Original paper

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The Relationship of Trauma History, Substance Misuse, and Religious Coping to Trauma Symptoms among Homeless Men in Residential Treatment: A Preliminary Study

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Abstract - Homelessness is a global health and well-being crisis that impacts millions of people annually. Individuals without housing experience higher rates of alcohol and drug use problems than the general community. They also report more trauma exposure and are at increased risk for trauma-related symptoms. Faith-based organizations are among the institutions that provide treatment and recovery programs for homeless persons with substance use problems. The aim of this study was to explore the relationship of trauma history, substance use problems, and religious coping methods to trauma symptoms in a sample of homeless men in a faith-based residential treatment program. An ethnically diverse sample of 98 men participated; their mean age was 42.5 years. Measures included a brief trauma history screener, the Alcohol Use Disorders Identification Test (AUDIT), the Drug Abuse Screening Test (DAST-20), the Brief Religious Coping Scale (Brief RCOPE), and the Trauma Symptom Inventory (TSI). As predicted, trauma history, AUDIT scores, DAST-20 scores, and negative religious coping were positively associated with trauma symptoms. Racial identity also accounted for significant variance in TSI scores, especially regarding trauma-related anxious and depressive symptoms. Positive religious coping appeared essentially unrelated to trauma symptoms. These findings support the utility of the instruments used for assessment with homeless persons in residential treatment programs for substance abuse.

Key words: homelessness; alcohol; drugs; trauma; religious coping

Introduction

Homelessness represents an enduring, complex, and tragic public health problem that is associated with a broad-spectrum negative health and well-being outcomes [1]. As many as 4.2 % of adults in the United States, i.e., 13.7 million persons, experience homelessness in their lifetimes and similar findings have been reported in European nations [2,3]. Racial identity is a risk factor for homelessness in the United States, with African Americans at substantially increased risk [4]. It is also well established that homeless persons experience higher rates of alcohol and drug problems than the general community [5-7]. In addition, trauma is unequivocally linked to homelessness, with the experience of homelessness itself regarded as sufficient to produce symp-

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toms of psychological trauma [8,9]. Homeless persons report higher levels of exposure to stressful life experiences and potentially traumatic events than housed persons and remarkably high rates of posttraumatic stress disorder (PTSD) have been observed among the homeless [1,10,11]. More research is needed on the forms of trauma experienced by homeless persons and how those aspects of their histories relate to trauma symptoms. Such research should also incorporate consideration of substance use problems, since problematic use of alcohol and drugs is associated with both homelessness and trauma. Trauma-exposed homeless persons, especially those with substance misuse and mental health problems, are among the most vulnerable in our communities and need more attention in health-related research.

Faith-based organizations are among the institutions that provide treatment and recovery program services to homeless individuals with substance use disorders [12]. Homeless persons who utilize such services are likely to identify as religious and may rely upon religious and spiritual coping practices to deal with challenges and stressors in life, including drug and alcohol addiction [13]. Research indicates that religion and spirituality are resources that aid recovery from alcohol and drug dependence [12]. Consideration of religious coping style may therefore shed light on resources and risk factors experienced by homeless persons in recovery programs.

Religious coping methods are "ways of understanding and dealing with negative life events that are related to the sacred" [14]. Pargament's Brief Religious Coping Scale (Brief RCOPE) has emerged as a reliable and valid measure of religious coping that has been utilized internationally to examine both positive and negative faith-based coping [15]. Positive religious coping refers to a positive focus on problem solving that incorporates concepts such as a secure connection with God, a sense of spiritual attachment to others, and a benevolent reframing of life situations [16]. Negative religious coping is conceptualized as incorporating an insecure connection with the divine, a lack of spiritual attachment to others, and a vindictive, vengeful, or punitive view of God [16].

The aim of this preliminary empirical study was to examine the relationships of trauma history, alcohol use problems, drug use problems, and religious coping style to trauma symptoms among homeless persons in a residential recovery program. It was hypothesized that trauma history, alcohol and drug use problems, and negative religious coping would be positively associated with trauma symptoms, while positive religious coping was predicted to be negatively associated with trauma symptoms. The contribution of ethnicity to score variance on selected trauma symptom scales was also examined.

Subject and Methods

Participants

The study was conducted at a comprehensive, faith-based shelter for the homeless in a major city in the western United States. There were 98 men in the sample, all from the shelter's 12 - month, residential substance abuse recovery program for men. The average age was 42.54 years (SD = 10.72), with a range of 21 to 61. Participants reported a mean of 11.97 years of education (SD = 2.81). The sample included 49 African Americans (50 %), 23 Latinos (23 %), 22 Caucasians (22 %), three Asian Americans (3 %), and one Native American. Most participants were single (59 %), with 27 % divorced and 7 % separated from their spouses. Consistent with earlier studies conducted in the same setting, the majority of participants (93 %) identified their religious orientation as Christian [13]. Most participants (79 %) reported multiple episodes of homelessness in their lifetimes; 72 % had been in jail or prison, with a lifetime mean of 19 months incarcerated. Alcohol was the most frequently reported substance of abuse, followed

in order by crack/cocaine, marijuana, methamphetamines, amphetamines, heroin, hallucinogens, and Ecstasy. The sample reported a mean of 230 days in the residential program at the time of data collection. The recovery program featured a multimodal approach that included a 12 - step program, access to psychological and medical services, case management, pastoral counselling, religious instruction, job training, and educational opportunities. Most of the sample (52 %) reported prior attempts at substance abuse treatment.

The Institutional Review Board (IRB) at Pepperdine University reviewed and approved the study, which ensured it met the relevant ethical guidelines for human subjects research. After obtaining permission from the shelter administrators, the first author posted flyers at the homeless shelter to invite participation in the study. Data collection took place in groups of 20 or less in a private classroom setting. Participation was voluntary and informed consent was carefully obtained from each participant. All participants received a $5 gift coupon to a fast-food restaurant for their involvement in the study.

Instruments

The Trauma History Screen (THS) developed by Allen, Huntoon, and Evans was utilized to assess for history of exposure to potentially traumatic events [17]. The THS is a self-report measure designed as a face-valid screener covering traumatic experiences likely to be relevant to males and females of all ages. According to its authors, development of the THS was informed by: review of epidemiological studies of trauma exposure; review of existing trauma-exposure measures; and consideration of DSM-IV diagnostic criteria for PTSD.

The THS inquires about exposure to potentially traumatic experiences. Respondents indicate how many times they have experienced each event on the following scale (rating numerical values appear in parentheses): Never (0), Once (2), A Few (3), Many (4). The instructions state, "If you are confused about or do not clearly remember if you experienced the traumatic event, circle the question mark (?)," which is assigned a numerical value of 1. Respondents also are instructed that if they experienced the event "more than once over a period of more than one year," they are to write in their corresponding age range. Higher THS scores represent greater exposure to potentially traumatic events. In an initial validation study among 102 subjects in inpatient treatment for trauma-related disorders, the THS showed promising convergent validity and internal consistency reliability [17]. THS responses correlated with similar items from a longer trauma questionnaire and with PTSD symptoms. The THS items used in the present study appear in Table 1.

The Alcohol Use Disorders Identification Test (AUDIT) was utilized to measure the extent of alcohol misuse among subjects. The AUDIT was developed by the World Health Organization for international use as a screening device and research has supported its reliability and validity [18,19,20]. It contains 10 items that assess the frequency and quantity of alcohol consumption (items 1-3), as well as problematic aspects of alcohol use (items 4-10). Responses are recorded on a 5-point rating scale and total scores range from 0 to 40. A score of 8 has often been used as a cut-off for hazardous drinking [19]. In primary health care, the AUDIT is the most extensively studied screener for alcohol problems [21].

Severity of drug use was measured with the 20-item version of the Drug Abuse Screening Test (DAST-20) [22]. The DAST-20 is among the most widely used self-report measures of problematic drug use and has been translated into multiple languages. Responses are recorded as "Yes" or "No," with total scores ranging from 0 to 20; higher scores indicate more severe drug use problems. Scores of 6-10 suggest a moderate level of problem severity. Research has strongly supported the reliability and validity of DAST-20 scores [23,24].

Religious coping was measured with the Brief RCOPE, a 14-item self-report measure of positive (7 items) and negative (7 items) religious coping [25]. Pargament and co-authors define religious coping as incorporating the beliefs and practices by which individuals connect with their understanding of the sacred and search for meaning during times of stress [26]. Religious coping there-

Table 1. Trauma History Screen Results

Items	N	M	SD
1. Learning of the sudden death or serious injury of a spouse, child, parent, close relative, or friend	96	2.02	1.32
2. Witnessing someone being killed, maimed, or seriously injured	97	1.41	1.47
3. Being in an accident that was life-threatening or resulted in serious injury	97	1.18	1.27
4. Being in a natural disaster (fire, flood, earthquake, tornado) that was life-threatening or resulted in serious injury	97	0.82	1.23
5. Having a life-threatening illness	97	0.72	1.07
6. Being physically threatened, assaulted, or attacked	98	2.01	0.40
7. Being sexually molested (someone touched or felt your genitals when you did not want them to)	95	0.40	0.90
8. Being in a military combat or war zone	98	0.13	0.59
9. Being imprisoned or held captive	98	1.14	1.49
10. Being tormented, terrified, stalked, or humiliated by someone repeatedly and intentionally	97	0.75	1.28
11. Being physically tortured	97	0.33	0.89
12. Accidentally causing serious injury or death to another person	95	0.54	1.04

fore can serve multiple functions and should be understood in its cultural and social context. The Brief RCOPE utilizes a 4-point rating scale and yields two scores. Positive and negative religious coping scores each range from 0 to 21. The Brief RCOPE is the most widely used measure of religious coping and has been translated into multiple languages [15]. Research has consistently supported the reliability and validity of Brief RCOPE scores [15,27].

The Trauma Symptom Inventory (TSI) was utilized as the criterion measure for acute or chronic trauma symptoms. The TSI is a 100-item inventory that has been widely used in trauma-focused research and clinical practice [28]. It includes three validity scales (Response Level, Atypical Response, Inconsistent Response) and 10 scales measuring clinical symptoms often associated with trauma: Anxious Arousal, Depression, Anger/Irritability, Intrusive Experiences, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behaviour, Impaired Self-Reference, and Tension Reduction Behaviour. Respondents indicate how often they experience each symptom on a 4-point scale, ranging from "Never" to "Often." Raw scores are converted to T scores with a mean of 50. Reviews of the TSI have been favourable and the test manual includes summaries of validation studies, including information about TSI performance in diverse communities [29]. The TSI is available in multiple languages and research has supported the reliability, validity, and clinical utility of its scores [29-30].

Results

Descriptive statistics

Data were analysed with SPSS. On the THS, the sample mean was 11.40 (SD = 7.78), and 93 of the 98 participants (95 %) reported experiencing one or more potentially traumatic events in their lifetimes; just 5 persons denied any such history. The internal consistency reli-

ability was 0.78, indicating adequate to good reliability. Mean scores for the THS items are reported in Table 1. The highest means were obtained on item 1, "Learning of the sudden death or serious injury of a spouse, child, parent, close relative, or friend," (M = 2.02); item 6, "Being physically threatened, assaulted, or attacked," (M = 2.01); and item 2, "Witnessing someone being killed, maimed, or seriously injured," (M = 1.41). A rating of 2 signified a lifetime incidence of once. Item 8, "Being in military combat or a war zone," obtained the lowest mean (M = 0.13).

The sample produced AUDIT and DAST-20 mean scores of 12.31 (SD = 5.12) and 13.08 (SD = 9.79), respectively. Both scores indicted problematic substance use. The AUDIT mean fell in the "medium" range of alcohol problems (scores of 8 - 15), while the DAST-20 sample mean fell in the "substantial" range of drug problem severity (scores of 11 - 15). Overall, 69 subjects (70 %) reported alcohol use falling in the medium or high ranges on the AUDIT, while 71 (72 %) reported substantial or severe levels of drug use on the DAST-20. On the Brief RCOPE, the sample produced mean scores of 15.14 (SD = 5.10) for positive religious coping and 5.83 (SD = 4.8) for negative religious coping. These values were similar to findings obtained in an earlier study conducted at the same homeless shelter [13].

Table 2 presents summary TSI data for the 92 participants who produced valid profiles. Six profiles were deemed invalid due to elevated validity scales, consistent with the TSI user guidelines. Those 6 cases were eliminated from subsequent analyses. Means on the three validity scales were within acceptable limits and indicated valid profiles for the remaining 92 participants. None of the clinical scale means reached clinical significance (T = 65), though means greater than 60 were obtained

Table 2. The Trauma Symptom Inventory Means, Standard Deviations, and Correlations with the Trauma History Screen

TSI Scales	N	M	SD	r
1. Atypical Response	92	66.85	20.06	0.19
2. Response Level	92	46.83	11.26	-0.38***
3. Inconsistent Response	92	57.75	12.27	0.07
4. Anxious Arousal	92	54.77	11.28	0.46***
5. Depression	92	57.33	11.46	0.32**
6. Anger/Irritability	92	55.50	11.62	0.45***
7. Intrusive Experiences	92	61.11	12.60	0.42***
8. Defensive Avoidance	92	60.44	10.82	0.37**
9. Dissociation	92	60.70	13.54	0.36**
10. Sexual Concerns	92	57.37	12.71	0.28**
11. Dysfunctional Sexual Behavior	92	64.16	17.86	0.28**
12. Impaired Self-Reference	92	59.99	12.63	0.31**
13. Tension Reduction Behavior	92	63.57	17.85	0.36***

TSI = Trauma Symptom Inventory.
**p < 0.01. ***p < 0.001.

on: Intrusive Exposure, Defensive Avoidance, Dissociation, Dysfunctional Sexual Behaviour, and Tension Reduction Behaviour.

Correlations

Assumptions for normal distribution were met for all measures, so Pearson product-moment correlations were calculated. As predicted, trauma history as measured by the THS was positively associated with the TSI clinical scales. Significant, positive correlations were obtained between the THS and all 10 clinical scales of the TSI (Table 2). The highest correlations were noted with Anxious Arousal (0.46), Anger/Irritability (0.45), and Intrusive Experiences (0.43), all of which reflect core symptoms of PTSD. Among the TSI validity scales, the THS was significantly and negatively correlated with Response Level (-0.38). These significant associations, obtained with an ethnically diverse sample of homeless men in a residential substance abuse recovery program, support the validity of the THS.

Positive associations were expected between AUDIT scores and the TSI clinical scales. As indicated in Table 3, all 10 correlations were positive and 9 were statistically significant at the 0.05 level. The highest correlations, indicating moderate strength, were obtained between the AUDIT and the Intrusive Experiences (0.36) and Defensive Avoidance (0.30) scales. Similarly, positive correlations were predicted and obtained between DAST-20 scores and the TSI clinical scales. The highest coefficients, reflecting moderate strength, were obtained between the DAST-20 and the Intrusive Experiences (0.39), Anxious Arousal (0.38), and Defensive Avoidance (0.38) scales.

Table 3. The Trauma Symptom Inventory Correlations with AUDIT, DAST-20, Positive RC, and Negative RC

TSI Scales	AUDIT (n = 91)	DAST-20 (n = 92)	Positive RC (n = 92)	Negative RC (n = 92)
1. Atypical Response	0.19	0.20	0.05	0.42**
2. Response Level	-0.16	-0.34**	-0.08	-0.02
3. Inconsistent Response	0.00	0.12	-0.01	0.08
4. Anxious Arousal	0.27**	0.38***	0.02	0.21*
5. Depression	0.23*	0.33***	0.02	0.19
6. Anger/Irritability	0.23*	0.32**	-0.11	0.31**
7. Intrusive Experiences	0.36***	0.39***	0.01	0.21*
8. Defensive Avoidance	0.30**	0.38***	0.03	0.22*
9. Dissociation	0.23*	0.23*	0.00	0.34***
10. Sexual Concerns	0.24*	0.30**	0.01	0.43***
11. Dysfunctional Sexual Behavior	0.21*	0.30**	-0.04	0.27**
12. Impaired Self-Reference	0.23*	0.30**	-0.02	0.32**
13. Tension Reduction Behavior	0.20	0.28**	-0.07	0.38***

TSI = Trauma Symptoms Inventory. AUDIT = Alcohol Use Disorders Inventory. DAST-20 = Drug Abuse Screening Test. RC = Religious Coping.
*p < 0.05. **p < 0.01 ***p < 0.001.

Table 3 also displays the associations between the Brief RCOPE and TSI scores. In contrast to the predicted negative associations, positive religious coping appeared essentially unrelated to trauma symptoms as measured by the TSI. A very different pattern was observed with negative religious coping. As predicted, negative religious coping scores were positively correlated with all 10 TSI clinical scales and 9 of the correlations were statistically significant. The highest coefficients, indicating moderate strength, were obtained with the Sexual Concerns (0.43), Tension Reduction Behaviour (0.38), and Dissociation (0.34) scales.

Regression Analyses

Five TSI clinical scales that are particularly associated with PTSD diagnoses were selected as criterion variables for a series of regression analyses [28]. The scales in question were: Anxious Arousal, Depression, Intrusive Experiences, Defensive Avoidance, and Dissociation. First, a multivariate analysis of variance (MANOVA) was conducted to determine whether racial identity was associated with score differences on the selected TSI scales. The independent variables in the MANOVA were the three main ethnic groups in the sample: African American (n = 44), Latino (n = 20), and Caucasian (n = 22). Due to the small numbers of Asian American (3) and Native American (1) persons, those cases were removed from the regression analyses. The dependent variables for the MANOVA were scores on the five TSI scales listed above.

The results of the MANOVA indicated significant differences between ethnic groups on the TSI scales, Wilk's $\Lambda = 0.715$, $F(10,158) = 2.887$, $p < 0.01$. Follow-up ANOVAs revealed significant differences with two TSI scales. On Anxious Arousal, the mean obtained by Caucasian men (57.44) was significantly higher than that of African American men (50.24). Depression scale means were higher for Caucasian (59.61) and Latino (57.56) men than for African American (52.71) men. No other mean contrasts were significantly different at the 0.05 level. Due to this finding, ethnicity was controlled for in all subsequent regression analyses.

Five hierarchical linear multiple regression analyses were conducted next, with the THS, DAST-20, AUDIT, positive religious coping, and negative religious coping scores as predictor variables and one TSI scale as the dependent variable in each analysis. In the first analysis, after controlling for ethnicity, DAST-20 scores accounted for 17.5 % of the variance in Anxious Arousal scores on the TSI, $F(5) = 3.711$, $p = 0.005$. The greater the drug use problems, the more severe the anxious arousal symptoms reported by the sample. After ethnicity and the DAST-20, none of the other predictors accounted for significant variance in Anxious Arousal scores. Similar results were obtained with the regression analyses for the Depression, Intrusive Experience, and Defensive Avoidance scales. After controlling for ethnicity, DAST-20 scores accounted for 13.8 % of the variance in Depression scale scores, $F(5) = 2.896$, $p = 0.019$. The DAST-20 accounted for 19.9 % of the variance in Intrusive Experience scale scores, $F(5) = 3.988$, $p = 0.003$. It also accounted for 18.9 % of the variance in Defensive Avoidance scores, $F(5) = 3.748$, $p = 0.004$. As self-reported drug use problems increased, so did trauma-related depressive, intrusive experience, and defensive avoidance symptom scores.

In the final regression analysis, after controlling for ethnicity, negative religious coping as measured by the Brief RCOPE accounted for 13.5 % of the variance in Dissociation scale scores on the TSI, $F(5) = 2.617$, $p = 0.031$. The greater the endorsement of the negative religious coping style, the more severe the dissociative symptoms reported on the TSI for the sample.

Discussion

This appears to be the first empirical study to examine the relationships of trauma history, substance use problems (alcohol and drug), religious coping, and ethnicity to trauma symptoms in a sample of homeless men. Approximately 95 % of the sample reported lifetime exposure to at least one potentially traumatic event, as measured by the THS. This was generally consistent with published reports of elevated trauma exposure among homeless persons and represented a higher rate of trauma exposure than experienced in the general community [31,32]. Scores on the THS were positively and significantly correlated with all 10 clinical scales of the TSI, supporting the construct validity of the THS.

Not surprisingly given the study was conducted in a residential substance abuse recovery program for homeless men, scores on the AUDIT and DAST-20 indicated moderate to severe alcohol and drug use problems. As expected, alcohol and drug use problems were consistently and positively associated with trauma symptoms. The present findings speak to the critical importance that substance abuse intervention and recovery programs for the homeless should occur in the context of trauma-informed care. Though the present study did not collect data on causative factors for homelessness among subjects, it is likely that substance misuse and trauma symptoms should be regarded as both risk factors and potential consequences of homelessness.

Negative religious coping was associated with greater severity of trauma symptoms, as predicted. This was consistent with prior research. Empirical findings in the United States and internationally have indicated that negative religious coping as measured by the Brief RCOPE is associated with mental health problems and diminished well-being including anxiety, worry, depression, stress, somatization, PTSD symptoms, lower levels of posttraumatic growth, and poorer self-control [15,33-34]. It has been theorized that among persons who identify as religious, negative forms of religious coping are characterized by an unsteady view of the universe and instability in interpersonal relationships [15]. While positive religious coping was essentially unrelated to trauma symptoms, negative religious coping displayed noteworthy associations with dissociative symptoms, trauma-related sexual concerns, and maladaptive tension-reduction behaviours in the present sample. For clinicians working with homeless persons in recovery programs, the beliefs and attitudes associated with negative religious coping may represent a type of "red flag" for greater severity of mental health symptoms. The present study demonstrates the potential usefulness of the Brief RCOPE for assessing religious coping among homeless persons in substance-related treatment.

Racial/ethnic identity accounted for significant variance in trauma symptoms in the present sample. For example, Caucasian men scored higher than African American men on the Anxious Arousal and Depression scales of the TSI; Latino men likewise scored higher on Depression than African American men. The modest but statistically significant differences on these scales did not appear to be due to chance. Extra-test information, such as clinician ratings of symptom severity, might have further illuminated the validity and meaning of these differences. Regardless, the present findings appear generally consistent with some prior research showing higher levels of self-reported depression among homeless Caucasian men than African American men [35]. The present finding needs replication with larger samples of homeless persons to determine its reliability and significance.

Limitations of the present study include that the sample was comprised solely of men. Future research on the issues explored in the present study should incorporate greater diver-

sity in gender identity. Because the study was conducted in a faith-based homeless shelter and most subjects identified as Christian, the findings may not generalize to non-religious individuals or to persons of other faith traditions. The subjects in the present study reported an average of 230 days in the residential program. This suggested they may have been progressing well on their treatment and recovery goals, compared to individuals who may have relapsed and dropped out earlier. The findings may not generalize to homeless individuals who do not respond well to residential programs or who do not seek treatment for substance-related concerns. A larger sample would have increased statistical power. Finally, the inclusion of data sources other than self-report could have enriched the findings and the explanatory power of the study.

To build upon the results of this preliminary study, future research should incorporate larger and more representative samples of homeless persons with substance use problems, both in the U.S. and internationally. Women, transgender, and nonbinary individuals should be included, as well as adolescents and persons of advanced age. In addition to religious coping methods, the role and efficacy of other coping strategies utilized by homeless persons should be investigated. The global reach of the homelessness crisis is such that sustained, multifaceted research efforts are needed to inform prevention, intervention, and policy development.

Trauma history, alcohol and drug use problems, and negative religious coping were all significantly associated with severity of trauma symptoms in a sample of homeless men engaged in a residential recovery program. Racial identity also emerged as related to trauma symptom severity among the homeless in the present sample, especially in regard to anxious and depressive symptoms. The construct validity of the THS was strongly supported, as was the utility of the AUDIT, DAST-20, Brief RCOPE and TSI for assessment with homeless men.

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Conflict of interest

None to declare.

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