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# What Works to Improve the Well-Being of Homeless Girls?

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Additional information is available at the end of the chapter

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## Abstract

Homeless girls are victims of physical, sexual, and psychological abuse more frequently than the rest of the population. Consequently, their well-being is severely affected. Nonetheless, there is little information about this social group which leads to lack of proper care that, in turn, reduces their quality of life. This research was conducted to develop and test a path model of well-being in a group of 240 Mexican homeless girls aged 6–23 years. Anxiety, depression, assertiveness, and emotion regulation strategies were used as predictors of well-being. Findings reveal significant direct effects of depression and functional emotion regulation strategies on well-being. Results also show significant indirect effects of anxiety, assertiveness, and dysfunctional emotion regulation strategies through depression. The fit indices achieved,  $\chi^2(3)=1.116$ ,  $p=.773$ ; NFI=.997, RFI=.985, IFI=1.005, TLI=1.026, CFI=1.000,  $p=.000$ ; RMSEA(90% CI)=.000(.000–.073),  $p=.889$ , demonstrate that the model reliably predicts well-being. Thus, the model fit is acceptable. The current study provides unique findings in terms of a path model that highlights anxiety, depression, emotion regulation strategies, and assertiveness as critical indicators for well-being in homeless girls. Hence, it is essential to consider such factors in order to promote well-being in this group, thereby improving their health and quality of life.

**Keywords:** well-being, homeless girls, anxiety, depression, emotion regulation

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## 1. Introduction

The promotion of child and youth well-being requires a conscious society convinced of the importance of children and youth's development as an essential component for its future sociocultural and economic progress. However, in the present times, the children and youth population is immersed in conditions of great vulnerability.

Vulnerability is the degree to which a sociocultural collective, individual, or organization is unable to anticipate, cope, and recover from the impact of adverse natural or human-induced circumstances [1]. That is, the stressful or deficient situations that families have to face and the resources they have to solve these problems or, in the case of the child or adolescent, any condition that forces them to live an experience that violates their physical and psychological integrity, and that annuls their decisions and their capabilities [2]. So, vulnerable groups are all those who, by virtue of their age, race, sex, economic, social, physical, cultural and political circumstances or sexual orientation, may face greater obstacles in the exercise of their citizenship rights [3]. As part of vulnerable people, are homeless children and youth who are the extreme manifestation of social deterioration and exclusion because they have below the minimum needed to access services or resources [4, 5], and lack admittance to decision-making power over their own social and economic destiny [6, 7]. Among this collective are homeless girls, who are the most vulnerable group whatsoever as a result of being women, underage, and homeless. But, who are the homeless? Specifically, who are the homeless girls?

According to a previous study [8], Mexican homeless girls are a social group which in turn comprises two subgroups, those at risk of homelessness and those who have abandoned their home (sheltered, unsheltered, or emergency sheltered), characterized by:

- Having been born and living in Mexico City with less than 30% coming from different states of the Mexican Republic.
- Having an average age of ( $M[SD]=12.07[3.754]$ ) years with an age range of 6–23 years; however, there could be younger girls (in this study, there were approximately 20 little girls between ages 3 and 5 years), and a grade level of middle school. It is important to highlight that only if they remain in an organization, they continue to study, because in their family, they do not receive any kind of support for their studies, and they are not self-sufficient. Their academic achievement and performance are low. Although few ( $n<5$ ), some are illiterate and the vast majority ( $n>50\%$ ) have severe problems with reading and writing.
- Participating in the formal economy system by having jobs with low salaries such as receptionist, assistant cook, saleswoman, and waitress. Similarly, although not legally considered an activity work, they contribute to domestic labor and, with increasing age, they are responsible for the care of their younger siblings. Also, they work in the informal economy system doing jobs such as street vendor, housemaid, and begging. They allocate their resources for their own support and/or assist the subsistence of their family. They can carry out criminal acts such as stealing, selling drugs, and prostitution, exposing themselves to risks that diminish their bio-psychosocial well-being.
- Consuming drugs, alcohol, and tobacco since approximately 12 years of age. The most frequently used drugs are inhalants, for their low cost and easy access, and marijuana. Substances are obtained within the family where usually there are members who use and abuse them, in their home community, at school, and in their peer group. Occasionally, in

the same institution they have access to these (inhalants<sup>1</sup>) or they themselves are able to introduce drugs. When using drugs, they can have sex under the influence of these.

- Having diverse skin, respiratory, and gastrointestinal diseases, malnutrition, and mental disorders. They usually enter the organization with a deplorable physical and mental health status, with oral and visual health problems, and a lack of hygiene and self-care behaviors. Commonly, they go to health centers for proper care. But in two or three cases, it was found that they have been victims of sexual violence by the physician who offers his services in exchange for sex or fondling. As part of their physical health, sometimes they have suffered accidents such as falls, bruises, and burns. Regarding mental health, only when they remain institutionalized, they receive psychological care. The most common mental disorders are anxiety and depression. Likewise, to a lesser extent, other typical disorders are attention deficit disorder with or without hyperactivity, personality disorders, and psychosis. Drugs commonly prescribed for psychiatric problems are sertraline, carbamazepine, valproic acid, and risperidone. They lack information concerning how to take care of their health and body, and they do not know what a psychologist does. They have suicidal thoughts, make suicide attempts, and have self-mutilation behaviors.
- Initiating sexual life usually as a consequence of having been sexually abused. As age increases, the probability of having sexual intercourse is higher. They may engage in sexual risk behaviors such as having unprotected sex, having sexual relationships with multiple partners, and/or under the influence of alcohol and drugs. They practically have very less information on contraception, sexually transmitted infections, how to take care of themselves, and their anatomy and physiology. More than 80–90% have heterosexual relationships, and approximately 10–20% involve in homosexual or bisexual relationships. They typically get pregnant and abort at ages 13–14 years. They can have children with several different men. When their partner leaves them or when the relationship is over, because they do not have any means of support, they seek aid of institutions where they can receive proper care and attendance. Their child-rearing practices are ambivalent: both violent and loving and caring.
- Engaging in risk behaviors such as drug use and abuse, self-mutilation, suicide ideation and attempts, delinquent activities (*e.g.*, theft, drug selling, and prostitution) to obtain resources necessary to survive, and consume psychoactive substances.
- Having unstable and informal couple relationships at younger ages, and more lasting and formal at older ages. Their couples provide security, support, affection, and protection. They can also become a source of violence and of risk behaviors. Their couple relationships are mainly heterosexual ( $n > 80\text{--}85\%$ ), and, in fewer cases, homosexual and bisexual ( $n < 15\text{--}20\%$ ).

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<sup>1</sup>That is, at the organization they can have access to inhalants such as detergents, liquid cleaners, glue, and other chemicals used without the knowledge and consent of the institution's staff in order to get high. Additionally, when they inhale these products they do so secretly hidden from the organization's authorities.

- Establishing at a younger age broad social networks, and at older ages the quality and size of these diminish. Their peer group provides affection, support, security, and protection. Also, if they abandon their family, their group becomes their new family and their means to satisfy their basic and emotional needs. Nonetheless, their peer group can induce them to risk behaviors and can turn into a source of violence.
- Developing in dysfunctional environments characterized by physical, sexual, and psychological abuse, emotional and physical abandonment, educational, physical, and psychological neglect, lack of resources necessary to survive, drug use and abuse, and extended and reconstituted families with lousy jobs or underemployment.
- Living in communities immersed in social problems like lack of access to basic services (e.g., water, paving, electricity, sewage, garbage collection, and public transportation, among others), substance use and abuse, theft and, although less frequently ( $n < 25\text{--}30\%$ ), drug trafficking, prostitution, gangs, kidnapping, and homicides. They live in overcrowded settlements, unsuitable for housing, and usually established on the outskirts of the city; and
- Entering a non-governmental or governmental organization due to domestic violence, lack of resources to satisfy their basic needs, and to obtain better life conditions. Over time, their institutional fellows become their new family. However, with age they become more reluctant to accept rules and regulations, and to follow orders. Likewise, among their same companions, there are several problems of coexistence, acceptance, and theft. It is worth mentioning that they could have been previously staying in another institution, but because of age or behavioral problems they were channeled to the actual organization.

Girls at risk of homelessness are a social subgroup that has the following features:

- Having been born and living in Mexico City ( $n > 80\%$ ).
- Having an average age of ( $M[SD]=10.16[2.964]$ ) years with an age range of 6–23 years; however, there could be younger girls (in this study there were approximately 20 little girls between ages 3 and 5 years), and a grade level of middle school. It is important to highlight that because they stay in an organization they are able to obtain a college degree. Their academic achievement and performance can be low, and they have problems with reading and writing.
- Not having a job as a result of remaining in an institution since their education and biopsychosocial well-being is prioritized.
- Not using drugs. Nonetheless, as they grow older they can begin to drink alcohol and/or smoke. They have access to such substances within their peer group and family, and at school. It is worth noting that their families usually have addiction and alcohol problems.
- Having diverse skin, respiratory, and gastrointestinal diseases, oral and visual health problems, malnutrition, and mental disorders such as anxiety, depression, posttraumatic stress, and attention deficit disorder with or without hyperactivity. They did not exhibit any sexually transmitted diseases. They lack hygiene and self-care behaviors, and information concerning how to take care of their health and body. They have suicidal thoughts,

make suicide attempts, and have self-mutilation behaviors. The most common drugs that are prescribed for their various mental disorders are sertraline, valproate, carbamazepine, fluoxetine, and risperidone.

- Most of them have not initiated sexual activity and have been victims of sexual abuse within their families. They have little information about contraception, their anatomy and physiology, and sexually transmitted diseases. They have not been pregnant and have not had any children.
- Engaging in risk behaviors such as drinking alcohol or smoking, ideation and suicide attempts, and self-mutilation behaviors.
- Having unstable, informal, and not lasting heterosexual couple relationships. They frequently exchange partners, and their relationship is seen more as a friendship. As they grow older, their couple relationships become more formal and durable. Their partners satisfy their affective needs, including support and security, and in their relationships they have not suffered intimate partner violence.
- Establishing at a younger age broad social networks of both genders, and at older ages the quality and size of these diminish since they have few friendships of their same gender. They usually associate with peers who rarely engage in risk behaviors and provide affection, support, security, and protection. However, their peer group can be a perpetrator of violence, especially at school.
- Coming from single-parent families, mainly single mothers who have elementary or middle school and get remarried. They typically live with the mother's family, which is why it is an extended family. Their family is also characterized by having a low socioeconomic status since they do not have the means necessary to survive, and low-paying jobs or underemployments, where there is physical, sexual, and psychological abuse, abandonment, and negligence because the mother works long hours and does not have time to take care of her children, and where there could be substance abuse, among others.
- Living in overcrowded communities without infrastructure and resources; occasionally, without access to basic services and with social problems such as substance use and abuse, alcoholism, and theft; and
- Entering a non-governmental or governmental organization due to domestic violence and lack of economic wealth. Over time, their institutional fellows become their new family. However, with age they become more reluctant to accept rules and regulations, and to follow orders. They choose to stay so they can complete their schooling, get job training and the chance of a better quality of life. It is worth mentioning that only because they remain in an organization they do not have to work for their own support and that of their families, they continue to study and do not engage in risk behaviors like substance abuse, sexual activity, and delinquent behavior.

Finally, Mexican sheltered, unsheltered or emergency sheltered girls are a social subgroup characterized by:

- Coming from either Mexico City ( $n < 40\%$ ) or from different states of the Mexican Republic ( $n > 50\%$ ).
- Lacking a stable housing, and having wandered through unsuitable housing spaces such as the street.
- Having an average age of ( $M[SD]=15.62[2.137]$ ) years with an age range of 11–21 years, and a grade level of middle school. Many of them are illiterate, have severe problems with reading and writing, and their academic achievement and performance are low. In their family they do not receive any kind of support for their studies, and they are not self-sufficient because if they work it is for their own survival, hence they do not obtain the means necessary to continue studying. Also, they frequently do not have the papers required to enroll in the educational system such as birth certificates. Furthermore, only if they remain in an organization they are able to continue their schooling. Nonetheless, since it is a very transitory group that constantly moves from one place to another and from one institution to another, they often fail to complete their formal education.
- Participating in the formal economy system by having jobs with low salaries such as assistant cook and saleswoman, and in the informal economy system doing jobs like street vendor, housemaid, and begging. They can carry out criminal acts such as stealing, selling drugs, and prostitution, thus, exposing themselves to risks that diminish their bio-psychosocial well-being. While remaining in an organization, they do not work because they are provided with vocational training in skills such as tailoring, gastronomy, hotel industry, and stylist, among others, in order to contribute to their life project.
- Consuming drugs, alcohol, and tobacco. The most frequently used drugs are inhalants, for their low cost and easy access, and marijuana. Substances are obtained within their peer group and/or the street. In fact, one of the reasons for abandoning an organization is to use drugs since it is forbidden due to institutional regulations. Nevertheless, they can introduce these substances in the organization.
- Having a deplorable physical and mental health status because they usually present oral and visual health problems; diverse skin, respiratory, and gastrointestinal diseases; malnutrition; anxiety; depression; personality disorders; and, less frequently, psychosis; and sexually transmitted diseases, the most common being human papilloma virus, gonorrhea, vaginosis, genital herpes, and, occasionally, AIDS. The drugs that are typically prescribed for their treatment of mental disorders are sertraline, carbamazepine, clonazepam, valproic acid, haloperidol, and risperidone. Their hygiene habits and self-care behaviors are deficient, and they have little knowledge regarding how to take care of their body and health. They have suicidal thoughts, make suicide attempts, and have self-mutilation behaviors. If they are not in an organization, they rarely attend health centers to receive medical and psychological assistance, and they do not have sufficient resources to afford such care, such as the required papers (*e.g.*, birth certificate, immunization record, address, social insurance). Moreover, they suffer discrimination for their status and are denied these services, which is why only when they remain in an organization they have access to health care centers and receive proper care. In the absence of treatment, their health status deteriorates, thus shortening their life.

- Having an active sexual life that could have originated as a consequence of having suffered sexual abuse within the family. They usually have multiple sexual partners both formal and informal, have unprotected sex, and have sexual relationships under the influence of alcohol and/or drugs. Their relationships can be heterosexual, homosexual, or bisexual. As a result of their sexual behavior, they frequently get pregnant and abort. If they have children, they are abandoned or given for adoption. If they decide to keep them, their child-rearing practices are ambivalent being both violent and loving and caring. They can have children with several different partners, who stay for a while with them and then end the relationship or abandon them. They practically have very less information on contraception, sexually transmitted infections, how to take care of themselves, and their anatomy and physiology. Since they lack a stable housing, a well-paid job, and money, they commonly do not receive proper care when pregnant, when having an abortion or a sexually transmitted disease, thus leading to premature death.
- Engage in risk behaviors such as drug use and abuse, self-mutilation, suicide ideation and attempts, and delinquent activities (*e.g.*, theft, drug selling, and prostitution). One of the reasons they abandon the organization in which they remain is to continue these risk behaviors.
- Having several heterosexual couple relationships, and, to a lesser extent, homosexual and/or bisexual. Their couples provide security, support, affection, and protection, but they can also become a source of violence, substance abuse, delinquent activity, and they can influence them to abandon the organization where they reside. Furthermore, they can become dependent on their partner, finding it extremely difficult to end the relationship even if it is unhealthy and quite harmful.
- Establishing stable and long-standing friendships of both genders with their peer group. Their closer social networks typically comprise three to five persons of their age or one or two years older. Their peer group provides affection, support, security, and protection. In fact, it becomes their new family that they can abandon the organization just to follow their friends, and their means to satisfy their basic and emotional needs. Nonetheless, their peer group can induce them to risk behaviors and can turn into a source of violence.
- Developing in dysfunctional environments characterized by risk behaviors, physical, sexual, and psychological abuse, emotional and physical abandonment, educational, physical, and psychological neglect, lack of resources necessary to survive, drug use and abuse, extended and reconstituted families with lousy jobs or underemployment, where they are forced to work, to collaborate with domestic chores, and to take care of their siblings, and where they lack educational, recreational, and employment opportunities.
- Living in communities immersed in social problems such as poverty, overcrowded settlements, drug abuse, delinquency, insecurity, violence, gang activity, and lack of access to basic services (*e.g.*, water, paving, electricity, sewage, garbage collection, public transportation, etc.), among others.
- Entering a non-governmental or governmental organization due to domestic violence and/or abandonment to satisfy their basic needs, and to obtain better life conditions. Their

permanence in an institution is temporal and brief of no more than about four years. Still, they form close ties with their companions in the organization that often endure over the years. They have problems with the institution's staff because they do not agree with the employees' attitudes and behaviors (e.g., "There is preferential treatment", "Some are granted internet access and they do not have consequences if they do not do their chores while others, like me, are overloaded with housework and scolded for everything", "They do not let me explain myself, and they do not believe me", "I get yelled for everything"), with the institutional regulations, norms and rules, and, lastly, not all of the organization's activities please them and they are bothered that they are mandatory. Moreover, among their companions, there are several problems of coexistence, and physical and psychological violence. Under these circumstances, it is usual for the girl to abandon the organization for a transitory lifestyle without the possibility to have an independent and autonomous life which leads to social adaptation.

To summarize, the main differences among girls at risk of homelessness and those sheltered, unsheltered, or emergency sheltered reside in that the former preserve their family, school and community ties, the majority of them are not sexually active, do not use drugs but with increasing age drink alcohol and smoke, stay for a long period of time in an institution for homeless people, their romantic relationships are unstable and informal, have not been pregnant or had abortions, the institutional staff and their housemates constitute their new family, do not work, continue studying, are victims of sexual abuse, and physical and psychological violence to a lesser degree, and their social networks vary with age so that with an increase in age, their size and quality diminish, and are conformed mainly of the same gender, although they usually relate to boys, however the bonds established with other girls are closer and deeper. The latter have little or no contact whatsoever with their family and community of origin, they form school ties only if they attend school, they work, the majority do not continue studying unless they remain in an institution for homeless people, suffer at a higher rate of sexual, physical, and psychological abuse, use and abuse drugs and, less frequently, alcohol and tobacco, have an active sexual life, have been pregnant and had abortions, their romantic relationships are enduring and more formal, they can get involved in homosexual and/or bisexual relationships, engage in risk behaviors including delinquent activities, their peer group forms their new family, stay for a brief period of time at shelters, organizations or homeless facilities, and their social networks include risk groups and individuals of both genders.

As it can be noted, homeless girls grow up in dysfunctional family environments, among communities immersed in social problems without effective governmental and societal solutions, in educational systems contrary to their needs and interests, and in precarious economic areas [9], with null or few opportunities of obtaining a better quality of life. Also, they suffer from sexual and labor exploitation, physical, sexual, and psychological abuse, and discrimination at a higher rate than the rest of the population [10], and they represent the fastest growing population [11], because currently, no country is without the presence of homeless women [12]. As a result of living under such extreme vulnerable conditions, they have low self-concept and self-esteem, they lack self-efficacy and coping skills. They present anxiety and depression more frequently than men [13, 14]; they are impulsive, aggressive,

emotionally unstable, and attempt suicide three to four times more than men [15]. They have difficulties to establish and maintain healthy relationships and to be socially competent, and they exhibit emotional problems [16]. This deficiency can extend to adulthood [17]. However, they rarely receive proper care since the majority does not have access to health care centers or are even denied attention [18]. Subsequently, they have poor psychological adjustment [19], which affects their ability to functionally adapt and cope with environmental stressors [20], thus diminishing their well-being and quality of life [21]. Consequently, homeless girls grow up in environments that favor the occurrence of physical and socio-emotional damages and that make it difficult to live with an acceptable minimum of well-being and security, including the dissatisfaction of their essential needs, which entails a series of repercussions that negatively affect their well-being, specifically their health. Therefore, the phenomenon increases leading to an exponential growth of social problems like delinquency, substance use and abuse, unwanted pregnancies, homeless families, violence, insecurity, poverty, low educational level and unemployment, and diseases including sexually transmitted infections, among others. All of these, in turn, augment the socioeconomic, educational, labor, and cultural backwardness of a country, which results in indirect and direct costs to society in terms of resources and efforts [22]. Although it is an overwhelming reality, previous studies with similar groups have focused mainly on socioeconomic and cultural matters, as well as risk behaviors, dismissing the relevance of psychological aspects and mental health [23]. So, particularly in Mexico, information about the psychological functioning and its associated factors in homeless girls are partially and superficially known. These data are crucial to help reduce their vulnerability, and to provide them with skills that induce changes in the short, medium and long term [24], because a person's ability to be productive, proactive, and prosocial is a function of his or her health.

### **1.1. Well-being and its associated factors**

Mental health is not just the absence of mental disorders. It is defined as a state of well-being by which the individual is aware of his or her own abilities, can cope with the normal stressors of life, work productively and fruitfully, and is able to make a contribution to his or her community. It includes subjective well-being, autonomy, competence, intergenerational dependence, and recognition of the ability to perform intellectually and emotionally [25]. For that reason, mental health is the foundation of individual well-being and effective functioning of the community. Thus, it constitutes the degree of psychological adjustment determined by, among other elements, the level of perceived subjective well-being. A higher subjective well-being leads to a better mental adjustment and a greater satisfaction with current living conditions [26].

Subjective well-being is the degree in which an individual generally judges the quality of his or her life as favorable and feels satisfied with it [27]. It has a cognitive and an emotional dimension. The cognitive dimension alludes to the judgment that is made about the satisfaction that one has with life. On the other hand, the emotional aspect refers to experiencing positive and negative emotions. A high level of well-being entails favorably assessing personal satisfaction and having positive feelings more frequently than negative emotions [28].

Consequently, a positive perception of subjective well-being associates with a series of benefits in various areas that go from mental health and longevity to labor performance and satisfaction, income, and the establishment and maintenance of healthy interpersonal relationships [29]. Likewise, having a high level of subjective well-being not only benefits people, but also society in general. Those who feel satisfied with their lives are more altruistic, engage in prosocial activities, participate in charity events and for community development, and are more tolerant of the government. As a result, promotion and preservation of the subjective well-being of human beings can contribute to the formation of a more stable, productive, and functional society [27]. In contrast, individuals dissatisfied with their current living conditions may present aggressive behavior, anxiety, depression, suicidal thoughts and ideation, sexual risk behavior, substance use and abuse including alcohol, eating disorders, and health problems. Furthermore, they tend to be more physically and psychologically victimized, have difficulty adapting to their surroundings, and have low academic performance and achievement. Due to this, their mental health status deteriorates [30]. So, subjective well-being is a factor affected by various components: sociodemographic issues [31] like socioeconomic status, schooling, unemployment, civil status, and psychosocial characteristics [32] such as anxiety, depression, and social and emotion regulation skills, among others. Learning and acquiring social skills such as assertiveness and an adequate regulation of emotions positively affect the psychological well-being of an individual; while the presence of mental disorders such as depression and anxiety affect it negatively. That is, as previous research has referred [33], anxiety and depression decrease the index of subjective well-being, while assertiveness and functional emotion regulation strategies increase it. For this reason, the Top-down Theory of Subjective Well-being [34] was used as the theoretical framework to guide this research since it explains well-being from a series of intrapersonal factors such as various psychosocial characteristics like the ones mentioned above. This theory states that personality, temperament, social comparison, goal-orientation, and social adaptation affect subjective well-being. That is, intrapersonal factors that include cognitive and emotional characteristics determine to a greater extent the degree of subjective well-being. Internalizing (*e.g.*, anxiety, depression, etc.) and externalizing (*e.g.*, aggression, impulsiveness, deficit attention, etc.) disorders, and psychosocial characteristics (*e.g.*, self-concept, self-esteem, self-efficacy, emotion regulation, assertiveness, coping skills, problem-solving abilities, etc.) form part of these cognitive and emotional aspects linked together as the intrapersonal factors associated to such well-being.

Anxiety and depression are among the most prevalent disorders worldwide [35]. These disorders occur two times more often in women than in men [36]. They are the first cause of disability in the female population [37], and they usually present together; this comorbidity is more frequent in girls [38], which leads to a greater bio-psychosocial deterioration [39]. Likewise, they inhibit and interfere with the acquisition of assertive behaviors since the ability to be assertive is not inherited and it is not something innate or immovable; it is learned through practice [40]. Consequently, it depends on personal, social, cultural, and emotional characteristics. For this reason, cognitive, emotional, and behavioral aspects of anxiety and depression associate with negative thoughts and disruptive actions concerning social aptitudes, thus increasing aggressive or passive behavior, and the inability to adequately defend one's right and to express personal thoughts and feelings appropriately; which is why life

satisfaction decreases [41]. As such, the lack of assertiveness makes the person feel socially incompetent and unable to adapt to a particular group and cope with stressful circumstances. Similarly, anxiety and depression are associated with low levels of emotion regulation [42], specifically with the use of dysfunctional emotion regulation strategies. These strategies, in turn, augment the possibility of exhibiting anxiety and depression [43]. Emotional regulation includes any strategy aimed at maintaining, increasing, or suppressing an ongoing affective state. As such, it refers to active attempts to influence anxiety and depression and constructively express emotions at the right time and place so that the person's resources are protected without self-confidence diminishing [44], which is why emotion dysregulation increases anxiety and depression.

Unassertiveness, emotion regulation deficiencies, anxiety, and depression, are factors that involve various negative consequences if not treated early and effectively, which is concerning, since these, as mentioned, can persist into adulthood. Some of them are [45]:

- a. low self-concept and self-esteem, and decreased perceived self-efficacy,
- b. lack of problem-solving and coping skills,
- c. social incompetence and absence of significant affiliative relationships,
- d. risk behaviors and affiliation to high risk groups,
- e. behavioral, anxiety and emotional disorders,
- f. isolation, withdrawal, rejection and social exclusion, antisocial behavior, physical and psychological victimization; and
- g. low academic performance and school achievement, school dropout and unemployment.

The deterioration of the quality of life and interpersonal functioning, along with the need for assistance and health care, represents a burden to the individual and to society because of the costs generated directly and indirectly [46]. These consequences are devastating for people and their communities, since it leads to further worsening of their subjective well-being and thus, of their physical and mental health. This results eventually in an early death.

To sum up, subjective well-being is important for health preservation and maintenance, and for having a better quality of life. Its absence negatively affects the mental health of individuals, leading to mental disorders [47] and the loss of physical and psychological integrity. Nonetheless, information surrounding issues of subjective well-being among this particularly diverse population is scarce [48], and little is known about the health and well-being of people who live on the streets although their lifestyle involves health risks [49]. Likewise, worldwide there are few studies addressing these specific factors in vulnerable people such as homeless girls. In fact as far as it has been reviewed, in Mexico, information concerning the well-being and its associated factors in homeless girls is only partially and superficially known. What is more, homeless girls have been scarcely considered as an object of study—a common circumstance in societies with a predominantly male orientation that discriminate

and exclude women [50]. Consequently, the phenomenon grows day by day surpassing societal response. Therefore, to remedy the lack of work and to encourage the design and implementation of effective policy actions based on the data collected, this research was carried out to develop and test a path model of subjective well-being in homeless girls taking into account the following intrapersonal factors: anxiety, depression, assertiveness, and emotion regulation. This would provide information essential to enhance the well-being of this collective and promote their physical and mental health, thus, contributing to diminish their vulnerable conditions.

Lastly, it should be noted that worldwide research on subjective well-being in homeless people has not taken into account anxiety, depression, emotion regulation, and assertiveness as its predictors. The extant research has focused on the effect of other variables such as: social support and expectations about the future in homeless young adults ages 18-23 years old in Texas, the United States [48]; the repercussions of weather in homeless people in Australia [51]; stigmatization, sexual involvement, and school enrollment in homeless children and orphans in Nigeria [52]; the cognitive development of homeless children and orphans in Cambodia, Ethiopia, India, Kenya, and Tanzania [53]; and sexual abuse, loneliness, and connectedness in homeless youth ages 16-23 years old in Texas, the United States [54]. Only a study carried out in Scotland in the year 2002 [55] has examined well-being specifically in the female homeless population of 18 years and older, although from a qualitative perspective. However, the research focused on how these women built their social identity, self-concept, and psychological well-being in relation to their experience of living in homeless facilities. This once again highlights the existence of little information about subjective well-being and its associated factors. In addition, the present work is one of the first studies to assess some psychosocial characteristics (anxiety, depression, emotion regulation, and assertiveness) as predictors of such well-being in homeless girls.

## 2. Research data

### 2.1. Method

#### 2.1.1. Participants

A total of 240 homeless girls between the ages of 6–23 years ( $M[SD]=11.13[3.47]$ ) were chosen with an intentional sampling method from various non-governmental organizations of Mexico City. Of these, 77% were born and lived in Mexico City, while 20% came from other states of the Mexican Republic. As many as 85% did not use or abuse any kind of substance, including alcohol and tobacco, 70% were in elementary school and 23% in middle school, 84% professed the catholic religion, 44% lived with their mothers during holidays, 16% remained in the organization all the time, and 65% entered an institution due to lack of resources, while 28% because of family abuse. Likewise, the girls had stayed in an institution for an average period of 42 months ( $M[SD]=42.30[37.346]$ ). Lastly, at least 50% had suffered some form of abuse either within their families, group of peers, or home community (**Figure 1**).

Percentage of Types of Abuse in Mexican Homeless Girls

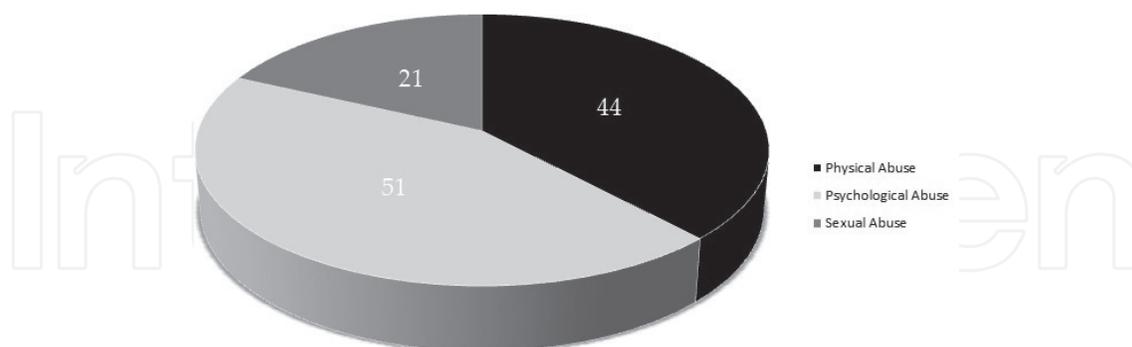


Figure 1. Percentage of the 240 homeless girls who have been victims of physical, psychological, or sexual abuse.

For being included in the current research, participants were required to reside in a non-governmental organization (*e.g.*, institutions, shelters, centers) which exclusively attends homeless children and youth. They were excluded in case they would not collaborate in the study and/or abandon their institution. Finally, it is important to mention that participation was voluntary with the acceptance of the legal guardians of the girls, when they were available, and/or the organization.

### 2.1.2. Measurement

Since commercial and standardized instruments are seldom valid for these vulnerable populations [56], all scales had to be developed during this study following the culturally relevant psychometric validation process proposed by [57] and, specifically for Mexican culture, by [58]. Items of each instrument are rated on a 6-point Likert scale from One (Never) to Six (Always) that also include equivalent percentage intervals (One: 0% of the time—Six: More than 80% of the time).

The self-report questionnaires measure anxiety symptoms, depression symptoms, assertiveness, emotion regulation, and subjective well-being:

- *Anxiety*: Self-report questionnaire that assesses anxiety symptoms with eight items grouped in two factors that together explain 56% of variance and both have a 0.59 Cronbach's Alpha.
- *Depression*: Self-report questionnaire that assesses depression symptoms with eight items grouped in two factors that together explain 50% of variance and both have a 0.75 Cronbach's Alpha.
- *Assertiveness*: Self-report questionnaire that assesses assertive behaviors with nine items grouped in two factors that together explain 52% of variance and both have a 0.64 Cronbach's Alpha.
- *Emotion regulation*: Self-report questionnaire that assesses emotion regulation strategies with seven items grouped in two factors that both explain 50% of variance and both have

a 0.60 Cronbach's Alpha. It also has an extra question to explore the type of strategies individuals use to manage and control their emotions when they experience anxiety and/or depression symptoms.

- *Subjective well-being*: Self-report questionnaire that assesses subjective well-being with 32 items grouped in five factors that altogether explain 61% of variance and have a Cronbach's Alpha ranging between 0.85 and 0.90. Furthermore, it evaluates the intensity and frequency of 10 emotions (five positive and five negative) using a 10-point scale from 0 (Never/None) to 10 (Very Often/A lot).

It is important to mention that these scales developed for the current study have not yet been used in other research with homeless people due to the fact that in Mexico it is a line of research in development with a long way for consolidation. Also, it is a group seldom taken into account for study.

### 2.1.3. Procedure

Taking into account that this social group is constantly moving from place to place and is difficult to approach [59], non-governmental organizations that assist homeless children and youth were approached in order to acquire information more rapidly and have easier access to this population. Work with this collective was possible thanks to the permissions granted by the institutions. Also, voluntary participation of the girls from the organizations to collaborate in the research was requested. The general objectives of the study were explained and it was emphasized that all data obtained would be kept confidential and used for study purposes only. Likewise, the doubts the girls had were clarified while paying attention not to bias their responses. There was no time limit for the applications, which were held in classrooms previously assigned by the organization's staff. Subsequently, the girls were thanked for their collaboration but as a means to guarantee their volunteer role, they did not receive any material reward for their participation. The questionnaires were applied individually in the form of interviews with an average time of 15–30 min approximately. The realization of this research required only the organization's approval and no individual informed consent, having previously noted that all the ethical procedures and guidelines specified in the Psychologist Code of Ethics [60] would be followed throughout the whole study. As participation was voluntary, the girls provided their written consent signing with their fingerprint. Their refusal to answer a question or all of them was respected at all times. Lastly, statistical analyses were conducted using SPSS version 22. These included descriptive and correlation analyses employing Pearson correlation. To test the path model, AMOS version 22 was also used.

## 2.2. Findings and conclusions

Among the main problems of homeless girls are anxiety and depression, since 82% presented anxiety symptoms and 47% depressive symptoms. Other features were the lack of assertiveness with 22% being unassertive, experiencing negative emotions more than 80% of the time and with great intensity (*i.e.*, on a scale from One [never] to Ten [always], great intensity corresponds to at least eight), and employing dysfunctional emotion regulation strategies to

manage and control emotions with 67% using strategies like self-mutilating behaviors, displaying hostile and aggressive behaviors toward others (*e.g.*, revenge, retaliation, etc.), using and abusing alcohol and drugs, being impulsive, and isolating themselves socially.

Moreover, it was found (**Table 1**) that anxiety and depression symptoms are positively associated, so that when one of them increases, so does the other and vice versa. Depression symptoms decrease the possibility of behaving assertively and of being satisfied with current living conditions. Additionally, they inhibit the use of functional emotion regulation strategies and augment those that are dysfunctional, which in turn exacerbates anxiety and depression symptoms. Meanwhile, assertive behaviors decrease anxiety and depression symptoms, increase the level of subjective well-being and the probability of using functional emotion regulation strategies that enhance perceived life satisfaction and social skills, and lessen anxiety and depression indexes.

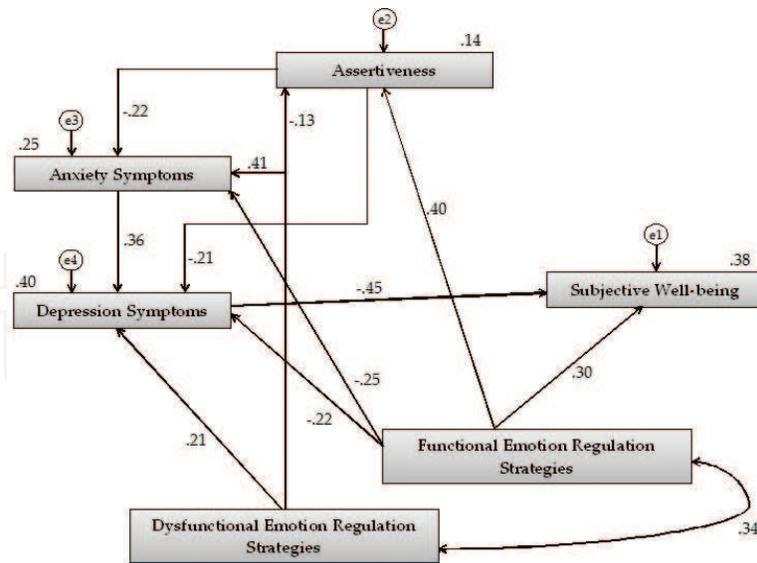
Also, according to the path model analysis carried out (**Figure 2**), the main predictors of subjective well-being for this group of homeless girls are depression symptoms and functional emotion regulation strategies, since they directly and significantly affect the level of satisfaction. As such, depression symptoms decrease the level of subjective well-being while functional emotion regulation strategies increase it. Meanwhile, anxiety symptoms and dysfunctional emotion regulation strategies, through their influence on depressive symptoms, negatively affect well-being, thus reducing it. Assertiveness, by diminishing depressive symptoms, augments the index of well-being. Moreover, functional emotion regulation strategies inhibit depression symptoms, hence increasing the level of subjective well-being. Also, assertiveness decreases anxiety and depression symptoms, thus leading to a greater perceived life satisfaction. Furthermore, functional emotion regulation strategies lessen anxiety and depression indexes and enhance the level of assertiveness. In contrast, dysfunctional emotion regulation

	Dysfunctional ER strategies	Anxiety symptoms	Depression symptoms	Assertiveness	Subjective well-being
Functional ER strategies	.344**	-.192**	-.294**	.357**	.438**
Dysfunctional ER strategies	-	.317**	.252**	.006	-.020
Anxiety symptoms	-	-	.541**	-.311**	-.269**
Depression symptoms	-	-	-	-.401**	-.544**
Assertiveness	-	-	-	-	.307**
Subjective well-being	-	-	-	-	-

Note. ER, emotion regulation.

\*\* $p \leq .05$ .

**Table 1.** Correlation analysis of variables associated with subjective well-being in Mexican homeless girls ( $N=240$ ).



**Figure 2.** Final version of the Path Model Analysis of Subjective Well-Being in homeless girls. Standardized regression weights are shown. All regression weights were significant ( $p \leq .05$ ) including the correlation between emotion regulation strategies.

strategies augment anxiety and depression symptoms and reduce social skills. As expected, both emotion regulation strategies are significantly correlated to each other.

To summarize, depression symptoms are a significant predictor of subjective well-being, and through these, anxiety symptoms, assertiveness and emotion regulation strategies affect either positively or negatively the index of well-being. Therefore, depression symptoms constitute a mediating variable of the effects that other variables have upon subjective well-being. Additionally, according to results obtained in this study, emotion regulation strategies are the most relevant factors of the model because not only do they affect all the other variables including depression, but also subjective well-being by either increasing it or reducing it.

Finally, fit indexes obtained,  $\chi^2(3)=1.116$ ,  $p=.773$ ; NFI=.997, RFI=.985, IFI=1.005, TLI=1.026, CFI=1.000,  $p=.000$ ; RMSEA(90% IC)=.000(.000-.073),  $p=.889$ , reveal that the model reliably predicts subjective well-being in a group of homeless girls regarding various psychosocial characteristics such as assertiveness, emotion regulation strategies, anxiety and depression symptoms. Thus, this path model provides an excellent fit to the data collected and the studies reviewed. Consequently, the model can be used in further research to explain subjective well-being in similar population.

As it can be seen, findings revealed that one of the key problems afflicting homeless girls is the presence of anxiety and depression symptoms. This coincides with previous studies in other countries [49, 61, 62] that show that such groups suffer from these because of growing up among vulnerable conditions that constitute one of the predominant reasons for abandoning their homes and entering an organization. Also, it was observed that they tend to be unassertive because they exhibit greater difficulty in defending their rights and interests; they cannot express their ideas and feelings without being aggressive, and are hostile and unable to establish healthy relationships. With respect to emotion regulation skills, the strategies they use to manage and control their emotions are mainly dysfunctional since they exacerbate the

unpleasant emotional experience, do not solve the problem, and do not cope effectively with stressful or adverse circumstances.

Furthermore, results indicated that higher rates of anxiety correlate with higher levels of depression and vice versa. This concurs with previous research done in other countries, which states that anxiety and depression are comorbid disorders [63], for they share common cognitive, emotional, behavioral, and physiological symptoms. Additionally, anxiety and depression symptoms are associated with lower levels of assertiveness and emotion regulation. These disorders inhibit and interfere with the acquisition of assertive behaviors leading to poor functioning and social adjustment [64], since they make the person feel socially incompetent and incapable of adapting to a specific group. Assertiveness, on the other hand, allows people to effectively cope with stressors by increasing the ability to cope with stress. This diminishes emotional and behavioral problems [65]. A lack of adequate emotion regulation skills can lead to depression [66]; while appropriate strategies reduce anxiety and depression indexes [67] and augment assertive behaviors. As for the level of subjective well-being, it decreases when presenting anxiety and depression symptoms [68], and increases with the use of effective emotion regulation strategies [69] and with the acquisition of assertive skills. This is because individuals with adequate social skills assess their daily experiences as less stressful and functionally adapt to society unlike those who lack such abilities [70].

Lastly, concerning the path model tested, it was found that depression symptoms and functional emotion regulation strategies are direct predictors for subjective well-being, while the rest of the factors, anxiety symptoms, assertiveness and dysfunctional emotion regulation strategies, act as indirect predictors. This is consistent with the Top-down Theory of Subjective Well-being [34] that states that cognitive and emotional characteristics of individuals determine well-being, where depression [71] is a primordial cognitive aspect.

Anxiety and depression reduce the index of well-being. This agrees with recent research that states that such symptoms are significantly associated with a low level of subjective well-being. Anxiety symptoms decrease well-being through their effect on depression by augmenting it, which in turn increases its effects. These results are consistent with evidence that demonstrates that anxiety precedes depression [72], which can be explained by the fact that anxiety can substantially increase stress and interfere with daily functioning, that in turn leads to depression [73]. On the other hand, appropriate management and control of emotions is positively correlated with life satisfaction [74] because it modifies unpleasant emotions and its associated negative thoughts that lead to disruptive behaviors. Hence, functional emotion regulation strategies enhance the index of subjective well-being, which enables the individual to move from a dysfunctional cycle to a more functional one in which he or she feels satisfied with him- or herself and with his or her surroundings. Additionally, when emotion management and control is functional, it reduces anxiety and depression symptoms. In contrast, when emotion regulation is dysfunctional, it increases such symptoms. These outcomes are consistent with previous work that shows that functional emotion regulation strategies positively correlate with resilience and negatively with depression and anxiety. These disorders have a high and positive correlation with dysfunctional strategies [75]. When negative emotions related to anxiety and depression are handled effectively, it is easier to modify and control associated dysfunctional cognitions and attitudes. Therefore,

the person is able to effectively cope with anxiety- and depression-inducing events. For that reason, functional emotion regulation strategies constitute a protective factor against presenting anxiety and depression [76]. As a result, it is expected that such emotion regulation strategies increase subjective well-being directly and indirectly by diminishing depression symptoms, as shown in this study. To finish, functional and dysfunctional emotion regulation strategies affect the index of assertiveness. Dysfunctional emotion regulation strategies are associated to a greater social incompetence and maladjustment [77], and thus, to a lack of assertiveness. On the contrary, functional emotion regulation strategies augment the probability of being assertive since it is a prerequisite for the effective use of social skills [78]. This enhances the level of subjective well-being by diminishing anxiety and depression symptoms in a way that it indirectly affects the satisfaction of life. In other words, assertiveness is a protective factor against the development of disorders like anxiety and depression because it allows a person to cope with stressors effectively. Consequently, self-trust and logical expression of emotions and ideas increase, anxiety lessens, social relationships improve, respect for others' rights is fostered, and the ability to cope with stress gradually augments [79]. However, the fact that assertiveness did not directly predict subjective well-being may be because subjective well-being is more associated to the quality and quantity of affiliative relationships of an individual [80] than with assertive behaviors. That is, social support is significantly correlated with perceived subjective well-being [81]. For example, in Japan [82] it was found that lack of perceived emotional and instrumental social support is associated with mental well-being.

To recapitulate, these results provide preliminary evidence of factors that significantly predict subjective well-being in Mexican homeless girls by increasing or decreasing it. To the best of my knowledge this is one of the first models of subjective well-being with various psychosocial characteristics as its predictors in this collective. Therefore, the clinical usefulness of the present study resides in designing and implementing interventions that take into account such factors in a way that the possibility of reaching developmental and emotional milestones increases, and homeless girls learn healthy social and emotion regulation skills and how to cope with problems when they arise, especially in the context of Latin American cities. This would lead to a greater well-being during childhood and youth [83], which will positively influence their quality of life [84].

In conclusion, subjective well-being is an essential factor for health and longevity [29]. Vulnerable populations as homeless girls lack subjective well-being which deteriorates their mental health. The promotion of mental health is achieved through actions that create environments and living conditions that enable individuals to adopt and maintain healthy lifestyles. Further research has to replicate the current results in order to obtain more information concerning well-being and its associated factors to have a more comprehensive understanding of the phenomenon and to promote mental health. Also, more studies are required to see how these variables behave in homeless girls from various countries and different cultures. In this way, it is possible to identify needs, characteristics, and dysfunctional and functional behaviors related to well-being that are present or absent in homeless girls. This data leads to a better design of sustainable and efficacious interventions that induce long-term changes and increase the probability that this collective adequately adapts to society with opportunities of obtaining an improved quality of life.

Finally, homelessness is a complex multifactor phenomenon product of economic, political, and social circumstances interrelated. These circumstances aggravate as a result of the lack of government's response and effective lines of actions. Among homeless people, children, particularly girls are the most vulnerable groups. Homeless girls are a severely neglected and marginalized group with an impaired well-being, physical and mental health deficiencies, and restricted opportunities of obtaining a better quality of life. All of this is in spite of the fact that childhood and adolescent development is a crucial factor for the consolidation of intellectual, physical, and social aptitudes that define a healthy adulthood; and that during these periods the foundations of health in adulthood, are established. In order to offer practical solutions from a psychosocial perspective to a phenomenon that leads to the deterioration of a nation and to a lack of individual and social well-being, it is vital to continue carrying out studies in which vulnerable people such as this collective are approached. It is the only way to obtain valid information through which it is possible to design effective lines of action, for early intervention leads to an exponential growth in health status in adult life, which in addition to providing incalculable well-being, is an investment in physical and mental health. On the other hand, it is a means for avoiding future pathologies, minimizing possible sequelae, and reducing risk factors.

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