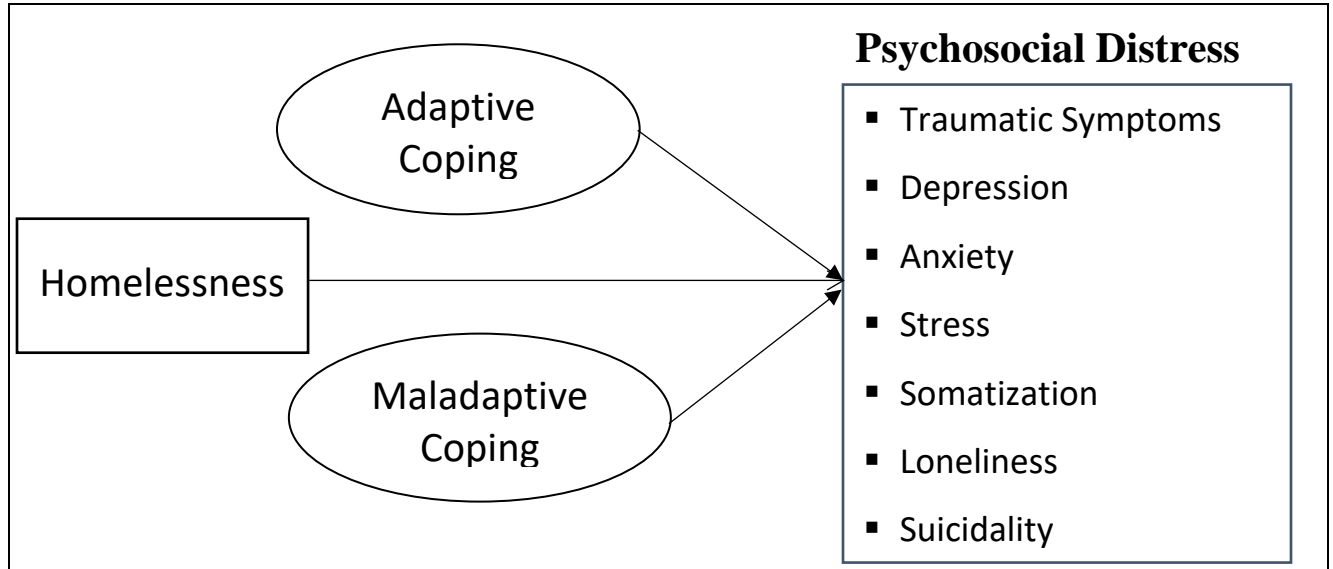
**Question 4:** What kind of optimism do homeless individuals have towards life?

**Question 5:** What type of interventional resources do individuals require to address their homelessness situation?

## 2.6. Operational Definitions of terms/concepts

- **Homelessness:** A state of being without a home and sleeping in shelters, outdoors, or in areas not fit for human dwelling.
- **Psychosocial distress:** Traumatic symptom, depression, anxiety, stress, somatization, loneliness, and suicidality.
- **Coping:** Strategies employed by the homeless in dealing with psychosocial distress associated with homelessness. It may be adaptive or maladaptive.
- **Adaptive coping:** Coping strategies involving the use of religion, planning, emotional support, positive reframing, acceptance, instrumental support, active coping, and humor.
- **Maladaptive coping:** Coping strategies involving venting, behavioral disengagement, substance use, self-distraction, self-blame, and denial.

## 2.7. Hypothesized Conceptual Model for the Study



**Figure 2.** Hypothesized model for the relationship between homelessness, coping mechanisms, and psychosocial distress.

The above model (Figure 2) predicts that homelessness is likely to affect psychosocial distress. Psychosocial distress was operationalized as traumatic symptoms, depression, anxiety, stress, somatization, loneliness, and suicidality. The model further hypothesizes that both adaptive and maladaptive coping mechanisms have influences on psychosocial distress of the homeless.

## CHAPTER THREE

### METHODOLOGY

This chapter outlines the methodological approaches in conducting the research. It provides justification for the choice of research design, and detailed information about the population of interest, the sample and sampling technique that was employed. The chapter also provides descriptions of the measuring instruments, procedure for data collection, and ethical issues which were addressed in the research process.

#### **3.1. Design**

A mixed-method design was used for the study. This design involves the application of both quantitative and qualitative research approaches in the investigation of the same phenomenon (Bogdan & Biklen, 2006). According to Maxwell and Loomis (2003), different research approaches should be used to address different research needs. However, it should be noted that each research approach has its intrinsic weaknesses and strengths. Consequently, there should be thoughtful considerations in the decision to combine different research approaches or in making a preference of one over others. In situations, where a particular research situation necessitates the combined use different approaches, their usage needs to be justified.

In the current study, an explanatory mixed method design was employed. It involved combination of two major research approaches (i.e., quantitative and qualitative approaches) in two studies (i.e., study I and study II) that investigated the same phenomenon. In so doing, triangulation technique was employed. Triangulation is a technique that enables the validation of research data through cross verification from different sources. The technique allowed the researcher to use quantitative data for the testing of specific research hypotheses and, at the same time, use qualitative data to address a set of clearly defined research questions. More importantly, the researcher was able to confirm the validity of earlier qualitative research

findings with quantitative data, and then verified the current quantitative findings with qualitative data (obtained through one-on-one interview with homeless participants).

First, the researcher conducted a quantitative cross-sectional survey to obtain quantitative data to test the research hypotheses in study 1. The quantitative cross-sectional survey captures self-report information of the participants' experiences, feelings, and thoughts on their psychosocial life. Structured questionnaires were used to achieve this purpose. According to Bryman (2004), questionnaires are the most useful quantitative tools for data collection in survey research. They are perceived as the most convenient way of obtaining information in a systematic order (Wilson & McClean, 1994). They facilitate the presentation of the same set of questions to respondents and numerical recording of their responses in a systematic and methodological manner that expedites analysis (Cohen, Manion, & Morrison, 2000). Given the time dimension, cross-sectional design was adopted. Individuals of different ages, gender, and socio-economic status were randomly selected from the target population and studied at a given time period (Bless & Higson-Smith, 2000).

In study II, the researcher conducted a one-on-one interview with homeless participants. The interview method focused principally on the biographic life pathways of homeless persons. As a result, it provided a considerable room for narration. Responses from homeless participants were not very structured. Given that participants were largely illiterate and could not communicate well in the English language, the researcher chose to conduct the interview in Twi – a local language that all the participants could easily relate to. The researcher made audio recordings of the interviews. Aftermath of the interview, the recordings were translated and transcribed into textual form.

### **3.2. Population**

Homeless people in the Greater Accra region of Ghana constituted the research population. Researchers have consistently found it challenging to study this population (Robertson et al., 2007). One major challenge is difficulty in accessing data on the homeless population, especially in developing countries. The lack of, or inaccurate, data on the homeless in many developing countries poses difficulties to researchers in their bid to gather relevant information on the subject matter. Researchers also face logistical constraints in efforts to conduct personal interviews with the homeless population, primarily due to their nomadic movement.

The second major challenge is the inconsistency in defining homelessness. As earlier mentioned, definitions of homelessness vary by intended use. For the purpose of this study, the definition in the HEARTH Act 2009 (HUD, 2016) will be used. This definition describes homelessness beyond literal homelessness to include individuals facing the imminent loss of housing, fleeing domestic violence, and other critical circumstances. The definition identifies literally homeless as individuals sleeping in shelters, in the open, or in areas not appropriate for human dwelling. The literally homeless category is particularly reflective of the homeless situation in Ghana.

### **3.3. Sample**

One hundred and eighty-three ( $n=183$ ) participants were drawn for the study. They were chosen from the Greater Accra Region which is the most populous region for the homeless. Greater Accra region is the capital region of Ghana and it attracts several individuals seeking greener pastures. The sample consisted of 47.0% homeless people ( $n=86$ ) and 53.0% non-homeless people ( $n=97$ ) who served as control.

Table 1  
*Demographic Characteristics of the Respondents*

Variable	Homeless <i>n</i> =86 (47.0%)	Non-homeless <i>n</i> =97 (53.0%)	Total <i>N</i> =183(100%)
<b>Gender</b>			
<i>Males</i>	41 (47.7%)	46 (47.4%)	87 (47.5%)
<i>Females</i>	45 (52.3%)	51 (52.6%)	96 (52.5%)
<b>Age range</b>			
14 – 49 years	<i>M</i> =27.37, <i>SD</i> =9.53	<i>M</i> =22.80, <i>SD</i> = 7.41	<i>M</i> =24.95, <i>SD</i> =8.75
<b>Marital Status</b>			
<i>Never married</i>	63 (73.3%)	76 (78.4%)	139 (76.0%)
<i>Married</i>	14 (16.3%)	21 (21.6%)	35 (19.1%)
<i>Divorced</i>	6 (7.0%)	0 (0.0%)	6 (3.3%)
<i>Widowed</i>	3 (3.5%)	0 (0.0%)	3 (1.6%)
<b>Educational Background</b>			
<i>No formal education</i>	36 (41.9%)	1 (1.0%)	37 (20.2%)
<i>Basic education</i>	43 (50.0%)	2 (2.1%)	45 (24.6%)
<i>Secondary education</i>	7 (8.1%)	60 (61.9%)	67 (36.6%)
<i>Tertiary education</i>	0 (0.0%)	34 (35.1%)	34 (18.6%)
<b>Religious Affiliation</b>			
<i>Christianity</i>	40 (46.5%)	89 (91.8%)	129 (70.5%)
<i>Islam</i>	46 (53.5%)	8 (8.2%)	54 (29.5%)
<b>Home Region</b>			
<i>Greater Accra</i>	0 (0.0%)	12 (12.4%)	12 (6.6%)
<i>Ashanti</i>	13 (15.1%)	18 (18.6%)	31 (16.9%)
<i>Central</i>	9 (10.5%)	15 (15.5%)	24 (13.1%)
<i>Western</i>	5 (5.8%)	2 (2.1%)	7 (3.8%)
<i>Eastern</i>	5 (5.8%)	15 (15.5%)	20 (10.9%)
<i>Volta</i>	6 (7.0%)	26 (26.8%)	32 (17.5%)
<i>Northern</i>	27 (31.4%)	7 (7.2%)	34 (18.6%)
<i>Brong Ahafo</i>	0 (0.0%)	2 (2.1%)	2 (1.1%)
<i>Upper East</i>	10 (11.6%)	0 (0.0%)	10 (5.5%)
<i>Upper West</i>	11 (12.8%)	0 (0.0%)	11 (6.0%)

Table 1 demonstrates the distribution of the demographic characteristics of the sample.

The ages of the participants ranged from 14 years to 49 years (*M*=24.95, *SD*=8.75). In terms of gender composition, descriptive analyses showed greater participation of females (52.5%) than

males (47.5%). Majority of the participants were singles who had never married (76.0%). With regards to religious affiliation, as many as 70.5% were Christians and the remaining 29.5% were Muslims.

Expectedly, there was a significant educational gap between homeless participants and non-homeless participants. Majority of homeless participants were either uneducated (41.9%) or had received only basic education (50.0%). On the contrary, non-homeless participants mostly had secondary education (61.9%) or tertiary education (35.1%). [See Table 1 for detailed analyses of demographic characteristics of the participants].

### **3.4. Sampling Technique**

Purposive sampling technique was adopted in choosing the sample. This technique requires the selection of participants due to the relevance of their characteristics to a research study. Here, the researcher purposely searched out for people who were either homeless or non-homeless from the general population and recruited them for the study. Given the vast nature the population, the lack of sample, sample-frame, and the difficulty in accessing homeless people, the choice of purposive sampling technique became most appropriate in addressing the peculiar needs of this research.

### **3.5. Measures**

Data collection was conducted through the use of questionnaire. The questionnaire had seven sections. The first section (Section A) measured the demographic variables of the participants. These variables included gender, age, level of education, religion, marital status, and housing conditions. The last six sections (Section B to G) of the questionnaire comprised standardized scales that measure the key research variables.

### **3.5.1. The Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980)**

The revised UCLA loneliness scale is a scale with 20-items that measures individuals' feelings of loneliness and isolation. The UCLA loneliness scale (Russell, Peplau, & Ferguson, 1978) was revised by Russell, Peplau and Cutrona (1980) through reversed scoring of some of its test items. Sample items include "There is no one I can turn to", "I am no longer close to anyone" and "I feel left out". Each item on the scale is rated as Never (1), Rarely (2), Sometimes (3), and Often (4).

For each participants total score may range from 20 (lowest) to 80 (highest). Higher scores represent greater level of loneliness and lower scores represent less level of loneliness. With regard to the psychometric properties of the UCLA loneliness scale, Russell (1996) reported Cronbach's alpha reliability coefficient range of .89 - .94, and a one year test-retest reliability coefficient of .73

### **3.5.2. The Depression, Anxiety and Stress Scale – 21 (DASS-21; Lovibond, & Lovibond, 1995)**

The DASS-21 assesses the psychosocial symptoms of depression, anxiety, and stress. It consists of three subscales with seven items each. The subscales are labeled DASS-D as (for depression), DASS-A (for anxiety), and DASS-S (for stress). DASS-D measures devaluation of life, dysphoria, lack of interest, hopelessness, self-deprecation, anhedonia and inertia. DASS-A evaluates situational anxiety, skeletal muscle effects, autonomic arousal, and subjective experience of anxious affect. DASS-S measures nervousness, difficulties in relaxation, and irritability.

Sample items include "I couldn't seem to experience any positive feeling at all", "I tended to over-react to situations" and "I found it difficult to relax". Each item on the scale is

rated Never (0), Sometimes (1), Often (2), and Almost always (3). Each sub-scale of DASS-21 is scored by adding up their respective rating scores. The cumulative score ranges from 0 to 21 for each sub-scale; and 0 to 63 for the whole scale. High Cronbach's alpha reliability has been reported for DASS-D (.90), DASS-A (.83), and DASS-S (.86).

### **3.5.3. Modified PTSD Symptom Scale-Self Report (MPSS-SR; Falsetti, Resnick, Resick, & Kilpatrick, 1993).**

The MPSS-SR is a 17-item measure that employs a 5-point Likert-type scale to measure the frequency and severity of post-traumatic stress disorder symptoms. Response options range from “not at all” (rated 0), “a little bit” (rated 1), “moderately” (rated 2), “quite a bit” (rated 3), “to extremely” (rated 4). Total rating scores range from 0-68. Sample items are, “Have you had repeated or intrusive upsetting thoughts or recollections of the event(s)?”, “Have you been having repeated bad dreams or nightmares about the event(s)?” and “Have you had the experience of suddenly reliving the event(s), flashbacks of it or acting or feeling as if the event were happening again?”. The MPSS-SR has high Cronbach's alpha reliability .96.

### **3.5.4. The Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001)**

The SBQ-R is a 4-item rating scale that measures the history of suicide behaviors, suicidal ideation, frequency of suicidal ideation, previous suicide attempts, and the probability of future suicidal attempts. Sample items from the scale are “Have you ever thought about or attempted to kill yourself?” and “How likely is it that you will attempt suicide someday?” Responses to the SBQ-R differ across its items. Rating scores are assigned with numbers in ascending order. Item 1 is scored on a rating scale of 1 – 6; item 2 is scored on a rating scale of 1- 5; item 3 is scored on a rating scale of 1 – 5; and item 4 is scored on a rating scale of 1 – 7. The rating scores on all 4 items are summed up to generate a single measure of suicidality for each respondent. The summated score may be as low as 4 and as high as 23. Higher scores

suggest greater risk of suicidality and lower scores suggest less risk of suicidality. The SBQ-R is known to have a Cronbach's alpha reliability coefficient of .88.

### **3.5.5. The Somatic Symptom Scale–8 (SSS-8; Gierk et al., 2013)**

The SSS-8 is a short version of the PHQ-15 questionnaire (Kroenke, Spitzer, & Williams, 2002). It was designed to measure fatigue, pain, cardiopulmonary and gastrointestinal elements of the somatic symptom burden. Sample items include “back pain”, “headaches” and “trouble sleeping”. Response options comprise not at all (rated 0), a little bit (rated 1), somewhat (rated 2), quite a bit (rated 3), and very much (rated 4). The total rating scores range from 0 – 32. The SSS-8 is reported to have a Cronbach’s alpha reliability of .81.

### **3.5.6. The Brief COPE (Carver, 1997).**

The Brief COPE (Carver, 1997) is a 28-item scale that exist in 14 subscales. It is used to measure various aspects of coping strategies in certain stressful situations. Each of its 14 subscales contains 2 items. The subscales are further categorized into adaptive and maladaptive coping strategies. Adaptive scales consist of religion, planning, the use of emotional support, positive reframing, instrumental support, acceptance, active coping and humor. Maladaptive subscales venting, behavioral disengagement, substance use, self-distraction, self - blame and denial. Sample items include “I've been turning to work or other activities to take my mind off things”, “I've been concentrating my efforts on doing something about the situation I'm in”, and “I've been getting comfort and understanding from someone”. Response to each item range from “I haven't been doing this at all” (rated 1), “I've been doing this a little bit” (rated 2), “I've been doing this a medium amount” (rated 3), and “I've been doing this a lot” (rated 4). The total rating scores range from 28 – 112. The Brief COPE is reported to have a Cronbach’s alpha reliability of .90.

### **3.6. Inclusion and Exclusion Criteria**

#### **3.6.1. Inclusion Criteria**

Individuals without stable housing conditions qualified for this study. Also individuals who are 10 years and above qualified for the study.

#### **3.6.2. Exclusion Criteria**

Individuals with chronic illness, physical or mental disabilities were not allowed to partake in the study. Individuals who are staying with friend and family were also not allowed to partake in this study. Individuals who were not able to speak and understand the language(s) used in this study were excluded from the study due to language barrier.

### **3.7. Procedure**

#### **3.7.1. Preliminary Preparation**

The researcher developed the research proposal, questionnaires, consent forms and other supporting documents and submitted them for ethical clearance from the Ethics Committee for Humanities (ECH) at the University of Ghana. Furthermore, the researcher obtained a letter of introduction from the Department of Psychology of University of Ghana. During data collection, the researcher used the letter of clearance and letter of introduction to introduce herself to prospective research participants. The letters also helped the researcher to declare the purpose of the study to the prospective participants.

The researcher translated the questionnaire into the major Ghanaian language (Twi) which most Ghanaians could relate to irrespective of their ethnic background. The translation process involved three steps. First, the questionnaire was translated from English to Twi with the aid of two individuals who were well acquainted with both languages. Second, there was a reverse-translation whereby two other individuals with good knowledge in both languages (i.e., English and Twi) translated the Twi version of the questionnaire to English. Finally, the

researcher compared the second translation (English version) to the original version of the questionnaire for consistency. The researcher then reconciled some slight differences that were observed in the two versions. The final product was piloted for accuracy before being used for data collection. In situations where a participant could not comprehend neither the English language nor the Twi language, the assistance of a native speaker of a particular Ghanaian language was sought to facilitate local translation to other languages.

### **3.7.2. Pilot Study**

A pilot study was carried out by the researcher to test the reliability of the measuring instruments (questionnaire). The pilot study was also meant to find out the resources that were required for the conduct of the actual study. Finally, the pilot study provided feasibility benefits in estimating time frame for the completion of research questionnaires by individual research participants and in forecasting possible duration for the entire data collection exercise. There were 22 participants (11 homeless and 11 non-homeless) who participated in the pilot study. They were drawn from the Greater Accra region and included both females and males of 10 years and above. Each homeless research participant spent approximately 25 minutes to complete their questionnaire. The non-homeless, on the other hand, spent an average of 18 minutes to complete their questionnaires. The difference in time rate was primarily due to the fact that homeless participants had a lengthier questionnaire than the non-homeless. The latter was excluded from responding to questions on coping based on the researcher's judgement that questions on coping were not particularly relevant to the non-homeless. Data collection for the pilot study lasted for about a week. Below is the results of reliability analysis of the scales in the pilot study.

Table 2

*Reliability Results on Psychosocial Distress Scales in Pilot Study*

Scales/subscales	Number of Items	Cronbach's alpha ( $\alpha$ )
Revised UCLA Loneliness Scale	20	.83
DASS-21	21	.93
<i>DASS-D</i>	7	.78
<i>DASS-A</i>	7	.80
<i>DASS-S</i>	7	.86
MPSS-SR	17	.92
SBQ-R	4	.60
SSS-8	8	.94

*n*=22

Table 3

*Reliability Analyses of Brief COPE among Homeless Participants in Pilot Study*

Brief COPE	Number of Items	Cronbach's alpha ( $\alpha$ )
Adaptive coping	16	.68
<i>Active coping</i>	2	.69
<i>Use of emotional support</i>	2	.55
<i>Use of instrumental support</i>	2	.58
<i>Positive reframing</i>	2	.51
<i>Planning</i>	2	.53
<i>Humor</i>	2	.80
<i>Acceptance</i>	2	.57
<i>Religion</i>	2	.86
Maladaptive coping	12	.63
<i>Self-distraction</i>	2	.48
<i>Denial</i>	2	.57
<i>Substance use</i>	2	.59
<i>Behavioral disengagement</i>	2	.76
<i>Venting</i>	2	.78
<i>Self-blame</i>	2	.64

*n*=11

Inferring from Table 3, most of the subscales of the Brief Cope had low reliabilities ( $\alpha < .70$ ). Item analyses of the subscales revealed that items 1, 5, 6, 17, and 25 were either contributing negatively or not contributing at all to the reliabilities of the subscales. Consequently, these items were reworded, rephrased, reconstructed, or retranslated to make them more meaningful and more related to the circumstances of the homeless participants.

### **3.7.3. Data Collection**

Following the pilot study, the researcher printed a total of 200 copies of the research questionnaires for the purpose of administering them to the research participants. Two university graduates were engaged as research assistants for the purposes of data collection and data entry exercises. The researcher and her assistants located homeless people at strategic locations in the major cities in the Greater Accra region. Particularly, the homeless were located in the open; on the streets, and market places which often serve as their place of abode at night. The non-homeless were located at their homes, institutions, and workplaces.

In line with ethical requirements, the researcher and her two assistances explained the nature and purpose of the study to prospective participants and requested for their participation. Upon consent, the researcher and her assistants provided the prospective participants with the informed consent forms to read and decide whether or not they were still willing and ready to participate in the study. While some prospective participants gave written consents, others did so orally. Individuals who declined participations were never forced, pressured, nor coerced to do otherwise. Only those individuals who willingly and freely consented were engaged in the study. Participants were allowed ample time to complete the questionnaires. Averagely, homeless participants spent 25 minutes on their questionnaires while their non-homeless counterparts spent 18 minutes based on the known fact that the former had a lengthier questionnaire.

The researcher and her assistants were thankful toward their participants for their time and effort. In the form of appreciation, the researcher gave out monetary compensation of GH¢10.00 (approximately US\$ 2.00) to each homeless research participants after their participation. The timing was to ensure that the offer was not perceived by the participants as an inducement for participation. The selective nature of the offer to only the homeless participants was based on two reasons. First, the researcher could not afford to give the offer to all participants given that there was no external financial sponsorship for the research. Second, the researcher found the homeless participants in most need for some form of assistance. Out of the 200 questionnaires which were administered, 191 were retrieved. Eight of the retrieved questionnaires were incomplete and were therefore rejected at the data entry stage. The remaining 183 questionnaires were deemed valid for the data analyses.

#### **3.7.4. Processing of Qualitative Data**

Oral responses of the participants in the one-on-one interviews were transcribed into textual form. Thematic analysis technique was applied to analyze the transcribed data. Data was transcribed and analyzed by four people comprising of three research assistants and the main researcher. Out of the three research assistants, one was a male first degree graduate and others were MPhil candidates (one male one female). The research assistants were natives of Akan (a tribe in Ghana) and were trained in the processes of transcription and qualitative data analyses. Data was transcribed individually by the research assistants and discrepancies were resolved at the group analyses level. The interview (conducted in Twi) was transcribed by two out of the three research assistants, one being an MPhil candidate (female) and the other being a first degree graduate (male), to ensure consistency. Disagreements in the verbatim transcription by

the research assistants were resolved through a consultation with a third individual with Twi specialty.

### **3.7.5. Ethical Issues**

The researcher conducted the study in accordance to the ethical principles set forth by the American Psychological Association (APA). First the researcher sought institutional approval for the study by submitting a research proposal to the ECH at the University of Ghana for review. Upon satisfactory review, the researcher was given an approval for the conduct of the study. Letter of clearance was issued by the ECH to that effect. Second, it is an ethical requirement that participants should be allowed to freely accept or decline invitation to participate in any research after having been fully informed about the nature and purpose of a research study. This principle is termed as *informed consent*. In the present study, the researcher obtained the informed consent of each of her participants before their enlistment into the study. They were provided with detailed information about the study, including the possible costs and benefits for their participation.

Further, the ethics of anonymity and confidentiality required a researcher to respect the privacy of every individual participants. The ethics of anonymity regulates disclosure of personal identity of research participants. The ethics of confidentiality regulates disclosure of personal data or information obtained from individual participant. These two ethical principles were strictly upheld in the present study. Only group data were reported in the study. Individual participants were never identified by names at any point in the course of the study. When found necessary, the researcher identified participants with pseudonyms in an effort to conceal their identity.

Finally, the researcher upheld the ethics of beneficence and maleficence. The ethical principle of beneficence requires that the research process or outcome should be beneficial to participants in particular and to society in general. In the reverse, the ethics of maleficence requires the researcher to avoid harm to participants in research. This research did not have any harmful effect on participants. Rather, it serves as an advocacy tool to create national awareness to the ills associated with homelessness in Ghana. It also provides suggestions for policies and interventional measures to improve the psychosocial wellbeing of the homeless.

## CHAPTER FOUR

### RESULTS

This chapter contains the research results from both the quantitative study (Study I) and the qualitative study (Study II). Findings from the testing of the research hypotheses are presented in Study I. Analyses of the research questions are also presented in Study II. The quantitative results are displayed in tables while the qualitative results are presented in textual forms.

#### **Quantitative Study (Study I)**

##### **4.1. Analyses of Quantitative Data**

The Statistical Package for the Social Sciences (SPSS) version 21.0 was employed in analyzing the research data. The main inferential statistical tests used are the Pearson Product Moment Correlation (Pearson  $r$ ) test, the Multivariate Analyses of Variance (MANOVA) test, the Repeated Measure test, and the Linear Regression test. These tests were used to analyze the four research hypotheses.

MANOVA was used to analyze the first two hypotheses of the study. Each of the first two hypotheses compared two groups of participants on seven distress variables simultaneously. Hypothesis 1 predicted a significantly higher level of psychosocial distress among homeless participants than non-homeless participants. Hypothesis 2 also predicted that female homeless participants are likely to experience significantly higher levels of psychosocial distress than male homeless participants. Hypothesis 1 has one independent variable (i.e., housing status) in two levels (i.e., homeless and non-homeless) and seven dependent variables (i.e., loneliness, depression, anxiety, stress, traumatic symptoms, suicidal behavior, and somatic symptoms) measured on the interval scale. Hypothesis 2 also has one independent variable (i.e., gender) in

two levels (i.e., male and female) and same seven dependent variables as in Hypothesis 1. Using the MANOVA test, two mutually exclusive groups of participants (i.e., homeless vs. non-homeless; and males vs. females) were compared on all seven dependent variables.

The third hypothesis predicted that the homeless will adopt adaptive coping strategies more frequently than maladaptive coping strategies. To test this hypothesis, the researcher employed the Repeated Measure test. The rationale for using this test was that same group of participants (i.e., the homeless) were assessed on fourteen different coping strategies. Data on the coping strategies were obtained on the interval scale. In addition to the use of this parametric test, the researcher made a graphical demonstration of the frequencies with which participants used these coping strategies. The graphical presentation was done with a bar chart.

Finally, Hypothesis 4 predicted that maladaptive coping will lead to significantly higher levels of psychosocial distress than adaptive coping. The Pearson  $r$  test and the Regression test were used to analyze this hypothesis. The Pearson  $r$  test was useful in determining the magnitude and direction of the relationship between participants' coping mechanisms and their psychosocial distress. Significant correlations were further analyzed with the Regression test. The regression analyses revealed the extent to which coping mechanisms predicted psychosocial distress.

#### **4.2. Preliminary Analyses**

The preliminary analysis was conducted in three steps. First, the researcher run reliability analyses of scales and subscales. This was followed by descriptive analyses which provided the means and standard deviation scores of variables in the study, analyses of normality in terms of skewness and kurtosis (see Tables 6 & 7), and inter-correlations among the key variables of the study (see Table 8). The internal consistency method of reliability analyses (Cronbach's  $\alpha$ ) was

adopted for the computation of the reliability of each of the scales and their subscales. Results of the analyses show that measures had significant reliabilities (see Tables 3 & 4).

Table 4  
*Reliability Analyses of Scales and Subscales of Psychosocial Distress*

Scales/subscales	Number of Items	Cronbach's alpha ( $\alpha$ )
Revised UCLA Loneliness Scale	20	.84
DASS-21	21	.88
<i>DASS-D</i>	7	.86
<i>DASS-A</i>	7	.75
<i>DASS-S</i>	7	.77
MPSS-SR	17	.87
SBQ-R	4	.85
SSS-8	8	.86

*N*=183

Table 5  
*Reliability Analyses of Brief COPE for Homeless Participants*

Scales/subscales	Number of Items	Cronbach's alpha ( $\alpha$ )
Adaptive coping	16	.77
<i>Active coping</i>	2	.85
<i>Emotional support</i>	2	.83
<i>Instrumental support</i>	2	.84
<i>Positive reframing</i>	2	.76
<i>Planning</i>	2	.80
<i>Humor</i>	2	.96
<i>Acceptance</i>	2	.63
<i>Religion</i>	2	.88
Maladaptive coping	12	.73
<i>Self-distraction</i>	2	.55
<i>Denial</i>	2	.88
<i>Substance use</i>	2	.87
<i>Behavioral disengagement</i>	2	.65
<i>Venting</i>	2	.63
<i>Self-blame</i>	2	.76

*N*=86

Nunnally (1978) suggests that an alpha coefficient of .70 or higher is good enough to qualify a set of items as a reliable scale. Except for coping scales, all scales in the study had alpha coefficients higher than .70.

Table 6  
*Descriptive Statistics on Measures of Psychosocial Distress*

Psychosocial Distress	Minimum	Maximum	Mean (SD)	Skewness	Kurtosis
Loneliness	32	65	52.39 (5.73)	-.95	1.68
DASS-21	0	51	18.14 (9.78)	.43	.06
<i>Depression</i>	0	18	7.15 (4.92)	.34	-.92
<i>Anxiety</i>	0	18	4.91 (3.55)	1.03	1.02
<i>Stress</i>	0	19	6.08 (3.73)	.51	.07
Traumatic Symptoms	0	60	19.17 (11.78)	.64	.46
Suicidal Behaviors	3	20	5.80 (3.82)	1.39	1.05
Somatic Symptoms	0	32	11.27 (8.01)	.49	-.47

*N*=183

Table 7  
*Descriptive Statistics of Brief COPE among Homeless Participants*

Coping Strategies	Minimum	Maximum	Mean (SD)	Skewness	Kurtosis
Adaptive coping	24	52	38.24 (6.34)	-.02	-.50
<i>Active coping</i>	4	8	5.99 (1.58)	-.02	-1.48
<i>Emotional support</i>	2	8	3.15 (1.39)	1.30	.89
<i>Instrumental support</i>	2	8	3.43 (1.45)	.93	.87
<i>Positive reframing</i>	2	8	4.51 (1.56)	.37	-.13
<i>Planning</i>	4	8	6.24 (1.46)	-.18	-1.22
<i>Humor</i>	2	8	3.21 (1.77)	1.30	.63
<i>Acceptance</i>	2	8	4.95 (1.56)	.74	-.28
<i>Religion</i>	3	8	6.76 (1.55)	-.90	-.41
Maladaptive coping	13	36	22.60 (5.31)	.55	-.01
<i>Self-distraction</i>	2	8	3.85 (1.44)	.94	.27
<i>Denial</i>	2	8	4.57 (2.11)	.37	-1.10
<i>Substance use</i>	2	6	2.84 (1.34)	1.31	.50
<i>Behavioral disengagement</i>	2	7	3.58 (1.18)	.26	-.05
<i>Venting</i>	2	8	4.31 (1.44)	.32	.03
<i>Self-blame</i>	2	8	3.50 (1.66)	1.06	.66

*n*=86

Tables 6 and 7 presents the descriptive statistics on the measures of psychosocial distress and coping respectively. Means scores and standard deviations are provided for each scale and its subscales. Additionally, measures of normality are provided in terms of skewness and kurtosis. The results show that each scale and subscales met the assumption of normality. This provided justification for the use of parametric tests for the data analyses.

Table 8  
*Correlations among Measures of Psychosocial Distress*

Psychosocial Distress	1	2	3	4	5	6	7
1. Loneliness	–						
2. Depression (D)	.10	–					
3. Anxiety (A)	.00	.51**	–				
4. Stress (S)	-.08	.46**	.40**	–			
5. Traumatic Symptoms	.02	.58**	.62**	.40**	–		
6. Suicide Behavior	.12	.48**	.01	.32**	.20**	–	
7. Somatic Symptoms	.01	.39**	.30**	.60**	.42**	.26**	–

\*\* $p < .01$ ;  $N = 183$

Table 8 displays the Pearson  $r$  correlation matrix for measures of psychosocial distress. It can be observed that loneliness did not have any significant relationship with other distress variables. However, all other measures shared significant inter-correlations except the correlation between measures of anxiety and suicidal behavior.

Table 9  
*Causes of Homelessness among Homeless Participants*

Causes	Frequency ( $n=86$ )	Percentage (%)
Unemployment	4	2.2
Migration	19	10.4
Death of parent(s)	4	2.2
Poverty	55	30.1
Domestic violence	2	1.1
Parental neglect	1	.5
Divorce of parents	1	.5

Table 9 provides frequencies and percentage scores on the causes of homelessness among the homeless 86 participants. In all, seven causes were reported by the homeless participants

based on their individual circumstances. Among them, poverty emerged as the leading cause of homelessness for 30.1% of the homeless participants. It was followed by migration which implicated 10.4% of the homeless participants. Unemployment and death of parent(s) each affected 2.2% of the homeless participants. Finally, parental neglect and divorce of parents affected just a few of the participants (0.5% each).

Table 10

*Traumatic Experiences among Homeless Participants*

Traumatic events	Homeless <i>n</i> =86 (100%)	Non-homeless <i>n</i> =97 (100%)	Total <i>N</i> =183(100%)
Abuse in romantic relationship	3 (3.4%)	8 (8.2%)	11 (6.0%)
Abuse by significant other	7 (8.1%)	5 (5.2%)	12 (6.6)
Attempted rape	9 (10.5%)	–	9 (4.9%)
Bereavement	5 (5.8%)	11 (11.3%)	16 (8.7%)
Divorce	–	3 (3.1%)	3 (1.6%)
False accusation	4 (4.7%)	–	4 (2.2%)
Hostile ejection by task force	39 (45.3%)	–	39 (21.3%)
Illness	2 (2.3%)	5 (5.2%)	7 (3.8%)
Marital abuse	–	4 (4.1%)	4 (2.2%)
Mosquito bites	57 (66.3%)	–	57 (31.2%)
Motor accident	–	2 (2.1%)	(1.1%)
Physical assault	13 (15.1%)	3 (3.1%)	16 (8.7%)
Rainstorm	63 (73.3%)	–	63 (34.4%)
Robbery	31 (36.0%)	4 (4.1%)	35 (19.1%)
Severe hunger	42 (48.8)	–	42 (23.0%)
Vandalism of belongings	21 (24.4%)	–	21 (11.5%)
Vehicular encroachment	5 (5.8%)	–	5 (2.7%)

The researcher also inquired about the events that may have traumatized participants in the course of their past life. Participants reported as many as 17 major incidents in their past that they felt traumatizing. Table 10 showcases the events and the frequency of report among both the homeless and non-homeless participants. Significantly, the homeless appeared to have had

unique traumatic experiences that were closely linked with their homelessness state of life.

Unsurprisingly, most of them reported rainstorm, robbery, severe hunger, mosquito bites, and vehicular encroachment as life-threatening events that were emotionally troubling.

Comparatively, the non-homeless participants reported fewer traumatic events than their homeless counterparts.

### 4.3. Testing of Research Hypotheses

**Hypothesis 1:** There will be significantly higher level of psychosocial distress among homeless participants than non-homeless participants.

Table 11

*Effects of Homelessness on Psychosocial Distress among the Participants*

Psychosocial Distress	Housing status	<i>N</i>	Mean ( <i>SD</i> )	<i>df</i>	<i>F</i>	<i>Sig.</i>	$\eta^2$
Loneliness	Homeless	86	53.43 (4.89)	1/181	5.21	.024	.03
	Non-homeless	96	51.51 (6.28)				
Depression	Homeless	86	10.65 (3.97)	1/181	146.46	.000	.45
	Non-homeless	96	4.08 (3.35)				
Anxiety	Homeless	86	5.53 (3.78)	1/181	4.86	.029	.03
	Non-homeless	96	4.39 (3.25)				
Stress	Homeless	86	7.09 (3.93)	1/181	12.40	.001	.06
	Non-homeless	96	5.20 (3.33)				
Traumatic Symptoms	Homeless	86	22.19 (11.98)	1/181	11.29	.001	.06
	Non-homeless	96	16.47 (10.97)				
Suicidal Behavior	Homeless	86	7.69 (3.85)	1/181	50.11	.000	.22
	Non-homeless	96	4.11 (2.94)				
Somatic Symptoms	Homeless	86	13.52 (8.20)	1/181	13.28	.000	.07
	Non-homeless	96	9.32 (7.45)				

*Pillai's Trace:*  $V=.52$ ;  $F_{(7, 174)} = 27.20$ ;  $p = .000$ ; *Partial Eta Squared* = .52

Table 11 displays MANOVA results on the effects of homelessness on psychosocial distress among the research participants. Using Pillai's trace, there was a significant impacts of homelessness on psychosocial distress ( $V = .52$ ,  $F_{(7, 174)} = 27.20$ ,  $p < .001$ ,  $\text{Partial } \eta^2 = .52$ ).

Separate univariate ANOVAs on the outcome variables revealed significant effects of

homelessness on loneliness, ( $F_{(1, 181)} = 5.21, p < .05, \text{Partial } \eta^2 = .03$ ), depression, ( $F_{(1, 181)} = 146.46, p < .001, \text{Partial } \eta^2 = .45$ ), anxiety ( $F_{(1, 181)} = 4.86, p < .05, \text{Partial } \eta^2 = .03$ ), stress ( $F_{(1, 181)} = 12.40, p = .001, \text{Partial } \eta^2 = .06$ ), traumatic symptoms ( $F_{(1, 181)} = 11.29, p = .001, \text{Partial } \eta^2 = .06$ ), suicidal behavior ( $F_{(1, 181)} = 50.11, p = .000, \text{Partial } \eta^2 = .03$ ) and somatic symptoms ( $F_{(1, 181)} = 13.28, p = .000, \text{Partial } \eta^2 = .06$ ).

The mean scores show that homeless participants felt more lonely ( $M=53.43, SD=4.89$ ) than their non-homeless counterparts ( $M=51.51, SD = 6.28$ ). They also felt more depressed ( $M=10.65, SD=3.97$ ) than the non-homeless ( $M=4.08, SD=3.35$ ), reported higher anxiety level ( $M=5.53, SD=3.78$ ) than non-homeless participants ( $M=4.39, SD=3.25$ ), and had higher level of stress ( $M=7.09, SD=3.93$ ) than non-homeless participants ( $M=5.20, SD=3.33$ ). Again homeless participants reported higher traumatic symptoms ( $M=22.19, SD=11.98$ ) than their non-homeless counterparts ( $M=16.47, SD=10.97$ ), engaged in more suicidal behaviors ( $M=7.69, SD=3.85$ ) than the non-homeless ( $M=4.11, SD=2.94$ ), and had higher level of somatic symptoms ( $M=13.52, SD=8.20$ ) than their non-homeless counterparts ( $M=9.32, SD=7.45$ ). These results confirm that there was higher psychosocial distress among the homeless than the non-homeless.

**Hypothesis 2:** Female homeless participants are likely to experience significantly higher levels of psychosocial distress than male homeless participants.

Table 12 demonstrates MANOVA results on gender differences in psychosocial distress among the homeless participants. Using Pillai's trace, there was a significant gender differences in psychosocial distress ( $V = .18, F_{(7, 78)} = 2.50, p < .05, \text{Partial } \eta^2 = .18$ ). Analyses of variance on individual distress variables reveal significant gender differences in stress ( $F_{(1, 84)} = 9.64, p < .01, \text{Partial } \eta^2 = .10$ ), and suicidal behavior ( $F_{(1, 84)} = 5.92, p < .05, \text{Partial } \eta^2 = .07$ ). Female homeless

participants reported higher stress levels ( $M = 8.29$ ,  $SD = 3.89$ ) than did their male counterparts ( $M = 5.78$ ,  $SD = 3.57$ ). Similarly, there was greater suicidality among female homeless participants ( $M = 8.62$ ,  $SD = 4.01$ ) than the male homeless participants ( $M = 6.66$ ,  $SD = 3.41$ ).

Table 12

*Gender Differences in Psychosocial Distress among the Homeless*

Psychosocial Distress	Gender	<i>N</i>	Mean ( <i>SD</i> )	<i>df</i>	<i>F</i>	Sig.	$\eta^2$
Loneliness	Female	45	52.51 (5.92)	1/84	3.44	.067	–
	Male	41	54.44 (3.20)				
Depression	Female	45	10.98 (3.65)	1/84	.64	.428	–
	Male	41	10.29 (4.31)				
Anxiety	Female	45	5.16 (4.32)	1/84	.95	.333	–
	Male	41	5.95 (3.08)				
Stress	Female	45	8.29 (3.89)	1/84	9.64	.003	.10
	Male	41	5.78 (3.57)				
Traumatic symptoms	Female	45	22.69 (12.92)	1/84	.17	.686	–
	Male	41	21.63 (11.00)				
Suicidal behaviors	Female	45	8.62 (4.01)	1/84	5.92	.017	.07
	Male	41	6.66 (3.41)				
Somatic symptoms	Female	45	14.64 (7.20)	1/84	1.78	.186	–
	Male	41	12.29 (9.10)				

*Pillai's Trace*:  $V=.18$ ;  $F(7, 78) = 2.50$ ;  $p < .05$ ; *Partial Eta Squared* = .18

However, there were no significant gender differences in loneliness ( $F_{(1, 84)} = 3.44$ ,  $p > .05$ ), depression ( $F_{(1, 84)} = .64$ ,  $p > .05$ ), anxiety ( $F_{(1, 84)} = .95$ ,  $p > .05$ ), traumatization, ( $F_{(1, 84)} = .17$ ,  $p > .05$ ), and somatic symptoms ( $F_{(1, 84)} = 1.78$ ,  $p > .05$ ). These results provide partial confirmation for the prediction that female homeless participants are likely to experience significantly higher levels of psychosocial distress than male homeless participants.

**Hypothesis 3:** The homeless will adopt adaptive coping strategies more frequently than maladaptive coping strategies.

Table 13

*Use of Coping Strategies among Homeless Participants*

Coping Strategies	Mean (SD)	df	F	Sig.	$\eta^2$
Active coping	5.99 (1.58)	13/72	59.23	.000	.41
Emotional support	3.15 (1.39)				
Instrumental support	3.43 (1.45)				
Positive reframing	4.51 (1.56)				
Planning	6.24 (1.46)				
Humor	3.21 (1.77)				
Acceptance	4.95 (1.56)				
Religion	6.76 (1.55)				
Self-distraction	3.85 (1.44)				
Denial	4.57 (2.11)				
Substance use	2.84 (1.34)				
Behavioral disengagement	3.58 (1.18)				
Venting	4.31 (1.44)				
Self-blame	3.50 (1.66)				

*n*=86

The repeated measure test results in Table 13 reveal that there were significant differences in the adoption of coping strategies among the homeless participants ( $F_{(13, 72)} = 59.23$ ,  $p = .000$ , Partial  $\eta^2 = .41$ ). Based on the significance of the  $F$  ratio of the repeated measure test, the researcher conducted post hoc analyses with the Least Significant Difference (*LSD*) test to assess the significance of observed mean differences.

Table 14

*Post Hoc Analyses on Mean Differences on Frequency of Coping Strategies employed by Homeless Participants*

Coping Strategies	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Active coping	–													
2. Emotional support	2.84*	–												
3. Instrumental support	2.56*	.28*	–											
4. Positive reframing	1.48*	1.36*	1.08*	–										
5. Planning	.26*	3.09*	2.81*	1.73*	–									
6. Humor	2.78*	.058	.22	1.30*	3.04*	–								
7. Acceptance	1.04*	1.80*	1.52*	.44*	1.29*	1.74*	–							
8. Religion	.77*	3.61*	3.33*	2.24*	.51*	3.55*	1.80*	–						
9. Self-distraction	2.14*	.70*	.419*	.66*	2.40*	.64*	1.11*	2.91*	–					
10. Denial	1.42*	1.42*	1.14*	.06	1.67*	1.36*	.38	2.19*	.72*	–				
11. Substance use	3.15*	.31	.59*	1.67*	3.41*	.37	2.12*	3.92*	1.01*	1.73*	–			
12. Beh. Disengagement	2.41*	.43*	.15	.93*	2.66*	.37	1.37*	3.17*	.27	.99*	.74*	–		
13. Venting	1.67*	1.16*	.88*	.20	1.93*	1.10	.64*	2.44*	.47*	.26	1.48*	.73*	–	
14. Self-blame	2.49*	.35	.07	1.01*	2.74*	.29	1.45*	3.26*	.35	1.07*	-.66*	.08	.814*	–

\* $p < .05$ ;  $N=86$ 

Table 14 presents a summary of the *LSD* test result. The results show that most of the means of the various coping strategies significantly differed from each other ( $p < .05$ ). Among the coping strategies, *religion* was the most frequently used strategy ( $M=6.76$ ,  $SD=1.55$ ), followed by *planning* ( $M=6.24$ ,  $SD=1.46$ ), and *active coping* ( $M=5.99$ ,  $SD=1.58$ ). One adaptive coping strategy, *positive reframing* ( $M=4.5$ ,  $SD=1.56$ ), and two maladaptive coping strategies, *denial* ( $M=4.57$ ,  $SD=2.11$ ) and *venting* ( $M=4.31$ ,  $SD=1.44$ ) occupied the fourth position with insignificant mean differences ( $p > .05$ ). Furthermore, there was no significant mean differences in the use of *humor* ( $M=3.21$ ,  $SD=1.77$ ), *behavioral disengagement* ( $M=3.58$ ,  $SD=1.18$ ), and *self-blame* ( $M=3.50$ ,  $SD=1.66$ ) ( $p > .05$ ).

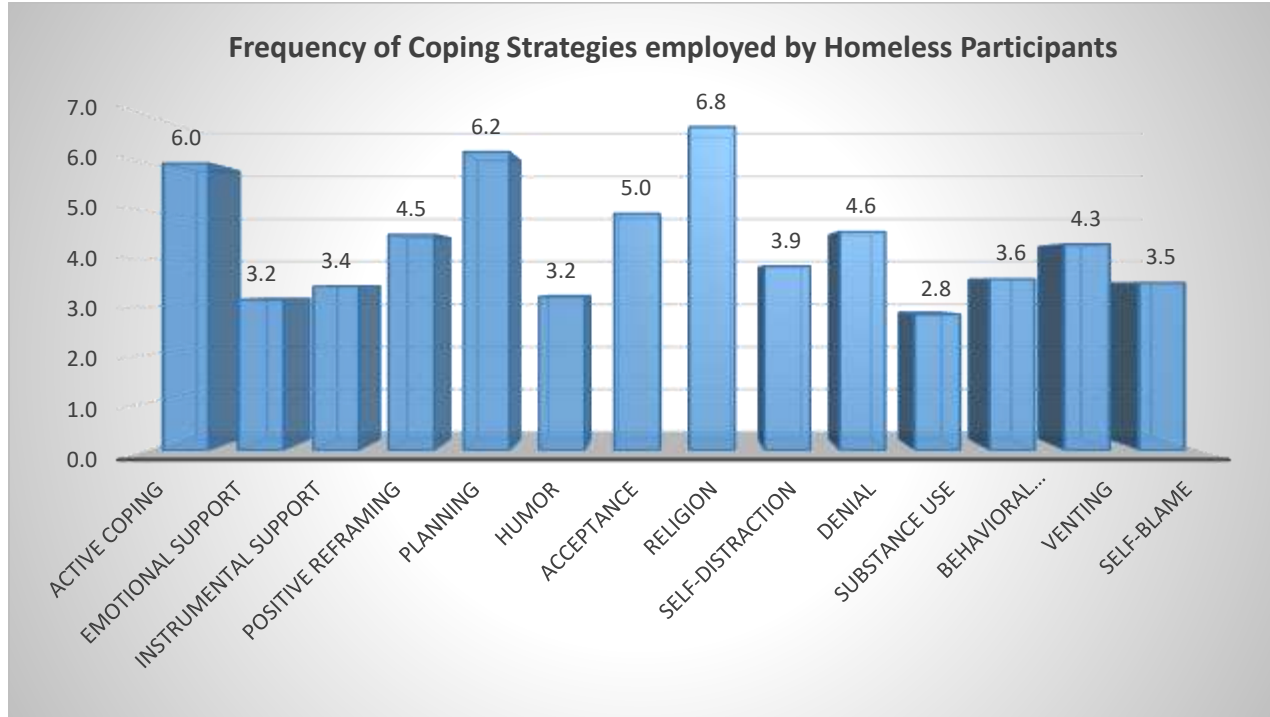


Figure 3. A bar graph on the coping strategies employed by the homeless

Finally, *emotional support* ( $M=3.15$ ,  $SD=1.39$ ) and *substance use* ( $M=2.84$ ,  $SD=1.34$ ) were the least adopted coping strategies with their mean differences not significantly different from each other ( $p > .05$ ). Figure 3 presents a bar chart on the frequencies with which homeless participants use various coping strategies. The first eight bars represent adaptive coping strategies (i.e. active coping, emotional support, instrumental support, planning, humor, acceptance, and religion). The last six bars signify maladaptive coping strategies (i.e., self-distraction, denial, substance use, behavioral disengagement, venting, and self-blame). Generally, the bars demonstrate greater reliance on adaptive coping strategies over maladaptive coping strategies among the homeless participants (see Figure 3). These results confirm that the homeless participants adopted adaptive coping strategies more frequently than maladaptive coping strategies.

**Hypothesis 4:** Maladaptive coping will predict higher levels of psychosocial distress than adaptive coping.

Table 15

*Relationship between Coping Strategies and Psychosocial Distress*

Variables	1	2	Loneliness	Depression	Anxiety	Stress	Traumatic symptoms	Suicidal behaviors	Somatic symptoms
1. Adaptive	–	-.08	.07	.10	.20	.13	.04	-.01	-.01
2. Maladaptive		–	.06	.27**	.47**	.05	.57**	.01	.20*

\*\* $p < .01$ , \* $p < .05$ ;  $n = 86$

Table 16

*Maladaptive Coping as a Predictor of Psychosocial Distress among the Homeless*

Psychosocial Distress	<i>B</i>	<i>S.E.</i>	$\beta$	<i>F</i>	$R^2$	<i>Sig.</i>
Depression	.20	.08	.27	6.59	.073	.012
Anxiety	.30	.07	.43	18.61	.181	.000
Traumatic Symptoms	1.29	.20	.57	40.85	.327	.000
Somatic Symptoms	.32	.17	.20	3.66	.042	.059

The Pearson  $r$  test results in Table 15 show that there was no significant relationship between adaptive coping strategies and loneliness ( $r = .07, p > .05$ ), depression ( $r = .10, p > .05$ ), anxiety ( $r = .20, p > .05$ ), stress ( $r = .13, p > .05$ ), traumatic symptoms ( $r = .04, p > .05$ ), suicidal behaviors ( $r = -.01, p > .05$ ), and somatic symptoms ( $r = -.01, p > .05$ ). Maladaptive coping strategies significantly and positively correlated with depression ( $r = .27, p < .01$ ), anxiety ( $r = .47, p < .01$ ), traumatic symptoms ( $r = .57, p < .01$ ), and somatic symptoms ( $r = .20, p < .05$ ), but not with loneliness ( $r = .06, p > .05$ ), stress ( $r = .05, p > .05$ ), and suicidal behaviors ( $r = .01, p > .05$ ). The positive correlations imply that greater use of maladaptive coping strategies were associated with higher levels of depression, anxiety, traumatic symptoms, and somatization. Likewise, less use of maladaptive coping strategies were associated with lower levels of depression, anxiety, traumatic symptoms, and somatization.

Sequel to the significant correlations, the researcher conducted regression analyses to test the predictive power of maladaptive coping on depression, anxiety, traumatic symptoms, and somatization [see Table 16]. The Linear Regression test revealed that maladaptive coping was a significant predictor of depression ( $\beta = .27, p < 0.05$ ). It accounted for 7.3% variance in depression ( $R^2 = .073, F_{(1, 84)} = 6.59, p < .05$ ). Similarly, maladaptive coping significantly predicted anxiety ( $\beta = .43, p = .000$ ), accounting for 18.1% of its variance ( $R^2 = .181, F_{(1, 84)} = 18.61, p = .000$ ). It also predicted traumatic symptoms ( $\beta = .57, p = .000$ ), explaining 32.7% of the variation in traumatic symptoms ( $R^2 = .327, F_{(1, 84)} = 40.8, p = .000$ ). However, maladaptive coping did not significantly predict somatic symptoms ( $\beta = .20, p > .05$ ). It could only explain 4.2% of the variance in somatic symptoms ( $R^2 = .042, F_{(1, 84)} = 3.66, p > .05$ ). These results provide partial support to the hypothesis that maladaptive coping will predict higher levels of psychosocial distress than adaptive coping.

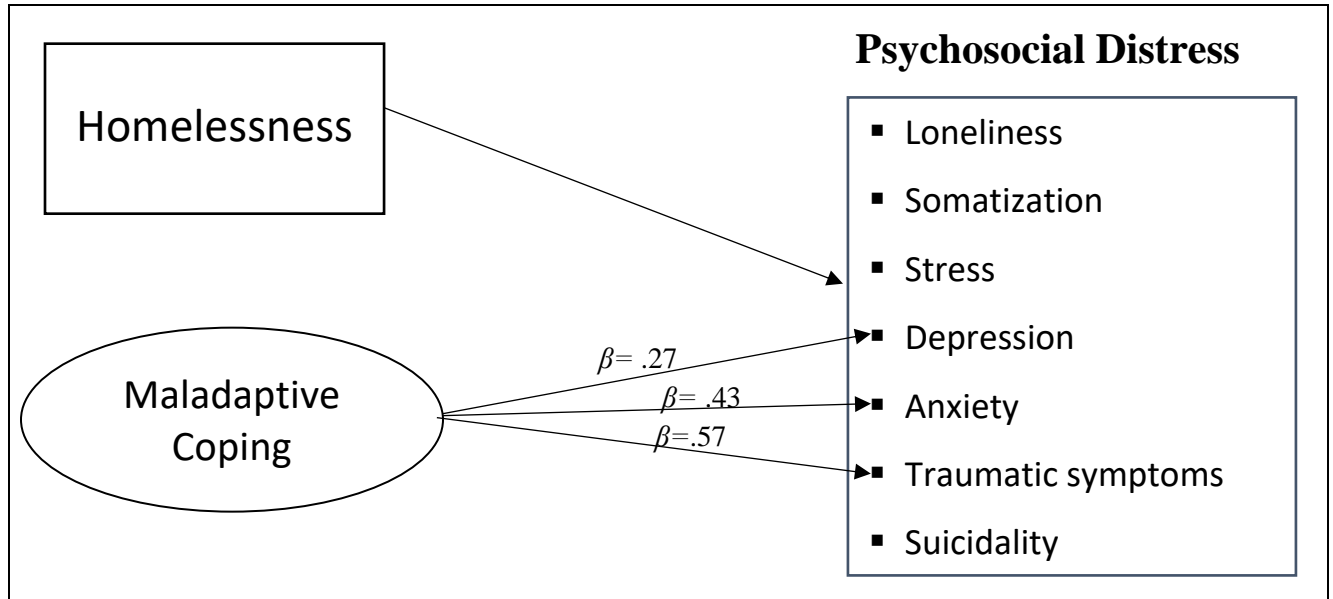
#### **4.4. Summary of Findings from Study I**

The following were the major findings from the quantitative study.

1. There was significantly higher level of psychosocial distress among homeless participants than non-homeless participants.
2. There was no significant gender differences in loneliness, depression, anxiety, traumatization, and somatic symptoms. Nonetheless, female homeless participants reported higher stress and greater suicidal behavior than the male homeless participants.
3. The homeless adopted adaptive coping strategies more frequently than maladaptive coping strategies.
4. Adaptive coping did not predict any of the psychosocial distress variables. However, maladaptive coping predicted higher levels of depression, anxiety, and traumatic symptoms.

In addition, maladaptive coping significantly and positively correlated with somatic symptoms but with weak predictive power.

#### 4.5. Observed Conceptual Model



**Figure 4.** Observed model for the relationship between homelessness, coping mechanisms, and psychosocial distress.

The above model (Figure 4) shows that homelessness had significant impact on psychosocial distress. Consistent with prediction, homeless participants reported higher levels of traumatic symptoms, depression, anxiety, stress, somatization, loneliness, and suicidality. The model further portrays maladaptive coping is a significant predictor of depression, anxiety, and traumatic symptoms. Specifically, the use of maladaptive coping predicted higher levels depression, anxiety, and traumatic single.

## Qualitative Study (Study II)

### 4.6. Sample Description

Qualitative data was obtained from one-on-one interviews involving 10 homeless participants. The participants were identified as Hamida, Rukaya, Zainab, Ohene, Kwaakye, Baah, Mohammed, Manu, Kwame, and Suraya. These are pseudonyms given to the participants to ensure anonymity. Hamida was a 22 year old female who was a Muslim. Rukaya was a 25 year old female who was a Muslim. Zainab was a 22 year old female who was a Muslim. Ohene was a 19 year old male who was a Christian. Kwaakye was a 17 year old male who was a Christian. Baah was a 21 year old who was a Christian. Mohammed was 19 year old male who was a Muslim. Manu was a 16 year old male who was a Christian. Kwame was a 20 year old male who was a Christian and Suraya was a 21 year old female who was a Muslim.

**Table 17**

*Demographic Characteristics of the Interview Participants*

Names*	Gender	Age	Marital Status	Religious affiliation	Education	Duration of Homelessness
Hamida (P1)	Female	22	Single	Muslim	Basic	2 years
Rukaya (P2)	Female	25	Married	Muslim	Basic	3 months
Zainab (P3)	Female	22	Married	Muslim	None	1 year
Ohene (P4)	Male	19	Single	Christian	Basic	2 years
Kwaakye (P5)	Male	17	Single	Christian	Basic	2 years
Baah (P6)	Male	21	Single	Christian	Basic	4 months
Mohammed (P7)	Male	19	Single	Muslim	Basic	5 years
Manu (P8)	Male	16	Single	Christian	Basic	3 years
Kwame (P9)	Male	20	Single	Christian	None	6 years
Suraya (P10)	Female	21	Single	Muslim	None	3 months

\*Pseudonyms of participants

From their characteristics, all the participants were not occupationally engaged. There were unequal number of females ( $n=4$ ) and males ( $n=6$ ). With regard to their religious affiliation,

5 of the participants were Christians and 5 were Muslims. Below is a demographic table which displays the composition of the sample.

#### **4.7. Qualitative Analysis of Data**

Oral responses of the participants in the one-on-one interviews were transcribed into textual form and analyzed at an individual and group level by the researcher and her three assistants. This helped to control possible researcher's personal biases in the analyses process. Thematic analysis technique was applied in analyzing the transcribed data. Thematic analysis involves the strict and systematic set of procedures for rigorous analysis, examination, and verification of the crux of textual data. According to Braun and Clarke (2006), in developing major and sub-themes from data, it could be based on either the research question or a theoretical bearing. The themes and sub- themes developed from the data gathered from the one on one interviews were established based on the research questions of the study and not theoretically.

In doing the thematic analysis, the researcher followed the guidelines suggested by Braun and Clarke (2006) which involves six phases which are (1) data familiarization, (2) generation of initial codes, (3) searching for themes among codes, (4) themes review, (5) defining and naming themes, and (6) production of final report. Familiarization with data involves the researcher getting familiar with the data through reading and re-reading to understand the data at hand. Therefore, after the interviews were transcribed, the researcher and the research assistants listened to the audios over again and re-read through the transcribed interviewed to add something they missed or re-write information that was not transcribed verbatim. Transcribed interviews were passed around for other research assistants to validate its authenticity.

Generation of initial codes refers to phrases that captures both a semantic and conceptual meaning of the data of quotes from participants. Initial codes from the transcribed data were

generated separately and agreed upon at the group level. Generated codes were further scrutinized by the researcher's supervisor. In searching for themes among codes, the researcher clustered the codes together to identify similar patterns (themes) at the group level. In the fourth phase, the themes were reviewed for similarity. Similar themes were clustered to avoid redundancy. The generated themes were further scrutinized and agreed upon by the researcher's supervisor. In defining and naming themes, the researcher looked for the essence of each theme and wrote out a detailed analysis for each theme. Thus the defined meaning of each theme was further analyzed. The final phase (i.e., production of final report) involved giving analytic narratives and putting narratives into perspective by supporting it with existing literature. Narratives were then sought to support the analyzed themes. Discrepancies in generated codes and themes were resolved in consultation with a third supervisor with specialty in qualitative data processing.

#### **4.7.1. Trustworthiness of the Qualitative Results**

According to Maxwell (1996), to ensure the validity of qualitative data, three steps need to be followed. These three steps included providing accurate and complete representation of respondents' accounts. Also, making interpretations on the basis of participants' perspectives that emerged from the data and finally, providing alternative perspectives on experiences that emerged from the data. Consequently, at the data collection stage, respondents' responses were written verbatim. At the data analysis stage, these responses were analyzed from respondents' perspectives and in-depth meaning derived. According to Green and Thorogood (2009), to warrant reliability of data obtained, there is the need for the use of quality tape recorder and detailed transcription of interviewed data. Thus a quality tape recorder was obtained and used for data collection. A detailed transcription of audios was done.

## 4.8. Analyses of Research Questions

### Challenges associated with Homelessness

Following thematic analysis of the account of homeless people, it emerged that participants experience numerous challenges. These challenges were grouped under 6 sub-themes namely financial hardship, sleeping condition, environmental hazards, crime victimization, physical hassles, and lack of social support.

The major challenge faced by the homeless was financial challenge. This makes it difficult for homeless people to meet their basic needs from day to day. The following excerpts describe the nature of the financial problems experienced by the participants. Whiles some homeless people go from little to nothing to eat on daily basis, some hardly get money to even get water to bath. Others also complain of walking long distances as a results of not having money on them.

*“Since I came to Accra...I have faced a lot challenges... someday what to eat is even a problem, if I don’t come and sell I won’t eat. So since I came here I’ve been facing a lot of hardships, I don’t have any helper unless I hustle myself before I can eat, and where to sleep too is a problem for me, I’ve been sleeping outdoors so its stressful, where to sleep is what matters to me”.* (Ohene, male, 19 years, 2 years of homelessness)

*“When I came here I haven’t had a job to get the money to rent an apartment that’s why I sleep outdoors. For us what we do is “arroglass” (cleaning the screen of cars), that’s what we do and that’s why we sleep outdoors, so there’s no money to go and rent an apartment”.* (Mohammed, male, 19 years, 5 years of homelessness)

In addition to the financial hardship, homeless individuals also experience difficult sleeping conditions. Some homeless persons go through a lot of sleep disruptions during their

sleep at night, shop owners waking them up in the middle of their sleep, having to change the sleep location as a result of being asked to leave, walking some distance away from where they were sleeping. Some homeless people also talked about not having cloth to cover themselves and the coldness of the weather: they get goosebumps as a result of sleeping in the open and develop bodily pains due to prolong exposure to the weather. This makes it stressful for homeless people to achieve the quality sleep they need for their wellbeing.

*“We can be sleeping and the shop owner will come and say we should stand up and leave the place, we make our children.... (Client gets another phone call and decides to cut it), or our children are unkempt. When the store owner asks us to leave we pray that God should give us someone to help us and give us a house to sleep in.”* (Zainab, female, 22 years, 1 year of homelessness)

*“When it’s night time and I go to sleep, mosquitos will bite me so we’ll be standing, even after bathing you don’t even know where to keep your things, so we’re praying that a rich person will see us and have pity on us and build a house for us so that when we close from work we can go and sleep.”* (Suraya, female, 21 years, 3 months of homelessness)

Additionally, homeless people are severely affected by environmental hazards. These environmental hazards include rain and mosquitoes. Some reported of mosquito bites that led to skin issues which they are not able to treat. Homeless people in this research sleep in the open, in conditions that makes them inescapable of the hazards that are mentioned. Some of them shared the environmental hazards that they faces at night:

*“Yes when... when its night time and we’re going to sleep and we don’t have cloth to cover our self we feel cold, and there are mosquitos there, if you don’t have a cloth*

*mosquitos also bite you when it happens that way it can make you fall sick When the mosquitos are biting me and I don't have something to cover myself, I go to buy mosquito repellent and apply it on my body and go to sleep.” (Manu, male, 16 years, 3 years of homelessness)*

*“Sometimes it will rain, when it rains you wouldn't get a place to sleep, unless we stand for long till the rain stops, when the rain stops too you can't sleep on the floor because it is wet, unless you look for a place to “chock” (stand) and sleep. So you'll keep standing and sleeping, if you don't stand firm / well too you fall on the ground, if you don't stand well you fall on the ground”. (Mohammed, male, 19 years, 5 years of homelessness)*

Crime victimization is another theme that emerged from homeless people's narratives. Some homeless people were victims of theft where personal items such as money and slippers can be stolen at night:

*“For Tema station the thieves, when you're sleeping someone can come and cut your pocket and take your money, someone can steal your slippers, sometimes not to even wear the slippers, the person will just use blade to destroy the slippers , someone can cut your dress, by the time you wake up your dress will be cut anyhow”. (Mohammed, male, 19 years, 5 years of homelessness)*

*“Sometimes when we go to sleep at Tema station they sack us and even when you sleep they will steal your money from your pocket, the little money you have on you will be taken, your slippers can be stolen, and all these are challenges we go through. Once it is*

*stolen there's nothing you can do about it so it takes you to crisis and despair” (Baah, male, 21 years, 4 months of homelessness)*

Another theme that emerged strongly was the stress that homeless individuals go through on daily basis. The day to day life of some homeless person involves a lot of physical activities such running after cars to get loads, in the case of head porters, to carry so that they can earn money. Some spend long hours in traffic doing menial jobs such as selling petty items and cleaning windcreens of cars and stand for long hours to make ends meet:

*“That's where we sleep, we sleep under the tree, when we sleep there and day breaks then we stand up when a car comes then we run after the cars till you go and there're no loads then it's in vain, (laughs) you've run in vain. So that's the struggles we go through, standing, we don't have any help. If someone doesn't have loads too, or someone can get down but will say no I don't need your services then you go back and go and stand. We feel pains all over because we are suffering running around, we are struggling.” (Suraya, female, 21 years, 3 months of homelessness)*

*“When I wake up in the morning I come to theatre (national theatre of arts in Ghana) and do “arroglass” (cleaning of car screens), and clean car front glasses and get something small. I clean car glass and get something small to help myself. There's no money, no money to help myself so “arroglass” (cleaning/wiping car front glass) is what I do to eat when its night time then I go and sleep at Tema station”. (Kwaakye, male, 17 years, 2 years of homelessness)*

This theme explained the situation of the homeless in terms of support. Some homeless people received no social support. They express concerns that they don't have anyone. With no family members and significant others to talk to, most homeless people feel lonely:

*“When I completed school there was no helper, then I said I will travel and come and hustle but when I came here too where to sleep is a problem for me.... I don't have any helper unless I hustle myself before I can eat”.* (Ohene, male, 19 years, 2 years of homelessness)

*“I was young when I came here, I was 3 years when I came here. My mum and dad died then my brother brought to Accra, I was 3 years when I was brought here. When my mum and dad died then they had to come to Accra, that time I was 3 years. When they brought me, I don't job u understand, those people I left the place, I left the place of the people who brought me, I don't like what he was doing so I left the place, now I'm sleeping outdoors. I said he should help me learn a trade, he said he won't help me learn a trade. I said he should buy things for me to sell, he should buy “okada”(motorcycle used as a means of transport) for me to work with he said he won't buy it for me”.* (Kwame, male, 20 years, 6 years of homelessness)

### **Coping behavior of the homeless towards their challenges**

Homelessness is a life changing event that comes with a lot of challenges. The homeless is faced with challenges that can be aversive to their well-being. These challenges can be dangerous and may lead to psychosocial distress such as depression, anxiety, stress, loneliness, suicidality and somatization. Two broad coping strategies used to cope with these challenges emerged from their narratives and included the use of prayers and optimistic outlook as well as

shielding. Most people when they are faced with life challenges will pray and some homeless people are just the same. Prayer becomes a resort when they face the challenges associated with homelessness. Some homeless people pray as a way of dealing with their problems and hope for solution. Additionally, some optimistic about the prospect of a better future despite their current predicaments:

*“When I’m going through these challenges I pray that I should get out of this struggle. In God’s doings maybe I don’t know where help will come from but maybe one day I’ll just be walking and I’ll meet my helper who will help me and save me. All I do is I pray that God should help me and change everything, He should renew me that’s my prayer.”*

(Ohene, male, 19 years, 2 years of homelessness)

*“[when going through challenges] I pray that when day breaks and I come out, when I come out I should get small small jobs to do, so that God will bless a rich person will see me and come and help me, I pray that... so we’re praying that a rich person will see us and have pity on us and build a house for us so that when we close from work we can go and sleep”.* (Suraya, female, 21 years, 3 months of homelessness)

It is very natural for humans to protect themselves in the face of danger. When faced with adverse weather conditions such as rainfall, some homeless people look for a place where they can stand till it stops raining, as a way of protecting themselves from the rain. Others use rubber to cover themselves as a way of coping till it stops raining.

*“When it’s raining we would go and stand on the veranda until it stops raining, then we will come and sweep the water away and sleep. We use rubber (the type that is spread to cover things*

*so that it doesn't get wet) to cover ourselves.”* (Hamida, female, 22 years, 2 years of homelessness)

*“When it rains, we stand, we can't sleep. Yesterday for instance we didn't sleep, we were there when it was raining till it stopped and we came here. If you have a child, you would have to buy rubber (the type that is spread to cover things so that it doesn't get wet) and use it to cover the child.”* (Rukaya, female, 25 years, 3 months of homelessness)

### **Impact of coping efforts**

In coping throughout some of the challenges associated with homelessness, some homeless people find their coping strategies working for them while others don't find their coping strategies working for them. Out of the perceived outcome of the coping strategies of the homeless, two themes were developed. The themes are relief and despair/crisis. Regarding the theme of relief, some participants reported that the coping strategies used led them to feel relief from their current situation. For example, for those who used prayers, they reported a sense of relief despite their current difficult situations:

*“When the store owner asks us to leave we pray that God should give us someone to help us and give us a house to sleep in... when I pray I do feel ok”.* (Zainab, female, 22 years, 1 year of homelessness)

*“When I'm going through these challenges I pray that I should get out of this struggle, I should get a helper to help me...because I'm praying to God to give me a helper to help me I get relieved”.* (Ohene, male, 19 years, 2 years of homelessness)

Despite relief felt by some participants, others reported that they did not experience any relief from their coping efforts. The failure of coping efforts resulted mainly from strategies used to manage physical challenges such as harsh environmental conditions such as rain:

*“No. When you standing there like that, you will be wet by the rain; when you use the rubber (the type that is spread to cover things so that it doesn't get wet) to cover yourself and it gets torn you will get wet...where I sleep is not good so I'm not satisfied.”* (Hamida, female, 22 years, 2 years of homelessness)

Some participants also did not put in any effort at managing the challenges but were hopeful of a positive outcome. For these individuals, the lack of support resulted in them feeling despair since to them, their coping efforts did not solve their status of homelessness and its associated challenges:

*“We've not gotten a helper, how do we become ok (relieved)? We've not gotten a helper yet so we can't be ok [relieved] ...”* (Kwame, male, 20 years, 6 years of homelessness)

*“No we don't get relieved, because we don't have a place to sleep so we don't get relieved”.*  
(Suraya, female, 21 years, 3 months of homelessness)

### **Sense of optimism towards life**

It is common for people to have hope for the future whether they like their current situation or not. Homeless people have challenges and they live their lives hoping for the better. The results showed that homeless individuals optimism come from two main sources, namely, faith in God, and expectation for help from benefactors. Some individuals put their faith in God for a better future despite their present problem:

*“Oh that’s in God’s hands. I can’t tell, it’s all in God’s hands”*. (Muhammed, male, 19 years, 5 years of homelessness).

*“I have believe in God that he can make it change”*. (Kwame, male, 20 years, 6 years of homelessness).

With some homeless people expressing faith in God, there were some who had expectation from benefactors and government interventions that they believe can help them provide for their needs and change their lives for the better:

*“If I get someone to help me, my situation will change”* (Hamida, female, 22 years, 2 years of homelessness).

*“Please if it would change, unless I look up to you. Unless you help us, then it will change – you the leaders, in government”*. (Rukaya, female, 25 years, 3 months of homelessness).

### **Preferred interventions to address their homelessness**

Participants were also asked of their perception of the nature of interventions that they believed could help their situation. Participants’ accounts highlighted three themes reflecting housing, employment/job/skill training and financial aid. Homeless people reported that having a stable housing condition will give them comfort. Housing was very important to the homeless because it was at the core of their status and challenges:

*“When we get a house to sleep in we prefer that”*. (Hamida, female, 22 years, 2 years of homelessness)

*“If I get someone to get me a place to sleep for me to have my comfort”.* (Ohene, male, 19 years, 2 years of homelessness)

Aside getting a house to sleep in, participants cited opportunity to learn a trade and acquire the necessary skill needed to help them earn an income as another significant needed intervention. To these participants, skills and source of income was perceived to be the necessary to progressively solve their problem(s):

*“For me the help is to learn a trade”.* (Baah, male, 21 years, 4 months of homelessness).

*“For me if they will help me to learn a trade I will like it, I will like to learn a trade”.*  
(Manu, male, 16 years, 3 years of homelessness).

Provision of jobs is another solution that homeless people require to solve their homelessness situation. It is very important that homeless people have a stable job. Being homeless and being unemployed is a situation that is double unpleasant. Most homeless people expressed their desire to work and make a living. Participants believe that getting a job can actually help them to live the life they deserve:

*“I need help that someone will help me and give me a job. Now I want to be a mechanic, for now if anyone should help by giving me a job, any job at all I have “vim” (I’m confident) that I can do the job well”.* (Mohammed, male, 19 years, 5 years of homelessness)

*“... if they get us a job to do too we like it.”* (Kwame, male, 20 years, 6 years of homelessness).

Financial support is also another important intervention for the homeless. Some of the homeless people expressed their desire to get financial support to start their own little business and to be off the streets and market places:

*“If we could get money too we prefer that”*. (Hamida, female, 22 years, 2 years of homelessness).

*“Please if I could get money to go and learn a trade in my hometown”*. (Zainab, female, 22 years, 1 year of homelessness).

Participants’ account also reflected different agents of interventions. These included God, government, and benefactors. These agents reflected participants’ spirituality, faith in the government and social system. However, it showed their lack of personal agency in their own ability to solve their problems:

*“Unless God helps those who will help us to get something little and help us”*. (Rukaya, female, 25 years, 3 months of homelessness)

*“Please it should come from government or God should let someone give me money”*. (Zainab, female, 22 years, 1 year of homelessness)

*“...maybe God touches a person’s heart who would see me and have pity on me and help”*. (Kwaakye, male, 17 years, 2 years of homelessness)

#### **4.9. Summary of Findings from Study II**

After a careful and systematic analyses on the themes of participants' responses in the interview, certain key elements/themes emerged. The emerging themes were in direct response to the research questions posed.

In response to the first research question, the thematic analyses revealed six major ways through which homelessness affected participants' personal life. Among them were financial hardship, poor sleeping condition, environmental hazards, crime victimization, physical hassles, and lack of social support.

Regarding their coping mechanisms, participants identified prayer and shielding as their means of dealing with their challenges. While 2 out of the 10 participants found relief from their coping strategy (specifically prayer), 5 participants found their coping strategies ineffective and expressed desperation with their situation.

Despite their desperation, participants were optimistic about the future. Two participants expressed hope in themselves; 2 others expressed faith in God; and 3 had expectation for help from benefactors. When asked about the type of intervention they required, participants appealed for housing, skill training, provision of jobs, and financial aid. They expected to receive these interventions through God, government, and/or benefactors.

## CHAPTER FIVE

### DISCUSSION, RECOMMENDATIONS, AND CONCLUSION

This chapter discusses the findings of the study. It points out the limitation association with the study and makes recommendations to shape future research and the design of interventional policies. The chapter ends with conclusion for the study.

#### **5.1. Discussion**

The purpose of the study was to investigate the psychosocial crises and coping among the homeless in Greater Accra region of Ghana. Specifically, the study assessed effect of homelessness on psychosocial distress, gender differences in psychosocial distress among the homeless, coping strategies employed by the homeless, and the impact of coping mechanisms on the psychosocial distress of the homeless. Psychosocial distress was defined in terms of traumatic symptom, depression, anxiety, stress, somatization, loneliness, and suicidality. A total of 86 homeless individuals in the Greater Accra region constituted the sample of interest with a comparison group of 97 non-homeless individuals.

As Cleverley and Kidd (2011) intimated, most of the homeless participants were found in the streets. They were largely uneducated and had little or no career skills. In assessing the research objectives, four hypotheses were formulated and tested with quantitative data. In order to gain deeper understanding of the quantitative findings, the researcher conducted one-on-one personal interview with 10 homeless participants. The findings obtained are discussed below.

##### ***5.1.1. Causes of Homelessness in Ghana***

Prior to testing the research hypotheses, the researcher inquired about the factors that led to homelessness among the research participants. It emerged that poverty was the major cause of homelessness among the participants (about 30.1% of the cases). Rural-urban migration was the

second leading cause of homelessness (10.4% cases). A search for better life such as job opportunities, and a desire to experience the niceties of urban life propelled such migration. Unemployment and death of parent(s) were the next most occurring cause of homelessness; each affected about 2.2% of the homeless participants. Other causes of homelessness revealed in the study were parental neglect, domestic violence, and parental divorce.

Notably, no single factor was responsible for homelessness among the research participants. Instead, a number of interactive and overlapping factors acted in complex way to render many of the participants homeless. Financial distress, which is deeply rooted in Ghana's weak economic performance, dysfunctional family structure, and personal motivation to migrate were the interactive forces that resulted in the unfortunate incident of homelessness. This observation is consistent with the social ecological model (McLeroy et al., 1988; Nooe & Patterson, 2010) which contends that a number of factors in a multi-layered social environment create homelessness among individuals. This theoretical assertion found support from Anderson and Christian (2003) who called for a shift in perspective from a single-model factor to a multilateral-model factor in the explanation of homelessness in the UK. Consistent with the tenets of the socioecological model, they recommended the use of sophisticated and interactive models of individual, structural and institutional factors. Thus, homelessness should not only be understood as the result dysfunctions in individual personal character, but more so, the result of ineffective institutional structures in the larger social context.

### ***5.1.2. Effects of homelessness on psychosocial distress***

In line with the first objective, the researcher predicted that there will be significantly higher level of psychosocial distress among homeless participants than non-homeless participants. Consistent with this prediction, the researcher found significantly higher level of

psychosocial distress among homeless participants than non-homeless participants. The data confirmed that compared to non-homeless, homeless participants felt lonelier, were more depressed, more anxious, more stressed, more traumatized, more suicidal, and had higher level of somatic symptoms. Interviews with the participants suggested that financial hardships, poor sleeping conditions, environmental hazards, crime victimization, physical hassles, and lack of social support may have significantly contributed to the psychosocial distress of the homeless.

The high incidence of psychosocial distress among the homeless participants supports the assertion of the Gelberg-Andersen behavioral model for vulnerable populations (Padgett, Struening, & Andrews, 1990; Padgett, Struening, Andrews, & Pittman, 1995; Swanson, Andersen, & Gelberg, 2003) which outlines the vulnerabilities common to homeless individuals such as environmental hazards, drug and alcohol use, and lack of access to health care (Kushel, Gupta, Gee, & Haas, 2006). The present study confirms that these common vulnerabilities among the homeless undermines psychosocial wellbeing, thus the need for health care service providers to focus attention on the reduction or elimination of these vulnerabilities among the homeless.

The above finding is also consistent with previously reported findings in the literature. Generally, homelessness studies suggest that there is greater stress among homeless individuals than the non-homeless. The Canadian Institute for Health Information (2006), for example, reported that homeless adults in Canada experience about 24% higher stress level than their non-homeless counterparts. Similarly, Votta and Manion (2003) found that Canadian homeless male youth had twice as high stress level than Canadian non-homeless male youth. Research on homelessness in the U.S. confirmed higher depressive symptoms, higher stress, poorer health,

and greater use of drugs and alcohol among youth who were homeless than those who were not (Unger et al., 1998).

Moreover, the current study is congruent with the study of Fekadu et al., (2014) which carried out in Ethiopia. In their study, Fekadu et al., reported extremely high prevalent rate of mental disorders among the homeless. As many as 90% of their sample of 217 homeless adults had experienced one form of mental disorder or another. Apart from the high prevalence rates, there was also high level of unmet needs for psychological care. For instance those with high levels of psychosis also had extensive unmet needs. Among these, 80% to 100% reported unmet needs across various domains. In the present study, homeless participants reported unmet needs in 7 major domains namely financial distress, sleeping conditions, sleep disruptions, environmental hazards, crime, physical hassles, and social support needs. Reasonably, these unmet needs may be significant contributory factors to psychosocial distress.

Within the Ghanaian context, the study validates the earlier finding of De-Graft Aikins and Ofori-Atta (2007) which showed higher prevalent rate of physical and psychological stresses among their homeless participants in Accra. Their definition of homelessness superficially bordered on individuals living in squatter settlements. However, the present study adopted the deeper meaning of homelessness which highlights a lack of access to settlement structures. Similarly, the present finding agrees with the conclusion of Asante et al., (2015) homeless people in Ghana experience severe psychosocial problems including hyperactivity, emotional difficulty, relationship problems, and conduct disorders. Beyond these, the present study reveals higher incidence of traumatic symptoms, depression, anxiety, stress, somatization, loneliness, and suicidality among homeless individuals in Ghana.

### ***5.1.3. Gender differences in psychosocial distress among the homeless***

The second research objective was to determine gender differences in psychosocial distress among the homeless. Pursuant to this objective, the researcher predicted that female homeless participants are likely to experience significantly higher levels of psychosocial distress than male homeless participants. The study revealed no significant gender differences in loneliness, depression, anxiety, traumatization, and somatic symptoms. Nonetheless, female homeless participants reported higher stress and greater suicidal behavior than the male homeless participants. The observed gender differences in psychosocial distress may have resulted from socio-cultural norms in Ghana that sometimes tend to put females at a disadvantaged positions and cause them to suffer unreasonably greater amounts of hardships. Discrimination against women in education, career development, and political participation are examples of socio-cultural factors that tend to limit opportunities for females. These factors may have contributed to the higher stress level among the homeless females.

The second finding confirms the observation made by Johnson et al., (2017) which established a stronger relationship between homelessness and physical health for females than for males. Johnson et al., (2017) also found the intergenerational impact of homelessness to be highly gendered. According to them, the indispensable role of women as heads of homeless families made the impacts of homelessness on children proportionally remarkable. In their study, children under the care of homeless women experienced poorer health outcomes. Those in schools exhibited lower achievement on cognitive tests. Although the current study did not assess intergenerational impacts of homelessness, it is reasonable to assume that in situations where homeless women in Ghana experience higher stress and suicidality, the wellbeing of children under their care will most likely be compromised. The extensiveness of the impacts of

women homelessness implies that any planned intervention should seek to prioritize homeless women over their homeless male counterparts, especially when homeless women carry the burden of child care in addition to their daily struggles.

#### ***5.1.4. Coping strategies employed by the homeless***

The researcher's third objective was to identify coping strategies frequently employed by the homeless. Drawing from the literature, the researcher broadly classified coping strategies into adaptive and maladaptive. Adaptive coping strategies describes stress-management techniques that reduce stress and improve individuals' wellbeing. Maladaptive coping strategies are ineffective stress-management techniques that sometimes aggravate stressful experience. In the present study, coping strategies involving the use of religion, planning, emotional support, positive reframing, acceptance, instrumental support, active coping, and humor were classified adaptive. On the other hand, coping strategies involving venting, behavioral disengagement, substance use, self-distraction, self-blame, and denial were classified maladaptive.

While some earlier researchers compared homeless and non-homeless on coping strategies ((Votta & Manion, 2003, 2004), the present study explored the frequency of use of various coping strategies within the homeless population. This was necessary because the stress experience of the homeless is unique and uncommon to the non-homeless; therefore the coping strategies adopted by the homeless and non-homeless are likely to differ. A more useful approach was to exclusively assess the use of coping strategies within the homeless population (Kidd & Carroll, 2007; Tadesse, 2017).

Accordingly, the researcher hypothesized that the homeless are likely to adopt adaptive coping strategies more than maladaptive coping strategies. A test of this hypothesis revealed that the homeless generally adopted adaptive coping strategies more than maladaptive coping

strategies. Among the coping strategies, *religion* emerged the most frequently used strategy, followed by *planning*, and *active coping*. *Positive reframing* (i.e., adaptive coping strategy), *denial* and *venting* (i.e., maladaptive coping strategies) emerged fourth in frequency of use. Contrary to previous findings, *substance use* was least frequent among the homeless participants in the present study. Substance use has been identified as one of the maladaptive means in coping with homelessness (Fox et al., 2016).

Demonstrably, the bar chart in Figure 3 confirms that there was more frequent use of adaptive coping strategies than maladaptive coping strategies among the homeless participants. The greater use of adaptive coping strategies suggests that the participants have cultivated an attitude of resilience in the management of the stressors associated with homelessness. This assertion is congruent with the emerging trend in research studies on resilience in at-risk populations as a product and a significant correlate of coping skills (Cronley & Evans, 2017). *Religion* as most frequently used coping strategy was evident not only in the quantitative study, but also it became central in participants' responses in the one-on-one interview session (i.e., study II). Many of the participants prayed for God's intervention and hoped that there will be divine intervention to their predicaments. The use of religion as a coping mechanism is not unique to the Ghanaian homeless sample. In Ethiopia, Tadesse (2017) observed that religion and spirituality was a dominant coping method of the homeless. This shows that religion as a coping mechanism is pervasive, at least in the African context.

#### ***5.1.5. Impact of coping mechanisms on the psychosocial distress of the homeless.***

The final objective of this research was to assess the impact of coping mechanisms on the psychosocial distress of the homeless. This objective led the researcher to hypothesize that maladaptive coping will predict higher levels of psychosocial distress than adaptive coping. The

study partially confirmed this hypothesis. It was observed that adaptive coping had no significant relationship with any of the distress variables (i.e., loneliness, depression, anxiety, stress, traumatic symptoms, suicidal behaviors, and somatic symptoms). However, maladaptive coping significantly and positively correlated with depression, anxiety, traumatic symptoms, and somatic symptoms, but not with loneliness, stress, and suicidal behaviors. Further, maladaptive coping significantly predicted higher levels of depression, anxiety, and traumatic symptoms.

The lack of relationship between adaptive coping strategies and psychosocial distress suggests that adaptive coping such as the use of religion, planning, emotional support, positive reframing, acceptance, instrumental support, active coping, and humor can only stabilize the psychosocial wellbeing of the homeless but they do not improve it. The positive correlations imply that greater use of maladaptive coping strategies is associated with higher levels of depression, anxiety, traumatic symptoms, and somatic symptoms. Equally, less use of maladaptive coping strategies was associated with lower levels of depression, anxiety, traumatic symptoms, and somatic symptoms. This points to the detrimental effect of maladaptive coping on the psychosocial wellbeing of the homeless.

The above finding provides support to the transactional model of stress and coping (Lazarus 1966; Lazarus & Folkman 1984) which emphasizes the role of cognitive appraisal in the management of stressful events. The transactional model evaluates the level of emotional impacts of daily stressful situations and individuals' cognitive appraisal of such events. Homeless individuals who used adaptive coping strategies may have relied on positive appraisal resources to manage their situation. For such group, psychosocial wellbeing was maintained. However, homeless individuals who used maladaptive coping strategies may have relied on negative appraisal resources in the management of their situation. Such individuals have the

tendency to retreat in efforts to overcome the homelessness situation. The outcome of using negative appraisal resources is the observed deterioration of psychosocial wellbeing.

The finding also confirms that the adverse impact of homelessness on individual mental health outcomes may largely be mitigated by differences in coping resources (Asante et al., 201; Chondraki et al., 2014). In resilience studies, different forms of coping strategies have been identified, with each of them having differential associations with mental health outcomes (Cronley & Evans, 2017). In Study II, only 2 out of 10 participants reported experiencing relief from prayer, confirming the significant role of spirituality in coping with adverse life circumstance (Cronley & Evans, 2017). It must be noted that prayer and spirituality are adaptive coping mechanisms. Perplexingly, as many as 5 out of 10 interviewed participants expressed feelings of despair with their coping strategies. They were disappointed about the ineffective nature of their coping efforts. To them, their homelessness situation was overwhelming and seemingly unsurmountable. Clearly, these findings are illustrative of critical nature of homelessness in Ghana and buttress the conclusion of De-Graft Aikins and Ofori-Atta (2007) that coping strategies only aid adaptation, but are not particularly effective in improving the living conditions of the homeless. In other words, coping strategies can only function as adaptation techniques but not solutions to the crises associated with homelessness.

#### ***5.1.6. Optimism in Homelessness.***

In addition to the four objectives, the researcher also inquired about the kind of optimism that homeless people rely on in their distress. Participants' responses in Study II established that optimism was a central trait in the homeless. Although majority of the interviewed homeless participants did not find their coping strategies effective, they were optimistic that their situation

could change for the better with the passage of time. This form of optimism was dominant among as many as 7 out of the 10 respondents.

Regarding the source of their optimism, some were intrinsic, expressing hope in themselves; some counted on divine source by expressing hope in God; and others were extrinsic – they had expectation for help from benefactors. Strikingly, the extrinsic participants conditionally expressed their optimism, couching their responses with the “*if...*” clause. This means the kind of optimism expressed by the extrinsic group was not absolute. In the view of Fitzpatrick (2017), optimism is an important protective factor in mental health. Optimism can be useful in mitigating the adverse mental health consequences of homelessness. Among homeless adult sample in Northwest Arkansas, Fitzpatrick (2017) found that higher level of optimism among the homeless predicted lower levels of anxiety and depressive symptoms. This underscores the relevance of optimism for homeless individuals in distress.

## **5.2. Limitation of the Study**

Notwithstanding the findings, the study was not without a shortfall. Notably, unlike previous studies (e.g., Ferguson et al., 2015; Kidd & Carroll, 2007; Votta & Manion, 2003), the present study examined the effectiveness of coping mechanisms in broader terms. Here, various coping strategies were classified as adaptive and maladaptive and their effects on psychosocial distress were assessed accordingly. Although analyses of individual coping strategy may have been more useful, the researcher did not find it appropriate based on the fact that there were as many as 14 individual coping strategies and respective analyses of their effects on psychosocial distress will not only be a daunting task but also unnecessarily cumbersome.

One must be reminded that the dependent measure (i.e., psychosocial distress) had seven dimensions, namely depression, anxiety, stress, somatization, loneliness, traumatic symptoms, and suicidality. This would have rendered individual analyses even more complex and cumbersome. Thus the parsimonious decision to broadly categorize the 14 coping strategies into adaptive and maladaptive. Nevertheless, this convenient decision may have potentially masked the true effects of the various coping strategies on the psychosocial wellbeing of the homeless. For instance, in the study of Kidd and Carroll (2007), it was observed that the use of avoidant coping, substance use and social withdrawal were associated with high levels of suicidal ideation and suicide attempts. Yet, the present study failed to unravel such an effect, assuming that it really existed among the Ghanaian sample.

### **5.3. Recommendations**

Two sets of recommendations are offered from the study. First, the researcher offers theoretical recommendations to shape the conduct of future research on the psychosocial crises and coping among the homeless. Second, the researcher articulates interventional recommendations based on the findings from the study.

#### ***5.3.1. Recommendation for Future Research***

Based on the limitation of the study, it is recommended that future researchers should explore the effects of each of the fourteen coping strategies on psychosocial distress among the homeless. To overcome possible clumsiness in analyses, future researchers should restrict the number of dependent measures to a reasonably few. In so doing, useful information on the impact of each coping strategy on psychosocial distress can be gathered.

### **5.3.2. *Interventional Recommendations***

According to Speak and Tipple (2006), many interventional policies for homelessness in developing countries have been unsuccessful. They are loosely drafted and poorly implemented in an uncritical and unsupervised environment with apathetic attitude towards intended beneficiaries. It is based on this assertion that the current study inquired about desired interventions from the homeless participants. Among the interventions suggested by the homeless participants were provision of housing, skill training, job creation, and financial aid. In the view of the participants, such intervention could come through God and the instrumentality of the government, and/or benefactors.

Provision of housing should be fundamental in the institution of any intervention that aims to provide lasting and effective solution to homelessness in Ghana. The request for housing intervention is consistent with the housing-first policy. Housing-first policy intervention does not only entail provision of housing facilities, but more importantly the provision of essential services that meet the social and health-care needs of the individual. It has been proven that the application of the housing-first model has facilitated the coping abilities of many homeless individuals in managing the myriad of problems associated with homelessness (Atherton & Nicholls, 2008). Although the housing-first policy intervention may be expensive to implement in developing countries, the government of Ghana through partnership with the private sector can have a laid down plan to make housing facilities both accessible and affordable to disadvantageous groups in the population. This may serve as a protective intervention for the at-risk population

Given that financial difficulty is one of the key causes of homelessness, it is recommended that job creation and skill training be integrated into interventional policies in

Ghana. Fortunately, the homeless participants were very forceful in their call for this form of intervention. As many as 7 out of 10 participants called for help with job creation and skill training. They appeared hopeful that having a decent job could help them overcome their present situation. With decent job, they can gain the financial ability to afford decent housing and fairly meet their daily needs. The task of creating jobs for the homeless should be a shared responsibility between government, the private sector, and other stakeholders like non-government organizations (NGOs), religious institutions, and philanthropic individuals. This mission, if faithfully executed, will see a comprehensive transformation of lives among the homeless population in Ghana.

Related to above, government should provide direct financial assistance to the homeless to enable them meet their daily needs. Unarguably, homelessness and poverty are threaded together. In study I, as many as 30.1% of the homeless participants attributed the cause of their homelessness to poverty. In study II, 2 out of the 10 interviewed participants made a direct request for financial assistance. Although financial aid may not be a sustainable intervention in a weak economy, it can serve as a head start for talented homeless individuals with unflinching determination to succeed. Financial aid can also be tied to specific efforts such as renting, skill training, and entrepreneurial adventure. When tied to efforts, financial aid can yield the most useful and lasting results to the homeless individual.

Finally, there is the need for acceptance and acknowledgement of homeless individuals as persons of worth and victims of unfortunate circumstances. It is not uncommon for homeless individuals to experience negative and derogatory portrayals from communities, particularly in developing countries. They are sometimes perceived as drunks, unemployed, beggars, and criminals. According to CARDO (2003), this perception is largely false. It is refreshing to know

that the interviewed homeless participants in the present study were hardworking individuals who carry goods on their head or assist in loading and unloading commercial vehicles in the city. They were individuals with aspirations and determination to overcome their homelessness situation. Therefore, they deserve to be accorded with respect and be included in the social fabric. This is a necessary condition for the achievement of a positive change in psychosocial wellbeing of the homeless. According to Speak and Tipple (2006), without correcting the pervasive misconceptions associated with homelessness, even the most well-intentioned interventional policies will yield little or no lasting effect.

#### **5.4. Conclusion**

The study has revealed the gravity of psychosocial distress that homeless people in Ghana experience. The homeless, compared to non-homeless, reported significantly higher levels of somatization, depression, stress, anxiety, traumatic symptoms, loneliness, and suicidality. Although no significant gender differences were observed on loneliness, depression, anxiety, traumatization, and somatic symptoms, female homeless participants were found to have higher stress and greater suicidality than their male counterparts. The observed gender differences in psychosocial distress may have emanated from socio-cultural norms that tend to limit economic opportunities for women and place restrictions on their social participation in the community.

The study also explored the nature and effectiveness of the coping strategies frequently employed by the homeless. The coping strategies were classified as adaptive (which includes the use of religion, planning, emotional support, positive reframing, acceptance, instrumental support, active coping, and humor) and maladaptive which includes (which includes venting, behavioral disengagement, substance use, self-distraction, self-blame, and denial). Among the coping strategies, *religion* was the most frequently used strategy, followed by *planning*, and then

*active coping*. *Positive reframing* (adaptive coping), *denial*, and *venting* (maladaptive coping) emerged as the fourth most frequently used strategies for coping with homelessness.

Comparatively, the homeless participants employed adaptive coping strategies more frequently than maladaptive coping strategies. Yet, adaptive coping did not have any significant relationship with their psychosocial distress. Maladaptive coping, on the other hand, significantly predicted higher levels of depression, anxiety, and traumatic symptoms. In addition, maladaptive coping significantly and positively correlated with somatic symptoms but with weak predictive power. Despite the intensity of their predicaments, the homeless participants expressed optimism for positive change in the future. The intensity and pervasiveness of psychosocial distress among the homeless in Ghana requires the urgent response of government and relevant stakeholders to find effective and lasting solution to address this awful situation.

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**Section B: Revised UCLA Loneliness Scale****Instructions: Indicate how often each of the statements below is descriptive of you.***The rating scale is as follows:*

1. Never
2. Rarely
3. Sometimes
4. Often

	<b>Items</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
1.	I feel in tune with the people around me				
2.	I lack companionship				
3.	There is no one I can turn to				
4.	I do not feel alone				
5.	I feel part of a group of friends				
6.	I have a lot in common with the people around me				
7.	I am no longer close to anyone				
8.	My interests and ideas are not shared by those around me				
9.	I am an outgoing person				
10.	There are people I feel close to				
11.	I feel left out				
12.	My social relationships are superficial				
13.	No one really knows me well				
14.	I feel isolated from others				
15.	I can find companionship when I want it				
16.	There are people who really understand me				
17.	I am unhappy being so withdrawn				
18.	People are around me but not with me				
19.	There are people I can talk to				
20.	There are people I can turn to				

**Section C: Depression, Anxiety and Stress Scale - 21 Items (DASS-21)**

**Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.**

*The rating scale is as follows:*

0. Never
1. Sometimes
2. Often
3. Almost always

	<b>Items</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
1.	I find it hard to wind down				
2.	I was aware of dryness of my mouth				
3.	I couldn't seem to experience any positive feeling at all				
4.	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)				
5.	I found it difficult to work up the initiative to do things				
6.	I tended to over-react to situations				
7.	I experienced trembling (e.g., in the hands)				
8.	I felt that I was using a lot of nervous energy				
9.	I was worried about situations in which I might panic and make a fool of myself				
10.	I felt that I had nothing to look forward to				
11.	I found myself getting agitated				
12.	I found it difficult to relax				
13.	I felt down-hearted and blue				
14.	I was intolerant of anything that kept me from getting on with what I was doing				
15.	I felt I was close to panic				
16.	I was unable to become enthusiastic about anything				
17.	I felt I wasn't worth much as a person				
18.	I felt that I was rather touchy				
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20.	I felt scared without any good reason				
21.	I felt that life was meaningless				

**Section D: Modified PTSD Symptom Scale-Self Report (MPSS-SR)**

The purpose of this scale is to measure the frequency and severity of symptoms in the past two weeks that you may have been having in reaction to a traumatic event or events. Please indicate the traumatic event(s) and rate how much you have experienced the following aftermath by selecting the number that fits best.

Please indicate or describe your past traumatic event(s) \_\_\_\_\_

*The rating scale is as follows:*

0. Not at all
1. A little bit
2. Moderately
3. Quite a bit
4. Extremely

	<b>Items</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
1.	Have you had repeated or intrusive upsetting thoughts or recollections of the event(s)?					
2.	Have you been having repeated bad dreams or nightmares about the event(s)?					
3.	Have you had the experience of suddenly reliving the event(s), flashbacks of it or acting or feeling as if the event were happening again?					
4.	Have you been intensely emotionally upset when reminded of the event(s), including Anniversaries of when it happened?					
5.	Do you often make efforts to avoid thoughts or feelings associated with the event(s)?					
6.	Do you often make efforts to avoid activities, situations, or places that remind you of the event(s)?					
7.	Are there any important aspects about the event(s) that you still cannot recall?					
8.	Have you markedly lost interest in free time activities that used to be important to you?					
9.	Have you felt detached or cut off from others around you since the event?					
10.	Have you felt that your ability to experience emotions is less (unable to have loving feelings, feel numb, or can't cry when sad)?					
11.	Have you felt that any future plans or hopes have changed because of the event(s) (for example: no career, marriage, children, or long life)?					
12.	Have you been having a lot of difficulty falling or staying asleep?					
13.	Have you been continuously irritable or having outbursts of anger?					
14.	Have you been having persistent difficulty concentrating?					
15.	Are you overtly alert (checking to see who is around you) since the event?					
16.	Have you been jumpier, more easily startled, since the event?					
17.	Have you been having intense physical reactions (for example: sweating, heart beating fast) when reminded of the event(s)?					

**Section E: The Suicidal Behaviors Questionnaire-Revised (SBQ-R)**

Please check the number beside the statement or phrase that best applies to you.

**1. Have you ever thought about or attempted to kill yourself? (Check one only)**

1. Never
2. It was just a brief passing thought
- 3a. I have had a plan at least once to kill myself but did not try to do it
- 3b. I have had a plan at least once to kill myself and really wanted to die
- 4a. I have attempted to kill myself, but did not want to die
- 4b. I have attempted to kill myself, and really hoped to die

**2. How often have you thought about killing yourself in the past year? (check only one)**

1. Never
2. Rarely (1 time)
3. Sometimes (2 times)
4. Often (3-4 times)
5. Very often (5 or more times)

**3. Have you ever told someone that you were going to commit suicide, or that you might do it? (Check one only)**

1. No
- 2a. Yes, at one time, but did not really want to die
- 2b. Yes, at one time, and really wanted to die
- 3a. Yes, more than once, but did not want to do it
- 3b. Yes, more than once, and really wanted to do it

**4. How likely is it that you will attempt suicide someday? (check one only)**

0. Never
1. No chance at all
2. Rather unlikely
3. Unlikely
4. Likely
5. Rather likely
6. Very likely

**Section F: The Somatic Symptom Scale–8 (SSS-8)**

During the past 7 days, how much have you been bothered by any of the following problems?

*The rating scale is as follows:*

0. Not at all
1. A little bit
2. Somewhat
3. Quite a bit
4. Very much

	<b>Item</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>1.</b>	Stomach or bowel problems					
<b>2.</b>	Back pain					
<b>3.</b>	Pain in your arms, legs, or joints					
<b>4.</b>	Headaches					
<b>5.</b>	Chest pain or shortness of breath					
<b>6.</b>	Dizziness					
<b>7.</b>	Feeling tired or having low energy					
<b>8.</b>	Trouble sleeping					

**Section G: The Brief COPE**

These items deal with ways you've been coping with the stress in your life since you found yourself in a homelessness situation. There are many ways to try to deal with life's challenges. These items ask what you've been doing to cope with this one. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

*The rating scale is as follows:*

1. I haven't been doing this at all
2. I've been doing this a little bit
3. I've been doing this a medium amount
4. I've been doing this a lot

	<b>Items</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
1.	I've been turning to other activities to take my mind off things.				
2.	I've been concentrating my efforts on doing something about the situation I'm in.				
3.	I've been saying to myself "this isn't real".				
4.	I've been using alcohol or other drugs to make myself feel better.				
5.	I've been getting emotional support from others.				
6.	I've been giving up trying to deal with it.				
7.	I've been taking action to try to make the situation better.				
8.	I've been refusing to believe that it has happened.				
9.	I've been saying things to let my unpleasant feelings escape.				
10.	I've been getting help and advice from other people.				
11.	I've been using alcohol or other drugs to help me get through it.				
12.	I've been trying to see it in a different light, to make it seem more positive.				
13.	I've been criticizing myself.				
14.	I've been trying to come up with a strategy about what to do.				
15.	I've been getting comfort and understanding from someone.				
16.	I've been giving up the attempt to cope.				
17.	I've been learning from my situation.				
18.	I've been making jokes about it.				
19.	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.				
20.	I've been accepting the reality of the fact that it has happened.				
21.	I've been expressing my negative feelings.				
22.	I've been trying to find comfort in my religion or spiritual beliefs.				
23.	I've been trying to get advice or help from other people about what to do.				
24.	I've been learning to live with it.				
25.	I've been thinking hard about what steps to take.				
26.	I've been blaming myself for things that happened.				
27.	I've been praying or meditating.				
28.	I've been making fun of the situation.				

***Thank you very much!!!***

**Section B: TWI TRANSLATION OF SCALES  
Revised UCLA Loneliness Scale Translated**

Indisuo: Kyere mpren sen a nsem a edidiso yi mu biao efa wo ho

Anoyie: (1) Daabida (2) Entaa nye saa (3) Ebiwohoa (4) Etaa ye saa

1. Me ho dwo me wo womoa wo ben me no mu
2. Me nni obiaa wo me ho
3. Obiara nni ho a metumi di me ho ato ni so
4. Me wo nkorofa wo ho a mame
5. Me wo ndanfofo a midi me ho bo wom
6. Me ne wom a woben me no nsonsonie biara nni yentem
7. Obiara mben me biom/ me ni obiara mben biom
8. Me nni obiara me ni o fa adwen
9. Me ye obi a me kika me ho ko nipa mu
10. Me wo nkorofa a me kika me ho ben wom
11. Me wo atinka se ye yi me afiri mu/ yeeko a me nko bi
12. Me nipa mu mu ayonkofa ye anisuo keke
13. Obiara nhyeda nnim me papa/obiara nni ho a onim me paa
14. Me hunu no se mati me ho/ me hunu no se nkorofa atwi womo ho afiri me ho
15. Se me jia obi wo me ho a menya
16. Ye wo nkorofa a womo ti masi yie
17. Manigye se me nkika me ho nko nipa mu
18. Nkorofa wo me ho die nanso nye woni me na ewoho
19. Me wo nkorofa wo ho a metumi ni womo adi nkomo
20. Me wo nkorofa a metumi di m'ani to womo so

**Section C: Depression, Anxiety and Stress Scale – 21 (Dass-21) Translated**

Indisuo : Mesire wo kenkan nsem yin a fa hwee, baako anaase miensa efa kyere sedie nsem yi mu biao efa wo ho wo ena wotwe a etwam yi mu. Nsem yi yenni emuaye papa anaa boni. Enkye bebree wo asembisa baako ho.

Anoyie : (0) Daabida (1) Ebiwohoa (2) Etaa ye (3) Etaa ye dabiaa / ayese dabiaa

1. Ahomeghie ye me din / Mentumi ngye m'ahome yie
2. Me hunu se m'ano awo
3. Nnansayi mu menni atinka kraa
4. Mentuimi nhomi yie
5. Eye me din se m<sup>3</sup>hy<sup>3</sup> biribi asi
6. M'akoma sori ntem wo nniema bi ho
7. Ewo ho a me ho woso
8. Me di ahu ye adie / Me di ayemhyihyie ye adie
9. Me dwendwen niema bi a ebema me yem ahyihyi me na m'akogu m'anim asi
10. Na eye me se hwii nni ho a me di m'ani be to so
11. Me hunu se abufu ahy<sup>3</sup> me ma / Me bufu ntem
12. Na eye me din se megye m'ahome
13. Na me hwore aho / Na m'aye bosaa
14. Menni abiter<sup>3</sup> emma bibiara etwitwa m'akan mu
15. Eyaa na m'akoma atu
16. Na menya ahokika wo bibiaa ho
17. Na me hu no se me nye nipa biao saa
18. Na me hu no se me bufu ntem
19. M'akoma bo periperi
20. Me yem hyihyi me na mennim nea entia
21. Aborabo nni nfasuo / Awiase nni nfasuo

**Section D: Modified PTSD Symptom Scale-Self Report (MPSS-SR) Translated**

Indisuo : Nsem yi dwumaa edi ni se, ebe susu yaayaadi anaa ohaw no a wokoo mu no mpren ahe ni sedie ako so wo nda wotwe mienu a etwamu yi mu. Mesere wo kyer3 sedie nsem yi fa wo ho wo oyaw a wo faa mu no ho

Anoyie : (0) Daabi kraa (1) Kakraabi (2) Honeho (3) Kakra (4) Paa do do

1. Dea esii ye no eyaa eta aba wo tirim aa wo nnim aa emma wo bufu anaa / Eha wo anaa
2. Wo soso ho daye anaa
3. Etumi ba wotirim tise die na esi noaa
4. Se wo kai die esi ye noaa ehye wo aufu anaa, anaa mmereaa saase no sii no se saa da no durua emma wo bufu anaa
5. Eyaa wo bo wo ho mmdin se wo wire befiri anaa
6. Dea esii ye no eme no ha wo beberee
7. Ye wo biribi a ehia wo die asii ye noho aa wo nkai aanaa
8. W'anigye afiri nniema bi aa anka wotaa ye wo abre a wo nni hwii ye ho anaa
9. Efirise adie no sii yei wo hunu no se w'ati wo ho afiri nkorofuo ho anaa / W'aye ankonam
10. Efiise adie no sii ye no wo hunu no se wo ntumi nya atinka anaa
11. Wo susu se dea asii ye no ama w'anidaso asisa
12. Dea esii ye no agya wo kodaanda anaa / eye wo din se wo beda
13. Wo bufu ntemtem anaa / Nniema ye wo ahi ntem
14. Eyaa wobre ansa w'atumi atwi w'adwin ako nie woo ye so
15. Amma wo ngye nipa ndi biom
16. Wo yem hyi wo ntem anaa, efiise adie no sii ye no
17. Se obi anaa se wo kai dea esii ye no aa anfifiri ti wo anaa w'akoma bo

**Section E: The Suicidal Behavior Questionnaire-Revised (SBQ-R) Translated**

Indisuo : Mesere wo yi nsem yi mu dea efa wo ho

1. W'adwin ho pen se wo bekum wo ho anaa w'aye se wo wo bekum wo ho da
  - (1) Daabida
  - (2) Ebaa m'adwin mu mmere tiawa bi k3k3
  - (3a) Aba me tirim da nanso m'anye se mecum me ho
  - (3b) Aba me tirim da nanso na memp3 se me wu ampa
  - (4a) M'aye se mecum me ho pen nso na memp3 se me wu
  - (4b) M'aye se mecum me ho pen na na me p3s3 me wu ampa
2. Mpren sen na aba w'adwin mu se kum wo ho
  - (1) Embaa me tirim da / Daabida
  - (2) Entaa emba me tirim (baako p3)
  - (3) Ebiwohoa (mienu p3 / mpren abien)
  - (4) Eta aba me tirim (miensa eko enan)
  - (5) Eta aba paa (anum eeko)
3. W'aka akyire obi da se wo kokum woho pen anaa se ahwea wo bekum wo ho
  - (1) Daabida
  - (2a) Aani maka akyire obi pen nanso na me mp3s3 me wu
  - (2b) Aani maka akyire oi pen na na me p3s3 me wu ampa
  - (3a) Aani eboro mpren baako nanaso na me mp3s3 me wu
  - (3b) Aani eboro mpren baako na na me p3s3 me ye ampa
4. Se wo hwe aa ebetumi aba ne se daakyi bi wo be ye se wo ko kum wo ho anaa
  - (0) Daabi kraa
  - (1) Emba saa daa
  - (2) Entumi emba ne saa
  - (3) Emba ne saa kraa
  - (4) Ebeba ne saa
  - (5) Ebetumi aba ne saa
  - (6) Ebetumi aba ne saa paa

**Section F: The Somatic Symptom Scale-8 (SSS-8) Translated**

Indisuo : Wo nda wotwi yi a etwamu yi mpren sen na nsem yi mu bi aha wo

Anoyie : (0) Daabi kraa (1) kakraabi (2) bibisaa (3) karaa (4) Paa

1. W’anya yafunu mu yarie / anaa yentuo
2. W’akyiri dompe mu ye wo ya
3. Wo ti yaw wo wo nsamu, wo nan mu, anaa w’aposo w’aposo
4. Wo tiri ye wo ya / w’anya atipaye
5. Wo poso ye wo ya anaa wo ntumi nhomi
6. W’aniso kyim wo / w’aniso biri wo / anisobirie
7. Wo bre ntem anaa w’ahuodin so ati
8. Wo ntumi nda / kodaanda

**Section G: The Brief COPE Translated**

Indisuo : Nsem yi kyere okwan a wo fa so di tena afiis3 ohaw yi baa ye yi (wo nni beebi da yi). Ye wo okwan beberee wo ho a ye fa so di tena abrabo haw mu. Nsem yi bias wo okwan a wo fa so di tena wo haw yi mu. Obiara wo okwan a ofa so di tena nehaw mu, nanso nsem yibisa wo potii wo okwan a wo fa so di tena wo haw yi mu. Me p3s3 me hu mpren sen potii a wo ye nsem yi mu bi. Se dea wooye no eye dwuma anna se enye dwuma no enfa ho, na emmom se wo ye saa nkoaa deaa. Fa emmuaye a etuaso yi mu bi. Yi nsem yi nyinaa ano baako baako wo w’adwin mu a wo nfa mbom. Ma w’anoyie no nye nokware mma wo sedie ese.

Mepa wo akyew keka, anaase, kyer3 me atowerenkyem bi a ato wo da kyer3 me.

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Anoyie : (1) Me nye wei kraa (2) Me ye wei karaabi (3) Me ye ne honiho (4) Me ye wei paa

1. Sedie ebeyea me ndwindwin pii inti ema me di me ho hy3 niema bi mu
2. Me rib o me ho mmodin se meye biribi afa ohaw a me wo mu yi ho
3. Me kakyire me ho se “enye mea” / “wei ntoo mi”
4. Eyaa me num nsa anaa me fa aduru boni sedie ebeye a ebema m’adwin afiri mehaw no so

5. Me nya ahwore kyikyire afiri nkorofuo ho / nkorofuo ma me ahwore kyikyire
6. Ma ba mu bu wo manamutu fa mehaw yiho
7. Me bo mme hp mmodin se ebe ye yie
8. Me ngyi ntum se asi
9. Me ka ahworekyikyiresem kyire me ho sedie ebeyye a m'adwin befiri me haw no so
10. Me nya mmua mi afutu firi nkorofuo ho
11. Me num nsa anaa aduru boni sedie ebeye a m'atumi agyina ohaw yi
12. Eyaa me hwe no wo okwan foforo so sedie ebeye a ebema m'ahunu biribi papa bi wo mu
13. Me kika nsem boni fa me ho
14. Me bo me ho mmodin se me hunu okwan a me faso asi ohaw yi ano
15. Me nya ahworekyikyire ni nteasi firi obi ho
16. Eduru baabi a na m'abre na okwan a me faso timentim no na m'agyae mu / eyaa na m'bre  
ohaw yi / eyaa na maba mu abu
17. Mesua biribi afiri mehaw yi mu
18. Eyaa me di ye sirie
19. Eyaa me ye biribi de yi m'adwin firi ohaw yi so
20. Me gyi tum se asi ampa
21. Eyaa me da oyaw no adi
22. Eyaa me hw<sup>3</sup> se menya ahworekyikyire wo me nyamesom mu / megyidie mu
23. Eyaa me ye se megyi afutuo anaa mmua efiri nkorofuo ho afa okwan a mefaso afiri saa  
ohaw yi mu
24. Me di animia ti ohaw yi mu saa
25. Me dwin dindindin efiri okwan a mefaso afiri ohaw yi mu
26. Me fa ne se me na mama no aba ne saa
27. Me bo mpae
28. Eyaa na me di ay<sup>3</sup> sirie / anaa me di ay<sup>3e</sup> mboguo

**APPENDIX II:**

**INTERVIEW GUIDE**

1. Please tell me about your situation, what are some of the challenges/problems you go through as someone who is homeless and how has it affected you as an individual – economic, financial, social, relationship etc? Any specific instance?
2. Please tell me, when you are going through these challenges/problems what are some of the things you do to cope? Any specific instance?
3. Please tell me, when you do these things do you get relieved? How effective is what you do to cope through these challenges/problems? Any specific instance?
4. Please tell me about how satisfied or happy you are about your life in general. Do you think your situation can change? Why? What are you doing to improve upon your situation?
5. Please tell me what you think will be an appropriate solution to homelessness. What type of help do you need to address your situation? Who do you think is the right person to provide this help?

**APPENDIX III:****CONSENT FORM**

UNIVERSITY OF GHANA

Official Use only  
Protocol number**Ethics Committee for Humanities (ECH)****PROTOCOL CONSENT FORM****Section A- BACKGROUND INFORMATION**

Title of Study: Psychosocial crisis and coping among the homeless in Greater Accra, Ghana

Principal Investigator: Nelly Betty Fosu

Certified Protocol Number: **ECH 030/17-18**

**Section B- CONSENT TO PARTICIPATE IN RESEARCH****General Information about Research**

This research will mainly involve the use of primary data in the form of responses provided to standardized measures in the questionnaire. Specifically, the study seeks to assess your psychosocial; distress (traumatic symptom, depression, anxiety, stress, somatization, loneliness, and suicidality) and coping as consequences of homelessness. The study also examines how social support and coping serve as buffers to the psychosocial distress among the homeless in Ghana.

**Benefits of the study**

Your participation will help you gain greater consciousness of your psychosocial state (for example self-development and improving interpersonal relations). The outcome of the study will also be useful in planning interventions for individuals who may have poorer psychosocial distress due to homelessness. Recommendations will also be made to policy makers about the need to create opportunities for the homeless in order to maximize their psychological health. Finally, the study will contribute to the body of knowledge in this area of research.

**Risks of the study**

No physical risk is anticipated in this research. However, your participation may cause you some psychological and emotional discomfort (for example mood swings, revisiting past traumatic

events, shedding tears, feeling sad). This is because you will be required to produce information about certain sensitive psychological issues such as depression, anxiety, and suicidal thoughts and behavior. In acknowledgement of this danger, the researcher has instituted remedial measures. Depending on the degree of discomfort you may suffer, the researcher will employ the service of professional psychologists to help in counselling in order to forestall psychological and emotional stability to you. The discussion will help address some personal problems you may bring across, thereby improving your general psychological wellbeing.

Moreover, your participation in this research will also deny you some precious time for yourself. The study is likely to take about 30 minutes of your time. Within such period, the researchers will engage you for the purpose of the research.

### **Confidentiality**

The data from this study is for academic purposes only and will be kept strictly and completely confidential. Your personal information will not be associated with the data nor with any written reports, presentation, or publications that may develop from this study. Any future use of the data will be for the same purposes and will be subjected to the same confidentiality guidelines.

### **Compensation**

You will not be paid for participating in this research since it is purely voluntary.

### **Withdrawal from Study**

You may leave the research at any time without penalty. If you choose to take part, you can change your mind at any time and withdraw without being adversely affected.

### **Contact for Additional Information**

In case you encounter any problem during this research or have any questions about the research, please call Miss Nelly B. Fosu, the principal investigator on 0240238302, or Dr. Benjamin Amponsah, the principal supervisor on 0244277255, or Dr. Joana Salifu Yendock, the co-supervisor on 0207700935, all in the Psychology Department of University of Ghana, Legon.

If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at [ech@isser.edu.gh](mailto:ech@isser.edu.gh) / [ech@ug.edu.gh](mailto:ech@ug.edu.gh) or 00233- 303-933-866.

### **Section C- PARTICIPANT AGREEMENT**

**"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to**

**participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."**

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature or mark of Participant

\_\_\_\_\_  
Date

**If participants cannot read and or understand the form themselves, a witness must sign here:**

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

\_\_\_\_\_  
Name of witness

\_\_\_\_\_  
Signature of witness / Mark

\_\_\_\_\_  
Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

\_\_\_\_\_  
Name of Person who Obtained Consent

\_\_\_\_\_  
Signature of Person Who Obtained Consent

\_\_\_\_\_  
Date

APPENDIX IV:

LETTER OF INTRODUCTION



**UNIVERSITY OF GHANA**  
**DEPARTMENT OF PSYCHOLOGY**  
**SCHOOL OF SOCIAL SCIENCES**

August 25, 2017

Ref. No.....  
PSYC 2/33/03

The Administrator  
Ethics Committee for Humanities (ECH)  
Office of Research Innovation and Development  
University of Ghana  
Legon

Dear Sir/ Madam,

**LETTER OF INTRODUCTION**  
**MS. NELLY BETTY FOSU - INDEX NUMBER-10344869**

The above-named student is an MPhil Clinical Psychology student in the University of Ghana.

As part of the requirement, Nelly Betty Fosú has to write and submit an original thesis. The title of her thesis is "**Psychosocial crisis and coping among the homeless in Greater Accra, Ghana**". She is planning to conduct her study in Greater Accra.

She is applying to your board for institutional approval/Clearance to enable her carry on with her research work. She has received approval from our department.

Yours faithfully,

  
Dr. Maxwell Asumeng  
(Head of Department)

COLLEGE OF HUMANITIES

P. O. Box Lg 84, Legon, Accra-ghana

• Telephone: +233 (0) 289 550 463

• Email: [Psychology@ug.edu.gh](mailto:Psychology@ug.edu.gh)

• Website: [www.ug.edu.gh](http://www.ug.edu.gh)

APPENDIX V:

LETTER OF INSTITUTIONAL APPROVAL



**UNIVERSITY OF GHANA**  
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

*P. O. Box LG 74, Legon, Accra, Ghana*

My Ref. No.....

1<sup>st</sup> November, 2017

Ms. Nelly Betty Fosu  
Department of Psychology  
University of Ghana  
Legon

Dear Ms. Fosu,

**ECH 030/17-18: PSYCHOSOCIAL CRISIS AND COPING AMONG THE HOMELESS IN GREATER ACCRA, GHANA**

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	31/05/18
On Agenda for:	Initial Submission
Date of Submission:	18/09/17
ECH Action:	Approved
Reporting:	Quarterly

Please accept my congratulations.

Yours Sincerely,

Rev. Prof. J. O. Y. Mante  
ECH Chair



CC: Dr. Maxwell Asumeng, Department of Psychology, University of Ghana.