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Pages 89 & 90
Spiritual Perspective Scale

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SPIRITUALITY, SELF-TRANSCENDENCE, FATIGUE, AND HEALTH STATUS
AS CORRELATES OF WELL-BEING IN SHELTERED HOMELESS PERSONS

by

Jennifer Jo Runquist

A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

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STATEMENT BY AUTHOR

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SIGNED:

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Pamela G. Reed, Ph.D.
Professor of Nursing

Date
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TABLE OF CONTENTS

LIST OF FIGURES ........................................... 6
LIST OF TABLES ........................................... 7
ABSTRACT ..................................................... 8

CHAPTER I STATEMENT OF THE PROBLEM .................. 9
  Purpose of Study .......................................... 10
  Background and Significance ............................. 10
  Conceptual Framework .................................. 14
    Well-Being ............................................ 15
    Self-Transcendence ................................... 16
    Spiritual Perspective .................................. 17
    Health Status .......................................... 18
    Fatigue .................................................. 19
    Long-term Versus Short-term Housing ................. 20
  Summary of Conceptual Model ............................ 21
  Research Questions ....................................... 26
  Summary .................................................... 27

CHAPTER II LITERATURE REVIEW ......................... 28
  Well-Being ............................................... 28
  Spirituality .............................................. 30
  Self-Transcendence ..................................... 35
  Health Status ............................................ 37
  Fatigue .................................................... 40
  Summary .................................................... 44

CHAPTER III METHODOLOGY ............................... 45
  Design ....................................................... 45
  Sample and Setting ...................................... 45
    Daily Routines ......................................... 46
  Protection of Human Subjects .......................... 47
  Procedure .................................................. 47
  Instruments ............................................... 48
    Spiritual Perspective Scale (SPS) .................... 48
    Self-Transcendence Scale (STS) ....................... 49
    Index of Well-Being (IWB) ............................ 49
    Health Status .......................................... 50
    Fatigue ................................................... 50
  Data Analysis ............................................. 51
  Summary .................................................... 52
# TABLE OF CONTENTS—Continued

## CHAPTER IV RESULTS

- Sample Characteristics ........................................ 53
- Instrument Reliability ......................................... 56
- Research Question One ......................................... 57
- Research Question Two .......................................... 58
- Research Question Three ........................................ 59
- Research Question Four .......................................... 61
- Summary .................................................................. 62

## CHAPTER V DISCUSSION

- Levels of Study Variables Compared to Published Findings .... 63
  - Spiritual Perspective ........................................... 63
  - Self-Transcendence ............................................. 64
  - Well-Being ......................................................... 65
  - Fatigue .................................................................. 65
  - Health Status ...................................................... 66
- Relationships Among Study Variables .......................... 68
- Self-Transcendence and Health Status as Predictors of Well-Being .... 71
- Differences Between Long-Term and Short-Term Housed Participants ... 72
- Limitations ............................................................. 73
- Proposed Changes to the Conceptual Model .................. 74
- Clinical Implications ............................................... 77
- Research Recommendations .................................... 77
  - Future Theoretical Directions .............................. 78
- Conclusions .......................................................... 79
- Summary .................................................................. 81

## APPENDIX A

PROTECTION OF HUMAN SUBJECTS

DISCLAIMER STATEMENT ........................................ 82

## APPENDIX B

HUMAN SUBJECTS COMMITTEE

APPROVAL LETTER .................................................. 84

## APPENDIX C

STUDY INSTRUMENTS ................................................ 86

REFERENCES .......................................................... 92
LIST OF FIGURES

Figure 1  Conceptual Model: Concept Level  ........................................ 24
Figure 2  Conceptual Model: Variable Level  ........................................ 25
Figure 3  Stepwise Regression  .............................................................. 60
Figure 4  Conceptual Model Modified Based on Results  ....................... 76
LIST OF TABLES

Table 1  Sample Characteristics: Sex and Ethnicity  . . . . . . . . . . . . . . 54

Table 2  Sample Characteristics: Educational Level  . . . . . . . . . . . . . . 56

Table 3  Central Tendency Measures of Spiritual Perspective, Self-Transcendence, Well-Being, Fatigue, and Health Status  . . . . . . . . 57

Table 4  Correlations (Bottom Half), Significance Levels, and Shared Variance (Top Half) Between Study Variables  . . . . . . . . . . . . . . 59

Table 5  Significant Differences Between Long-term and Short-term Groups  61

Table 6  Comparison Between Literature and Study on Percentage in Each Category of Health Status  . . . . . . . . . . . . . . . . . . . . 67
ABSTRACT

The relationships surrounding well-being, spiritual perspective, self-transcendence, health status, and fatigue in homeless persons have not been studied from a nursing perspective. This original descriptive study explored relationships among well-being, spiritual perspective, self-transcendence, health status, and fatigue in a sample of 61 homeless men and women in two shelters. A conceptual model based upon Rogers' Science of Unitary Human Beings and Reed's Theory of Self-Transcendence was constructed and tested. Multiple significant correlations were calculated between the study variables indicating that health status and spiritually-related variables correlate positively with well-being. Additionally, self-transcendence and health status were significant predictors of well-being in this sample. Significant differences were also found between the long-term and short-term housed participants on spiritual perspective, self-transcendence and well-being. Clinical implications and research recommendations are provided.
CHAPTER I

STATEMENT OF THE PROBLEM

In nursing, spirituality has become increasingly recognized as an important and relevant correlate of well-being. As evidence of its significance accumulates, nursing is seeking out methods to incorporate spirituality into nursing care. Enhancing spirituality facilitates patients' ability to endure and derive meaning from difficult life circumstances. Spirituality can be defined as an inner resource by which the person has the propensity to make meaning through a sense of relatedness to dimensions that transcend the self in such a way that empowers and does not devalue the individual (Reed, 1992).

Self-transcendence is one manifestation of spirituality. Self-transcendence is described as a characteristic of developmental maturity, regardless of chronological age, whereby a person experiences an expansion of self-boundaries and an orientation toward broadened life perspectives and purposes (Reed, 1991b). Throughout life, this inner resource can be drawn upon to facilitate inner growth, meaning, purpose, and goals in times of adversity and hardship. Thus, variables such as enhanced spiritual perspective and self-transcendence may relate to well-being.

Homelessness is a situation of adversity, hardship, and often suffering. One's sense of security, connectedness, and belonging are immediately and irrecoverably altered when one becomes homeless. Spirituality and self-transcendence may be relied upon for strength when the material society fails homeless persons. Unfortunately, because these resources are not often studied in homeless populations, nursing does not
understand what, if any, role spirituality and self-transcendence play in homeless person's lives. Additionally, if these resources are important to homeless persons, do they affect well-being in spite of the host of physical problems the homeless often face?

For the purposes of this study, a homeless person was defined according to the Stuart B. McKinney Homeless Assistance Act (1998) as: 1) an individual who lacks a fixed, regular, and adequate nighttime residence; or 2) an individual whose primary nighttime residence is that of a supervised, publicly or privately operated shelter designed to provide temporary living accommodations.

Purpose of Study

The purpose of this descriptive study was to explore relationships among well-being, spiritual perspective, self-transcendence, health status, and fatigue in a sample of homeless persons. Well-being was defined as a subjective experience of satisfaction with one's life experiences (Campbell, Converse, & Rodgers, 1976). More precisely, well-being was correlated with indicators of spirituality (spiritual perspective and self-transcendence) as well as with physical health indicators (fatigue and health status). By exploring relationships among well-being, spiritual resources, and physical health, this study contributes to a more holistic understanding of homeless persons' needs.

Background and Significance

Homelessness is an ever-increasing societal condition in the United States. The transient nature of being homeless coupled with varying definitions of homelessness increases the difficulty in accurately estimating the number of homeless. The National
Coalition for the Homeless (NCH) estimates that on any given night, over 700,000 men, women, and children are homeless, and up to 2 million persons endure homelessness each year (NCH, 2001). Even in prosperous economic times, this number continues to increase as affordable housing decreases (Choi & Snyder, 1999). Unfortunately, because homelessness is as much a political issue as a social issue, the policy necessary to remedy homelessness is complex and slow to evolve.

The detrimental effects of homelessness on individuals, families, and children, however, are clear. Homeless persons suffer from similar types of chronic health problems as domiciled persons, but in greater prevalence and severity (Gelberg, Linn, Usatine, & Smith, 1990; Segal, Gomory, & Silverman, 1998; White, Tulsky, Dawson, Zolopa, & Moss, 1997). Access to health care is often limited by lack of transportation, and when homeless people have adequate access to health services, underutilization proportional to health needs often occurs (Segal et al., 1998; Wojtusik & White, 1998). Families suffer from uprootedness, lack of security, and lack of privacy to conduct family discussions. Families also suffer from decreased parental functioning, separation, role confusion, and fatigue. When doubling up with others, families are forced to live in confining spaces often in poor and dangerous neighborhoods (Choi & Snyder, 1999, p. 21). In turn, the effects of such family conditions multiply the problems children face when homeless or marginally housed. Children endure malnutrition, fatigue, greater prevalence of acute and chronic illnesses, and cognitive and emotional difficulties (Choi & Snyder, 1999, pp. 21-24).
Nurses provide health care to the homeless in the United States each day. In health care literature, the incidence and proposed management of physical and mental health needs of the homeless are most often researched. While nursing recognizes that spirituality is an integral part of health and well-being, there is little research published concerning the spiritual needs of homeless persons or spiritual care delivered by nurses to this population. Indeed, in a time of crisis such as homelessness, one’s ability to maintain resiliency may, in part, be based on a spiritual orientation that enables a person to cope and draw meaning from the experience. Preserving and enhancing life’s meaningfulness through the maximization of the human health potential is a goal of nursing. This goal, in part, can be achieved by the respect and enhancement of patients’ spiritual strengths and resources.

The physical and mental consequences of homelessness have been well documented. In order to learn how homeless persons cope with their situations, researchers have begun investigating the use of spiritual practices from the perspective of homeless persons. Tryssenaar, Jones, and Lee (1999) wrote that homelessness nurtures an awareness of meaningfulness and spiritual issues. These beliefs are closely guarded and therefore, not often seen by others, because of the vulnerability experienced by homeless persons.

In the literature, descriptions of spirituality in homeless persons have most commonly taken the form of inquiring about the use and effectiveness of spiritual and religious practices. Shuler, Gelberg, and Brown (1994) asked 50 homeless women about
their spiritual/religious practices. Ninety-two percent described engaging in at least one spiritual/religious practice, while 82 percent reported two or more practices. Murray (1996) found that homeless men who attributed being homeless to situational crisis, severe and persistent mental illness, or alcohol and/or drug dependency used spiritual coping strategies to some extent. As defined by the Murray study, spiritual beliefs and practices included prayer, putting trust in God, hoping things would get better, reading the Bible, and obtaining strength from religious beliefs. Nyamathi, Bayley, Anderson, Keenan, and Leake (1999) found that homeless women who did not use alcohol or drugs were more likely to cope with their problems by praying than those women who did use addictive substances. Finally, Herth (1996) described the importance of hope in homeless families as an important coping strategy. Hope enabled families to transcend their current circumstances and conceive of a better future.

At this juncture, it is important to note that many studies of homeless persons consider religious practices synonymous to spirituality. However, in this study, religious practices are viewed as only one possible manifestation of spirituality. For instance, a person can be religious yet not spiritual. Alternatively, a person can be spiritual without necessarily holding religious beliefs.

Martha Rogers (1970) wrote that the role of the nurse was to help patients develop patterns of living that accommodate environmental change rather than conflict with it. This calling can prove to be a great challenge when giving nursing care to homeless persons, since much of treatment in today’s medical model is predicated on having the
necessary resources to acquire and carry out the treatment. Rogers called on nurses to be creative and explore non-traditional methods of nursing when she stated: “Nor can the continuation of the traditional focus on categorical diseases contribute meaningfully to man’s well-being” (p. 130). The study of well-being, spirituality and self-transcendence in homeless persons, while non-traditional, deserves investigation in order to learn how nursing can facilitate well-being in people experiencing this crisis.

Conceptual Framework

The overarching theoretical foundation for this study was based on Rogers’ Science of Unitary Human Beings (1980) and Reed’s Theory of Self-Transcendence (1991b). Rogers described the human being as a unified whole whose identity cannot be perceived as parts, but only as that which is greater than and different from the sum of the parts (Rogers, 1970). This unified whole exhibits itself as an open and complex energy field that is in continuous exchange with the surrounding environmental field. The continuous exchange of matter and energy between the human and environmental fields is an evolving process which follows a unidirectional path towards increasing complexity. Rogers postulates that sentience and thought arise from this interaction, enabling humans to develop and evolve. Rogers also believes that humans are goal-directed and are continuously “becoming” whereby humans increase self-awareness, understanding, well-being, and search for life’s meaning.

Martha Rogers acknowledges the complexity of studying human behaviors and interactions. Her creation of a complex framework to explain the intricacies of human
existence is admirable in light of the desire by many theorists to break human experience into small manageable parts. Unfortunately, in the process of studying relationships between parts, researchers can lose sight of the whole. Additionally, Rogers states that models of causation are often inadequate to explain nursing phenomenon as they relate to the human life experience. A complete understanding of self-transcendence, spirituality, health, and well-being continues to elude researchers. Rogers provides a framework that encourages nursing to look beyond traditional paradigms in order to better understand the human health experience.

Well-Being

Well-being has been described as an overall satisfaction with life (Campbell et al., 1976, p. 50). Rogers (1970) postulated that the human-environment process influences well-being. Since humans are in a continuous state of becoming, they progress towards greater well-being throughout life. In this study, it was proposed that self-transcendence, spiritual perspective, and fatigue would relate significantly to well-being in a sample of homeless persons. Health status in relation to well-being was also measured, but the direction of the association was not predicted due to the complexity of the variable as discussed below.

Self-Transcendence

Reed (1991b, 1997) created a middle-range theory of self-transcendence based on Rogerian principles. Self-transcendence is a process of developmental maturing whereby personal conceptual boundaries expand beyond physical experience. Consequently, the
person discovers greater meaning and purpose to life. The manifestations of this process can most readily be measured in persons nearing the end of life. However, persons of any age who gain awareness of their mortality may enhance the process of self-transcendence. The life experiences of aging, illness, and loss can facilitate the development of self-transcendence (Reed, 1996). In self-transcendence, personal conceptual boundaries fluctuate multidimensionally (inwardly, outwardly, and temporally). This may occur over decades or within a short period of time (minutes, hours, days, weeks), a concept termed "microgenesis". Personal conceptual boundaries refer to the people, ideas, values, and events that are encompassed within a person's life (P. G. Reed, personal communication, August 8, 2001).

In this study, homelessness was conceptualized as a loss experience and a microgenic life event during which time self-transcendence may become important to well-being. Homelessness requires a person to redefine their conceptual boundaries in order to cope with a changed relationship with the environment. The redefinition of conceptual boundaries enables homeless persons to strive towards the discovery of meaning in their current life circumstances. Self-transcendence may become a salient resource for well-being at this time.

Spiritual Perspective

Spiritual perspective has been described by Reed (1992) as a human pattern by which self-transcendence becomes evident. Spirituality includes one's belief in a higher power or purpose, while also incorporating one's connection with self, others, the
environment, and universe. Similarly, in this study, spiritual perspective referred to the awareness of one's inner self and sense of connection to a higher being, nature, others, or to a greater purpose (Reed, 1992). Spiritual development in humans may proceed towards broader perspectives and boundaries, increasing complexity, and enhance life's meaning.

Rogers (1970) postulated that the broadening of self-boundaries enhances well-being. Reed supported this idea when she found that spiritual perspective and self-transcendence correlated positively with well-being in a variety of populations (Reed, 1986a, 1986b, 1987, 1989). Other researchers, whose work will be discussed later, have supported Reed's findings (Chin-A-Loy & Fernsler, 1998; Coward, 1990, 1991, 1995; Coward & Lewis, 1993).

Health Status

Health status is a measure of health that is often used in homeless populations. This study defined health status as a measure of one's current health, ranging from poor to excellent, as defined by the individual. Even though Ratner, Johnson, and Jeffery (1998) found that people who rate their health status often consider only their physical health, this analysis has not been conducted within homeless populations. In any case, health status continues to be a well-accepted measure of health in the health care community.

The results of studies assessing the physical health of homeless persons suggest that homeless persons suffer from the same kinds of health problems as domiciled
persons. However, they have a higher prevalence of health problems than domiciled persons (Gelberg, Linn, Usatine, & Smith, 1990; Segal et al., 1998; White et al., 1997; Wojtusik & White, 1998). Studies investigating health status among the homeless have found that while homeless persons rate their health as poor or fair (as opposed to good or excellent) more often than the general population, their health status does not always correlate with the length of time being homeless or the number of health conditions (Gelberg et al., 1990; White et al., 1997; Wojtusik & White, 1998). These findings suggest that while well-being may be influenced by physical, social, spiritual, and/or psychological realms, more specifically, well-being is an individual preference based on what dimension of health is most important to the individual.

Studies have revealed that health status has a complex and possibly indirect relationship with well-being. This is partly due to the indirect manner in which health status is studied, and to the lack of research investigating the relationship between health status and well-being. Coward (1996) revealed a moderate negative correlation ($r = -0.42$, $p < 0.01$) among health status and the Cognitive Weil-Being Scale in a group of healthy adults. However, the author discusses how this association was not significant in a previously studied terminally ill population. Health status has also been studied with spiritually-related measures like the Self-Transcendence Scale (STS) and the Herth Hope Index (Coward, 1998; Herth, 1993a,b, 1996). Results from these studies have varied from negative correlations to no significant correlations. Additionally, health status was a significant factor in one study when investigated in relation to hope and fatigue (Herth,
In this study, participants reporting poor health status and high fatigue also reported lower hope, while those participants with lower fatigue and better health status reported higher levels of hope.

Fatigue

Fatigue is a concept not often studied in the homeless. Yet, life on the street, in homeless shelters and in the confining quarters of those marginally housed significantly contributes to lack of sleep. The lack of sleep is often attributed to noise, lack of temperature control and lack of comfort in sleeping arrangements. Surprisingly, however, the effects of fatigue (physical and mental) on the health and quality of life of the homeless are not well researched. Segal et al. (1998) commented on this fact and inquired about homeless persons "tiring very quickly" in an assessment of health problems and health status. Thirty percent of the 310 participants acknowledged having a problem with fatigue. Herth (1996) conducted a study on hope (a spiritually-related variable) and homeless families. The study participants expressed a high level of fatigue. Additionally, while there were no significant differences between level of hope and age, gender, race, educational level, and perceived health status, there was a significant inverse relationship between hope and level of fatigue. In this study, fatigue was defined in terms of the extent to which the person identified feelings of physical and mental tiredness.
Long-term Versus Short-term Housing

Whether or not a participant was housed in a long-term or short-term shelter was of relevance to this study. It was theorized that participants in long-term housing may exhibit significantly different levels of spirituality, self-transcendence, fatigue, health status, and therefore, well-being. A participant who is housed on a long-term basis theoretically has more energy to devote towards discovering and incorporating the meaning of homelessness into their lives. This, in turn, may allow the person to gain greater spiritual depth, and well-being (Hall, 1986). Additionally, a lower level of fatigue and higher health status may be enjoyed by persons who are housed in long-term shelters, since the basic needs of shelter, food, and health care are met. Since people inherently strive to improve their well-being, this study theorized that lower fatigue enable a person to direct creative energies towards those experiences that enhance well-being.

Definitions for long-term and short-term housing were based on the programs at the shelters from which the data was collected. A long-term housed participant was a person housed in the long-term shelter program for up to 18 months. A short-term housed participant was one who was housed in the short-term program, residing at the emergency shelter for between 4 and 30 days.

Hall’s (1986) study is important to this author’s examination of differences between short-term versus long-term housed homeless persons. Hall noted that persons who had time to reflect on the experience of crisis expressed a greater depth of spiritual orientation. Those people who expressed a greater depth of spirituality and use of
spiritual values in daily life experienced greater life satisfaction (well-being). It was assumed then, that homeless persons who have secure housing for a long period of time will have greater ability to reflect on their past experience of crisis. If so inclined, the luxury of time would give these people the opportunity to incorporate the meaning of the experience of crisis into their lives, deepen their spiritual beliefs, and enhance their well-being. Conversely, homeless persons who are given housing for only a few nights may still be immersed in the experience of crisis and less able to reflect on their experience. Short-term housed persons may utilize their inner strength and resources to cope with their immediate situation; however, the spiritual depth and well-being that comes with reflection over time may be demonstrably less than in persons whose housing is secure. Therefore, I expected to find that persons who were housed on a long-term basis would exhibit greater spiritual perspective, self-transcendence and well-being.

**Summary of Conceptual Model**

In summary, this study proposed the investigation of relationships between well-being, spiritual perspective, self-transcendence, health status, and fatigue, in a sample of marginally housed persons. Figures 1 and 2, which are found on pages 24 and 25, are illustrations of this study's conceptual framework. Two levels of abstraction, the concept level and the variable level are depicted separately in each figure. The concept level is represented with proposed positive associations between the concepts “physical health,” “spiritual health,” and “well-being”. At the variable level, solid bold lines with plus or minus signs (indicating positive or negative relationships) denote how self-transcendence,
spirituality, and fatigue may relate to well-being. The line between health status and well-being is marked with a plus and minus denoting both the positive and negative relationships found in the literature between these variables. Finally, since correlations between variables will also be analyzed, curved lines are drawn between each variable depicting all possible associations.

A positive relationship among well-being, spiritual perspective, and self-transcendence was expected. Since becoming homeless is a life event that shatters previously held views of security and connection with the world, homeless persons may redefine their conceptual boundaries through microgenic changes. These changes may then enable them to develop and use spiritual perspective and self-transcendence to assist them in striving for well-being despite their difficult circumstances.

Further, it was also expected that higher levels of self-transcendence and spiritual perspective would be associated with higher levels of health status and lower levels of fatigue. Fatigue may preclude homeless persons from utilizing spirituality and self-transcendence, especially if they need to limit their conceptual boundaries in order to meet the basic needs of food and shelter in spite of their fatigue. Alternatively, lower use of spiritual perspective and self-transcendence could contribute to greater fatigue. The causal direction among these variables could not be determined within the methods of this study. Thus, correlational rather than causal relationships were proposed, with an inverse relationship expected between fatigue and spiritual perspective/self-transcendence. A direction of association between health status and well-being was not
predicted due to the complex relationship between the variables as reported by other studies (Coward, 1996, 1998; Herth, 1993a,b, 1996). Finally, it was expected that persons housed in the short-term program would report significantly greater levels of fatigue as compared to persons in the long-term program, which in turn, may lead them to experience lower levels of well-being.

Little research is available that examines these relationships. Therefore, this research breaks new ground in examining spiritual perspective, self-transcendence, as well as health status and fatigue as potential correlates of well-being in homeless persons.
Figure 1. Conceptual model: Concept Level.

Physical Health  +  Spiritual Health  +  Well-Being
Figure 2. Conceptual model: Variable level.
Research Questions

The following research questions were proposed based on the conceptual framework.

In homeless adults:

1. What are the levels of well-being, spiritual perspective, self-transcendence, perceived health status, and fatigue?

2. What are the relationships among well-being, spiritual perspective, self-transcendence, health status, and fatigue?

3. Which variables best relate to well-being?

4. Are there differences between homeless persons who are sheltered on a short-term basis versus those who are sheltered on a long-term basis in well-being, spiritual perspective, self-transcendence, health status, and fatigue?
Summary

The consequences of being homeless include a multitude of health concerns. Knowledge of the correlates of well-being in homeless persons is of particular interest to nurses as health care providers of this population. This study proposed to enhance nursing's knowledge of well-being in homeless persons through a quantitative examination of spiritual perspective, self-transcendence, fatigue and health status. The results of this study will be discussed theoretically from the perspective that people's conceptual boundaries dynamically fluctuate inwardly, outwardly, and temporally on a microgenic level in response to one's changing environment.
CHAPTER II
LITERATURE REVIEW

This chapter reviews the literature that investigates relationships between the study variables (well-being, spiritual perspective, self-transcendence, health status, and fatigue). Special attention is paid to studies that examine these variables in homeless populations. The study variables have been examined more often in domiciled populations, however, connections between domiciled and homeless populations will be theorized based on similarities between the groups' experience of mortality awareness through events such as stress, crisis, and aging.

Well-Being

A paucity of published studies specifically explore well-being in homeless persons. Shuler, Gelberg, and Brown (1994) believed in the idea that people who rely on the inner strength afforded by spiritual beliefs coped more effectively with their situations, and therefore exhibited high levels of psychological well-being in times of crisis. The study included 50 homeless women ages 18 to 44 years in an anonymous chart review at a family planning clinic in downtown Los Angeles that provided reproductive care to homeless women. When women made contact with the clinic they filled out a history/research questionnaire. Items from this questionnaire that were used in the study included demographic characteristics, spiritual/religious practices, psychological status, and substance use.

Protestant was the most common religious preference (50%) followed by Catholic
The mean number of religious practices reported was 2.3, with 92 percent reporting use of at least one spiritual practice. Eighty-eight percent of the women prayed, 70 percent attended a church or mission worship service on a regular basis, and 68 percent reported they read the Bible. Also worthy of note, 90 percent agreed that their spiritual/religious practices and beliefs were helpful to them. Relative to psychological well-being, women who reported prayer was not an effective coping strategy were twice as likely to report more than five depressive symptoms. Additionally, number of worries (e.g. personal safety, health, loneliness, drug addictions) was significantly linked with effectiveness of prayer. Of women who reported prayer was not helpful, 50 percent had seven or more worries in their lives as compared to only 21 percent of women who reported prayer as helpful. In this sample of homeless women, prayer was used frequently and contributed to improved well-being by serving as a coping mechanism.

Another study attempted to clarify the concept and measurement of well-being using structural equation modeling in both cross-sectional and longitudinal data from mentally ill and non-mentally ill homeless persons (Marshall, Burnam, Koegel, Sullivan, & Benjamin, 1996). This study found that life satisfaction was significantly correlated with objective life circumstances as measured by housing status and income. Of note, the study did not find evidence that supported the previously held notion that subjective well-being (i.e. psychological distress and perceived self-mastery) promoted objective well-being (improved housing status and income). Thus, in mentally ill homeless persons, measures of objective well-being such as housing and income played a greater role in
subsequent life satisfaction than did the belief that one could achieve a better life through personal struggle.

The paradox that people with disabilities often have high quality of life despite their physical impairments was qualitatively examined by Albrecht and Devlieger (1999). One hundred fifty-three disabled adults of varying ethnic backgrounds were interviewed using a semi-structured format. Over half of the participants with serious disabilities reported good or excellent quality of life. A balance between mind, body, and spirit was a significant influence on participants' quality of life. Spirituality gained or rediscovered after the disabling event occurred also contributed to a sense of well-being and improved quality of life. People reported that their spirituality gave them strength, direction, and meaning in life. These findings are applicable when considering the experience of homelessness. Even though people's lives as they appear from the outside may seem insufferable, from the inside, they may have great resilience, strength, and purpose.

Spirituality

Brush and McGee (2000) described the spiritual perspective of 100 homeless men in a shelter for recovering substance abusers. This study found an overall high level of spiritual perspective and spoke to the usefulness of the spiritual perspective scale (SPS) for assessing spirituality in homeless persons. In addition to providing valuable empirical information, the SPS provides a starting point for discussion between the client and the nurse clinician that may ultimately enhance the meaningfulness the client finds in his or her life.
Murray (1996) inquired about the use and effectiveness of physical, cognitive, psychological, sociocultural, and spiritual practices as ways in which to cope with stress in a stratified group of homeless men. One hundred fifty men in a Day Treatment Program for homeless mentally ill and chemically dependent persons were equally divided into three groups at intake by program staff. The men were categorized as in situational crisis (SC), severely and persistently mentally ill (SPMI), or alcohol/drug dependent (AD). All three groups stated they used spiritual beliefs or practices (e.g. prayer, putting trust in God, hoping things would get better, strength from beliefs), but the SC and A/D groups reported greater frequency of use and effectiveness. Also of note was the finding that with increased duration of homelessness all coping strategies were reported with less frequency and effectiveness.

Reed (1986b) theorized that religious symbols assist people to manage crisis and reported on the relationship between religious perspective and well-being in groups of terminally ill patients and healthy adults. The Religious Perspective Scale (RPS) and the Index of Well-Being (IWB) measured the extent of religious beliefs and behaviors and satisfaction with current life respectively. Fifty-seven adults in each of the two groups were matched on age, gender, education and religious affiliation. Well-being in both groups was moderately high with no difference in well-being noted between the groups. Religious perspective was significantly higher in the terminally ill group, but especially high amongst the terminally ill women. A significant positive relationship was found between religious perspective and well-being in the healthy group, but not in the
terminally ill group. Reasoning for the lack of a significant relationship between religious perspective and well-being in the terminally ill group was based in the fact that well-being in terminal adults is a complex variable that is not explainable by the solitary measurement of religious perspective.

Reed (1987) published a similar study shortly thereafter that divided 300 participants into equally numbered groups based on participants with terminal illness in the hospital, terminal illness in the community, and healthy adults. Reed had revised the RPS into the Spiritual Perspective Scale (SPS) in order to encompass the broader concept of spirituality that includes a sense or expression of relatedness or connectedness to a transcendent dimension, or to something greater than the self. Reed theorized that developmental maturity brought on by a sense of mortality may facilitate self-transcendent perspectives during the experience of terminal illness or crisis. In addition, self-transcendence may serve as a resource for well-being during critical life events. Again, the IWB was used as a measure of well-being. Health status was used as a measure of physical health status to verify that terminally ill participants were aware of the decline of their physical bodies. Overall, moderate degrees of well-being were found in the study participants. Additionally, significant positive moderate correlations were found between well-being and health status in all three groups. As was hypothesized, spiritual perspective was found to be significantly higher in the terminally ill hospitalized group than the other two groups. Additionally, a small positive relationship was found between spiritual perspective and well-being in the hospitalized group, but not in the
other groups.

In the same study, Reed (1987) inquired about changes in spiritual views over time and found that while participants from all three groups had expressed a change in their spiritual views over time, the groups experiencing terminal illness stated the change was movement towards greater spirituality whereas the change occurring in the healthy group was more often based in questioning and doubting their views. These findings are in agreement with the idea that crisis can enhance spiritual perspectives if meaning is derived from the experience.

Connections can be drawn between Reed’s (1987) description of spirituality among people in a health crisis and the experience of crisis in homeless persons. Those participants with terminal illnesses more often expressed greater spirituality than healthy participants. This can be compared to the experience of crisis in homeless persons and that one would expect them, if so inclined, to express greater spirituality rather than simply changing views based upon questioning and doubting. In the midst of crisis, questioning and doubting of spiritual beliefs seems counterintuitive, since many people find spiritual beliefs to be a source of comfort. Doubting spiritual beliefs may increase the magnitude of crisis, since people often express need for inner strength to cope with crisis.

Based on clinical experience and research, Hall (1986) proposed that crisis is an opportunity for spiritual growth for both individuals and families. Hall’s theoretical orientation is an evolutionary theory by Teilhard de Chardin that has propositions similar
to Martha Roger's framework. Hall explains how the theory proposes that evolution is unidirectional and purposeful and that levels of consciousness are enhanced by way of a process of gradual change in the universe. Hall collected data for over 14 years on 400 participants in a family therapy setting. Examination of spiritual growth was conducted by interviews of both families experiencing crisis (longitudinal data) and families not in crisis (cross-sectional data). The author noted, however, that nearly all families at some point in time had experienced crisis, such that differentiation into crisis vs. non-crisis categories was ineffectual.

Hall (1986) described patterns in spiritual growth and behavior. Ten percent of participants had a strong spiritual orientation, and 80 percent of those individuals reported developing this orientation after experiencing a family crisis. Participants who had contemplated, examined, and formulated their own spiritual values (10% of sample) were most able to articulate their spiritual orientation and were noted to live the most satisfying lives. Participants who turned to religion rather than spirituality in crisis were likely to think of religion as a compartmentalized area of their life. These participants did not include the religious values and lifestyle choices in their daily lives as often as those who had seriously examined their beliefs in response to a crisis. The author drew several conclusions relevant to this study: 1) crisis in certain persons can increase the rate of spiritual growth over non-crisis condition; 2) crisis, in and of itself, does not enhance spiritual growth, because spiritual orientation is a "conscious cultivation" of inner strength; 3) the utilization of spiritual values in daily life enhances functioning and life
satisfaction; and 4) persons who reoriented their spiritual values through serious contemplation after crisis had greater depth of spiritual orientation as compared to persons who said they had a strong spirituality in their lives, but had not integrated those beliefs into their lives. Overall, the author observed: "The breadth of vision articulated by the more reflective respondents appeared to enable them to transcend given conditions of their existence: the reflective respondents appeared to live fully rather than to focus their energies on survival or situational difficulties (p. 13)."

Self-Transcendence

With the exception of one study that described the spiritual perspective of 100 homeless men in an addictions recovery shelter (Brush & McGee, 2000), research investigating spiritual perspective and self-transcendence in homeless populations was not found. One other study encouraged clinical use of the SPS in homeless persons, but did not measure spiritual perspective and did not address the concept of self-transcendence (Brush & McGee, 1999). Theoretically, Coward and Reed (1996) described how patients may express self-transcendence through communication or belief in a spiritual perspective. Participants in earlier qualitative studies on the lived experience of self-transcendence also described the importance of a spiritual perspective in deriving meaning from the experiences of having AIDS and advanced breast cancer (Coward, 1990; Coward & Lewis, 1993).

In addition to articulating the Theory of Self-Transcendence (Reed, 1991b), Reed (1991a) explored self-transcendence as a correlate of mental health in 55 adults between
the ages of 80 and 97 years. Quantitatively a significant negative correlation was found between self-transcendence and mental health. Qualitatively, matrix analysis supported the quantitative findings with four conceptual clusters (Generativity, Introjectivity, Temporal Integration, and Body-Transcendence) that participants stated were related to their well-being. The findings of this study support the idea that self-transcendence is a significant correlate of well-being.

Coward (1996) described the relationship between self-transcendence and psychological well-being in a sample of 152 healthy adults. The self-transcendence scale (STS) and Cognitive Well-Being (CWB) scale and perceived health status operationalized the variables. Self-transcendence was moderately and positively correlated with well-being ($r = .60, p< .01$). Additionally, small to moderate negative correlations were found between health status and the STS ($r = -.27$) and CWB ($r = -.42$) scale ($p<.01$).

Coward (1998) tested a pilot intervention study which collected baseline and post-intervention data in sixteen women with breast cancer divided into two support groups that met each week for eight weeks. Self-transcendence was assessed using the STS and Purpose-in-Life test (PIL); emotional well-being was assessed using the Affect Balance Scale (ABS), the Profile of Mood States (POMS), and the Cognitive Well-Being (CWB) scale; and physical well-being was assessed using the Karnofsky Performance Scale (KPS), and the Symptom Distress Scale (SDS). Perceived health status was assessed for the purposes of describing the sample, and exhibited a moderate negative correlation
(r = -0.51, p = 0.03) with the STS in the pre-intervention phase. However, self-transcendence was positively and more highly correlated with measures of emotional well-being pre- and post-intervention. The results support this study's expected positive relationship between self-transcendence and well-being.

**Health Status**

Health status has been studied often in homeless persons. Ropers and Boyer (1987) published a study discussing the health status of new urban homeless. Interviews were conducted with 269 homeless men and women in Los Angeles County. Perceived health status was used as an indicator of global, social, and physical health. The authors also collected a large amount of demographic data including age, gender, ethnicity, education, veteran status, employment status, self-reported health status, mental health indicators, health service utilization, presence of chronic and acute illnesses, and reasons for homelessness. Questions for the interviews were taken, in part, from the Basic Shelter Interview Schedule, NIMH Diagnostic Interview Schedule, Los Angeles Health Survey Questionnaire, Center for Epidemiological Study Depression scale, and the Diagnostic Interview Schedule. Multiple regression was then employed to identify correlates of perceived health status and to determine construct validity of health status as a general indicator of health in homeless persons.

Perceived health status was reported by participants as poor (12.2%); fair (21.2%); good (38.4%); and excellent (28.2%). The best correlate of poor health status was having a chronic condition. The four best correlates of health status (chronic
condition, consultation of a physician for an acute condition, duration of depressed mood, and alcoholism symptomatology) explained 26% of the variance of perceived health status. Another seven variables that also correlated significantly with health status explained 12% of the variance. The authors concluded that while physical health was the greatest contributor to perceived health status, physical health was not the only indicator of health status, since indicators of psychological health also correlated to health status. While the single item perceived health status has multiple contributing factors, overall, this study supported the construct validity of perceived health status as a measure of general health in homeless persons. This view was substantiated by previous empirical literature and the numerous significant correlates of health status (Ropers & Boyer, 1987).

Clarke, Williams, Percy, and Kim (1995) also inquired into the health status of homeless persons and found numbers similar to Ropers and Boyer (1987). However, this study concluded perceived health status was solely a measure of physical health. Reichenbach, McNamee, and Seibel (1998) asked participants specifically about their physical health status. This study grouped health status results into two categories: poor/fair (37%), and good/excellent (63%), which are also similar results to previously conducted studies on health status in homeless persons.

Another characteristic of perceived health status that validates the use of the variable in homeless populations is its use in models predicting mortality. Barrow, Herman, Cordova, and Struening (1999) surveyed 1260 men and women from 29
homeless shelters in New York City. The identifying data of the participants was compared to the National Death Index between the years of 1987 and 1994. Alarmingly, the mortality rate for the sample was found to be four times the mortality rate for the general US population. While self-rated poor health status, was not found to independently predict mortality, the authors included the variable in a multivariate logistic regression model of mortality predictors that included six other predictors (race/ethnicity, mental health problem, substance abuse problem, ever injected drugs, ever incarcerated, and extended homelessness).

Studies examining perceived health status in homeless persons have traditionally used health status only to describe the physical health of the sample. The reviewed studies have not theorized relationships between health status and well-being. Since support for a proposed relationship between health status and well-being is lacking, this study will also refrain from proposing a positive or negative relationship, believing that health status may play an indirect or complex role in one’s well-being. This idea is supported by the results of other studies (Coward, 1998; Herth, 1993a,b, 1996). In domiciled populations, people experiencing high fatigue rate their physical health lower than those with low fatigue. On the other hand, persons experiencing disability or terminal illness may experience a high level of well-being, in part, due to their spiritual and self-transcendent resources. The nature of the relationship between health status and well-being remains to be fully understood.
Fatigue

Studies linking the experience of fatigue, well-being, and related measures are most frequently found in cancer literature. Additionally, in this literature, quality of life measures are more commonly used measures of well-being. Ferrell, Grant, Dean, Funk, and Ly (1996) reported on the impact of fatigue on quality of life (QOL) in a secondary analysis of 4 separate studies which included 910 persons who either currently had cancer or were cancer survivors. Fatigue as described by the authors included physical, psychological, social, and spiritual dimensions. This study highlighted a previous study done by Dean and Ferrell (1995) in which fatigue influenced spiritual well-being by increasing awareness of uncertainty and hopelessness. The results of this study were placed into four categories: physical well-being, psychological well-being, social well-being, and spiritual well-being. Physically, fatigue decreased pain tolerance, while pain caused further fatigue. Psychologically, participants reported feelings of uselessness, depression, and anxiety when fatigued. Socially, fatigue strained familial and sexual relationships. Spiritually, participants reported varying experiences with regard to fatigue. Some participants reported feeling abandoned by their bodies, while others discovered that being fatigued allowed them the time they needed to contemplate meaning in their lives.

Segal et al. (1998) published the only quantitative study found that included an assessment of both health status and fatigue in a homeless sample. This descriptive study assessed the health of 310 participants in mental health self-help agencies in the
San Francisco Bay area. Participants were asked to report the presence of 34 health problems from the Diagnostic Interview Schedule in addition to demographic indicators, housing status, employment, health status, and fatigue. The authors grouped poor and fair health status into one group (42.9%) with 32 percent rating their health as good, and 23.9 percent as excellent. These findings are similar to the previously reviewed studies of health status in homeless persons. In addition, 29.7 percent of participants reported they "tired very quickly". Unfortunately, because fatigue and health status were not correlated, the presence of a relationship between the variables cannot be ascertained.

Herth (1996) qualitatively and quantitatively studied fatigue and hope as viewed by homeless families. Fatigue was measured by perceived energy level on a 4-point scale ranging from high energy to high fatigue. Hope is related to this study's variables in that it can be viewed as a spiritually-related inner resource similar to self-transcendence and spirituality. For the cross-sectional portion of the study, 108 adults from 52 families were interviewed using a semi-structured format that focused on the definition and meaning of hope in the participants' lives. Additionally, these participants completed both the Background Data Form (BDF), which assessed age, gender, race, educational level, length of time homeless, health status, and perceived energy level; and the Herth Hope Index (HHI), an instrument to assess the overall level of hope in participants. Longitudinally, sixteen participants completed the interview, BDF, and HHI at three intervals corresponding to when the family changed housing arrangements.

Qualitatively, fatigue (mental and physical), was a hope-hindering category.
Quantitatively, no significant differences were noted between level of hope and age, gender, race, educational level, or perceived health status. However, a significant relationship was found between level of hope and level of fatigue. Those participants with a high level of fatigue also reported significantly lower levels of hope ($p<.05$). The author concluded that hope: “as perceived by the participants in this study, is an inner power that mobilized one to move beyond what is and envision a better tomorrow for oneself and others” (Herth, 1996, p. 750). In this description, hope may be viewed as an inner strength that enables one to become self-transcendent.

The findings of Herth’s (1996) study supported the findings of two earlier studies by Herth (1993a, 1993b). In one study, hope was assessed in 25 family caregivers of terminally ill people (Herth 1993b). Reliance on spiritual beliefs and successful balancing of both psychological and physical energy demands were hope-fostering strategies in caregivers. Additionally, caregivers who reported poor health status and high level of fatigue had significantly ($p<.05$) lower levels of hope than those who reported fair/good health status and a low/moderate level of fatigue.

Similar results were found in Herth’s (1993a) study on hope in older adults. Sixty adults between ages 60 and 100 were divided into three categories based on their living situation (private home, senior citizen housing, or long-term care facility). While no significant difference was found between level of hope and health status on the basis of place of residence, a significant relationship was found between hope and level of energy ($p<.05$). Tukey HSD post hoc comparison revealed those participants in long-term care
facilities reported a high level of fatigue, and a significantly lower level of hope. The investigator reported that the qualitative data supported these findings.
Summary

Parallels between well-being, spirituality, self-transcendence, fatigue, and health status have been examined qualitatively and quantitatively in the literature. In general, studies have supported the idea that spiritual perspective and self-transcendence may enhance well-being, while fatigue of both body and mind is often experienced as a burden that drains one’s ability to direct energy towards improving well-being through enrichment of inner resources. These associations were also theorized in this study’s sample of homeless persons in light of the evidence that many homeless persons, like many domiciled persons, engage in spiritual behaviors which serve to assist them to effectively cope with their hardships. The nature of the relationship between health status and well-being is not theorized in light of the proposed complexity of the relationship.
CHAPTER III

METHODOLOGY

Design

This descriptive study was a cross-sectional and correlational design. Comparisons between subgroups was also conducted. Descriptive statistics were used to describe the sample demographically and to describe levels of well-being, spiritual perspective, self-transcendence, health status, and fatigue. Correlative statistics were employed to detect associations among the study variables. A nonparametric analysis was used to detect differences between the short-term and long-term housed groups with regards to study variables. Additionally, the reliability of the SPS and STS and the IWB was evaluated using Cronbach's alpha coefficient as an estimate of internal consistency.

Sample and Setting

Inclusion criteria were as follows: 1) Over age 18, 2) Not intoxicated by shelter staff assessment and administration of breathalyzer test (if indicated), 3) English speaking, and 4) Defines self as currently homeless through residency at a homeless shelter.

A convenience sample of 61 persons was obtained from one men's and one women's homeless shelter in Tucson, AZ. Both the men's and women's shelters have short-term and long-term housing, and data were collected from persons in both programs. Approximately 28 women live at the women's shelter each day with their children. On average, about ten women are in the long-term recovery program in which they stay for up to 18 months. The remaining women stay at the short-term emergency...
shelter for between 4 and 30 days depending on needs and circumstances. The men's program houses approximately 11 men in the long-term recovery program for up to 18 months. The men's short-term emergency shelter has beds to house 62 men for up to 4 days per month. On cold or wet nights, the shelter can house up to 100 men with mattresses on the floor. Both the men's and women's shelters had "work beds" where selected persons worked at the shelter in exchange for longer stays. People in work beds who participated in the study were considered short-term participants.

Daily Routines. Men and women in the short-term programs entered the shelter during "intake" time, which took place approximately one hour before dinner. During this time beds were assigned, showers taken, and clothing exchanged. After dinner, chapel services were held for those persons remaining the night. Persons had free time between chapel and lights out. Men and women in the long-term programs had structured classes and studying time throughout the day. Instruction included obtaining GEDs, job and computer skills, life skills, and Christian-based religious education. Childcare was provided for women with children during the day if children were not yet school age. It is important to mention the strong Christian undertones that were present in both shelters. Full participation in the long-term programs included the constant recognition of Jesus' and God's continuing presence and guidance in daily life. These behaviors were evidenced by long-term participants through observation of the primary investigator during data collection at the shelters.
Protection of Human Subjects

Approval to conduct this study was granted by the Institutional Review Board: Human Subjects Committee of the University of Arizona (see Appendix A). Before filling out the survey, participants were given the disclaimer statement to read. At the same time, the primary investigator explained the disclaimer statement, purpose of the project, and procedures for completing the questionnaire. Participants were assigned a number that was used for data entry identification.

Procedure

Two separate procedures based on the shelter (men’s versus women’s) were used to obtain participants and collect data. For long-term participants in the women’s shelter, the investigator instructed a 15 minute class on the effects of stress and methods to cope with stress as part of the shelter’s established health curriculum. Participants read the disclaimer statement and filled out the questionnaire at their convenience both immediately before and after the class. Short-term women were approached individually after checking into the shelter and settling into their room. The investigator was present during all data collection to explain the project and to answer any questions.

Men in the long-term program were approached as a group at a time agreed upon with the director of the program. In the men’s long-term group, disclaimers were read and instruments filled out with the investigator present to answer questions. Men in the short-term program were approached individually between intake and dinner, and again after dinner. Approximately 15 minutes was required to fill out the study instruments.
The researcher read the survey to participants who were illiterate in a place that allowed privacy.

**Instruments**

Three instruments and seven demographic questions were used in this study (see Appendix B). The instruments included: The Spiritual Perspective Scale (SPS), The Self-Transcendence Scale (STS), and the Index of Well-Being (IWB). Demographic information included age, gender, ethnicity, and educational level.

**Spiritual Perspective Scale (SPS).** The SPS was a ten item questionnaire that assessed participants’ spiritual views and the extent to which they hold those views and engage in spiritually-related behaviors. This instrument was derived from the Religious Perspective Scale in order to encompass broader spiritual views of people (Reed, 1986b, 1987). Participants placed an “x” along a 6-point horizontal scale with descriptors that ranged from “not at all” to “about once a day” or “strongly disagree” to “strongly agree”. Examples of questions that inquire about frequency of spiritually-related behaviors included: “How often do you share with others the problems and joys of living according to your spiritual beliefs?” and “How often do you engage in private prayer or meditation?”. Examples of questions pertaining to spiritual views included: “My spirituality is a significant part of my life,” and “My spiritual views have had an influence upon my life”. The score was calculated by averaging responses across the ten questions. Scores could range from 1.0 to 6.0 with a higher number indicating greater spiritual perspective. Internal consistency of the SPS has been demonstrated in previous studies.
with Cronbach’s alpha ranging from .90 to .95 (Reed, 1986b, 1987). Support for construct validity of the SPS, in previous research, is evidenced by the fact that overall, women and people who state they have religious views score higher on the SPS than men or people who state they do not hold religious views (Reed, 1987).

Self-Transcendence Scale (STS). The STS was a 15 item instrument that measured developmental maturity through one’s ability to expand personal boundaries while continuing to value the self. The STS was developed from the Developmental Resources of Later Adulthood (DRLA) scale (Reed, 1986a). Participants marked an “x” on a 4-point scale ranging from “not at all” to “very much”. Examples of questions include “Finding meaning in my past experiences,” and “Finding meaning in my spiritual beliefs”. The STS was scored by averaging all responses into a score that could range from 1 to 4 with a higher number indicating greater self-transcendence. Reliability has been measured in previous studies where Cronbach’s alpha ranged between .77 and .85 (Coward, 1991, 1996; Reed, 1991a). A study of a small sample (n=23) of older men reported a moderate Cronbach’s alpha coefficient (.52), but cited the homogeneity of the sample and small variances as reasons for the lower alpha coefficient (Chin-A-Loy & Fernsler, 1998). Construct validity was supported by participants reporting the items in the STS as relevant to their current lives (Reed, 1991a).

Index of Well-Being (IWB). The IWB was a 9 item instrument that assessed current life satisfaction (Campbell et al, 1976). In this study, the IWB operationalized well-being since the original authors concluded the instrument measured both affective
and cognitive dimensions of general well-being. The IWB was scored by summing two scores: 1) the average of the first 8 responses, and 2) the weighted score of the last question, a single item indicator of overall life satisfaction. Scores for the IWB could range from 2.1 to 14.7. Participants marked one of six unnumbered divisions along a continuum between two descriptors of their current life. Examples of these descriptors included: boring-interesting, lonely-empty. Previous alpha coefficients for the IWB ranged from .89 to .93 (Campbell et al., 1976; Reed 1986b, 1987).

Health Status. Health status was assessed on a 4-point Likert-type scale with potential responses ranging from “poor” (as 1) to “excellent” (as 4) in response to the question: “How would you describe your present health?”

Fatigue. Level of fatigue has been assessed by Herth (1993a, b) using two methods. The first study (Herth, 1993a) assessed participant’s energy on a 4-point scale with possible responses including: “Full of energy,” “Little fatigue,” “Moderate fatigue,” and “High fatigue”. The second study assessed fatigue by asking participants to rate their “perceived fatigue level” as low, moderate or high (Herth, 1993b). Herth (1996) qualitatively distinguished between mental and physical fatigue in a homeless sample. In the current study, level of mental and physical fatigue were each assessed with a one-item question asking: “How physically tired do you feel?” and “How mentally tired do you feel?” Potential responses ranged from “not tired” (as 1) to “very tired” (as 4) on a 4-point Likert-type scale. The two items were summed for an overall fatigue score that could range from 2 to 8.
Data Analysis

Interval and categorical (demographic) data were gathered, coded, entered into the Statistical Package for the Social Sciences (SPSS), checked for reliability, and cleaned. Frequencies were obtained from demographic data to describe characteristics of the sample. Description of the central tendency (mean), dispersion (standard deviation), and skew of spiritual perspective, self-transcendence, well-being, fatigue, and perceived health status answered the first research question. The second research question was answered utilizing bivariate correlation statistics (Pearson's r) to detect associations among the study variables. Multiple regression determined which study variables related best to well-being to answer the third research question. The fourth research question employed nonparametric statistical analysis (Mann Whitney) to detect differences between the short-term and long-term housed groups on spiritual perspective, self-transcendence, fatigue, health status, and well-being. A priori alpha for determining significance was set at .05.
Summary

This study collected data from 61 adult men and women residing at two homeless shelters. The SPS, STS, IWB, measurement of mental and physical fatigue, and health status operationalized the study variables. Data analysis used descriptive and correlational statistics to describe the sample and detect relationships among spiritual perspective, self-transcendence, well-being, fatigue, and health status. Multiple regression was used to examine predictive relationships between the variables and well-being. Finally, nonparametric equivalents to t-tests examined differences between long-term and short-term housed groups on the study variables.
CHAPTER IV

RESULTS

Chapter four first details the sample characteristics on age, ethnicity, education, and long-term versus short-term program status. Next, statistical results for the four research questions are answered in turn. Frequencies for spiritual perspective, self-transcendence, well-being, fatigue, and health status are listed for question one. Bivariate zero order correlations between the five variables are presented for research question two. Multiple regression results are presented under research question three. Finally, comparison between the long-term and short-term program participants is detailed under research question four.

Sample Characteristics

Sixty-one homeless people participated in this study, which included 14 females (23%) and 47 males (77%) (see Table 1). Participant age ranged from 19 to 62 years with a mean of 41.88 years (SD = 11.15), and a median of 42 years (n=60). Age was normally distributed based on Lilliefors test for normality. One participant did not report their age. The mean age for this study was slightly higher than in previously reviewed studies in homeless populations. In those studies, mean age ranged from 37 to 38 years (Clarke et al., 1995; Marshall et al., 1996; Ropers & Boyer, 1987; Segal et al., 1998).

The majority (59%) of the sample described themselves as Caucasian (see Table 1). Seven percent of the sample chose "other ethnicity" and wrote their ethnicity on the survey. These included two Native Americans, one multi-racial, and one American. Two
participants did not report ethnicity. Comparing the representation of ethnicity between this study and other studies in homeless populations was difficult. Previously reviewed studies, which included both convenience and random sampling, varied so widely that conclusions about the representation of ethnicity in this study's sample cannot be ascertained (Brush & McGee, 2000; Clarke et al., 1995; Marshall et al., 1996; Reichenbach et al., 1998; Ropers & Boyer, 1987; Wojtusik, & White, 1998). While participants in this study were predominantly Caucasian, people from multiple ethnic groups were represented.

Table 1. Sample Characteristics: Sex and Ethnicity.

<table>
<thead>
<tr>
<th></th>
<th>Frequency (%)</th>
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<tbody>
<tr>
<td><strong>Sex (N=61)</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>47 (77)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (23)</td>
</tr>
<tr>
<td><strong>Ethnicity (N=59)</strong></td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>7 (12)</td>
</tr>
<tr>
<td>Asian-American</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>36 (59)</td>
</tr>
<tr>
<td>Mexican-American</td>
<td>11 (18)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (7)</td>
</tr>
</tbody>
</table>
Table two details educational level, which ranged from eighth grade or less to degree from college. Three-quarters of the participants reported having a high school diploma or higher level of education. Two percent of participants chose other, which was described as "career college". Educational levels of participants in this study were comparable to Ropers and Boyer’s (1987) findings which included: eighth grade or less (11.9%), some high school (24.3%), high school diploma (26.1%), and some college (29.1%). Educational level of participants in the current study were comparable, but varied slightly more from Brush and McGee’s (2000) study of homeless men’s spiritual perspectives, which included the following educational levels: less than high school (35%), completed high school/GED (48%), some college (14%), completed college (2%), and post college (1%). Additionally, sixteen participants (26%) were in the long-term program, and 45 (74%) resided in the short-term program.
Table 2. Sample Characteristics: Educational Level.

<table>
<thead>
<tr>
<th>Education</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eighth grade or less</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Some high school</td>
<td>12 (20)</td>
</tr>
<tr>
<td>High school diploma or GED</td>
<td>21 (34)</td>
</tr>
<tr>
<td>Some technical school</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Degree from technical school</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Some college</td>
<td>17 (28)</td>
</tr>
<tr>
<td>Degree from college</td>
<td>4 (7)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2)</td>
</tr>
</tbody>
</table>

Instrument Reliability

Reliability values for the SPS, STS, and IWB were calculated using Cronbach’s alpha. Reliability for the SPS in this study was .93, which is consistent with past reliability findings that ranged from .89 to .95 (Brush & McGee 2000; Reed, 1986b, 1987). Cronbach’s alpha for the STS was .83, which is also consistent with previous range of .77 to .85 (Coward, 1991, 1996; Reed, 1991a). Previous alpha coefficients for the IWB in the examined literature ranged from .89 to .93 (Campbell et al., 1976; Reed 1986b, 1987). In this study, the alpha coefficient for the IWB exceeded this range at .95.
Research Question One

What are the levels of spiritual perspective, self-transcendence, well-being, fatigue, and perceived health status? Table 3 lists the scores for each instrument. The mean SPS score for the group was 4.8 (SD = 1.2), which ranged from 1.0 to 6.0. The mean STS score was 3.1 (SD = 0.5) and ranged from 1.8 to 3.8. The average level of well-being on the IWB was 9.5 (SD = 3.4) and ranged from 2.1 to 14.7. The mean health status score was 2.6 (SD = 0.9) and ranged from 1.0 to 4.0. Thirteen percent (n=8) reported poor health, 28% (n=17) reported fair health, 46% (n=28) reported good health, and 13% (n=8) reported excellent health. The fatigue score, which was a summation of mental and physical fatigue, was 4.6 (SD = 1.9) for the group, and ranged from 2.0 to 8.0.

Table 3. Central Tendency Measures of Spiritual Perspective, Self-Transcendence, Well-Being, Fatigue, and Health Status.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>(SD)</th>
<th>Actual Range</th>
<th>Possible Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPS</td>
<td>60</td>
<td>4.78</td>
<td>1.24</td>
<td>1 to 6</td>
<td>1 to 6</td>
</tr>
<tr>
<td>STS</td>
<td>61</td>
<td>3.11</td>
<td>.50</td>
<td>1.8 to 3.8</td>
<td>1 to 4</td>
</tr>
<tr>
<td>IWB</td>
<td>57</td>
<td>9.50</td>
<td>3.43</td>
<td>2.1 to 14.7</td>
<td>2.1 to 14.7</td>
</tr>
<tr>
<td>Fatigue</td>
<td>61</td>
<td>4.56</td>
<td>1.90</td>
<td>2 to 8</td>
<td>2 to 8</td>
</tr>
<tr>
<td>Health Status</td>
<td>61</td>
<td>2.58</td>
<td>.88</td>
<td>1 to 4</td>
<td>1 to 4</td>
</tr>
</tbody>
</table>
Research Question Two

What are the relationships among spiritual perspective, self-transcendence, fatigue, health status and well-being?

Zero order correlations were calculated on these continuous random variables using Pearson’s r. Lilliefors test for normality calculated a normal distribution for well-being. The remaining variables were not normally distributed (SPS, p = .001; STS, p = .002; fatigue, p = .017; health status, p = .000). Based on visual Q-Q plot linearity for all five variables and the use of parametric statistics with these variables in the literature, the decision was made to continue with parametric statistics.

Eight of the ten correlations were statistically significant (see Table 4). Spiritual perspective correlated positively with self-transcendence (r = .65, p = .000, R² = .42). Spiritual perspective also correlated positively with well-being (r = .57, p = .000, R² = .32). Additionally, spiritual perspective was positively correlated with health status (r = .28, p = .031, R² = .08). Self-transcendence correlated positively with well-being (r = .68, p = .000, R² = .46). Likewise, self-transcendence positively and significantly correlated with health status (r = .35, p = .007, R² = .12). Well-being was inversely correlated with fatigue (r = -.41, p = .001, R² = .17). Well-being was also positively correlated with health status (r = .57, p = .000, R² = .32). Fatigue was inversely correlated with health status (r = -.52, p = .000, R² = .27).

Overall, as fatigue increased, well-being and health status decreased. Additionally, participants whose health status was high also reported high levels of well-
being, self-transcendence and spiritual perspective. Likewise, participants who reported low health status more often reported low well-being, self-transcendence and spiritual perspective.

| Table 4. Correlations (bottom half), significance levels, and shared variance (top half) between study variables. |
|---|---|---|---|---|---|
|     | STS | SPS | IWB | Fatigue | Health Status |
| STS  | .46 | .42 | .04 | .12 |
| SPS  | .32 | .32 | .06 | .08 |
| IWB  | .17 | .57** | .32 |
| Fatigue | -.41** | -.52** | .27 |
| Health Status | .57** | -.52** | .27 |

* Correlation is significant at p = .031.
** Correlation is significant at p ≤ .007.

Research Question Three

What spiritual and health-related variables best relate to well-being?

Stepwise regression analysis was employed to determine the extent to which the independent variables (spiritual perspective, self-transcendence, fatigue and health status) described the variance in well-being (see Figure 3). For step one, self-transcendence as
measured by the STS, explained 47 percent of the variance of well-being. Self-transcendence was a significant predictor of well-being in this sample of homeless persons ($\beta = .561, p = .000$) as determined by ANOVA. In step two, health status and self-transcendence together explained 60 percent of the variance in well-being. ANOVA analysis in this step determined self-transcendence (Beta = .56) and health status (Beta = .38) were both statistically significant predictors of well-being ($R^2_{a} = .59, p = .000$). Since $\beta$ coefficients are positive, increasing levels of self-transcendence and health status predict increasing well-being. Partial correlations for spiritual perspective and fatigue were not significant, so these variables did not enter into the regression equation. Thus, self-transcendence and health status together explained a sixty percent of the variance in well-being.

Figure 3. Stepwise regression.

```
<table>
<thead>
<tr>
<th>Variable</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>STS</td>
<td>.56</td>
</tr>
<tr>
<td>Health Status</td>
<td>.38</td>
</tr>
<tr>
<td>Well-Being</td>
<td>$R^2_{a} = .59$</td>
</tr>
</tbody>
</table>
```
Research Question Four

Are there differences between homeless persons who are sheltered on a short-term basis versus those who are sheltered on a long-term basis in well-being, spiritual perspective, self-transcendence, health status, and fatigue?

Due to the small number of short-term participants, non-parametric statistical analysis (Mann-Whitney) compared short-term (N=16) and long-term (N=45) groups on the study variables (See Table 5). The long-term group scored significantly higher than the short-term group on the STS (U=219, p=.02), SPS (U=72, p=.00), and IWB (U=109, p=.00). Fatigue (p=.43) and health status (p=.69) did not show a significant difference between the long-term and short-term housed participants. Mean instrument scores for short-term and long-term groups respectively, were as follows: IWB (8.54, 11.93); SPS (4.40, 5.82); STS (3.02, 3.38); health status (2.56, 2.69); and fatigue (4.69, 4.19).

<p>| Table 5. Significant Differences Between Long-term and Short-term Groups. |
|-----------------------------|-----------------------------|-----------------------------|</p>
<table>
<thead>
<tr>
<th></th>
<th>Long-term Mean Rank</th>
<th>Short-term Mean Rank</th>
<th>Two-tailed p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>STS</td>
<td>39.84</td>
<td>27.86</td>
<td>.02</td>
</tr>
<tr>
<td>SPS</td>
<td>48.00</td>
<td>24.14</td>
<td>.00</td>
</tr>
<tr>
<td>IWB</td>
<td>42.72</td>
<td>23.65</td>
<td>.00</td>
</tr>
</tbody>
</table>
Summary

Sample age, ethnicity, sex, and educational levels were described. In this group of sixty-one homeless men and women, significant positive correlations were found among spiritual perspective, self-transcendence, and well-being. Additionally, statistically significant positive correlations were found among well-being and health status as well as a significant negative correlation between well-being and fatigue. Self-transcendence and health status were significant predictors of well-being. Finally, participants in the long-term group scored significantly higher on spiritual perspective, self-transcendence, and well-being than persons sheltered on a short-term basis.
CHAPTER V
DISCUSSION

This last chapter presents a discussion of the relationship between well-being, spiritual perspective, self-transcendence, health status, and fatigue in a sample of sixty-one homeless persons. The findings are related to the literature and discussed within the context of the conceptual framework. Study limitations, clinical implications, proposed changes to the conceptual model, and suggestions for future research are also provided.

Levels of Study Variables Compared to Published Findings

Spiritual Perspective

Only one published study has measured spiritual perspective homeless persons (Brush & McGee, 2000). Brush and McGee administered the SPS to a convenience sample of 100 homeless men in a substance addiction recovery shelter. The mean sample SPS score and standard deviation were 4.76(1.07), which is comparable to the current study's mean and standard deviation of 4.78(1.24). Levels of spiritual perspective overall, were high for both studies.

Two other studies also measured spiritual perspective, although not in homeless populations. It is beneficial, however, to gain an idea of how participants in this study compare to other populations. Bauer and Barron (1995) sampled 50 community-based adults greater than 60 years old. The average participant age was 80 years, and the mean SPS score was 5.3. Participants in this group reported slightly higher spiritual perspective than this study's mean of 4.8. Likewise, Reed (1987) assessed the spiritual
perspective of three groups of adults: healthy adults, terminally ill hospitalized adults, and nonterminally ill hospitalized adults. Spiritual perspective was slightly higher in the homeless adults as evidenced by comparison with the following mean SPS scores: 4.16 for the healthy group; 4.53 for the terminally ill hospitalized group; and 4.16 for the nonterminally ill group. Overall, this study's mean SPS scores were comparable to previously published SPS scores in other populations.

Self-Transcendence

Measurement of self-transcendence in homeless persons has not been previously published. Therefore, the level of self-transcendence in this study will be compared to levels of self-transcendence in other published studies. The mean level of self-transcendence in the current study was 3.1. Reed (1991) assessed the self-transcendence of the oldest old in a sample of 55 independent living elders where the mean age was 85 years. She found the average STS score was 3.3 amongst these participants. Similarly, Coward (1991) assessed self-transcendence in 107 women with breast cancer and reported a mean of 3.4. Again in 1996, Coward reported self-transcendence scores in a sample of 152 healthy adults (mean age 46 years). In this study, the average STS score was 3.2. Finally, Chin-A-Loy and Fernsler (1998) reported an average STS score of 3.34 in a sample of 23 men in a prostate cancer support group. Men chosen were 60 years or older, and the mean sample age was 69 years. As evidenced by comparison with previous self-transcendence literature, levels of self-transcendence were similar in this group of homeless adults. Hall's (1986) proposal that crisis affords an opportunity for
spiritual growth is congruent with the findings of this study where levels of spiritual perspective and self-transcendence are comparable between a variety of populations, several of which were facing health challenges through aging, illness, stress, and loss.

Well-Being

Well-being in homeless persons as measured by life satisfaction using the IWB has not been reported in the published literature to date. Mashall et al. (1996) explored life satisfaction in homeless persons using another instrument. However, these authors concluded that "the psychological toil of impoverishment is readily detectable in the form of impaired satisfaction with life (p. 54). The mean IWB score in this study was 9.5 with a possible range from 2.1 to 14.7, which indicates that well-being was neither particularly high nor low. However, the significant difference discovered between the short-term and long-term housed participants indicates there was a dichotomy in the sample that the mean was not able to illuminate. Persons housed on a short term basis where the majority of their days and nights were spent on the streets reported significantly lower well-being than participants with long-term shelter housing.

Fatigue

The literature recognizes that fatigue is a complex, multidimensional concept that may not be adequately captured with only two questions. Ferrell, et al. (1996) encouraged researchers to explore the physical, psychological, social, and spiritual aspects of fatigue. This study inquired explored the physical and mental aspects of fatigue of homeless adults and found that the group averaged "a little tired". Comparison
between this study and other groups of homeless persons cannot be performed, because
the measurement of physical and mental fatigue in this manner had not been published in
the literature. Overall, however, this group’s mental and physical fatigue was relatively
low with the mean fatigue level being “a little tired”.

Health Status

The results of this study compare closely with the levels of current health status
reported in other studies of homeless persons (see Table 6). This study reported 13% of
participants in poor health, 28% in fair health, 46% in good health, and 13% in excellent
health. Discrepancies with other studies, however, are noted. The percentage of persons
reporting good health (46%) exceeded the “good health” reported in other studies of
homeless samples by 7% to 14% (Brush & McGee, 2000; Wojtusik & White, 1998;
Ropers & Boyers, 1987; Segal et al., 1998). Conversely, the percentage of participants in
this study reporting excellent health status (13%) was 11% to 15% lower than in the
Ropers and Boyers (1987) and Segal et al. (1998) studies. On the other hand, Brush and
McGee (2000) and Wojtusik and White (1998) reported a nearly equal percentage to this
study, 14% and 12% respectively, of persons reporting excellent health. Reasoning for
these discrepancies other than randomness within variable measurement is not offered.
Overall, the representativeness of health status in this sample in comparison to other
published studies speaks to the stability in measurement of this variable amongst
homeless persons.
Table 6. Comparison between literature and study on percentage in each category of health status.

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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Poor (%)</td>
<td>13</td>
<td>11</td>
<td>12</td>
<td>4</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair (%)</td>
<td>28</td>
<td>38</td>
<td>21</td>
<td>16</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good (%)</td>
<td>46</td>
<td>39</td>
<td>38</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent (%)</td>
<td>13</td>
<td>12</td>
<td>28</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Poor/Fair (%)</td>
<td>41</td>
<td></td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good/Excellent (%)</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Blank spaces are values not reported in the study. Columns may not total 100% due to the reporting of only values from other studies that matched this study’s health status adjectives exactly (i.e. poor, fair, good, excellent).
Relationships Among Study Variables

Numerous significant associations were calculated between spiritual perspective, self-transcendence, well-being, fatigue, and health status. Bauer and Barron (1995) reported a $r = .45$ ($p < .01$) correlation between the SPS and STS. Additionally, a positive correlation was proposed in this study’s conceptual model. This study’s findings supported both the previous study as well as the conceptual model with a high positive association among self-transcendence and spiritual perspective.

Along these same lines, a positive correlation was theorized and empirically supported among spiritual perspective and well-being. Lending support to this idea is the finding from Reed’s (1987) study where a significant positive correlation was reported among these variables ($r = .22$, $p < .02$) among terminally ill hospitalized adults. Additionally, an earlier study of healthy adults using the Religious Perspective Scale (RPS) (from which the Spiritual Perspective Scale was derived) reported a correlation of .43 ($p < .001$) among the RPS and IWB (Reed, 1986). Findings were similar in this study’s sample of homeless adults, although the correlation ($r = .57$) was much higher than in the reviewed literature.

A positive correlation was theorized among self-transcendence and well-being. No published literature to date empirically explores this relationship. However, the positive correlation among self-transcendence and spiritual perspective as well as among spiritual perspective and well-being lead one to conclude that a positive correlation would also be expected among self-transcendence and well-being. Additionally, Reed and
Rogers theorize that one's ability to discover meaning in life enhances well-being (Reed, 1991b, 1997, Rogers, 1970). Likewise, Coward and Reed (1996) propose that self-transcendence may lead to a greater sense of well-being via an awareness and integration of one's whole self into all dimensions of one's being. These ideas were well supported with this study's finding of a high significant positive correlation \( r = .68 \) among self-transcendence and well-being.

This sample demonstrated a statistically significant negative correlation \( r = -.41 \) between fatigue and well-being. This finding is congruent with this study's conceptual model which proposed a negative relationship. However, the finding that fatigue had a negative although nonsignificant correlation with spiritual perspective and self-transcendence is in conflict with Dean and Ferrell's (1995) theoretical postulate that fatigue negatively affects patients' abilities to carry out those activities and roles that give meaning and value to life. Overall, however, the significant negative relationship among fatigue and well-being was supported. This provides support for the recommendation that nurses should assess fatigue when assessing the overall well-being of homeless persons.

Additionally, the finding of a significant negative correlation between fatigue and hope in the Herth (1996) study was not duplicated in this study. While hope was conceptualized as a spiritually-related variable like self-transcendence, it is possible, that these variables are fundamentally different from each other and comparisons cannot be made. Additionally, fatigue was measured differently in the two studies with no
differentiation in the Herth study between physical and mental fatigue. It is hypothesized that differences in measurement of hope, self-transcendence, and fatigue between this study and Herth's study prevent one from comparing the significant inverse relationship between fatigue and hope in Herth's study and the nonsignificant relationship between fatigue and self-transcendence in the current study.

No theoretical relationship was proposed linking health status to spiritual perspective or self-transcendence. However, the findings demonstrated small significant positive correlations among these variables, respectively ($r = .28$ and $r = .35$). Coward's (1996) study revealed a small significant negative correlation ($r = -.27$, $p < .01$), but no explanation was given for this association. Additionally, Brush and McGee (2000) found non-significant correlations among health status and SPS items. These associations deserve further exploration in future studies, since self-transcendence may be a variable that has therapeutic value in nursing care.

On the other hand, a positive correlation was predicted in the conceptual model among health status and well-being. Reed's (1987) study empirically supports this idea with significant positive correlations ($r = .23$ to $.44$) in all three groups (healthy, nonterminally ill, and terminally ill adults), and with significance ranging from $p < .05$ to $p < .001$. This study's findings supported the conceptual model and Reed's findings with a high significant positive correlation ($r = .57$, $p = .000$) indicating that health status is positively associated with well-being.

Finally, a negative correlation was predicted conceptually among fatigue and
health status. Associating fatigue with health status is a new practice within homeless populations. However, it was theorized that one would perceive one's current health status as lower if persistently fatigued than if not. Additionally, frequent fatigue as depicted in the literature of homeless shelters may contribute to one's reporting lower health status (Segal, et al., 1998). The findings of this study supported the theoretical hypothesis of a significant negative association among fatigue and health status ($r = -0.52$). Those participants reporting higher physical and mental fatigue tended to report significantly lower health status.

Self-Transcendence and Health Status as Predictors of Well-Being

To date in the published literature, multiple regression between the study variables has not been explored. Therefore, the finding that self-transcendence and health status are significant predictors of well-being in this sample of homeless persons is research that lays the foundation for future studies to replicate. However, clinical implications of these findings are immediately applicable. Health status as single item assessment of one's perception of current health is readily accepted and has been reported as a predictor of mortality in homeless persons (Barrow et al., 1999). The value of this single question in the clinical setting is unmeasurable. Not only is the assessment brief and easily interpretable, but a sense of the client's perception of well-being as well as the future mortality risk makes health status a valuable assessment tool. Additionally, this measure is readily accepted by the homeless population and can easily be read to and understood by illiterate persons.
The application of the Self-Transcendence Scale is not as easily administered or interpreted (takes time to calculate a score), however, few tools exist that measure meaningfulness in one's life as reliably as this tool. Additionally, this tool supplies the nurse and client with a beginning point for initiating discussion about well-being and meaningfulness in life in relation to the experience of homelessness. Therefore, the STS should be part of comprehensive nursing assessments of homeless persons.

Differences Between Long-Term and Short-Term Housed Participants

Differences between short-term and long-term participants were predicted based on the fact that people in the long-term program would have had more time to process, draw meaning from, and grow from the crisis of being homeless (Hall, 1986). The results did find that long-term housed participants reported significantly higher spiritual perspective, self-transcendence, and well-being. However, as discussed in detail in the limitations section, the difference in spirituality between the long-term and short-term groups may have been confounded by the incorporation of Christian attitudes and behaviors into every aspect of daily life for participants in the long-term program. This limitation is viewed as significant enough to warrant not applying the differences between short-term and long-term housed participants to the revised conceptual model discussed later. Further exploration between short-term and long-term housed participants is needed to support the findings of this study before additional conclusions can be offered.
Limitations

A significant limitation of this study was the use of convenience sampling from two homeless shelters that were heavily guided by religion as a means to help homeless persons "find their way". It is likely that the use of participants in the long-term program biased the sample by raising the sample's average self-transcendence, and spiritual perspective. This bias was made most apparent by the questionable significant differences found between the long-term and short-term groups on these variables. It was the primary investigator's (PI) observation that merely being housed on a long-term basis did not account for the difference in self-transcendence and spiritual perspective. The PI concluded that the nature of the long-term program where a continuous alluding to Christian traditions was observed, may have influenced the SPS and STS scores. On the other hand, short-term persons were required to listen to the Christian message and traditions. However, short-term participants were not required to abide by them day after day. Therefore, the scores of short-term participants were less likely to be biased by the religious influence, because they were not required to accept and live out the Christian message as was the case for the long-term participants.

The fact that a convenience sample was chosen prevents one from generalizing the study results to the population of homeless persons. However, the similarities between demographic data as well as data from variables reported in other published literature allow one to conclude that this sample might be more representative of the population of homeless persons than one would have first considered. True random
sampling is next to impossible in this population due to the population's transient nature and lack of ability to control the location of people. Therefore, an inherent flaw in homeless research is the norm of convenience sampling to which researchers judge the representativeness of their samples.

Proposed Changes to the Conceptual Model

Changes to the original conceptual model are proposed in light of this study's empirical findings (see Figure 4). As a result of this study finding a high positive and significant correlation among health status and well-being ($r = .57$), the plus/minus sign between health status and well-being in the model was changed to only a plus sign to reflect the results of this study. Also, since this study found that self-transcendence and health status predict well-being, the lines leading from self-transcendence and health status to well-being were made bold indicating a non-equal relationship between these variables and other variables, which correlate, but do not predict a relationship.

Since nonsignificant correlations were calculated among fatigue and self-transcendence/spiritual perspective, in addition to there being no theoretical reasoning why these variables would be related, the lines indicating any possible relationship among fatigue and spiritual perspective and fatigue and self-transcendence were removed. Likewise, while there were small, significant negative associations among physical health status and self-transcendence and physical health status and spiritual perspective, no evidence for this being a theoretically significant relationship exists (Coward, 1996). Additionally Brush and McGee (2000) found no significant correlation between health
status and spiritual perspective. Therefore, the lines between these variables were removed for the purposes of this study. Further theoretical discussion and empirical testing of the relationships among all study variables is recommended. Overall, these changes clarify the conceptual model as based upon the empirical findings of this study.
Figure 4. Conceptual model modified based on results.
Clinical Implications

As mentioned above, the use of the Self-Transcendence Scale and health status in clinical practice would be a valuable addition to a comprehensive assessment. Overall, however, the findings of this study reiterate the importance of assessing more than physical health when assessing well-being. A person’s well-being is composed of multiple facets of life including physical health, spiritual health, and fatigue to name a few. The nurse is wise to assess spiritual perspective and self-transcendence as a means of coping with the crisis of being homeless to assist the person to draw strength and meaning from the experience. Ultimately, nursing has an obligation to intervene to enhance well-being in spite of the often meager material resources homeless persons have. However, as discovered in this study, inner resources may be plentiful and worthy of further understanding.

Research Recommendations

Continued investigation into the expression and role of self-transcendence in homeless persons is recommended based on the unique finding of a substantial predictive relationship between self-transcendence and well-being. Use of both quantitative and qualitative research methods are necessary if nursing is to gain a comprehensive understanding of the expression of self-transcendence in homeless persons. A deeper understanding of self-transcendence in homeless persons would improve nursing’s understanding of what is most meaningful to homeless persons. In turn, this knowledge would allow for more specific and relevant plans of care that would most appropriately
address the patient's needs and goals, and ultimately improve well-being.

Further investigation into the importance of well-being in addition to correlates and predictors of well-being is warranted in light of the findings. Likewise, research into the difference in well-being and self-transcendence between the newly homeless versus the chronically homeless who are not necessarily experiencing the "crisis" of being homeless is needed and may extend the theoretical model by clarifying relevant parameters of the theory. Finally, understanding the role housing plays in well-being may help nurses determine which part of health housing improves (physical health, spiritual, social etc.) and how to improve those aspects of health that cannot be enhanced by housing. For those persons who are chronically homeless, those interventions that aim to improve well-being that are not linked directly to housing will most benefit the segment of the homeless population who chooses homelessness as a way of life.

Future Theoretical Directions

A causal relationship between self-transcendence and well-being is proposed in order to guide future investigations and theory development. The methods used in this study do not provide empirical support to conclude a causal relationship between self-transcendence and well-being. However, the results of this study, coupled with the theoretical framework and findings from previous research (Coward, 1996, 1998; Coward and Reed, 1996; Reed 1991a) support the strong possibility of a significant predictive relationship between self-transcendence and well-being such that self-transcendence is predictive of well-being. The literature that examines self-transcendence as an experience
that enhances well-being, discusses the relationship between these variables in a manner that suggests a causal relationship leading from self-transcendence to well-being. The literature, as well as this study's conceptual model theorize that well-being is an outcome related to self-transcendence. Given this, nursing may attempt to enhance well-being through interventions focused upon self-transcendence. The combination of these three factors: 1) the published literature’s treatment of these variables, 2) the finding of a significant relationship between self-transcendence and well-being in this study, and 3) theoretical and empirical support for well-being as the outcome variable, enable the primary investigator to theoretically suggest that self-transcendence may predict well-being. This proposition may be incorporated into future research studies to further elucidate the nature and significance of this relationship for both nursing theory and practice.

Conclusions

As a whole, the population of homeless persons is one that nursing knows little about. This lack of understanding causes difficulties in communication, collaboration, care-taking, and outcome achievement. Rather than assuming the attitude that the nurse will “fix” the problem, the promotion of well-being in homeless persons requires the nurse to assist clients to make the best with what material resources they have or have available to them. Additionally, the nurse should attempt to connect with the person in a manner that enables the nurse to explore, and possibly enhance, the meaning they find in their life’s experience, for this intervention may ultimately predict well-being. Further
research, however, is needed to fully elucidate this relationship between self-transcendence and well-being. Meaning in life may be found in a relationship with a higher being, the earth, music, other people, or their present capacity to move beyond the pain and isolation they experience. Connecting with homeless persons forever changes both the client and the nurse, because they learn from each other, and incorporate the meaning of the experience into their life to draw upon in the future. In essence, the spiral of life continues.
Summary

This sample reported levels of spiritual perspective, self-transcendence, well-being, fatigue, and health status congruent with the available literature. Multiple correlations among the variables supported the tenants of the conceptual framework and the literature. The significant predictive relationship of self-transcendence and health status to well-being has multiple implications for clinical assessment of well-being and future nursing research. A significant limitation to this study was the use of a convenience sample from a long-term Christian-based shelter program. Refinements to the conceptual model were proposed to both simplify and clarify relationships within the model. The importance of assessment of multiple facets of life when assessing the well-being of homeless persons in the clinical setting was emphasized. Future research recommendations included further investigation into how homeless persons find meaning and maintain well-being.
APPENDIX A:

PROTECTION OF HUMAN SUBJECTS DISCLAIMER STATEMENT
UNIVERSITY OF ARIZONA HEALTH SCIENCE CENTER
SUBJECTS DISCLAIMER FORM

SPIRITUALITY, SELF-TRANSCENDENCE, FATIGUE, AND HEALTH STATUS AS CORRELATES OF WELL-BEING IN HOMELESS PERSONS

You are being asked to voluntarily participate in a study exploring the inner strengths, health, and well-being of homeless persons. By responding to questions in four questionnaires, you will be giving your consent to participate in the study.

The interview will take place in a location convenient for you and will last approximately 15 minutes. Your identity will not be revealed and your confidentiality will be maintained in all reports of this project. The questionnaires will be locked in a cabinet in a secure place.

You may choose not to answer some or all of the questions. Any questions you have will be answered and you may withdraw from the study at any time with no consequences whatsoever. There are no known risks involved in your participation.

The overall aim of this study is to help nurses understand the strengths of homeless persons.

I can obtain further information from my project advisor Dr. Pamela Reed at 626-6151. If I have questions concerning my rights as a research subject, I may call the Human Subjects Committee office at 626-6721.

Thank you.

_________________________  _______________________
Investigator                                                Date

520-626-7124
Telephone Number
APPENDIX B:

HUMAN SUBJECTS COMMITTEE APPROVAL LETTER
20 November 2000

Jennifer Runquist, RN, BSN
Advisor: Pamela Reed, Ph.D.
College of Nursing
PO BOX 210203

RE: SPIRITUALITY, SELF-TRANSCESSION, FATIGUE AND HEALTH AS CORRELATES OF WELL-BEING IN HOMELESS PERSONS

Dear Ms. Runquist:

We received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(2)] exempt this type of research from review by our Committee.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely,

David G. Johnson, M.D.
Chairman
Human Subjects Committee

cc: Departmental/College Review Committee
APPENDIX C:

STUDY INSTRUMENTS
Demographic Questions

ID # __________

Age in years:_______

Gender:
   (1) Female
   (2) Male

Ethnicity:
   (1) African-American
   (2) Asian-American
   (3) Caucasian
   (4) Mexican-American
   (5) Other (please describe)_____________________

Please circle the most education have you had:
   (1) Eighth grade or less
   (2) Some high school
   (3) High school diploma or GED
   (4) Some technical school
   (5) Degree from technical school
   (6) Some college
   (7) Degree from college
   (8) Other (please describe)_____________________

How would you describe your present health?
   (1) Poor
   (2) Fair
   (3) Good
   (4) Excellent

How physically tired do you feel?
   (1) Not tired
   (2) A little tired
   (3) Somewhat tired
   (4) Very tired

How mentally tired do you feel?
   (1) Not tired
   (2) A little tired
   (3) Somewhat tired
   (4) Very tired
INDEX OF WELL-BEING

Directions: Here are some words and phrases which I would like you to describe how you feel about your present life. Put an “X” over the line that you think best describes how you feel about your life at this time. For example: My present life is: wonderful / / X / / / / / / terrible.

1. My present life is:
   BORING ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / INTERESTING

2. My present life is:
   ENJOYABLE ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / MISERABLE

3. My present life is:
   USELESS ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / WORTHWHILE

4. My present life is:
   LONELY ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / FRIENDLY

5. My present life is:
   FULL ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / EMPTY

6. My present life is:
   DISCOURAGING ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / HOPEFUL

7. My present life is:
   REWARDING ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / DISAPPOINTING

8. My present life is:
   DOESN’T GIVE ME ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / BRINGS OUT
   MUCH CHANCE ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / THE BEST IN ME

9. In thinking about my life as a whole I am:
   COMPLETELY ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / COMPLETELY
   DISSATISFIED ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / SATISFIED

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Pages 89 & 90
Spiritual Perspective Scale

This reproduction is the best copy available.
DIRECTIONS: Please indicate the extent to which each item below describes you. There are no right or wrong answers. I am interested in your frank opinions. As you respond to each item, think of how you see yourself at this time of your life. Circle the number that is the best response for you.

**Self-Transcendence Scale**

**AT THIS TIME OF MY LIFE, I SEE MYSELF AS:**

<table>
<thead>
<tr>
<th></th>
<th>NOT AT ALL</th>
<th>VERY LITTLE</th>
<th>SOMEWHAT</th>
<th>VERY MUCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having hobbies or interests I can enjoy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Accepting myself as I grow older.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Being involved with other people or my community when possible.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Adjusting well to my present life situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Adjusting to the changes in my physical abilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Sharing my wisdom or experience with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Finding meaning in my past experiences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Helping younger people or others in some way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Having an interest in continuing to learn about things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Putting aside some things that I once thought were so important.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Accepting death as a part of life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Finding meaning in my spiritual beliefs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Letting others help me when I may need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Enjoying my pace of life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Dwelling on my past unmet dreams or goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Thank you very much for completing these questions. Please feel free to list below or on the back any other issues that are important to you at this time of your life that were not listed above.

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References


