Attributions and self-acceptance among homeless individuals:

Implications for behaviour and well-being

by

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ABSTRACT

Objective: The current study longitudinally examined the role of the attributions homeless individuals made for the cause of and solution to their homelessness in predicting their progress toward exiting homelessness as well as their psychological well-being. Attributions were measured according to Brickman and colleagues' (1982) model of helping and coping, which assesses the degree to which the cause of and solution to problems are attributed internally versus externally. We also investigated the role of global self-acceptance in predicting behaviour and well-being.

Design: 69 individuals who were homeless in the previous 6 months were interviewed at baseline and 4-week follow-up. Attributions, self-acceptance, and several demographic variables were measured at baseline. Outcome variables included ratings of progress toward exiting homelessness based on coding the behaviours from participants' descriptions of their typical days, as well as depressive symptoms and satisfaction with life. Outcomes were measured both at baseline and follow-up.

Results: Hierarchical multiple regression analyses revealed that to the extent that participants made internal attributions for the cause of their homelessness, they made less progress towards exiting homelessness over the 4-week follow-up, whereas more internal attributions for the solution to homelessness predicted greater progress toward exiting homelessness. Results also indicated that greater self-acceptance predicted decreased depressive symptoms and increased satisfaction with life, while attributions about homelessness were not related to these well-being outcomes.
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INTRODUCTION

Homelessness is an important and growing problem in North-American society. Research has confirmed that homelessness is associated with a variety of negative outcomes for individuals such as high levels of substance abuse, chronic physical and mental illness, as well as social isolation and stigma (Martens, 2001; Rossi, 1990; Rossi, Fisher, & Willis, 1986; Small, 2005). Homelessness has also been associated with negative societal outcomes such as crime, diminished economic productivity, and increased burden on the health-care system (Kershaw, 2003; Rossi, 1990). In British Columbia, the level of absolute homelessness is increasing as shown by increased numbers of shelter clients, people being turned away from shelters due to overcrowding, and by greater visibility of people experiencing homelessness in mid-sized towns (BC Ministry of Social Development and Economic Security, 2001). In Vancouver alone, the number of homeless individuals nearly doubled from 1121 in 2002 to 2174 in 2005, with the large majority of that increase seen among the street rather than sheltered homeless (2005 Greater Vancouver Homeless Count). Millions of dollars are spent on public programs devoted to addressing the problem of homelessness, and yet little is known about the psychological factors that contribute to both the well-being of homeless individuals and their successful exit from homelessness.

In investigating the predictors of well-being and exit from homelessness, research to date has largely focused on the role of 'individual deficit' variables such as health, chemical dependency, poor education, and social isolation, as well as structural or 'institutional' variables such as availability of employment, access to housing, income and social services (e.g. Lam, & Rosenheck, 2000; Wong, & Pillavin, 1997; Zlotnick,
Robertson, & Lahiff, 1999). While these variables have been found to predict outcomes in homelessness, much of the variance in well-being, coping behaviour and housing stability remains unaccounted for. From a social psychological perspective, this is not an altogether surprising finding, because the appraisals and attributions individuals make regarding themselves and their circumstances are important contributors to well-being and coping efforts (e.g. Lazarus & Folkman, 1984). Specifically, the extent to which homeless individuals hold themselves responsible for their housing situation, the beliefs they hold about their abilities and resources to cope and their general evaluations of themselves should have important implications for the way they respond to their homelessness. The primary purpose of this study was to examine the role of attributions for the cause of and solution to homelessness in longitudinally predicting both homeless individuals' behavioural efforts and progress aimed at exiting homelessness as well as their psychological well-being.

One framework that may be helpful in understanding the behaviour of homeless individuals is Brickman and colleagues' attributional model of helping and coping (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder, 1982). While attribution models traditionally focused only on attributions made for the cause of a particular problem or outcome, or confounded the cause of and solution to a problem (e.g. Abramson, Seligman & Teasdale, 1978; Hill & Larson, 1992; Rotter, 1966; Sweeney, Anderson & Bailey, 1986; Weiner, 1988), Brickman and colleagues argued that attributions for both the cause of and solution to a problem are required to understand helping and coping strategies. In their view, failure to account for the uniqueness of cause and solution attributions can lead to faulty conclusions (Brickman et al., 1982;
Stepleman, Darcy, & Tracey, 2005). According to Brickman, responsibility for the origin of a problem involves blame, whereas responsibility for the solution to a problem involves control (Brickman et al., 1982). While attributions for the cause of and solution to a problem may often coincide, there are certainly situations in which they can differ. For example, it is possible that someone could blame themselves for having caused their homelessness, but not feel like they have personal control over their exit from homelessness. Conversely, one might also feel that their homelessness was caused by external factors, but that despite this, they are personally responsible for getting themselves out of homelessness.

Brickman further argued that certain patterns of attributions may be more or less adaptive for problem resolution and coping. For instance, he noted that in many cases it would be beneficial for a person to make external attributions for the cause of their problem but internal attributions for the solution. Brickman argued that making internal attributions of responsibility for the solution to problems is essential in promoting competence and active striving rather than accepting one’s fate or passively waiting for others to help. He also suggested that it may be preferable not to hold people responsible for the cause of their problems in order to allow people to direct their energy toward solving their problems or transforming their environment without berating themselves for their role in creating these problems. Interestingly, Brickman notes that in contrast to his analysis, many popular and effective self-help programs such as Alcoholics Anonymous promote internal attributions for cause and external attributions for solution. In other words, these programs require new recruits to take responsibility for their drinking rather than blaming others or making excuses for it, while also admitting that overcoming their
drinking is beyond their own control, and that they will always need the help of God and/or the community of sufferers to which they now belong. For both theoretical reasons and in order to best facilitate the development of intervention programs, it is important for research to determine which pattern of attributions for problem cause and solution is most likely to lead to optimal well-being and coping efforts.

While there has not been a standardized or consistent method of testing Brickman's models of coping, several studies have examined the effects of attributions of responsibility for problem cause (or of blame) and/or attributions of responsibility for solution (or of control). The evidence relating attributions of responsibility for the cause of a problem to outcomes is equivocal. Some studies have shown that blaming oneself for the cause of problems is associated with depression and distress (Anderson, Miller, Riger, Dill, et al., 1994; Bennett, Compas, Beckjord, & Glinder, 2005; Jospeph & Kuyken, 1993; Kingree & Thompson, 2000; Wall, & Hayes, 2000), as well as lower self-efficacy and avoidance coping (Stepleman, Darcy, & Tracey, 2005). However, other studies have found no effects of internal attributions for the cause of problems on well-being (e.g. Karuza, Zevon, Gleason, Karuza, & Nash, 1990). Feeling in control of the solution to problems, on the other hand, is consistently associated with positive outcomes. Internal attributions for the solution to problems have been associated with greater positive affect and quality of life (e.g. Karuza et al., 1990), as well as greater self-efficacy, more effective and proactive coping, and greater persistence in the face of difficulties (e.g. Dweck, 1975; Seligman, 1975; Stepleman, Darcy, & Tracey, 2005).

Among studies that examine Brickman's model by looking at attributions for the cause of and solution to one particular type of problem, it again seems that internal
attributions of responsibility for the cause of a problem, if there is a relationship at all, is related to poorer progress, whereas acceptance of personal responsibility for recovery is associated with enhanced improvement. For example, Frey et al. (1985) observed that better recovery of non-paralyzed accident victims was associated with those who believed that their own willpower was important in their recovery, and with those who did not hold themselves responsible for the accident; Moulton et al. (1987) found that in people suffering from AIDS, internal attributions of responsibility for the problem were positively related to dysphoria, while internal attributions for improvement were positively related to health behavior change; Gray and Silver (1990) found that adjustment of divorced couples was unrelated to attributing responsibility for the breakup to the self, but was positively related to attributing control over the separation process (i.e., responsibility for the solution) to the self; and Clary and Thieman (2002) found that students who attributed responsibility for solving their academic problems to themselves had higher GPAs at the end of the semester than did students who assigned more responsibility to other (external) factors, while there was no relationship between GPA and attributions of responsibility for creating problems.

The available evidence concerning Brickman's attribution model suggests that making internal attributions for the cause of one's problem either is unrelated to or is associated with poorer both well-being and coping efforts, while making internal attributions for the solution to one's problem is associated with improved quality of life and active coping efforts. The primary purpose of the current study was to investigate the role of this model in the context of homelessness. We sought to longitudinally investigate how self-reported attributions of responsibility for the cause of and solution to
homelessness would predict participants' efforts to exit homelessness, as well as their psychological well-being 4 weeks later.

We believed that if people saw themselves as being responsible for their negative circumstances, they would be more likely to maintain poor well-being and get stuck in a cycle of despair and apathy. On the other hand, if people felt that they were responsible for changing their circumstances, they would be more likely to thrive and successfully break the cycle. Specifically, we hypothesized that internal attributions of responsibility for the cause of homelessness would be negatively related to behaviour aimed at exiting homelessness, and would be associated with increased depression and decreased life-satisfaction. We also hypothesized that internal attributions for the solution to homelessness would positively predict efforts to exit homelessness.

A secondary goal of this study was to evaluate the role of an additional predictor that may be associated with the well-being of homeless individuals, namely self-acceptance. While the specific attributions made by individuals regarding the cause of and solution to their homelessness certainly seem important to their behaviour and well-being, research has shown that the experience of homelessness calls an individual's entire character into question, and is accompanied by a global, devalued sense of self (Boydell, Goering, & Morrell-Bellai, 2000). It is said that homeless individuals often lose their sense of identity, self-worth, and self-efficacy (Buckner, Bassuk, & Zima, 1993; Taylor, 1993). Because of this, it seems that global self-evaluations may have important associations with the well-being of homeless individuals; however, it is not clear whether perceptions of self-worth might be the result of more specific attributions about
homelessness, or whether they would contribute independently to well-being and behaviour.

In research examining both global self-evaluations and specific attributions, there seems to be an important, independent role of self-evaluations in predicting emotional distress. For example, Haugen and Lund (2002) examined the role of both general self-esteem and attributional style in depression, and found that self-esteem predicted a substantial part of the variance in depression in a student group, while the contributions of attributional style were of minor importance. Also, Dutton and Brown (1997) conducted two studies showing that global self-esteem predicted participants' emotional reactions to their performance outcomes (success or failure), even after participants' beliefs about their more specific abilities and attributes were taken into account. These authors argue that feelings of humiliation and shame reflect a more general and undifferentiated feeling that one is a bad person, rather than simply being bad at things, and that these feelings are the essence of low self-esteem (or low self-acceptance) (Dutton & Brown, 1997). Therefore it seems that emotional outcomes may be at least as closely tied to global self-evaluations as they are to specific attributions.

Given the importance of self-worth to the experience of homelessness and the evidence suggesting that global-self evaluations may be associated with well-being independently of the attributions made for a particular event, we hypothesized that among homeless individuals, a global sense of self-acceptance would predict psychological well-being over and above the influence of attributions of responsibility for the cause of and solution to homelessness. We did not hypothesize a relationship between self-acceptance and behaviour aimed at exiting homelessness.
METHOD

Participants and Procedure

All participants were recruited through the Salvation Army’s Belkin House, a homeless shelter in downtown Vancouver, through advertisements posted in the elevators and lobby of the shelter. Participants signed up to participate by putting their name on a schedule left at the front desk of the shelter. Participants were included in the study if they could speak English fluently, were over the age of 19, and had stayed outdoors, at a homeless shelter, or at a friend’s place but not in a bed for at least 3 nights in the previous 6 months. Participants were interviewed at baseline as well as at a 4-week follow-up by trained research assistants. Each interview lasted between an hour and an hour and half, and consisted of both open-ended questions as well as several scales. Compensation was given in the form of gift certificates worth $20 for the first visit and $25 for the second.

131 participants were interviewed at baseline, however 63 of these participants did not return for our follow-up interview, either because they were not interested in continuing with the study, or because they did not show up at the follow-up and could not be contacted to reschedule. Though this seems like a very high attrition rate, the difficulty in tracking individuals without stable phone numbers or addresses makes this type of attrition fairly common in research on homelessness (e.g. Toro, 2002). Further, the means for participants who dropped out after the baseline visit did not differ from the means for participants who remained in the study on the attribution for cause (t = -.70, p = .49), attribution for solution (t = .74, p = .46), self-acceptance (t = 1.43, p = .15), behaviour (t = -1.17, p = .25), depressive symptoms (t = .42, p = .68) or satisfaction with life measures (t = 1.43, p = .16).
In total, our sample included 69 participants, 50 men and 19 women, ranging in age from 20 to 66 years (mean = 42.81, SD = 9.62) who had been homeless an average of 10.9 months (SD = 15.7). At baseline, participants were primarily clients of the shelter; however 11.6% were residing outside the shelter (i.e. in other shelters, recovery houses, single-room-occupancy dwellings, or sleeping outside). 46.4% of participants were residing in the emergency shelter at baseline. The emergency shelter consists of dormitory-style sleeping arrangements; clients are given 3 meals a day, are asked to leave the building throughout the day, and can stay for a maximum of 30 days. The other 42% of our sample consisted of participants in Belkin House’s Personal Development Program in which clients pay a portion of their welfare income to renting a single room in the shelter. These clients can come in and out of the shelter as they please, must participate in life-skills classes and have regular visits with counselors in the shelter, and can stay for a period of 3 months or more. Only 6% of our sample reported being married or living as married, while 56% reported being single, and 38% reported being separated, divorced or widowed. Participants varied considerably in their level of education, with 38% having a high school education or less, 43% having partially completed or completed a college program, and 19% having some university or a university degree. At baseline, 14% of participants reported having some form of employment. At baseline, approximately 19% of participants answered ‘yes’ when asked if they currently considered themselves as having a drinking problem, 36% of participants answered ‘yes’ to currently having a drug problem and 44% reported having been diagnosed with a mental illness.
Measures

Attributions of responsibility for the cause of and solution to homelessness were measured by interview in person at the baseline interview using a modified version of the Attribution of Problem Cause and Solution Scale (Stepleman, Darcy, & Tracey, 2005) which was designed to measure Brickman’s models of helping and coping. We initially chose the 4 items from this scale with the highest factor-loadings on each of the responsibility for cause and responsibility for solution subscales (8 items in total) and adapted the items to make them specific to the problem of homelessness (eg. Cause: I am responsible for the cause of my homelessness, I am an innocent victim (reversed); Solution: My own capabilities should be used to get me out of homelessness; Solving the problem of my homelessness is someone else’s responsibility (reversed). Participants rated their agreement with each item on a 7-point likert scale ranging from ‘Strongly disagree’ to ‘Strongly agree,’ with higher numbers representing greater internal responsibility. Responsibility for cause items showed good internal consistency (Cronbach’s $\alpha = .86$). The mean on this scale at baseline was 4.80 ($SD = 1.87$). Responsibility for solution items did not show strong internal consistency (Cronbach’s $\alpha = .37$). The most poorly correlating item was dropped from the scale, bringing the reliability up somewhat (Cronbach’s $\alpha = .53$). The mean on the 3-item scale at baseline was 5.83 ($SD = 1.01$).

Self-acceptance was also measured by interview at baseline, using the 3-item version of the self-acceptance subscale from the Psychological Well-being Scale (Ryff & Keyes, 1995). Self-acceptance is described as the extent to which an individual possesses a positive attitude toward the self, acknowledges and accepts multiple aspects of self,
including good and bad qualities, and feels positive about one's past (e.g. I like most aspects of my personality; In many ways, I feel disappointed about my achievements in life (reversed)). Participants rated their agreement with these items on a scale from 1 (Strongly disagree) to 6 (Strongly agree), with higher numbers representing greater self-acceptance. This scale was relatively reliable (Cronbach's $\alpha = .61$) and the mean for our sample was 3.57 ($SD = 1.03$).

In order to measure well-being, we administered a measure of depressive symptoms, namely the 10-item version of the Center for Epidemiological Studies Depression Scale (Andresen, Carter, Malmgren, & Patrick, 1994), as well as the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) by interview at both the baseline and follow-up visits. Depressive symptoms were rated for their frequency in the previous week on a scale from 1 to 4. At baseline this scale was internally reliable (Cronbach's $\alpha = .80$). The means for this scale, based on total score, were 22.54 ($SD = 5.72$) at baseline and 21.13 ($SD = 6.19$) at follow-up. This decline in depressive symptoms over time was marginally significant ($t(73) = 1.81, p = .075$).

Satisfaction with life was measured on a scale from 1 to 7. At baseline, this scale was internally reliable (Cronbach's $\alpha = .78$). The means on this scale were 2.83 ($SD = 1.30$) at baseline, and 3.29 ($SD = 1.45$) at follow-up. The increase in satisfaction with life over time was significant ($t(73) = 3.76$, $p < .001$).

We measured behaviour aimed at exiting homelessness by coding participants' descriptions of their typical days. While it would have been interesting to measure actual housing status, only 8 of our participants had transitioned into an independent living situation within the 4-week follow-up period. Because of this, we instead measured how
much participants were progressing toward exit from homelessness in terms of their actual efforts and behaviours. In order to measure this, participants were asked to describe what a typical day was like for them, and what sorts of things they did during the course of a typical day. This question was asked as part of the open-ended interview questions, both at baseline and at the 4-week follow-up. Responses to this question were transcribed, and then two raters coded these transcripts by giving global ratings of progress toward exiting homelessness. This global rating was based on three factors: how close the participant was to exiting homelessness, how much effort they were putting in to activities aimed at exiting homelessness, and the degree to which they were engaging in these activities with a long-term, future-focused orientation, rather than simply as a means of survival. Raters used a scale from 0 to 5 on which 0 represented a complete lack of effort toward exiting homelessness and a purely survival focus (e.g. killing time, walking around aimlessly, sleeping, etc.); while 5 represented a totally independent housing situation in which the participant was earning their own money to pay rent. Ratings 1 through 4 were applied to a range of activities and states falling between killing time and being independently housed, such as being enrolled in a substance abuse treatment program, volunteering, looking for employment, working part-time and seeking independent housing. Ratings were based on the combination of activities described, as well as the extent to which participants were exerting their full effort on these activities versus the degree to which they could have been doing more to improve their situations. 80 % of typical-day descriptions were coded by two raters, and inter-rater reliability was .74. Any discrepancies in coding were resolved by consensus. The mean on this scale at baseline was 1.54 (SD = 1.15), and the mean at follow-up was
2.20 ($SD = 1.13$). This change in behaviour was significant over time ($t (68) = 5.48, p < .001$).

We also obtained self-reports at baseline of some potential confounding variables including gender, age, education, classification within the homeless shelter, drinking problem, drug problem, and diagnosis of mental illness. Education was measured categorically by asking participants to indicate the highest level of education they have achieved, with choices ranging from less than a high-school diploma to a university degree. For shelter classification, we simply asked whether participants were in the emergency shelter or the Personal Development Program. Drinking and drug problems were assessed by asking participants to report whether or not they considered themselves as currently having a drinking or drug problem. We chose this measure rather than using frequency of consumption because many participants were no longer drinking or doing drugs at the baseline interview but had abused these substances in the past and still considered themselves to be in the process of recovering from their addictions. Finally for mental illness we simply asked participants to report whether or not they had ever been diagnosed with a mental illness.
RESULTS

Preliminary Analyses

In the first wave of our analyses, we conducted bivariate correlations to assess the relationship between study variables and potential confounds. We examined several demographic and homelessness-related variables that could provide alternative explanations for relations between attributions and behaviour or well-being outcomes.

Education was not significantly related to attributions, depression, satisfaction with life or behaviour aimed at exiting homelessness ($p's > .33$), but there was a marginally significant relationship between education and self-acceptance ($r = .24, p = .05$). Age was significantly related to baseline behaviour, such that younger people were engaging in more efforts aimed at exiting homelessness ($r = -.25, p = .045$), but was not significantly related to any other variables ($p's > .21$). Differences based on shelter classification were found for baseline depressive symptoms scores, such that participants in the emergency shelter (mean = 24.19) had higher levels of depressive symptoms than participants in the Personal Development Program (mean = 20.79), $t(59) = 2.45, p = .017$. No other differences on shelter classification were significant, $p's > .36$.

Gender differences were found for attribution of responsibility for the solution to homelessness, such that men (mean = 6.01) made more internal attributions than did women (mean = 5.29), $t(20.03) = 2.08, p = .05$. Gender differences were marginally significant for attribution of responsibility for the cause of homelessness, such that men (mean = 5.06) made more internal attributions than did women (mean = 4.04), $t(63) = 1.98, p = .05$. Gender differences were also found for baseline behaviour aimed at exiting homelessness, such that men (mean = 1.32) were rated lower than women (mean = 2.11)
on their efforts to exit homelessness, $t(67) = -2.66, p = .01$. No other gender differences were significant, $p's > .19$.

Differences based on self-reported drinking problem at baseline were found for attribution of responsibility for cause, such that those who reported a drinking problem (mean = 6.12) reported more internal attributions than those who did not report a drinking problem (mean = 4.47), $t(49.16) = -4.81, p < .001$, for self-acceptance, such that those who reported a drinking problem (mean = 3.03) reported lower self-acceptance than those who did not report a drinking problem (mean = 3.70), $t(34.22) = 3.08, p = .004$, and for satisfaction with life, such that those who reported a drinking problem (mean = 2.22) reported less satisfaction than those who did not report a drinking problem (mean = 3.00), $t(28.07) = 2.62, p = .014$. No other differences were significant, $p's > .19$.

Differences based on self-reported drug problem at baseline were marginally significant for attribution of responsibility for cause, such that those who reported a drug problem (mean = 5.33) reported more internal attributions than those who did not report a drug problem (mean = 4.48), $t(63) = -1.81, p = .076$. There were also significant differences for baseline depressive symptoms, such that those who reported a drug problem (mean = 25.76) reported greater levels of depressive symptoms than those who did not report a drug problem (mean = 20.78), $t(64) = -3.71, p < .001$, and for baseline behaviour aimed at exiting homelessness, such that those who reported a drug problem (mean = 1.16) were rated as exhibiting less effort than those who did not report a drug problem (mean = 1.73), $t(62.04) = 2.14, p = .036$. No other differences were significant, $p's > .11$. 
Finally, differences based on mental illness were found for baseline satisfaction with life such that those who had been diagnosed with a mental illness (mean = 2.41) were less satisfied than those who had not been diagnosed with a mental illness (mean = 3.11), \( t(65) = 2.24, p = .028 \), and for baseline depressive symptoms, such that those who had been diagnosed with a mental illness (mean = 24.37) experienced greater depressive symptoms than those who had not been diagnosed with a mental illness (mean = 21.11), \( t(65) = -2.36, p = .02 \). No other differences were significant, \( p's > .13 \).

Based on the results of these analyses, we decided to include any covariates with a significant or marginally significant (i.e., \( p < .10 \)) relationship to predictor variables in all regression analyses, and any covariates with a significant or marginally significant relationship to outcome variables in the relevant regression analysis for that particular outcome variable. Thus, we included gender, age, education, drinking problem, and drug problem as covariates in the analysis predicting behaviour; gender, education, shelter classification, drinking problem, drug problem, and mental illness in the analysis predicting depressive symptoms; and gender, education, drinking problem, drug problem, and mental illness in the analysis predicting satisfaction with life.

**Testing Predictions**

In order to test our hypotheses concerning the associations between attributions of responsibility for the cause of and solution to homelessness, and of self-acceptance with the behaviour and well-being of homeless individuals, we conducted three hierarchical multiple regression analyses, one for each of our outcome variables (behaviour aimed at exiting homelessness, depressive symptoms, and satisfaction with life). In each analysis, the outcome variable at follow-up was predicted from attribution of responsibility for
cause, attribution of responsibility for solution and self-acceptance entered simultaneously, while also controlling for the outcome variable at baseline, as well as the covariates mentioned above. Results are summarized in Table 1.

Our primary hypotheses concerned the association between attributions of responsibility for the cause of and solution to homelessness, and behaviour and well-being. With respect to attributions of responsibility for the cause of homelessness, our first hypothesis was that greater internal attributions would negatively predict efforts to exit homelessness. This hypothesis was confirmed; the analysis indicated that to the extent that participants made internal attributions for the cause of their homelessness, they made less progress towards exiting homelessness over the 4-week follow-up, $\beta = -.27$, $t(54) = -2.15$, $p = .036$, $\text{part-}r^2 = .044$. We also hypothesized that internal attributions of responsibility for the cause of homelessness would be associated with increased depressive symptoms and decreased life-satisfaction. These hypotheses were not confirmed, as the analyses revealed that attributions of responsibility for cause did not significantly predict changes in depressive symptoms ($\beta = .083$, $t(44) = .50$, $p = .62$) or satisfaction with life ($\beta = .033$, $t(53) = -.284$, $p = .78$) over time.

Our hypothesis concerning attributions for the solution to homelessness was that internal attributions would positively predict efforts to exit homelessness. Results confirmed this hypothesis, indicating that to the extent that they made internal attributions for the solution to their homelessness, participants made greater progress towards exiting homelessness over four weeks, $\beta = .31$, $t(54) = 2.50$, $p = .016$, $\text{part-}r^2 = .060$. We did not make any hypotheses regarding attribution of responsibility for the solution to homelessness and well-being, and there was no evidence of a relationship
between these constructs, either for depressive symptoms ($\beta = -.094, t (44) = -.60, p = .56$) or satisfaction with life ($\beta = -.041, t (53) = -.37, p = .71$).

Our secondary hypotheses in this study focused on the possible relationship between global self-acceptance and well-being, above and beyond the relationship between well-being and attributions about homelessness. Results supported our hypotheses, indicating that self-acceptance was a significant predictor of a decline in depressive symptoms, $\beta = -.30, t (44) = -2.12, p = .040$, $\text{part-}r^2 = .053$, and an increase in satisfaction with life, $\beta = .33, t (53) = 2.92, p = .005$, $\text{part-}r^2 = .065$ over the follow-up period. On the other hand, self-acceptance did not significantly predict changes in behaviour aimed at exiting homelessness, $\beta = -.075, t (54) = -.66, p = .51$. 
DISCUSSION

The primary purpose of this study was to longitudinally examine Brickman and colleagues' (1982) model of helping and coping in the context of homelessness. Based on previous research, we first hypothesized that the extent to which individuals held themselves responsible for the cause of their homelessness would predict lower behavioural efforts to exit homelessness as well as poorer psychological well-being. This hypothesis was supported for behaviour aimed at exiting homelessness, such that greater internal attributions of responsibility for the cause of homelessness predicted less progress towards a stable housing arrangement over a 4-week period. Our hypothesis was not supported for well-being, however, as results indicated no significant relationship between attributions of responsibility for the cause of homelessness and either depressive symptoms or satisfaction with life. Possible reasons for our failure to support this hypothesis, which are discussed later in this section, include the greater role of self-acceptance in predicting well-being, as well as the potential moderating influence of the stability of attributions. Results also confirmed our hypothesis that greater internal attributions of responsibility for solution would predict progress towards exiting homelessness.

Our results concerning attributions of responsibility for the cause of and solution to homelessness generally provide support for Brickman's model of attribution. Specifically, our results highlight the importance of distinguishing between attributions regarding the cause of versus the solution to a problem, as we found these attributions to predict behaviour in opposite directions. This result is in line with previous research examining Brickman’s model; for example, Stepleman, Darcy, and Tracey (2005) found
that internal attributions of responsibility for cause were negatively related to self-efficacy while internal attributions of responsibility for solution were positively related to self-efficacy. Our results are also consistent with previous research finding that attributions of responsibility for the cause of problems are either unrelated to, or negatively associated with improvement, while taking responsibility for the solution to problems is associated with enhanced recovery. Further, because our study used a longitudinal design, we were able to account for the associations between attributions and subsequent well-being and behaviour independent of the influence of concurrent well-being and behaviour. We also controlled for several factors that may have influenced attributions and their relationship to outcomes, such as self-reported drinking and drug problems and mental illness. Thus, our results are consistent with a scenario in which the type of attributions individuals make for the cause of and solution to their homelessness influences the amount of progress they make at exiting homelessness. Of course, we cannot make causal inferences from an observational study like this, but the longitudinal design and control for potential confounds does help rule out many of the obvious competing explanations for our findings.

Our findings also generally support Brickman’s (1982) idea that taking personal responsibility for solving one’s problems while minimizing personal blame for having caused the problem leads to the most effective and healthy coping efforts and outcomes. Interestingly, this pattern of attributions is exactly opposite to that described by Brickman as characterizing programs such as Alcoholics Anonymous, which he claimed promote personal blame for causing the problem and a surrendering of personal control in order to solve the problem (Brickman et al., 1982). Although there is some disagreement as to the
type of attributions characterizing Alcoholics Anonymous (e.g. Morojele & Stephenson, 1992), our findings nevertheless suggest the importance of considering what type of attributions are being promoted by various interventions programs aimed at homelessness or other problems. Our results are in line with research on attributions and substance abuse suggesting that it might be more useful to direct people to focus more on potential solutions than on causes for their problems or distress (Kingree & Thompson, 2000). In future research it will be important to evaluate this view more rigorously, perhaps by randomly assigning homeless individuals to interventions emphasizing different attributional perspectives, and then following them over time to see which approach brings about greater housing stability.

While Brickman’s distinction between attributions of responsibility for cause versus solution proved to be important in the context of homelessness, there are also limitations to his model that should be considered in interpreting our results. Brickman and colleagues (1982) measure attributions along the dimension of locus (internal versus external), but do not consider dimensions common to other models of attribution such as stability (whether or not something varies over time) and controllability (whether or not one can volitionally alter something) (Weiner, 1988). Beyond knowing whether an individual blames themselves for causing a problem, for example, it is also important to know whether they attribute the cause of the problem to something unstable and controllable about themselves, such as a lack of effort or a poor choice, or whether attribute the cause of the problem to some stable, uncontrollable aspect of themselves and thus believe that they are destined to fail regardless of their actions. The dimensional properties of an attribution, including locus, stability and controllability, have been
shown to differentially affect expectancies, emotions and subsequent behaviours (e.g. Weiner, 1988; Struthers & Perry, 1996).

In the context of homelessness, the distinctions between stable/uncontrollable and unstable/controllable internal attributions for cause are particularly relevant, as they involve different types of self-blame, leading to potentially different consequences for well-being and behaviour. Making an internal, unstable, and controllable attribution for a negative event can be considered behavioural self-blame, as this type of attribution focuses on one’s flawed actions, while making an internal, stable, and uncontrollable attribution for a negative event can be considered characterological self-blame as it focuses on one’s flawed character (Janoff-Bulman, 1979; Tracy & Robbins, 2006). Research has shown that behavioural self-blame attributions lead to feelings of guilt, and motivate us to take reparative action, while characterological self-blame attributions lead to feelings of shame and depression, and motivate withdrawal behaviour (Anderson et al., 1994; Tagney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007; Tracy & Robbins, 2006). It could be then that making an internal, stable and uncontrollable attribution for the cause of homelessness leads to negative emotions, poor well-being and withdrawal of effort to change one’s circumstances, while making an internal but unstable and controllable attribution would not negatively affect well-being, and would lead to increased efforts to exit homelessness. Thus, these dimensions of attribution may be quite important in accurately predicting outcomes for homeless individuals. Further, the absence of the stability and controllability dimensions from Brickman’s attribution model may be one of the reasons we did not find attribution of responsibility for cause to be a significant predictor of depressive symptoms or satisfaction with life. Future research
examining Brickman’s model of attribution would benefit from adding measures of the stability and controllability of attributions of responsibility for the cause of and solution to problems.

A secondary objective of this study was to examine the role of a more global self-evaluation in predicting the well-being of homeless individuals. Specifically, we were interested in whether self-acceptance would predict well-being over and above attributions for the cause of and solution to homelessness. Supporting our hypothesis, results indicated that self-acceptance was indeed a significant predictor of changes in depressive symptoms and satisfaction with life when controlling for the effects of attributions for cause and solution. Further, and in line with previous research on self-evaluation, self-acceptance significantly predicted well-being while neither attribution of responsibility for cause nor for solution to homelessness were significantly related to well-being. It is possible that the predictive power of self-acceptance also accounted for our failure to support the hypothesis that internal attribution of responsibility for the cause of homelessness would predict poorer well-being. That is, while blaming oneself for cause of problems has often been related to distress, perhaps one’s global self-evaluation is more strongly related to well-being than is the more specific attribution of blame for a particular event. This scenario would be consistent with Dutton and Brown’s (1997) suggestion that people’s emotional reactions to failure are not reducible to their attributions about that specific incident, and are rather associated with their global self-evaluations.

Overall, our results suggest that while homeless individuals’ behavioural efforts to improve are associated with their attributions for the cause of and solution to their
homelessness, their well-being is instead associated with their global feelings of self-acceptance. One possible reason that global self-evaluations are more predictive of well-being is that individuals with high self-acceptance may be better insulated from the negative effects of failure because they believe they have so many other positive qualities (e.g. Josephs, Larrick, Steele, & Nisbett, 1992), while those with lower self-acceptance are likely to fully experience the negative emotional consequences of failure.

There are a number of limitations to this study that should be noted. First, our sample was not a representative sample of the homeless population of Vancouver. Our participants were recruited at a shelter which provided various programs and services not commonly offered at homeless shelters, as well as a very controlled and secure environment, and longer-term housing options than many other shelters. As a result, our participants are likely to have experienced more stability and perhaps greater motivation to improve their lives than homeless individuals residing in other shelters, or living outdoors. Future research should examine attributions and self-acceptance in a wider range of homeless individuals to see whether our findings generalize beyond our sample. Second, while our study controlled for various factors potentially related to participants’ attributions such as substance abuse problems or mental illness, our study did not specifically examine the actual causes of participants’ homelessness. It may be plausible that attributions for the cause of homelessness could be the result of actual circumstantial factors that we did not control for in this study. Also, as mentioned previously, our study did not measure the stability or controllability dimensions of attributions, and they could have important moderating influences on the associations we observed. Finally, in terms of housing stability, our study used a soft outcome coded from descriptions of
participants’ typical day, and assessed only a brief follow-up period. Stronger conclusions could be drawn if we were able to measure actual housing status and stability of housing over a longer period of time.

In summary, our study suggests that the attributions homeless individuals make for the cause of and solution to their homelessness have important associations with their efforts at exiting homelessness. Specifically, the more individuals blame themselves for having caused their homelessness, the less likely they are to engage in behaviours aimed at exiting homelessness, whereas attributing responsibility to themselves for solving their homelessness is more likely to be associated with active efforts to exit homelessness. Further, our study indicates that homeless individuals’ global level of self-acceptance is an important predictor of their psychological well-being. In the context of addressing the problem of homelessness, the findings of the current study highlight the importance of looking beyond structural and demographic factors in predicting housing and well-being outcomes. Our findings also suggest that intervention programs addressing homelessness should encourage individuals to focus on their role in solving their problem, rather than in causing the problem, and should promote healthy self-acceptance. Given the daunting tasks many individuals face in overcoming addiction, reestablishing social relationships, seeking out employment and finding housing, it seems especially important to consider that negative attitudes about homeless people being failures or being lazy will do nothing but undermine their motivation to improve their circumstances. On the other hand, we can be hopeful that encouraging individuals to accept themselves and to feel in control of solving their problems will encourage them to strive against their circumstances and flourish.
Table 1

*Multiple Regression Analyses Predicting Changes in Each of Behaviour, Depressive Symptoms and Satisfaction with Life Over 4 Weeks, Including Key Predictors and Also Controlling for Various Demographic Characteristics as well as Status on the Outcome at Baseline.*

<table>
<thead>
<tr>
<th>Model</th>
<th>Behaviour Aimed at Exiting Homelessness</th>
<th>Depressive Symptoms</th>
<th>Satisfaction with Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>β</td>
<td>part-(r^2)</td>
<td>β</td>
</tr>
<tr>
<td>Attribution of Responsibility for Cause</td>
<td>-.27*</td>
<td>.044</td>
<td>.083</td>
</tr>
<tr>
<td>Attribution of responsibility for Solution</td>
<td>.31*</td>
<td>.060</td>
<td>-.094</td>
</tr>
<tr>
<td>Self-Acceptance</td>
<td>-.075</td>
<td>.004</td>
<td>-.30*</td>
</tr>
<tr>
<td>(R^2)</td>
<td>.486</td>
<td></td>
<td>.476</td>
</tr>
</tbody>
</table>

*\(p < .05\).  **\(p < .01\).*
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