Homelessness: A qualitative genogram analysis of trauma and addictions

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HOMELESSNESS: A QUALITATIVE GENOGRAM

ANALYSIS OF TRAUMA AND ADDICTIONS

by

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Bachelor of Science, Psychology
University of Central Florida
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A thesis submitted in partial fulfillment of the requirements for the

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ABSTRACT

Homelessness: A Qualitative Genogram Analysis of Trauma and Addictions

By

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Dr. Patricia A. Markos, Examination Committee Chair
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This study conducts a qualitative analysis of genograms based from a homeless population sample. The purpose of the study is to illustrate a pattern within the homeless population of a generational history of the conditions of traumatic experiences and addictions during childhood and young adulthood, prior to becoming homeless. This study is not intended to show causal relationships between the two conditions of homelessness, rather, a prior pattern of the two conditions.

The data was collected by graduate students at the University of Nevada, Las Vegas, during the student’s advanced practicum/internship classes occurring in the final year of the master program.

The data reported show a consistent and extensive history of the two conditions of trauma and addictions prior to becoming homeless, which includes the client’s previous three generations. The significant condition is addictions, however, the condition of trauma is also extensive, particularly as reported by the female participants.
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CHAPTER 1

INTRODUCTION

Homelessness has become a significant problem around the United States over the past several decades. Las Vegas, Nevada is no different from the remaining cities and states in this regard. Having had experience providing individual counseling services, as well as being employed in a helping capacity with the homeless over the past two years, the issues facing this population in regard to trauma and addictions had become evident. Also evident, was the information being reported by homeless clients pertaining to their family background and history relevant to the two conditions of trauma and addictions.

Through studying the past and present literature related to the homeless population and the conditions of trauma and addictions, it also became apparent that the literature was lacking. Particularly, the literature relating to the generational patterns of the two conditions and how those generational patterns may be related to current individuals who are facing homelessness.

Purpose

The purpose of this thesis was to focus on two of the conditions associated with homelessness: trauma and addictions, and to illustrate the generational patterns of how trauma and addictions can affect an individual becoming homeless.
Although the conditions are listed separately, both trauma and addictions can be associated with homelessness independent of each other, or in combination; both conditions may be the cause of or the result of homelessness; in other words, bi-directional. In some instances, trauma and/or addictions are neither the cause of, nor the consequence of homelessness, but rather conditions that were aggravated by loss of housing (McCarty, Argeriou, Huebner, & Lubran, 1991). McCarty et al. (1991) state that clearly, addictions, trauma, and homelessness are most likely interrelated – complicating and exacerbating each other.

Being homeless and having an addiction has been the focus of numerous research studies over the past three to four decades (McCarty, et al., 1991). Most of the past studies have indicated a causal relationship with the homeless population (particularly combat veterans and the mentally ill) and addictions. However, it is only recently that research has began to study other segments of the homeless population, such as women, children, the elderly, and families, and how they may be affected by addictions to alcohol and other drugs (Bastiaens & Kendrick, 2002; Dansky, Saladin, Coffey, & Brady, 1997; Galaif, Nyamathi, & Stein, 1999; Markos & Smith, n.d.; McCarty et al., 1991; North, Thompson, Smith, & Kyburz, 1996; Salomon, Bassuk, & Huntington, 2002; Young & Boyd, 2000).

On the other hand, those individuals who have experienced trauma as well as being homeless have not been researched extensively (Clements & Sawhney, 2000; Davis & Kutter, 1998; Martin, 1991; Morse, 2000; Schweidson, 1998;). Recent studies pertaining to the homeless population and trauma has been limited to combat veterans almost exclusively until the 1980s (Davis & Kutter, 1998). Again, the premise was that
the trauma suffered through combat caused men to become homeless due to suffering from severe symptoms of post-traumatic stress disorder (PTSD), such as re-experiencing and hyperarousal. This may then lead to addictions as a means to self-medicate the symptoms since alcohol acts as a nervous system depressant that allows the individual to avoid negative feelings, which ultimately would lead to becoming homeless (Davis & Kutter, 1998; McLeod, Koenen, Meyer, Lyons, Eisen, True, & Goldberg, 2001; Savarese, Suvak, King, & King, 2001; Steindl, Young, Creamer, & Crompton, 2003).

In reality, though, several other types of trauma currently are associated with the homeless population (Davis & Kutter, 1998). The types of trauma the homeless population may have experienced, can include domestic violence, physical or sexual assault, loss of a home through fire or a natural disaster, significant deaths to loved-ones, physical or mental disabilities, physical, sexual, or mental abuse, and generational patterns of homelessness, to name a few (Davis & Kutter, 1998).

Currently, and as has been in the past, a segment of the homeless population were combat veterans, and were addicts, and were mentally ill prior to becoming homeless; however, the current homeless population is changing demographically – and changing rapidly (Benda & Schroepfer, 1995). It is becoming more and more difficult for many members of society with limited educational attainment, with limited ability to cope with present-day life’s stress as well as early-life traumatic experiences, with limited ability to afford housing and utilities and health insurance and food, to function and to be a valued and accepted member of society (Benda & Schroepfer, 1995).

During the past decade researchers have recognized the severity of the homeless problem in the United States as a result of the substantial increase in the number of people who have become homeless (Baumohl, 1992). The reasons individuals become
homeless have changed, as well as the type of individual who may become homeless
during his or her lifetime. The definition of the homeless population has also changed
significantly.

Presently, the concern of becoming homeless is not discriminating – people of all
races, socioeconomic backgrounds, employment history’s, mental and emotional
history’s, religions, ages, and genders can become homeless. Some of us fear that we,
too, may find ourselves homeless (Martin, 1991). And some of us have developed our
own form of numbing by trying to distance ourselves, by pretending not to see, not to
hear, not to know the misery of others; and by doing so, we are closing off a part of our
common humanity (Martin, 1991).

As a graduate student providing individual counseling services to people who are
homeless over the past two years, my experience tells me that a number of homeless
people have experienced trauma and/or addictions prior to becoming homeless.
Furthermore, a significant amount of the traumatic experiences and addictions, based on
client self-reports, usually occurred during the client’s childhood, adolescence, and late
adolescent or early adulthood periods of life, several years prior to experiencing
homelessness. This is important since it reveals the inability of some individual’s to cope
emotionally or mentally with their prior experiences, which in turn, may lead to
unacceptable behaviors that translate into the ineptness to function successfully within
society. Some of these individuals may cope through the use of alcohol and/or drugs;
others may cope by internalizing their feelings of despair or lack of hope; both conditions
may increase these individual’s chances of becoming homeless later on in life (Labouvie
& Bates, 2002).
The data collected for the purpose of this qualitative analysis of the homeless population and the conditions of trauma and addictions is important because it will illustrate, (1) that a vast majority of the present homeless population have experienced trauma and addictions on a personal level or through a family history, prior to becoming homeless; (2) the necessity for the counseling, psychology, and social work communities to direct future research into developing the mechanisms for this population to understand who, what, and why they are in the vulnerable position they are in and be taught the necessary skills needed in order to change their situation; (3) the need for society to recognize the importance of correcting the causes of homelessness through local, state, and federal governments in order to help the present homeless population to attain the skills needed to succeed financially and to attain the ability, as well as the aptitude, to survive in today's culture in an acceptable manner; and (4) the augmentation to the existing body of knowledge gained in this area via the exploration of data through the analysis of genograms, since the analysis of genograms provides a vast amount of data not only pertaining the client, but to the generational patterns which influence the client's environment throughout life.

The Study of Homelessness

The study of homelessness began during the late 19th and early 20th centuries (McCarty et al., 1991). Prior to the 1980s, the last vast rise of homelessness occurred during the 1930s, when the country was in the middle of the Great Depression (Elder, Hogue, Shipley Jr., & Shandler, 1994). During this time investigators who studied the homeless populations observed elderly White men in soup lines and shelters (McCarty et al., 1991).
Over time, the description of people who are homeless has significantly changed. The present-day homeless are more heterogeneous; they are no longer limited to older White men (McCarty et al., 1991). By now, we are all aware of the nomadic homeless—the bag lady, the disheveled individuals scavenging in garbage cans, those who are mentally ill, those who are addicts, the shapeless forms in doorways with possessions in dirty bags or shopping carts, the individuals standing on a street corner holding up a sign to find work, dislocated women and/or men and their children, runaway children, and the growing number of beggars, to name a few (Martin, 1991).

The past, as well as the current estimates of the number of the homeless population differ slightly depending on the source. However, regardless of the source, all the estimates are staggering. The overwhelming number of homeless individuals corroborates the magnitude of the problem homelessness has become for our society. It has been difficult to accurately count the homeless population because estimates vary so widely, as do the definitions of homelessness, as just stated and which will be expounded upon later in this chapter (Martin, 1991). Depression-era estimates of the number of homeless people ranged from 200,000 to 1.5 million (Elder et al., 1994). Over a decade ago Martin (1991) stated that according to a Congressional Report in 1985, surveys had produced figures ranging from 250,000 to 3 or 4 million people who were homeless, with families at that time constituting the fastest growing group among the homeless in the United States at that time, accounting for over 30%. There were roughly 500,000 to 750,000 homeless children of school age, of whom 57% did not attend school regularly.

By 1994, Link and his colleagues reported the results of a landmark research project that found 13.5 million (7.4% of the United States population) had been homeless at some point in their lives (Morse, 2000). Also disturbing was the information from this
study that homelessness disproportionately affects poor and disabled persons, especially those with mental disorders. As recently as 2-3 years ago, Reese (2000) reported that between 600,000 and 700,000 Americans were homeless on any given night. If we extend the definition of homelessness to include those people doubled up with family and friends, these figures would grow dramatically (Baumohl, 1992).

As these statistics confirm, the enormous jump in the number of the homeless population during a six-year period, from 3 or 4 million in 1985, to more than 13 million in 1991, indicates the issue of homelessness within this country as grown significantly. Because of this surge in the number of homeless individuals, the importance of this study becomes evident. Evident, specifically, is the importance of the need for preventative steps for those individuals at risk for becoming homeless.

Compared to the homeless population studied in the 1950s and 1960s, the new homeless of the 1980s and beyond are not only more numerous, but they are also more visible (Martin, 1991). The new homeless are not limited to the bad side of town; they are sleeping in our neighborhoods, in public places, under bridges, over heat venting grates on sidewalks, in parks, under bridges, in makeshifts, and they also set up large makeshift camps for protection (Baumohl, 1992; Markos, Baron, Allen, n.d.; McCarty et al., 1991; & Morse, 2000). The definition of the present day homeless consists of people of all races, genders, marital status, employment status, medical issues, and mental health issues (Alexander, 1996; Markos, Baron, et al., n.d.; Morse, 2000). There are men, women, and children sleeping in shelters or on the streets in almost every city within the United States. While many experience situational hardships and are healthy people, others experience mental illness, physical disabilities, or mental incapacities (Alexander, 1996; Dodgen & Shea, 2000; Markos, Baron, et al., n.d.). In regard to homeless women,
today, most are mothers, under 35 years of age, are members of a minority group, most likely have not completed high school, and have usually experienced more than one episode of homelessness during their lifetime (Elder, et al., 1994).

According to Strawser, Markos, Yamaguchi, and Higgins (2000), homelessness was also defined for the purposes of the Stewart B. McKinney Homeless Assistance Act of 1987. The McKinney Act defines homeless individuals as those who lack a regular or permanent residence, and who sleep in supervised shelters that are either public or private, temporary institutional settings, and/or public or private places that are not typically viewed as residential accommodations for humans. Therefore, the definition of homelessness encompasses a broader range of individuals, such as those who may be both employed and unemployed, part-time workers, seasonal workers, etc. based on the circumstances in which they may be living (Strawser, Markos, Yamaguchi, & Higgins, 2000).

As provided with the numerous definitions of homelessness, there are many conditions that may be associated with becoming homeless. However, for the purpose of this study, the two conditions of importance to be analyzed are the conditions of trauma and addictions.

Homelessness as it relates to trauma and addictions, which will be discussed directly, has overlapping similarities. In some cases, when discussing the topics, it has been difficult to separate the two. Therefore, there are occasions when the topics are interspersed within each other. The reason for this is based on the bi-directional relationship when considering homelessness as it relates to the two conditions of trauma and addictions.
Homelessness as it Relates to Trauma

In regard to trauma, studies of homeless women reveal high lifetime rates of childhood physical and sexual abuse and of assault by intimate male partners (Browne, 1993). As a group, minority women and women living in poverty are at especially high risk for victimization by violence. Browne uses the term “violence” to connote physical assaults – including sexual aggression – with the potential to cause physical harm, as well as implicit or explicit threats to kill. In previous studies many homeless women reported histories of childhood and adult violence. Even when compared to poor housed single women or mothers or with housed African American women in urban populations – groups in which victimization rates are known to be high – homeless women reported childhood physical or sexual abuse, rape, or physical assault more frequently.

In referring to traumatic events the homeless populations may have experienced, one can also refer to those incidents that constitute a psychic trauma (a natural disaster or house fire) which frequently result in an acute or chronic stress disorder (Martin, 1991). The victims of a traumatic event such as those just stated, share many of the emotional experiences associated with a stress disorder: confusion, despair, and acute uncertainty about the future. In addition to the initial shock and actual or potential life-threatening events, sudden uprooting often follows, with the loss of home and possessions, loss of personal security, identity, community, and disturbance of the normal flow and routines of life. More than likely, the family or individual may be thrown into a temporary shelter, which can also be a violent environment (Markos, Baron, et al., n.d.; Martin, 1991).

Despite the fact that homelessness has become all too commonplace within modern society, the issues of loss and recovery among people who have been homeless,
or who are homeless...are poorly understood (Morse, 2000). Being homeless in and of itself is a traumatic experience. Becoming homeless includes material loss, the most obvious being the house itself, which represents shelter and protection. Other material losses could include the loss of pets, furniture, and personal and sentimental belongings.

Becoming homeless includes social and psychological losses, which can also be associated with trauma (Morse, 2000). For many a home is the primary location for companionship and family gatherings, social support; a home promotes a sense of social connectedness and belonging. Becoming homeless can create considerable disorder in these areas. Psychological losses can also be profound. Losing one’s home is an emotionally traumatic experience that often precipitates fear, anxiety, and insecurity, as well as feelings of anger, bitterness, mistrust, and alienation. As homelessness persists, the losses of hope and meaning, loss of identity, and loss of a sense of control undoubtedly explain in part the staggering finding from a large study that more than one in five homeless people had thought about suicide in the past seven days (Morse, 2000).

Morse (2000) found that individuals who are homeless are far more likely to have experienced a loss of family or home environment (such as being placed in foster care or an institutional setting) as a child. Qualitative and case study reports also suggest that homeless people have frequently suffered the losses of premature death of parents or siblings or other significant relationships. Individuals who have been homeless are also more likely than the general public or a psychiatric population to have experienced other stressful or traumatic events in the year immediately prior to becoming homeless.

Unfortunately, little attention has been focused on the trauma caused by the severe losses the homeless have suffered (Morse, 2000). Morse continues that service providers tend to focus their assessments and interventions on the most obvious needs
such as housing, income, medication, and psychosocial services. Even though the fundamental nature of these needs are important, it is ironic that people who are homeless and have experienced these losses receive very few inquires or services for these issues that have been the cause of such significant trauma. It is rare that a shelter worker or even a mental health service provider will ask about particular losses that may have occurred, or about the individual’s own emotional and cognitive understanding of the loss. In this way, the common social service response may further bolster the experience of being overlooked and forgotten, inadvertently contributing to the developing sense of alienation and depersonalization (Morse, 2000).

Homelessness as Relates to Addictions

The prevalence of alcoholism and drug use among the homeless varies, depending on the sample and the definitions of homelessness, alcoholism, and drug abuse; the setting; and the methods and assessment tools used (Elder et al., 1994; McCarty et al., 1991). However, the consensus is that homeless people experience advanced levels of substance abuse and mental illness when compared to the general population (Dodgen & Shea, 2000). Additionally, “homeless women have lower rates of substance abuse than homeless men, while minority groups, the unemployed, and the impoverished are over represented in this population” (p. 155) (Dodgen & Shea, 2000).

The relationship between abuse of alcohol and drugs and homelessness can also be considered bi-directional (McCarty et al., 1991). Although, alcohol and drug abuse can increase the risk of homelessness, displacement and loss of shelter can also increase the use and abuse of alcohol and other drugs. There has been a significant amount of data concerning the homeless populations with current addictions. However, the magnitude of
those homeless individuals developing addictions prior to becoming homeless (with the exception of combat veterans) has not been extensively studied (Elder, et al., 1994; McCarty et al., 1991).

McCarty et al. (1991) and Elder et al. (1994) found that the prevalence of alcohol-related problems ranged from 2% to 70% and 1% to 70% respectively. The rates of apparent alcohol and drug use tended to be highest in samples drawn from shelters, streets, and clinics. Among the homeless, men were more likely to report alcohol- and drug-related problems, whereas higher rates of mental illness were reported among women. Age, sex, and race are among the strongest variables associated with alcohol and drug abuse among the homeless. Also, Ethnic backgrounds also influence the prevalence of alcohol- and drug-related problems. McCarty et al. (1991) go on to state that the homeless who abuse either drugs or alcohol are generally in the worst possible [medical] shape, more estranged, less intact, and with the poorest prospects for the future.

It has been determined, generally speaking, that homeless men are more likely to use alcohol than homeless women (Elder et al., 1994). However, when it comes to the use of illicit drugs, there appear to be no significant difference across genders. Furthermore, as stated by Elder et al. (1994) Fischer and Breakey reported that illicit drug users are more likely to abuse alcohol in addition to the drug use, whereas alcohol users are less likely to abuse drugs in addition to alcohol use. McCarty et al. (1991) also found a negative relationship between age and nonalcoholic drug use; the younger the homeless person, the less likely he or she is to use alcohol exclusively as opposed to other illicit drugs.

The condition of homelessness itself is to be considered a health risk (Elder et al., 1994). However, when substance use is added to the risk, the consequences are even
more disconcerting. In regard to medical concerns, homeless people who abuse alcohol or drugs are up to twice as likely as non-abusing homeless people to have problems such as liver disease, seizure disorder, pulmonary and arterial disease, and nutritional deficiencies. The most common medical problem faced by the homeless population who also abuse substances, is hypertension. However, homeless persons are also at a higher risk for such problems as influenza, colds, bronchitis, and tuberculosis.

Homeless substance abusers have also been homeless for longer periods of time then non-abusing homeless (Elder et al., 1994). Elder et al. (1994) continue that the homeless substance abuser is more likely to have arrest histories, are victimized more often then non-users, and are more likely to be using more dangerous substances, such as cocaine, crack, and heroin, and that they are more likely to acquire income from illegal activities compared to other homeless individuals. The data collected for use in this thesis is similar to these findings.

Information regarding homeless women who abuse substances is even more disturbing. Homeless women face the additional problems of suffering from more recent and acute illnesses as compared to homeless men; women have more chronic health problems (Elder, et al., 1994). Because of the high levels of intravenous drug use and prostitution among homeless women, they are subject to various sexually transmitted diseases as well. Women are also at higher risk, in terms of alcoholism, because the illness occurs more rapidly than with men, and women also begin drinking at a later age then men do (Dodgen & Shea, 2000; Jacobson, 1987; Elder, et al., 1994). In regard to violence and abuse, homeless women who abuse substances are at much higher risk then housed women to have experienced abuse (both physical and sexual), or other traumatic events as children. For instance, 22-66% of homeless women have been battered, 31-
33% have been sexually molested as children, and over 40% have been or are currently being physically abused. Again, the data collected for use in this thesis is similar in context to these findings.

Genograms: Use and Methodology for this Study

A genogram, also known as a visual family tree, is a clinical tool used for acquiring, storing, and processing data about a family (Papadopoulos, Bor, & Stanion, 1997). The data gathered is displayed graphically in the form of a chart or can be displayed as a table, and provides a visual aid in order to decipher the often, complex patterns of relationships that exist within families. The data that is often collected through the use of a genogram includes medical, behavioral, genetic, cultural, and social histories of a family system (DeMaria et al., 1999; Papadopoulos et al., 1997).

Genograms help to reveal patterns and events, which may have recurrent substantial consequences within the family system. Papadoulos et al., (1997) state that the act of constructing a family genogram with a client or family, which maps relationships and functioning patterns, acts in a similar way as language does to organize and arrange thought processes. To this end, genograms can be conceptualized as both a therapeutic intervention and a part of the counseling process.

Much of the past data concerning homelessness as relates to trauma and addictions have been quantitatively based empirical studies. For the purpose of this study the data will be qualitatively analyzed from genograms. Master of Science graduate students constructed the genograms during their advanced practicum or internship at the University of Nevada, Las Vegas (UNLV) Department of Counseling. The graduate students in the UNLV program were attending one of two tracks: community counseling or marriage and family therapy.
The genograms were obtained at a local homeless advocacy organization. The homeless organization did not provide substance abuse rehabilitation or domestic violence advocacy services. The UNLV students offered individual counseling services within the shelter itself to the residents, as well as local community walk-in clients at the crisis intervention center. Those clients who were walk-in's were all homeless; however, some were living on the street, some were living in other homeless shelters or domestic violence shelters, some resided at local motels or rooming houses, and others were living with friends and family members.

The genograms were not constructed for the purpose of this analysis; they were constructed as part of the requirements for an advanced practicum or internship class. Therefore, the information gained from the sample is indiscriminate since the graduate students were not focusing on only trauma and addictions associated with their clients (as stated earlier) and all of the clients were not living in the homeless advocacy organization or in domestic violence shelters in the local community. Also, the data accumulated within the genograms were not limited to the information used for this study. For instance, the emotional features of family life, themes of culture, romantic love, anger, and attachment and sexuality, are all included in the genograms, but were not utilized for this study.

The total number of genograms selected for use in this analysis was 55. There were 32 female and 23 male genograms in the final selection. The ages of the clients varied from 15 – 62.

The data compiled from the genogram analysis is expected to show a pattern between experiencing homelessness and having experienced the conditions of trauma and addictions. More specifically, those individuals experiencing homelessness have also...
experienced trauma (such as post-traumatic stress disorder; PTSD) and/or addictions at some time during their life prior to becoming homeless. Even though there are numerous reasons an individual may become homeless, as was discussed earlier, the focus of this study will be directed at the conditions of trauma and addictions.

Qualitative vs. Quantitative Research

When deciding to undertake this study, a qualitative research method was chosen over a quantitative method. The reasons for this decision were based on the chosen methodology of collecting the data and the expected results of the study, which will be discussed directly.

First, there were no assessment inventories (self-reported or administered clinically) used in this study. Second, since genograms were being used as the source of the data to be collected, which had to be subjectively interpreted, and since the end result is to show patterns of homelessness and the prior conditions of trauma and addictions simply by the number of the incidents of trauma and addictions reported by each client, there was no need to complete statistical analysis of the data. Therefore, it appeared prudent to conduct a qualitative analysis rather than a quantitative analysis.

The method of qualitative research utilized for this study is a modified use of ethnographic research methodology as illustrated by Spradley (1980) in *Participant Observation*. However, not all of the tools and constructs normally associated with an ethnographic analysis, as indicated by Spradley (1980) were utilized for this study, which will be discussed later.

The data were initially collected by gender and incorporated into a database according to domains (e.g., a core category of data). The data from each genogram were interpreted for the incidences or occurrences as determined by the ethnographic domains
and then by the taxonomies, or sub-categories within each domain. The data were then further broken down into smaller, more specific tables of data in order to compare the demographic data and to allow the data to become more easily comprehensible.

Selecting a process of analysis using a modified ethnographic methodology stems from the central aim of ethnographic research as defined by Spradley (1980). “The central aim of ethnography is to understand another way of life from the native point of view. [Ethnography]...involves the disciplined study of what the world is like to people who have learned to see, hear, speak, think, and act in ways that are different. Rather then studying people, ethnography means learning from people” (p. 3).

This study is a means to understand the culture of the homeless population from the vantage point of the reasons one may become homeless; focusing on the two conditions of trauma and addictions, and how experiencing these conditions during life may enhance certain individuals chances to become homeless. As previously mentioned, there are numerous reasons an individual may become homeless; however, the focus of this analysis are the conditions of trauma and addictions experienced prior to becoming homeless.
CHAPTER 2

LITERATURE REVIEW

While collecting literature relating to the homeless population and the two conditions of trauma and addictions, the difficulty of separating the two conditions as they relate to homeless individuals became apparent. Past literature combines, for the most part, both trauma and addictions when discussing the relationship to homelessness. Therefore, throughout this chapter, the two conditions of trauma and addictions are interspersed within each condition’s literature review.

Homelessness and Trauma

A significant amount of research has been conducted on the topic of homeless women and trauma over the past several decades. Along with reviewing a segment of that literature in this section, data pertaining to homeless men and trauma will also be reviewed. The amount of data pertaining to homeless men and trauma, as well as the data pertaining to the homeless population in general and trauma, is much more limited than for homeless women and trauma.

Women who are homeless have become a quickly escalating dilemma in the United States over the past decade (Davis & Kutter, 1998). The percentage of women who are homeless has increased from 3% in the 1960s to 20-25% during the 1990s. In 1996, the homeless population was estimated to include one-third women with dependent
children.

Davis and Kutter’s (1998) study disclosed that homeless women have a disproportionate amount of substance abuse, as well as mood, anxiety, and personality disorders. These disproportionate amounts are accounted for by trauma histories that had not been recognized prior to current studies.

Davis and Rutter (1998) also discuss the high incidence of traumatic events reported by homeless women, which are also associated with a high prevalence of PTSD. Thirty-four percent of a sample of 300 homeless women met the criteria for a lifetime condition of PTSD. This rate was 10 times higher than was observed in women with low socioeconomic status who were not homeless, and 30 times higher than women with greater incomes in a community sample within the same city. Studies during the 1990s consistently report traumatic experiences to be associated with women who are homeless; in fact, approximately 90% of women who are homeless had reported this information.

In 1992 a study indicated that PTSD preceded homelessness in three-quarters of a female sample (Davis & Kutter, 1998). Posttraumatic stress disorder may impede the ability to perform important tasks of daily living. For example, avoidance and numbing symptoms may be associated with withdrawal from social support networks and from involvement in activities and interpersonal contact outside of the home.

As mentioned earlier, the types of situations that may produce trauma in both women and men are numerous. For the purposes of this study, the types of traumatic situations to be discussed will be limited to the following information: (1) physical or sexual assault initiated by a stranger or strangers; (2) natural disasters; (3) medical conditions including surgeries; (4) personal trauma (such as being raped, experiencing a house fire, being threatened with death (related to the participants themselves or a family
member or child), or being ridiculed as a child or an adult); (5) experiencing combat; and (6) interpersonal trauma such as domestic violence (which can be physical, sexual, emotional, verbal, or financial) from a significant other, family member or someone else known to the victim.

Among the many reasons men and women may become homeless or houseless, a significant amount of them can be physically and mentally traumatic for the survivor. According to Martin (1991), “a study completed in New York City stated many reasons for loss of permanent housing in New York and elsewhere. They include: (1) fires (20%); (2) eviction because of failure to pay rent (sometimes as a result of interruption of public assistance); (3) eviction by the city because of unfit, substandard, condemned housing; the need for separation from an abusive spouse; or reasons connected with drug use; (4) de-institutionalization of the mentally ill without adequate community residential and medical/social programs; (5) overcrowding (families that have exhausted the resources and space of relatives and friends are forced to find other accommodations); (6) unemployment; (7) cuts in federal assistance programs; and (8) scarcity of low-income housing” (p. 19). Markos and Smith (n. d.) similarly report the importance of poverty, deinstitutionalization, lack of community support, under- or un-employment, and dual diagnoses as it affects the homeless population.

Martin (1991) found it particularly surprising that a significant number of families have had repeated traumatic experiences in having been burned out or evicted from more than one home. The findings suggest that many children have known nothing but temporary shelter, where second and third generations have continued to live in shelters or hotels all of their lives. In some cases, teen-age daughters who had been raised in such conditions are currently raising their own children in shelters and hotels.
Davis and Kutter (1998) similarly state the identifying factors that may contribute to a higher risk of homelessness for women. These conditions “include economic factors (e.g., low wages, inability to manage funds), societal factors (e.g., scarcity of safe, low-income housing; reductions in public assistance), personal factors (e.g., lack of social support, substance abuse, mental illness), and traumatic experiences” (p. 40). Simply living in poverty increases a woman’s risk for victimization.

Domestic violence has also become a severe problem associated with traumatic symptoms, once thought to be rare in occurrence (Clements & Sawhney, 2000; O’Farrell et al., 2003). Current investigations reveal that as many as 1.6 million women are abused by their husbands and that 1 in 10 women report violence within their relationships in any given year. These numbers do not include the incidents that go unreported.

Early studies involving domestic violence centered more on the violence that occurred within families then with the psychological, emotional, or mental affects of the abuse (Clements & Shawhney, 2000). However, researchers have since become more interested in the psychological reactions to abuse, such as depression with accompanying suicidal ideation and suicide attempts. It has been ascertained that women who suffer depressive symptoms following abuse are less likely to seek out alternative solutions because of the motivational and cognitive deficits associated with the depression, which, in turn, perpetuates the abuse.

Sexual and physical abuse may very often be an undertone in the histories of women’s (and men’s) homelessness (Brown, 1993). In numerous studies completed in the early 1990s involving homeless Caucasian, African American, and Hispanic women, the percentage of those who had a history of childhood physical and sexual assault range from 34% to over 60%. In comparison, the percentages for the number of housed women
within the same categories ranged from as low as 4% to 27%. As Browne's data reflects, the highest percentage pertaining to the housed women, is smaller than the lowest number pertaining to the homeless women. Both percentages, however, are overwhelming.

After being threatened or attacked, some post-traumatic effects are typical responses for men and women (Browne, 1990). Emotional reactions can include fear, anger, guilt, shame, feelings of powerlessness or helplessness, a sense of failure, and a sense of contamination or worthlessness. Victims of both personal attacks and natural disasters react with shock, denial, disbelief, withdrawal, and confusion. While victims are normally scared of injury or death, survivors of assaults such as rape usually react with extreme anxiety, loss of control, vulnerability, self-blame, and depression (Browne, 1990; Rosen et al., 2001).

In the instances discussed above, posttraumatic stress disorder symptoms of physical or sexual assault may be very severe (Browne, 1990). For example, in a study of rape victims, effectively all (94%) met the diagnostic criteria for PTSD for the first weeks after the attack and almost half (47%) met the PTSD criteria 3 months later. Survivors may become extremely dependent or suggestible, and can also find it problematic to make basic decisions or to function alone. Victimization also significantly increases the risk for substance abuse disorders in both men and women.

The stress involved for women of lower socioeconomic classes who are also head-of-the-household can also be an indicator leading to homelessness. Browne (1990) reported that a study completed in 1989 of 704 women in New York City who were requesting emergency shelter or who were in the process of recertifying their public assistance funding, developed certain risk factors that may contribute to homelessness. "The study of 1989...found that 95% of the families interviewed were female headed;
and that 11% of the homeless compared to 7% of the housed sample reported childhood physical abuse, 10% compared to 4% reported childhood sexual molestation, and 27% compared to 17% reported assaults or threats of violence by at least one intimate partner in adulthood. Browne expounds, "the data suggests that each of the types of victimization, taken separately, proved to be a good predictor of homelessness" (p. 372). Browne continues, along with other gauges of unsettling experiences (such as placement in an institution or foster home, living on the streets, or running away from home before the age of 18), a woman head-of-family was at a far more significant risk for homelessness than were heads of housed families.

With regard to unemployment or under-employment being a precursor to homelessness among women who have been traumatized, Fairbank, Ebert, and Zarkin (1999) discuss the topic of adult women who are incest survivors. Apparently a "significant relationship was found between incest victimization and employment status, with twice as many incest victims as non-victims being unemployed" (p. 187). The researchers continue, that among women reporting one or more incestuous abuse incident, those women who perceived the abuse as extremely traumatic "evidenced a consistent pattern of more negative socioeconomic outcomes. Compared with women who reported lesser degrees of trauma, women in the extreme trauma group [of the study] were less likely to have attended college, held positions of lower occupational status during their adult lives, and had lower household incomes for the year prior to the study" (p. 187).

However, abuse severity was the most compelling determinant of the acuteness of the trauma reported in this study (Fairbank et al., 1999). The more severe the abuse, which was based on the sexual activities involved, the more pronounced was the
relationship to the indices of poverty and downward social mobility. For this study, Russell defined poverty as a total household income of less than $7,500 in 1978. Downward social mobility was defined, for this study, as the respondent having a lower occupational status and/or educational accomplishment than her mother.

Fairbank et al. (1999) also discussed a similar study, which was completed in 1994 by Mullen and his colleagues. The key findings in this study were similar to that of the 1978 Russell study. Childhood sexual abuse was defined as “unwanted sexual advances before the age of 16” (p. 188). Those women who reported a history of childhood sexual abuse were more likely to (1) have a lower socioeconomic status based on types of employment throughout their history, (2) be employed as an unskilled laborer even if the subject had a more positive educational attainment status, and (3) declined in their socioeconomic status level from their family of origin to their current status at the time the study was completed.

The Mullen study similarly stated that the results also indicated three risk factors for both childhood sexual abuse and labor market outcomes: “frequent parental discord, and physical and emotional maltreatment in childhood. Furthermore, women who reported childhood sexual abuse involving intercourse were four times as likely to experience a decline in socioeconomic status than non-abused controls” (p. 189).

Therefore, the results of these two studies imply that a history of childhood sexual abuse can have harmful affects on women’s economic welfare, and the affects increase significantly for those women who had experienced more severe forms of abuse (Fairbank et al., 1999). Although, childhood sexual abuse is not a direct traumatic causal factor leading to homelessness, it can be implied to affect later socioeconomic status and the economic welfare of those women who suffered more extreme types of abuse.
As an aside, Fairbank et al. (1999) go on to discuss a study by Hyman (1993), which was intended as a broad assessment of childhood sexual abuse among gay, lesbian, and homosexual participants. Also noted, was a study conducted by Lisak and Luster (1994), which reported on a subject pool of childhood sexually and physically abused men. The Hyman study reported similar results as the two previous studies discussed; however, the Lisak and Luster study reported that those men who experienced childhood sexual abuse without simultaneously experiencing physical abuse had many more jobs and more negative reasons for leaving jobs. However, those male subjects who reported both sexual and physical childhood abuse, did not encounter significant occupational difficulties than non-abused men. The latter outcome was unexpected.

Most of the data pertaining to trauma and homeless men centers around being combat veterans, being victims and predators of childhood abuse, culture (to a slight degree), and genetic and environmental environments; and virtually all of these conditions are combined when researched with drug addictions – primarily alcohol (Blondell, Looney, Krieg, & Spain, 2002; Cloitre, Tardiff, Marzuk, Leon, & Portera, 2001; Jainchill, Hawke, & Yagelka, 2000; McLeod et al., 2001; Norris, Perilla, Ibanez, & Murphy, 2001; Ritter, Stewart, Bernet, Coe, & Brown, 2002; Savarese, Suvak, King, & King, 2001; Steindl et al., 2003). The virtual lack of studies concerning the consequences of male childhood victimization has been attributed to a range of sources including gender stereotypes of men that disqualify perceptions of them as victims, and the perception that childhood abuse is not as serious or as traumatizing for men as it is for women (Cloitre et al., 2001).

It has been well documented comparing rates of childhood abuse between boys and girls have consistently indicated that although sexual abuse occurred among boys
only about one-third as often as girls, boys were more likely to be victims of physical abuse — particularly during the years from 1 – 11 (Ritter et al., 2002). Even though there has been a limited number of studies completed, the percentage of sexual abuse among boys has been reported at 2.5% - 17%, depending on the definition of sexual abuse; and there was one report that studied the presence of physical abuse (with or without sexual abuse) and stated the rate to be 34%.

Although most of the data pertaining to trauma and homeless men centers around being combat veterans, recently there has been publications pertaining to homeless men being victims and predators of childhood abuse, their culture (to a slight degree), and genetic and environmental environments; and virtually all of these conditions are combined when researched with drug addictions — primarily alcohol (Blondell et al., 2002; Cloitre, Tardiff, Marzuk, Leon, & Portera, 2001; Jainchill et al., 2000; McLeod, Koenen, Meyer, Lyons, Eisen, True, & Goldberg, 2001; Norris et al., 2001; Ritter et al., 2002; Savarese, Suvak, King, & King, 2001; Steindl, Young, Creamer, & Compton, 2003;).

In a contemporary study, Savarese, Suvak, King, and King (2003) completed an analysis concerning alcohol use, PTSD symptoms, such as hyperarousal, marital abuse, and Vietnam veterans. The authors estimate that over 1.8 million women are battered by their husbands in any given year, which is believed to be under-estimated. However, the reasons cited for the violence are interesting, as compared to earlier studies.

The authors found, that at least a limited justification of partner battering and domestic violence lies with the perpetrator’s history of trauma exposure and the subsequent consequences (Savarese et al., 2003). Savarese et al. (2003) discuss several studies related to this issue. The results are as follows: PTSD-positive Vietnam veterans
are more likely to report aggression toward their partners, particularly physical aggression; violence reported by the spouse or partner was significantly more common in families of male Vietnam veterans with PTSD than in families of male Vietnam veterans without PTSD; violent men reported significantly more PTSD-like symptoms than non-violent men; and higher levels of PTSD were associated with higher intensities of verbal and physical partner aggression in Vietnam veterans. Therefore, it can be postulated, that past traumatic events are related to current levels of violence in men; particularly combat veterans (Savarese et al., 2003).

Although this topic only recently began to be studied, the data for men who have experienced trauma is similar to that of women in that men who have experienced trauma in the past, to the degree of exhibiting symptoms of PTSD, are more violent toward their partners than those men who have not experienced trauma (Savarese et al., 2003). However, besides the similarity of becoming violent, men typically go on to abuse alcohol (primarily) and other drugs, while women suffer more mental illness and their drugs of choice are those drugs other than alcohol (Savarese et al, 2003).

In regard to suffering more mental illness, Lauterbach and Vrana (2001) discuss two of the relationships between personality traits and trauma exposure. Specifically, the authors found preliminary findings that suggested personality traits related to impulse control may be associated with a greater risk of encountering a traumatic event. One of the personality traits being studied is antisocial personality, in particular, one of the factors of antisocial personality, early behavioral problems. The authors cited several studies on veterans, which suggest that early behavioral problems may be related to a history of experiencing trauma. The second personality characteristic of antisocial personality disorder that may be associated to multiple traumatization is sensation
seeking; Apparently the more willing an individual is to engage in sensation seeking behaviors, the more prone an individual is to experience traumatic events throughout his or her lifetime (Lauterbach & Vrana, 2001).

Homeless children are also at a higher risk for trauma then those children who are not homeless. The loss of a home, in itself, is especially traumatic for children. Ryglewicz and Pepper (1996) state the fundamental meaning of 'home' for children is a place of security, in which children are protected while they grow to be young adults men and women. For children of families with a significant amount of alcoholism and other drug use, and physical or sexual abuse and neglect, the home becomes a unsafe place, rather then a safe haven. When the home becomes a dangerous place, or if it has always been a dangerous place, the world outside of the home can then become more overpowering to the children. For instance, these children may live in neighborhoods that are crime- and drug-ridden, and there is most likely a loss of protection in their schools, streets, and subways as well (Ryglewicz & Pepper, 1996).

It has become known through studies of PTSD that when the experience of stimulations exceeding the child’s or adult’s capacity to cope, it may lead to numbing desensitization and acting out (Ryglewicz & Pepper, 1996). Some children are also particularly vulnerable to the outside images of behaviors, such as destructive role models or learned values. Adults, too, may respond to traumatic domestic events and anxiety on a daily basis, by treating it all as if it doesn’t exist. The child who is not sufficiently cared for and socialized is at greater threat of failing to develop adequate tolerance of frustration, anxiety, and anguish. The more vulnerable the child, the greater the risk that he will turn to substance abuse or other self-destructive behavior as a quick source of stimulation, relief, and short-lived pleasure (Ryglewicz & Pepper, 1996). It is
also important to note, that although many parents report trying to protect their children from violence within the home, the research suggests that children who live in violent homes typically see, hear, and at times, try to intervene during episodes of marital violence (Kitzmann, Gaylord, Holt, & Kenny, 2003).

In regard to the trauma of experiencing a natural disaster, Norris et al. (2001) conducted an interesting study on natural disasters and the prevalence of traumatic reaction of men and women, based on two separate cultures. The study focused on two natural disasters; hurricane Andrew in Homestead, Florida, and hurricane Pauline in Acapulco, Mexico. Two hundred Mexican victims and 270 non-Hispanic victims in Florida were interviewed for this study.

The authors of the above study hypothesized that a sex-by-country interaction would emerge in the data, especially the result that more women would fare poorer than men, particularly Mexican women. In other words, the effects “should be stronger among Mexicans than among Americans, even though the effects would be observed in both cultures (Norris et al., 2001). This was based on the authors understanding of the influence of culture within a society, particularly when one culture has been suppressed by another. Because Black Americans typically do not “possess the resources afforded White Americans, they, as a group, may be more vulnerable to the effects of stress and change” (p. 13). The female role within Black American families differs from that of White families, in that the Black female is often both the wage earner and homemaker, therefore, they should be more resourceful and strong. Black men, on the other hand, like men of other cultures, value power and achievement, which have been denied to the Black man by the dominant culture. Given this understanding, the author’s hypothesis
that the difference between African American men and women should be less pronounced then that of the Anglo-American men and women (Norris et al., 2001).

The results of the study showed the effects were stronger among Mexican and weaker among African Americans than among Anglo-Americans (Norris et al., 2001). In other words, women, especially Mexican women, were more extremely troubled than their male counterparts following major disasters in their communities. American women were slightly higher then American men in the categories of intrusion, avoidance, and remorse. However, Mexican women were significantly higher then Mexican men in the same categories. “The hypothesis that the historical circumstances and culture of African Americans would satisfy these differences was also supported” (p. 21).

In terms of trauma and the reactions of men and women, cognitions, such as helplessness, are more inharmonious with men’s self-concepts and men are more likely to alter their thoughts and the trauma to reduce the dissonance. Therefore, men may suppress symptoms whereas women will tend to disclose them (Norris et al., 2001).

Homelessness and Addictions

As opposed to the amount of data concerning the homeless population and experiences of trauma, there is a substantial amount of data relative to the homeless population and addictions. Although unlike homelessness and trauma, the data pertaining to homeless men and addictions is much more readily available. However, the data pertaining to homeless men and addictions has usually focused on either combat veterans or the mentally ill. The past research literature concerning the homeless population and addictions for both genders will be discusses directly.
Homeless addicted women are possibly the most marginalized and economically impoverished demographic pool in this country (Deming, McGoff-Yost, & Strozier, 2002). Single mothers with dependent children are presently the fastest growing segment of the homeless populations within the United States. Race and family size appear to have an influence on homelessness for women. One study reported that with each additional child, the chances of obtaining stable housing decreases, and that African American mothers have greatly increased tribulations in finding such housing (Deming, McGoff-Yost, & Strozier, 2002).

In 1999, Galaif et al. conducted a study, which concentrated on homeless women and drug use and dependency. The authors estimated that frequency estimates for homeless women with drug use problems range from 10% to 23%, and 25% to 50% for drug abuse; sixty-one percent of those homeless women with a significant duration of alcohol problem also had a history of drug abuse, and 42% of the drug abusers also had an alcohol problem. Therefore, the authors determined that drug problems and drug abuse are prevailing among homeless women. Not only is drug abuse the most common health problem among the homeless, it is also understood that drug abuse is a factor that may lead to homelessness by exacerbating its adverse consequences (Galaif et al., 1999).

In addition, the homeless pregnant woman who is addicted to substances is also much more vulnerable to high-risk behaviors that result in negative consequences for not only for herself, but for her children as well (Deming, et al., 2002). There is an increased risk for problems occurring during pregnancy, such as miscarriage, poor prenatal care, higher infant mortality rates due to poor nutrition, and limited access to medical care (Deming et al., 2002). Martin (1991), also discussed the effects of the lack of prenatal care on children born to teen-age and/or substance abusing homeless mothers. The
children of homeless, substance-abusing mothers display a high frequency of prematurity, low birth-weight, failure to thrive, and infant mortality. Medical care is typically neglected, and immunizations have been delayed, making these children susceptible to preventable diseases. Studies have revealed malnutrition and anemia, high lead levels, frequent infections, asthma, and increased neurological disorders among homeless children who have been born to substance-abusing mothers (Martin, 1991).

Pagliaro and Pagliaro (2000) note that substance use has been related to the occurrence of accidents among and acts of violence against women. The accidental injuries most related with women are falls and motor vehicle accidents. Considerable morbidity and mortality are associated with assaults, including: battery during pregnancy; dating violence; physical abuse/assault; and sexual abuse/assault. And, finally, women are frequently the victims of substance use related homicide and suicide (Pagliaro & Pagliaro, 2000). Also noteworthy, Bastiaens and Kendrick (2002) state that “exposure to a traumatic event and PTSD are more prevalent among persons with substance use disorders than in the general population” (p. 634).

Similarly, North et al. (1996) assert the well established past data among the general population that substance abuse has been associated with both violent trauma and aggression. In a community sample, being diagnosed with substance abuse was correlated with vicious trauma and childhood abuse, a history of having been sexually assaulted, and the risk for successive sexual assault. The authors also cited a 1993 study, which reported that 87% of women in treatment for addictive disorders had a history of one or more violent traumas. North and colleagues (1996) continue a diagnosis of substance abuse was linked with lifetime experiences of violence – with victimization experiences as well as with continuation of violence in the study of homeless women.
overall finding was that drug and alcohol problems were related with higher rates of victimization among women.

Salomon (2002) has also determined a correlation between substance abuse and histories of traumatic events. Similar to the statements pertaining to the previous studies, Salomon (2002) found that researchers have acknowledged high rates of interpersonal violence during the course of a lifetime in clinical samples of substance users, as well as high rates of substance use in samples of women who have been battered. Salomon also states that women in treatment for substance abuse were more likely to have histories of childhood sexual abuse, and also that women with histories of childhood sexual abuse were more likely to abuse substances and use illicit drugs; women who experience a history of interpersonal partner violence were also more likely to abuse alcohol, illicit drugs, and prescription drugs; and finally, pregnant women with a history of interpersonal partner violence were more likely to use alcohol and drugs.

In addition to the problems drug use or abuse that homeless women confront, there are also numerous psychosocial problems that can contribute to the vulnerability of homeless women who use substances (Galaif et al., 1999). The list is long, and individually the factors can be overwhelming. However, most homeless women have more than one of these factors to contend with. The most obvious of the factors include, an indigent lifestyle, limited education, gender discrimination, insufficient financial resources, unemployment, disjointed social support, futile coping, dependent children, health and mental problems (e.g., psychological distress and depression), and barriers to services. Women who are homeless are more likely to struggle with stress by using atypical, dysfunctional strategies, or by associating with a abnormal social network that encourages drug use; and finally, they tend to make use of avoidant vs. active coping
abilities (the authors declare, through their study, that drug use was expected by avoidant coping strategies).

Not all homeless women with an addiction are addicted to substances (Deming et al., 2002). Other forms of addictions that plague this population can be sexual addictions, gambling, and eating disorders. All of which, can be as equally detrimental to the homeless women as an addiction to substances. The most common eating disorder is compulsive over-eating. This disorder usually begins as a means of self-comfort. Sexual addictions are formed based on the sex-trade activities the homeless woman may have to engage in to obtain money, drugs, or shelter. Gambling, particularly in Las Vegas, can become a problem as an attempt to change the financial status; gambling addiction has also been proven to provide the rush associated with drug use: a quick high while she has daydreams of the big result, followed by the breakdown when she realizes she has lost again (Deming et al., 2002).

As stated earlier, Deming et al. (2002) confer, that domestic violence has also been viewed as a principal cause of homelessness for women and children, and those who use substances are at a particularly great risk. As much as 80% of homeless women have a history of domestic violence, which can be associated with becoming homeless. The violence often begins in childhood, and substance abuse exacerbates the issue (Deming et al., 2002). Fals-Stewart (2003) notes that intimate partner violence has become more recognized as a significant health concern over the past 20 years, and the research suggests that a substantial proportion of the violent events involve alcohol consumption. The author continues, that the likelihood of male-to-female aggression was significantly higher on days when the male partner was drinking, as opposed to days when the male partner was not drinking. Also, the data revealed a clear and highly significant
relationship between the past history of the male partner drinking (particularly heavy drinking) with a significant risk for recurrent physical aggression.

During the 1980s, crime related posttraumatic stress disorder (CR-PTSD) was documented through research. Studies determine that the “rates of victimization and CR-PTSD among individuals seeking treatment for a substance use disorder are very high” (p. 431) (Dansky et al., 1997). The percentage of individuals in treatment for substance abuse, according to studies completed from 1982 through 1995, indicate that between 27%-74% of the women, and 17%-54% of the men, have been the victim of a sexual assault, and between 57%-84% of women and 60%-91% of men have been the victim of aggravated assault. Not only have studies determined that leaving CR-PTSD untreated, can be associated with less compliance with substance use treatment and less than favorable outcomes, but also the increased risk of relapse to substance use (Dansky et al., 1997).

In regard to adolescents with substance abuse disorders, the sooner the onset of alcoholism, compared with a much later onset, has been established to be associated with more antisocial distinctiveness and, in some studies, more depression and anxiety disorders (Clark & Scheid, 2001). When discussing violence and/or anxiety, which may begin in adolescence, in most cases, multiple perpetrators inflict more frequent sexual and emotional abuse, including incest and rape on homeless drug abusers then are inflicted on women with homes who are not drug abusers (Deming et al., 2002). Taking into account the data relating to domestic violence, which accompanies substance abuse, and how it relates to becoming homeless, among individual factors, substance abuse persists to rank as a primary cause of homelessness as well (McCarty et al., 1994).
When discussing the motivations for drug or other substance use beginning in adolescence, it has been attributed to the belief that the substances reduce the depression and anxiety that may be associated with growing up experiencing traumatic events (Clark & Scheid, 2001). Escaping from destructive emotional states is not only associated with motivation, but is also associated with more pathological consumption throughout life. In the literature, childhood abuse has been presented as a risk factor for substance use disorders: a relationship has been found to be common between childhood abuse and substance use disorders, and, in community samples, childhood sexual abuse has been associated with an increase in alcohol ingestion. Among juvenile detainees, physical and sexual abuse during childhood precedes alcoholic ingestion that, in all probability will become problematic (Clark & Scheid, 2001).

In 1990, a longitudinal study, as reported in Clark and Scheid (2001), constructed and tested a representation sampling of relationships among childhood abuse, alcohol use, and emotional functioning with adolescents in custody in a criminal justice system facility. The model showed impacts of child abuse experiences on alcohol use and emotional functioning. Emotional functioning acted as a go-between on the effect of physical and sexual abuse during childhood on alcohol use during a 1-year follow-up period.

Over time, it has been found that homeless men, when compared to homeless women, develop addictions at a similar rate compared to the general population: men drink more than women (Elder, et al., 1994). These gender differences are similar across ethnic groups, although the difference is less significant for Blacks then for Whites. Men, as opposed to women, tend not to focus on the societal non-approval of being drunk, and men believe that alcohol is an acceptable way for them to socialize. Homeless
men are more likely to drink in groups and have more social contacts then homeless women. Men are expected to behave with a risk-taking attitude, which is accepted by society, and produces more unconventional, heavy drinking then in women. Twenty-nine percent of men versus 16% of women are more likely to drink to relieve tension; and, finally, twice as many men were more likely to abuse alcohol only (16% versus 6%) (Elder, et al., 1994).

Homeless alcohol and drug users are also disaffiliated (fallen through the network of social relationships that bond most people to others) than non-using homeless individuals (Elder, et al., 1994). Homeless drug users are more apt to use harder and more damaging drugs, such as crack, heroin and cocaine, then non-homeless drug users. Homeless alcoholics have less occupational skills than non-homeless alcoholics do (Elder, et al., 1994; Young & Boyd, 2000). Young and Boyd (2000) also note that crack cocaine is the drug of choice used by homeless, African American women; and the number of users has risen at an epidemic rate over the past two decades.

Benda and Schroepfer (1995) found similar results during a study that compared the homeless population that had been treated for alcohol abuse and those who had not. The results indicated that those who had been treated were most likely to be male, white, veteran, service user, victim of child abuse, former prisoner, and former psychiatric patient. The authors continue, those who had been treated are currently drinking at least a six-pack of beer or four drinks 5 or more days a month; they began drinking and using other drugs at an earlier age, were older, and fewer were married at the time of the study (Benda & Schroepfer, 1995). It is the author’s contention, that even though the individuals had received treatment, those who returned to drinking, had increased the consumption of alcohol to greater levels than had been used prior to getting treatment.
Janchill et al. (2000) conducted a study at treatment centers that were established in New York City shelters. Their sample included 62% men, 79% African American, 40% were over the age of 35 years, 32% were married minorities, and 70% had been born in New York City. Sixty-five percent indicated crack as the drug of choice; the authors stated no significant differences between race/ethnicity distribution or age. Men, however, began drinking at an earlier age and used for more years than the women. Women were more likely to be referred for services through a social service agency then were the men. Sixty-six percent had reported being homeless at least 1 week as an adult, and 31% were homeless most of the year pre-treatment. There were no significant differences by gender on either of the two latter measures. Seventy-five percent (75%) indicated a history of physical and/or sexual abuse, with most reporting the abuse prior to the age of 15 years. In summary, the sample presented with significant psychopathology and a history of physical and sexual abuse. (Janchill et al., 2000).

The ethnic background of homeless men has also been found to influence substance use problems. McCarty et al. (1991) established that even though 60% of American Indian men, 28% of Latino men, 38% of African American men, 35% of White men, and 17% of Asian men had alcohol abuse problems, with the exception of the American Indian group, the remaining groups fall below the average of 47% of men with alcohol abuse issues.

During the past several decades, in regard to the coexistence of alcohol misuse with combat related PTSD has been well established (Donovan et al., 2001; Dutton, 1998; Steindl et al., 2003). Since 1990, both small scale and major scale studies have found the range of comorbid alcohol misuse in those with PTSD to be 41-85% (Steindl et al., 2003). The range for the general male population has been found to be 19-29%.
Most all of the symptoms of PTSD can be reduced by alcohol, which in turn, leads to tension reduction, and negatively reinforces drinking (Steindl et al., 2003). Ouimette, Moos, and Finney (2003) similarly found that one-third of patients with substance use disorder have a comorbid posttraumatic stress disorder diagnosis as well. The authors have found that substance use disorder withdrawal symptoms may trigger and aggravate PTSD symptoms, starting a repeated process that trigger relapse and continued substance use (Ouimette et al., 2003). McLeod et al. (2001) cited two studies showing similar statistics, male veterans who had experienced high levels of combat exposure were more likely to develop an alcohol-related disorder then those combat veterans who experienced low or moderate levels of combat exposure; a high rate of combat exposure increases the risk for both PTSD and alcohol abuse and dependence.

McLeod et al. (2001) state three hypotheses related to the significance of high combat exposure as it relates to an increase in substance use and abuse. The first hypothesis is that there is another factor being important in the relationship between the two. The second hypothesis is that one may develop as a consequence of the other; for example, self-medicating PTSD symptoms would lead to an increase in alcohol use. The third hypothesis states that they occur together due to a shared vulnerability, which in turn, increases the risk for both disorders. The vulnerabilities can be either environmental because of experiencing events within a family; or genetic. The genetic factor has gained favor over the past fifteen years.

The results of McLeod et al. (2001) study showed consistency with the ‘shared vulnerability’ model. Even though the results indicated both environmental and genetic factors do influence an individuals susceptibility to PTSD and substance use disorders, the environmental factors were more relevant than the genetic factors. The authors state
that a personality characteristic, such as sensation seeking or impulsivity can be attributed to both genetics and an increase in substance use. For instance, the characteristics may influence a young man to join the military at a younger age and therefore, be exposed to higher levels of combat. In relation to the environmental factor, the characteristics of impulsivity and sensation seeking can also be associated with an increased vulnerability for developing an alcohol-related disorder. Also, the two personality characteristics can also be associated with anti-social behavior and childhood conduct problems. Taken together, these data suggest that personal characteristics that are, at least in some way, genetically transmitted, such as impulsivity, might provide a common susceptibility to combat exposure, PTSD, and alcohol use (McLeod et al., 2001).

The past literature on homeless men does not address familial issues, other than the demographic data pertaining to the number of children fathered by homeless men (Elder, et al., 1994). Currently, the data pertaining to familiar issues is still lacking. Therefore the literature review in this area is lacking. There are studies on male childhood abuse, however, which show similar results, such as that a significant percentage of survivors of child sexual abuse are men (Steever, Follette, & Naugle, 2001).

Steever et al. (2001) conducted a review of the literature. The author's cite studies that contend male child abuse survivors are at a substantially greater risk for depression, PTSD, personality disorders, poor self-image, substance abuse problems, suicidality, and sexual disorders. The authors also cite studies that state that male survivors are more likely to have been abuse by same sex assailants, experience significant levels of violence and physical harm during victimization, and are more likely to be victimized by multiple perpetrators. Steever et al. (2001) go on to cite studies that
state that a history of childhood sexual abuse is consistently associated with significantly higher rates of substance abuse in men as opposed to men who have not been abused (54.4% vs. 26.7%). A second study that the authors quote, which was conducted on university undergraduates, found an overall substance abuse rate of 50% for men with a history of childhood sexual abuse, as opposed to a control sample on non-abused men who reported a rate of 18%.

As cited from other studies performed, in addition to substance abuse problems being a result of a history of childhood sexual abuse, other characteristics of men with this history are: anger (which is the most prevalent theme); compulsive sexual behaviors (such as frequent sexual partners and experiences, significant levels of masturbation and use of pornography; and homosexual behavior in men that claim to be heterosexual); issues with gender identity; sexual dysfunction, maintaining relationships; five times the number of physical abuse experiences within relationships then men with no history of childhood sexual abuse; and the group as a whole, is more unlikely to seek mental health treatment for trauma or abuse related symptoms (Steever et al., 2001). The reason given for not seeking treatment are due to issues of gender role identity or societal bias, or because the men do not feel harmed by the abuse experienced and/or are not experiencing symptoms of the abuse. The authors state that there is no data to determine which of the above reasons may be relevant.

Ritter et al. (2002) maintain that children of alcoholics are at a higher risk for drug and alcohol use. The studies conducted on adult children of alcoholics (ACOA) assert that, in addition to behavioral problems and emotional difficulties, there are biological and environmental basis for the increased risk of alcohol and drug use by this group. The environmental factors have been studied extensively over the past several decades.
Having experienced a history of family violence is important to the understanding the relationship between current use of substances and being raised with an alcoholic parent, since family violence is a common occurrence with familial alcoholism. These children are often subjected to harsher punishments, less social support from parents, and are more likely to be physically abused. Children who are witness to violence within the home are known to demonstrate psychosocial difficulties comparable to those observed among children of substance-abusing parents (e.g., aggression, cruelty to animals, juvenile delinquency, disobedience, sadness, withdrawal, suicidality, somatic complaints, fear, anxiety, low self-esteem, lower social competency, and poor school performance).

When summarizing the data available on the substance use of the homeless population, and what the causal factors may be, it becomes apparent very quickly, that through several decades of research, it cannot be determined. However, there are many environmental, and genetic and biological factors that can be related to the characteristics of the homeless population. As stated previously, these characteristics, or conditions, of the homeless population, are considered by many researchers to be bi-directional in nature.
CHAPTER 3

METHODOLOGY

The qualitative methodology utilized for this study encompassed the collection of data through the use of interpreting genograms, which were constructed as a clinical tool by graduate students while providing individual counseling sessions to homeless individuals while completing either an advanced practicum or internship class. The data were collected in the form of a database, which were analyzed through the use of tables. The interpretation of the data utilized ethnographic constructs as asserted by Spradley (1980). For example, the use of domains and taxonomies were utilized in the construction of the tables, and the cultural foundations of ethnographic research were utilized in order to discuss the implications of the final data analysis.

Participants

Participants for this study consisted of individuals either residing at a homeless advocacy organization, or those individuals utilizing the services offered through the homeless advocacy organization. In both situations, the individuals participating in this study were homeless or houseless at the time the data was collected through the use of genograms. Graduate students attending The University of Nevada, Las Vegas, Department of Counseling offered the homeless clients individual counseling services.
The department offered two counseling tracks; community counseling or marriage and family counseling.

The homeless advocacy organization was located within the city limits of Las Vegas, Nevada, and was an approved practicum and internship location for the students of the Department of Counseling at The University of Nevada, Las Vegas.

The final selection of data included 32 female and 23 male participants in this study, varying in age from 15 years to 62 years. All of the participants requested individual counseling services from the graduate students; none were mandated to participate.

The presenting problems of the participants included phase of life issues, alcohol and drug addiction, gambling addiction, mental illness and emotional issues, domestic violence as well as physical and sexual assault histories, employment or under-employment issues, parenting and child-rearing issues, sexual dysfunction issues, and eating disorders.

Clinical Efficacy of Genograms

The genogram is a method of drawing a family so that the entire family is able to be viewed at a glance (Pistole, 1995). It is a display, which usually consists of three generations, is constructed by using symbols (e.g., circles for females and squares for males, triangles for an unknown gender in the case of a pregnancy) and lines (e.g., horizontal to connect married partners, or a line with 2 dashes through it to represent a divorce (DeMaria et al., 1999; Pistole, 1995). The genogram can also be designed to show emotional relationships within the family structure by the use of symbols, (e.g., a half-moon or a single, double, or triple solid or dashed line between members, which
indicate an enmeshment, conflict, violence, corporal punishment, or a positive/stable relationship between the members). Information concerning addictions and extramarital affairs is also represented through the use of symbols. Both clinically relevant and demographic data is documented within the genogram (e.g., age, date of birth and marriages, problems, diagnoses, substance abuse or health problems, etc). The genogram has been widely used as a clinical tool in family therapy and social work because of it’s ease of summarizing data, and because of its assessment and therapeutic functions (e.g., to identify patterns) (Balaguer & Levitt, 2000; Becker & Lewis, 1992; Freidman & Krakauer, 1992; Friedman, Rohrbaugh, & Krakauer, 1998; Gerson & McGoldrick, n.d.; Hardy & Laszlof, 1995; Kuehl, 1995; Kuehl, 1996; Massey, Comey, & Just, 1998; Papadopoulos et al., 1997; Pistole, 1995; Rohrbaugh, Rogers, & McGoldrisk, 1992; Stanion, Papadopoulos, & Bor, 1997). Figure 1 is an example of a genogram indicating gender through six generations showing the use of circles and squares (DeMaria et al., 1999).

Figure 1  Genogram Gender Example
Figure 2 shows genogram symbols and relationship symbols (DeMaria et al., 1999).

The Multifocused Family Genogram (MFG) can be used as a tool for conducting a thorough and efficient review of a client’s family system (DeMaria, Weeks, & Hof, 1999). With the MFG, the clinician has multiple viewpoints from which to examine the family system. Beginning with the basic genogram through to the addition of family maps and time lines and the addition of focused genograms, the MFG brings together a series of composite pictures blended together to form a collection of information used to distinguish patterns. The MFG identifies key intergenerational themes and patterns, reveals relationship patterns, and highlights developmental issues. The structure of the MFG speaks to these issues in detail. Consequently, the MFG expands tradition use of the genogram (DeMaria et al., 1999).
The basic genogram organizes names, dates, descriptions of family members, marriage and divorce patterns, birth order, occupations, health problems, and other generic, yet essential elements of life (DeMaria et al., 1999). It is also the guide for each of the other focused genograms that help to organize themes within a family structure. The basic genogram follows a family’s structure for three generations.

The family map visually depicts the emotional and behavioral patterns within a family, as well as the social, political, and community resources available (DeMaria et al., 1999). Family maps can be generic in format, or focused. The focused genogram is a tool designed to investigate the important areas of family life in great detail. The areas typically included in a focused genogram, include attachment styles, emotions, gender and sexuality, and culture and race.

The timeline imparts a sequential view of an individual and his or her family development (DeMaria et al., 1999). It is often very detailed and supplies the clinician an explicit account of the client’s navigation through his or her life. The timeline also, in some incidents, provides a more detailed account of the client’s passage through life.

The initial outline of the family structure is known as the ‘pedigree’, and it is the basis for the basic genogram (DeMaria et al., 1999). The focused genogram enhances the MFG throughout the various stages and phases of the interviewing process and treatment. One of the purposes of the focused genogram is to identify patterns within a family generational structure.

The genogram is a clinical tool that is mastered over time. When the clinician has mastered the techniques of constructing the MFG, it becomes an important clinical tool, used more frequently and consistently (DeMaria et al., 1999). Because of its structure, the MFG keeps the clinician and the client focused on addressing symptoms and
functioning. The analysis of attachment patterns and emotional expression provides an important link among intrapsychic, interactional, and intergenerational patterns” (p. 198).

Copeland, Serovich, and Glenn (1995) cite several studies pertaining to the reliability of the use of genograms in practice. Although, Copeland et al. (1995) believe that establishing reliability of the genogram “is not necessarily possible or even relevant” (p. 252), the authors cite a study conducted in 1980 discusses three types of reliability and how the different types of reliability relate to the use of genograms.

The first type of reliability discussed is consistency or stability, which refers to the level to which a process is invariant or fixed over time. This type of reliability is time associated. To establish consistency in a genogram study of reliability, data must be attained under test-retest conditions, such as when the same individual is asked to construct a genogram twice, at two or more different points in time. The consistency rate recognized for the use of genograms through a study in 1990 was 74%; which is a high degree of consistency (Copeland et al., 1995).

The second type of reliability is ‘reproducibility’, or the degree to which a process can be recreated under varying circumstances, at different locations, using different individuals. In this case, reliability in context is associated and becomes manifest under test-retest conditions. An example is when two or more individuals apply the same guidelines to construct genograms independently on the same subjects. A study was conducted in order to determine the reproducibility of genograms in 1980. The reproducibility levels reached in this study were moderate to very high. In 1992, two other studies are noted by Copeland and colleagues (1995). The first study found reproducibility levels of low to moderate; the second study found a low reproducibility level, or poor agreement.
The final type of reliability, 'accuracy', is the degree to which a process functionally conforms to a known standard, or yields what it is designed to yield. Reliability of this type is form associated (e.g., data collected under test-standard conditions is necessary to establish accuracy, such as when a genogram constructed by an individual is compared with a correct or standardized genogram). This type of reliability was studied in 1991 and found to be moderately accurate (Copeland et al., 1995).

All of the studies used to determine the three types of reliability were conducted within a medical setting, and produced mixed results (Copeland et al., 1995). The reliability, for the time periods prior to the execution of the Copeland study, had not been undertaken in a marriage and family therapeutic environment. In 1995, Copeland et al. conducted a study in order to determine the reliability of the use of genograms within a marriage and family therapeutic environment.

The results showed that some characteristics of genogram information were more accurately recorded than others (Copeland et al., 1995). Only two categories (named persons and symbols for named persons) were highly accurate. Six other categories (unnamed persons, occupations, relationship descriptors, medical issues, and descriptive phrases, and other significant symbols) were recorded moderately accurately. The two categories of dates and ages were recorded with little accuracy. The disparity is considered not surprising to the authors, though, because symbols and names of persons make up the basic genogram and any other additional information can be regarded as debatable or subject to personal preference (Copeland et al., 1995).

Balaguer & Levitt (2000) disagree with Copeland and colleagues that establishing the reliability of genograms is not possible or relevant because the genogram is a heuristic tool with which marriage and family therapists can record family information.
and processes for the purpose of hypothesizing and planning interventions. The current authors believe the current rush of specializations and standardization techniques and suggestions have reduced "the heuristic value and power of genogram use in treatment. Balaguer & Levitt (2000) content that the definition of collaboration the authors propose emphasizes (a) the importance of the client as having expertise in his or her own life and solutions to problems; (b) mutuality in the search for solutions to problems; (c) a disdain for the impositions of theories, techniques, or opinions; and (d) an understanding of the power of the social interaction in generating and maintaining meaning for people.

Ethnographic Constructs Included in Methodology

Spradley (1980) describes his ethnographic research approach as the Developmental Research Sequence (DRS) method. In other words, in order to understand the cultural differences through ethnography, a researcher needs to become a student and learn by observing teachers (members of a culture). According to Spradley (1980) this learning process requires a sequence of steps, beginning with the ability of the researcher to set aside his or her beliefs that all members of a culture are the same. The second in the series of steps is the researcher's ability to learn the language of the culture by actively participating and understand the meaning of the lives the teachers are living.

Spradley's (1980) method includes observation of a culture while a researcher is participating within the culture. However, for the purposes of this study, rather then observe the participants over a period of time while participating within the culture of homeless individuals, the data chosen had been collected by counseling students providing individual therapeutic counseling sessions to the participants. Even though the counseling students were not participating directly in the lives of the clients, the cultural
implications of the data collected through the use of genograms are apparent and will be discussed in later chapters.

By choosing this method, the basic concepts that Spradley (1980) sets forth when studying a culture are still being applied. For instance, Spradley (1980) states that cultural inferences are made by the researcher based on three types of information; observing cultural behavior, observing things people make and use, and finally, listening to what people say (speech messages). Researchers take this information and create inferences involving the ability to reason from evidence (what we perceive) and from premises (what we assume).

The method utilized for the purpose of this study by analyzing information gathered through the use of genograms encompasses the same concepts of ethnographic observation as Spradley (1980) dictates. Through the observation of clients participating in individual counseling sessions the counseling student is able to observe behavior, observe how the individual utilizes cultural artifacts (his or her belongings, services offered, etc), and finally the counseling student is able to observe how an individual speaks and actively listens to what the client is discussing.

Spradley (1980) also discusses the use of what he describes as an ethnographic record, which consists of field notes. There are three principles that should be utilized when completing field notes; the language identification principle, the verbatim principle, and the concrete principle.

The language identification principle should reflect the language within a culture. In other words, a researcher will write notes based on what he or she has seen and heard, and will automatically encode this information into a language or jargon. This language,
however, should not be translated or simplified; it should be stated as spoken by the individual within the culture.

The verbatim principle not only identifies the language, but the researcher must use native terms in recording the language. For instance, the researcher, ideally, should not use his or her own observer and/or technical terminology, which are an interpretation of the cultural meaning of the language; it is not an accurate, verbatim record.

The concrete principle should be used when describing observations. When observing a culture, a researcher should not generalize or expand, fill out, or enlarge the observation. The observation should be recorded in accurate detail.

Again, the method of ethnographic methodology being utilized in order to complete this study includes these principles. Counseling students have been trained to observe and accurately record the presenting issues of the client. To this end, the genograms were constructed according to Spradley's DRS method. Each genogram includes notes for each person included in the genogram; and also provides more detailed notes on the time-line included for each genogram.

Also, the final step of analysis and interpretation of the field notes (genograms) provide a link between the ethnographic record and the final written ethnographic data (Spradley, 1980). This step allows the recording of generalizations and insights into the culture that has been studied. This step is often referred to as brainstorming or thinking on paper. Most of the tasks in the remaining steps of analyzing the ethnographic data that has been accumulated are based on this step of recording the data in the form of a genogram.

The final step pertains to the method of analysis used to evaluate the data from each individual genogram. The steps taken to analyze the data are as follows: a table was
created that includes the client demographic information. The demographic information includes client age, race, number of siblings, education level completed, current marital status, number of children, and employment status.

There will also be several tables constructed based on the data collected for each domain. The information that is most pertinent to the outcome of the data analysis will be included in the domain tables included in this study. The remaining domain information will be included in the Exhibits Chapter. A domain, as defined by Spradely, is a set of information that is a category of cultural meaning, which may include other smaller categories. For instance, one of the cultural domains included for analysis is the Addiction Domain (AD). The AD consists of the following taxonomies, alcohol, drugs, sexual, gambling, and nicotine.

Figure 3, “Domains of Study: Flowchart # 1” illustrates the domains, as well as the sub-categories, or taxonomies, for each domain used as the basis of the data collection for this study.

The domains included, in addition to the Addiction Domain (AD), are the Domestic Violence Domain (DV), which includes the following taxonomies; physical, sexual, financial, and emotional. The Trauma Domain (TD) includes the following taxonomies; personal (this includes rape, victimization of domestic violence, kidnapping, house fire, etc), natural disasters (including earthquakes, tornadoes, etc.), significant death, combat, and other. The Medical/Psychological Domain (MPD) includes the following taxonomies; general medical, surgeries, psychological (self), psychological (others), and miscellaneous. And finally, the Criminal History Domain (CHD), which includes the following taxonomies; DUI/Drugs, domestic violence, jail/prison.
parole/probation, and other. See Figure 3 Domains of Study Flowchart #1 on the next page.

Once the data had been collected from the genograms according to gender, the data were collected and analyzed by each domain, as well as by race, age, education level, and the other demographic data that has been collected using the information provided with each genogram. In some instances, some of the demographic information was not complete. For instance, race was only included on approximately 10% of the genograms completed. Therefore, using race as a demographic analysis was not completed.

The final outcomes of the data were revealed in the form of numerous tables. The data from the tables were then, as a final step, interpreted in order to determine whether the number of incidents listed for each taxonomy within the domains, indicate an association between experiencing homelessness and having had a prior experience of trauma and/or addictions.
Flowchart # 1: Domains of Study

Flowchart # 1: Domains of Study

Collection of Data

The Internship in Counseling Course Syllabus gives the following instructions for completing a genogram: “Measurement procedures: Students will be evaluated based on the degree to which they utilize the basic components of a genogram (i.e., family functioning, marital patterns, divorce, extramarital affairs, birth order, adoption, mental illness, addictions, abuse)” (p. 3) (Markos, 2002).
Although included in the directions, the topics of addictions and abuse were not the main concentrations of the data collected within each genogram. Therefore, the data collected with each genogram were randomly selected based on the emphasis decided by the counseling student collecting the data, the therapeutic relationship, and the presenting problem or problems of the client.

Each genogram was selected for this study based on the (1) number of generations included in the genogram (minimum of 3 generations), (2) a timeline must have accompanied the genograms selected, (3) the data from the genograms was explicit and easily interpreted, and (4) the genograms selected included at least five of the 8 instruction topics required on the course syllabus. Therefore, the total number of genograms selected for use in this analysis was 55, with 32 female and 23 male genograms in the final selection. The ages of the clients varied from 15 – 62.

The data were compiled each of the genograms individually. The data were broken down into demographic information and five domains (addiction, trauma, domestic violence, general medical and psychological, and criminal history).

Qualitative Treatment of Data

When designing this study it became apparent, since the purpose of the study was to show patterns of behaviors by the number of incidents occurring, no statistical analysis would need to be completed. This decision had a major effect on the style of collecting the data, as well as documenting the outcome of the data.

The initial step of the data collection began during individual counseling sessions. The counselors were advanced graduate students attending The University of Nevada,
Las Vegas, Department of Counseling (UNLV). The students had attended one of two tracks within the department: community counseling and marriage and family therapy.

The practicum/internship location the students worked from, was a local homeless advocacy organization. The organization provided a homeless shelter on the location, as well as a crisis intervention center (CIC). The shelter provided meals, a safe and secure, drug-free environment, case management services, and child care services. In addition to the services offered at the shelter itself, the clients were also able to utilize the services located within the CIC, often considered a ‘one-stop-shop’.

The services within the CIC included local, county, and state government offices (e.g., welfare, food stamps, veterans administration, department of motor vehicles, etc.); case management and referral services; a free health clinic available to individuals without health insurance; a pro-bono lawyer; a community mental health out-reach counselor; employment services through the Workforce Investment Act (e.g., a federal program offering employment services, cost-free training, OJT, apprenticeships within the community (plumbing, welding, electrical), cost-free vocational training and/or college courses, rental/utility assistance, etc.); baby find (which was a county service offered to individuals which provided baby supplies, such as formula, diapers, strollers, etc.); Clark County School District; a resource center (e.g., offering job search services such as resume assistance, a telephone answering service for job search, free fax service, free internet services, typing classes, Microsoft software certified training classes, GED classes, etc.); various social educational classes, such as life skills, anger management, time management, parenting and child care classes, substance abuse and gambling classes; and finally, individual counseling services for the clients living in the shelter and
also for community walk-in clients (all of whom were homeless) in cooperation with UNLV.

The counseling center meeting rooms on location within the CIC were set up for student supervision. Each room was equipped with two-way window mirrors for supervision by observing the student and client, and video and audio recording devices.

The homeless shelter and the CIC did not offer substance-abuse rehabilitation services of any kind (e.g., inpatient or outpatient), domestic violence shelter services, mental health services typically found within a community mental health center, or gambling rehabilitation services. The CIC did, however, offer a referral service for clients requesting such services within the community.

The UNLV students offered individual counseling services at the organization for one semester (approximately 14 weeks). The UNLV students conducting the individual counseling sessions constructed the genograms within the first three - four meetings with a client. Because of the nomadic characteristic of homeless individuals, some clients attended only one or two counseling sessions (in some cases, none), particularly the clients who were recommended through the CIC as opposed to those clients living within the homeless shelter. The assumed reason for this, is that the clients recommended through the CIC were living on the street, in other shelters, community domestic violence shelters, or with family and friends, and therefore needed transportation to attend the sessions. The main barrier for the CIC clients to attend the individual counseling sessions appeared to be transportation to the shelter. Secondary reasons, most likely, were lack of opportunity for personal grooming, childcare needs, and/or the spontaneity of day-labor work that may have come available. Most of the shelter clients, however, would attend an average of five – six sessions with each student.
The instructions given to the UNLV students on the Internship/Practicum class syllabus was as follows: “Measurement procedures: Students will be evaluated based on the degree to which they utilize the basic components of a genogram (i.e., family functioning, marital patterns, divorce, extramarital affairs, birth order, adoption, mental illness, addictions, abuse)” (p. 3) (Markos, 2002).

Although included in the directions, the topics of addictions and abuse were not the main concentrations of the data collected within each genogram. Therefore, the data collected with each genogram were randomly selected based on the emphasis decided by the counseling student collecting the data, the therapeutic relationship, and the presenting problem or problems of the client. The presenting problems of the clients ranged from phase of life issues, parenting issues, family of origin issues, mental health issues, gambling addiction, sexual addiction, substance abuse, anger management, social skills, domestic violence, physical and sexual abuse issues, housing concerns, employment concerns, gender identity issues, eating disorders, stress management, and money management.

The data recovered from each genogram were placed into a table, which included demographic information (in Exhibit Chapter), and five domains and their accompanying taxonomies. Each of the tables can be found in Chapter 4, and include only the data pertaining to this study.

The demographic table data consist of a number representing each demographic category contained within the data. The tables referring to the domains included the number of family members that may have been included in the reported data for each individual taxonomy listed within each domain. Therefore, the end result of the tables
included the demographic information, each of five domains, and the number of incidents reported for each taxonomy within the domains.

In addition to analyzing the data through the use of tables, several case studies were constructed (4 male and 4 female) in order to emphasize the extreme cases of the data collection. The number selected for the amount of case studies was limited because the number of ‘extreme’ cases reported by the male clients was limited to four. The female clients, however, provided a minimum of eight extreme cases that could have been selected for use case studies. The final selection of four cases for the females was made by randomly selecting the client numbers out of the entire pool of eight cases.

The case studies included demographic data for each client; showed the client history for each domain and its accompanying taxonomies; and finally, the family of origin history for each domain and the accompanying taxonomies.

Along with the case studies, a generalized description was provided for the demographic data, client history, and family of origin history for the remaining clients. The generalized description provided a summary of the less extreme cases, which, as the data included in this study has alluded to, were quite similar in nature to the case study genograms. Although similar in nature, and although the remaining cases were generalized as a group, the experiences of the remaining clients was also severe, and in some cases drastic; the severity, however, was not consistent across domains. As stated earlier, the selection used for the case studies included information across all domains, which may have pertained to the client and/or past generations.
CHAPTER 4

DATA ANALYSIS

Past literature on the homeless population includes information concerning the perceptions of homeless individuals; perceptions such as a homeless person’s frame of reference pertaining to daily life. For instance, what daily occurrences may make a homeless person feel victimized by society? Based on the author’s prior observations of, providing individual counseling sessions for, and conversations with, the homeless population, the perception (or misperception) of what a homeless individual may consider normal will be postulated.

Homeless people do not use drugs and alcohol because they feel victimized by society. They feel these behaviors are normal; they have been raised by parents, and in some cases grandparents, who have used and/or abused drugs and alcohol. They have brothers, sisters, aunts, uncles, and children who also use and/or abuse drugs and/or alcohol. This is considered the norm to this population.

This information is not relevant to this study, however, it is important in understanding the culture of homelessness. Since the incidences of abuse and trauma are also substantial, which will be discussed shortly, and since there is a high prevalence of mental illness within the current homeless population and many previous generations, most homeless individuals also consider these feelings (or lack of feelings; numbness) as
normal. Most homeless people are not aware that these are problems they may need to correct, since the behaviors and feelings of anger and frustration, are repeated day after day, and are considered the norm. In some cases, the behaviors and feelings have been passed down from generation to generation.

In understanding the culture of the homeless population, it can only enhance the ability of society to focus on what specific immediate needs have to be met for this group of individuals. Research has been conducted for the past ten years or longer focusing on the immediate needs of this group, however, the number of homeless individuals only continues to rise, with no hope of eliminating the issues the homeless population face each and every day.

Analysis of Data

The demographic data provided for the male genograms was as follows: the ages provided for the male genograms include 52% (12) of the sample over the age of 40 years, 35% (8) of the sample between the ages of 26 and 39 years, and 13% (3) of the sample between the ages of 15 and 25. Only 6 included race (2 African Americans, 3 Caucasians, 1 Pakistan-American). Nine were high school dropouts, 9 completed high school, 4 had an unknown education history, 8 had attended college, trade school, or the military. Five men were single, 13 were divorced or separated, 4 were married, and 1 was widowed. Based on the data provided, all the men who reported having children, the children were biological, rather than adopted or referred to as stepchildren. Sixteen of the men were unemployed, 1 was retired, 2 were disabled, 2 were currently working (unskilled employment), and 2 were students.
The demographic data as provided for the female genograms was as follows. The percentage of female genograms within the 15-25 year old age-group was 25% (8), between the ages of 26-39 was 41% (13), and over 40 years old was 34% (11). The number of unknown race/ethnic origin was 24, African American was 1, Caucasian was 5, Mexican was 1, and 1 Polish/Black/American. The number of females who were high school dropouts, was 6. The number with an unknown education history was 19, the number of women with some college, trade school, or military was 6, and the number of women attaining a GED was 1. Twelve of the women were single, 9 were married, 2 were separated, 8 were divorced, and 1 was a widow. Although most of the children were biological to the women, more than half of the sample's children were by more than one father. Of the sample, none were employed, 25 were unemployed, 2 were students, and 1 was disabled. See Table 1: Demographic Data by Gender, p. 115.

The data contained in the Addiction Domain was quite extensive, regardless of gender. Only two (9%) of the male genograms, and 4 (12.5%) of the female genograms excluded any data pertaining to this domain. All participants who did include data for this domain, from both genders, included two-three generations of addictions, for at least one of the taxonomies within this domain. Alcohol addiction, however, was the taxonomy the participants provided the most extensive data. The second most prominent taxonomy is drug use. The remaining taxonomies, gambling, sexual, and nicotine addiction had the least amount of information provided. However, these results may not be an accurate representation of the sample. The counselors constructing the genograms, for instance, may not have asked the client's about the family history in these areas. Therefore, the client's, based on the presenting issues, may not have considered this
information as important, and subsequently, would not have offered the information. The female genograms also included a significant pattern of addictions through the three generations included within the genogram.

Concerning the male and female participants and the Addiction Domain, the data showed a considerable amount of generational behaviors (all 3 generations) associated specifically with the Alcohol taxonomy. In other words, the client, as well as his parent’s generation, and his grandparent’s generations, participated in behaviors associated with alcohol use and/or abuse. See Table 2 Addiction Domain.

The Drug taxonomy also showed a two generational pattern of behaviors (client and parent generations) associated with drug use and/or abuse. The grandparent generation showed much less behavior opposed to the Alcohol taxonomy. However, the client generation of the Drug taxonomy showed considerable more behaviors from the client, his children, and siblings, then did the client generation of the Alcohol taxonomy. The parental generation of the Drug taxonomy included a lower number of incidents as opposed to the Alcohol taxonomy. See Table 2 Addiction Domain.
The data collected for the Domestic Violence domain was vastly different based on the gender of the participants. The male participants offered less data pertaining to themselves, and offered less specific or detailed data. When a male participant did include information for this domain, it primarily pertained to the physical taxonomy. The second most prominent taxonomy for the male participants within this domain related to the two taxonomies of emotional and verbal abuse. Sexual abuse was rarely included in

<table>
<thead>
<tr>
<th>Table 2  Addiction Domain</th>
<th>Male Participants</th>
<th>Female Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>16/2</td>
<td>12/17</td>
</tr>
<tr>
<td>Siblings</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>14/3/5</td>
<td>19/4/4</td>
</tr>
<tr>
<td>Grandparents</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>14/6</td>
<td>11/16</td>
</tr>
<tr>
<td>Siblings</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Children</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>5/0/1</td>
<td>9/2/2</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

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the male genograms, and financial abuse was only included in one male genogram, and pertained to the generation including the client's parents and grandparents.

The female genograms that provided data for the Domestic Violence Domain was extensive. The primary taxonomies for the female genograms included sexual and physical. Many females admitted to being sexually abused by their fathers, grandfathers, stepfathers, siblings, uncles, strangers, and in some cases, their mothers or aunts. Also a significant amount of data pertained to past generations being sexually and physically abused, including the client's mothers, aunts, cousins, and also grandmothers. Physical and sexual abuse occurred primarily within the family of origin home while the clients were young. However, numerous females asserted being raped by strangers either as date-rape, assault by strangers, and in one instance, being raped by a drug dealer. The female that had been raped by her drug dealer became impregnated and later went on to bear a son. Another female admitted to being assaulted as a teenager, by a group of 4 male teenagers.

The female participants, it appears, did not hesitate to share information concerning domestic violence experiences during their lives. The taxonomies of emotional and verbal abuse were the next most prominent within this domain. A significant amount of the females who reported physical and sexual abuse, also included emotional and verbal abuse as well. The taxonomy of financial abuse was rarely included in the data. This may be a misrepresentation of the data for many reasons. For instance, the female client's were all homeless, therefore, the sample in general, most likely did not have the financial resources to survive, let alone any additional funds. Since there was a lack of funds available to the families, the women did not associate
financial control as a form of abuse. Also, most of the sample, including both genders, were substance users, therefore they may have been ‘controlled’ by drugs and alcohol being withheld from them rather than money being withheld. Consequently, the females also did not associate the withholding of drugs as a form of financial control. And, finally, since addictions were prominent with this population, the importance of securing drugs may have outweighed the importance of securing the necessities for survival. As a result, the clients may not have associated the lack of money or necessities as a form of control. Similar to the male genograms, the females reported significant generational patterns of domestic violence. See Table 3 Domestic Violence Domain. The numbers reflected within the Domestic Violence Table are the number of individuals within each category that were reported as victims of domestic violence. The emotional and verbal taxonomies were combined because of the tendency of the participants to report similar incidents within each of these two taxonomies.

The data included in the Domestic Violence Domain Table include the prevalent taxonomies related to this study, as is indicative of all the tables included within this study.
Table 3 Domestic Violence Domain

<table>
<thead>
<tr>
<th>Taxonomies</th>
<th>Male Participants</th>
<th>Female Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>9/0</td>
<td>22/2</td>
</tr>
<tr>
<td>Siblings</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>5/2/0</td>
<td>16/3/4</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>6/0</td>
<td>12/1</td>
</tr>
<tr>
<td>Siblings</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>1/1/1</td>
<td>4/1/1</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Verbal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>7/1</td>
<td>22/5</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>4/0/0</td>
<td>11/0/2</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
When collecting the data for the trauma domain, the male participants, again, were less likely to provide information pertaining to their own traumatic experiences. The male participants listed the following as the primary types of personal trauma: significant deaths (most likely a parent, caregiver, spouse, or sibling); parents divorce; being homeless (usually on more than one occasion through their life); and being estranged or detached from other family members, and society in general. Other forms of personal trauma listed by the male participants included being kidnapped as a child (most likely by a parent), physical abuse as a child, two reported being forced into child pornography, and one included his daughter being born addicted to drugs. The male participants also reported numerous suicidal deaths as significant, particularly parents and siblings. In some cases, the individual who the male participant considered his primary caregiver, such as an aunt or grandparent, were also reported as a significant death.

The female genograms included the following types of personal trauma experienced during their lives: a history of domestic violence; being physically or sexually assaulted; significant violence in the home while growing up; significant deaths; being abandoned either by a parent or spouse; 1 female included to loss of her family home to a fire; 1 female included being kidnapped as a child; and several females included homelessness as a form of personal trauma. One female participant reported being adopted out by her mother at the age of 10 years; while another female participant reported that she, as well as all of her siblings, were sold by their mother to perform sexual acts with strangers in order to pay for the mother’s drug habit. One female participant reported being arrested for a felony DUI (vehicular manslaughter) as a traumatic event in her life. Another reported the abandonment by her spouse and filing
for bankruptcy as traumatic events. However, the primary reason reported as a traumatic events in the lives of the female participants, by far, was sexual and physical abuse. The abuse occurred by family members and strangers as well. See Table 4 Trauma Domain. The numbers in this table reflect the number of participants reporting a traumatic event.

Table 4 Trauma Domain

<table>
<thead>
<tr>
<th>Taxonomies</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participants</td>
<td>Participants</td>
</tr>
<tr>
<td>Personal:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>15/0</td>
<td>32/0</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>2/0/0</td>
<td>11</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Significant Death:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Siblings</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Children</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>7/0/1</td>
<td>9/1/0</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
The Medical/Psychological Domain included a various amount of data pertaining the general medical taxonomy by both genders. Several of the genograms did not include any information pertaining to the general medical taxonomy, however, the data that were reported included medical conditions such as heart problems, liver problems relating to alcoholism, strokes, Alzheimer's Disease, diabetes, glaucoma, various types of cancer, birth defects, premature births, ulcers, Parkinson’s Disease, hypertension, children born positive for drugs, emphysema, and arthritis. The reported data pertaining to this taxonomy were not unexpected.

The data included on the psychological (self) and psychological (others) taxonomies were quite extensive. The male and female genograms reported generational patterns including, but not limited to, bipolar disorder, schizophrenia, depression, antisocial personalities, eating disorders, OCD, dyslexia, borderline personality disorder, ADD and ADHD, narcissism, low self-esteem, guilt and grief issues, anxiety, frustration, PTSD, attachment and anger issues, suicidal ideation or attempts, emotional issues, and uncontrollable violence. This data varied across genders in that the female participants included more mental illnesses for themselves and prior generations; particularly the more severe mental illnesses. These data were self-reported, therefore, it may not be an accurate representation of the homeless population. However, since most of the population reported a lack of education, it may be postulated that the participants were aware of specific diagnoses, rather than assuming these diagnoses were relevant.

The female genograms did report experiencing more surgeries, and also included more data than the male genograms in the general medical taxonomy. Although, as stated earlier, the information in regard to the general medical taxonomy was limited
compared to the other domains and taxonomies used for data collection within the study.

Table 5 Medical/Psychological Domain includes the data relevant to this study’s outcome. For each group the major presenting issue(s) will be named.

Table 5 Medical/Psychological Domain

<table>
<thead>
<tr>
<th>Taxonomies</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological (self):</td>
<td>Anger, impulsive, violence, attachment, estranged, suicidal</td>
<td>Bipolar, schizophrenia, depression, self-esteem, borderline, PTSD, dyslexia, ADHD, guilt, detachment</td>
</tr>
<tr>
<td>Psychological (others):</td>
<td>Depression, anger, OCD, dysfunction</td>
<td>Schizophrenia, anxiety, bipolar, depression, suicide, multiple personality, mental illness</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>Borderline, distant, Anger, suicidal</td>
<td>Anger, ADHD, schizophrenia, depression, homicidal,</td>
</tr>
<tr>
<td>Siblings</td>
<td>Only medical reported</td>
<td>Suicidal, depression, anxiety, schizophrenia</td>
</tr>
</tbody>
</table>

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The Criminal History Domain included an extensive amount of information across genders. The male genograms, however, were more specific and detailed than the female genograms. The male participants admitted to more personal criminal behaviors, as well as to a more extensive generational pattern of criminal history than the female participants. The primary descriptions of male criminal behaviors include driving under the influence of both alcohol and drugs, dealing drugs, gang violence, criminal possession of drugs, and shoplifting and burglary in order to secure drugs.

The generational patterns provided by the male participants include being arrested and/or jailed for murder, assault, driving under the influence, domestic violence, burglary with a weapon, and intent to sell drugs. Mostly, the past generations included were siblings, parents (primarily the father), and aunts. Although one male participant reported that his mother has spent time in a federal prison for unknown reasons. And, finally, most of the criminal history was a result of drug or alcohol use.

The female genograms, as relates to the Criminal History Domain, include incidents pertaining to the client and the client’s spouse or significant other. A few of the genograms included a parent’s history (1 female genogram included an offense committed by a grandfather), but the information regarding past generations was very limited.

The primary personal criminal behaviors for the female participants include drug and alcohol offenses (DUI, possession, “cooking meth”, and dealing drugs), assault, shoplifting, and 1 female reported assault with a deadly weapon. As a matter of fact, this particular participant, when discussing domestic violence stated that she was not only a victim, but she “did it to others too”. One female participant also reported a felony DUI
offense, which included the death of another person. The criminal offenses reportedly committed by a spouse or significant other includes, prostitution, murder or attempted murder, embezzlement, domestic violence offenses, burglary, and rape. Parental, and other family member offenses reported include murder, drug and alcohol offenses, and credit card fraud. One of the female participant's also included a report that her son was under the supervision of Child Protective Services (CPS) in this domain. Her frame of reference caused her to believe that being under the supervision of CPS was a criminal behavior. Whether this perception was intended as a criminal behavior based on her own actions or not was not clear.

This data, too, may be a misrepresentation of the homeless population because of the lack of data provided. This result of a lack of data, may be interpreted based on the number of the sample who were addicted to substances, and the behaviors normally associated with securing drugs and alcohol are criminal in nature. The study participants may not have reported the extent of their criminal behaviors for fear of being turned in to authorities. This interpretation may be based on the rules of confidentiality within the counseling profession. All clients are initially informed, and should be reminded throughout the counseling process, that one of the reasons confidentiality may be broken with a client, is the intent to harm oneself or others. If the clients had interpreted this confidentiality rule as a danger to themselves, the client's may have been hesitant to reveal the true degree of criminal behaviors. Most of the client's, however, did not hesitate to acknowledge the extent of other family members, spouses, and significant other's criminal behaviors over time. See Table 6 Criminal History Domain.
Table 6 Criminal History Domain

<table>
<thead>
<tr>
<th>Taxonomies</th>
<th>Male Participants</th>
<th>Female Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DUI/Drugs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>12/0</td>
<td>6/6</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Jail / Prison:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client/Spouse</td>
<td>9</td>
<td>4/10</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Children</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parents/Aunts/Uncles</td>
<td>1</td>
<td>3/0/0</td>
</tr>
<tr>
<td>Grandparents</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

The general description of the typical male genogram based on the data collected follows. The average age of the male participant was between 35-46. He had less than 4 siblings, although some of the male participants reported 6 or more siblings (up to 13 in one case). The education level reported was having less than a high school education. Most of the sample have been divorced at least once, had an average of 3 children, were unemployed, and homeless.
The average male participant, as well as having had an extensive family history of being addicted to alcohol and drugs, used alcohol and drugs himself. Approximately one-fifth of the males were also addicted to gambling, and some reported sexual and nicotine abuse as well. Most of the sexual addictions reported by the males included the use of pornography during high school or earlier; and, the pornography was most likely forced upon the male participants by a family member.

The average male reported a personal history of being physical, emotionally, and verbally abused, as well a generational pattern of domestic violence. The most significant personal trauma reported by the male participants was one or more significant deaths of family members, most of which were suicidal and/or violent in nature. Only 1 of the male participants was a combat veteran, although a few more reported a family member who was a combat veteran. The other primary personal trauma’s reported were parental divorces, being homeless, and abandonment issues.

The typical personal psychological issues were related to depression, anger, attachment, violence, and family of origin problems. The psychological issues of others known to the client, included depression, anger, violence within the family home, and some mental illnesses (such as schizophrenia, bipolar disorder, and PTSD). The typical male participant’s criminal behaviors were related to drug and alcohol use or other violent behaviors (such as murder, assault, burglary, and gang violence). The family history of criminal behaviors was similar to the content of the client history.

The typical age of the female participants was from 30 – 39. The race/ethnic information was not included on most of the genograms selected for use in this study. The typical female participant had fewer than 4 siblings, did not provide information
pertaining to education level, was primarily single or divorced/separated, had children, was unemployed, and homeless.

The average female participant was addicted to both alcohol and drugs, and also had an extensive family history in this category as well. Very few female participants reported an addiction to gambling, sex, or nicotine.

The information pertaining to the Domestic Violence Domain was extensive. The typical female participant had a history of severe physical, sexual, emotional, and verbal abuse. Along with the client, the client’s family history in this category was also extensive, typically extending through three generations. The financial abuse taxonomy within this domain was very rarely reported. The interpretation for this lack of data is similar to the explanation provided previously as pertained to the typical male genogram section of this study.

A significant amount of the personal trauma experiences faced by the female participants is related to physical or sexual assault (physical assault primarily by a spouse or father or brother; sexual assault was equally represented by family and strangers); domestic violence; significant deaths of family members, spouses, or children (opposed to the male genograms, most of the deaths were not violent); being homeless; 1 female reported being a Vietnam veteran as a personal trauma; the consequences of drug and alcohol abuse; and abandonment issues (either by a parent or a spouse).

Medical histories reported by the typical female participant included a diagnosis of hepatitis C or AIDS, various cancers (uterine, skin, etc.), emphysema, and diabetes. Some of the less prominent diagnoses included fetal alcohol syndrome, liver problems,
ulcers, epilepsy, and childhood diseases such as mumps and chicken pox. The family medical histories included heart problems, Alzheimer's disease, and various cancers.

The psychological history reported by the typical female participants included schizophrenia and bipolar disorders, depression and anxiety, poor self-esteem, and PTSD. Other types of psychological issues reported by the client include, ADD and ADHD, insomnia, guilt and grief issues, stress, and dyslexia.

The primary psychological family history reported, including three generations of family members, are schizophrenia, bipolar disorder, and depression; mental illnesses not specified; anger and control issues; suicidal ideation and attempts; and multiple personality disorder.

The primary criminal behaviors reported by the typical female participant involve drug and alcohol use (use and selling of drugs; DUI (including felony vehicular manslaughter); and burglary or shoplifting in order to secure drugs. The reported family histories, including at least three generations, include similar offenses related to drugs and alcohol as just states; attempted murder or murder; embezzlement; rape (1 female reported a cousin raped a women with a gun); and domestic violence arrests.

When comparing the information above regarding the typical male and female genograms with the case studies immediately following this section, there are many similar behaviors. The primary difference between the typical genogram and the case study selections, is the extent of the behaviors. Even though the genograms included in the case study are similar in nature to the typical genograms, the case study genograms are much more extreme in occurrence and degree of behaviors.
Case Studies

Along with providing 4 male and 4 female case studies consisting of the most illustrative genograms included in the study, a general summarization (for male and female genograms) has been provided in the previous section, “Analysis of Data”, based on all of the genograms that were selected for use in this study.

The criteria used when selecting the case studies was quite simple. Each of the genograms selected illustrate elements from across all domains with incidents reported in at least two of the corresponding taxonomies, include a minimum of two generations of deviant behaviors, and include more severe information pertaining to types of abuse, trauma, and addictions. For instance, if a genogram includes an extensive history of addictions, but did not include incidents for the remaining domains, then that genogram would not have been selected as a case study.

The number of genograms meeting the criteria to be included as a case study, were more numerous than the final number of genograms needed for the case study section. Therefore, the genograms that were selected for use as case studies were randomly selected, based on the client number, by literally pulling the client numbers out of a hat.

Male Case Study #1

Demographic Information.

Brian is 30 years old. His race/ethnicity was not included as part of the genogram. He has two biological sisters, was a high school dropout, is currently estranged from his wife and his daughter. He is unemployed and is currently homeless.

Client History.
The client has an extreme history of alcohol abuse. Brian had his first drink at the age of 12 years and by the time he was 17 years, he had lost his first job due to the use of alcohol. His history of alcohol abuse includes 6 driving-under-the-influence (DUI) infractions. His first infraction occurred at the age of 18 years, the second at 19 years, the third at 20 years, and the forth at 21 years. The forth infraction also included a hit-and-run accident. By the time the client was 30 years old, he had 2 more DUI infractions.

The client suffered both physical and sexual abuse as a young adult. The father of a friend inflicted both of these abuse experiences. His father, who subsequently abandoned Brian when he was left with relatives, kidnapped Brian at the age of 2 years. Following his stay with relatives, Brian’s father left him to live with a friend of his father’s, whose name was Ray. Ray was an alcoholic and also abused Brian.

Brian eventually married and had a daughter. The marriage ended when Brian’s wife had an affair with Brian’s father. Brian’s wife left him, taking his daughter, and became involved with an ex-boyfriend. At that time, Brian became homeless.

Brian did not report any significant medical or psychological issues concerning himself. Brian’s criminal history focuses primarily on his experiences with alcohol and Due’s. He was arrested 6 times, once for each DUI. He spent only three months in prison for the DUI infractions, and is currently on parole. Brian also was arrested for receiving stolen property, but did not spend any time in jail or prison for that offense. However, he is on probation for that offense.

*Family of Origin History.*

Alcohol also plays a part of Brian’s family of origin history. Brian’s father has been an alcoholic most of his life, however, Brian asserts that his father is currently
recovering. Brian’s uncle (father’s side) also has a history of alcohol abuse. According to Brian, his uncle is a functioning alcoholic. Brian states that his uncle works during the weekdays, however, on the weekend his uncle drinks beer until he passes out.

*Male Case Study #2*

**Demographic Information.**

Jim is 49 years old. His genogram data did not include any race/ethnic information. Jim has four biological brothers and one sister, however one of his brothers is dead. Jim did not state a reason for his brother’s death, except that his brother had died when his brother was only a few months old. Jim completed high school and went on to become an ordained minister. Jim has three sons and currently works as a janitor.

**Client History.**

Jim did not state that he has used drugs or alcohol during his lifetime. However, he did indicate a sexual addiction. Jim claims this addition came about following his being introduced to pornography by his father as an adolescent.

Jim asserts that he was repeatedly physically assaulted while attending school at the age of 7 years; his father also physically and sexually abused Jim for many years. Jim did not mention any abuse at the hand of his mother. As a matte of fact, Jim did not offer any information concerning his mother at all in his genogram.

The trauma Jim asked to be included in his genogram was very limited as well. Jim stated that the death of his youngest brother when only a few months old was a personal trauma for him, and also the death of Jim’s father was significant in Jim’s life. The reason Jim felt his father’s death was significant, was because it was a violent death caused by a gunshot.
Psychologically, Jim stated numerous incidents that occurred during his life. For instance, at 14 years old Jim fantasized about suicide; at 18 years old, Jim stalked his girlfriend; when 40 years old Jim lost his ministry and developed a “deep depression”. Jim also stated that while attending school he was exposed to pornography and also during this time, he became very socially isolated. He engaged in numerous fights during high school and, at home, was always “blamed” for all the fights that occurred between his siblings.

Jim stated no criminal history or actions that may be considered criminal in natural during his life.

*Family of Origin History.*

Jim claims that his grandfather (father’s side) is an alcoholic. No other addictions were stated, except for the sexual addictions Jim engaged in, as well as all of his siblings. Jim, as well as all of his brothers, was subjected to pornography; Jim states that his father forced pornography on him and all of his brothers as well.

Jim stated that his grandmother (father’s side) was physically abusive to Jim’s mother. This statement is the only reference to Jim’s mother in the entire genogram. In addition, Jim noted that all of his brothers were also sexually abuse by their father throughout their adolescence and through the teenage years (from 12-18 years).

There are numerous significant deaths reported by Jim. One of his brothers committed suicide, which Jim attributes to the physical and sexual abuse by their father, as well as the experiences with pornography. Jim’s uncle (father’s side) also committed suicide, which Jim attributes to his uncle’s alcoholism. And finally, a second uncle (Jim’s mother’s side) also committed suicide. Jim asserts his fantasies concerning
suicide are a result of experiencing so many tragic deaths due to suicide within his family.

Male Case Study # 3

Demographic Information.

Jim is 23 years old. Jim's genogram did not include any race/ethnic information. He has no siblings, and he did not state whether he had completed high school or not. He is currently married, however, his wife left him to move to California, and also took their daughter with her. Jim is currently unemployed and homeless.

Client History.

Jim claims to not have a history of alcohol or drug use throughout his life. Nor does Jim claim to engage in any other addictive behaviors currently or in the past. Jim does state that there was a significant amount of abuse in his family home. Jim was physically abused by his stepfather, as well as an uncle (Bob). Uncle Bob also sexually abused Jim. The other information concerning abuse will be stated in the family of origin history. Uncle Bob also forced Jim into child pornography. Jim stated being forced into child pornography was a personal trauma for him. He also stated that his girlfriend had aborted his child, which Jim also included as a personal trauma. The final personal trauma listed by Jim, was the experience of being “forced into witchcraft”, again, by Uncle Bob. Jim claims he was “brainwashed by Uncle Bob” into believing in and practicing witchcraft.

Psychologically, Jim claims to be a pathological liar and narcissistic as well. He also claims to have a violent temper, and that he is extremely demanding.
Jim claims no criminal behaviors during his life, “except for participating in the child pornography”. Although, there was never criminal charges involved in the child pornography experience.

*Family of Origin History.*

Although Jim claimed no history of alcohol or drug use, Jim’s father, stepfather, and Jim’s father-in-law are all alcohol users. In addition, Jim’s father and mother are also drug users.

The physical abuse that occurred in the family home was from Jim’s father to his mother, Jim’s wife to her ex-husband, and Jim’s uncle to all of the family members. Sexual abuse occurred from Jim’s grandmother toward Jim’s uncle, financial abuse from Jim’s grandfather toward Jim’s grandmother, and also from Jim’s stepfather to his mother. Emotional abuse occurred from his grandfather toward his grandmother, his stepfather to his mom, Jim’s wife toward her mother and father and vice-versa (Jim claims his wife’s parents did not accept Jim), and finally, from Jim’s grandmother toward every family member.

Medically, Jim’s family of origin has a history of lupus and cancer. Psychological issues as stated by Jim include his mother’s breakdown, his aunt has severe depression and is on anti-depressant medications, his uncle has been diagnosed with schizophrenia, and Jim’s aunt is narcissistic.

Jim’s aunt is the only family member ever imprisoned, although Jim was not aware of the reason for it.

*Male Case Study #4*

*Demographic Information.*
David is 31 years old. His genogram did not include any race/ethnic information, or information concerning his high school education. David has two brothers and 1 sister. David is currently married, with two sons and one daughter. David is currently unemployed and homeless.

Client History.

David has an extensive history using both alcohol and other drugs. He began using both before the age of 8. David asserts that his alcohol and drug use began because of his association with gangs, since the age of 7 1/2. According to David, he has "used almost every drug known to man." David’s family of origin also has a significant history with alcohol and drug use, which will be discussed later.

David claims no specific history of domestic violence, however, he does admit that he grew up "surrounded by violence" both within the home and on the streets. Because of his association with gangs, David has an extensive criminal history as well. He claims to have been "in and out of jail and prison since the age of 9". His first prison experience was due to a charge of attempted murder at 9 years old. He continued, that between the ages of 15 – 17 he was in jail several times for gang violence and drug charges. He is currently on parole and will be for several more years.

In regard to personal traumas experienced during his life, David refers to the gang associations. He feels that his experience with gangs was traumatic for him; but unfortunately, he was not aware of it at the time. He only came to realize the extent of the trauma after he was able to leave the gangs.

David also refers to several significant deaths that were personally traumatic to him during his life. One death was that of his father at 49 years old. His sister died at the
age of 37 and she was pregnant at the time of her death. David also refers to “several”
gang members who died as a result of the violence the gangs were exposed to, and David
feels particularly troubled by those deaths.

Medically, both David and his wife have been diagnosed with hepatitis C and
David had his appendix removed at the age of 7. Psychologically, again, David refers to
the problems caused as a result of the gang violence he exposed himself to over the years.
He has never been diagnosed with a mental illness however he does claim that his family
of origin was “very dysfunctional”, and he feels that has affected him also.

_Family of Origin History._

In regard to addictions, David’s brother and oldest sister use alcohol and other
drugs. His mother and stepfather, as well as his grandfather on his mother’s side, also
have a history of alcohol use. David’s aunts and uncles on his father’s side (4 uncles and
1 aunt), all have a history of alcohol use, and finally, David names his gang “family” of
using alcohol extensively over the years. David’s wife also has a history of drug use.
His mother has a gambling addiction, and David’s brother and three uncles all smoke
nicotine.

As stated earlier, David did not specifically refer to acts of domestic violence
(physical, sexual, financial, emotional, or verbal). However, again, he did state that he
grew up “surrounded by violence both within and outside of the home.”

Medically, his family has a history of diabetes, heart attacks, strokes, and cancer.
Psychologically, David states the dysfunctional nature of his family of origin, but again,
does not state anything specific to quote.
Other than David’s criminal history, no other family member has been arrested, jailed, or imprisoned during his lifetime.

*Summary of Male Case Studies.*

As stated earlier, the data that comprises the male genograms was much more limited than the data that comprises the female genograms. Given that, the male genograms selected for use as a case study did include illustrative data across all of the domains in order to give the reader a sense of the more extreme cases of the male genogram information available for this study.

The male case study genograms were not limited in the data provided for the Addiction Domain. However, a large number of the male genograms do not include a significant amount of data pertaining to traumatic events, whether discussing the Trauma Domain or the Domestic Violence Domain. The information provided to the counselors by the male participants concerning trauma typically encompassed significant deaths of family members, spouses, or children. However, the case study genograms did include information, although not specific, of physical and sexual abuse suffered either as children, teenagers, or young adults. The typical male genograms were not as informative as the case study genograms in these areas. Also the case study genograms contained more detailed information in the Medical and Psychological Domain, specifically, the taxonomy of “psychology (others)”.

This finding similarly represents the information stated in Chapter 2 of this study pertaining to the reasons postulated as to why men do not admit to traumatic events during their lives. There are many reasons included in the data to determine why male
clients do not historically share this type of information, none of which can be related to this study based on the methodology used for the data collection and analysis.

**Female Case Studies**

The female case studies, as opposed to the male case studies, included much more detailed information across all of the domains. The information provided in the Addiction Domain is specific, similar to the male case study data. There is a significant difference, however, with the amount of data provided in the Trauma Domain, the Domestic Violence Domain, and the Medical/Psychological Domains. All of the female genograms were much more detailed and specific in regard to those domains, not only the genograms selected for use as a case study.

The information provided in the female genograms was also much more likely to include the women admitting to being a perpetrator as well as a victim. The male genogram information was extremely limited in this regard.

**Female Case Study #1**

**Demographic Information.**

Ann is 32 years old. Her ethnic background includes Indian, “Black”, and Polish descent. Ann has 2 biological brothers and 3 biological sisters; 2 adopted brothers and 3 adopted sisters. The information concerning her educational level is not complete. Ann is currently single, unemployed, and homeless.

**Client History.**
Ann does not admit to a history of addictions, other than nicotine. However she does have an extensive family of origin history of alcohol and other drug use, as well as sexual addictions, which will be discussed in the next section.

In regard to the Domestic Violence domain, since the history includes all of Ann’s siblings, it will be discussed in the Family of Origin History section as well.

In regard to the Trauma Domain, Ann admits to being sexually abused by her father, as well as an extraordinary amount of other men. The abuse from the other men was in response to Ann being “sold” by her mother to strangers in order for her mother to pay for her drug habit. Another personal trauma stated by Ann was that she was adopted out of her family at the age of ten by her mother. Ann also states being homeless as a personal trauma.

Ann also experiences a significant death. Her biological brother died by suicide at the age of 16 years. Ann does not specify a reason for the suicide, but does include this death as a traumatic event in her life.

The Medical/Psychological Domain regarding Ann is somewhat uneventful. Ann claims an early diagnosis of schizophrenia. She does discuss the extensive family history of psychological issues though. Which will be discussed shortly.

Criminally, Ann does not have a background. However, her father was in prison (Ann does not elaborate on it), and he died there. Other than her father, no other family member was stated as having a criminal background.

*Family of Origin History.*

Not only does Ann states an extensive history of addictions for her biological family, but also for her adopted siblings as well. In regard to alcohol use, Ann’s
biological father, brother, and mom are all abusers of alcohol. Drug use also includes her adopted siblings. Ann includes her biological father, 2 sisters, brother, and mother as abusing drugs, as well as 2 of her adopted sisters. There is no history of gambling addiction in Ann’s family. However, sexual addictions are attributed to Ann’s biological father and brother, and one of Ann’s adopted sisters as well. The family members that abuse nicotine are 2 of Ann’s biological sisters and her father, as well as Ann’s 2 adopted sisters. As mentioned earlier, Ann also admits to using nicotine as well.

The Domestic Violence Domain includes a significant history of sexual abuse. Ann’s father sexually abused all of her siblings, as well as herself. In addition to being sexually abuse by their father, Ann’s mother, as mentioned earlier, sold all of her children to strangers for sex in support her mother’s drug habit. Her mother, also abused Ann’s biological brother as well.

In regard to the Medical/Psychological Domain, under the General Medical Issues, Ann lists her father’s death in prison. Ann does not state the nature of the death, therefore, the information is not useful in determining a pattern of illness within the family. Psychologically, one of Ann’s sisters and her father are both schizophrenic, her mother is considered bipolar, as well as being diagnosed with multiple personality disorder. Ann also includes another of her biological sister’s as having homicidal tendencies, and states that her biological brother committed suicide following numerous episodes of sexual abuse. In regard to Ann’s mother, Ann states that she had been “in and out of mental institutions throughout her life.”

Female Case Study #2

Demographic Information.
Rita is 37 years old. No race/ethnic information was provided in the genogram. Rita has one step brother and one step sister. She is a high school dropout. She is married for the second time, however, she also lists two significant relationships with boyfriends in the past, and also a lesbian relationship in the past as well. Rita has 2 biological sons, and 1 biological daughter; she also has 2 adopted sons as well. Rita is currently unemployed and homeless.

Client History.

Rita does not admit to a history of alcohol use, however, she does admit to a history of drug use, as well as a sexual addiction, which emerged following her becoming interested in pornography. Her family history with addictions will be discussed shortly.

Regarding domestic violence, Rita was physically abused by her first and second husbands, as well as by her mother. Sexually, beginning at 13 years old, Rita was abused for five years by her father. Rita suffered emotional and verbal abuse as well from her mother and Rita’s 2 husbands.

Rita lists several personal traumas that have had a lasting affect on her. First she lists being raped at the age of 13 by her mother’s second husband. Rita also lost a son prematurely as a result of his own drug use. Being homeless a minimum of five times throughout her lifetime has also been very traumatic for Rita, as well as suffering extensive domestic violence throughout her life. Rita also included the death of her aunt, who was also her caretaker, when Rita was 18 years old. Rita was very close to her aunt and was devastated by her death; her aunt “protected” Rita throughout her lifetime.
Medically, Rita and her second husband have both been diagnosed with hepatitis C and Rita had a hysterectomy after the birth of her last child. Psychologically, Rita has been diagnosed with bipolar disorder.

Rita's criminal history, as well as her family history of criminal behaviors, is extensive. Rita's criminal behaviors include dealing drugs, and she was also arrested and went to jail for possession with intent to sell, grand theft auto, and fraud. Rita does not state the length of time she has spent in jail and/or prison, just that she has been to jail and/or prison.

Family of Origin History.

Rita's first and second husband's, her ex-boyfriend, her stepbrother, mother and father, stepfather, and both grandparents on her mother's side of the family, all have a history of alcohol use and/or abuse. Rita also notes that her mother has been recovering from alcohol abuse for the past 20 years. In reference to drug use and/or abuse, Rita, her girlfriend, both husbands, 2 ex-boyfriends, her adopted son, stepbrother, father, and stepfather all have a history of consumption. Rita also lists herself, as stated earlier, as having a sexual addiction that is related to pornography movies.

Physical abuse occurred frequently within Rita's home growing up, as well as in the home she shared with her spouses and children. In addition to the abuse listed previously that Rita had suffered, Rita's stepfather also physically, emotionally, and verbally abused her mother. Rita's both husbands also physically abused Rita's children on a regular basis.

Rita's grandparents on her mother's side of the family both died of liver problems due to the use of alcohol. Psychologically, Rita's son suffers from depression and is
bipolar; Rita’s father is bipolar and schizophrenic, and her mother is bipolar as well. In addition, both Rita’s first husband and Rita’s father were steadfast followers of Manson. Rita did not mention any reaction to this specifically, however, she is aware that it has affected her in some way.

Criminal behavior occurred in Rita’s family of origin on a regular basis. Rita’s girlfriend was a drug dealer, but did not spend any time in jail or prison. Rita’s second husband was arrested for and spent time in prison for domestic violence inflicted on Rita and her children. In addition to Rita’s history of jail time, the following family members have spent time in jail and/or prison: first husband (murder) and second husband (domestic violence); boyfriend #2 (grand theft); and her father (murder).

*Female Case Study #3*

*Demographic Information.*

Sherri is 16 years old. The information regarding her race/ethnic background was not included in the genogram. Sherri is a high school dropout, single, unemployed, and homeless. Sherri also has 2 sons less then 2 years old.

*Client History.*

Sherri has a history with alcohol and drug use/abuse. But she does not admit to any other addiction.

Her history of domestic violence is extensive. Sherri was physically abused by her grandfather on her mother’s side, her grand-stepfather on her mother’s side, and from her mother’s numerous boyfriends. Sherri also states that her family of origin was “severely physically, emotionally, and verbally abusive” not only to Sherri, but to each
other. When Sherri was five years old, her mother’s boyfriend repeatedly sexually abused her.

In regard to personal traumas, Sherri includes the numerous rapes she suffered as well as the extensive abuse she suffered from her family of origin throughout her life. Sherri’s mother’s death, which was an overdose, was also included as a personal trauma for Sherri.

Sherri does not list any medical issues for herself, but she does list the following psychological issues: the grief she has been unable to “come to terms with” when her mother overdosed, a problem with anger, and irrational thinking.

Sherri does not admit to any criminal behaviors during her life. But her family has been involved with the criminal justice system, which will be discussed shortly.

*Family of Origin History.*

Sherri’s 4th stepfather abused alcohol, and her mother, father, and second boyfriend all abused drugs. There were no other addictions included on Sherri’s genogram.

Sherri’s family history of domestic violence is extensive. Physical abuse occurred from Sherri’s grandfather (mother’s side), her grand-stepfather (mother’s side), from her mother’s numerous boyfriends, and “from her family of origin in general the physical abuse was extreme.” The Sexual abuse was listed under client history. No financial abuse was included, but emotional and verbal abuse “from her family of origin was extreme” as well.
The medical history of Sherri’s family was not included within her genogram. This domain’s information was limited to “Psychological (self)”, which was discussed in the client history section.

The family criminal history includes the arrest and jail time Sherri’s mother’s boyfriend received for raping Sherri, Sherri’s grandmother (mother’s side) being arrested and jail time for credit card fraud, and the arrest, jail time, and parole for Sherri’s second boyfriend. Sherri does not state the extent of jail time or the reason for the jail time in regard to this boyfriend, other than what was previously discussed.

Female Case Study #4

Demographic Information.

Tiffany is 22 years old, and her race/ethnic information is unknown. Tiffany has 1 brother and a step sister. Her educational level is unknown, she is currently married, has 3 sons (by three fathers; one of which was Tiffany’s rapist), she is currently unemployed, and homeless.

Client History.

Tiffany states that she has a history of both alcohol and drug abuse. She does not include any information concerning the other addictions within this domain. She also has an extensive family history of addictions, which will be discussed later.

In regard to domestic violence, Tiffany was physically, emotionally, and verbally abused by her husband. Tiffany does not include financial abuse as part of her background.

The personal traumas listed by Tiffany include, the history of domestic violence at the hand of her husband, as well as being raped by her drug connection, which in turn,
produced a son for Tiffany. Tiffany also considers the verbal abuse by her mother as a personal trauma, as well as the domestic violence that occurred in her home while growing up. As opposed to most of the other genograms analyzed for this study, Tiffany is one of the few participants not listing a significant death as a traumatic event.

Tiffany does not discuss any medical or psychological issues concerning herself in the genogram. However, she does talk about her family history, which will be discussed later.

Tiffany’s criminal behavior is limited to being arrested and spending time in jail for writing bad checks, and the fact that Tiffany sold drugs. She was not arrested, nor did she spend time in jail for the drug selling. Again, there is a family history of criminal behavior, but that will be discussed shortly.

*Family of Origin History.*

Other than the alcohol and drug use/abuse that Tiffany alluded to previously, her first boyfriend, husband, brother, stepsister, father, grandfather (father’s side), and her mother’s five out of five husbands, all have a history of alcohol abuse. The family members that also used drugs are Tiffany’s first boyfriend, her rapist, her brother, her mother’s five husbands, and her father. The only family member not included in both taxonomies of alcohol and drugs, is Tiffany’s grandfather. There are no other addictive behaviors listed for Tiffany or her family.

Other than Tiffany suffering physical, emotional, and verbal abuse from her husband, the only other family member with a history in this domain is Tiffany’s mother. She has experienced extensive physical, emotional, and verbal abuse from each of five husbands throughout her lifetime. Each of Tiffany’s stepfather’s also subjected
abuse on Tiffany and her siblings as well. Tiffany, as stated earlier, was also subjected to emotional and verbal abuse from her mother.

The medical history Tiffany discussed is limited to the heart attack suffered by her grandmother on her mother's side. Psychologically, Tiffany includes the suicide of her grandmother on her father's side, her father's history of mental illness (not specific), and her aunt's (father's side) depression. There are no other medical, surgical, or psychological issues provided.

The criminal behaviors provided by Tiffany include the drug dealing of her husband and her rapist, and that her mother's forth husband bought drugs from Tiffany and her husband for many years. Tiffany's grandmother (mother's side) was also arrested and spent time in jail for embezzlement. Tiffany does not include the length of stay in jail for the grandmother, or any other family member's criminal behaviors.

*Summary of Female Case Studies.*

The amount of data provided on the female case studies is much more specific and extensive then the data provided by the males for their case studies. The females provided more information concerning abuse, trauma, psychological issues, and in some cases, criminal behaviors. As stated earlier, in the past literature it has been postulated as to why women offer more information, or admit to more abuse and trauma then men do. However, the data provided for use in this study will not, and is not expected to, reveal additional information regarding this phenomenon.
CONCLUSIONS AND RECOMMENDATIONS

Cultural Implications of Data Results

In order to understand the cultural implications of this study, it is important to understand what the norm is among the culture of the homeless population. The extent of the personal experience the author has been subjected to with this population is based on prior observations of this population, noting that this prior observation information does not pertain to this study, but rather supports the construct of what is considered normal for this group of individuals. While making observations, certain cultural characteristics of homeless individuals became evident.

For instance, the majority of homeless individuals consider drug and alcohol use the norm. Whether this cultural characteristic is based on the client’s exposure to prior generational use of alcohol and drugs, or whether it is derived from the participants use, the use and/or abuse of substances are not considered a form of victimization. Also considered normal are the criminal acts executed by this group in order to survive. Survival can relate to continued existence by acquiring daily needs, such as food, shelter, and daily necessities. These criminal acts are the result of feeling victimized, though, because of the overall belief within this population that the ‘system’ has let them down. When approaching the ‘system’ for assistance, a homeless individual is routinely shuffled from one agency to another, with long wait times, only to be told eventually that there are
either no services available or the services that may be available are extremely limited or will take weeks to materialize. The majority of homeless individuals are under the belief that the ‘system’ is not in place to offer assistance to them. Members of the homeless population are extremely untrusting of the ‘system’, particularly the welfare, food stamp, housing, and criminal justice systems.

In regard to the daily need of sleep, there are a limited number of free shelter beds available to this population. If a single parent, or two-parent family tries to obtain a shelter bed, the odds of securing a bed become worse. Free shelter bed waiting lists are usually very long. Or, if interested in obtaining a shelter bed, an individual may need to wait on a line beginning at 6 or 7 A.M. every day for several hours, until a bed can be obtained. In most cases, as a result of waiting for a bed, most homeless individuals are not able to work that day. In the meantime, the only other option available is for the individual or family to sleep outside. Sleeping outside is not only a health threat, it is also a threat to life and belongings, unsanitary, stigmatizing, intimidating, sleeping on private property is against the law, and if children are involved, children protective services can become involved and remove the homeless parent’s children if found living on the street.

Consider the above information, along with the following problems. Has a history of domestic violence within your family of origin, probably also in your marital household. In addition may be suffering from depression or some other type of mental illness. Are most likely having suicidal ideations; are most likely addicted to a drug that will cause severe withdrawal symptoms if the individual doesn’t get high again soon; probably has not eaten most of the day or had a shower or use of a restroom for more
than one or two days, may be suffering from a cold, flu, or diabetes, hasn’t spoken to
more than one family member for the past several years, has no support system
whatsoever, and has no money.

Which of the above needs should this person place as high priority? Which of the
above needs will the ‘system’ be most able to assist this individual with immediately?
History has proven to this group of individuals that there is little hope. There is not much
hope for survival, let alone a successful outcome. The level of hope becomes even less if
the homeless individual is illiterate, has a learning disorder (such as dyslexia or ADHD),
is traumatized to the point of being immobilized, has a severe mental illness such as
bipolar disorder or schizophrenia, has a criminal background, or is ill with hepatitis or
AIDS; all of which, unfortunately, is typical within the homeless population.

Within Las Vegas, in order to secure a shelter ‘bed’ (e.g., a mattress typically on
the floor or a cot), a person has to be drug and alcohol free, in the shelter by 7 or 8 P.M.,
pay a fee (usually five dollars or more) for a night stay or agree to work for the agency
supplying the bed for at least a full day, and must be awake, dressed, and exit the shelter
by 7 A.M. Imagining the typical day of a homeless person in response to these shelter
rules, very few are drug and alcohol free, if they have been lucky enough to get chosen to
work as a day laborer, he or she will not be in the shelter before the time deadline and as
a result will lose the bed, and will not have the fee needed to secure a bed. In addition to
the above, staying in a shelter, even for one night, does not eliminate the personal safety
factor. It has been found in prior literature, that shelters are not safe places. Belongings,
including clothes, food, illicit or prescription drugs, and money are typically stolen while
one sleeps in a shelter. There are also reports of shelter residents being abusive to each
other. This abuse may be the result of drug use, or it may also be the result of drug withdrawal, or the inability to control anger, or due to mental illnesses. Therefore, the majority of homeless individuals choose not to seek the assistance of shelter beds.

Based on the many limitations of this study, which will be discussed shortly, there are many steps researchers may initiate in duplicating the methodology of this study. Future studies may include constructing two genograms with each client; one genogram during the early stages of the counseling process, and another near the end of the counseling process. This would assist in determining the reliability of the data reported.

The methodology used of gathering information through the use of genograms provides an extensive amount of data and insight into the life of the client. It is also an exceptional method for collecting data pertaining to the behavioral patterns of past generations and how those patterns relate to the client. Future quantitative analyses may show causal generational patterns, which can eventually help to assist this population in the form of preventative measures, rather than society waiting for the homeless population to fall too deep in despair that it becomes too time consuming and too costly to dig them out.

Discussion of Overall Results and Case Studies

The purpose of this study was to illustrate generational patterns of trauma and substance use within the homeless population during the participant’s childhood, adolescent, and young adult years. The patterns may be indicative of future behaviors, which may be directly or indirectly related to contributing to an individual’s chance of becoming homeless.
The data collected across genders from the participants did show a generational pattern of behaviors/experiences/incidents relating to several of the domains that may contribute to becoming homeless in the future. The two conditions of homelessness that were being studied were trauma and addictions. The methodology of the data collection included one Addiction Domain, and two domains related to trauma: the Domestic Violence Domain, and the Trauma domain. The three above domains included patterns of experiences and behaviors spanning two-three generations that may be related to behaviors that are not typically accepted by society, which may lead to environmental circumstances, which may, in turn lead to becoming homeless.

The Medical/Psychological and Criminal History Domain’s both afforded a vast amount of information pertaining to the client, parent, and the grandparent generations. The general medical taxonomy within the Medical/Psychological Domain did not include any alarming data, however, the psychological taxonomies relating to self and others did provide overwhelming data. For instance, the data showed several of the male and female client’s had a history of schizophrenia, bipolar disorder, and depression. This data also continued across all generations, particularly as reported by the female participants. The expected results of the psychological taxonomies included depression, anxiety, PTSD, and stress, which were also reported by the participants. However, the male participants revealed a greater amount of generational history including depression and suicide, while the female participants revealed a greater generational history consisting primarily of bipolar disorder, schizophrenia, PTSD, and depression. This result is indicative of recent research studies pertaining to the homeless population and mental illness, as stated previously in this study.
The recent trends of research that have been conducted have focused, primarily, on female homeless individuals; however, the male segment of the homeless population needs further study. As stated previously, a recent study reported a large percentage of the homeless population had considered suicide within the past week. The causal relationship between suicide and the homeless population has not been researched extensively in the past. Determining the relationship of suicide and the psychological correlates associated with the homeless population has an overwhelming potential for alleviating, or at least diminishing, the number of homeless individuals attempting or committing suicide each year. Future research concerning mental illness and the homeless population may also determine the number of individuals affected by fetal alcohol syndrome, bipolar disorder and schizophrenia as they relate to childhood abuse, PTSD, depression, and the causal relationship of these illnesses and becoming homeless. The amount of preventative measures that may be offered to this population once a causal relationship has been determined are unlimited.

The Criminal History Domain did reveal a generational pattern of deviant behaviors, primarily related to drug and alcohol use. Specifically, the most prevalent criminal offenses reported were DUI offenses, which include property damage and homicides. The male and female participants were equally represented in this domain. Except, the male participants revealed more violent crimes as well as a generational pattern of more violent crimes. The female participants and their past generations were, by no means, innocent in this domain; they also reported histories of assault, drug possession with intent to sell, murder and attempted murder. However, the female participants also included several reports of less violent crimes, such as embezzlement,
credit card fraud, and shoplifting. All of the less violent offenses, across genders, were related to securing drugs and alcohol, or daily necessities such as food, for the participant's own consumption. This area of research has not been sufficiently studied in the past. Future studies into this condition of the homeless population would be a significant contribution to the knowledgebase of this population.

The examples used for the case study histories included in this study were illustrated for several reasons. First, the number of client histories that could have been selected for use as a case study were numerous, which is indicative of the extreme behaviors of this population in general. As stated earlier, the criteria used for the selection of the case study participants was simply that the participants were required to have at least one incident listed for each domain of the study. Not necessarily a three generational history, but at least two generations of behaviors were required for at least two taxonomies within each domain. Since so many participants meeting the selection criteria, the level of extreme behaviors was apparent within the sample as a whole.

Second, by illustrating the more extreme examples of the sample, the reader was able to compare the general, or typical, history of the participants to the case study participants. This was done for two reasons: (1) the differences between the typical genogram and the case study genograms was not particularly severe, and (2) because of reason number one, the extent of the behaviors reported within this population are consistent across generations, genders, and domains. Some of the gender differences reported by the participants were obvious. Such as less abuse and trauma reported by the males as opposed to the females, and the more anger and attachment issues pertaining to the psychological histories reported by the male participants, as opposed to the more
severe mental illnesses reported by the female participants. However, in general, the data was similar across genders and domains. In summary, the history of the participants, as well as earlier generations, show a tremendous amount of trauma, abuse, and addictions, regardless of gender, age, marital status, or employment status.

The method of collecting and analyzing data through the use of genograms provides researchers with an extensive amount of data. Since the genograms selected for use in this study were not constructed intentionally for use in this study, the data is more indiscriminant than if the participants and the data were targeted for trauma and addictions within the homeless participants. This is very important to the results of the data collection because the counselors constructed the genograms based on the client’s presenting problems and the counselor’s interpretation of the client’s needs, not on the research base for this study.

Also, the data were not collected at a location that provided substance abuse counseling or domestic violence advocacy services. Therefore, the clients attending individual counseling at the homeless advocacy organization were not seeking the counseling service based on addictions or trauma. This is also important to the results of the data collection since the client’s reporting problems were not associated with addictions or trauma, these conditions most likely became apparent to the counselor and client throughout the counseling process.

In summary, the actual results of the data collected through the use of genograms, were consistent with the expected results. Having had the experience of counseling this population, the actual results concerning addictions and trauma confirmed the extent of these issues with the population as a whole, including prior generational patterns. In
actuality, the Medical/Psychological Domain was more extensive as reported by the 
participants than was expected. The severity of the participant and generational history 
of psychological diagnoses were more extensive than was expected. The information that 
was expected was depression, anxiety, and stress (PTSD). Instead, the participants 
reported bipolar disorder, schizophrenia, multiple-personality disorder (as stated by the 
participants), and suicide. Again, the severity of the presenting issues facing the clients 
regarding this domain, were remarkable.

Conclusions and Recommendations for Further Study

There were several limitations associated with this study that need to be 
discussed. First, the data was collected by a group of counseling students without a 
specific design or matrix. Therefore, each of the genogram designs was subjective to 
each counseling student. Future studies following this methodology may consider 
developing a specific genogram design with specific interviewing methods. Following a 
specific design would allow for consistency by the interviewers. For instance, designing 
a matrix to include information that would be expected within each genogram, such as 
race and ethnic information and religious information, and what information would be 
expected to be included on the timeline, as opposed to the information within the 
genogram itself. As an example, if the genogram focused on a specific area of life, such 
as a pattern of addictions or familial issues such as significant deaths or divorce, the 
timeline, then could include other information, such as major life events specific to the 
client's siblings, children, or self, or positive experiences such as becoming a college 
graduate, marriage, or the birth of children. The genograms used for this study lacked
positive information associated with the client’s lives. This is important since the counseling student should also be providing the client with an awareness of the positive patterns throughout his or her life as well as the negative patterns.

Second, because the recording of data was subjective, personal, and individual to each client it is difficult to pool the information into specific categories. Therefore, conducting statistics in order to determine specific correlations on the data is problematic. For instance, a female client may have reported physical abuse to herself by several family members, spouses, and strangers, as well as reporting the physical abuse of other family members, and the physical abuse to a spouse’s ex-wife or children. The attempt to categorize the many types of data reported into any specific pool becomes difficult for the researcher. Each client would have his or her own pools of data. It would be very difficult to place the data into consistent pools across gender. Although, the clinician may utilize the first word used as a description of the abuse for the client and other family members, as a title for each pool of data, and therefore, the pooling of data may be possible. The approach to determining the pool categories would be broad, futile, and wide-ranging. Whether or not statistical data could be appropriate for this task has yet to be determined. Future studies using this methodology may consider determining specific categories in which to place the data in order to perform statistical analysis of the data.

The third limitation of this study has to do with the verifying the data as accurate. For instance, the self-reporting of the psychological and diagnoses of the mental illnesses of the participants, as well as the family members. The reported information is based on the client’s perception. Whether or not the diagnoses are accurate is unknown. Also, one male participant admitted to being a pathological liar, and yet, the genogram pertaining to
this client was included in this study. Even if a participant is not an admitted pathological liar, the participant may perceive a more severe history as positive, in that the irrational data may explain the client’s current situation (homelessness) more easily. In addition to the client’s perception of his or her own circumstances, he or she may believe, that by exaggerating the past circumstances of his or her life, he or she is justifying the blaming of others as opposed to blaming oneself.

Clinicians utilizing this methodology in the future may consider also administering one or more assessment inventories to each client pertaining to trauma and addictions, along with analyzing the data within each genogram. This would also provide the clinician with a means to verify the reliability of the data provided. Weiss et al. (1998) conducted a study that found self-report inventories, when used to monitor the substance use in non-psychotic, dually diagnosed clients were highly valid.

The fourth limitation of this study has to do with the use of secondary data. Again, the interpretation of the information provided by the client to the clinician is subjective. Also subjective, is the interpretation used in categorizing the final data in order to determine generational patterns of behaviors. If a genogram was constructed during the second or third meeting with the client, and then, subsequently, throughout the counseling process other information is provided that contradicts the original information, the final analysis does not include the later information.

The fifth limitation of this study pertains to the limited number of veterans participating in the study. As asserted in past literature pertaining to the homeless population, veterans represent a fairly large percentage of this population. The CIC did provide a free clinic to those individuals without health insurance. However, veterans did
not utilize the services offered by the CIC Health Clinic since veterans are supplied
health insurance through the Veterans Administration; therefore, veterans were referred
to the Veterans Administration for health services. Subsequently, the number of veterans
who may have utilized other services through the CIC, such as individual counseling, was
limited since veterans, as a group, utilized services elsewhere.

The final limitation to this study has to do with the participant’s perception of the
presenting issues as reported to the student counselors. For instance, the reporting of
incidents pertaining to the Domestic Violence Domain regarding the financial abuse
taxonomy was extremely limited. As stated earlier, this may be the result of the
misperception of the participants to realize or understand the extent of the abuse he or she
may have suffered, because the participant’s frame of reference regarding abuse and
addictions perceive these behaviors as normal. The participant’s frame of reference
misperception may also apply to other domains and/or taxonomies as well.

Future study of the homeless population concerning the conditions of trauma and
addictions should include longitudinal studies relating to the social support networks of
the homeless population, the substance abuse treatment, and mental health treatment for
the homeless population, and the immediate needs of homeless individuals and families,
particularly homeless women and children. The debate continues as to whether inpatient
or outpatient treatment is better suited for the homeless population, however, unless the
immediate needs (e.g., survival needs) of the population are being met, the treatment
method for addictions and abuse become insignificant. Future studies should also include
what the long-term treatment goals should include based on gender. For instance,
homeless women may require more extensive mental health services, whereas, male
homeless individuals may not require this service, but rather more services pertaining to addictions and criminal behaviors.

Societal services for the homeless also need to be the focus of future studies. For instance, how can an individual who may have been homeless more than half of his or her life, be expected to succeed within society without the needed skills. Some of the skills that need to be addressed, are life skills, employment skills, parenting skills, anger and money management, educational needs, and mental health services. All of these skills are important to the successful integration of the homeless individuals into society, however special emphasis needs to be placed on mental health needs. As previously stated, most helping professionals do not address the emotional needs of homeless clients. Some of the emotional needs can focus on the numerous losses that may have occurred, the guilt and shame of deviant behaviors an individual may have engaged in to survive such as prostitution or drug use, the loss of a support network, and the shame and stigma felt because of being alienated by society.

Our society, historically, has not placed the homeless problem as a priority. Our governmental institutions, as well, must place a higher priority on this population. Although, it is not completely the responsibility of the government to address this problem; each member of society, as well as private and not-for-profit businesses can also address the issues facing the homeless population. Hawks (1992) addresses this issue by asking what would need to happen at a community level in order for the community to become therapeutic? Although many suggestions are listed, Hawks (1991) also states that the immediate needs of this population need to be realized. Blondell et al. (2002) include that another barrier associated with screening, intervention, and referrals
to help substance using and mentally ill clients is related to the limitations of the healthcare system. Specifically, Blondell et al. (2002) focus on the negative attitudes of physicians toward substance users, and the lack of awareness of institutions and healthcare providers as well.

Baumhol (1992) discussed this problem over ten years ago. He postulated that no more ‘bad’ shelters need to be built, and hospitalizing this population is not a solution. However, society should combine available housing with treatment, and to provide humane and flexible atmospheres in order to support, house, and in some cases control, the homeless population who may be substance users and mentally ill as well. McCarty et al. (1991) similarly state the importance of providing such services to the homeless population. For instance, the authors state that individuals who return to the street without adequate housing, without friends or a social support network, and without a job, are more than likely, not going to remain sober over time.

Benda and Schroepfer (1995) also discussed these problems eight years ago. According to the authors, “an integrated network of services needs to be developed from prevention and crisis intervention through institutionalization to aftercare and psychosocial rehabilitation. This must include housing, job creation and training, and in-depth therapy. A variety of residential settings...are needed, from crisis hotels to transitional housing, and from communal apartments to sober hotels and independent living. These must be linked to other services, including mental and physical care, vocational preparation and placement, and financial support” (p. 44).

Since the above research studies all addressed the issues relating to the immediate needs of the homeless population, on average, ten years ago, it becomes apparent that
society has been lacking in the development of services for this population. As stated, ten years or more have passed since these studied have been completed. It is disheartening to believe that our society has placed such a non-committed approach to providing services for this population. How much more suffering has to take place in order for our governments, businesses, helping organizations, and the members of society to realize the extent of the damage occurring directly to the homeless population and, indirectly to society in general, before steps are taken to alleviate the problems?

While completing this study, particularly while interpreting the data within the genograms, the author was overwhelmed at the level of suffering this population has endured throughout their lives. When realizing the extent of abuse such as rape and domestic violence, and the personal traumas the homeless participants have survived, it is not difficult to comprehend the immediate needs of these individuals. As stated previously in this study, most of us try to ignore the homeless’ plight, until it affects us on a personal level. It can be postulated, then, that there has not been enough of us personally affected; it can only be hoped that during the next decade enough research may be completed so as to bring this information to the general society. Acts of giving by members of society, such as donations to helping organizations, are appreciated and needed. However, unless preventative measures are taken to alleviate or eliminate the causal events or behaviors, the number of homeless individuals and families within our society will only increase.

The homeless population is not simply going to go away; in fact, based on the current statistics available the homeless population has continued to grow dramatically over the past several decades. Unless steps are taken to address the issues the homeless
population face every day, the numbers will continue to rise. As stated by Martin (1991), “the deprivations [the homeless population] are suffering is affecting not only the present generation but future ones, as more people become lost to alienation, despair, drugs, and physical and mental illness” (p. 26).
EXHIBITS
Table 1 Demographic Data By Gender (Continued on next page)

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