A descriptive study of life experiences and social characteristics of homeless, HIV infected, chemically dependent, African-American males

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This study surveyed the life experiences and social characteristics of 18 HIV infected, homeless, and chemically dependent African-American males. The men ranging in age from 23-52 years were all participants of a community based day program. Each participant was interviewed and their answers to a self-report questionnaire were recorded by the investigator. The questionnaire was designed to assess specific demographics, as well as certain life experiences and social characteristics. Each participant also completed four separate psychometric scales. The findings revealed that the majority of the respondents were middle aged (mean age of 37.8 years) and had at least a high school education. Most of the respondents lacked medical insurance and social support systems outside of the "Home Street Home" program. All of the respondents had extensive alcohol and/or drug use history and many of the respondents had criminal histories. Mental health characteristics and scores on the four Hudson indices are also discussed.
A DESCRIPTIVE STUDY OF LIFE EXPERIENCES AND SOCIAL
CHARACTERISTICS OF HOMELESS, HIV INFECTED,
CHEMICALLY DEPENDENT, AFRICAN-AMERICAN MALES

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY

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SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

APRIL 1992

$R = \infty \quad T = 72$
ACKNOWLEDGEMENT

I would like to convey my gratitude and appreciation to all the individuals that made this research possible. First of all I would like to thank my advisor, Dr. Williams, for all the time and effort he spent working with me. Thanks to everyone at AID Atlanta and the Home Street Home program, for without whom this research would not have been possible. As always I would like to thank my parents for all of their love, support and encouragement throughout my educational career. My thanks also goes to Jeff, who always kept me smiling. Last, but certainly not least, I would like to thank my fellow second year MSW brothers and sisters for their support, comradeship and jovial remarks during the more difficult times. Thank you all.
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CHAPTER I
INTRODUCTION

Currently there is intense public policy interest in the homeless.¹ The United States has always been "home to winos, tramps, hobos, and skid row bums", as well as to entire uprooted cultures, such as the migrants created by the Midwest dust bowl in the 1930's.² However, since the early 1980's the general public has become increasingly aware that many people cannot house themselves, and the phenomenon of homelessness has become generally recognized.³ Unfortunately, there has not been a viable solution for the ever growing and ever changing homeless population.

One of the "new" segments of the homeless population is the HIV infected, chemically dependent, African-American male. African-Americans make up approximately 51.9 percent of the U.S. homeless population.⁴ And although homelessness can be

²Ibid.
³Ibid.
the result of a variety of circumstances, for an increasing number of African-Americans, Acquired Immune Deficiency Syndrome (AIDS) is the catalyst that makes homelessness a personal reality. AIDS can cause financial devastation, rejection based on fear of contagion, and/or rejection based on fear of the dying process. In cases where homelessness was a factor prior to diagnosis of AIDS, having AIDS can create additional barriers for those attempting to find somewhere to live.

First considered to be a disease that only affected white homosexual men, AIDS is now spreading rapidly in heterosexual and African American communities. Although African Americans represent only 12 percent of the U.S. population, they account for approximately 28 percent of AIDS cases reported in adults. Of the African American adults living with AIDS, 46 percent are intravenous (IV) drug users, compared with 15 percent of white anglo adults with AIDS. As these numbers show, a growing proportion of the people becoming HIV positive are homeless drug, as well as alcohol users, who bring into the health system a range of social

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"Helen Schietinger, "Housing for People with AIDS," Death Studies 12 (Fall 1988): 481-482.


'Ibid.
problems and a need for drug treatment and counseling that providers say they had not originally planned for.8

The stigma that AIDS creates can also affect the person with AIDS social being, his relationship with family, and his relationship with friends. An infection with the virus does require the individual to adopt a new social role as he adjusts to a new source of stigma and the creation of a special sick role.9 It affects the entire spectrum of his social being, both family and peer relationships. These, in turn, bear on his inner concept of himself.10 Often, it can either push the infected individual further into, or more firmly outside, society. For the African-American male, who is chemically dependent and may already be homeless, his life and social supports may continue to become fragmented. For these individuals, dealing with high levels of uncertainty is a daily struggle that often further compounds their problematic situation.

As this information suggests, AIDS, chemical dependency, and homelessness are overlapping problems that do not fit neatly into research or service agencies organized around single problems. In addition, once the component of


10Ibid.
African-American is added, we are then faced with a population of people who have very distinct issues, concerns and needs. In order for intervention strategies and program designs to be most effective in reaching this target population they must be multifaceted and culturally specific. Moreover, there must be a working knowledge of the characteristics and experiences of this forgotten group.

Significance of the Problem

Ambiguity often confuses the study of homelessness. Despite their common experience of being without a home, the homeless are a heterogeneous group of individuals, who's homeless situations stem from a variety of circumstances.

In the terminology of those who write about structuring social problems, homelessness is a messy, ill-defined problem. A major deficiency in the current literature on homeless people is the lack of a classification that differentiates the apparent subgroups. Classification is essential to empirically grounded theory and policy formation, as well as program and agency development. Without an organized process of characterizing the diverse subgroups, theory, policy and program development tend to give


12Ibid.

13Ibid.
prejudicial treatment to certain subgroups and to ignore others.\textsuperscript{14}

When it comes to the homeless, African-Americans have consistently been one of these ignored subgroups. The characteristics and service needs of minority homeless persons and the causes of their homelessness have received scant attention from researchers, policy makers and practitioners.\textsuperscript{15} The plight of the homeless African-American male has been severely overlooked, with more attention and service being available for women and women with children. The complete reasons for the high numbers of African-American homeless are unclear. Socioeconomic factors no doubt play the most significant role; however, not enough is known about the ways in which the problem differs from African-American homeless persons as compared with white homeless persons in an urban community.\textsuperscript{16}

Furthermore, not enough is known about the African-American who is living with HIV. Since the first large population of individuals in the U.S. which were infected with this virus were homosexual white men, the majority of research has been conducted using this population. African-Americans are a relatively new and rapidly growing population of HIV victims. Many of these HIV infected African-Americans are

\textsuperscript{14}Ibid.

\textsuperscript{15}First, Roth, and Arewa, "Problem for Minorities," 120.

\textsuperscript{16}Ibid.
also finding themselves homeless. Whether, it was because they lost their employment because they were no longer able to perform their jobs and subsequently lost their homes, or because they were kicked out of their home for fear of contagion or the stigma surrounding HIV, there is a growing population of homeless struggling with this terminal illness.

The association of alcoholism/drug dependency and homelessness is long standing with research showing that alcoholism is very prevalent among the contemporary homeless. Researchers have shown that as much as 70% of homeless men reported to have a dependency on alcohol. Although not as prevalent as alcoholism amongst the homeless, drug dependency can be found in large percentages among homeless men. Therefore, realizing that African-Americans comprise over half of the homeless population, one can assume that African-American males make up a large percentage of homeless, chemically dependent men. As these statistics suggest, social workers can no longer speak of "the homeless" as if they comprise a single, unitary group. Homelessness is not one problem but many, and African-American male


homelessness is an issue that has been neglected in research and practice efforts and warrants further inquiry.
Concern about the homeless in America has been evident for at least a century, yet no solution has been forthcoming. While homelessness occurs everywhere, its extent seems most shocking in America, where economic resources, technology, and egalitarian philosophies should combine to make a solution not only attainable but obligatory. But when one cannot rely upon economic resources, technology and philosophies, one must turn to research literature in hopes of better understanding the characteristics of the homeless population and in turn displaying a possible solution. The following is a group of research literature pertaining to the homeless, HIV infected, chemically dependent African-American male for the purpose of shedding some light on the distinctive features of this segment of America’s population.

**Homeless Men Characteristics**

Mental health and social characteristics of the homeless men were explored in a study by Fisher, Shapiro, Breakey, Anthony and Kramer. The researchers selected mental

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health and social characteristics of 51 homeless persons (94.1% were men) and compared them to 1,338 men living in households in Eastern Baltimore. Of the 94.1 percent male population, 47.1 percent were African-American.²

The researchers found that differences between the two groups were small with respect to age, race, education, and military service but the differences in mental health status, utilization patterns, and social dysfunction were large. Approximately one-third of the homeless scored high on the General Health Questionnaire (GHQ) which measures distress. The homeless men's score on the GHQ was three times that of the men living in households. Scores for both the homeless men and men living in households were similar in proportion on the Diagnostic interview Schedule (DIS) as on the GHQ. Homeless men also reported higher rates of hospitalization than household men for both mental (33% vs 55%) and physical (20% vs 10%) problems, but a lower proportion received ambulatory care (41% vs 50%). In addition the homeless men reported fewer social contacts and higher rates of arrests than the men living in households, indicating possible social dysfunction.³

In a similar study by Gelberg, Linn and Leake in which 73 percent of the homeless respondents were men, mental


³Ibid, 523.
health, alcohol and drug use, and criminal history were researched. The investigators conducted community-based area survey of homeless adults in two Los Angeles County communities. Using a sample of convenience, the findings showed that 64 percent of the respondents were white and 24 percent were African-American. Their mean age was 34 years, with a range of 18-78 years. Forty-nine percent of the respondents had never married. A large percentage of the sample, 63 percent, were high school graduates and 48 percent had some college education.

With respect to mental health, drug use and criminal history, 9 percent of the sample of 520 homeless persons reported a previous hospitalization for a mental, emotional, or nervous problem, 22 percent for an alcohol problem, and 14 percent for a drug problem. Further, 21 percent of the respondents had made an outpatient visit for a mental or emotional problem within the past year, and only 6 percent had visited a community mental health center during the past month. One-hundred and thirteen of the respondents had a felony conviction, and 59 percent of the respondents had been arrested at least once since the age of 18. Overall, the researchers found that a large percentage of the homeless adults have an overwhelming set of social, mental health,


criminal, alcohol and drug problems, that have presented society with a number of expensive social ills that will hopefully challenge us to find satisfactory solutions.\(^6\)

Benda and Dattalo investigated the problems and use of services of homeless women and men. Using monthly lists of persons who contacted two local agencies, the authors drew systematic random samples each month for 19 months. The male sample, which was 51 percent white and 49 percent black, had slightly lower mean education level than the women (10.8 vs 11.0). When asked how many weeks they had now been homeless in the area where the study was being conducted, the mean length of time for the men, 311.7 weeks, was much shorter then the mean length of time for the women, 416.8 weeks. Yet the men did appear to have a greater incidence and prevalence of problems than did the women in certain areas. Twenty-three percent of the men reported to have attended alcohol treatments, as opposed to only 13 percent of the women. Twenty-five percent of the men had been imprisoned, which is 15 percent more than the women sample.\(^7\) In the area of non-prescription drug use, however, the women (38 percent) had a higher current prevalence rate then men (27 percent).\(^8\)

\(^6\)Ibid, 195.

\(^7\)Brent B. Benda and Patrick Dattalo, "Homeless Women and Men: Their Problems and Use of Services," Women and Social Work 5, no 3 (Fall 1990): 50.

\(^8\)Ibid, 56.
The study's data support the general perspective that a significant proportion of the homeless drift down into their current circumstance via a path of crime, substance abuse or mental illness. Also the data indicate that there are important gender differences in which drift-down path is selected. A larger percentage of the men than of the women appear to have ended up homeless after years of crime and alcohol abuse. The women were more likely than were the men to have been using non-prescription drugs at the time of the interviews. However, the prevalence and incidence of past treatment for drug abuse were greater among the men. The prevalence of alcohol problems among the homeless was investigated by Roth and Bean (1985). The study had a sample of 979 homeless persons, 204 which responded as having an alcohol problem. Of the 204 respondents, 191 were male. When compared to the non-alcohol respondents (34.5%), the alcohol-problem respondents (56.4%) were more likely to be older men who were divorced or separated. A large portion of the group, 45.1 percent, were also veterans. An even larger proportion, 86.8 percent, reported having been in jail or prison. Furthermore, respondents with alcohol problems had been homeless for a longer period of time and appeared to be more transient than non-alcoholic respondents. Alcohol problems were also related to other difficulties. More

frequently than homeless respondents without alcohol problems, the alcohol group who reported physical health problems were likely to have used and had trouble with non-prescribed drugs or medications. Also the alcohol-problem group experienced higher rates of psychiatric hospitalization.¹⁰

The findings of this study suggest that homeless people with alcohol problems are very likely to have human service needs that are not being met. Most obvious are the need for housing and the need for services targeting alcohol use. Employment or training opportunities, health care (both physical and mental), and development of social supports are also areas in which the homeless alcoholic could greatly benefit.¹¹

The effects of homeless on the health of individuals was explored in 1987 by Ropers and Boyer. A self-reported index of health status was used as an indicator of mental, social and physical health. The interviews were conducted using the Basic Shelter interview Schedule (BSI). This schedule contains 200 questions subdivided into 9 sections: (1) demographic characteristics, (2) welfare status, (3) economic and employment history, (4) homelessness history, (5) physical and mental health status, (6) health service

¹⁰Ibid.

¹¹Ibid.
utilization, (7) drug and alcohol use patterns, (8) criminal history, and (9) crime victimization.\textsuperscript{12}

Results showed that two-thirds (66.6\%) of the sample rated their overall health status as either good or excellent. Only slightly more than one-tenth (12.2\%) considered themselves to be in poor health. More than 40 percent of the respondents perceived that their health had deteriorated since they had become homeless. Nevertheless, 38 percent indicated no change and 16.3 percent considered that their health had improved.\textsuperscript{13}

Concerning the area of alcohol use, 64 percent of the sample indicated that they sometimes drank beer, wine, or other alcoholic beverages. Using information on life-time experience with alcohol of all the respondents, 55 percent were categorized as asymptomatic, 26 percent as alcohol abusers, and 19 percent as alcohol dependent.\textsuperscript{14}

Nearly 40 percent of the homeless sample reported one chronic health problem. The most prevalent chronic or recurring illness reported was hypertension. Nearly 10 percent of the respondents reported this condition, which was most prevalent with the African-American homeless population.\textsuperscript{15}

\textsuperscript{12}Richard H. Ropers and Richard Boyer, "Homelessness as a Health Risk," \textit{Alcohol, Health and Research World} 10, no. 3 (Spring 1987): 38.

\textsuperscript{13}Ibid, 39.

\textsuperscript{14}Ibid, 40.

\textsuperscript{15}Ibid.
As for access to health care, nearly 80 percent of the sample reported having no medical coverage. Of those who said they had some health insurance, the majority (63.6%) reported being covered by either Medicaid or Medicare. Only 23.6 percent reported having any private insurance. Surprisingly, only 2 percent of the respondents reported coverage by veteran’s benefits, although more than 43 percent of the males interviewed were veterans.

In the area of mental health, 50 (18.6%) of the respondents reported having a psychiatric hospitalization. When each respondents was asked if he or she had seen a doctor for managing life problems, 71 (26.4%) answered yes.

The results from the study reinforces the fact that a large segment of the homeless population does not consult or have access to medical care. This implies that more direct effort should be devoted to epidemiological research among the homeless, in order to develop further strategies that will allow for improved health care for this population.\textsuperscript{16}

Understanding the problems that face minority homeless was the topic of concern for researchers First, Roth and Arewa. The researchers utilized a sample of 979 homeless persons, 292 which were African-American. Of the 292 African-Americans, 81.9 percent were male.\textsuperscript{17} The researchers

\textsuperscript{16}Ibid, 40.

\textsuperscript{17}Richard J. First, Dee Roth, and Bobbie Darden Arewa, "Homeless: Understanding the Dimensions of the Problem for Minorities," Social Work 34 (March-April): 120.
analyzed the findings that related to the 292 African-American homeless persons interviewed and looked for the characteristics, problems, and specialized service needs of this population.

The Ohio data for African-American homeless persons indicated that African-Americans are over-represented in the homeless population, tend to be younger, have a somewhat higher education level, and represent a slightly greater proportion of Vietnam veterans than other homeless persons. On average, the African-American were homeless for shorter periods than the white respondents, but were more likely to move in and out of homeless conditions. Reports of African-American homeless people of being homeless for a shorter time and of more family conflict (16.8 percent, n=49 for African-American respondents and 12.1 percent, n=77 for white respondents) suggest that African-American homeless people may move from homeless conditions to living with family or friends for certain periods.18 However, African-American respondents showed no greater support from family than white respondents, reported fewer friends on whom they could depend, and also were much less mobile.

First, et. al. also found that African-American respondents' primary explanations for their homelessness were economic. African-American respondents were less likely to have had income from earnings in the last month and almost 20

18Ibid, 121.
percent had never had a job. These data support the contention that blacks suffer more than whites from unemployment, even when they have more education and appear better prepared for work.

African-American respondents reported more use of the social service system than did white respondents, as is evident by their greater use of shelters (61.6 percent vs 55.7 percent) and the greater receipt of welfare as income (30.8 percent vs 20.5 percent). Contrary to expectations, however, African-American respondents did not report as much psychiatric hospitalization, jail detention, alcohol problems, and physical health problems. These dimensions of the problem offer some clues for isolating variables that might account for the higher rates of homelessness reported among African-Americans.

In another study specifically concerning homeless, African-American males, drug and sexual activity was investigated. Researched in 1991 by Bassel and Schilling, the study utilized a sample of 108 homeless, African-American men in a free lunch program. All of the men had histories of drug abuse and were surveyed to determine the relationships among

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19Ibid.

20Ibid, 122.
drug use, sexual activity, AIDS prevention practices, and perceived risk of AIDS.\textsuperscript{21}

Ten percent of the respondents were employed part- or full-time. Public assistance was the major source of income for 54 percent of the population. Two-thirds of the respondents reported they had been graduated from high school or received a GED degree, and almost one fourth indicated that they had attended college. Only 8.4 percent were married or living with a significant other; 56.1 percent indicated that they were never married; and 35.5 percent were divorced, separated, or widowed.\textsuperscript{22}

All of the subjects reported past use of marijuana, heroin, cocaine, crack, or combinations of drugs. When asked about the previous 3 months, 27.8 percent indicated using one of the four substances, 31.5 percent used two, and 25.9 percent used three or more. The remainder, which constituted 14.8 percent, reported using none of these substances recently. More than half (52 percent) of the respondents reported IV drug use in the past, and 13 percent did so during the last 3 months. Of the total sample, 38 percent had shared needles in the past for an average of 9.2 years; 18.5 percent rented used needles; and 35.9 percent reported they had borrowed needles. Unfortunately, only 12 percent of the


\textsuperscript{22}Ibid, 587.
respondents reported being treated currently for drug abuse, including 7.5 percent who were enrolled in methadone maintenance.

With respect to self-reported HIV antibody testing, 44.4 percent of respondents who indicated that they had taken the HIV antibody test, 11.4 percent indicated that they were HIV positive; 77.3 percent said they tested negative, and the remainder did not receive the results. A smaller proportion, 18.7 percent, indicated that their sexual partners had taken the HIV antibody test. A total of 39 (36.4 percent) had close friends who died from AIDS. A total 76 percent of the respondents perceived themselves at risk for AIDS and 50.6 percent believed that this risk was great.

When it came to preventive sexual practices in order not to contract HIV the majority of the respondents, 40 percent, stated they had used condoms every time they had vaginal intercourse in the last 3 months, 12.9 percent used condoms most of the time, 8.2 percent used condoms sometimes and 38.8 percent did not use condoms at all during vaginal intercourse. Respondents who were in monogamous relationships tended to use condoms less frequently. Among the 58 men who had recent oral sex, 86 percent never used condoms; of the 27 who had anal sex, 77.8 percent never used condoms. The findings of this study suggest that attitudinal, interpersonal, and socioeconomic influences determine high-risk drug use and sexual risk-taking. Although altering both
drug use and high-risk sexual behavior may seem beyond the scope of any single program, there is considerable overlap between the attitudes and skills needed to adopt safer sex measures, reduce high-risk drug use, and seek drug treatment.²³

AIDS, HIV and Their Effects

In a study by Lang conducted in 1991, the psycho-social responses to the risk of AIDS was investigated. Sixty-four homosexual respondents were divided into five categories and were arrayed along a continuum of severity as the medical model of the disease would display it.

Several psychometric scales were administered to individuals from each of these categories in order to measure variables believed to relate to an individual’s response to the disease, variables that appear to co-vary with a person with AIDS constructive or negative acceptance of his disease, depression versus generalized contentment, sexual satisfaction, peer relations, family relations, and feelings of self-esteem.²⁴

The results of the study showed that on the Index of Self-Esteem (ISE), all of the respondents scored within a

²³Ibid, 589.

range from 19.0 to 29.3. Since none of the mean scores was higher than 30, none of the major categories at the group level expressed any significant problem with self-esteem. On the Index of Peer Relations (IPR), none of the mean groups scores were higher than 21.3. On the Index of Sexual Satisfaction (ISS), none of the groups scored a mean score higher that 27.4, demonstrating that there is no evidence of dysfunction in this area. The Index of Family Relations (IFR) revealed dysfunction for members of all five categories, with the AIDS group having the highest mean score of 46.2. Lastly, the Generalized Contentment Scale (GCS) revealed that the ARC group and the AIDS group both had dysfunction in this area.

The results of this study may suggest that once a gay male has been diagnosed with AIDS or HIV, there is a shift from support of family to support of peers. Because the study did not include results from the respondents IFR and IPR scale prior to diagnosis, there is also the possibility that the scores were not a result of the HIV diagnosis, but rather an indication that due to the respondents homosexuality they originally felt more accepted by their peer group than by their families.

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25Ibid, 68.
26Ibid.
27Ibid.
The ISS mean scores indicate that sexual satisfaction is not a problem for most members of the worried well, those tested HIV-, those who tested HIV+, or ARC. The lower score for the final category of AIDS is a result of the fact that a number of PWA's have become celibate in response to their diagnosis.28

The mean scores for the GCS indicates that depression is not a major concern for the majority of respondents who are worried well, HIV-, or HIV+. It is understandable, however, that depression is a problem for PWARC's or PWA's. Uncertainty with respect to what the future holds in the case of the individual diagnoses as ARC and almost certain doom for those with AIDS makes depression a not unexpected psychological variable.

In a similar study by Borden, the beneficial outcomes in adjustment to HIV seropositivity in homosexual males was investigated. The subjects participated in semi-structured interviews that assessed perceptions of self, life experience, anticipated future, and social relationships between 12 and 21 months after discovery of HIV seropositivity.

Of the 15 participants, 14 reported beneficial changes in perceptions of self, others, life experience, and future events following discovery of HIV seropositivity.29 Positive

28Ibid.

outcomes, listed in order of frequency, were placed in categories. The respondents highest frequency of response was concerning a greater awareness of health status and commitment to health-related behaviors (N=14, 93%). The respondents two lowest response frequencies was shared between the categories of disengagement from negative relationships with peers or family (N=2, 13%) and greater empathy for others (N=2, 13%).

The results of the study show that the respondents reported a range of negative as well as positive outcomes following discovery of HIV seropositivity. All but one of the subjects reported heightened feelings of vulnerability as well as periods of depression, anxiety, demoralization, and depletion in the weeks following notification of test results. Participants acknowledged ongoing anxiety and episodic depression about health status and concern over the implications of potential HIV-related problems for life activities, intimate relationships, plans, and goals. More than half of the men said that they expected to develop serious a illness or die within 5 years.

In spite of the traumatic character of the experience, however, most of the participants reported that they had experienced beneficial outcomes and described changes in

30Ibid, 440.

31Ibid.
perceptions of self, core values, and life priorities; health-related behaviors and life-style; and social relationships.

Although, AIDS can bring about beneficial outcomes in the lives of those living with it, AIDS can also bring a great deal of uncertainty for PWA's. In a study by Weitz in 1989, the uncertainty and the lives of persons with AIDS was explored. The study utilized interview data to explore how 23 gay and bisexual men who had AIDS were affected by and managed uncertainty.32

The results of the interviews showed that uncertainty affects PWA's at many levels. The areas of uncertainty for the PWA's were placed into six categories by the interviewer. The six categories of concern were 1) "What do my symptoms mean?", 2) "Why have I become ill", 3) "Will I be able to function tomorrow", 4) "Will I be able to live with dignity?", 5) Will I be able to beat AIDS?", and 6) "Will I be able to die with dignity?".33

The results of the study suggest that persons with AIDS respond to the uncertainties of their illness by attempting to assert as much control as possible over their lives, through such divergent strategies as seeking and avoiding knowledge about their illness.


33Ibid, 272-277.
The adaptive tasks of seropositive homosexual men was investigated by Siegel and Krauss. Based on interviews with 55 seropositive gay men, the researchers identified three major adaptive challenges: dealing with the possibility of a curtailed life span, dealing with reactions to a stigmatizing illness, and developing strategies for maintaining physical and emotional health.34

In dealing with the possibility of a curtailed life span, two areas were most prevalent. The first was dealing with a sense of urgency to attain life goals. Deciding to what extent to invest in the future was the second area.

In dealing with reactions to a stigmatizing illness, the first area of concern was deciding whom to tell of their infected status. Most of the men had been quite selective in deciding to whom they disclosed their infected status. Four considerations influenced whom they told: 1) fears of rejection, 2) the wish to avoid the pity of others, 3) the wish to spare loved ones emotional pain, and 4) concerns about discrimination.35 Feelings of shame and contamination was the second area of concern. Several men expressed feelings of shame about their condition.

In the last area of developing strategies for maintaining physical and emotional health the first concern


was the need to take control of one's health. Lastly, taking responsibility for following a healthy lifestyle, and trying to sustain a positive and hopeful outlook toward the future, were two other ways in which the respondents stated they were taking control of their health.

The information provided by the respondents reinforces insights provided by other researchers in chronic illness; insights on the importance of individual representations of threats to health, on the challenge to "self" posed by illness, and on the emphasis on process and on person-environment interaction.36

Theoretical Framework

This study embraces the theory of self-regulation. Conceptualized by Nerenz and Leventhal in 1983 the self-regulation theory to chronic illness suggests that adaptation begins as individuals process their diagnosis conceptually and incorporate additional illness episodes to form "schemata of their relationship to their illness".37 In chronic illness, the chronically ill are likely to come to see them "selves" as either 1) overwhelmed and identified with the illness, 2) at risk for further episodes of illness, or 3) relatively


disease-free, with the illness encapsulated in a component of the "self". Each characterization has different implications for adjustment. Individuals are likely to be disconcerted, according to Nerenz and Leventhal's (1983) hierarchical model, by discrepancies between their sensory experience and their schematic representations of their self and their illness. Finally, an important feature of this model is the parallel and somewhat independent processing of dangers (threats from illness situations) and emotions (representations of subjective feeling states); this feature was necessary to encompass situations in which knowledge and emotion motivated similar or different actions.

This theoretical framework, in relation to homeless, HIV infected African-American males, underlies the idea that these individuals will fall into one of the three categorical reactions of self-regulation. Once testing HIV seropositive, each individual will see themselves as overwhelmed and identified with HIV, at risk for further episodes of HIV, or relatively HIV-free.

**Purpose of the Study**

The recent recognition of homelessness as a social problem has focused a fair amount of attention on the general characteristics and needs of homeless people. What this new

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38Ibid.

39Ibid.
found attention is lacking is a focus on the specific needs and characteristics of the subgroups within this general population. The characteristics and unique service needs of minority homeless persons have received little attention in the literature and in service delivery efforts. The purpose of this descriptive study was to identify, examine and address the life experiences and social characteristics of homeless, HIV infected, chemically dependent, African-American males.

**Definition of Terms**

For the purpose of this study the following terms were placed in the form of descriptive and operational definitions:

**AIDS (Acquired Immune Deficiency Syndrome):** A viral disease that impairs the body's ability to fight disease. People with AIDS are susceptible to a wide range of unusual and life-threatening diseases. These diseases can often be treated, but there is no known treatment for the underlying immune deficiency caused by the virus.

**ARC (AIDS Related Complex):** The mid-stage in the spectrum of infection between asymptomatic infection and diagnosed AIDS.

**AZT (Azidothymidine):** An FDA-approved drug that inhibits the replication of HIV. While not a cure, it does prolong survival among some patients with AIDS or symptomatic
HIV. It is also used with asymptomatic patients to possibly delay the onset of symptoms.

**Chemical dependency**: a behavior pattern of compulsive drug use characterized by overwhelming involvement, with the use of a drug and the securing of the supply; as well as a tendency to relapse after completion of withdrawal.

**DDI (dideoxynosine)**: An FDA-approved drug that also inhibits the replication of HIV.

**HIV (Human ImmunoDeficiency Virus)**: The virus believed to cause AIDS; previously referred to as HTLV-III or LAV.

**Homelessness**: The state of being without a home; lacking a place to live.
CHAPTER III
METHODOLOGY

Research Design

In order to ascertain the life experiences and social characteristics of homeless, HIV infected, chemically dependent African-American males, this study utilized a descriptive survey design.

The Setting

AID Atlanta is a non profit social service agency which was organized to respond to the AIDS epidemic. Direct services are offered to people living with AIDS, ARC (AIDS Related Complex), and HIV. Education is also provided to the community about the disease and its prevention. AID Atlanta offers its services to the metro Atlanta area and fifteen surrounding counties. Services are provided to anyone who has a Centers for Disease Control definition of AIDS, ARC or HIV, and are available to all who need them; without regard to age, race, sex, sexual orientation, economic class, physical limitations, and past or present addictive history.

Request for services for a person living with AIDS, ARC or HIV must be made by the person with AIDS, or by another
person with the infected individual's permission. All information is held in strictest confidence.

AID Atlanta is funded both publicly and privately. Public funds are provided by such organizations as: Health Resources and Services Administration (HRSA), the Georgia State Legislature, and Dekalb County. Private funds come from organizations such as the Robert Wood Johnson Foundation, Heartstrings, and other private persons and institutions. The agency also has sites at Grady Hospital Infectious Disease Clinic, Southside Health Care, Veteran's Administration Hospital and Dekalb County Health Clinic.

The "Home Street Home" program was designed to provide a continuum of care for HIV infected, homeless, chemically dependent persons. The life planning curriculum of this program intended to provide skills in personal, physical, emotional and fiscal management; information about available resources and intervention programs designed to address substance abuse, safer sex practices, resource networking, literacy and housing programs.

The Sampling

The sampling consisted of 18 Homeless, HIV infected, chemically dependent, African-American males. Each individual was a participant in a community-based day program.
Questionnaire Package

In order to ascertain certain life experiences and social characteristics of HIV infected, homeless, chemically dependent, African-American males, a questionnaire package was developed. The instrument used in this survey was a 68 item questionnaire. It included descriptive data about the subjects, e.g. age, sex, specific questions regarding drug, alcohol, and arrest history, e.g. length/frequency of time use, whether ever arrested/convicted, specific questions regarding support networks, e.g. family, friends and support groups and questions regarding outlook on life, e.g. whether or not outlook has changed since HIV diagnosis and goals that subject wishes to accomplish.

Four indices from Hudson's 1990 clinical assessment package were selected as appropriate psychometric scales to measure the degree of adjustment, or impairment, by an individual to certain life events, affect states and attitudes following a positive HIV diagnosis and after becoming homeless. The first scale used was the Generalized Contentment scale (GCS), which has a reliability score of .92. The second scale used was the Index of Self-Esteem (ISE), which has a reliability score of .93. The third score used was the Index of Family Relations (IFR), which has a reliability score of .95. The fourth scale used was the Index of Peer Relations.
(IPR), which has a reliability score of .94. All four indices have excellent validity.¹

Each scale is a 25-item measure of the degree, severity, or magnitude of a problem in the individual’s life. Each scale has a cutting score of 30 (±5), with scores above 30 indicating the respondent has a clinically significant problem and scores below 30 indicating the respondent has no such problem.² Each participant was interviewed and asked the questions pertaining to the questionnaire. The indices were completed solely by each participant. Completion of the entire questionnaire package took approximately 35 minutes. A copy of the questionnaire package can be found in the appendix.


CHAPTER IV

PRESENTATION OF RESULTS

Table 1 displays the demographic characteristics of the respondents. The age range for the homeless respondents was from 23 years to 52 years, with a median age of 37.8 years. The majority of the respondents had graduated from high school (50.0%, n=9), or had some post high school education (22.2%, n=4). Most of the respondents had never been married (27.2%, n=13), 22.2 percent (n=4) were divorced and 5.6 percent (n=1) was separated.

Almost one-third of those interviewed (27.8%, n=5) were not receiving any form of financial assistance, while 38.8 percent (n=7) were receiving food stamps, 22.2 percent (n=4) were receiving unemployment insurance benefits, and 5.6 percent (n=1) were receiving either social security or disability. Not surprisingly, almost the entire sample had no type of medical insurance (83.3%, n=15), while only 11.1 percent (n=2) had Medicaid and 5.6 percent (n=1) had private/HMO insurance.
Table 1

DEMOGRAPHIC CHARACTERISTICS OF HOMELESS, HIV INFECTED, AFRICAN-AMERICAN MALES (N=18)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>25-31</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>32-38</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>39-45</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>46-52</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Median</td>
<td>37.8</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some high school (9-11)</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>High school graduate</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>Some post high school</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>13</td>
<td>72.2</td>
</tr>
<tr>
<td>Married</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Financial assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Food stamps</td>
<td>7</td>
<td>38.8</td>
</tr>
<tr>
<td>Unemployment insurance benefits</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Social security</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Disability</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Medical insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td>Private/HMO</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Medicare</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Veteran’s Administration</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Table 2 provides the reasons for homelessness, daily activities and eating characteristics of homeless respondents. Of all the respondents, 44.4 percent (n=8) reported that their homelessness was a result of loss of employment, while 27.8
percent (n=5) reported drugs or alcohol as the reason, and
16.7 percent (n=3) named relocation and the lack of employment
as the cause. In addition, 11.1 percent (n=2) stated that a
dispute with family member (in which they were living with) or
roommate as the precipitating factor for their homelessness.
When responding to the question of where they slept the night
before the interview, more than half of the respondents
(55.5%, n=10) reported at a shelter, 16.7 percent (n=3)
reported at a friend’s home, 11.1 percent (N=2) reported
either they rented a room for the night or slept on the
street. Only 5.6 percent (n=1) reported that they slept at a
family member’s home (Table 2). Sixty-one percent (n=11)
stated that each day prior to the "Home Street Home" program
they were in the street (Table 2). Sixteen percent (n=3)
responded that they usually went the public library before the
program begins.

The public library was the most popular place for the
majority of the respondents to go once the "Home Street Home"
Program ended. Seven of the respondents (38.8 %), reported
that the public library was where they spent their afternoons,
while 27.8 percent (n=5) reported that they went back to the
street, 16.7 percent (n=3) reported that they find a shelter,
11.1 percent reported that they attended a NA (Narcotics
Anonymous) or some other type of recovery meeting, and 5.6
percent (n=1) reported that they went to a soup kitchen.
### Table 2

**REASONS FOR HOMELESSNESS, DAILY ACTIVITIES AND EATING CHARACTERISTICS OF HOMELESS RESPONDENTS (N=18)**

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for homelessness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs or alcohol</td>
<td>5</td>
<td>28.8</td>
</tr>
<tr>
<td>Loss of employment</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>Relocated-could not find employment</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Dispute with family or roommate</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Place of stay night before interview</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Family member’s home</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Friend’s home</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Street</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Rented room for night</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Place of stay morning before &quot;Home Street Home&quot; begins (daily)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Family member’s home</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Street</td>
<td>11</td>
<td>61.0</td>
</tr>
<tr>
<td>Soup kitchen</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Library</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Place of stay afternoon following &quot;Home Street Home&quot; ends (daily)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Street</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Soup kitchen</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Library</td>
<td>7</td>
<td>38.8</td>
</tr>
<tr>
<td>NA or other recovery meeting</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Source of majority of meals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Street Home program</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Project Open Hand</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Shelter</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Soup kitchen</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Purchase on own</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Number of meals eaten each day on average</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>4+</td>
<td>1</td>
<td>5.6</td>
</tr>
</tbody>
</table>
The eating patterns of the respondents was also investigated. When the respondents reported where they received the majority of their meals, more than half of the respondents (55.5%, n=10) reported from "Home Street Home". The next largest group of respondents (16.7, n=3) reported that they purchase their meals on their own (Table 2). Two of the respondents (11.1%) reported that they received most of their meals from a shelter or a soup kitchen, and one respondent (5.6%) stated that he received the majority of his meals from Project Open Hand (Table 2). Project Open Hand, is a non-profit organization that provides prepared, healthy meals for HIV-infected individuals who cannot afford food on their own, or are not physically able to prepare their own food. Over forty-four percent (n=8) responded that they ate two meals a day, 27.8 percent (n=5) stated that they ate one meal a day, 22.2 percent (n=4) stated they ate three meals a day, and 5.6 percent (n=1) stated he ate four or more meals a day.

Table 3 displays the health characteristics of the homeless respondents. The most frequently reported mode of HIV transmission for the respondents was male to male sexual contact (55.5%, n=10). Five of the respondents (27.8%) reported that their mode of transmission was intravenous (IV) drug use, 11.1 percent of the respondents (n=2) reported that they did not know their exact mode of transmission, and one
respondent (5.6%) reported that his mode of transmission was female to male sexual contact.

Table 3

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mode of HIV transmission</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Male-to-male sexual contact</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Female-to-male sexual contact</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Receipt of blood/blood products</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Intravenous (IV) drug use</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td><strong>Reason for HIV test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Went on own</td>
<td>8</td>
<td>44.4</td>
</tr>
<tr>
<td>Friend/partner suggested</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Doctor suggested</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>Tested while incarcerated</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Gave blood</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Primary health care provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grady Infectious Disease Clinic</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Mercy Mobile Health Care</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Last time saw physician for HIV</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one month ago</td>
<td>11</td>
<td>61.1</td>
</tr>
<tr>
<td>One-to-two months ago</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Taking any HIV medication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>50.0</td>
</tr>
</tbody>
</table>

When responding to the question of why they were tested for HIV, 44.4 percent (n=8) reported that they went on their own, 33.3 percent (n=6) reported that a doctor suggested they get tested, 11.1 percent (n=2) stated they were tested while incarcerated, and 5.6 percent (n=1) stated that either a
friend or partner suggested, or that they were tested when they gave blood.

The primary health facility for the majority of the respondents (55.5%, n=10) was Grady Hospital's Infectious Disease Clinic. The Infectious Disease Clinic (IDC) is the part of the county run hospital that specialized in infectious diseases, particularly HIV. Over 27 percent of the respondents (n=5), received the majority of their health care from Mercy Mobile Health Care. Mercy Mobile Health Care (a mobile health unit facility) has an agreement with AID Atlanta to provide health services for those in the "Home Street Home" program, who so desire it. Two of the respondents (11.1%) reported that they used other public facilities for the majority of their care and 5.6 percent (n=1) reported he used a private hospital.

The last time that each respondent saw a physician concerning HIV was also another area of concern. Fortunately, the majority of the respondents (61.1%, n=11) reported that they had seen a physician less than one month before the interview, 33.3 percent (n=6) reported they had seen a physician one to two months ago, and only one respondent (5.6%) reported they had never seen a physician (other than for an initial diagnosis) for HIV. When responding to the question of whether they were taking any type of medication or treatment for HIV, 50.0 percent (n=9) reported yes.
Unfortunately, an equally large percentage of respondents (50.0%, n=9) reported no.

Table 4 displays the use of alcohol and drugs for the respondents. All of the respondents reported past use of alcohol. Regarding the question of current use of alcohol, 27.8 percent of the respondents (n=5) reported that they were currently using. When asked the length of their alcohol use, 38.8 percent (n=7) reported more than 17 years, 22.2 percent (n=4) reported 5-8 years, 16.7 percent (n=3) reported 9-12 years, 16.7 percent (n=3) reported 13-16 years, and 5.6 percent (n=1) reported 1-4 years. The frequency of alcohol use (past or present) was also investigated. The majority of the respondents (50.0%, n=9) reported they use or used alcohol daily, 27.8 percent (n=5) reported weekly use, and 22.2 percent reported monthly use.

Regarding the question of current use of non-prescription drugs, 16.7 percent (n=3) reported they were currently using. Regarding the question of past drug use, 83.3 percent (n=15) reported they had used drugs in the past. Length of drug use, for those who reported past or present use, was also investigated. More than 27 percent of the respondents (n=5) reported that they had used drugs for 17 or more years, 16.7 percent (n=3) reported 1-4 years, 16.7 percent (n=3) reported 9-12 years, 11.1 percent reported 5-8 years and 11.1 percent reported 13-16 years. Frequency of use for the total 83.3 percent was reported as follows: 55.5
### Table 4

**USE OF ALCOHOL AND DRUGS, MENTAL HEALTH AND CRIMINAL HISTORY OF HOMELESS RESPONDENTS (N=18)**

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Currently using alcohol</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>72.2</td>
</tr>
<tr>
<td><strong>Length of alcohol use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 years</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>5-8 years</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>9-12 years</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>13-16 years</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>17+ years</td>
<td>7</td>
<td>38.8</td>
</tr>
<tr>
<td><strong>Frequency of alcohol use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>Weekly</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Monthly</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td><strong>Currently using drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td><strong>Used drugs in past</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td><strong>Length of drug use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>1-4 years</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>5-8 years</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>9-12 years</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>13-16 years</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>17+ years</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td><strong>Frequency of drug use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Daily</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Weekly</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Monthly</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Drug of choice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>7</td>
<td>38.8</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Crack</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Heroin</td>
<td>1</td>
<td>5.6</td>
</tr>
</tbody>
</table>
percent (n=10) reported daily, 22.2 percent (n=4) reported weekly and 5.6 percent (n=1) reported monthly. Alcohol prevailed as the drug of choice for 38.8 percent (n=7) of the respondents, while 27.8 percent (n=5) reported cocaine (in powder form) and 22.2 percent (n=4) reported crack cocaine as their drug of choice. Only 33.3 percent (n=6) reported that they had any previous treatment for drug and/or alcohol use.

Table 5 displays the characteristics pertaining to the respondents relationship with family, friends and other social support networks. Regarding the question of how many family members they communicated with, 33.3 percent (n=6) reported 2 to 3 family members, 22.2 percent (n=4) reported 1 family member, 22.2 percent (n=4) reported no family members, 16.7 percent (n=3) reported 6 or more family members, and 5.6 percent (n=1) reported 4 to 5 family members. Fifty percent of the sample (n=9) reported that their family members were aware of their HIV status.

The majority of the respondents (33.3%, n=6) reported that they had 2 to 3 friends, while 22.2 percent (n=4) reported they had 4 to 5 friends, 22.2 percent (n=4) reported

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous treatment for drug and/or alcohol use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>66.7</td>
</tr>
</tbody>
</table>

Table 4 (cont.)
they had 6 or more friends, 16.7 percent (n=3) reported they had no friends and 5.6 percent (n=1) reported he had only 1 friend. In the area of confidants, the majority of the respondents (38.8%, n=7) reported they had 1, 33.3 percent (n=6) reported 2 to 3, 16.7 percent (n=3) reported none, 5.6 percent (n=1) reported 4 to 5 and 5.6 percent (n=1) reported 6 or more.

Over seventy-two percent (n=13) reported that they were currently attending religious services. The "Home Street Home" program was the major source of emotional support for over half of the respondents (55.5%, n=10), while 22.2 percent (n=4) reported their was family their greatest emotional support system, 16.7 percent (n=3) reported their church as the greatest emotional support system and 5.6 percent (n=1) reported his friends as the greatest support.

Table 6 displays the mean scores and standard deviations, for all of the respondents, on the four separate Hudson scales. The scores for the Generalized Contentment Scale (GCS) ranged from 21 to 114, with a mean score of 47.1 and a standard deviation of 22.6. The scores for the Index of Self-Esteem (ISE) ranged from 13 to 93, with a mean score of 46.0 and a standard deviation of 19.2. The scores for the Index of Family Relations (IFR) ranged from 5 to 91, with a mean score of 42.7 and a standard deviation of 25.8. Lastly, the scores for the Index of Peer Relations ranged from 12 to
105, with a mean score of 47.4 and a standard deviation of 25.6.

Table 5
RELATIONSHIP WITH FAMILY, FRIENDS AND OTHER SOCIAL SUPPORT NETWORKS OF HOMELESS RESPONDENTS (N=18)

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of family members communicating with currently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>2-3</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>4-5</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>6+</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Family members aware of HIV status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>50.0</td>
</tr>
<tr>
<td>Number of friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>2-3</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>4-5</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>6+</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Number of confidants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>38.8</td>
</tr>
<tr>
<td>2-3</td>
<td>6</td>
<td>33.3</td>
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<tr>
<td>4-5</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>6+</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Currently attending religious service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13</td>
<td>72.2</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Primary source of emotional support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Friends</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Home Street Home Program</td>
<td>10</td>
<td>55.5</td>
</tr>
<tr>
<td>Church</td>
<td>3</td>
<td>16.7</td>
</tr>
</tbody>
</table>
Table 6

MEAN SCORES AND STANDARD DEVIATIONS OF THE GENERALIZED CONTENTMENT SCALE (GCS), INDEX OF SELF-ESTEEM (ISE), INDEX OF FAMILY RELATIONS (IFR) AND INDEX OF PEER RELATIONS FOR HOMELESS RESPONDENTS (N=18)

<table>
<thead>
<tr>
<th></th>
<th>GCS</th>
<th>ISE</th>
<th>IFR</th>
<th>IPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>47.1</td>
<td>46.0</td>
<td>42.7</td>
<td>7.4</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>22.6</td>
<td>19.2</td>
<td>25.8</td>
<td>25.6</td>
</tr>
</tbody>
</table>
CHAPTER V

SUMMARY AND CONCLUSION

The results from the study show that majority of the respondents were middle aged men, with fairly decent educations. The majority had either graduated from high school (50.0%, n=9) or received some post high school education (22.2 percent, n=4). Therefore, if they had the resources and opportunities, adequate employment would not be an impossibility for many of the respondents.

Although one-third of the respondents were not receiving any form financial assistance, most of the respondents were eligible. This raises the questions of whether the respondents were uninformed of the potential financial assistance available to them, or whether much of the red tape involved in applying for governmental aid is too exasperating for many of the respondents to decipher. Of those who were receiving either social security or disability, none had the usual accompanying Medicaid or Medicare health insurance. Not surprisingly, almost the entire sample (83.3 percent, n=15) had no form of medical insurance, which would lead one to believe that the majority of the respondents would have very little or no health care. According to the data reported, this is partially true. A large percentage of the
respondents did state that they had seen a physician, regarding HIV, in less than a month prior the interview and all, but one respondent, reported seeing a physician no more than two months prior. Unfortunately, of those respondents who had seen a physician recently, only 50.0 percent (n=9) were taking any medication for HIV. This leaves a large percentage of the respondents living without the benefit of medical treatments. All of the respondents reported that their HIV status was HIV positive. This means that all of the respondents were in the best possible situation to receive early treatments, that could possibly prolong their quality of life and life expectancy. Why almost half of the respondents are not taking medication is unknown. There could be several possible reasons. One possible explanations could be that certain physicians may feel that drugs such as AZT or DDI, are too expensive to use on homeless, chemically dependent individuals who lack medical insurance and whose quality of life is already suspect. Another possible explanation could be that the respondents themselves may simply choose not to take any medication. Lack of education concerning the importance of the medication, may also be a reason why many of the respondents are not taking any treatments. Whatever the reason, the importance and functions of the medications should be expressed, and HIV treatments should be an offered option for those in need.
The data also further stress the importance of more supportive programs for the homeless. A large percentage of the respondents had no where to go before (61.1%, n=11) or after (27.8%, n=5) the "Home Street Home" program, except for the street. Many of the respondents (55.5%, n=10) stated that the major source of emotional support for them was the "Home Street Home" program. This brings about the question of whether many of the respondents would have any type of support system if it was not for the program.

The "Home Street Home" program was also the major provider of meals for the majority of the respondents (55.5%, N=10). If the program was not equipped to feed each individual, one could only wonder if several of the respondents would go hungry each day. One respondent did report that he received the majority of his meals from Project Open Hand. Because P.O.H. must have a semi-stable address in order to deliver meals to the recipients, very few homeless people are eligible for this free public resource. Some homeless individuals are able to stay at a shelter or friend's home for a somewhat prolonged period of time, but this is a rarity.

One component of the "Home Street Home" program is treatment for chemical dependency. All of the individuals in the program, have admitted to a drug and/or alcohol problem. The data on use of alcohol and drugs, show that 27.8 percent (n=5) of the respondents admitted that they were currently
using alcohol and 16.6 percent (n=3) admitted that they were currently using drugs. This does not necessarily mean that the program is not working. Many of the respondents had been using alcohol or drugs for several years, and it may take a significant amount of time before they will be drug and alcohol free. The data show that over-half of the respondents have been using alcohol for 9 or more years, and 50.0 percent of the respondents use or used alcohol daily. The data for drug use are also quite extensive, although 16.7 percent (n=3) of the respondents stated that they never used drugs (all of the respondents stated they had used or were using alcohol). Only six of the respondents (33.3%) stated that they had any drug or alcohol treatment in the past. The evident need for alcohol and drug treatment programs, that are equipped to deal with the special concerns and issues of those with HIV, must become a concern for all who work with the homeless.

Over 22 percent (n=4) of the respondents stated that they had a previous diagnosis for a mental health disorder. All of the respondents, that fit into this category, stated that they were diagnosed with some form of depression. Not surprisingly, all of the diagnoses of depression came either after a seropositive HIV diagnosis or after they became homeless. Luckily, all of the respondents diagnosed with depression had received some form of mental health treatment. Unfortunately, a large percentage of the total sample had no
type of medical insurance, so the quality and quantity of mental health treatment should be questioned.

Over 77 percent (n=14) of the respondents stated that they had been arrested, at least once, in their adult life. Twelve of those arrested, were also convicted of their crime. These statistics are representative of other studies that have found that a large percentage of homeless individuals have criminal histories.

Data on the respondents relationships with family and friends showed that 22.2 percent (n=4) of the respondents did not communicate, at all, with any family members. The data also showed that only half of the respondents had informed their family of their HIV status. It is possible that some of respondents seem to feel that they can not rely on their family for support and understanding. Over 16 percent (n=3) reported that they have no friends or no confidants. As stated previously, the majority of the respondents (55.5%, n=10) reported that the "Home Street Home" program was their primary source of emotional support, more than church (72.2%, n=13 stated they regularly attended church service). The respondents may feel more support at the "Home Street Home" program because they are able to talk openly with others who are in a similar situation.

The scores on the Hudson scales revealed, that as a group, the respondents had a degree of dysfunction in all areas. The mean score on the Generalized Contentment Scale
(GCS) was 47.1, showing that depression was a major concern for the majority of the respondents. Only one respondent scored lower than 30 on this scale. The mean score on the Index of Self Esteem (ISE) was 46.0, showing that the majority of the respondents expressed a significant problem with self-esteem. Only three respondents scored lower than 30 on this scale. The mean score on the Index of Family Relations (IFR) was 42.7, showing that the majority of the respondents had dysfunction in this area. Six respondents (the highest number of respondents who scored lower than 30 in any scale) did not show any individual dysfunction. Lastly, the mean score on the Index of Peer Relations (IPR) was 47.4, showing that this area was a problem area for the group. Five respondents scored lower than 30 on this scale.

**Limitations**

This study had two methodological limitations. First, the sample selection raises questions about the generalization of the findings, and it cannot be assumed that the selected participants in this study are representative of all participants in similar settings and/or situations. Second, self-reported data are subject to biases related to social desirability and fear of disclosing sensitive, personal information.
Suggested Research Directions

Future research in this area of study may benefit from using a larger population sample for a more significant representation of the entire population. Future research may also benefit from a comparative study between either homeless minorities living with HIV and homeless whites living with HIV; or homeless minorities living with HIV and homeless minorities who are not HIV infected.
CHAPTER VI

IMPLICATIONS FOR SOCIAL WORK

The special needs and conditions of homeless persons who are also members of racial and ethnic minority groups have not been a part of the agenda for social work action on homelessness. This not-so-benign neglect of basic needs for growing number of the minority poor clearly conflicts with the goals of a just an equitable welfare system.¹ Historically, issues related to race, poverty, and inequality do not become salient until the pressure for reform builds to the point of crisis.² Because the national crisis of homelessness has not yet been addressed completely at federal, state or local levels, social work advocacy efforts should focus of minority issues of social justice and inequality. To address the multiple forces leading to and perpetuating homelessness, more long-term and intensive services such as employment opportunities, educational/vocational training, counseling, alcohol/drug treatment, medical care, and transitional/


²Ibid.
supportive living environments will be needed, particularly for the mentally and chronically ill.

In the area of AIDS and HIV, social workers, as well as other public health workers, must make intensive efforts to reach and educate minorities, especially the African-American population. African-Americans are a segment of the population whose incidence of HIV is growing rapidly. Education, that is culturally specific, is the only way social workers, as well as others, will be able to effectively reach this population.

For those who are already living with the reality of homelessness and HIV, social workers must also realize the importance of social support networks. The majority of the homeless do not have friends or family to rely on, consequently they rely heavily on the few programs and services that provide any type of emotional support. Because the homeless, HIV infected individual often receives little or no emotional support from traditional sources, social workers must be willing and able to provide services and programs that can function as surrogate support systems.
APPENDIX
Dear Participant:

My name is Stacey Valrie. I am a second year MSW Student at Clark Atlanta University. I am also MSW Intern at AID Atlanta. In pursuit of my graduate degree, I am conducting a survey designed to assess the life experiences of homeless males living with HIV. Please assist me by completing the attached questionnaire. Your participation is completely voluntary. If you choose to participate, your assistance in completing the questionnaire will enable me to evaluate your life experiences, social characteristics, as well as your feelings about several aspects of your life.

You may find some questions to be quite personal in nature and you might feel uncomfortable or embarrassed about answering some of the questions. Please be assured that your answers will be completely anonymous. At no point will your name be associated with your completed questionnaire or scales. I would like for you to answer each item as carefully and truthfully as possible. If, however, you do not wish to finish the questionnaire please return it to me.

It is my hope that this research will contribute to an increased understanding of the homeless, HIV infected population so that future programs and agencies can be developed to provide more useful and relevant services. It is also my hope that preexisting programs and agencies can use this research to "fine tune" their services for the homeless. Your time and care in completing this questionnaire and following scales is greatly appreciated. If you would like to find out about the results of this study, please contact me through AID Atlanta or Clark Atlanta University.

Sincerely,

Stacey E. Valrie
MSW Student
STATEMENT OF CONSENT

I have read the preceding knowledge statement. I understand that my participation in this study is completely anonymous and voluntary; and that I have the right to withdrawal my participation at any time. I also understand that my participation in the study will not in any way affect my participation in the "Home Street Home" program or my status as an AID Atlanta client. I further understand that the results of the study will be available to me if it is my desire to view them.

_________________________________________  ____________
Signature of Participant                        Date

_________________________________________  ____________
Signature of Investigator                      Date
PART I--DEMOGRAPHICS

1. What is your age? ______________

2. Why were you tested for HIV? ______________________________

3. What is your current diagnosis? (circle one)
   a. HIV+
   b. ARC
   c. AIDS

4. What was your mode of transmissions for HIV? (circle one)
   a. male to male sexual contact
   b. intravenous (IV) drug use
   c. female to male sexual contact
   d. receipt or transfusion of blood/blood products
   e. don't know

5. What year were you diagnosed for HIV? ______________

6. What is the highest level of education you have completed?
   ______________________________

7. What is your marital status?
   a. never married
   b. married
   c. separated
   d. widowed
   e. divorced

8. Do you have any children? (circle one)
   a. yes
   b. no (go to question 11)

9. How many children do you have? ______________________________

10. What is each child's HIV status? (circle one)
    a. all are negative
    b. 1 or more are positive________ (write exact number)
    c. all are positive
11. What was your employment status before you were diagnosed? (circle one)
   a. employed full-time (35-40 hours a week)
   b. employed part-time (less than 35 hours a week)
   c. unemployed
   d. attending school
   e. unable to work due to disability
   f. retired

12. If you were employed (full or part time) before your diagnosis, what was your job title/position?

13. What is your present employment status? (circle one)
   a. employed full-time (35-40 hours a week)
   b. employed part-time (less than 35 hours a week)
   c. unemployed
   d. attending school
   e. unable to work due to disability
   f. retired

14. If you are currently employed (full or part time), what is your job title/position?

15. If your job status has changed for the worse since being diagnosed for HIV, why did it change? (circle one)
   a. was not physically able to perform job
   b. was fired on basis of HIV diagnosis
   c. fired because of absenteeism due to illness
   d. fired because of absenteeism due to stress
   e. other

16. Have you ever served in the Military? (circle one)
   a. yes
   b. no (go to question 19)

17. Have you gone to war? (circle one)
   a. yes
   b. no (go to question 19)

18. What war did you serve in? (circle one)
   a. World War II
   b. Korean War
   c. Vietnam War
   d. Gulf War
   e. other
19. What type of financial assistance do you currently receive? (circle all that apply)
   a. no financial assistance
   b. food stamps
   c. unemployment insurance benefits
   d. Social Security (Non-disability)
   e. Disability
   f. General Assistance

20. Where do you go for the majority of your medical care? (circle one)
   a. Grady I.D.C. (Infectious Disease Clinic)
   b. Mercy Mobile Health Care
   c. Private Hospital____________________(please specify)
   d. other____________________(please specify)
   e. none

21. When was the last time you saw a doctor concerning HIV? (please specify in months) ______________________

22. What medications are you currently on for HIV-related symptoms?
   Type of Medication
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

23. What type of medical insurance do you currently have? (circle all that apply)
   a. Private/HMO
   b. Medicaid
   c. Medicare
   d. Veteran’s Administration
   e. none
   f. other

PART II—CHEMICAL DEPENDENCY, MENTAL HEALTH AND ARREST HISTORY

24. Are you currently using any form of alcohol? (circle one)
   a. yes
   b. no (go to question 26)
25. How long have you been using alcohol? ________________
   (go to question 28)

26. Have you used alcohol in the past?
   a. yes
   b. no (go to question 30)

27. For how long did you use alcohol in the past?___________

28. How frequently do or did you use alcohol? (circle one)
   a. daily
   b. weekly
   c. monthly
   d. other_________________(please specify)

29. How much do or did you drink each time?________________
   ________________________(please specify)

30. Are you currently using any form of drugs (non-prescription)? (circle one)
   a. yes
   b. no (go to question 32)

31. How long have you been using drugs?_____________________
   (go to question 33)

32. Have you used drugs in the past?
   a. yes
   b. no (go to question 36)

33. How long did you use drugs in the past?__________________

34. How frequently do or did you use drugs? (circle one)
   a. daily
   b. weekly
   c. monthly
   d. other______________________(please specify)

35. What is your drug of choice? (circle one)
   a. alcohol
   b. cocaine
   c. crack
   d. marijuana
   e. LSD
   f. heroin
   g. other_____________________ (please specify)

36. Have you ever been arrested?
   a. yes
   b. no (go to question 41)
37. When were you arrested? (please specify)  

38. What were you arrested for? (please specify)  

39. Where you convicted? (circle one)  
   a. yes  
   b. no (go to question 41)  

40. What was your sentence? (please specify)  

41. Have you ever received any inpatient or outpatient counseling/treatment? (circle one)  
   a. yes  
   b. no (go to question 45)  

42. What did you receive counseling/treatment for? (circle all that apply)  
   a. alcohol addiction__________length of stay  
   b. drug addiction__________length of stay  
   c. mental health issues__________length of stay  
   d. other________________________length of stay  

43. Why did treatment/counseling end? (circle one)  
   a. treatment/counseling program ended  
   b. no longer desired to be in program  
   c. kicked out of program due to violation of program rules  
   d. could no longer afford program  
   e. other________________________(please specify)  

44. If you were in treatment for a mental health issue, what was your mental health diagnosis? (please specify)  

45. Are you on any mental health medications?  
   a. yes  
   b. no (go to question 47)  

46. What mental health medication(s) are you currently on? (please specify)  

PART III---FAMILY, FRIENDS, SOCIAL SUPPORTS AND NETWORKS  

47. Do you communicate with any of your family members? (circle one)  
   a. yes  
   b. no (go to question 49)
48. How many family member do you communicate with?

49. Do you have any family members in Georgia?
   a. yes
   b. no

50. Do you have any family members in Atlanta?
   a. yes
   b. no

51. Have you told any of your family members of your HIV diagnosis? (circle one)
   a. yes
   b. no

52. What was your family member(s) reaction to your diagnosis?

53. How many friends do you have?

54. How many confidants do you have?

55. Do you receive any financial support from family members? (circle one)
   a. yes
   b. no

56. Do you receive any financial support from friends?
   a. yes
   b. no

57. Where did you sleep last night? (circle one)
   a. shelter
   b. friend’s home
   c. family member’s home
   d. street
   e. other ________________________(please specify)

58. Where do you go the majority of the week before the "Home Street Home" program begins? (circle one)
   a. shelter
   b. street
   c. friend’s home
   d. family member’s home
   e. other ________________________(please specify)
59. Where do you go the majority of the week once the "Home Street Home" program begins? (circle one)
   a. shelter
   b. street
   c. friend’s home
   d. family member’s home
   e. other ____________________________ (please specify)

60. Did you attend religious services on a regular basis before you were diagnosed? (circle one)
   a. yes
   b. no

61. Do you currently attend religious services on a regular basis? (circle one)
   a. yes
   b. no

62. Who do you feel you receive the most emotional support from? (circle one)
   a. family
   b. friends
   c. Home Street Home program
   d. church
   e. other ____________________________ (please specify)

63. How did you become homeless?

64. On average, how many meals do you eat each day? (please specify)

65. Where do the majority of your meals come from? (circle one)
   a. Home Street Home program
   b. Project Open Hand
   c. shelter
   d. family
   e. friends
   f. purchase food on own
   g. other ____________________________ (please specify)

66. How do you spend the majority of your day?

67. Has your outlook on life changed since being diagnosed? (a. yes
   b. no (go to question 66)

68. How has your outlook on life changed?

69. What would you say is the most important goal in your life that you wish to accomplish?
GENERALIZED CONTENTMENT SCALE (GCS)

Today’s Date: ______________

This questionnaire is designed to measure the way you feel about your life and surroundings. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ___ I feel powerless to do anything about my life.
2. ___ I feel blue.
3. ___ I think about ending my life.
4. ___ I have crying spells.
5. ___ It is easy for me to enjoy myself.
6. ___ I have a hard time getting started on things that I need to do.
7. ___ I get very depressed.
8. ___ I feel there is always someone I can depend on when things get tough.
9. ___ I feel that the future looks bright for me.
10. ___ I feel downhearted.
11. ___ I feel that I am needed.
12. ___ I feel that I am appreciated by others.
13. ___ I enjoy being active and busy.
14. ___ I feel that others would be better off without me.
15. ___ I enjoy being with other people.
16. ___ I feel that it is easy for me to make decisions.
17. ___ I feel downtrodden.
18. ___ I feel terribly lonely.
19. ___ I get upset easily.
20. ___ I feel that nobody really cares about me.
21. ___ I have a full life.
22. ___ I feel that people really care about me.
23. ___ I have a great deal of fun.
24. ___ I feel great in the morning.
25. ___ I feel that my situation is hopeless.

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INDEX OF SELF ESTEEM (ISE)

Today's Date: ________________

This questionnaire is designed to measure how you see yourself. It is not a test, so there are no right or wrong answers. Please answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ____ I feel that people would not like me if they really knew me well.
2. ____ I feel that others get along much better than I do.
3. ____ I feel that I am a beautiful person.
4. ____ When I am with others I feel they are glad I am with them.
5. ____ I feel that people really like to talk with me.
6. ____ I feel that I am a very competent person.
7. ____ I think I make a good impression on others.
8. ____ I feel that I need more self-confidence.
9. ____ When I am with strangers I am very nervous.
10. ____ I think that I am a dull person.
11. ____ I feel ugly.
12. ____ I feel that others have more fun than I do.
13. ____ I feel that I bore people.
14. ____ I think my friends find me interesting.
15. ____ I think I have a good sense of humor.
16. ____ I feel very self-conscious when I am with strangers.
17. ____ I feel that if I could be more like other people I would have it made.
18. ____ I feel that people have a good time when they are with me.
19. ____ I feel like a wallflower when I go out.
20. ____ I feel I get pushed around more than others.
21. ____ I think I am a rather nice person.
22. ____ I feel that people really like me very much.
23. ____ I feel that I am a likeable person.
24. ____ I am afraid I will appear foolish to others.
25. ____ My friends think very highly of me.

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3, 4, 5, 6, 7, 14, 15, 18, 21, 22, 23, 25
INDEX OF FAMILY RELATIONS (IFR)

Today's Date: ____________

This questionnaire is designed to measure the way you feel about your family as a whole. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ___ The members of my family really care about each other.
2. ___ I think my family is terrific.
3. ___ My family gets on my nerves.
4. ___ I really enjoy my family.
5. ___ I can really depend on my family.
6. ___ I really do not care to be around my family.
7. ___ I wish I was not part of this family.
8. ___ I get along well with my family.
9. ___ Members of my family argue too much.
10. ___ There is no sense of closeness in my family.
11. ___ I feel like a stranger in my family.
12. ___ My family does not understand me.
13. ___ There is too much hatred in my family.
14. ___ Members of my family are really good to one another.
15. ___ My family is well respected by those who know us.
16. ___ There seems to be a lot of friction in my family.
17. ___ There is a lot of love in my family.
18. ___ Member of my family get along well together.
19. ___ Life in my family is generally unpleasant.
20. ___ My family is a great joy to me.
21. ___ I feel proud of my family.
22. ___ Other families seem to get along better than ours.
23. ___ My family is a real source of comfort to me.
24. ___ I feel left out of my family.
25. ___ My family is an unhappy one.
INDEX OF PEER RELATIONS (IPR)

Today's Date: __________________

PEER GROUP ____________________________

This questionnaire is designed to measure the way you feel about the people you work, play, or associate with most of the time; your peer group. It is not a test, so there are no right or wrong answers. Place the name of your peer group at the top of the page in the space provided. Then answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ___ I get along very well with my peers.
2. ___ My peers act like they don't care about me.
3. ___ My peers treat me badly.
4. ___ My peers really seem to respect me.
5. ___ I don't feel like am "part of the group".
6. ___ My peers are a bunch of snobs.
7. ___ My peers understand me.
8. ___ My peers seem to like me very much.
9. ___ I really feel "left out" of my peer group.
10. ___ I hate my present peer group.
11. ___ My peers seem to like having me around.
12. ___ I really like my present peer group.
13. ___ I really feel like I am disliked by my peers.
14. ___ I wish I had a different peer group.
15. ___ My peers are very nice to me.
16. ___ My peers seem to look up to me.
17. ___ My peers think I am important to them.
18. ___ My peers are a real source of pleasure to me.
19. ___ My peers don't seem to even notice me.
20. ___ I wish I were not part of this peer group.
21. ___ My peers regard my ideas and opinions very highly.
22. ___ I feel like I am an important member of my peer group.
23. ___ I can't stand to be around my peer group.
24. ___ My peers seem to look down on me.
25. ___ My peers really do not interest me.

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1, 4, 7, 8, 11, 12, 15, 16, 17, 18, 21, 22
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