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VIOLENCE WITHIN THE LIVES OF HOMELESS PEOPLE

By

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Charlotte Couldrey

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Abstract

Narrative Literature Review

Experience of victimisation and violence is prevalent within homeless people's lives, and frequently begins in childhood through the experience of childhood abuse and trauma. The impact of childhood abuse and trauma has been associated directly and indirectly as a pathway into homelessness. Furthermore the psychological impact of childhood abuse and trauma has been linked to victimisation and perpetration of violence within homeless people. Victimisation and perpetration of violence has been predominately researched on homeless adolescents and women, with homeless men significantly under researched. Victimisation and violence is associated with a number of similar factors including childhood abuse, re-victimisation, deviant peers, substance misuse and mental illness. Furthermore, research suggests homeless people frequently have a dual role as both victim and perpetrator. This review discusses these factors, the limitations of the current research, areas for further research and the clinical implications.

Empirical Paper

The current study was conducted to further explore the mechanisms surrounding childhood abuse and trauma and its association with aggression in homeless people. Emotion dysregulation has a growing body of research suggesting it has the unifying function to a number of maladaptive behaviours. Research suggests childhood aversive experiences are associated with developing emotion dysregulation difficulties and aggression. This study found that emotion dysregulation significantly mediated the relationship between childhood abuse and trauma, and aggression, within a sample of homeless people. The implications of the findings are discussed with reference to the need for psychological interventions for homeless people and highlights the importance of incorporating emotion regulation strategies within interventions for aggression.

Key words: Childhood abuse and trauma, Victimisation, Violence, Emotion dysregulation, Aggression, Homelessness.

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NARRATIVE LITERATURE REVIEW

Homeless people's experience of violence and victimisation

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Abstract

This narrative review of homelessness found that experience of victimisation and violence is highly prevalent. Research suggests the experience of victimisation frequently begins in childhood in terms of childhood abuse and trauma and has a number of implications both as a pathway into homelessness has been associated with victimisation and perpetration of violence within the homeless population.

Victimisation has been most comprehensively reviewed in terms of sexual victimisation within homeless female adolescents and adults, with victimisation of men significantly under researched. The factors associated with increasing the risk of victimisation and violence are explored and a number of factors including association with deviant peers, mental illness, re-victimisation, substance misuse and the environmental factors associated with homelessness are identified. Furthermore, research suggests a dual role as both victim and perpetrator as they negotiate the hostile environment of homelessness. The review concludes that victimisation and perpetration of violence is multi-directional and is a complex relationship between victimisation in childhood, re-victimisation and perpetration of violence and highlights that our understanding of it is within its infancy. Finally, the findings are discussed in terms of limitations of the current research, directions for future research and implications.

Key words: Victimisation, Violence, Childhood abuse and trauma, Homelessness

1.0 Introduction

1.1 Homelessness

Homelessness is a significant problem both for the individual and for society and is well understood to be more complex than merely not having a roof over your head (Crisis, 2004). Homeless people frequently have multiple and complex psychological difficulties, and being homeless is associated with a variety of disadvantages including exposure to victimisation, poor physical and mental health, high prevalence of substance misuse problems, antisocial and aggressive behaviour, lack of legal work opportunities and enduring negative attitudes from the public (Evans & Forsyth, 2004). Research has begun to explore some of the psychological difficulties experienced by the homeless population, however is in its infancy. Within the current research a pervasive theme of victimisation and violence emerges, with experience of violence frequently occurring across homeless people's life span (Ryan, Kilmer, Cauce, Watanabe & Hoyt, 2000).

1.2 Victimisation and violence

Homeless people are among the most impoverished members of society and experience higher rates of victimisation compared with their housed counter parts and are associated with perpetration of violence. Homeless people's experience of violence frequently begins in childhood in the form of childhood abuse and trauma, with experience of childhood abuse and trauma significantly over represented within the homeless population in comparison to the general population (Kipke, Simon, Montgomery, Unger & Iverson,

1997; Ryan et al., 2000). Experience of childhood abuse and trauma has considerable implications for homeless people as a pathway into homelessness directly and indirectly, and through increasing personal vulnerability to a number of psychological difficulties and maladaptive behaviours generally. The psychological difficulties associated with experiencing childhood abuse and trauma have been associated with increased vulnerability which may perpetuate homelessness, and specifically to this paper, by increasing personal vulnerability to being re-victimised sexually and physically and/or perpetrating violence (for example North, Smith & Spitznagel, 1994; Wenzel, Koegel & Gelberg, 2000; D'Ercole & Struening, 1990).

In general, research suggests that experience of victimisation and violence is a common experience for homeless people. The hostile environment of the streets and hostels has been associated with increasing risk, as people try to survive in these conditions without protective shelter, in high crime areas and frequently engaging in high risk activities (Kushel, Evans, Perry, Robertson & Moss, 2008). Combined with the high prevalence of psychological difficulties resulting from childhood abuse and trauma, and factors associated with homelessness itself (mental health difficulties and substance misuse), being homeless provides an increased vulnerability to repeated victimisation (sexual and physical) and increases risk of perpetration of violence both as a conflict resolution strategy and in reciprocal violence (Whitbeck & Hoyt, 1999).

Victimisation and violence within homeless people's lives is complex and the repercussions are detrimental in terms of psychological trauma, misuse of substances, re-victimisation, further perpetration of violence, mental and physical health difficulties, and contact with the Criminal Justice System (Maguire, 2006) which may perpetuate homelessness. All of these factors may contribute to making escaping homelessness challenging, and result in people experiencing a cycle of repeated exposure to victimisation and opportunity for perpetration of violence.

1.3 Literature Search Strategy

The following electronic bibliographic databases were searched: Web of knowledge, PsycINFO, Social Sciences Citiation Index, EMBASE, and MEDLINE. The following terms were searched for in the titles, abstracts, and topics in each database homeless, violence, aggression, victim, victimisation, victimization. The search identified studies published over the last 25 years and only considered articles published in the English language. Reference sections from relevant studies were scrutinised for additional pertinent articles. This process was conducted until it was considered all useful articles had been retrieved and reviewed. The final number of articles referred to in this paper is 78 and are psychological and social perspectives on victimisation and violence within homelessness.

1.4 Aim and scope of this literature review

The aim of this narrative literature review is to explore the experience of violence in homeless people's lives. The body of research is limited and

within its infancy therefore this paper is explorative. The literature will be presented in terms of childhood experience of victimisation, victimisation within homelessness, violence within homelessness and the dual role of victim and perpetrator. The clinical implications of findings, the limitations of the current research and areas for further research will be discussed.

2.0 Child abuse and trauma in homeless people

The experience of violence in the form of abuse and trauma frequently begins in childhood for a number of homeless people. Research suggests a high prevalence of childhood abuse and trauma including physical, sexual and emotional abuse and neglect across the homeless population (Ryan et al., 2000; Janus, Burgess & McCormack, 1987; Zugagzaga, 2004; Nyamthi, Wenzel, Lesser, Flaskerud & Leake, 2001; North et al., 1994). The majority of the research on experience of childhood abuse and trauma is on homeless adolescents and indicates a high prevalence (Baron & Hartnagel, 1998; Boris, Heller, Gwadz, Nish, Leonard & Strauss, 2007; Janus, et al., 1987; Tyler & Cauce, 2002; Tyler, Hoyt, Whitbeck & Cauce, 2001; Ryan, et al.,2000; Whitbeck, Hoyt, Yoder, Cauce & Paradise, 2001; Whitbeck, Hoyt & Ackley, 1997a & b; Whitbeck & Simons, 1993), and a similar pattern is found within the much smaller body of literature exploring homeless adult's experiences of childhood abuse and trauma (North et al., 1994) .

The majority of research within the adult literature focuses on homeless adult women and the detrimental impact of their experiences such as re-victimisation in intimate partner relationships and sexual victimisation (D'Ercole & Struening, 1990; Goodman, 1991; Zugazaga, 2004; Nyamthi et

al., 2001), with few studies systematically exploring this in men (North et al., 1994).

Despite the considerable body of research, methodological and definition differences have resulted in a lack of consensus in the actual prevalence rate of childhood abuse and trauma in this complex population. Regardless of precise prevalence rates, it is well established that childhood abuse and trauma has a considerable impact on functioning, is a risk factor and a pathway for homelessness (Martijn & Sharpe, 2006) and for further victimisation and violence (North et al., 1994).

The impact of childhood abuse and trauma is significant, with deleterious consequences to children's development and longer term effects, evident both in adolescence and adulthood. In terms of child development, the physical, social and emotional effects are considerable (Hampton, Gullotta, Adams, Potter & Weissberg, 1993), with research indicating children who have been abused are likely to have affective and behavioural difficulties, insecure attachment style, poor educational attainment, disturbances in interpersonal relating and social functioning, self-destructive behaviour, difficulties with emotion regulation, hyperactivity and excessive aggression (Cicchetti & Toth, 1995; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Ryan et al., 2000). Longer term, in adolescence and adulthood the impact of childhood abuse has been associated with numerous psychological difficulties including depression, anxiety, isolation, learned helplessness, posttraumatic stress disorder (PTSD); borderline personality disorder (BPD), substance misuse; self harm, suicidal ideation, low self-esteem, sexual

promiscuity, externalising behaviours such as aggression and self destructive behaviour, engagement in high risk activities and repeated victimisation (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Beitchman et al., 1992; Browne & Finkelhor, 1986; Green, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993; Malinosky-Rummell & Hansen, 1993; Rowan & Foy, 1993; Tyler, Melander & Almazan, 2010).

It is clear that the impact of experiencing childhood abuse and trauma is associated with developing a number of difficulties, and that homeless people who have these experiences are likely to be highly vulnerable people with limited psychological resources and coping strategies to protect themselves and to manage distress. Although research has found a direct association of childhood abuse with re-victimisation and violence, other psychological difficulties (for example depression, PTSD) associated with experiencing childhood abuse and trauma, have been found to further contribute to increasing individual's vulnerability to victimisation (Tyler, Hoyt & Whitbeck, 2000) and perpetration of violence (Chen, Tyler, Whitbeck & Hoyt, 2004).

Furthermore, experience of childhood abuse and trauma has been associated directly and indirectly with entering homelessness. Studies on homeless adolescents have shown that individuals will become homeless as a means of escaping abuse at home directly and indirectly specifically in homeless women, as research suggests a complex history of childhood abuse is associated with re-victimisation in intimate partner relationships (domestic violence), which is frequently cited as a route into homelessness.

2.1 Direct relationship of child abuse as a pathway

For adolescents, the experience of childhood abuse both physical and sexual is associated with entering homelessness. Research suggests homeless adolescents who have experienced childhood abuse frequently report that the abuse is generally by their caregivers, which results in limited options for escaping the abuse (Gwadz et al., 2007; Janus et al., 1987; Ryan et al.,2000; Martijn & Sharpe, 2006). Whitbeck, Hoyt, Yoder, Cauce & Paradise (2001) found in their sample of homeless young people, that rates of caregiver violence were high: 77% reported being pushed, shoved or grabbed and 7 % reported being harmed by a weapon used by their caregiver and that homeless adolescents frequently reporting running away to escape the violence (Martiji & Sharpe, 2006; Whitbeck et al., 1997a & b; Tyler, Whitbeck & Cauce, 2001, Whitbeck et al., 2001). A similar pattern emerges in those who have experienced sexual abuse. Chen et al., (2004) found sexual abuse significantly influences adolescents leaving home, with those who specifically experienced sexual abuse often leaving home at a much earlier age (Tyler et al., 2000; Whitbeck and Hoyt, 1999). Unfortunately, escaping physical and sexual abuse at home frequently means exposure to the unpredictable and hostile conditions of homelessness. For many homeless young people the violence they are exposed to when living on the streets and in shelters is consistent with their previous experiences of violence (Martijn & Sharpe, 2006) and they are often re-victimised sexually (Chen et al., 2004). Therefore leaving home may in fact exacerbate potential risk of victimisation both physical and sexual, and being immersed in street culture associated with

engagement in perpetration of reciprocal violence, creating a cycle of exposure to violence (Baron & Hartnagel, 1998; Boris et al., 2002; Whitbeck & Simons, 1993).

2.2 Indirect relationship of childhood abuse and domestic violence as a pathway

Domestic violence is a well established pathway into homelessness for women (Hagan, 1987; Vostanis, Tischer, Cumella & Bellerby, 2001). A study by Browne & Bassuk (1997) on homeless women found that half were homeless due to leaving an abusive situation. Research suggests that homeless women who cite domestic violence as their route into homelessness frequently have a complex history of childhood abuse, which it is suggested, increases their risk of re-victimisation in intimate partner relationships. It is suggested that women who have experienced childhood abuse have few psychological resources to cope, and are vulnerable to forming relationship with abusive men (Browne, 1993). Coupled with poverty (reduced alternative options), childhood abuse creates an indirect pathway into homelessness, through intimate partner violence.

Studies exploring the relationship between childhood abuse and intimate partner violence in homeless women, again due to methodological and definition difficulties, disagree as to the precise prevalence of homeless women who have experienced childhood abuse and are victimised by their intimate partners. Studies indicate between 33% and 60% of homeless women report experiencing childhood abuse and trauma, and intimate

partner violence (D'Ercole & Struening,1990; Goodman,1991; Redmond & Brackmann, 1990; Zugazaga, 2004).

Regardless of the different prevalence rates, the relationship between childhood abuse and re-victimisation in intimate partner violence is demonstrated by this research; however casual pathways are not clearly understood. It is likely that the impact of childhood abuse psychologically (self esteem, learned helplessness) and in terms of mental illness (notably PTSD) play a prominent role in selecting into relationships which are abusive (Browne,1993) and these difficulties may reduce personal psychological resources available to them to enable them to protect themselves. Therefore, childhood abuse appears to provide an indirect pathway into homelessness, through vulnerability to abusive relationships.

Research has established the high prevalence of childhood abuse and trauma in samples of homeless men (for example North et al., 1994) and it is increasingly understood that men are also victims of abuse from intimate partners (British Crime Survey, 2009). In a study on pathways to homelessness, Evans & Forsyth (2004) found that women were most likely to report becoming homeless as a result of domestic violence, whereas men were more likely to report becoming homeless as a result of unemployment, alcohol abuse and release from prison. Given the established prevalence of childhood abuse and trauma in men, and our understanding that men are the also victims of domestic violence, it is interesting that domestic violence is not an established pathway into homelessness for men. It is possible that the

stigma of being the victim of intimate partner violence prevents homeless men from disclosing domestic violence.

Pathways into homelessness require more research and it is likely that childhood abuse and trauma, and its consequences considerably impact on entering homelessness in general, but is beyond the scope for this paper (one recent paper which has begun to consider the factors or pathways into homelessness in young people by van den Bree et al (2009) may be of interest to the reader). The impact of childhood abuse has been associated with a direct and indirect route into homelessness for young people and women in particular. Tragically, escaping one abusive situation leads them into an equally abusive situation, on the streets and within hostels. Experience of childhood abuse and trauma appears to place people on a trajectory for further abuse and for perpetration of violence. The impact of childhood abuse on risk of re-victimisation and perpetration of violence will be discussed alongside the other factors identified within current literature that are associated with victimisation and violence within homeless people.

3.0 Victimisation within homelessness

Research indicates that the experience of physical and sexual victimisation while homeless is a common experience for homeless people (North, et al., 1994). Crisis (2005) found that homeless people are significantly more likely to be the victim of violence than the general public. However, the research is divided with studies disagreeing as to whether homeless females are more at risk of victimisation than homeless males. North & Smith (1993) found that homeless women were at greater risk than homeless men of both sexual and

physical assault. However, many studies suggest that homeless women and homeless female adolescents are at greater risk of sexual victimisation only, in comparison to their male counterparts (Kipke et al., 1997; Tyler et al., 2001; Gwadz et al., 2007; Whitbeck et al., 1997a; Whitbeck, Hoyt & Yoder, 1999; Whitbeck & Simons, 1993; Whitbeck et al., 2001) and that there is no difference between rates of physical victimisation (Wenzel et al., 2000; Evans and Forsyth, 2004). There may be many factors which influence these findings. It is possible that men may be less likely to report sexual victimisation due to stigma and there is the issue of women generally being physically weaker than their male counterparts which may impact on level of victimisation. These factors are speculative and further research to understand gender differences in the prevalence of physical and sexual victimisation focusing on these factors make this research richer.

As an explanation for this Whitbeck and Hoyt (1999) suggest female homeless people are more likely to be re-victimised sexually than males due to gender differences in internalising and externalising. In their study of victimisation in homeless young people who had experienced childhood abuse, they found gender differences in terms of depression. Female homeless people who had experienced sexual victimisation during childhood were significantly more likely to have depressive symptoms (internalising symptoms) than the males, and as a result reduce their ability to protect themselves against further victimisation. Male participants tended to externalise resulting in an increase in antisocial traits, including reciprocal

aggression (Whitbeck et al., 1999). However, this is not representative of the number of males who do experience victimisation.

Research including homeless men's experience of victimisation is under represented within the current research. The majority of research on victimisation focuses on female's experiences, predominately adolescents. Presumably as a result of this, victimisation research comprises predominately on the factors associated with sexual assault, with a smaller body of research exploring the impact of mental illness and substance misuse on victimisation in general.

3.1 Factors associated with sexual victimisation

Experience of sexual victimisation has received attention from researchers and it is generally agreed that the prevalence sexual victimisation within homeless females is high. Further to this, research suggests female adolescents and adults who experience sexual victimisation while homeless have frequently been sexually abused as a child (D'Ercole & Struening, 1990; Goodman, 1991; Noell, Rohde, Seeley & Ochs, 2001; Redmond & Brackmann, 1990; Zugazaga, 2004). Gwadz et al.,'s (2007) study of homeless adolescents found that three quarters of their female participants had experienced at least some form of sexual abuse across their lifespan. They also found it was common for females to have experienced multiple types of sexual victimisation, including assault by a stranger and someone known to them, both during childhood and adolescence.

Other studies have found similar patterns. Tyler et al., (2000) again found high prevalence of childhood sexual abuse and that these experiences increased risk of re-victimisation indirectly. They found that childhood sexual abuse was associated with having a number of sexual partners; which research itself suggests increases the risk of being a victim of sexual assault (Abbey, Ross, McDuffie & McAuslan, 1996). Tyler et al., (2000) propose that the psychological difficulties associated with childhood sexual abuse (low self esteem, isolation and depression) may mean that the victims engage in numerous sexual relationships to seek the attention they desperately want.

Furthermore, Tyler et al., (2000) suggest homeless females who are desperate for shelter, food and substances may trade sex (frequently called survival sex) for these resources, and demonstrated that those who have experienced childhood sexual abuse were highly associated with engaging in survival sex (Tyler et al., 2000). Tyler et al., (2000) also found engaging in survival sex was significantly associated with demoralisation and feelings of degradation. Tyler et al., (2000) assumptions about the motivation of the homeless young females, in particular attention seeking, appears unsupported by research and it is possible other factors motivate these individuals to engage in numerous relationships. Furthermore, it is unclear how the 'numerous relationships' differ from survival sex, it is possible the two are connected. Further research is needed to address these limitations.

Tyler at al., (2000) also found that association with peers who sold sex was significantly associated with individuals becoming involved in selling sex themselves, potentially as a result of peer pressure. Other authors also

support this and suggest young people's affiliation with other deviant peers has a strong influence over their behaviour (Kipke et al, 1997; Whitbeck et al., 1997a; Whitbeck & Simons, 1993, Whitbeck et al., 1999, Whitbeck et al., 2001). It has been considered that peers act as mentors or tutors who teach skills and knowledge about criminal activity and survival on the streets (Hagan & McCartley, 1997).

A study by Weisberg (1985) found that female homeless young people are at risk from pimps who use coercion, physical force, flattery and promise of money, to persuade female homeless young people to become prostitutes. Prostitution was found to be significantly associated with sexual assault and violence from customers and pimps (Weisberg, 1985). In general engagement in selling sex whether in prostitution or through desperation in terms of survival, increases visibility on the streets and visibility in itself has been found to increase the risk of victimisation (Tyler et al., 2000). Therefore, the very nature of selling sex makes homeless females vulnerable to further victimisation both sexually and physically. Since most young people have few options available to them when it comes to survival, they are likely to continue this pattern and remain at risk of re-victimisation and potentially increasing their level of psychological distress, further increasing their vulnerability.

There is limited literature exploring the impact of sexual abuse on rates of re-victimisation in male homeless people. In one study that does explore the impact of sexual abuse in a sample of runaway homeless youths, further supported the research that experience of childhood abuse was high (71%

and 31% sexual and physical abuse respectively) and found a relevant finding in terms of sexual victimisation (Janus et al., 1987). The authors compared non-sexually abused male runaways with sexually abused male runaways, and found that those who had been sexually abused were significantly more likely to be paid to have sex with adult men, were fearful of adult men, and had difficulties forming interpersonal relationships. Not surprisingly, similarly to findings in homeless females, they found being paid to have sex with men significantly increased the risk of repeated sexual victimisation (Janus at al., 1987).

3.2 Mental illness

Research suggests homeless people with mental health difficulties are at increased risk of victimisation (North et al., 1994; Kushel et al., 2008). Within the homeless population there is a high prevalence of mental health difficulties (Martens, 2001) and it is theorised that mental health difficulties may increase risk of victimisation for a number of reasons. It is suggested that mental illness may reduce the individual's level of vigilance in hazardous environments, such as the streets, making them less able to identify and avoid danger (Wenzel et al., 2000). It is also thought that their appearance may draw attention to their vulnerability to potential perpetrators (Wenzel et al., 2000; Kushel et al., 2008). This vulnerability to re-victimisation within homeless people with mental health difficulties is of considerable concern, as it is likely that victimisation will exacerbate their mental health difficulties. Suicidality is high in homeless people (Molnar, Shade, Kral, Booth and Watters, 1998) and repeated experience of victimisation for those already

vulnerable due to their mental health difficulties, makes breaking this cycle a pressing issue.

3.3 Substance misuse

Substance misuse has been associated with risk of victimisation (Wenzel et al., 2000), both in the nature of obtaining the substance and similarly to mental illness, in reducing vigilance for threat. Obtaining substances is fraught with danger of victimisation. The environment in which substances are sold are likely to be dangerous due to lack of formal social control (Wenzel et al., 2000), exposing people to the risk of victimisation. Being under the influence of substances is associated with impairment, which like symptoms of mental illness, reduces level of awareness of threat, increasing their vulnerability to potential perpetrators (Nurius & Norris, 1996). It has been found that substance misuse is associated with being sexually assaulted, and studies suggest drugs and alcohol are frequently used post a sexual assault (Nyamthi et al., 2001), potentially as a way of coping with this distressing, traumatic event and paradoxically may further exacerbate risk of victimisation.

Summary

In summary, experience of victimisation within homeless people is high and associated with a number of difficulties, including mental illness, substance misuse, survival sex, prostitution and association with deviant peers. Victimisation appears to be an interaction between environmental factors associated with surviving homelessness (survival sex, obtaining substances,

prostitution) and personal vulnerability (childhood abuse, mental illness and substance misuse). The trauma and distress associated with being a victim is catastrophic, included risk of developing PTSD (Whitbeck, Hoyt, Johnson & Chen, 2007) and may serve to maintain current psychological difficulties (mental illness, substance misuse) and result in a cycle of victimisation, all of which may contribute to perpetuating homelessness.

Literature on homeless people has also shown that perpetration of violence is a common experience for homeless people. Within this body of literature similar factors in terms of experience of childhood abuse, substance misuse, mental health difficulties and the environment emerge as risk factors

4.0 Violence

Research into perpetration of violence provides mixed results in terms of whether perpetration of violence is higher within the homeless population than the general population. A study by Snow, Baker & Anderson (1989) found that there was no difference between the level of violence perpetrated by homeless people from that of the general population. However a number of more recent studies have found that the level of violence is significantly higher within homeless people (North et al., 1994; Swanson et al., 2002) and this may reflect methodological problems with Snow et al's., (1989) study. Snow et al's., (1989) reviewed all aspects of criminal history (such as burglary etc) in homeless people and when looking at violence focused on severe violent acts such as murder, rape and aggravated assault. The data used was based on arrest rates, so potentially did not take into account aggression and violence which is not severe enough to warrant police

attention and that is potentially representative of the subculture of homelessness (Wardhaugh, 2000).

The level of perpetration of violence within homelessness is illustrated by a study by Gilders (1997) of five UK agencies which provide day services for people who are homeless, and found significantly high levels of aggression and violence towards staff and other homeless people. The incidents ranged from verbal arguments to threatening people with a knife and serious assault. North et al's., (1994) study found a similar pattern in their sample of male and female homeless people. They found half of the sample reported at least one incident of being violent in adulthood, and nearly half of the men and a fifth of the women participants reported engaging in aggressive behaviour as children. A study by Fischer, Shinn, Shroud & Tsemberis (2008) which also included homeless women, supported these findings and suggests that gender does not significantly predict violence, and that homeless women are equally likely to be violent as homeless men. North et al., (1994) found within their study aggressive behaviour predated homelessness, and that those with a history of aggressive behaviour continued with the behaviour when they were homeless. This has important implications in terms of violence as a predisposing or risk factor for homelessness. North et al., (1994) suggest that aggression should be included in the variables that predispose individuals to homelessness, and that it may indeed prolong homelessness.

Within the literature the majority of the research is on homeless adolescents and suggests violent behaviour to be a complex interaction between experiences of childhood abuse and trauma, association with deviant peers

and subcultural expectations. Other factors applicable generally to the homeless population include substance misuse, the environment of homelessness and the elevated risk of violence within homeless veterans.

4.1 Childhood abuse and Risk Amplification Model

Experiencing childhood abuse has been associated with violence within the general population (Widom & Maxfield, 2001) and within a growing body of research on homeless people (Baron & Hartnagel, 1998; Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a &b; Whitbeck & Simons, 1993). However, the processes and variables which link experiences of childhood abuse to perpetration of violence are not comprehensively understood. Whitbeck and colleagues propose an empirically supported Risk Amplification Model specifically for the homeless adolescent population (Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a; Whitbeck & Simons, 1993). The model suggests previous experiences of abuse or trauma increases the risk of violence by association with deviant peers.

Whitbeck and colleagues' model is based on and provides empirical support to the theoretical work of Patterson, Dishion & Bank (1984) who suggest that families provide a 'basic training' for antisocial behaviour. They suggest that parental lack of the use of effective discipline techniques in dealing with coercive interactions between family members, results in children learning coercion a as means of controlling others, and this interaction style is then generalised to other contexts. Research has linked coercive and inconsistent parenting styles with difficult children, for example children with conduct

disorder, attention deficit hyperactivity disorder and learning disabilities which can result in children being socialised to be aggressive (Patterson et al., 1984).

Whitbeck and colleagues propose this modelling effect of inconsistent and coercive parenting and growing up in families where aggression and antisocial behaviour is the norm, often results in developing coercive and abusive coping styles. These abusive coping styles are then used in peer interactions. As a result adolescents are rejected by their 'normal' peer group and therefore select into deviant peer groups where the interaction is familiar and congruent with their interaction style. They miss out on the protective factors of peer acceptance, support and positive peer perceptions which buffer against later maladjustment (Harper, Davidson & Hosek, 2008). Therefore, within the deviant peer groups their interaction styles are reinforced, labelled by Patterson et al., (1984) as 'advanced training', and may be 'life course persistent' resulting in ongoing engagement in deviant and anti social behaviour including violence (Moffitt, 1997).

A series of studies by Whitbeck and colleagues provide empirical support to the model's theory, they found high levels of childhood sexual and physical abuse in their samples (Whitbeck et al., 1997a) and associated affiliation with deviant peers with risky sexual behaviour, re-victimisation and substance misuse which they link with reciprocal violence (Whitbeck et al., 1999, Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a & b; Whitbeck & Simons, 1993). Although providing support for the high levels of abuse and the elevated risk of violence by

association with deviant peers in homeless adolescents, the model falls short of accounting for other potential processes and psychological difficulties which have been associated with experiencing childhood abuse, and many aspects of the model remain theoretical. However, a number of studies provide support for the relationship between street subculture and association with deviant peers and violence described by Whitbeck and colleagues.

4.2 Street subculture and deviant peers

Baron & Hartnagel (1998) add support to Whitbeck and colleagues (Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a & b; Whitbeck & Simons, 1993) model and suggest that for homeless young men street subculture lifestyle and economic deprivation alongside family violence and victimisation, are risk factors for young homeless people's violent behaviour.

In terms of street subculture, the authors revealed that violence was associated with self selecting into friendships with 'like-minded' violent peers who had similar conflict management strategies to their own (this supports Whitbeck and colleagues model of involvement with deviant peers) and spending a longer length of time on the street (Baron & Hartnagel, 1998). They found spending more time on the street significantly increased their involvement in violent crime because they were isolated from conventional society and became immersed in street life. It also enabled them to witness a number of different conflict management styles and possibly learn that violence is an effective method of settling disputes (adding further empirical

support to Patterson et al's., (1984) 'advanced training'). It is also suggested that have more opportunity to 'pick' potential attractive victims (Baron & Hartnagel, 1998).

Baron & Hartnagel (1998) also found that there was a cultural expectation of violence and found that a lot of the incidents of violence could be accounted for by violation of rules of honour and retributive justice. A number of respondents cited experiencing violations of honour such as name calling or being 'wronged' in business dealings and that these violations of the subcultural rules were avenged by violent assault. In further support of this, Tyler & Johnson (2004) found that violent behaviour in their sample of homeless male and female young people, violence was associated with financial gain, invulnerability (portraying an image of strength or infallibility) or as payback or revenge from an incident against them or a friend.

Baron, Forde & Kennedy (2001) applied the theoretical Model of Dispute Transformation by Luckenbill & Doyle (1989) to homeless adolescents, and further added support to these findings by comparing conflict resolution styles of homeless and non-homeless adolescents.

The Model of Dispute Transformation (Luckenbill & Doyle, 1989) suggests three key stages: naming, claiming and aggression. Naming is the process of perceiving or recognising harm from another; this is subjective and requires interpretation of the injured party's behaviour. This interpretation is considered to be the vital step in the transformation of a dispute as it influences the level of conflict which may emerge. Claiming transforms the perceived injurious behaviour into a conflict, how they react is dependent on

the magnitude of perceived harm, the importance of rules that have been violated and the relationship with the person who has caused the harm. The final step is aggression, which is defined as 'willingness of the individual to persevere and use force to settle the dispute' (Luckenbill & Doyle, 1989). Based on this model, Baron et al., (2001) compared conflict management styles, and perpetration of violence by young homeless adolescents with adolescents in the general population. They found that homeless young people compared to the general population were more likely to demand reparation from those who they perceived had done them harm and were more likely to use violence to settle the dispute. The homeless sample was also more likely to legitimate violence.

Research also suggests the environment, mental illness, substance misuse and being a veteran are relevant in perpetration of violence.

4.3 Environment

Research has considered the interaction with the environment in which homeless people inhabit as a risk of violence, and that violence is not just related to the individuals vulnerable to this behaviour (Haggard-Grann & Gumpert, 2005). Research suggests that factors associated with being homeless such as: the lack of protective shelter, proximity to high crime areas, engagement in high risk activities and lack of sleep act as risk factors as triggers for violence and aggression (Kushel, et al., 2008; Haggard-Grann & Gumpert, 2005; Bartels, Drake, Wallach & Freeman, 1991; Fischer et al., 2008).

In a recent study, Fischer et al., (2008) found that homeless mentally ill people were more likely to be violent within the unstructured environment of homelessness. This study compared rates of violence within two types of homeless settings, street homeless and those living in a temporary homeless shelter. Results indicated that being resident in a temporary shelter significantly predicted an increase in violent crime (Fischer et al., 2008). The authors suggest this could be due to the close proximity of other people who are also experiencing high levels of stress which may increase risk of confrontation. A study by Haggard-Grann & Gumpert (2005) supports this. In their study on violent relapse in a sample of mentally disordered offenders they found that environmental factors including homelessness acted as antecedents for violence. The antecedent homelessness, coupled with triggers such as stress, lack of sleep and strong emotional states resulted in violence for their participants.

4.4 Substance misuse

Martin, Palepu, Wood, Li, Montaner & Kerr's (2009) study investigated the impact of drugs and alcohol on violence within a sample of homeless young people. Their study contradicted previous studies (not on homeless populations) which links violence with substance misuse and found no association between substances and violence generally. However, did find that alcohol use was associated with violence. Those who did admit to violence while taking drugs stated that they had perpetrated violent incidents before they began to regularly take substances, suggesting that a personal

vulnerability to settle disputes with violence was a stronger factor than the influence of the substance.

This indicates that personal vulnerability to violence plays a role in perpetration of violence when homeless. North et al., (1994) study supports this, and found that aggressive behaviour predated homelessness, and that those with a history of aggressive behaviour continued the behaviour when they were homeless. Potentially personal vulnerability to violence from experiencing childhood abuse is an important factor, coupled with exposure to the hostile environment of homelessness, which causes these individuals to use violence to settle disputes.

4.5 Veterans

Military veterans make up approximately a third of homeless populations within the USA, (Gamache, Rosenheck & Tessler, 2001) and frequently present with a number of personal vulnerability factors which increase the risk of perpetrating violence. A study by Elbogen, Beckham, Butterfield, Swatz & Swanson (2008) on violent homeless veterans found a number of risk factors which were associated with being a veteran and that they suggested that increased the risk of perpetration of violence. These include: coming from a lower socioeconomic status, lower levels of educational achievement, history of childhood abuse, substance misuse and head injury and PTSD. This study suggests that personal vulnerability to violence within veterans, due to factors associated with being a veteran, increases the risk of violence when coupled with instability of homelessness.

Summary

In summary a number of factors exacerbate risk of violence within homelessness. It appears that a complex interaction between environment including association with deviant peers, and personal vulnerability (re-victimisation, mental illness, childhood abuse, alcohol misuse, PTSD) increase the risk of the use of violence. Given the overlap between the risk factors for victimisation and violence, it is not surprising that a body of research has found that homeless adolescents and in one study on homeless women, homeless people are not either victims or perpetrators but frequently are both victim and aggressor.

5.0 Victims and perpetrators

Several studies have found that homeless adolescents are both victims and perpetrators of violence (Baron & Hartnagel, 1998; Baron, Forde & Kennedy, 2007; Chen et al., 2004; Scurfield, Rees & Norman, 2009;Tyler et al., 2000; Tyler et al., 2001; Tyler et al., 2009; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a & b; Whitbeck & Simons, 1993) and one study on homeless women revealed a similar pattern (Weschberg, Lam, Zule, Hall, Middlesteadt & Edwards, 2003).

Tyler & Johnson (2004) suggested that specifically homeless adolescents cannot be separated into ‘victim’ and ‘offender’, but form one ‘homogenous pool in which offenders are victimised and victims offend’. Whitbeck and colleagues’ Risk Amplification Model highlights the pattern of victim and

perpetrator within adolescents involved in deviant peer groups (Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a; Whitbeck & Simons, 1993). Furthermore, Baron & Hartnagel (1998) and Baron, Forde & Kennedy (2007) found that victimisation increases the risk of violent behaviour in their sample of street youths, finding that young people who have been the victims of aggravated assaults were more likely to participate in violent behaviour.

Several other studies have found a similar pattern of victim and perpetrator in adolescent homeless people. A study by Kipke et al., (1997) interviewed male and female homeless youths, and explored their experiences of witnessing or exposure to violence including physical attacks, sexual assaults or murders of another person, being the victim of a physical or sexual assault and being the perpetrator of violence, while being homeless and before they were homeless. Results indicated being exposed to violence was very high: 85% had seen someone physically attacked, 31 % seen someone being sexually assaulted and 24% had witnessed someone being murdered. Respondents also reported extensive histories of victimisation: 70% reported being victimised across their life span, with 51 % reporting being punched, burnt or beaten up, 50% threatened with serious harm, 15% sexually assaulted, while homeless. In terms of perpetration of violence, 17% of respondents reported having attacked someone and 14% reported having shot at someone.

A similar pattern emerged in Boris et al., (2002) study which found the dual role of victim and perpetrator amongst their sample of male and female

young homeless people. They found that young homeless people experience significant amounts of violence, both within the community and between intimate partners. A large majority reported experiencing violence which included being beaten, burned or knifed, and just over a third reported moderate (fractures, minor burns or large bruises) or severe (major wounds, severe bleeding, loss of consciousness) injury from a partner (Boris et al., 2002). One participant reported permanent damage from their injuries (visual loss, hearing loss or disfigurement) as a result of intimate partner violence. As a group being in at least one relationship where violence had occurred was the norm. In terms of intimate partner violence, no gender differences emerged, however male participants were more likely to report perpetrating more community violence. Tyler, Melander & Noel (2009) support these findings and found that the majority of their sample of homeless young adolescents had been in a relationship where violence had been bidirectional.

Research exploring dual role of victim and perpetrator in homeless adults is limited. A study by Weschberg et al., (2003) explored this dual role within a sample of African American homeless women who used crack cocaine. They found that the women had dual roles as both victims and perpetrators of violence within the community. They found that when compared to women crack users who were housed, homeless women had higher appraisals for threat. It seems likely that living in the dangerous environment of the streets coupled with histories of victimisation, that the women in this study experience high levels of fear, and engage in violence to protect themselves

(Weschberg et al., 2003). The authors do suggest that using crack cocaine has been shown to make people on edge and on-guard and may result in perceived exaggerated hostility in others (Weschberg et al., 2003). This contradicts research which has suggested substance misuse generally results in decreased vigilance which was associated with victimisation (Nurius & Norris, 1996). However, it is important to consider that different substances may have a different impact on vigilance and vulnerability. It is therefore likely that substance misuse is a significant factor both in victimisation and violence, and may have a moderating role and as such requires further investigation.

This research suggests a complex pattern of victim and perpetrator, where victims are perpetrators and perpetrators also victims. None of the studies suggest a direction for victimisation and perpetration of violence, so it is unclear if being victimised predates being a perpetrator of violence. It would appear that the relationship is complex and that it is unlikely to be linear.

6.0 Summary of findings

Homeless people are in a very challenging situation when trying to survive without the support and protection of housing, family support and other stable relationships, and many are too young (adolescents), uneducated and inexperienced to gain legitimate employment. Therefore, in order to survive, many will steal, sell drugs and engage in sex work (Whitbeck & Hoyt, 1999). The very nature of survival in this challenging environment increases risk of victimisation and perpetration of violence.

Research has shown that being homeless increases vulnerability towards being victimised purely by being exposed on the streets (Whitbeck et al., 2001). These risk factors, survival strategies and personal vulnerabilities make homeless people vulnerable to both being violent (Baron & Hartnagel, 1998; Tyler & Johnson, 2004) and to being victimised. Those who are violent are often responding to being victimised themselves (Hagan & McCarthy, 1997).

Within the homeless population there is a high prevalence of childhood abuse and trauma, which predisposes individuals to a number of psychological difficulties, including victimisation and violence. Within the homeless population there are high levels of mental illness and substance misuse which are associated with violence, however, the direction of these difficulties is unclear. It is likely that these individuals experience a complex interaction of childhood abuse, victimisation, perpetration of violence, mental illness and substance misuse, and that these perpetuate each other.

What is clear is that the lack of resources, both personal and economic, means homeless individuals have limited options available to them. This results in continued patterns of violence and victimisation, with the very nature of homelessness and personal vulnerability making remediation of homelessness very difficult.

7.0 Limitations and directions for further research

The research into homelessness and experience of victimisation and violence has a number of limitations both in terms of conceptualisation and

methodological weaknesses. There is significant scope for further research to enable a better understanding of this complex and diverse population.

7. 1 Generalisation Issues

The homeless population is very diverse (DCLG, 2008b) and the current literature does not explore this adequately, firstly in terms of age. The majority of the research into these experiences focuses on adolescents, both in terms of victimisation and violence, with only a small body exploring these experiences in adults and none in older adults. Secondly, in terms of gender research in men's experiences of victimisation is significantly lacking and in studies with both male and female participants they are frequently comparing genders in terms of prevalence. Also, people from ethnic minorities are not significantly represented within these studies. Finally, the majority of the current research is based on samples of American homeless people, the only UK studies available and included within this paper are by Gilders (1997), Hagan & McCarthy (1997), Maguire (2006),Scurfield et al., (2009) and van den Bree et al., 2009. This suggests that the research presented here is not generalisable to the homeless population as a whole and more research is needed on the groups of individuals currently not adequately researched, and for further research within the UK specifically. On the whole adult homeless people's experiences of victimisation and perpetration of violence are poorly understood.

7.2 Methodological limitations

Within the literature there are a number of methodological weaknesses.

Childhood abuse

There are a number of difficulties associated with researching childhood abuse and trauma. Most of the data for these studies is based on self report which can result in under and over reporting. It is have suggested that if there were any reporting bias, the direction is more likely to be under, rather than over reporting of abusive experiences (Chen et al., 2004). This suggests, potentially prevalence rates are higher than are reported. Further to this, frequently studies do not control for collaborating evidence, such as multiple reporters, therefore potentially limiting the accuracy.

Another limitation is the retrospective nature of asking about potentially traumatic experiences such as victimisation and childhood abuse and trauma. Participants are required to recall highly emotional events which frequently occurred at a low developmental age and due to the traumatic nature of the incidents, memories may be incomplete or repressed, potentially reducing accuracy. Some studies utilised interview methods to gather information, which potentially enables a clearer understanding of the exact nature of the abuse. However, this it is a highly sensitive issue, and participants may not feel comfortable disclosing sexual and physical abuse.

There is also an important ethical consideration about asking people about abusive and traumatic experiences. However, it is important to acknowledge that research suggests that the benefits of asking about abuse frequently

outweigh the costs of not asking (Becker-Blease & Freyd, 2006; Edwards, Dube, Felitti, & Anda, 2007). In particular in terms of research on homeless people, gathered information is vital in increasing our understanding into this complex population.

Questionnaires

Studies differ in their use of questionnaires to measure childhood abuse and trauma and methods of recording violence and victimisation, making comparison between studies and establishing prevalence difficult. To assess childhood abuse, Gwadz et al., (2007) utilised a standardised questionnaire The Childhood Trauma Questionnaire, CTQ (Bernstein and Fink, 1998) which has demonstrated good reliability and validity, potentially providing an accurate report of childhood abusive and traumatic experiences. Other studies however, (Chen et al., 2004; Tyler et al., 2000) use measures such as the Early Sexual Abuse Scale devised by Whitbeck & Simon (1993) without reporting validity data. Similarly scales used to assess violence (Criminal Activity Questionnaire, Fischer et al., 2008; Problem Behavior Scale, Ryan et al., 2000) are frequently devised by the authors, and again few studies report the psychometric properties of their measures and therefore it is difficult to determine validity and reliability of these measures.

Furthermore, on review of the literature on victimisation it is clear that there is not a standardised tool for measuring victimisation. A number of studies utilise an adapted version of the Conflict Tactics Scale (Straus & Gelles, 1990; Boris et al., 2002; Goodman, 1991; Whitbeck et al., 1997a; Whitbeck et

al., 1999; Wenzel et al., 2004; Wechsberg et al., 2003; Whitbeck & Simons, 1993). This scale was originally devised to explore intimate partner violence, both as a perpetrator and victim, so is potentially useful for intimate partner violence but less so for victimisation from an acquaintance or stranger.

Other studies (Kushel et al., 2003; Janus et al., 1987; Noell et al., 2001; Whitbeck et al., 2001; Whitbeck et al., 1999; Nyamthi et al., 2001; Wenzel et al., 2000) use non-validated dichotomous indicators, asking participants to answer yes or no to questions regarding sexual or physical victimisation. This means severity or frequency is not recorded. Some studies (Kipke et al., 1997; North et al., 1994; Browne & Bassuk, 1997; Zugazaga, 2004) have approached victims in interview format which provides a good, rich resource of exploratory information. However, there is still the issue of willingness to disclose within this setting. Research suggests a combination of both questionnaire and interview would be useful, as it is posited that using multiple, behaviourally specific questions about abusive experiences is associated with high rates of reporting (Kushel et al., 2008), however few studies utilise this approach.

Violence

In terms of violence, some studies have used use police arrest data (for example Snow et al., 1989), however this does not take into account smaller violent offences and those which are not reported for a number of reasons. Violence appears common place within the subculture of homelessness and due to this homeless people may have a belief about legitimacy of violence

(Baron et al., 2001), therefore it is possible that they are unlikely to report assaults to the police (Wardhaugh, 2000). This potentially makes research utilising police reports limited in terms of accuracy.

Studies exploring violence utilising self report again are potentially flawed by over and under reporting. Also, particularly in young homeless people, potentially notoriety may make people wish to rate their level of violence higher (Baron & Hartnagel, 1998), or minimise in case of repercussions. Also, it is possible that people who have experienced repeated exposure to violence may have different views about what is the 'norm' in terms of violence or be emotionally numbed (Litz & Gray, 2002), which makes reporting of violence accurately challenging.

7.3 Summary and areas for further research

This review highlights research into victimisation and violence is significantly in its infancy, particularly for homeless adults and on UK samples. However, it is clear that victimisation and violence is over represented in homeless people, but the current research does not enable a comprehensive understanding of the risk factors associated with homelessness and homeless individuals. Further systematic research is needed generally, and in a way that reflects the diverse homeless population (adolescents, adults, older adults, ethnic minority groups).

In particular, there is a significant gap in the literature surrounding men's experiences of victimisation both physically and sexually. This review found that when men were included in research predominately they are assessed in

comparison to women and the risk factors for men generally poorly understood. Literature from the psychiatric population indicates men are often both victims and perpetrators of violence (Cloitre, Tardiff, Marzuk, Leon & Portera, 2001) and it is possible a similar pattern may emerge within homeless men. In terms of re-victimisation this review highlighted the association between childhood abuse and intimate partner violence as a pathway into homelessness for women. It is well understood that men are also the victims of childhood abuse and domestic violence, therefore explorative research into the impact of childhood abuse on re-victimisation within intimate partner relationships and research sensitively assessing the role of domestic violence as a potential factor in entering homelessness for men, may be insightful.

Furthermore, it appears likely that victimisation and violence and the psychological factors associated with these experiences are complex and appear multi-directional. A complex relationship emerges between victim of childhood abuse, re-victimisation in intimate partner relationships and within deviant peer groups, perpetration of violence due to psychological vulnerability and in reciprocation, however the direction is not fully explained by the current research. Potentially further longitudinal research would be useful, to establish pathways or directions of difficulties.

Finally, although childhood abuse and trauma is prevalent in homeless people, it is important to note that not all homeless people who have experienced child abuse and trauma report suffering further victimisation and/or are perpetrators of violence. Therefore research exploring which

factors and processes that might mediate experience of childhood abuse and victimisation, and childhood abuse and violence would be useful to understand why some individuals are more vulnerable than others and would have important implications for interventions.

In general considering the number of limitations associated with the current research and significant gaps, robust research on homeless people in general is very much needed to understand this complex and vulnerable population.

8.0 Clinical Implications

This review of the literature highlights the complexity of victimisation and perpetration of violence within homeless people's lives and therefore it is important to consider the implications. Research indicates homeless people have a number of difficulties including childhood abuse and trauma, mental health difficulties, vulnerability to violence, and substance misuse problems, which could be alleviated by psychological interventions, have practical implications for staff at hostels and suggests the importance of early preventative interventions.

The difficulties indentified by this review indicate that homeless people may benefit from psychological interventions. In particular trauma focused interventions (such as Cognitive Behavioural Therapy approaches; Beck, 1976), anger management (Cognitive Behavioural Therapy, Beck, 1976; Beck & Fernandez, 1998) and substance misuse programmes (such as Motivational Interviewing; Miller & Rollnick, 2002) may be beneficial.

However, engaging homeless people in standard services is likely to be problematic both due to the nature of homeless and the complexity of their difficulties. The transient nature of homelessness, results in people frequently move in and out of different catchment areas for NHS services may mean they ‘slip through the net’ of services. Furthermore it appears homeless people’s difficulties may be complex and multiple and standard interventions may not be accessible. Therefore, it appears necessary for specialist services to be available to provide psychological interventions to meet the needs of this complex population (Maguire, 2006; Warnes, Crane, Whitehead & Fu, 2003). Currently within the UK there are some services specifically for homeless people, in particular in Leicester and Brighton. These services offer individual and group work (CBT and motivational interviewing) and work psychologically with hostel staff teams. To enable services to be developed in other areas of the UK, research is very much needed to establish an evidence base for psychological intervention for this population and to ensure that interventions are offered in an accessible and acceptable way for homeless people.

Given the current lack of specialist services countrywide it is vital that organisations which provide hostel accommodation, day centres and domestic violence shelters for homeless people are aware of the complexity of people’s psychological difficulties. It important that staff are offered training to understand people difficulties. Working with homeless people is a challenging occupation and therefore access to supervision and support is essential (Maguire, 2010). Detection is especially essential for individuals

suffering from mental health difficulties, as they should have access to appropriate interventions in line with National Institute for Clinical Excellence (NICE, 2007), therefore hostel staff need to understand signs and symptoms of mental illness and how homeless people may access services. Furthermore, given that violence is common, it essential that staff at hostels and day centres are provided with training to deescalate aggressive or violent incidents, both towards themselves and other homeless individuals (perhaps considering Guidance for Violence NICE, 2005).

Finally, in order to break the pattern of homelessness, preventative interventions are essential. The Department for Communities and Local Government (DCLG, 2007) outline early intervention and prevention strategies for young people, which include family mediation work, dealing with antisocial behaviour and addressing accommodation difficulties. However, potentially preventative work should be extended to other groups who are vulnerable to homelessness, in particular those with mental health difficulties, people who are released from prison and veterans. It is these individuals alongside young people who are at considerable risk of victimisation and further violence.

It is also important to highlight that in 2009 the American Psychological Association's (APA) president commissioned a task force to report on 'Psychology's Contribution to End Homelessness', and they published a report in February (2010). The report recommended that psychologists should educate service providers and the public about the psychological factors associated with homelessness including childhood abusive

experiences. The reports requests psychologists to highlight the need for homeless people to have access to mental health services and substance misuse programmes, and suggest the way forwards is for further research, training and advocacy.

9.0 Conclusion

The literature on homeless people's experiences of violence indicates exposure to, perpetration of and being a victim of violence is common place and frequently occurs across their life span. The literature to date has only begun to provide an understanding of risk factors for victimisation and violence within this highly complex and diverse population however, highlights that homeless people constitute a vulnerable and severely disadvantaged population with multiple and complex needs. This review highlights the complexity of victimisation and perpetration of violence, and that it is likely the experience of childhood abuse and trauma places individuals on a trajectory for re-victimisation and perpetration of violence. Furthermore, it appears those who are perpetrators are also victims, creating a complex cycle of victim and aggressor. The impact of these experiences is likely to be significant and further increase vulnerability. What is clear from the literature is the need for further robust research to better understand victimisation and violence in the lives of homeless people in order to provide evidence based interventions specific for this complex population, with the significant aim reducing the distress and destruction violence brings.

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EMPIRICAL PAPER

The role of emotion dysregulation in mediating the relationship between childhood abuse and trauma and aggression in homeless people

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Abstract

Within the homeless population violence and aggressive behaviour is common place and may have implications for escaping homelessness. It has been shown that the prevalence of childhood abuse and trauma is high within the homeless population in comparison to the general population, and it is well understood that experience of childhood abuse and trauma is associated with a number of psychological difficulties, including aggression. However, the processes which associate childhood trauma and aggression are poorly understood. Childhood abuse and trauma has been associated both theoretically and empirically with developing emotion regulation difficulties. Emotion regulation difficulties has been associated with aggression in preliminary research, which suggests aggression may function to regulate emotion. The current study investigated whether emotion dysregulation mediates the relationship between childhood abuse and trauma, and aggression within the homeless population.

A sample of 80 homeless people completed self report measures on childhood abuse and trauma, emotion dysregulation and aggression. Statistical analysis was conducted to ascertain relationships between variables and Baron & Kenny (1986) mediation steps were conducted, followed by bootstrapping to ensure significance utilising confidence intervals (Preacher & Hayes, 2008) to establish the mediation.

Results indicated the emotion dysregulation mediated the relationship between childhood abuse and trauma and aggression. The results add to the body of research on the emotion regulation function of aggression and highlights the importance of including adaptive emotion regulation strategies in interventions for aggression and violence.

Key words: Childhood abuse and trauma, Emotion dysregulation, Aggression, Homelessness.

1.0 Introduction to homelessness

Homelessness within the United Kingdom (UK) is a significant problem. It is estimated that approximately 67,500 households are officially considered homeless and the national rough sleeping estimate states 483 people are 'sleeping rough' on the streets on any single night in England (DCLG, Sept 2009). Due to the transient nature of homeless people and difficulties in definition, it is likely that these figures are a significant underestimation. Crisis (2004) suggests that there could be as many as 400,000 who are not visually homeless and are not counted in the government statistics. They consider these individuals to be 'hidden homeless' and are frequently people who are not visually homeless, for example sleeping rough. These individuals often are living in temporary accommodation such as B and Bs, squats, overcrowded accommodation or on sofas or floors of friends and family (Crisis, 2004). Therefore, the actual homeless population is likely to be higher than estimated and a larger problem than is represented within official statistics. This suggests that homelessness is a considerable problem in the UK and as such requires attention in terms of increasing our understanding of the difficulties perpetuating homelessness and subsequently developing appropriate services and interventions to support people to escape homelessness.

Understanding homelessness is complicated by the diversity of the population and the complexity of their needs. Previously, it was considered that the homeless population predominately comprised of single white males, under 35 years of age (Warnes, Crane, Whitehead, & Fu, 2003).

However, the population is growing in heterogeneity with increasing numbers of females, people from black and ethnic minorities and adolescents becoming homeless (DCLG, 2008b). There is also a considerable difference in terms of chronicity. The majority of homeless people are homeless for a short time and require practical help and advice to move out of homelessness, for example to find accommodation and employment (DCLG, 2008b). However, there are a number of people who remain homeless for long periods or have repeated episodes and therefore need further intervention. It is these individuals who experience chronic and repeated homelessness that are amongst the most vulnerable and disadvantaged people in society (Crisis, 2004).

Homeless people present with complex needs. Research has found within the homeless population there is a high prevalence of a range of difficulties including mental and physical illness, substance misuse, anti-social and aggressive behaviour and that they are frequently the victims of domestic violence and have experienced childhood abuse and neglect (Fazel, Khosla, Doll & Geddes, 2008; Heffron, Skipper & Lambert, 1997; van den Bree, Shelton, Bonner, Moss, Thomas & Taylor, 2009). This creates a complex population with a range of difficulties and subsequently indicates that solving homelessness is challenging.

Awareness of the complexity of homelessness has risen and in recent years reducing homelessness has become the focus of government policy (DCLG, 2003, 2006, 2008; Office of the Deputy Prime Minister, 2005). However, government policies surrounding homelessness frequently focus on the

practical, social and economic issues, such as providing homes. This may be short sighted as research suggests remediation of homelessness is more complex than providing people with a roof over their head (Crisis, 2004). Research suggests homelessness is a complex interaction between macro-factors such as political, economic and social issues, and micro-factors (or personal risk factors including: family and relationship breakdown; childhood abuse, domestic violence, leaving institutional settings, mental and physical illness; substance abuse, aggression) which are associated with the pathways into homelessness and with the maintenance of homelessness (Morrell-Bellai, Goering & Boydell, 2000; Fazel, et al., 2008; van den Bree et al., 2009). This suggests that in order to address homelessness, personal vulnerability factors need consideration and indicates a multifactorial approach of practical and psychological interventions is needed to support people to escape homelessness.

1.1 Aggression and homelessness

Within homeless people aggression is problematic, with research suggesting high levels of perpetration of violence (Boris, Heller, Sheperd & Zeanah, 2002; Gilders, 1997; Kipke, Simon, Montgomery, Unger & Iverson, 1997; North, Smith & Spitnagel, 1994; Whitbeck, Hoyt & Ackley, 1997 a & b; Tyler, Hoyt, Whitbeck & Cauce, 2001**;** Swanson et al., 2002). Gilders (1997) examined violence within UK homeless agencies and found high levels of reported incidents of aggression and violence from homeless people both towards staff and to other homeless people. The incidents ranged in severity from verbal arguments to serious assault. This type of behaviour is likely to

have considerable implications for the maintenance of homelessness, as violence and aggressive behaviour may compromise hostel accommodation and reduce opportunities for legal employment (Maguire, 2006). Therefore, violence and aggression may be factors perpetuating homelessness and support and potentially interventions specifically helping people manage their aggression are needed, if they are to successfully escape homelessness.

The unstable and unpredictable environment of homelessness has been associated with aggression and prolonged periods of homelessness associated with increased risk of engaging in criminal and violent behaviour (Hagan & McCarthy, 1997). Research suggests factors associated with being homeless such as the lack of protective shelter, proximity to high crime areas, engagement in high risk activities, and lack of sleep are risk factors and triggers for violence and aggression (Bartels, Drake, Wallach & Freeman, 1991; Fischer, Shinn, Shroud & Tsemberis, 2008; Haggard-Grann & Gumpert, 2005; Kushel, Evans, Perry, Robertson & Moss, 2008). Further to this, strategies frequently used to survive homelessness including the process of gaining substances, association with deviant peers, and psychological vulnerability including mental health difficulties (notably PTSD) and alcohol misuse, all increase personal vulnerability to violence (Fischer et al., 2008; Elbogen, Beckham, Butterfield, Swatz & Swanson, 2008; Tyler, Hoyt & Whitbeck, 2000;; Tyler & Johnson, 2004).

Importantly, research has found that aggressive behaviour frequently predates homelessness and may indeed be a potential pathway into homelessness (Chen, Tyler, Whitbeck & Hoyt 2004; North et al., 1994; Tyler

et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck, Hoyt & Ackley, 1997 a &b; Whitbeck & Simons, 1993). This suggests aggression within homeless people cannot solely be attributed to the homeless environment. This indicates that homeless people may have a predisposition to behave aggressively which is exacerbated by the factors associated with homelessness. Research has shown that homeless people frequently have complex traumatic life events which may predispose them to a number of psychological difficulties. One area of this that has received attention is the high prevalence of childhood trauma within homeless people (Davis-Netzley, Hurlburt, & Hough, 1996;Gwadz, Nish, Leonard, & Strauss, 2007; Herman, Susser, Struening & Link, 1997; Stein, Leslie, & Nyamathi, 2002, Johnson, Rew, & Sternglanz, 2006; Martijn,& Sharpe, 2006; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Slesnick, Kang, & Aukward, 2008; van den Bree et al., 2009) which has been associated both as a pathway into homelessness (Martijn & Sharpe, 2006) and as risk factors for violent and aggressive behaviour (Baron & Hartnagel, 1998; Chen et al., 2004; North et al., 1998; Tyler & Johnson, 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a & b; Whitbeck & Simons, 1993).

1.2 Childhood abuse and trauma and aggression

Research has established that the prevalence of childhood abuse and trauma is higher within the homeless population than within the general population (Ryan, et al., 2000; Kipke, Simon, Montgommery, Unger & Iverson, 1997). Experience of childhood abuse and trauma is associated with a number of difficulties both in terms of development during childhood

(Cicchetti & Toth, 1995; Mullen, Martin, Anderson, Romans, & Herbison, 1996**)** and later in the development of dysfunctional behaviours and psychological difficulties (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Beitchman et al., 1992; Browne & Finkelhor, 1986; Green, 1993; Kendall-Tackett, Williams, & Finkelhor, 1993; Malinosky-Rummell & Hansen, 1993; Rowan & Foy, 1993; Tyler, Melander & Almazan, 2010).

Within the general population there is a well established relationship between childhood abuse and trauma and adolescent delinquency, adult criminality and violence (Widom & Maxfield, 2001; Felson & Lane, 2009) and there is a growing body of research linking childhood trauma with aggression and violence in homeless adolescents and adults (Baron & Hartnagel, 1998; Chen et al., 2004; North et al., 1998; Tyler & Johnson, 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a & b; Whitbeck & Simons, 1993). Although the association of childhood abuse and trauma, and aggression is established, and there are a number of theories underpinning aggression (Social learning Theory, Bandura, 1973; Cognitive Models, Beck & Fernandez,1998; Risk Amplification Model, Chen et al., 2004; Tyler & Johnson, 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a; Whitbeck & Simons, 1993), however, the processes and factors which associate the experience of childhood abuse and trauma with a vulnerability to aggression and violent behaviours are poorly understood.

1.3 Mediation analysis

A growing body of research has begun to utilise mediation analysis to establish how or why one variable predicts or causes an outcome variable. Rather than hypothesising a direct causal relationship between a predictor variable and an outcome variable, a mediational model hypothesises that the predictor variable influences the mediator variable, which in turn influences the outcome variable (Baron & Kenny, 1986). This approach may be useful in considering processes which may mediate the relationship between childhood trauma and aggression.

Although currently the factors which could mediate the relationship between childhood abuse and trauma, and aggression specifically are not well understood, a growing body of research has suggested a number of processes and factors that associate childhood abuse and trauma with the later development of maladaptive behaviours, one of which that is receiving increasing attention is the role of emotion dysregulation (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Gratz & Roemer, 2008; Maughan & Cicchetti, 2002; Shields & Cicchetti, 1998).

1.4 Emotion Dysregulation

Emotion dysregulation has been most comprehensively conceptualised by Gratz & Roemer (2004) and they provides a useful model encompassing a large body of research on the components of emotion dysregulation. Their conceptualisation indicates emotion dysregulation is a multifaceted construct and suggest that people who have difficulty regulating emotion will have the

following deficits : lack of awareness and acceptance of emotions; inability to engage in goal directed behaviour and inhibit impulsive behaviours when experiencing emotions; have difficulty controlling behaviours and accomplishing tasks in the face of emotional distress; have the belief that there is nothing that can be done to regulate distressing emotions and are unwilling to experience negative emotions as part of pursuing meaningful activities in life (Gratz & Roemer, 2004). Important to this conceptualisation of emotion regulation is that emotion dysregulation involves the inability to control behaviours when experiencing negative emotions not the inability to control negative emotions (Gratz & Roemer, 2004).

Essentially, emotion regulation difficulties results in individuals utilising maladaptive behaviours, which function to prevent, escape, or reduce contact with negative emotions (Blackledge & Hayes, 2001; Gratz, 2006; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). It has been pointed out, that these strategies are psychologically effortful and may have paradoxical, further dysregulating consequences (Hayes et al., 1996). The utilisation of maladaptive behaviours has been associated with detrimental long term consequences, however, despite this maladaptive behaviours are still utilised, because, in the short-term, they function to alleviate or avoid painful and unwanted thoughts and feelings (Gratz & Roemer, 2004).

The experience of invalidating childhood (characterised by childhood abuse, neglect, psychological abuse and poor attachment, van der Kolk, 1996) has been extensively theorised to be associated with development of emotion dysregulation (Linehan, 1993a; Gardner & Moore, 2008) and evidence

suggested aversive childhood experiences are associated with a decreased capacity to regulate emotions (Maughan & Cicchetti, 2002; Mounier et al., 2003; Shields & Cicchetti, 1998; Shipman, Zeman, Penza, & Champion, 2000).

There is also evidence indicating that emotion regulation difficulties mediate the relationship between childhood abuse and trauma and later psychological distress and maladaptive behaviours, in particular self harm (Cloitre et al., 2008; Gratz, 2003; Gratz & Roemer, 2008; Gratz, Tull, Rosenthal & Lehuez, 2009; Maughan & Cicchetti, 2002; Shields & Cicchetti, 1998), and preliminary research has found this relationship in homeless people (Day, 2009).

Importantly, there is a small body of empirical research suggesting the maladaptive behaviour of aggression may function to regulate emotion (Gratz & Roemer, 2004; Jakupcak, Lisak & Roemer, 2002; Bushman, Baumeister & Phillips, 2002). To date, this has been explored in three studies. Within two studies of intimate partner violence , it was found that perpetration of violence served to regulate emotions (Gratz & Roemer, 2004; Jacupcak, et al., 2002) and in a experimental laboratory study, it was found that aggressive behaviour has an affect regulation function (Bushman, et al., 2001). These studies have begun to provide empirical support for the role of emotion dysregulation in aggression and perpetration of violence. However, they are based on college students and experimental laboratory tests.

Although currently, there is no comprehensive evidence base, helping people to develop adaptive emotion regulation strategies has been increasingly

included in interventions for anger and violence. Evidence suggests inclusion of strategies for emotion regulation are an effective component to Cognitive Behavioural interventions for anger and aggression, and are useful in reducing aggressive behaviour (Day, Howells, Mohr, Schall & Gerace, 2008; Walker & Bright, 2009).

Summary

Research suggests prevalence of childhood abuse and trauma is high within homeless people and they frequently display aggression. Research links childhood abuse and trauma to aggression and to the development of emotion regulation difficulties, and a growing body of evidence suggests that aggressive behaviour may have an emotion regulation function. Therefore, it is possible that the relationship between childhood abuse and trauma, and aggression is mediated by emotion dysregulation. This is highly relevant for homeless people who research suggests have high levels of aggression and violence and where difficulties with aggression may be a factor in the maintenance of homelessness.

1.5 The Current Study

This study aims to explore the relationship between emotion dysregulation and aggression, childhood trauma and aggression and to explore whether this relationship is mediated by emotion dysregulation. An exploration of this relationship may provide a valuable understanding of aggression and may have important implications for clinical interventions for anger, aggression and violence.

1.6 Research objectives

The following hypotheses will be addressed:

Hypothesis 1

Childhood abuse and trauma is associated with aggression

Hypothesis 2

Childhood abuse and trauma is associated with emotion dysregulation

Hypothesis 3

Emotion dysregulation will be associated with aggression

Hypothesis 4

There is an indirect relationship between childhood abuse and trauma and aggression which is mediated by emotion dysregulation.

2.0 Methodology

2.1 Design

This study is a cross-sectional correlation design, utilising self report questionnaires designed to measure childhood trauma, emotion dysregulation and aggression administered to homeless men and women. Participants were also given an anxiety and depression questionnaire to consider whether mood impacted on the relationships between the other variables.

2.2 Participants

A power calculation was made prior to participant recruitment to establish the necessary sample size for a medium effect size. The calculation indicated a sample of 76 would provide a medium effect size of .05 (Cohen, 1992) sufficient for multiple regression (Tabachnick and Fidell, 2001).

Participants were 83 homeless men and women recruited from four homeless hostels in Southampton. Recruitment took place over seven sessions, with multiple visits to several hostels. Individuals were included in the study only if they had been homeless for at least a month. In terms of homelessness, anyone who did not have a permanent place to live, including homeless hostels, shelters, flats, rough sleepers or any other form of temporary accommodation were included in the study. The only exclusion criteria was if participants did not have sufficient written and spoken English, because alternative language versions of the questionnaire or interpreters were not available.

2.2.1Participant demographics

Three participants were excluded from the study due to a succession of the same response across the whole questionnaire regardless of reversed items. This was considered to make the questionnaires invalid and as a result were not included in the final sample. The final sample was therefore 80.

The majority of the participants were male (80%) and white British (87.5%). Participants ranged from 18-76, with a mean age of 36.51 (SD 11.695). Demographic information for participants is presented in Table 1.

Table 1- Demographic information (N=80)

Variable	Category	N	Frequency %
Gender	Male	64	80
	Female	16	20
Age	18-25	17	21.3
	26-35	20	25
	36-49	34	42.5
	>50	9	11.2
Ethnicity	White British	70	87.5
	Black Caribbean	2	2.5
	White Other	2	2.5
	Indian	1	1.3
	Black Other	1	1.3
	Other	4	5
Homeless status	Hostel	57	71.3
	Shelter	1	1.3
	Friends sofa	4	5
	Overcrowded	1	1.3
	Other-shelter flat	16	20
	Street homeless	1	1.3

2.3 Measures

Each participant was given a questionnaire pack, consisting of a screening questionnaire (Appendix C), a demographics form (Appendix D), four questionnaires to assess childhood abuse and trauma, emotion dysregulation, aggression and depression and anxiety.

Assessment of Childhood Abuse and Trauma

Childhood abuse and trauma was measured by The Child Abuse and Trauma Scale (CATS, Sanders & Becker-Lausen, 1995). The CATS is a 38 item self report scale for different abusive or negative experiences during childhood and rates their frequency. The scale provides a total score and four individual subscales, which are: childhood sexual abuse; childhood physical abuse, childhood emotional abuse and neglect. Participants are required to rate how frequently they experienced the abuse on a four point scale ranging

from 0 (never) to 4 (always). An example of the items include ‘Did you ever witness the sexual mistreatment of another family member’ (Sexual abuse) and ‘Did your parents ever hit or beat you when you did not expect it’ (Physical abuse). Total scores were used in this study and a higher score indicated an increased frequency and severity of experiences.

The CATS has been written in such a way as to reduce over or under reporting (Sanders & Becker-Lausen, 1995). Sanders & Becker-Lausen (1995) felt that admitting to an abusive childhood is not socially desirable and therefore expected a degree of underreporting or that some individuals may exaggerate their childhood experiences ‘because of a complaining response style or a depressive outlook’. In light of this the CATS has been worded in a ‘purposefully mild fashion’ rather than direct questions. For example instead of asking ‘were you sexually molested’ the CATS asks questions such as ‘were there traumatic or upsetting experiences when you were a child or teenager that you couldn’t speak to adults about’ (Sanders & Becker-Lausen, 1995).

The CATS has good psychometric properties including internal consistency (α = .63 to .90) and adequate test-retest reliability (*r* =.24 to 41). The CATS has been used for previous research on exploring the relationship between childhood abuse and psychological difficulties (for example Hartt & Waller, 2002; Sanders & Giolas, 1991; van Hanswijck de jonge, Waller, Fiennes, Rashid & Lacey, 2003).

Assessment of Emotion Dysregulation

Emotion dysregulation was measured by The Difficulties in Emotion Regulation Scale (DERS, Gratz & Roemer, 2004). The DERS is a 36 item self report questionnaire. The scale provides a total score of difficulties with emotion regulation and six subscales, these are: non acceptance of emotions; difficulties in engaging in goal directed behaviour; impulse control difficulties, lack of emotional awareness; limited access to strategies for emotion regulation and lack of emotional clarity. Participants are required to rate each item on how often it applies to them on a five point scale, 1 (almost never) to 5 (almost always). Items included on the scale for example: 'When I'm upset I feel out of control' (Impulse control difficulties) and 'When I'm upset it takes me a long time to feel better' (limited access to strategies for emotion regulation). A higher score on the scale indicated greater degree of emotion dysregulation or greater difficulties with emotion regulation.

The DERS has good psychometric properties including high internal consistency in total (α = .93) and across all subscales (α = .84 to .89) and test-retest reliability (*r* = .88), Gratz and Roemer (2004). A number of studies have used the DERS on a range of psychological difficulties including self harm, borderline personality disorder and substance misuse (for example Gratz, 2003; Gratz & Roemer, 2008; Rosenthal, Tull, Lejuez & Gunderson, 2006).

Assessment of Aggression and Aggressive Behaviours

Aggression was measured by The Aggression Questionnaire (Buss and Perry, 1992). The Aggression Questionnaire is a 29 item self report

questionnaire. The scale provides a total score of aggression and 4 subscales, which are: physical aggression; verbal aggression; anger and hostility. Participants are required to rate how characteristic each item is of them, on a five point scale ranging from 1 (extremely uncharacteristic of me) to 5 (extremely characteristic of me). Items included, for example: 'If I have to resort to violence to protect my rights, I will' (Physical aggression) and 'I have trouble controlling my temper' (Anger). A higher score on the questionnaire indicates high levels of aggression.

The Aggression Questionnaire has good internal consistency for the total score (α = .89) and the subscales (α = .72 to .85) and test-retest reliability (*r* = .80), Buss and Perry (1992). A number of studies have used the aggression questionnaire in research on problematic aggression including international validation studies, offender and mentally ill offender populations and veterans (Garcia- Leon et al., 2002; Gerevich, Bacskai & Czobor, 2005; Diamond, Wang & Buffington-Vollum, 2005; Freeman & Roca, 2001; Williams, Boyd, Cascardi & Poythress; 1996).

Assessment of Depression and Anxiety.

It was decided to include a measure of anxiety and depression to ensure results were not adversely affected by anxiety and/or depression. The Hospital Anxiety and Depression Scale (HADS, Snaith & Zigmond, 1994) was included to ensure that mood (depression or anxiety) was controlled for and the results accurately indicate the relationships between the three variables. The HADS is a 14 item questionnaire, and provides two subscales: anxiety and depression. The questionnaire yields two scores one for each

subscale, and scores represent normal, mild, moderate and severe levels of symptoms.

The HADS has good internal consistency for both subscales (anxiety α = .93 and depression α = .90) and test-retest reliability (anxiety *r* = .89 and depression *r* = .92). The scale has been tested for validity on a number of different populations including medical outpatients (Zigmond and Snaith, 1983) and psychiatric patients (Bramley, Easton, Morley & Snaith 1988).

2.4 Procedure

Participants were recruited from four voluntary homeless hostels in Southampton between October and December 2009. Hostels managers were initially approached and if they agreed to support the study, were given posters to display and an information sheet (Appendix E) to give to interested participants. The posters displayed the time and date that the researchers would be attending the hostel and interested participants were invited to be at the designated room to participate. This system satisfied ethical considerations of informed consent.

Participants were given a verbal explanation of the study which included information regarding the purpose of the study and potential advantages and disadvantages of taking part. It was made clear that some of the questionnaires asked about sensitive issues such as childhood experiences. It was emphasised that participation was voluntary, information was confidential and that they could withdraw from the study at any time. Participants were asked to complete a screening form (Appendix C) which ascertained reading ability and asked whether they would like to complete

the questionnaires independently, or with support in an interview format. Participants then completed a demographics form (Appendix D) and then the questionnaire pack. Each questionnaire pack had a number, which was on each of the questionnaires to ensure the questionnaires remained a set, but could not be linked to any individual ensuring anonymity and confidentiality.

83 participants completed the questionnaire packs, either independently or with some support from the researcher (reading questions aloud and the participant circling the response, answering queries and helping with reading and comprehension). In the case of interview format participants were interviewed on a one to one basis in a private area to ensure confidentiality. The number of participants at each session at any one time was limited to ensure participants were able complete the questionnaires without their answers being made visible or audible to other participants and to ensure that they did not confer. The researchers were available throughout the sessions to offer assistance, guidance, support and to answer any questions.

Recruitment was completed jointly with two other researchers (both Trainee Clinical Psychologists, see Appendix I) who were also investigating childhood trauma within the homeless population. Therefore the questionnaire packs consisted of questionnaires from all three of the researchers' studies. On average the questionnaires took an hour and a half to complete depending on level of support participants needed. Participants were encouraged to take frequent breaks. On completion of the questionnaires, the questionnaire pack was placed in an envelope which was sealed and returned to the researchers. Participants were verbally debriefed and given a debrief sheet

(Appendix G) containing relevant contact details and were provided with a £9 supermarket gift card as a ‘thank you’ for taking part in the study. Hostel staff and participants were made aware that a summary of the results would be available on request.

2.5 Ethical considerations

The study received approval from the University of Southampton Ethics Committee (Appendix G) and was sponsored by the University of Southampton (Appendix H). Approval was sought from the managers of the hostels included in the study.

2.6 Statistical Analysis Strategy

The data obtained was analysed using the Statistical Package for the Social Sciences (SPSS) version 17.0. Firstly, descriptive statistics were obtained and normality tests undertaken to assess variables distribution and to establish whether parametric tests were appropriate. The relationships between the three variables was assessed using correlation analysis. In order to assess the mediation hypotheses regression was utilised (Baron & Kenny, 1986). Finally the Bootstrapping method was utilised to assess whether mediation effects were significant (Preacher & Haynes, 2004)

2.6.1 Mediation Analysis

There are a number of methods of testing mediation, however Baron & Kenny (1986) steps strategy is widely used and recognised. This method suggests using a series of regressions in four steps which must be satisfied to establish regression (see diagram 1)

These steps are:

Step 1: The independent variable (Childhood abuse and trauma) must significantly affect the mediator variable (Emotion dysregulation), path a.

Step2: The independent variable (Childhood abuse and trauma) must significantly affect the dependent variable (Aggression), path c.

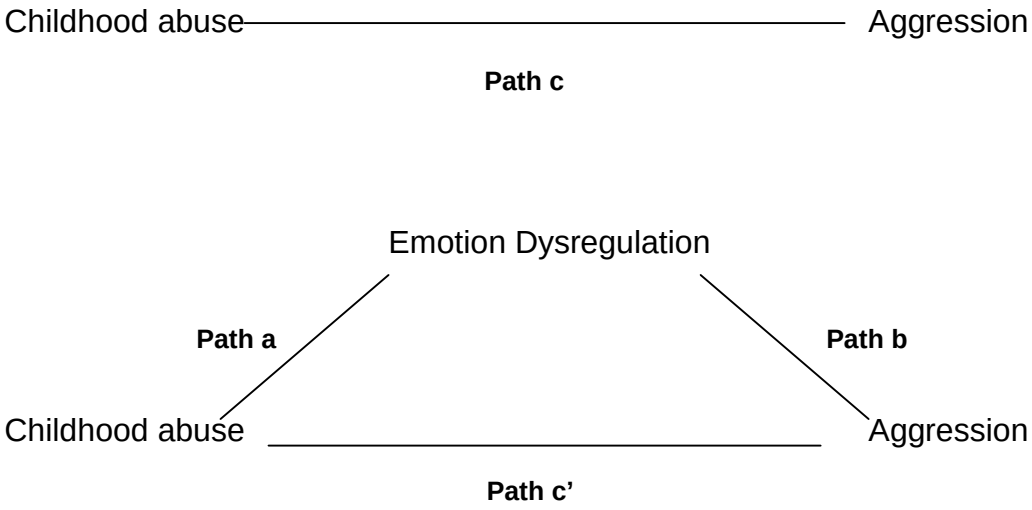
Step 3: The mediator variable (Emotion dysregulation) must significantly affect the dependent variable (Aggression), path b.

Step 4: The effect on the independent variable (Childhood abuse and trauma) must be reduced on addition of the mediator variable (Emotion dysregulation) to the model (path c'). To establish complete mediation the independent variable should have no effect (zero) on the dependent (Aggression) variable when the mediator (Emotion dysregulation) is included.

Baron and Kenny (1986) recommend a fifth step to their mediation, Sobel's test. This estimates the true quantity of interest in mediation analysis, the size of the indirect effect of the predictor through the mediator on the outcome of interest. In this study it is the magnitude of effect of child abuse on aggression that is 'mediated' through emotional dysregulation. However, the Sobel's test has received criticism for its use on small sample sizes and its assumptions of normality (MacKinnon, Lockwood , Hoffman, West & Sheets, 2002; Preacher & Hayes, 2004, 2008). It was therefore decided to use the bootstrapping method to test the significance of the indirect effect by generating bootstrap confidence intervals, as this method is considered to be more robust (Preacher & Hayes, 2008). The analysis was conducted using a

SPSS macro for bootstrapping and utilised 5000 bootstrapping samples (Preacher & Hayes, 2008). A second bootstrap was conducted including depression and anxiety scores as co-variants, to ensure the mediation could not be solely attributed to mood (depression and anxiety).

Diagram 1 Mediation design (Baron & Kenny, 1986; Preacher & Hayes, 2004, 2008)



3.0 Results

3.1 Preliminary statistics

Preliminary statistics were explored to establish whether the data conformed to the assumptions of normality. The data was assessed using stem and leaf plots to identify outliers, and it was concluded there were no significant outliers. Kolmogorov-Smirnov tests were conducted to measure skewness and kurtosis and this demonstrated that the data was sufficiently normally distributed to enable the use of parametric tests.

3.2 Descriptive statistics

3.2.1 Cronbach's alpha was used to test for internal reliability of total scores for each questionnaire. Table 2 shows the results for all the scales. All scales total scores demonstrated good reliability (Pallant, 2007).

Table 2 Cronbachs alpha for scales

Scale	Cronbachs Alpha (α)
CATS Total	.947
DERS Total	.888
AGG Total	.912
HADS- anxiety	.783
HADS-depression	.716

AGG= The Aggression Questionnaire; DERS= Difficulties in Emotion Regulation Scale; CATS= Child Abuse and Trauma Scale HADS= Hospital Anxiety and Depression Scale.

3.2.2 Mean scores for childhood trauma and abuse, emotion dysregulation, aggression and anxiety and depression were calculated for the whole sample (See results in table 3) and then divided for gender (See table 4). Results indicate that in the three variables of interest participants scored highly, indicating high levels of childhood abuse, high levels of emotion dysregulation and high levels of aggression. Interestingly results for male and female participants do not significantly differ on most of the questionnaires with the exception of the Difficulties with Emotion Regulation Scale.

In terms of impact of mood, on average participant's scores were within the mild and normal ranges for anxiety and depression respectively.

Table 3 Mean scores for scales overall

Scale	Mean
CAT	1.57 (SD=.81)
DERS	101 (SD= 21.2)
AGG	88.03 (SD= 23.1)
HADS - anxiety	10 (SD= 4.083)
HADS - depression	7.21 (SD=4.8)

AGG= The Aggression Questionnaire; DERS= Difficulties in Emotion Regulation Scale; CATS= Child Abuse and Trauma Scale HADS= Hospital Anxiety and Depression Scale.

Table 4 Mean scores for male and female participants

Scale	Male	Female
CATS	1.5 (SD=.78)	1.8 (SD=.90)
CATS- neglect	1.60 (SD=.97)	1.87 (SD=1.1)
CATS-physical abuse	2.07 (SD=.71)	2.1 (SD=1.04)
CATS-sexual abuse	.614 (SD= .834)	1.02 (SD=.73)
CATS-emotional abuse	1.67 (SD= 1.08)	2.17 (SD=1.24)
DERS	99 (SD=20.58)	109.5 (SD= 21.8)
AGG	87.9 (SD=23.5)	88. 37 (SD= 21.78)
Agg- physical aggression	26.1 (SD=8.95)	23.7 (SD=7.39)
Agg-verbal aggression	15.7 (SD= 5)	15.8 (SD=5.7)
Agg-anger	22.4 (SD=7.16)	23.3 (SD=7.25
Agg-hostility	23.67 (SD=8.95)	25.0 (SD= 7.62)
HADS-anxiety	9.9 (SD= 4.297)	10.13 (SD=3.2)
HADS- depression	7.3 (SD= 4.0)	6.8 (SD=4.2)

AGG= The Aggression Questionnaire; DERS= Difficulties in Emotion Regulation Scale; CATS= Child Abuse and Trauma Scale HADS= Hospital Anxiety and Depression Scale.

3.2.3 Pearson's correlation coefficients were calculated to test whether each measure correlated with another one. This was conducted using total scores for each measure and demonstrated that each measure did correlate with the others, indicating further mediation analysis was acceptable. Table 5 displays Pearson's correlations for the variables. This demonstrates hypotheses1, 2, and 3 can be accepted.

Participant's scores on anxiety and depression are also included, in order to explore the relationships. Anxiety positively correlated with all the other variables, childhood abuse and trauma, aggression and emotion dysregulation. However, depression only correlated with emotion dysregulation and anxiety, but did not significantly correlate with the other variables.

Table 5- Pearson's Correlation Coefficients- Total scores (N=80)

Scale	CATS	DERS	AGG	HADS-anxiety	HADS-dep
CATS	-				
DERS	.435**	-			
AGG	.310**	.505**	-		
HADS-anxiety	.404**	.583**	.366*	-	
HADS-dep	Non-sig	.343*	Non-sig	.401*	-

*p < .005 **p< .001

AGG= The Aggression Questionnaire; DERS= Difficulties in Emotion Regulation Scale; CATS= Child Abuse and Trauma Scale HADS= Hospital Anxiety and Depression Scale.

3.3 Mediation Analysis

A series of regressions were performed to test out Baron & Kenny (1986) conditions of mediation on the three variables.

A simple linear regression was conducted to demonstrate that childhood abuse and trauma did significantly predict emotion dysregulation (standardised β = .435, t = 4.265, p <.001) and accounts for 18% of the variance, indicating step 1 (path a) was met, hypothesis 2.

A second regression was performed on childhood abuse and trauma and aggression and found that childhood abuse and trauma did significantly predict aggression (standardised β = .310, t = 2.879 p <. 005), accounting for 9 % of the variance, indicating step 2 was met (path c), hypothesis 1.

A third regression was performed to determine step 3 was met; this ensured that emotion dysregulation (mediator) predicts aggression (path b, hypothesis 3) whilst controlling for childhood abuse and trauma, the predictor, this was condition was met (standardised β = .456, t = 4.206 p<.001). Step 4 was also met (standardised β =.111, t = 1.024, p>.005), when controlling for emotion dyrsregulation (path c'), the relationship between childhood abuse and trauma and aggression became non significant, and the co-efficient had reduced from regression 2(.310 to .111) and emotion dysregulation accounts for 26% variance when included in the model, higher than childhood abuse and trauma alone (path c, 9%). This indicates that emotion dysregulation fully mediates the relationship between childhood abuse and trauma and

aggression, and supports hypothesis 4 Results are displayed in table 6 and displayed diagrammatically in diagram 2.

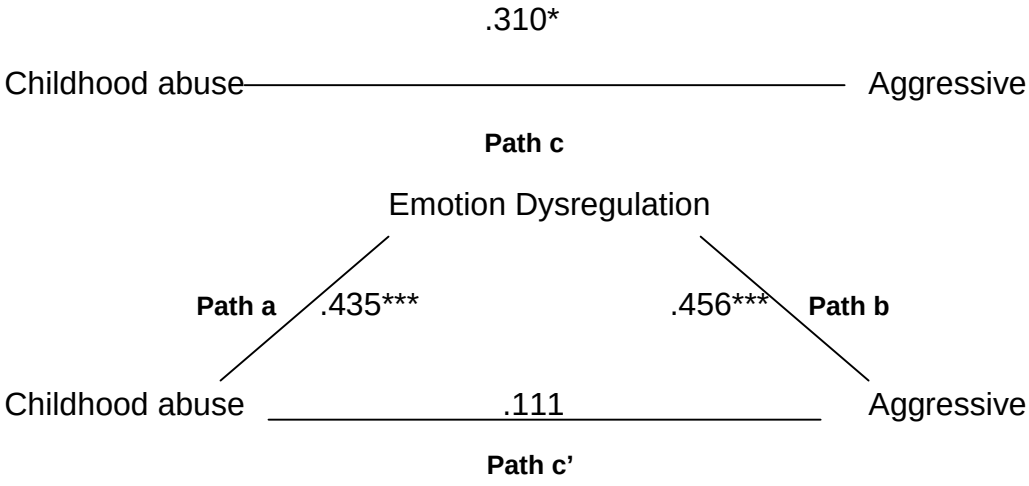
Table 6- Results from regression to test mediation

Regression		B	SE B	t	β	R_2	P
1 Path a							
Outcome:DERS							
Predictor:CATS		11.334	2.657	4.265	.435	.189	.000
2 Path c							
Outcome: AGG							
Predictor:CATS		8.811	3.064	2.876	.310	.096	.005
3 Path b & c'							
Outcome: AGG							
Mediator:DERS	(pathb)	.498	.118	4.206	.456	-	.000
Predictor:CATS	(path c')	3.163	3.088	1.024	.111	.265	.309

AGG= The Aggression Questionnaire; DERS= Difficulties in Emotion Regulation Scale; CATS= Child Abuse and Trauma Scale

Note: *B* = unstandardised beta weights, β = standardised beta weights

Diagram 2- Co-efficient for mediation analysis (Baron & Kenny, 1986; Preacher & Hayes, 2004, 2008



* p < .05, ** p < .01, *** p < .001

Bootstrapping was conducted and indicated that the total indirect effect through the mediator is significant with a point estimation of 5.5105 and a 95% confidence interval (CI) of 2.65 and 8.9, consistent with the hypothesis that emotion dysregulation mediates the relationship between childhood abuse and trauma and aggression.

A second bootstrap was conducted and included anxiety and depression scores as co-variants. Results indicated that the indirect effect through the mediator remained significant with a point estimation of 2.9597 and a 95% confidence interval (CI) of .5178 and 6.9736. Further supporting that emotion dysregulation mediates the relationship between childhood abuse and trauma and aggression and that the relationship remains significant when controlling for mood (depression and anxiety).

4.0 Discussion

This study aimed to build on research which associated difficulties in emotion dysregulation with aggression, to further develop the evidence base for the high prevalence of childhood abuse and trauma and aggression within the homeless population; and to assess whether emotion dysregulation mediated the relationship between childhood trauma and abuse and aggression.

4.1 Key findings

Aggression

A number of participants scored highly on aggression, supporting previous studies which have found similarly high levels (North et al., 1994; Boris et al.,

2002; Gilders, 1997; Whitbeck et al., 1997; Kipke et al, 1997; Tyler et al., 2001**;** Swanson et al., 2002). Gender was not found to be a factor with both male and female participants reporting similar levels of aggression. These high levels of aggression may be particularly problematic for homeless people, who are daily provided with triggers for anger (environmental risk factors) and where their aggressive and violent behaviour may have detrimental consequences to escaping homelessness (Maguire, 2006).

Furthermore, this study offers a different view of the way women frequently have been researched within the homeless population. Predominately homeless women have been viewed as victims only (for example D'Ercole & Struening, 1990; Browne & Bassuk, 1997). This study found similar levels of aggression in this sample of homeless women to their male counter parts, supporting a small body of research that has found aggression is also problematic for homeless women (North et al., 1993; Weschberg, Lam, Zule, Hall, Middlesteadt & Edwards, 2003)

Childhood abuse and trauma

Again, consistent with previous studies, the current study found a high prevalence of childhood abuse and trauma, with all participants reporting some form of abusive or neglectful experience (Gwadz, et al., 2007; Johnson et al., , 2006; Martijn,& Sharpe, 2006; Ryan et al., 2000; Slesnick et al., 2008) Davis-Netzley et al., 1996; Herman, et al., 1997; Stein et al., 2002, van den Bree et al., 2009)

Gender was not found to be a factor in the experience of childhood abuse and trauma generally and showed similar levels for both male and female participants, in particular on physical abuse. However, female participants reported more sexual abuse, again consistent with previous research (Kipke, et al., 1997; Tyler et al.,2001; Gwardz et al., 2007; Whitbeck et al., 1997a; Whitbeck & Simons, 1993, Whitbeck et al., 1999). These findings contribute to the evidence base that childhood abuse and trauma is over-represented within the homeless population. It is well established that these experiences have a number of detrimental consequences, making this sample of homeless people likely to be highly vulnerable individuals.

Childhood abuse and trauma, and aggressive behaviours

The current study also contributes further evidence to research which has associated childhood experiences of abuse and trauma with aggression (hypothesis 1). Previous research has demonstrated this within the general population (Widom & Maxfield, 2001; Felson & Lane, 2009) and the current study adds to the body of research finding this pattern within the homeless people (Baron & Hartnagel, 1998; Tyler & Johnson, 2004; Chen et al., 2004; Tyler et al., 2000; Tyler et al., 2001; Whitbeck & Hoyt, 1999; Whitbeck et al., 1997a; Whitbeck & Simons, 1993). This provides further evidence that childhood abusive and traumatic experiences are risk factors for developing difficulties with aggression.

Childhood abuse and trauma, emotion dysregulation and aggressive behaviours

Within this study childhood trauma was significantly associated with difficulties in emotion dysregulation (hypothesis 2). This adds empirical support to both the theoretical and empirical research which associates childhood trauma and development of emotion regulation difficulties (Linehan, 1993; Gardner & Moore, 2008; Maughan & Cicchetti, 2002; Mounier et al., 2003; Shields & Cicchetti, 1998; Shipman et al., 2000). A number of participants within this study demonstrated high levels of emotion dysregulation which was significantly associated with high levels of aggression. This indicates deficits in emotion regulation demonstrated by high emotion dysregulation may result in people using aggression (hypothesis 3), potentially due to the absence of more effective, adaptive methods or strategies of managing emotion. The current study adds empirical support to previous research which found that intimate partner violence had an emotion regulation function and the affect regulation function of aggression in laboratory studies (Gratz & Roemer, 2004; Jakupcak et al., 2002; Bushman et al., 2001).

Finally, the most significant finding was that emotion dysregulation mediated the relationship between abusive and traumatic childhood experiences and aggression (hypothesis 4). This furthers previous research which has shown emotion regulation difficulties mediated childhood trauma and a number of maladaptive behaviours (Cloitre et al., 2008; Day, 2009; Gratz & Roemer, 2008; Maughan & Cicchetti, 2002; Shields & Cicchetti, 1998). The current study demonstrated that emotion regulation is an important process in the

association childhood abuse and trauma with aggression and as such has a number of clinical implications which are discussed below.

4.2 Clinical Implications

The findings from this study have a number of implications both in terms of increasing our understanding of some of the psychological difficulties within homelessness and for developing interventions focusing on these difficulties.

Currently, government policies predominately focus on social interventions for homelessness. This study further supports the research which has begun to highlight the psychological factors which may be maintaining homelessness and which must be taken into account when considering remediation of homelessness. This study contributes to the evidence base suggesting aggression is high within homeless people and as such is likely to have considerable implications for escaping homelessness. Aggressive behaviour is likely to result in breakdown of tenancies, reduce legal work opportunities and may bring people into contact with the Criminal Justice System (Maguire, 2006). However, it is important to acknowledge how stressful it is surviving within hostels and on the streets, in particular that the living conditions and associated frustrations may exacerbate violent behaviour. Therefore interventions specifically to alleviate psychological difficulties and in particular difficulties with aggression, combined with social interventions may contribute to enabling people to successfully escape homelessness.

Difficulties with emotion regulation was significantly associated with aggression, therefore interventions aimed at teaching people emotion regulation strategies may be useful in reducing this behaviour. Within Dialectical Behaviour Therapy (DBT, Linehan, 1993) teaching people effective emotion regulation skills (for example labelling emotions, increasing positive emotions and increasing interpersonal effectiveness) is central. Currently DBT has been most extensively applied to treating borderline personality disorder (Linehan et al., 2006; Linehan et al., 1999); however the principles and strategies may be effective in treating other maladaptive behaviours associated with emotion regulation difficulties including aggressive behaviour. Further to this, there is a growing body of research which suggests including emotion regulation strategies within Cognitive Behavioural Therapy (CBT, Beck & Fernandez,1998) interventions for anger and aggressive behaviour are effective (Day et al., 2008; Walker & Bright, 2009). This study provides evidence for the importance of including emotion regulation strategies in CBT programmes.

Unfortunately despite the clear need for interventions for psychological difficulties and in particular aggressive behaviour in homeless people, currently accessing services is problematic. This is partly due to the transient nature of homelessness with people frequently moving between catchment areas for NHS services, and it is likely that the complexity of their difficulties makes standard interventions inaccessible (NICE guidelines, 2007). This study highlights the need for evidence based interventions specifically for the homeless population which are both accessible and tailored to their needs.

This study further demonstrates the high prevalence of childhood abuse and trauma within homeless people and highlights the importance of preventative work, to reduce both the risk of entering homelessness (Martiji & Sharpe, 2006) and for developing problematic aggression. As such, early intervention within child and adolescent mental health services (CAMHS) and within schools for children who experience neglectful and abusive experiences is essential. It is likely that early detection and intervention for childhood maltreatment may prevent longer term difficulties.

Dyadic Developmental Psychotherapy (Becker-Weidman & Hughes, 2008) is an evidence based intervention effective for treating children with complex trauma and includes developing emotions regulation strategies and increasing self-awareness. This may therefore be an effective intervention for childhood trauma and may prevent the development of emotion regulation difficulties which may reduce the risk of the utilisation of aggression.

The current study highlights the importance of interventions for homeless people with problematic aggression, and the role of early intervention preventative work. It further highlights the need for psychological interventions alongside practical support, to help people to escape homelessness.

4.3 Strengths and Limitations of Current Study

The current study has a number of strengths. Firstly it contributes to the body of research which has found a high prevalence of childhood abuse and trauma within homeless people. It is also one of only a few studies that have

explored childhood abuse and trauma in homeless people within the UK. Secondly, it provides evidence of the relationship between emotion dysregulation and aggression, furthering previous research on college students and laboratory based studies. It is also, to the best of the author's knowledge, the first study to specifically explore the mediation effect of emotion dysregulation on childhood abuse and trauma, and aggression and has relevance for clinical interventions. Although the current study has a number of strengths, it is also important to consider its limitations.

This study was a cross-sectional design and was based on correlational data; therefore it is impossible to confidently state the direction of the relationships between variables. This is relevant to the emotion dysregulation and aggression, as it is possible that aggression increases difficulties with emotion regulation. Furthermore, this study did not include other factors which may be associated with aggression for example substance misuse, severe mental illness and cognitions. In particular, given the prevalence of victimisation within homelessness, it did not take into account that aggression may be reciprocal or as an attempt to defend oneself. Therefore the potential impact of these other factors is not understood or controlled for. However, a strength of this study was the inclusion of a measure of depression and anxiety. This was useful in suggesting mood was not a factor in responses to the questionnaires, a consideration a number of previous studies have not taken into account.

A further limitation was recruitment for the study. Recruitment took place at hostels and supported flats for homeless people and only included a small

number of people who were sleeping rough. Therefore, this study failed to recruit a variety of homeless people. The individuals who took part in the study were already utilising services and potentially the 'hidden homeless' (Crisis, 2004) were not included. Participants were also predominately white British males around the age of 36, with only a small number of women and people from black or ethnic minority groups. This suggests that potentially the findings from this study may not be generalisable to the homeless population as a whole. The number of women who took part in the study was low; therefore in future research of these variables, in particular aggression, on samples of homeless women may be useful to establish accuracy. Furthermore recruitment to the study was voluntary, and participants may have been motivated to complete the study due to the 'thank you' food voucher. This potentially could have resulted in inaccuracies, however on the contrary, may have encouraged homeless people who do not readily engage with services (hostel staff, hostel GP) to take part, potentially accessing those whose difficulties make them challenging to engage.

A further potential difficulty relates to completion of the questionnaires. Research suggests there are low levels of literacy and some degree of cognitive impairment evident within the homeless population, although prevalence is unknown (Parks, Stevens, & Spence, 2007; Spence, Stevens, & Parks, 2004; Warnes et al., 2003). As such some homeless people may not have wanted to take part because the research was questionnaire based. In those who did take part, there may have been some individuals who struggled to read the questions. A strength of this study is the use of the

screening form and presence of the researchers, who offered help with reading individual questions to participants and offered interview based administration. However, only a few participants utilised the interviews, and others may have declined support. Further to this the screening form only required participants to have basic literacy and some of the items on the questionnaires use relatively complex language, so potentially these factors reduce the accuracy of the responses. Participants may also have been under the influence of substances during completion of the questionnaires, this may have impaired their ability to accurately respond to questions. Also, due to multiple researchers, the questionnaire packs were lengthy and participants may have lost concentration. In order to account for this, questionnaire packs were assimilated in random order and participants were encouraged to take regular breaks. It is important to note, that the researchers observed that the majority of the participants completed all the questionnaires conscientiously.

There are also methodological difficulties associated with assessing childhood abuse and trauma retrospectively. Asking people about childhood traumatic experiences has been associated with a degree of under-reporting (Fergusson, Woodward & Horwood, 2000). It is possible that people may not be willing to disclose these highly emotional events and may have repressed or incomplete memories of events which frequently occur at a low developmental age. This indicates that there may be difficulties with inaccurate reporting. It has been suggested that a combination of both questionnaire and interview is most effective at gathering reliable data, as it

is posited that using multiple methods and specific questions about abusive experiences is associated with high rates of reporting (Kushel et al., 2003). It may also be useful to gather other evidence which may substantiate self report, for example social work reports and police records. However, this may results in significant under reporting as frequently child abuse is not reported to social services and police records may not reflect the subculture of violence within the homeless population (Wardhaugh, 2000). However, due to practicalities it was decided not to utilise this approach. The questionnaire (The Child Abuse and Trauma Scale Sanders & Becker-Lausen, 1995) used within this study has been used in previous research and has good psychometric properties, therefore relative accuracy can be assumed.

There may also be inaccuracies in the reporting of aggression, and again there also may be a degree of over and under-reporting. Tyler & Johnson (2004) found that violent behaviour in their sample of homeless adolescents was associated, alongside other variables, with invulnerability (portraying an image of strength or infallibility). Potentially, similar cognitions may have existed within this sample and may result in people wanting to appear more aggressive than they actually are, which may be a defensive mechanism for surviving homelessness. It is also possible, on the contrary that people may also have been under-reporting due to fear of repercussions, although confidentiality was made explicit.

There is also an important ethical consideration about asking people about abusive and traumatic experiences when there is limited access to psychological services. In order to manage this risk, this study gave

participants a debrief sheet and due to the majority of participants residing in hostels, they were encouraged to access staff if they were feeling distressed to contact the hostel GP. Participants were also encouraged to speak with the researchers and there was access to a clinical psychologist should participants experience difficulties as a result of participation in the study. Although the impact of asking people about distressing events was carefully considered and a number of options were available to participants if they were effected by participation, it is also it is important to acknowledge that research suggests that the benefits of asking about abuse frequently outweigh the costs of not asking (Becker-Blease & Freyd, 2006; Edwards, Dube, Felitti, & Anda, 2007). In particular in terms of research on homeless people, gathered information is vital in increasing our understanding to enable development of evidence based interventions specifically for this population.

4.4 Directions for future research

Homelessness is a significantly under researched area, especially within the UK. Therefore, further research which explores homelessness in general is vital to further increase understanding of homeless people's needs and provide effective interventions.

Replication of this study on a larger more diverse sample of homeless people would strengthen the findings. Due to the sample size investigation of the components within the scales was not possible. Future research could consider which aspects of childhood abuse and trauma (sexual abuse, physical abuse, emotional abuse and neglect) were associated specifically

with aggression. Furthermore research exploring which aspects of the construct of emotion regulation (as conceptualised by Gratz & Roemer, 2004) are associated with aggression would add to the findings and have important implications for 'targeting' specific aspects of emotion regulation in interventions. Furthermore, the mediating role of emotion dysregulation on childhood trauma and aggression has relevance for other populations (clinical and prison) and therefore completing similar studies on these populations may further these findings and contribute to understanding of the difficulties within these populations.

This study explored the role of emotion dysregulation as a mediator between childhood abuse and trauma and aggression. However, it is possible that other factors also provide a unifying process (low self esteem, cognitions) and further research is needed to establish relationships. Importantly not all people who experience childhood abuse and trauma develop difficulties with emotion regulation or are aggressive. Therefore research into the factors and processes that 'buffer' against development of difficulties, in particular aggression would be helpful and have implications for preventative work.

In general, future research on homeless people would benefit from more robust methodology, including longitudinal studies, larger sample sizes and research which accurately assesses the varied and complexity of the population (women, adolescents, ethnic minorities, elderly people, rough sleepers and the 'hidden homeless'). This would enable a more sophisticated understanding of this complex homeless population.

5.0 Conclusion

This study contributes to the body of empirical UK research on homelessness in general, and the evidence for the prevalence of childhood abuse and trauma and aggression within homeless people. It adds to the preliminary research on the emotion regulation function of aggression and provides empirical evidence on a 'real life' population where aggression is problematic. This study highlights the detrimental impact of childhood trauma both on developing difficulties with emotion regulation and with aggressive behaviour, and importantly that emotion dysregulation mediates the relationship between childhood abuse and trauma and aggression, which has relevant implications for treatment and preventative interventions.

These findings add to our understanding of homelessness and offer a psychological perspective to an important economic, political and social concern. This highlights the need for psychological interventions alongside practical support if people are to successfully escape homelessness, and as such, psychological interventions should be implemented in policies addressing homelessness. This study highlights the need for further research into homelessness, both to increase our understanding and to development of effective evidence based psychological interventions for this population.

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Appendix A- Instructions to authors - Clinical Psychology Review

Guide for Authors

Preparation

Use of wordprocessing software

It is important that the file be saved in the native format of the wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the wordprocessor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Do not embed "graphically designed" equations or tables, but prepare these using the wordprocessor's facility. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier: http://www.elsevier.com/guidepublication). Do not import the figures into the text file but, instead, indicate their approximate locations directly in the electronic text and on the manuscript. See also the section on Electronic illustrations.
To avoid unnecessary errors you are strongly advised to use the "spell-check" and "grammar-check" functions of your wordprocessor.

Article structure

Subdivision - numbered sections

Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to "the text". Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

Results

Results should be clear and concise.

Discussion
This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions
The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices
If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on.

Essential title page information
Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. **Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.**

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address"' (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract
A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be

avoided, but if essential, they must be cited in full, without reference to the reference list.

Keywords
Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, "and", "of"). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations
Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Footnotes
Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.
Table footnotes
Indicate each footnote in a table with a superscript lowercase letter.

Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Save text in illustrations as "graphics" or enclose the font.
• Only use the following fonts in your illustrations: Arial, Courier, Times, Symbol.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Produce images near to the desired size of the printed version.
• Submit each figure as a separate file.

Appendix B- Instructions to authors - Journal of Consulting and Clinical Psychology

Instructions to Authors

Length and Style of Manuscripts

Full-length manuscripts should not exceed 35 pages total (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a standard font (e.g., Times New Roman) of 12 points (no smaller). The entire paper (text, references, tables, etc.) must be double spaced.

Instructions on preparing tables, figures, references, metrics, and abstracts appear in the *Publication Manual of the American Psychological Association* (6th edition).

For papers that exceed 35 pages, authors must justify the extended length in their cover letter (e.g., reporting of multiple studies), and in no case should the paper exceed 45 pages total. Papers that do not conform to these guidelines may be returned without review.

The References section should immediately follow a page break.

Authors can publish auxiliary material as online supplemental material. These materials do not count toward the length of the manuscript. Audio or video clips, oversized tables, lengthy appendixes, detailed intervention protocols, and supplementary data sets may be linked to the published article in the PsycARTICLES database.

Supplemental material must be submitted for peer review at the end of the manuscript and clearly labeled as "Supplemental Material(s) for Online Only." Please see Supplementing Your Article With Online Material for more details.

Brief Reports

In addition to full-length manuscripts, the *JCCP* will consider Brief Reports of research studies in clinical psychology. The Brief Report format may be appropriate for empirically sound studies that are limited in scope, contain novel or provocative findings that need further replication, or represent replications and extensions of prior published work.

Brief Reports are intended to permit the publication of soundly designed studies of specialized interest that cannot be accepted as regular articles because of lack of space.

Brief Reports must be prepared according to the following specifications: Use 12-point Times New Roman type and 1-inch (2.54-cm) margins, and do not exceed 265 lines of text including references. These limits do not include the title page, abstract, author note, footnotes, tables, or figures.

An author who submits a Brief Report must agree not to submit the full report to another journal of general circulation. The Brief Report should give a clear, condensed summary of the procedure of the study and as full an account of the results as space permits.

This journal no longer requires an extended report. However, if one is available, it should be submitted to the Editorial Office, and the Brief Report must be accompanied by the following footnote:

Correspondence concerning this article (and requests for an extended report of this study) should be addressed to [give the author's full name and address].

Letters to the Editor

JCCP considers primarily empirical work and occasionally reviews. Letters to the Editor are no longer published.

Title of Manuscript

The title of a manuscript should be accurate, fully explanatory, and preferably no longer then 12 words. The title should reflect the content and population studied (e.g., "treatment of generalized anxiety disorders in adults").

If the paper reports a randomized clinical trial (RCT), this should be indicated in the title, and the CONSORT criteria must be used for reporting purposes.

Abstract and Keywords

Manuscripts must include an abstract with a maximum of 250 words. All abstracts must be typed on a separate page (p. 2 of the manuscript). Abstracts must contain a brief statement about each of the following:

- the purpose/objective;
- the research methods, including the number and type of participants;
- a summary of the key findings;
- a statement that reflects the overall conclusions/implications

After the abstract, please supply up to five keywords or short phrases.

Participants: Description and Informed Consent

The Method section of each empirical report must contain a detailed description of the study participants, including (but not limited to) the following: age, gender, ethnicity, SES, clinical diagnoses and comorbidities (as appropriate), and any other relevant demographics.

In the Discussion section of the manuscript, authors should discuss the diversity of their study samples and the generalizability of their findings.

The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians) and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Measures

The Method section of empirical reports must contain a sufficiently detailed description of the measures used so that the reader understands the item content, scoring procedures, and total scores or subscales. Evidence of reliability and validity with similar populations should be provided.

Statistical Reporting of Clinical Significance

JCCP requires the statistical reporting of measures that convey clinical significance. Authors should report means and standard deviations for all continuous study variables and the effect sizes for the primary study findings. (If effect sizes are not available for a particular test, authors should convey this in their cover letter at the time of submission.) *JCCP* also requires authors to report confidence intervals for any effect sizes involving principal outcomes.

In addition, when reporting the results of interventions, authors should include indicators of clinically significant change. Authors may use one of several approaches that have been recommended for capturing clinical significance, including (but not limited to) the reliable change index (i.e., whether the amount of change displayed by a treated individual is large enough to be meaningful; see Jacobson et al., *Journal of Consulting and Clinical Psychology*, 1999), the extent to which dysfunctional individuals show movement into the functional distribution (see Jacobson & Truax, *Journal of Consulting and Clinical Psychology*, 1991), or other normative comparisons (see Kendall et al., *Journal of Consulting and Clinical Psychology*, 1999). The special section of *JCCP* on "Clinical Significance" (*Journal of Consulting and Clinical Psychology*, 1999, pp. 283-339) contains detailed discussions of clinical significance and its measurement and should be a useful resource.

Discussion of Clinical Implications

Articles must include a discussion of the clinical implications of the study findings or analytic review. The Discussion section should contain a clear statement of the extent of clinical application of the current assessment, prevention, or treatment methods. The extent of application to clinical practice may range from suggestions that the data are too preliminary to support widespread dissemination to descriptions of existing manuals available from the authors or archived materials that would allow full implementation at present.

General Instructions

APA Journals Manuscript Submission Instructions For All Authors

The following instructions pertain to all journals published by APA and the Educational Publishing Foundation (EPF).

Please also visit the web page for the journal to which you plan to submit your article for submission addresses, journal-specific instructions and exceptions.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts appear in the *Manual*.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Review APA's Checklist for Manuscript Submission before submitting your article.

Submitting Supplemental Materials

APA can now place supplementary materials online, available via the published article in the PsycARTICLES database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article:
Herbst-Damm, K. L., & Kulik, J. A. (2005). Volunteer support, marital status, and the survival times of terminally ill patients. *Health Psychology*, *24*, 225–229. doi:10.1037/0278-6133.24.2.225

Authored Book:
Mitchell, T. R., & Larson, J. R., Jr. (1987). *People in organizations: An introduction to organizational behavior* (3rd ed.). New York: McGraw-Hill.

Chapter in an Edited Book:
Bjork, R. A. (1989). Retrieval inhibition as an adaptive mechanism in human memory. In H. L. Roediger III & F. I. M. Craik (Eds.), *Varieties of memory & consciousness* (pp. 309–330). Hillsdale, NJ: Erlbaum.

Appendix C Screening Form

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SO17 1BJ

A STUDY INVESTIGATING THE EXPERIENCES OF HOMELESS PEOPLE

AND THE PROBLEMS THEY MAY FACE

Researchers: Rebecca Barrett, Charlotte Couldrey, Helen Stanley & Dr. Nick Maguire

SCREENING FORM

1. Are you able to read one of the daily newspapers (e.g. The Mirror, The Independent)?

YES ☐ **NO** ☐

2. Are you able to fill in your own benefit forms without any help / support?

YES ☐ **NO** ☐

3. For this study, how would you prefer to fill in the questionnaires?

You will be able to change your mind on the day, if you wish. **Please tick one box**

I would like to fill in questionnaires by myself ☐

I would like to fill in questionnaires with some help ☐

I would like to fill in questionnaires in an interview ☐

Appendix D Demographics Form

Demographics Form

1. Age _____

2. Gender **(please tick)** Male ☐ Female ☐

3. What is your ethnicity? **(Please tick one box)**

White British		White & black African		Pakistani		Black African	
White Irish		White Asian		Bangladeshi		Black other	
White other		White & other		Asian other		Chinese	
White Black Caribbean		Indian		Black Caribbean		Other	

4. What is your current circumstance with regards to accommodation? **(Please tick one box)**

Sleeping on the streets	☐	Staying in a squat	☐	Staying in a shelter	☐
In derelict buildings	☐	Staying on friends sofa's	☐	Staying in homeless hostel	☐
Other outdoor _____	☐	Overcrowded housing	☐	Other _____	

Appendix E Information sheet

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INFORMATION SHEET

You are being asked to take part in a research study. Before you decide whether to take part, you need to understand what it will involve. Please read this information sheet carefully and talk to one of the researchers or a member of staff if you wish. If you are not sure about something, or need more information, please ask. Thank you.

WHO ARE WE?

We are Rebecca Barrett, Helen Stanley and Charlotte Couldrey, trainees on the Doctoral Programme in Clinical Psychology at the University of Southampton. This study forms part of the training and has been reviewed by the School of Psychology Research Ethics Committee.

WHAT IS THE PURPOSE OF THIS STUDY?

This study aims to look at the experiences of homeless people and the problems they may face. It is hoped that the study will help in the provision of more appropriate services for homeless people.

DO I HAVE TO TAKE PART?

It is up to you to decide if you wish to take part. If you do decide to take part in this study you will be given this information sheet to keep. If you fill out the questionnaires, this will be taken as you giving informed consent to participate in this study. You can withdraw from the study at any time, without this affecting the services you receive.

WHAT WILL I HAVE TO DO IF I TAKE PART?

You will be asked to fill in several questionnaires and one computer task. Altogether these should take approximately 1hour and 30 minutes to complete. Once you have completed them, you will be given an envelope to put the questionnaires in so that one of the researchers can collect them. If you need help to complete the questionnaires, please let one of the researchers know, and we can arrange this.

WIILL THE INFORMATION I GIVE IN THIS STUDY BE CONFIDENTIAL?

All the information collected from the questionnaires will be kept strictly confidential (and only identifiable by the researchers for data collection purposes). You will be given a unique identification number which will be put on all of the questionnaires to enable the researchers to match up individual responses. All information collected will be stored in a locked filing cabinet and will be separate from any identification. The results of this study will be written up in a report and you can get a summary of these results if you wish by contacting us.

WHAT MIGHT BE THE DISADVANTAGES OF TAKING PART?

It is possible that some of the questionnaires you will be asked to fill out may make you feel upset or distressed. If this should happen, you will be free to stop participating and will be offered support from the researchers or staff members if you would like it.

WHAT MIGHT BE THE BENEFITS OF TAKING PART?

The information from this study will help provide clearer information about the experiences faced by homeless people. It is hoped that this information in turn will help to inform the future development of services for homeless people. Also as a ‘thank you’ for completing all the questionnaires and computer task, you will be offered a £9.00 food voucher.

HOW WILL YOU BE ABLE TO CONTACT US?

If you have any questions or would like further information, please contact us at:

School of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton

34 Bassett Crescent East

Southampton

SO16 7PB

Tel: 02380 595320

THANK YOU

Appendix F Debrief sheet

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AND THE PROBLEMS THEY MAY FACE

Researchers: Rebecca Barrett, Charlotte Couldrey, Helen Stanley & Dr. Nick Maguire

DEBREFING FORM

Thank you for taking part in this study and for providing us with lots of valuable information. Our study aimed to investigate the experiences of homeless people and the problems they may face. It is hoped that the study may help to provide better information regarding future provision of services for homeless individuals.

When the research is completed, it will be submitted for publication and may be presented at conferences to other researchers and clinicians. This final report will NOT include any identifying information but instead will group together the results of all participants. A summary of these findings will be available upon completion of the research. If you would like a copy of this report, please inform us and we will be happy to forward a copy of this report to you.

The contents of these questionnaires may produce strong emotions, feelings, or thoughts. These are normal experiences. However, if you feel that this is a concern for you, please speak to a member of staff or one of the researchers. Alternatively, should you need further help and support, please contact any of these people who will be able to help.

- Your **support worker** at the service
- Dr (the service's healthcare GP)
- The **Samaritans** on 08457 909090

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 5578

Appendix G School of Psychology Ethics Committee Approval

Your Ethics Form approval
Psychology.Ethics.Forms@ps2.psy.soton.ac.uk [Psychology.Ethics.Forms@ps2.psy.soton.ac.uk]

This email is to confirm that your ethics form submission for "An exploration into the relationship between childhood trauma, emotion dysregulation and aggression in homeless people" has been approved by your supervisor and has been sent to the ethics committee

Project Title: An exploration into the relationship between childhood trauma, emotion dysregulation and aggression in homeless people
Study ID : 798
Approved Date : 2010-01-28 12:38:33

Click here to view Psychobook

Please note project originally was going to be based on homeless men only, and later amended and approved by ethics and Research Governance to include homeless women too.

Appendix H Research Governance Committee Approval

Appendix I Statement about recruitment

Recruitment for this project was conducted jointly with two other Trainee Clinical Psychologists. This was due to all three projects utilising the Childhood Abuse and Trauma Scale and the Hospital Anxiety and Depression Scale, and to manage risk. In terms of risk it was considered important for at least two researchers to be present during recruitment. Following data collection all three projects were completed independently.

Appendix J Measures used in empirical paper

Difficulties with Emotion Regulation Scale (Gratz & Romer, 2003)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item:

1----------2----------3----------4----------5

almost never sometimes about half the time most of the time almost always

(0-10%) (11-35%) (36-65%) (66-90%) (91-100%)

_____ 1) I am clear about my feelings.

_____ 2) I pay attention to how I feel.

_____ 3) I experience my emotions as overwhelming and out of control.

_____ 4) I have no idea how I am feeling.

_____ 5) I have difficulty making sense out of my feelings.

_____ 6) I am attentive to my feelings.

_____ 7) I know exactly how I am feeling.

_____ 8) I care about what I am feeling.

_____ 9) I am confused about how I feel.

_____ 10) When I'm upset, I acknowledge my emotions.

_____ 11) When I'm upset, I become angry with myself for feeling that way.

_____ 12) When I'm upset, I become embarrassed for feeling that way.

_____ 13) When I'm upset, I have difficulty getting work done.

_____ 14) When I'm upset, I become out of control.

_____ 15) When I'm upset, I believe that I will remain that way for a long time.

_____ 16) When I'm upset, I believe that I'll end up feeling very depressed.

_____ 17) When I'm upset, I believe that my feelings are valid and important.

_____ 18) When I'm upset, I have difficulty focusing on other things.

_____ 19) When I'm upset, I feel out of control.

_____ 20) When I'm upset, I can still get things done.

_____ 21) When I'm upset, I feel ashamed with myself for feeling that way.

1----------2----------3----------4----------5

almost never sometimes about half the time most of the time almost always

(0-10%) (11-35%) (36-65%) (66-90%) (91-100%)

_____

_____ 22) When I'm upset, I know that I can find a way to eventually feel better.

_____ 23) When I'm upset, I feel like I am weak.

_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.

_____ 25) When I'm upset, I feel guilty for feeling that way.

_____ 26) When I'm upset, I have difficulty concentrating.

_____ 27) When I'm upset, I have difficulty controlling my behaviors.

_____ 28) When I'm upset, I believe that there is nothing I can do to make myself feel better.

_____ 29) When I'm upset, I become irritated with myself for feeling that way.

_____ 30) When I'm upset, I start to feel very bad about myself.

_____ 31) When I'm upset, I believe that wallowing in it is all I can do.

_____ 32) When I'm upset, I lose control over my behaviors.

_____ 33) When I'm upset, I have difficulty thinking about anything else.

_____ 34) When I'm upset, I take time to figure out what I'm really feeling.

_____ 35) When I'm upset, it takes me a long time to feel better.

_____ 36) When I'm upset, my emotions feel overwhelming.