12-2014

The Role of Time and Place in Understanding the Quality of Life among Homeless Persons

Gail O'Connor
University of Arkansas, Fayetteville

The Role of Time and Place in Understanding Quality of Life among Homeless Persons

The Role of Time and Place in Understanding Quality of Life among Homeless Persons

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Sociology

by

Gail E. O'Connor
Missouri State University
Bachelor of Arts in Sociology, 2011

December 2014
University of Arkansas

This thesis is approved for recommendation to the Graduate Council.

_____
Dr. Kevin Fitzpatrick
Thesis Director

_____
Dr. William Schwab
Committee Member

_____
Dr. Steve Worden
Committee Member

ABSTRACT

This study examines the role that life chances and choices play in determining quality of life among homeless people. Given the prominent negative impact of homelessness, this paper specifically examines the impact of length of time homeless and location on adverse quality of life. Data from Birmingham, Alabama and Northwest Arkansas Point-in-Time Homeless Census' was utilized and combined to create a sample of 264 homeless individuals. Using a quantitative approach, the topic of adverse quality of life for the homeless is analyzed through a three-model OLS regression, using a life chances and choices framework, with the addition of experiential context--time and place. Statistical analysis shows no significant impact of life choices on quality of life but a significant impact of life chances such as strong social ties and mastery of fate, on adverse quality of life. Length of time homeless yielded a significant impact on quality of life, but location did not, indicating that the homeless experience with regards to subjective quality of life did not vary between Birmingham and Northwest Arkansas.

ACKNOWLEDGEMENTS

I would like to acknowledge the chair of my committee, Dr. Kevin Fitzpatrick for his continued support, guidance, and patience with me as I worked on this project and my graduate school career. His mentorship allowed me to not only become a better sociologist, but to also work on projects that serve those in need within the Fayetteville community. Additionally, I would like to thank my committee, Dr. William Schwab and Dr. Steve Worden for their helpful feedback and guidance through this project. Finally, I would like to thank my family and friends for their love and support while I've been in graduate school. I am so thankful to have such wonderful people in my life that support me in pursuing my dreams.

DEDICATION

This thesis is dedicated to everyone who works relentlessly every day to better the lives of those in need in our communities.

“Be the change you want to see in the world.” – Mahatma Gandhi

TABLE OF CONTENTS

INTRODUCTION

Society's classification of those often referred to as "others" has evolved considerably over the last several decades. It began with drunkards, vagrants, and the insane, eventually evolving into the "addicted," "poor," and homeless individuals (Weinberg 2005:10). The homeless population is a major group classified by society as an "other," or someone who does not follow or meet the collective expectations that society has set for individuals to be considered "normal" (Weinberg 2005). This at-risk population is often ostracized and stereotyped by the "normal," and thus is narrowly defined as persons with problems such as substance abuse or mental illness resulting in their homeless state. Every person's individual life experience is unique, even though there tends to be commonalities among the homeless, it is difficult to compare personal experiences whether they are homeless or domiciled, yet we continue to be interested in the homeless story. How did they become homeless? What was their childhood like? Are they educated? What kind of neighborhood did they grow up in? What does their social network look like?

STATEMENT OF THE PROBLEM

Most studies of homelessness focus on the concentrated problems that social scientists deem as "risky" such as substance abuse, mental illness, unsafe sex and other deviant behaviors (LaGory, Ritchey, and Mullis 1990; Rossi 1990; et al. 1999; Fitzpatrick, LaGory, and Ritchey 2003; Hawkins and Abrams 2007). In order to understand their lives and the complicated pathways to homelessness, it is important to examine both their **life chances**, or the things that have paved a distinguished path in their lives such as gender, race, age, crime victimization, life events, along with their **life choices**, the things that they elect to engage in such as their social interactions, etc. (Evans et al. 1997; LaGory, Fitzpatrick, and Ritchey 2001; Athiyaman 2008).

By examining life chances and choices of the homeless population we can begin to distinguish a person's quality of life to the extent of how risky behavior compares to homeless living in one part of the country compared to homeless persons living in a different part of the country. It is important to note that homelessness is not the same in every city, small town, state, or even country. A person who lives in a large city in the south may have different life chances and choices than someone who lives in a small southern, rural town, and their experiences and choices could be reflected not only by who they are, but by where they are (Fitzpatrick and LaGory 2000; Biswas-Diener and Diener 2006; Perron et al. 2008).

Another important aspect of the homeless population is the time they are experiencing the homeless circumstance. The length of time a person is homeless can be a reflection of their life choices or chances, or even by how or where they choose to live. Where a homeless individual lives has an immediate impact on their lifestyle and ultimately their life chances and choices. There may not be job opportunities in a certain area or there may be a lack of services to those in poverty forcing homeless individuals to remain in their situation (Fitzpatrick and LaGory 2000).

This study is interested in examining the role that life chances and choice play in determining quality of life among homeless people. Specifically we want to answer the following questions: How do life chances and choice affect quality of life? And how does length of time homeless and place (location) further mediate these relationships?

We hope to shed light on the issues of time and place and how they impact a person's quality of life, in the context of these sometimes overwhelming chances and choices they confront. While services and shelters play an important role in combatting homelessness, we believe that there is a problem not being addressed as it relates to the combinative effect of time

and place, and the life chances and choices that each person is exposed to during their homeless experience.

SIGNIFICANCE OF STUDY

The aim of this research is to shed new light on the problem of homelessness by examining the relationship of life chances and choices as it relates to general quality of life. LaGory and colleagues have already examined the idea of life chances and choices and its relation to quality of life among homeless individuals surveyed in the Birmingham MSA, but it is the continuance of this idea that propels this study (2001). The study will further investigate this relationship by expanding the model to include a measure of both time and place, which offers a new perspective and new information pertaining to how these aspects impact homeless populations. Additionally, this study will also introduce a new scale that measures adverse quality of life loosely based on the World Health Organizations interpretation of quality of life, which will be discussed later in the paper.

A FRAMEWORK FOR EXPLORING QUALITY OF LIFE

Homelessness and Quality of Life

Homelessness is often examined through the lenses of health status, well-being, shelter use, and chronicity status. Poor physical and mental health is often examined among the homeless population because of the high rates of illness compared to the general population (Hubley, Russell, Palepu, and Hwang 2014: Hwang 2001: Ritchey, LaGory, Fitzpatrick, and Mullis 1990). Issues with substance abuse are other topics of high interest for researchers, but the overall category of quality of life of the homeless that encompasses all of these topic areas, is less often explored. Not only is quality of life rarely examined for the homeless population, but

the way it is researched often varies across disciplines. Bognar (2005) explains that quality of life is identified differently across disciplines with economists and philosophers distinguishing quality of life as welfare; sociologists as life satisfaction or happiness; and psychologists as subjective well-being. This lack of precision in the research of this subject area opens up possibilities to understanding the life of homeless individuals.

The World Health Organization (WHO) defines quality of life as "an individual's perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, and concerns" (2000). This definition provides several contexts to understanding how an individual lives based on their environment and perceived status within that environment. As mentioned earlier, there are several ways to examine quality of life; one method is to look at life quality through a subjective point of view and the other is to examine individuals through a more objective lens. Subjective quality of life assessments offer information about how an individual perceives their life to be based on their circumstances and provide insight to the feelings and emotions regarding a person's life satisfaction. Objective quality of life assessments offer more information pertaining to the actual health status and life conditions of an individual and often disregard feelings of life quality. Some argue that objective assessments of quality of life are "often not sufficient explanations of individuals experiences and their abilities to cope with negative life circumstances or their responses to positive and negative changes in their live" (Hubley et al. 2014:510). Hubley and colleagues (2014) claim, based on the WHO definition of quality of life that includes culture, societal values, and personal values in its definition, that subjective assessments offer a more inclusive evaluation of a homeless individual's life satisfaction. However, it is important to note, "Quality of life concerns individual (physical and psychological health), interpersonal (social

relationships) and contextual (environment) aspects, which are both subjective and objective" (Fassio, Rollero, and Piccoli 2013: 479).

It is obvious there are multiple strategies for studying, interpreting, and understanding quality of life. However, for the purpose of this study, we view quality of life from the perspective that there are many factors that are used to assess quality of life; most researchers include mental health, physical health, social connectedness, and environment in their models (Hubely et al. 2014; Gattino et al. 2013; Athiyaman 2008; Bognar 2005; LaGory et al. 2001). WHO's survey instruments assess the overall well-being of an individual and alludes to a person's overall life satisfaction and quality. Many researchers use the survey instruments developed by WHO in order to gain perspective on quality of life through a cross-cultural lens that is comparable worldwide (Fassio et al. 2013; Gattino et al. 2013; Hawthorne, Herman, and Murphy 2006). Hubley et al. (2014) found that homeless individuals tend to have a lower sense of quality of life compared to the general population, but our understanding of the relationship between subjective quality of life and health status is very limited.

Homeless individuals are often sufferers of mental and physical pain throughout their life; in fact, this is what many researchers focus on when examining this at risk population. The struggle with mental illness, including depression, is very common for homeless individuals, and it often contributes to the negative quality of life that they experience (LaGory, Ritchey, and Mullis 1990). Within the homeless population, it has been found that individuals that are younger, ill, less educated, chronically homeless, or living on the street are more likely to suffer from depression (LaGory, Ritchey, and Mullis 1990; Perron et al. 2008). It has also been shown that depression may develop as a result of homelessness (LaGory, Ritchey, and Mullis 1990; Rossi 1990).

Homeless individuals with a history of mental illness and previous stressful life events are shown to be more prone to distress, which also contributes to a perceived negative quality of life (LaGory et al. 1990). Drug and alcohol abuse are common issues that homeless individuals struggle with on a daily basis (Rossi 1990). Several studies have shown that the strength and continued substance abuse addiction may lead homeless individuals to partake in desperate or disconcerting behaviors with social groups that put them even more at risk for staying homeless and experiencing negative attitudes toward their quality of life (Drake et al. 1998; Perese and Wolf 2005). Our relationships also shape our quality of life.

When social bonds, or the strength of ties between individuals, are considered to be weak, the likelihood of homelessness increases (Eyrich et al. 2003). For instance, the lack of attachment to groups, families, organizations, and individuals can make it difficult for any person to find employment, financial assistance, or even temporary housing. Scholarly research has also found that many homeless individuals have exhausted their social bonds with families or friends by over using them as financial and housing resources (Toro et al. 1991). Research has also discovered that those who are currently experiencing homelessness tend to "drain" their network of resources during their journey to homelessness (Euyrich 2003). It has even been shown that weak social bonds can predict homelessness. This is apparent among all types of homeless such as youth, women, men and even families (Maram 2007; Sikish 2008). Hawthorne, Herman, and Murphy found that "although social indicators (e.g., economic resources, gross domestic product) form the milieu within which individuals live, their quality of life is determined by evolution of their personal lives and social situation" (2006:37). Along with overall quality of life, the impact of life chances and life choices on overall quality of life of the homeless

population is rarely researched. As a result, there is little data to support the relationship between quality of life and life chances and choices.

Life Chances

Each individual's life path is defined in the beginning by their personal life chances such as their gender, race, and other demographic information. Some things in life are not chosen by an individual, and thus the individual has little power over their basic human characteristics that place them into certain racial, social class, or gendered groups. "Demographic characteristics such as race, gender, and age represent ascribed statuses that influence general and health-specific quality of life. Since they are aspects of personal identity beyond the individual's control, they represent life chances" (LaGory, Fitzpatrick, and Ritchey 2001). The idea that we are born with these predetermined characteristics makes it difficult to avoid obstacles that arise when others identify you according to certain social groups based on race, gender, and age. These defining features provide a basic foundation to personal identity that allows others to automatically classify a person into a specific group with specific stereotypes.

LaGory and colleagues contend that the "homeless condition itself is a life chance, setting the parameters for a pattern of life" (2001:635-36). Constructing homelessness as a life chance provides the insight that homeless individuals have similar life experiences and daily lives that contribute to their homeless status. Snow and Anderson believe that "what these similarly situated individuals have in common is not a strong and recognizable set of values, but a shared fate and the determination to make do as well as they can" (1993:39). The issue of survival forces a unique set of options for the homeless population and forces them to make dangerous choices for their survival on a daily basis.

The circumstances in life considered to be out of the control of the individual and influence their life, as well as their quality of life, are labeled as life chances and act as stressors that increase the likelihood of mental and physical illness (LaGory, Fitzpatrick, and Ritchey 2001; Lin, Dean, and Ensel 1986). Stressful life events in a person's lifetime such as serious health problems, loss of a job, spending time in jail or prison, death of loved ones, or sexual and physical abuse serve as life chances that have been shown to have a negative impact on quality of life, as well as increase the likelihood of homelessness (LaGory et al. 1990; 1991; Zugazaga 2004; Baron, Forde, and Kay 2007). These negative life experiences shape how homeless individuals view the world which makes homeless individuals more likely to take dangerous risks on a daily basis that may become detrimental to their physical and mental health and also influence them on a social level as well (Fitzpatrick and LaGory 2000; 2001).

Life Choices

Life choices can simply be explained as the choices we make on a daily basis that impacts our life quality and experience. These choices constantly redefine our lifestyle and are based on each person's age, gender, race, education and other life chances. Fitzpatrick and LaGory explain that "life chances refer to the likelihood of achieving a particular lifestyle based on past experiences, social status, and power, and social networks. Thus one's life chances are clearly constrained by social, political, and economic circumstances, which, in turn, affect life choices" (2011:86). Life chances provide the structure of our lifestyle while life choices shape our individual agency, thus we make daily decisions based on the structure and experience of our past. This means that if an individual's life circumstances are generally labeled as negative, such as being a minority, experiencing abuse, homelessness, or extreme poverty, then the life choices you make can be detrimental to your success and survival in society. Life choices that have a

positive influence on quality of life include strong social ties, and mastery of fate. Fitzpatrick and associates (1999) found that strong senses of mastery and social support consistently predict low levels of mental health issues and by doing so increases the quality of life for homeless individuals.

Life Chances and Choices

The life chances and choices framework examined in this study is based on Weber's lifestyle theory that explains one's lifestyle and quality of life is a function of the life choices and chances that an individual experiences (1922; 1946). Cockerham and colleagues (1997) assert that Weber believes life chance is based on the social context, and not based solely on the chance itself. They continue explaining, "chance is socially determined, and social structure is an arrangement of chances. Hence, lifestyles are not random behaviors unrelated to structure but are typically deliberate choices influenced by life chances" (Cockerham, Rutten, and Abel 1997:325). Homelessness is itself a life chance and it is socially constructed to be a negative and debilitating life experience that results because of poor life choices or by a lack of opportunity because of an individual's life chances.

Weber posits that individuals do not only have life choices, but we also have constraints on our choices that determine a distinctive lifestyle for a person or group based on the reality of the circumstances for them (Cockerham et al. 1997). The circumstance of homelessness does not offer many positive choices for individuals and thus influences their quality of life and ability to be successful members of society. "Unrealistic choices are not likely to be achieved or maintained. Realistic choices are based on what is (structurally) possible and are more likely to be operationalized, made routine, and can be changed when circumstances permit" (Cockerham

et al. 1997:325). Realistic choices for homeless individuals tend to include staying at shelters and relying on community organizations for food and other necessities, which make many homeless individuals completely dependent on others. Fitzpatrick and LaGory find that "those who can literally call 'no place' their own are socially and psychologically devalued or, perhaps more accurately, viewed as without value" (2000:137). This means that the 'realistic choices' that Weber defines only enforces the idea that homeless individuals are devalued citizens because of their lack of choices and opportunities within the structure of society. This drives some homeless individuals to participate in risky activities such as sleeping in cars, stealing, or turning to drugs and alcohol for survival in order to avoid devaluing and dependency, which can be described as an 'unrealistic choice.'

Life chances are directly related to personal identity and because of this connection, life chances shape our social standing in society. Weber's idea of life chances and choices puts these two concepts at opposite sides of the spectrum; life chances are generally preset for individuals while life choices are controlled by individuals. But empirically, "individuals have a range of freedom, yet not complete freedom, in choosing a lifestyle" (Cockerham et al. 1997:325). The social structure of society leaves few positive choices for homeless individuals because of their unfortunate homeless life chance. Fitzpatrick and LaGory relate identity to environment by stating "while place matters, being without place matters most to human beings. We spend our entire lives struggling to find 'our place' in society, in history, and in the cosmic order; the link between place and identity is basic" (2000:137).

Experiential Context-Place

Snow and Anderson explain "the behaviors of the homeless should be viewed first and foremost as adaptations to environmental exigencies" (1993:38). The place in which a homeless

person lives has a great impact on their life satisfaction. Geographic landscape, community structure, safety, and population density, are all aspects of a place that can positively or negatively influence quality of life, especially for a homeless individual (Athiyaman 2008; Biswas-Diener and Diener 2006; Fassio et al. 2013; Fitzpatrick, LaGory, and Ritchey 1999; LaGory, Fitzpatrick, and Ritchey 2001; Fitzpatrick, Myrstol, and Miller 2014). Where a person chooses to live shapes their life chances and life choices because the diverse structure of community and the social ideals that depend on its location within the world (Biswas-Diener and Diener 2006).

Where a person lives also shapes personal identity. For instance, Fitzpatrick and LaGory explain that "place is a meaningful unit, not simply because a population uses various places as the stage on which to carry out its behaviors and actions, but because the stage (or place) itself shapes these actions and experiences" (2011:11). The stage that society carries out its interaction does not regard homeless individuals as contributing members of society, which results in a lack of belonging and a low sense of well-being and life satisfaction for this at risk population (Biswas-Diener and Diener 2006). Place has a unique effect on any individual and it is contingent on the social and cultural forces within a community that impact the individual (Fitzpatrick and LaGory 2011).

Fitzpatrick and LaGory conclude that "while place matters, being without place matters most to human beings" (2000:137). The homeless population struggles to find their place in society as well as within the community in which they live. This fight for survival and acceptance can produce negative health outcomes for this population. Fassio and colleagues (2013) found that a person's relationship to their living environment is directly related to their well-being when considering physical and mental health, social relationships and environmental

aspects of their quality of life. Fitzpatrick and LaGory argue that "our physical and mental health is a product of not only how we live, but also where we live" (2011:11). In fact, Gattino and associates (2014) found that health and quality of life are linked to the community in which you live and the attachment you feel to that community. It is difficult to find studies that discuss the importance of where you live and how it influences your life as it pertains to the homeless individual. However, we already know that "placelessness is a fundamentally distressing circumstance - a chronic stressor" for the homeless population and it continues to influence their quality of life (Fitzpatrick and LaGory 2011:129).

Experiential Context-Time

A chronically homeless person is defined by the Department of Housing and Urban Development (HUD) as: "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years" (HUD 2013). Chronicity is a debilitating circumstance with daily hassles such chronic stress, poor health outcomes, and risky lifestyle that these individuals experience for an extended period of time (Weinberg 2005).

In 2013, the United States Department of Housing and Urban Development (HUD) reported 109,132 people being chronically homeless in the U.S. (2013). Of those accounted for, almost 85 percent or 92,593 people were chronically homeless as individuals and about 15 percent or 16,539 were people in families (HUD 2013). This is a decrease since 2007 when the U.S. reported 123,833 chronically homeless individuals (HUD 2013). An astonishing 58% of chronically homeless individuals were unsheltered in 2013 and only 27 percent of individuals

reported being sheltered (HUD 2013). Even though chronic homelessness is on the decline, it is still a health impacting issue that needs to be more thoroughly examined.

Chronic homelessness has negative impacts on quality of life and overall well-being of these at risk individuals. The National Alliance to End Homelessness explains that the chronically homeless are often the group with the most vulnerability within the homeless population because of their long term risky lifestyles (2014). The Alliance report that the chronically homeless have high rates of behavioral health issues including substance abuse disorders, severe mental illness, conditions caused by continued physical illness, injuries, and traumas leading to excessive use of emergency services and crisis centers (National Alliance to End Homelessness 2014). The extensive physical and mental health issues that the chronically homeless show that the length of time homeless does influence quality of life and overall well-being.

Snow and Anderson assert that "all else being equal, behavioral patterns and cognitive orientation ought to vary with the length of exposure to any particular set of objects or circumstances" continuing to explain that the homeless experience differs due to the amount of time spent on the street (Snow and Anderson 1993:43). Other studies indicate that previous life experiences have an effect on length of time homeless as well. Homeless individuals that indicated a history of sexual or physical abuse, uncommon housing arrangements during childhood, or unhappy childhood memories are more likely to experience homelessness for a longer length of time (LaGory et al. 1995). It is clear that those who suffer from long term homelessness experience many negative health outcomes that produce a low quality of life.

RESEARCH QUESTIONS AND HYPOTHESES

The central research questions addressed in this study: Do life chances and choices transcend, or are they conditioned by, time and place when examining quality of life outcomes?

This study examines the relationship between life chances/choices and adverse quality of life outcomes. We expect to find that being non-white, female, older, and less educated will result in higher levels of adverse quality of life. We also expect that homeless individuals with a higher number of stressful life events in their lifetime to experience higher levels of adverse quality. We expect that life choices will have a stronger influence on the homeless quality of life than life chances. We expect that the longer a person experiences homelessness the more likely their quality of live will be adverse.

DATA AND METHODS

Northwest Arkansas Sample

The data utilized in this research is based on the 2007 Point-in-Time Homeless Census (PIT) count in Northwest Arkansas, as well as in-depth interviews from a random probability sample of those counted in the PIT. The PIT surveyed the highly visible homeless within the Northwest Arkansas community in early January of 2007. The Northwest Arkansas area includes the cities of Fayetteville, Bentonville, Rogers, and Springdale which are all defined as small cities. The census count was executed over a 24-hour time period and included a survey of basic demographic information, such as gender, age, race and their homeless status, as well as a needs assessment of the visible homeless. A comprehensive list of organizations and agencies serving the homeless population was created in order to locate the homeless population in the Northwest Arkansas community. Volunteers were trained before the PIT occurred and were

assigned a location and time to survey individuals based on what and when the organization provided services to the homeless population. For instance, volunteers were sent to food pantries and soup kitchen during hours of distribution and sent to shelters for evening shifts when the facilities were utilized.

Following the census, forty-five minute intensive interviews from a random probability sample of the homeless population that fulfilled quotas for the race, sex, and geographic site variables were given. Approximately 100 homeless individuals were interviewed following the census counts (N = 103). The interviews offer more personal information on the respondents, such as duration and causes of homelessness, social support, social capital, mental and physical health, access to health services, stressful life events and circumstances, and history of housing.

The Northwest Arkansas 2007 Point-in-Time Homeless Census reported that a majority of participants considered themselves to be Caucasian (78%). Around 60% of those surveyed were male, and the median age of participants was 36 years. Sixty-eight percent reported that they had completed high school and received a diploma. An astounding 63% of Northwest Arkansas's homeless population had been without a home for eight months or less and the average reported time homeless was around four and a half months.

Birmingham, Alabama Metropolitan Statistical Area (MSA)

Another source of data for this research project is from the Point-in-Time Homeless Census (PIT) in the Metropolitan Statistical Area of Birmingham, Alabama. The city of Birmingham is identified as the main central city in the Birmingham MSA. Executed in early 2005, this census was also accompanied by an intensive interview from a random probability sample of individuals that were considered to be highly visible homeless. The census provides

insight on basic demographic information including age, gender, race, and homeless status. Following the census, in-depth interviews were given to a representative sample of homeless individuals in the area. A conclusive list of service providers, community meal destinations, and other services areas that supply needs to the homeless population in the Birmingham MSA was created to identify areas to survey. Volunteers were trained beforehand and assigned specific times and places to survey the visible homeless based on the agencies and organizations that serve this population. Community meals and food pantries were surveyed during the day and overnight shelters were surveyed during the evening in order to reflect the times of use of the agencies.

The intensive interviews were administered to the individuals who met the race, sex, and geographic quotas determined by the Point-in-Time Homeless census (N = 161). Interviews lasted around one hour and asked respondents about more personal information. Topics include their housing histories, social capital, social support, duration and causes of homelessness, mental and physical health, access to health services, and stressful life events and circumstances that they had experienced.

The Birmingham MSA's census reported that a majority or about 66% of homeless individuals in that area are male. The same percentage (66%) identified themselves as African-American. The average age of respondents was 41 years and almost 43% completed high school. About 60% of those surveyed reported that they had been homeless for a year of less.

Northwest Arkansas & Birmingham Metropolitan Statistical Area

For the purpose of this research, the Northwest Arkansas and Birmingham MSA data will be combined to form one overarching dataset (N = 264). Even though the censuses and intensive

interviews were administered at different times, the questions were identical. The two samples are close enough in time to portray the same political, economic, and social settings that the nation was experiencing. This means that both Birmingham MSA and Northwest Arkansas were undergoing similar national influences such as the same president being in office and the economic recession not yet occurring, and thus had similar influences politically, socially and economically at a national level. The data collection methods were identically created by LaGory and colleagues (2005) and thus provide the same information even though the areas differ. Each area trained their volunteers similarly, carried out their Point-in-Time Homeless censuses in the beginning of the year with similar strategies of where to survey, executed similar in depth interviews of a random probability sample, and created similar datasets from the data collected. Variable names and descriptions were taken from the Northwest Arkansas dataset and coding of variables differed due to the content of the variable, thus allowing coding from both data sets. Each dataset was constructed separately until variables matched accordingly, and then were merged with the addition of a place variable to identify what information came from each area.

Even though the research methods of the Birmingham MSA and Northwest Arkansas were practically identical, it is important to note the differences between these areas. The Birmingham MSA is considered to be a large urban area in the southern section of the United States, but Northwest Arkansas is a small and rural southern U.S. area. This sample size reflects the difference in size of the two areas; the Birmingham MSA is much larger than Northwest Arkansas, and thus has a larger sample size of 161 compared to 103. Another difference is found in the racial composition of our two samples. Birmingham MSA's homeless population is predominantly African-American while Northwest Arkansas' homeless population is mainly

Caucasian. However, these differences will strengthen the theory that where you live does influence your quality of life and reveal that issues surrounding homelessness is place based.

We believe that the combination of these two datasets will provide a new perspective of homelessness by allowing the researchers to examine the relationship between life chances and choices with quality of life as it pertains to the duration homeless and the location where an individual experiences homelessness.

Dependent Variables

Adverse Quality of Life Scale

The scale depicting the current quality of life of homeless respondents assesses the extent of adverse life outcomes due to life chances and choices. Its name depicts the negative variables associated with it that prevent success are considered to be harmful or unfavorable. This scale addresses some of the issues of homelessness, including sleeping situation, mental and physical health, daily hassles, and other problems that keep this at-risk population in their current situation. The adverse quality of life scale contains fourteen variables that illustrate negative problems and situations that are experienced daily by the homeless population. By utilizing the World Health Organization's (WHO 1997) own quality of life measures, we were able to construct a modified scale encompassing the negative items that impact quality of life. Themes derived from the World Health Organization's quality of life measures include psychological health, physical health, level of independence, and environment. Each item was transformed into a dichotomous variable (Yes = 1; No = 0). The scores from the scale range from 0 – 14, with higher scores indicating a **lower, or adverse** quality of life for the homeless individual with lower scores signaling a higher quality of life. This scale was designed in order to reflect a

current state of the homeless individual, with questions asking respondents about experiences in the last year, last 30 days, or how the respondents were feeling at the moment during the interview. The scale is moderately reliable with a Cronbach's alpha of .653.

Mental Health Category

The first category included in this scale concerns the mental health of each homeless individual surveyed. This emotional health variable was derived from the Center for Epidemiological Studies Depression Scale (CESD) developed by Radloff in 1977. This scale encompasses the major self-reported aspects of mental health including psychomotor retardation, loss of appetite, sleep disturbance, feelings of helplessness and hopelessness, depressed mood, feelings of guilt and worthlessness (LaGory, Fitzpatrick and Ritchey 2001). The respondents were asked how often they experienced each feeling or emotion in the week before the questionnaire through twenty questions about these topics. Lin and associates (1986) concluded that a score of 16 or higher on this scale that ranges from 0-60 indicates a potentially depressed respondent with a score of 21 or higher indicating a strong probability of a clinical case of depression.

For the purpose of the adverse quality of life scale in this research, the CESD scale was transformed into a dichotomous variable. The homeless respondents that reported a score of 15 or less on the scale received a "No" response for the probability of a clinical case of depression with those who scored a 16 or above on the scale receiving a "Yes" response (Yes = 1).

Physical Health Categories

Physical health is assessed by three variables that examine the respondents perceived health status at the time of the interview and also since they became homeless. The first question

asks if they feel sick more often since they became homeless and the responses were in a Likert scale ranging from “strongly disagree” to “strongly agree.” This variable was altered to become dichotomous for the purpose of this scale. Answers reflecting, “strongly disagree” or “disagree” were assigned a zero because of their lack of being sick more often since homeless. Those who recorded “strongly agree” or “agree” for this question received a one for this response because they had experienced more health problems while homeless (Yes = 1).

The homeless respondents were also asked to report their ability to stay healthy since they had become homeless. Likert scale responses included “strongly disagree,” “disagree,” “agree,” and “strongly agree.” Respondents who reported “strongly agree” or “agree” indicating that it is difficult to have a healthy lifestyle while homeless received a one (Yes = 1). Homeless individuals who reported “strongly disagree” or “disagree” did not believe that it was difficult to stay healthy while homeless, and thus received a zero for a lack of negative life experience.

The final question reflecting a perceived sense of physical health from the homeless individuals inquired about the homeless respondent’s current physical health situation. “How is your health right now?” was asked with a range of answers from poor to excellent to reflect current health. This Likert scale was altered to reflect a negative current life experience or a positive current life experience. Homeless respondents that indicated their current health to be “excellent” or “good” were assigned a zero. Those who responded with “poor” or “fair” were given a one, demonstrating a negative sense of current health (Yes = 1).

Level of Independence Category

Level of independence is defined by the World Health Organization to include aspects of work capacity, daily living activities, dependencies on drugs or alcohol, and mobility (WHO

1995). This category serves a unique importance for homeless individuals because many rely on services provided by the community to survive. Five questions provide an overall view of each homeless respondent's independence level ranging from their ability to get food, to their main income source. A lack of independence for these questions was recorded as a one and independent practices were assigned a zero.

Another issue surrounding independence is the ability to get enough food and to find a place to sleep. Respondents were asked to identify if they had a problem getting enough to eat and were able to respond with "never," "sometimes," or "often." For the purpose of this study, we sorted the responses to reflect any difficulty reported to being a negative life quality. Homeless individuals that indicated "never" having problems getting food were assigned a zero and those indicating any difficulty getting food were assigned a one (Yes = 1). Homeless respondents were also asked about the ability to find a place to sleep while homeless. For this study we dichotomized this variable and assigned those who responded with "never" a zero and those that had any difficulty finding a place to sleep by responding with "sometimes" or "often" with a one.

The topic of work capacity was examined through whether or not the respondent had worked in the last month, as well as their main sources of income. Both variables were dichotomized in order to show whether or not they experienced a negative quality of life. If respondents worked full or part time in the last month they were assigned a zero, indicating a level of monetary independence. If the respondent reported no employment they were assigned a one, indicating monetary dependence. Homeless individuals' main source of income was divided into two groups; one group shows income based on work and relationships and the other group's income is based around government support and unconventional ways of making money. The

groups were separated this way in order to highlight the risk and uncertainty of relying on government funding and alternative ways of making money. The first group was assigned a zero and includes income from working, support from friends or relatives, and money from a pension. The second group reflects negative life quality and was assigned a one. It includes receiving income from social security, supplemental security income, social security disability insurance, other disabilities, temporary assistance for needy families, unemployment, selling blood or plasma, selling your personal items or things you made, panhandling, selling sex or drugs, and having no income at all.

Environment Categories

The last category included in the scale provides information about where the homeless respondents experience their daily lives including where they sleep, how they get around, and their perceived sense of how hard their life is. Six questions contribute to the research of this category of the quality of life of the homeless. This category in particular provides a brief idea of why place matters in the context of the homeless. This at-risk population constantly struggles with having their own space to live and they often depend on others for shelter, food, and other everyday facilities that are needed. The fact that many homeless do not have a space or place to call their own is important when considering how place influences quality of life and life satisfaction, which is a main component of this research.

Respondents were asked to describe what life was like in the city they lived in with the response choices including “pretty easy,” “so, so” and “pretty hard.” This variable was dichotomized in order to define the idea of life being difficult or easy in the city in which they lived. Homeless individuals that reported life in their area being “pretty easy” were assigned a

zero and those indicating life as “so, so” or “pretty hard” were assigned a one to identify life being difficult in their cities. In order to study the mobility, or the ability to leave the area, of the homeless respondents, they were asked to determine if they owned their own transportation. Those that did have transportation were assigned a zero, defining that they did have the ability to move, or to be mobile. Those that reported no ownership of transportation were assigned a one, depicting a lack of mobility.

The daily hassles scale reflects problems that the homeless individual experienced the night before the interview. Twelve questions asked if the respondent had problems with crowding, filthy conditions, rules, no privacy, noise, theft, bathrooms, other people at the facility, staff, availability of handicapped facilities, or getting sleep or food. Each problem reported was assigned a one, which created a scale ranging from 0 to 12. The median score for the daily hassles scale for the combined sample was two daily hassles. This scale was dichotomized for the purpose of the adverse quality of life scale with those experiencing two or less daily hassles being assigned zero. Respondents that indicated three or more daily hassles were identified as having high amounts of negative experiences at the place they stayed at the night before the interview and were assigned a one. Respondents were also asked “Do you plan on staying here again?” referring to the shelter or location they stayed at the night before the interview. This question provides more information about our respondent’s daily life experience and the relationship they share with the shelters and facilities they were staying the night at. Homeless individuals that indicated they would stay at the facility again were assigned a zero, identifying a lack of issues with the place they were sleeping. Respondents that indicated they were looking elsewhere, had no choice because there was nowhere else to go, or had no choice because they

were not allowed to stay again by the staff members were assigned a one, indicating they were unhappy in their sleeping situation.

Following the daily hassles, respondents were asked to identify where they had slept the night before. This variable was divided into two categories; the first included safe or adequate sleeping environments, while the second involved sleeping in risky or less safe areas. The first category, safe or adequate environments, was assigned a zero and included the following sleeping environments: emergency shelter, transitional housing, hotel or motel, hospital, jail, other institutions, treatment facility, permanent supportive housing, boarding home, or dwelling of a friend or relative. The second category was assigned a one and included the following unsafe sleeping areas: on the street, in a car, abandoned building or building under construction, public place indoors, or some other situation. To provide more information on sleeping situation the respondents were also asked if they had slept in a public place or outdoors in the last two weeks. Those that had slept outdoors in the last two weeks were seen as having an unfavorable life experience and were assigned a one.

Independent Variables

The independent variables in this study are broken up into three groups; life chances, life choices, and experiential context. Life chances consist of demographic information about the respondents, as well as variables that explain life experiences of the homeless population studied, such as stressful life events, educational experiences, and being a crime victim. Life choice variables explain experiences that the respondent has chosen or actively participates in during their life such as mastery of fate, their relationships or ties with others, and the use of drugs or alcohol (LaGory et al. 2001). Life chances cannot always be decided by a person and thus

unintentionally create the foundation of a person's life. Life choices can have a positive or negative impact, but it is up for the individual to choose good or bad options for their life. The idea that an individual may choose, whether it be positive or negative, makes life choices a strong contributor to the understanding of homelessness at a micro and macro level. This research illustrates the life chances and choices that this at-risk population has already experienced in life, now we are interested in the effect these chances and choices have on quality of life, and whether or not the length of time homeless and where you live (experiential context) have an impact on quality of life as well.

Life Chances

Examining life chances begins with predisposed demographic information such as race, age, and gender. Race was transformed into a dichotomous variable for white and non-white (white = 1). Age was left to reflect the exact age of the respondent and ranged from 18 to 71 years old at the time of the interview. Finally, the gender variable coded males and females (females = 1).

Life chances also include variables that reflect the life experiences that a respondent may have encountered throughout their lifetime. The stressful life events in their lifetime variable are derived from twelve yes or no questions inquiring about difficult life events that the respondent had ever experienced. The questions included if they had ever experienced sexual or physical abuse, been sued, had ever had serious health problems, lost a job, experienced marital troubles, been evicted, spent time in jail or prison, had anyone close to them die such as a friend, child, or spouse, or been kicked out of school (yes = 1).

Education level of the respondents will also be used to help define the topic of life chances. This ordinal level variable ranges from four years of schooling to earning a college degree. The eight education level categories include; 1 = 0–4 years of education, 2 = 5-7 years of education, 3 = finished grammar school, 4 = 9–11 years, or some high school education, 5= high school degree, 6 = post high school, and/or business or trade school, 7 = 13-15 years of education or some college, and finally, 8 = finished college.

The final life chance variable to be examined concerns the respondent's experience with being a victim of a crime. A victim scale was made to assess three crimes that a respondent may have fallen victim to in the last six months. The questions inquired if they had been robbed, attacked, or attacked with a weapon in the last six months. The scale ranges from zero to three and every question that corresponded with yes was assigned a one (Yes = 1). The total number of yes's from each respondent's questions contributes to their number on the crime victim scale.

Life Choices

The mastery of fate scale determines how strongly a respondent believes he or she is in control of their own life choices and chances. It provides a psychological perspective of how confident someone feels in their ability to determine their life course. The Likert scale of mastery of fate originally determined by Pearlin and Schooler (1978) uses seven questions to assess one's control of their destiny. Items inquire about the respondent's control over things that happen to them, belief of their ability to solve life problems, if they feel they can change important things in their lives, feelings of helplessness in dealing with life's problems, belief that they are being pushed around in life by others, ability to achieve anything they can set their mind to, and the ability to control their future. The Likert responses for the seven questions ranged from "strongly

disagree" to "strongly agree." The mastery of fate scale begins at zero and spans to twenty-one with higher scores indicating a high psychological sense of being in control of your life.

A second life choice variable that will be utilized in this research is the strong social tie support scale developed by Lin and colleagues (1986) which determines an individual's strength of social connectedness. The scale features three questions that examine relationships among the respondents' closest friends, family, and other influential people in their lives over the last six months. Respondents were asked three questions investigating if not having a companion, close friends, or not seeing people enough has bothered them in the last six months. Likert scale responses included most of the time = 1, occasionally = 2, some = 3, rarely = 4, and never = 5. The scores on the strong social tie support scale begins at 3, meaning the respondent has issues with all social connections most of the time and end at 15, which indicates no problems with social relationships.

Experiential Context

As mentioned earlier, two datasets from two different areas of the country were combined for this study. We are proposing a "place effect" on quality of life and life chances and choices; thus, a variable for place was created to assess this relationship. Place was constructed as a dichotomous variable with the Birmingham MSA labeled as zero and Northwest Arkansas as one (NWA = 1).

Length of time homeless provides the researchers with information concerning the issue of chronicity of our homeless sample. The U.S. Department of Housing and Urban Development (HUD) describes chronic homelessness as "an unaccompanied individual with a disability who has either been continuously homeless for one year or more or has experienced at least four

episodes of homelessness in the last three years" (HUD 2013). For the purpose of this study, we defined any individual that was continually homeless for less than one year as "non-chronic," and assigning them a zero to emulate a less severe case of homelessness (non-chronic = 0). Homeless individuals indicating that they were homeless for more than one year, but less than two years, were considered to be "sporadic" and assigned a one to indicate a moderately risky lifestyle (sporadic = 1). Homeless individuals indicating that they were homeless for two years or more were considered to be living an extremely risky lifestyle and were assigned a two to indicate chronicity (chronic = 2).

Research Design

The purpose of this study is to advance the research concerning quality of life of the homeless as it relates to life chances and choices by examining this relationship as it is conditioned by the length of time a person is homeless along with the place they live. In order to accomplish these goals, descriptive statistics, and correlations among the variables will be first examined. Additionally, three models of OLS regression will be utilized. The first model includes life chance variables of race, age, gender, education, and crime victim. Model two adds the life choice variables of mastery of fate and strong social ties. Finally, length of time homeless and place (experiential context) will be added in the third model to see if they further influence adverse quality of life after controlling for life chances and choices. Do context variables mediate the influence of chances and choices?

RESULTS

Descriptive Statistics

As seen in Table 1, the average adverse quality of life score was 6.17 on a scale ranging from 0 to 14. The average age of respondents is about 39 years of age with a standard deviation of 10.75 years. Only 35.6 percent of respondents were female; the racial composition of the sample was almost equal, with a slight majority (51%) non-white.

Table 1. Descriptive Statistics for Model Variables

	%	Mean	S.D.
Dependent Variable			
Adverse Quality of Life (0-14)	--	6.17	2.77
Demographics (Life Chances)			
Age	--	39.37	10.75
Sex (1=Female)	35.60%	--	--
Race (1=Nonwhite)	51.10%	--	--
Life Chance			
Life Events in Lifetime (0-12)	--	5.89	2.38
Education (1=High School +)	71.60%	--	--
Crime Victim Scale (0-3)	--	.481	.799
Life Choices			
Mastery of Fate Scale (0-21)	--	12.88	3.69
Social Ties Scale (3-15)	--	8.16	3.46
Experiential Context			
Chronicity (0-2)	--	.742	.838
Place (Birmingham = 0)	61.00%	--	--

Life chances also include experiences within a lifetime that influence their perception of life. Life events within the respondent's lifetime ranged from 0 to 12. The average life events for the homeless in Birmingham and Northwest Arkansas are 5.89 with the average distance of any

life events in lifetime score from the mean was 2.38. An overwhelming majority of respondents (71.6%) reported having a high school diploma or better. Very few respondents experienced being a victim of a crime with an average score of .481 on a scale ranging from one to three.

Life choice variables provide some insight to the positive or negative choices that respondents may experience on daily basis such as strong relationships with others or substance abuse problems. The mastery of fate scale ranges from 0 to 21 and describes the extent to which a respondent feels in control of their life and future. The average mastery of fate score was a 12.88 with a standard deviation of 3.69. Strong social ties variable refers to the strength of relationships to others, and our respondents reported an average score of 8.16 on a scale of 0 to 15. The average distance of any strong social tie score from the mean was 3.46.

The experiential context variables in this study include the length of time homeless, or chronicity status, and the place where respondents experienced homelessness, either Birmingham, Alabama or Northwest Arkansas. The chronicity variable ranges from 0 to 2 and has a reported mean of .742. A majority of respondents (61%) experienced homelessness in Birmingham while the remaining 39 percent were located in Northwest Arkansas.

Bivariate Relationships

Table 2 provides a correlation table that allows us to examine the direction, magnitude, and most importantly, statistical significance of each association between all the variables included in this model. These relationships provide the foundation for the research at hand and offer an important piece of the puzzle regarding the role that life chances and choices play for the homeless population.

Table 2. Correlations

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Adverse QoL										
2. Age	.038									
3. Sex	-.082	-.123*								
4. Race	-.009	-.053	-.001							
5. Life Events	.194**	-.034	-.030	-.118*						
6. Education	-.117*	.175**	-.075	-.038	.078					
7. Crime Victim	.192**	-.119*	-.012	.039	.123*	-.094				
8. Mastery of Fate	-.427**	-.106*	.087	-.006	.001	.154**	-.031			
9. Strong Social Ties	-.232**	.016	.039	.140*	-.210**	.051	-.091	.150**		
10. Chronicity	.181**	.194**	-.121*	.066	.062	-.043	-.030	-.093	.002	
11. Place	-.121*	-.225**	.054	.028	-.170**	-.064	-.025	.014	.087	-.246**

p< .05*; p < .01** (One-tail t-test)

As you can see in Table 2, adverse quality of life has an association with every variable except age, gender, and race. Adverse quality of life has a strong negative relationship to mastery of fate (-.427) and a moderate negative association with strong social ties (-.232). This means that the more in control of your life that you feel and the stronger your relationships are with others produces a lower score on the adverse quality of life scale. Other significant relationships to adverse quality of life include life events (.194), crime victim scale (.192), chronicity (.181), and place (-.121).

Multivariate Relationships

Table 3 provides the standardized and unstandardized coefficients calculated from the multiple regression analysis. The standardized coefficients compare relative strength and direction of the independent variables and the unstandardized coefficients, or b, describe the direction and magnitude of the effect. The regression consists of three models, the first containing the life chances variables of race, sex, age, education, crime witness, and life events in lifetime as the independent variables and adverse quality of life scale as the dependent variable.

This model allows us to evaluate any possible differences in adverse quality of life among the variables that make up the homeless population's life history. The overall model is significant at the $p < .001$ level. For this model, the life events in lifetime variable is significant, as well as education (-.133) and .167 for crime victim. This means that the more life events in a person's lifetime increase the adverse quality of life. In addition, persons with higher education (high school or more) were more likely to have a more positive quality of life while crime

victims had a higher adverse quality of life than those persons not reporting being victims of crime.

Table 3. Quality of Life OLS Models (N = 264)

Variables	Model 1 b (B)	Model 2 b (B)	Model 3 b (B)
Life Chances			
Age	.017 (.065)	.003 (.010)	-.004 (-.015)
Sex (1=Female)	-.393 (-.068)	-.168 (-.029)	-.098 (-.017)
Race (1=Non-White)	-.492 (-.089)	-.593 (-.107)	-.537 (-.097)
Life Events	.218 (.188)**	.181 (.156)**	.167 (.144)**
Education (1=H.S. Diploma or Better)	-.817 (-.133)*	-.328 (-.054)	-.263 (-.043)
Crime Victim	.578 (.167)**	.515 (.149)**	.525 (.152)**
Life Choices			
Mastery of Fate	--	-.291 (-.388)***	-.286 (-.381)***
Strong Social Ties	--	-.109 (-.136)*	-.111 (-.138)*
Experiential Context			
Chronicity	--	--	.428 (.130)*
Place	--	--	-.043 (-.008)
Constant	4.92***	9.98***	9.86***
df	6	8	10
R^2	.100***	.275***	.291***

$p \leq .05$*; $p < .01$**; $p < .001$*** (Hierarchical F-test R^2 Change)

The explained variation for the adverse quality of life model that only includes life chances was .100. This means that approximately 10 percent of the variation in a homeless individual's adverse quality of life was explained by their life chances.

In the second model, life choice variables were added to further explore the adverse quality of life outcome. This model was significant at the p <. 001 level and both mastery of fate and strong social ties were significant correlates of adverse quality of life. Mastery of fate was -.388 and strong social ties were -.136. These both were significant negative relationships; persons with a high mastery of fate had lower adverse quality of as was the case with persons with higher/greater social ties. Life events and crime victimization continued to have a significant positive relationship to adverse quality of life; education was no longer significant. We can see how the addition of positive life choices can change adverse quality of life scores. By looking at the unstandardized regression coefficient (b) we can see that homeless individuals with a better sense of mastery will experience an average decrease of .291 in adverse quality of life scores, and with strong social ties an average decrease of -.11. The R-squared value for adverse quality of life in the second model is .275, which is a .175 increase from model 1 and was statistically significant. This is a substantial increase and therefore, we can conclude that about 28 percent of the variation in adverse quality of life is explained by the combination of life chances and choices.

The third and final model introduces the experiential context variables-- time and place. Looking at adverse quality of life, we can see that stressful life events in lifetime, being a victim of a crime, mastery of fate, strong social ties and chronicity remain significant as they did in Model 2. Very little change in the size of the coefficients and/or their direction took place after we added the experiential context variables. The chronicity variable was significant and in the

expected direction. Thus, persons remaining homeless for longer periods of time experienced more adverse quality of life outcomes. Unlike what we predicted earlier, there were no significant differences between homeless living in Birmingham and Northwest Arkansas regarding quality of life outcomes. Nevertheless, the model is statistically significant as R2 increased to about 29 percent.

Conclusions

The findings from this study are similar to the previous research about quality of life and the homeless population. We found that the stressful life events homeless individual experience are significant correlates of adverse quality of life, as predicted earlier in our hypotheses. When life choice variables, such as mastery of fate and strong social ties are introduced into the model, they help to lower the negative influence of stressful life events' impact on adverse quality of life. We can infer that positive life choices, such as believing that you are in control of your own destiny, counterbalance previous negative life experiences that are reported by homeless respondents. Stressful life events are still important in all three models. This significance may be accounted for in the psychological impact that stressful life events have on homeless individuals. Homelessness itself can be considered a stressful life event and it has been shown to increase the likelihood of depression in individuals (LaGory, Ritchey, and Mullis 1990; Rossi 1990).

The hypothesis stating that less educated homeless individuals will experience higher levels of adverse quality of life was found to be true in model 1. However, education does not appear to be significant for any other models. We did find that race, gender, or age were not significant correlates in any of the models designed to assess adverse quality of life. We can conclude that in this study, ascribed statuses do not have an impact on quality of life and that

education is only significant predictor when life choice variables or experiential context variables were not included.

Falling victim to a crime was found to be a significant correlate of higher levels of adverse quality of life in all three models. Homeless individuals are at risk to be victims of crimes because of their lack of privacy in society and they are seen as outcasts. The National Coalition for the Homeless found that hate crimes against homeless individuals have significantly increased in the last few years (2014). If they are sleeping on the streets or at a shelter they are constantly in the public sphere, exposed to everyone and may be seen as an easy target because of their homeless condition.

In this study, we hypothesized that life choices would have an additional influence on adverse quality of life and we expected that these choices were lower the adverse quality of life scores. Both mastery of fate and strong social ties were significant correlates and as expected had lowering effects on adverse quality of life. We can conclude that in this particular study, these two variables helped to partially alleviate the negative impact on quality of life that the life choice variables produce, thus improving quality of life circumstances and adverse life quality. Fitzpatrick and colleagues (1999) confirm that strength of social ties and mastery of fate have often been predictors of happier lives for the homeless population.

The foundation of this study came from common curiosity that place and length of time homeless (experiential context) should have some role to play in understanding quality of life for the homeless population. We were expecting to find a place effect, but in fact place had no significant influence on adverse life quality. This could be apparent for several reasons; for example, Birmingham and Northwest Arkansas may be too similar or different in composition.

They are both in the Southern region of the United States, but Birmingham is considered a metropolitan area while Northwest Arkansas is rural which means there is a large difference in population. This finding in our study can infer that it doesn't necessarily matter where you are homeless because you experience similar things no matter where you are homeless. However, we did find that chronicity (time spent homeless) does significantly impact the adverse quality of life of homeless individuals. From this information we can conclude that the longer you remain homeless, the more likely you would report higher adverse quality of life scores. The chronically homeless circumstance has been shown to produce poor health physically and mentally, chronic stress, and other adverse outcomes (Weinberg 2005; National Alliance to End Homelessness 2014).

Discussion

This study provides additional insights into the impact that (experiential context) place and time have on adverse quality of life for the homeless population. With three significant, and progressively stronger predictive regression models, we conclude that the life chance and life choice variables are relatively good predictors of adverse quality of life for this population. Our findings support the notion that life choices have a stronger influence on quality of life than life chances, which is slightly different than Weber's theory of life chances and choices stating which proposed that life chances shape our circumstances more so than choices (Weber 1922). This discovery lends new opportunities for researchers to further examine and try to understand more about quality of life among this at-risk population.

This research offers new insight regarding the influence of life chances and choices on subjective quality of life for the homeless. Our findings allude to the importance of how

homeless individuals view their life at the time of the interview. Those that report being connected to others and feel in control of their life report better life quality, even if they have a troubled past. The importance of the here and the now for the homeless population introduces the idea that that everyday life choices are the main factor contributing to their current state of wellbeing. Even though we were unable to find that place matters when looking at quality of life, future research should consider the importance of life chances and the location of the homeless population at hand. Understanding daily life choices and the environmental impact of those choices would provide new insight to the homeless condition in our society.

Homelessness has long been deemed a social issue rooted by personal problems of substance abuse, depression, poor physical health, and many other debilitating circumstances. We predicted that the homeless experience would vary by place, but it did not. This may be based on the two locations we observed being too similar, or it could mean that we are not understanding how the homeless survive. It could have nothing to do with environmental forces. As mentioned before, Snow and Anderson believe that "what these similarly situated individuals have in common is not a strong and recognizable set of values, but a shared fate and the determination to make do as well as they can" (1993:39). It could be that the homeless experience is not very unique, or that it is dependent on societal influences. Either way, it calls for more investigation on environmental factors and the homeless circumstance.

Limitations and Future Research

The limitations to this study are grounded in the data collection methods that were used for this research. Using secondary data always provides potential issues. For example, the two secondary datasets used were created from the same survey, but were not coded, labeled, or

entered in a similar manner. Many variables had completely different codes and had to be reworked to make the two datasets as cohesive as possible. This disadvantage allows for many hidden mistakes in the coding and merging of the two datasets that may have not been detectable.

The data used for this study is also slightly outdated and provides a story of the homeless populations in Northwest Arkansas and Birmingham from several years ago. The economic recession was not very prevalent at the time that the surveys were admitted which means that the type of individuals experiencing homelessness may have changed since then. This change in the economic structure of society forced many people into poverty and homelessness and has the potential to reshape the way we view and study homelessness in the future.

Another issue with secondary data is that you do not get to choose what questions are asked of the respondents. In the datasets there was little information on the environmental influences of the communities that homeless individuals were occupying. We were unable to find a significant influence of place in this research and it may be because we did not look at the community impact on the homeless population in the survey. Future research on the influence of place for homeless individuals might want to include data on the differing service providers, services available, employment opportunities, weather patterns, public opinions on homeless individuals and other environmental factors that could provide a significant influence of place.

Finally, there are several policy implications that arose from the study at hand. Our results report that positive life choices mediate the effect of most life chances, which means that current outlook on life, can have a very strong effect on well-being and life quality. Homeless individuals that experience many stressful life events or have fallen victim to a crime are more

likely to have a lower adverse quality of life score. However, we did find that higher levels of mastery of fate and strong social ties diminish the negative effect of being a victim or stressful life events. Policies that would address this issue would be very beneficial to homeless individuals. If communities were able to reduce victimization of the homeless and current stressful life events by providing counselling and protection for this population, then the homeless population would yield better quality of life scores.

Community involvement aimed at improving the well-being of the homeless might also increase the ties that homeless individuals have to the community and also increase their sense of control over their life. Policies offering more services that cater to these specific needs for this population would greatly impact life satisfaction and quality as well such as more shelters, permanent supportive housing, and counseling. Increasing community knowledge and involvement in understanding and aiding at-risk populations will remove the long standing stigma associated with being homeless and provide the first step to quality of life for this population.

REFERENCES

Athiyaman, A. (2008). Managing quality of life in communities: theory and applications. *Journal of Organizational Culture, Communications and Conflict, 12(2*), pp. 21-38.

Baron, S. W., Forde, D. R., & Kay, F. M. (2007). Self-control, risky lifestyles, and situation: The role of opportunity and context in the general theory. *Journal of Criminal Justice, 35(2),* pp. 119-136.

Biswas-Diener, R., & Diener, E. (2006). The subjective well-being of the homeless, and lessons for happiness. *Social Indicators Research, 76(2),* pp. 185-205.

Bognar, G. (2005). The concept of quality of life. *Social Theory and Practice, 31(4),* pp. 561-580.

Center for Disease Control (CDC). (2010). Vital signs: binge drinking prevalence, frequency, and intensity among adults—U.S., 2010. *MMWR Morb Mortal Wkly Rep 2012; 61(1),* pp. 14 –19.

Cockerham, W. C., Rütten, A., & Abel, T. (1997). Conceptualizing contemporary health lifestyles. *Sociological Quarterly, 38(2),* pp. 321-342.

Drake, R. E., Brunette, M. F., & Mueser, K.T. (1998). Substance use disorders and social functioning in schizophrenia. In K.t. Mueser and N. Tarrier (Eds.), *Handbook of Social Functioning* pp. 280-289. Boston: Allyn & Bacon.

Evans, T. D., Cullen, F. T., Burton, V. S., Dunaway, R. G., & Benson, M. L. (1997). The social consequences of self-control: Testing the general theory of crime. *Criminology, 35(3),* pp. 475-504.

Eyrich, K. M., Pollio, D. E., & North, C. S. (2003). An exploration of alienation and replacement theories of social support in homelessness. *Social Work Research, 27,* pp. 222–231.

Fassio, O., Rollero, C., & De Piccoli, N. (2013). Health, quality of life and population density: A preliminary study on "contextualized" quality of life. Social Indicators Research, 110(2), pp. 479-488.

Fitzpatrick, K., LaGory, M., & Ritchey, F. (1999). Dangerous places: exposure to violence and its mental health consequences for the homeless. *The American Journal Of Orthopsychiatry, 69(4),* pp. 438-447.

Fitzpatrick, K. M., & LaGory, M. (2000). *Unhealthy places: The Ecology of Risk in the Urban Landscape.* New York: Routledge.

Fitzpatrick, K.M., Myrstol, B.A., & Miller, E. (2014). Does context matter? Examining the mental health of homeless people. *Community Mental Health Journal, June 2014.*

Fitzpatrick, K., LaGory, M., & Ritchey, F. (2003). Factors associated with health-compromising behavior among the homeless. *Journal Of Health Care For The Poor And Underserved, 14(1),* pp. 70-86.

Fitzpatrick, K. M. and Mark LaGory. (2011). *Unhealthy Cities: Poverty, Race, and Place in America.* New York, NY. Routledge.

Fitzpatrick, K. M., & Myrstol, B. (2011). The jailing of America's homeless: Evaluating the rabble management thesis. *Crime & Delinquency, 57(2),* pp. 271-297.

Gattino, S., De Piccoli, N., Fassio, O., & Rollero, C. (2013). Quality of life and sense of community: A study on health and place of residence. *Journal of Community Psychology, 41(7),* pp. 811.

Hawkins, R. L., & Abrams, C. (2007). Disappearing acts: The social networks of formerly homeless individuals with co-occurring disorders. *Social Science & Medicine, 65(10),* pp. 2031-2042.

Hawthorne, G., Herman, H., & Murphy, B. (2006). Interpreting the WHOQOL-Brief: Preliminary population norms and effect sizes. *Social Indicators Research, 77,* pp. 37-59.

Hubley, A. M., Russell, L. B., Palepu, A., & Hwang, S. W. (2014). Subjective quality of life among individuals who are homeless: A review of current knowledge. *Social Indicators Research, 115(1),* pp. 509-524.

Hwang, S. (2001). Homelessness and health. *Canadian Medical Association Journal. 164,* pp. 229-33.

LaGory, M., Fitzpatrick, K., & Ritchey, F. (2001). Life chances and choices: Assessing quality of life among the homeless. *The Sociological Quarterly, 42(4),* pp. 633-651.

LaGory, M., Ritchey, F. J., & Fitzpatrick, K. (1991). Homelessness and affiliation. *The Sociological Quarterly, 32(2),* pp. 201-218.

LaGory, M., Ritchey, F., & Mullis, J. (1990). Depression among the homeless. *Journal Of Health And Social Behavior, 31(1),* pp. 87-102.

Lin, N., Dean, A., & Ensel, W. eds. (1986). *Social Support, Life Events, and Depression*. New York: Academic Press.

Lindsey, E. W., Kurtz, D., Jarvis, S., Williams, N.R., & Nackerud, L. (2000). How runaway and homeless youth navigate troubled waters: Personal strengths and resources. *Child and Adolescent Social Work Journal, 17(2),* pp. 115-140.

Maram, A. (2009). The St. Louis 10-year plan to end chronic homelessness: Analyzing the policy from a social capital perspective. *Poverty and Public Policy, 1(1).*

National Alliance to End Homelessness. (2014). Issues: Chronic homelessness.

National Coalition of the Homeless (2014). Vulnerable to hate: Survey of hate crimes and violence committed against the homeless in 2013.

Pearlin, L.A., & Schooler, C. (1978). The structure of coping. *Journal of Health and Social Behavior, 19,* pp. 2-21.

Perese, E. F., & Wolf, M. (2005). Combating loneliness among persons with severe mental illness: Social network interventions' characteristics, effectiveness, and applicability. *Issues in Mental Health Nursing, 26,* pp. 591-609.

Perron, B. E., Alexander-Eitzman, B., Gillespie, D. F., & Pollio, D. (2008). Modeling the mental health effects of victimization among homeless persons. *Social Science & Medicine, 67(9),* pp. 1475-1479.

Radloff, L. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement 1*, pp. 385-401.

Ritchey, F., LaGory, M., Fitzpatrick, K., & Mullis, J. (1990). A comparison of homeless, community-wide, and selected distressed samples on the CES-Depression scale. *American Journal Of Public Health, 80(11),* pp. 1384-1386.

Rossi, P. H. (1990). The old homeless and the new homelessness in historical perspective. *American Psychologist, 45(8),* pp. 954-959.

Sikich, K. (2008). Global female homelessness: A multi-faceted problem. *Gender Issues, 25(3),* pp. 147-156.

Snow, D.A. & Anderson, L. (1993). *Down on Their Luck: A Study of Homeless Street People.* University of California Press.

Toro, P.A. & Warren, M.G. (1991). Homeless, psychology, and public policy. *American Psychologist, 46(11),* pp.120-5.

Trumbetta, S. L., Mueser, K. T., Quimby, E., Bebout, R., & Teague, G. B. (1999). Social networks and clinical outcomes of dually diagnosed homeless persons. *Behavior Therapy, 30(3),* pp. 407-430.

U.S. Department of Housing and Urban Development (HUD). (2013). The 2013 annual homeless assessment report (AHAR) to congress. Part one: Point-in-time estimates of homelessness. Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Community Planning and Development.

Weber, M. (1922) *Wirtschuft und Gesellschaft (Economy and Society).* Tubingen. Germany: Mohr.

Weinberg, D. (2005). *Of Others Inside: Insanity, Addiction, and Belonging in America.* Philadelphia, PA: Temple University Press.

World Health Organization. (2000). Quality of Life. Journal of Clinical Epidemiology. 53(1) pp. 13-17.

The WHOQOL Group. (1995). The World Health Organization quality of life assessment (WHOQOL): Position paper from the World Health Organization. Social Science and Medicine, 41(10) pp. 1403-1409.

Zugazaga, C. (2004). Stressful life event experiences of homeless adults: A comparison of single men, single women, and women with children. *Journal of Community Psychology, 32*(6), pp. 643-654.