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A Qualitative Analysis of Homeless Women with Children in Transitional Housing: What Are Their Needs?

Urmi B. Jani

Philadelphia College of Osteopathic Medicine, urmija@pcom.edu

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Philadelphia College of Osteopathic Medicine

Department of Psychology

A QUALITATIVE ANALYSIS OF HOMELESS WOMEN WITH CHILDREN
IN TRANSITIONAL HOUSING: WHAT ARE THEIR NEEDS?

By Urmi Jani, M.A., M.S.

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Psychology

April 2011

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by Urmi Jani on the 18th day of May, 2010 in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Bruce Zahn, Ed.D, ABPP, Chairperson

Petra Kottsieper, Ph.D.

Stewart Barbera, Psy.D.

Robert A. DiTomasso, Ph.D., ABPP, Chair, Department of Psychology

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Abstract

In 2004, the National Law Center on Homelessness and Poverty indicated that approximately 3.5 million people experienced homelessness. The literature indicates that families, specifically female-headed ones, are the fastest growing segment of the homeless population. The development of transitional housing has shown promise by seeking to move these homeless families towards independent living. A qualitative study based in grounded theory was utilized to explore the experiences of 10 female homeless participants at two regional transitional living facilities. Consistent themes that emerged included dissolution of relationships and a lack of personal supports as being the primary pathways that lead to homelessness. Concrete goals of women in transition focused on establishing housing and steady vocation. In an attempt to identify potential constructive programming congruent with the needs of homeless mothers, results overwhelmingly indicated that this population would benefit from problem-solving training, as well as additional networking opportunities. Application of the recovery model to the phenomenon of homelessness is also presented.

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Chapter 1

Introduction

Statement of the problem.

Homelessness is a complex and multifaceted issue. In the early 1990s, this intricate social phenomenon was recognized as being in heightened crisis in the United States. The subsequent years have seen a steep rise in the number of homeless individuals, due in part to economic decline, as well as diminishing support for these individuals in both the public and private sectors (Bassuk, 2004).

It is noteworthy that the homeless are part of a heterogeneous population consisting of diverse races, ages, sexual orientations, and family structures. Historically, men have comprised the most significant portion of homeless persons in the United States. However, recent reports indicate that the number of homeless single women and of single women who are heads of household with children is on the rise (Anooshian, 2005; Averitt, 2003; Culhane, Avery, & Hadley, 1998; Page & Nooe, 2004; Roll, Toro, & Ortola, 1999; Zugazaga, 2004). The escalation is attributed to a number of risk factors, including domestic violence, unemployment, and drug and alcohol abuse. Some lesser researched, though nonetheless significant risk factors that lead to female homelessness include lack of education, and familial conflict. These are identified as the most prevalent pathways to female homelessness found in the literature (Anooshian, 2005; Kahne, 2004; Munoz, Crespo, & Perez-Santos, 2005; Roll, Toro & Ortola, 1999; Rosenheck, Bassuk & Salomon, 2001; Swigart & Kolb, 2004; U.S. Conference of Mayors, 2007; Vostanis, 2002). This notable gender shift has resulted in a fragmented

axis of care for these women, who often lack viable resources or options related to upward mobility (Wenzel, Anderson, Gifford, & Gelberg, 1999).

Transitional living facilities allow for stays between several months and 1 to 2 years and offer a variety of social support services that strive to prepare families to reenter more conventional living situations (Toro, Passero-Rabideau, Bellavia, Daeschler, & Wall, 1997). As mental health practitioners, perhaps our best effort towards preventing the increasing incidence of chronic homelessness among single women with children lies within these transitional facilities. Specifically, it is hypothesized that psychological services and ancillary support can greatly benefit homeless mothers and their children because their stay in transitional housing allows them to undergo the changes necessary to become both fiscally and emotionally stable, thereby helping to prevent the reoccurrence of homelessness.

Research by Acosta and Toro (2000) indicated that the needs of parents with children who are homeless differ greatly from those of childless homeless adults. They reported that a significant reason for the underutilization of services by homeless mothers and their children was, in part, a discrepancy between the kinds of services that communities generally provide and services that the homeless families actually need. In general, research shows that our society has historically struggled with formulating successful programs or infrastructure to meet the challenges that face such a bleak existence (Acosta & Toro, 2000).

Purpose of the study.

The purpose of the present study was to critically examine the needs of homeless women with children living in two suburban faith-based transitional living facilities. It is

suggested that the results of this study may primarily assist current and future residents of the transitional living facilities by having staff develop and/or enhance programming that will promote personal growth, development, and maintenance of domiciliary stability. Secondly, it may serve to aid the transitional living facilities as well as other similar facilities in determining what types of services and support may be offered to their residents. These findings will add to the current homelessness literature by providing information that may be considered for prevention of the reoccurrence of family homelessness among this population.

Overview of the literature.

The subsequent literature review will describe the journey into homelessness, as well as the struggles faced at that pivotal juncture. General epidemiology will be presented, including historical trends related to ethnicity and gender. Salient health and mental health issues will be explored with regard to how accessible care is for those who are facing this circumstance. Protective factors and coping mechanisms, once a woman becomes homeless, will also be discussed. Finally, transitional living facilities will be reviewed with respect to the kinds of ancillary support services that are offered to their residents.

Viewing homelessness from a cognitive behavioral perspective.

This study is relevant to the field of psychology because it provides homeless mothers an active voice to inform providers what types of services are the most effective in helping them achieve independence. Further, collecting evaluative data directly from persons receiving or lacking services is congruent with empowering this marginalized

population and advocating on their behalf, which is a core component of being an effective mental health clinician.

To increase the multicultural relevance of this study, this researcher made attempts to utilize a diverse sample. The number of single person households among African American women is disproportionately high (Killon, 2000). Many of these socioeconomically disadvantaged women have limited earning power due to deficits in job skills and education. Those with children are further overwhelmed by child care responsibilities if they are employed (Levy & Sidel, 2006; Rosenheck, et. al., 2001). Given these facts, minority women who are heads of households are at greater risk of homelessness. Research indicates that women of a cultural or ethnic minority who are referred to transitional housing will likely have had a different experience of homelessness than their Caucasian counterparts (Killon, 2000). As a result, the unique ethnic and cultural background of each individual must be considered and factored into future planning and training protocols. As practicing clinical psychologists, we must be active in supporting and advocating for these individuals on a personal, professional, and societal level.

Chapter 2

Review of the Literature

Stewart McKinney Act.

Homelessness is a complex and multifaceted issue. The Stewart McKinney Act of 1987 defines a homeless person as anyone who lacks a fixed permanent night-time residence, or whose night-time residence is a temporary shelter, welfare hotel, or any public or private place not designated as sleeping accommodations for human beings (National Alliance to End Homelessness, 2008). Included in the homeless population are people who stay with friends or family for a short period of time and then decide to find shelter on the streets because of conflict with the people whom they are staying with (National Alliance to End Homelessness, 2008).

Statistics.

It is worth noting that there is an inherent difficulty in reporting accurate figures of individuals who are homeless because of its transitional nature. Due to methodological and financial constraints, it appears that research is somewhat limited in its scope, and studies tend to include individuals who only reside in shelters or on the streets (National Alliance to End Homelessness, 2008; National Law Center on Homelessness and Poverty, 2004; Urban Institute, 2000; U.S. Conference of Mayors, 2007). This type of information can generate useful data about social service systems (or lack thereof) in place to meet the needs of the homeless population; however, it neglects to report a significant subgroup of homeless individuals who seek shelter elsewhere. Therefore, the data that is produced from such studies is incomplete at best.

Moreover, there may be individuals who seek out shelters and are turned away due to limited capacity of the sites. A recent study conducted by the U.S. Conference of Mayors found that 12 of the 23 cities surveyed had to turn people in need of shelter away due to a lack of capacity (U.S. Conference of Mayors, 2007). In addition, a study of homelessness in 50 cities found that in virtually every city, the cities' official estimated number of homeless people greatly exceeded the number of emergency shelter and transitional housing spaces (National Law Center on Homelessness and Poverty, 2004).

Additionally, research suggests that certain geographic regions, particularly rural areas, which house a substantial population of the homeless individuals lack sites to assist those in need altogether (Brown, 2002). In fact, the Council for Affordable and Rural Housing estimates that about 9% of the nation's homeless are in rural areas (Council for Affordable and Rural Housing, 2006). As a result of these and other factors, many people in homeless situations reside with relatives or friends. These individuals are experiencing homelessness, but are less likely to be counted in the overall statistics.

Nevertheless, several national estimates of homelessness exist. It would seem that the best approximation comes from a study conducted by the National Law Center on Homelessness and Poverty, which states that approximately 3.5 million people, 1.35 million of them children, are likely to experience homelessness in a given year (National Law Center on Homelessness and Poverty, 2004). These numbers are based on findings from the National Law Center on Homelessness and Poverty, the Urban Institute, and specifically the National Survey of Homeless Assistance Providers. They based their estimates on a study of service providers across the country at two different times of the year in 1996. It was found that, on a random night in October, 444,000 individuals

experienced homelessness. The figures increased when a random night in February was surveyed, resulting in about 842,000 individuals experiencing homelessness. Researchers then converted these estimates into an annual projection, and the results were significant. It was estimated that 2.3 million people (based on the October estimate) and 3.5 million people (based on the February estimate) are homeless or living in poverty in a given year. This translates to approximately 1% of the U.S. population that experience homelessness each year with, 38% (October) to 39% (February) of the homeless being children (National Law Center on Homelessness and Poverty, 2004; Urban Institute, 2000).

It is important to note that these estimates were based on a national survey of service providers. Since not all people experiencing homelessness utilize service providers, the actual statistics on individuals experiencing homelessness are likely higher than those found in these analyses.

In early 2008, the National Alliance to End Homelessness reported a point-in-time estimate of 744,313 people experiencing homelessness in January 2005 (National Alliance to End Homelessness, 2008). These results suggest consistency as far as the overall statistics are concerned.

Finally, a distinction between the chronic and acute nature of homelessness must be distinguished. The National Alliance to End Homelessness identifies the chronic homeless individual as one who has been without shelter for a long period and/or continues to be repeatedly homeless (National Alliance to End Homelessness, 2008). The federal government's definition of a chronically homeless individual is "an unaccompanied homeless individual who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years"

(National Law Center on Homelessness and Poverty, 2004). By federal definition, then, the chronically homeless excludes the following groups of people: parents who are homeless and who have children with them, youth on their own who have not been homeless long enough to fit the federal definition, and unaccompanied individuals who have not been homeless long enough to fit the federal definition. Furthermore, many chronically homeless people have serious mental illness or disability, including schizophrenia and/or alcohol or drug addiction (National Law Center on Homelessness and Poverty, 2004). As such, most people who experience chronic homelessness have been in treatment programs, sometimes on dozens of occasions (National Alliance to End Homelessness, 2008). The most recent available statistics suggest that there were approximately 124,000 chronically homeless people in January 2007. The Alliance, however, believes that this number has declined over time, due in part to an increase in permanent supportive housing (National Alliance to End Homelessness, 2008).

The acutely homeless, on the other hand, may include individuals who have suddenly become homeless due to natural disasters or recent economic declines resulting in home foreclosures. Literature regarding the acutely homeless is actually quite scarce. The lack of data may be largely due to the transient nature of acute homelessness. Nevertheless, it warrants further review.

The face of homelessness.

The homeless individual is part of a vast heterogeneous population consisting of diverse races, ages, sexual orientations, and family structures. In the past, a significant portion of the homeless population consisted of men: however, in recent reports the number of single women, and single women who are heads of household with children, is

on the rise (Anooshian, 2005; Averitt, 2003; Culhane, Avery, & Hadley, 1998; Page & Nooe, 2004; Roll, Toro, & Ortola, 1999; Zugazaga, 2004).

Studies have reported that homeless mothers and their children tend to be more concealed in society than their male counterparts and are often referred to as the “hidden homeless.” This term refers to those individuals who are in fact homeless, but are not living on the street, where their situation is public and visible. Often homeless families can be found living in overcrowded apartments, in garages, or in motels and largely remain uncouned in U.S. homeless data (Anooshian, 2005; Page & Nooe, 2002; Roll, Toro, & Ortola, 1999; Tischler, Rademeyer & Vostanis, 2006; Zugazaga, 2004).

Likewise, they have received little consideration in research, despite the fact that in the United States, homeless families account for approximately 40% of the total homeless population (National Coalition for the Homeless, 2005; Tischler et. al., 2006).

Furthermore, a review of the family homelessness literature reveals that most homeless parents are women in their 20s (Haber & Toro, 2004; Tischler, et. al., 2006). Due to this evolving demographic, it would seem that additional research is essential.

Women of color heads of households.

It is without a doubt that ethnic minorities, namely African Americans, are overrepresented among the homeless in the United States. Rosenheck et al. (2001) compared the proportion of African Americans among the homeless in urban settings to their Caucasian counterparts. Results indicated that poor African Americans were twice as likely to be homeless as poor Caucasians in the same city (Rosenheck, Bassuk, & Salomon, 2001). There are a number of factors that can account for this disparity. Gentrification, or the relocation of affluent families into historically poorer

neighborhoods, has pushed the prior inhabitants onto the streets. This is further augmented by segregation of certain housing developments by race and class (Rosenheck et al., 1996) often resulting in overcrowding and inevitable residential instability.

Studies have also noted the existence of methodical differences between homeless African Americans and homeless Caucasians. Research has found that while mental illness coupled with social isolation and a lack of education contributes to the origins of homelessness among Caucasians, African Americans are additionally affected by the historical legacy of bigotry coupled with prevalent urban issues such as gentrification, which may consequently increase the likelihood of residential instability (Rosenheck et al., 1996). Thus, the racial disparity in homelessness is likely to be increasingly prevalent in urban areas versus rural ones.

It has been established that the number of single person households among African American women is disproportionately high (Killon, 2000). A study by Averitt in 2003 revealed that minority women who were homeless reasoned that their dependence on others, the lack of adequate financial resources, and the stigma associated with being homeless led some to consider suicide. These women perceived stereotyping and discrimination as further limiting their options for housing, jobs, and other services (Averitt, 2003). Given these facets, it appears that single homeless women who are heads of households and are of an ethnic minority bear a greater burden.

Pathways to homelessness.

The transition that a woman undergoes from having a home to becoming homeless is multifaceted. Homelessness research has indicated a number of risk factors that contribute to such an altered lifestyle. Domestic violence, unemployment, and drug

and alcohol abuse are among the most prevalent pathways to homelessness found in the literature. Lack of higher education and familial conflict were also significant pathways to homelessness, though less often documented in the literature (Anooshian, 2005; Kahne, 2004; Munoz, Crespo, & Perez-Santos, 2005; Roll, et. al., 1999; Rosenheck et al., 2001; Swigart & Kolb, 2004; U.S. Conference of Mayors, 2007; Vostanis et al., 2002).

Pathways to homelessness: Domestic violence and trauma history.

Domestic violence research in homelessness has primarily been guided by the premise that violence or aggression contributes to the relationship problems, dissolutions, and eventual social isolation that is experienced by women and children (Anooshian, 2005). When a woman leaves an abusive relationship, she often has nowhere to go. This is particularly true of women with few financial resources or support networks. Research indicates that more than 50% of all homeless women and children become homeless as a direct result of escaping from domestic violence (Donohue, 2004). Lack of affordable housing and long waiting lists for assisted housing mean that many women and their children are forced to choose between living with the abuse at home or becoming homeless. Moreover, shelters are frequently filled to capacity and must turn away battered women and their children. Additionally, shelters that are available may not cater specifically to the unique needs of families, and ultimately, the risk of sheltering in a non-family-friendly shelter is often too great. An estimated 29% of requests for shelter by homeless families were denied in 2006 due to lack of resources (U.S. Conference of Mayors, 2006).

Studies report that the contribution of domestic violence to homelessness, specifically among families with children, is significant (Anooshian, 2005; Stainbrook &

Hornik, 2006). In fact, 39% of cities surveyed in a multi site study cited domestic violence as the primary cause of family homelessness (U.S. Conference of Mayors, 2007). An alternate study revealed that victims of domestic and community violence are overrepresented among the homeless population (Vostanis et al., 2002). The prevalence of lifetime exposure to physical and sexual abuse is much greater among homeless individuals than in the general population (Holt, Montesinos, & Christensen, 2007). Moreover, traumatic abuse history is observed at consistently higher rates for homeless women than men (Holt, et al., 2007). Furthermore, once a woman becomes homeless, she may still be highly vulnerable to experiencing violence and exploitation on the streets or in shelters (Page & Nooe, 2002), which can further compound her problems.

Pathways to homelessness: Unemployment or minimum wage employment.

Unemployment or minimal wage employment is another significant factor that contributes to maintaining the complex societal concern of homelessness. A recent study by the U.S. Conference of Mayors revealed that approximately 5.4 million American families spend more than half of their income for rent (U.S. Conference of Mayors, 2007). This results in the inability of heads of households to afford additional yet necessary living expenses. Further, an estimated 13% of the homeless individuals in major American cities are actually employed (U.S. Conference of Mayors, 2007), yet cannot or do not make enough money to sustain and house themselves and their families due to their low income. It is easy to see, then, that families who live on such a marginal income, either due to characteristics of jobs or to health issues of children or the mothers, have a difficult time when it comes to upward social or financial mobility.

Low-wage single-mother families are represented significantly among this population. They are overwhelmingly affected by the current economic state, coupled with their familial responsibilities (Kahne, 2004). As recently as 2002, the U.S. Department of Commerce stated that 50% of persons in poverty live in female-headed families, and of all female-headed families, over 25% have incomes below the poverty level (U.S. Department of Commerce, 2002). A single mother who is homeless in today's society has multiple burdens; she is not only facing a very difficult labor market, but also has considerable family duties, often with a limited education and no financial assets for coping with emergency situations. A 2003 study by Lovell and Salas reported that female heads of households had an unemployment rate of 9%, compared to a rate of 5% for all workers. This higher rate was attributed in part to the instability of frequently held low-skills jobs that tend to be temporary in nature or part time. This rate was also higher due to skilled workers laid off from their primary occupations who successfully acquired employment in low-skill jobs. This led to low-skilled workers being replaced by more skilled workers (Kahne, 2004; Lovell & Salas, 2003) and was particularly detrimental to single mothers who lacked a high school degree (Kahne, 2004). It is clear that a lack of a higher education can be a compounding factor that also contributes to the lower level of skill among single women heads of households (Kahne, 2004).

In addition to high rates of unemployment, the length of joblessness has also been detrimental to the upward social mobility of homeless women. The Center on Budget and Policy Priorities (2003) indicated that women's long term unemployment rates are approximately equivalent if not higher, to that of their male counterparts (Center on Budget and Policy Priorities, 2003). This may be attributed to a number of factors,

including the lack of availability of adequate child care. Homeless mothers who manage to find employment may be forced to leave their jobs. Other individuals face barriers when seeking jobs due to lack of education or skills or, as discussed previously, higher skilled individuals seeking lower skill employment opportunities due to the declining economic situation.

Another trend that has been noted in the literature for low wage women earners relates to the inequality of income disbursements (Kahne, 2004). The causes of such a disparity are multifaceted. Higher incomes are consistently earned by individuals with higher levels of skill and advanced educational backgrounds (Blank, 1997; Kahne, 2004). Bonuses and stock options are also given to individuals who are in higher managerial positions, which can significantly contribute to the assets that they can rely on in times of economic crisis. Relatively greater tax deductions have also been available to individuals who have higher incomes (Blank, 1997). Yet another reason for disparaging income disbursement may be attributable to increased technological changes and globalization. Individuals who are not well-off financially may have difficulty accessing resources to learn the evolving skills necessary to compete in a dynamic work environment. Finally, continued gender discrimination in the workplace may also play an important role in the disparity (Kahne, 2004). There are clearly limitations in place that hinder the growth of the low-wage or unemployed earner.

Pathways to homelessness: Substance abuse.

Alcohol and illicit drug use among homeless adults is overwhelmingly recognized as a critical issue that is more prevalent among the homeless than among the general population. Prevalence estimates of substance use among homeless individuals are

approximately 20% to 35%, and as many as 10% to 20% of those have an additional mental health disorder (Bassuk, Buckner, & Perloff, 1998; Zerger, 2002). There has been a large body of research identifying drugs and alcohol as contributing risk factors among the male population of homeless individuals (Munoz, et al., 2005; Roll, et al., 1999; Rosenheck et al., 2001; Swigart & Kolb, 2004). However, literature on their female counterparts is not as abundant.

Ascertaining the prevalence of substance use among the female heads of households is inherently difficult and inconsistent. Due to major methodological limitations, current findings on homeless women with children are not necessarily representative of the population as a whole (Bassuk, 1998; Robertson, 1991).

Nevertheless, the available literature does suggest a high prevalence of substance use and related problems among homeless women with children. Zima et al. found that 72% of homeless mothers had a probable lifetime prevalence of substance use disorder, mental disorder or both (1996). Likewise, a study in Los Angeles yielded results indicating that homeless women represent a rapidly growing population at risk for poor health outcomes due to drug and alcohol use (Nyamathi, Keenan, & Bayley, 1998).

A woman's substance use can have a host of negative consequences for herself, her children, and the family unit. The misuse of substances may result in behavioral disinhibition which can, in turn, lead to risky sexual behaviors and increased chance of pregnancy or exposure to sexually transmitted diseases, including the human immunodeficiency virus (HIV) (Nyamathi, et al., 1998; Robertson, 1991). In fact, research has shown that drug and alcohol use underlies one third of reported HIV and AIDS cases (Nyamathi, et al., 1998). The disinhibition due to the substances may also

lead individuals to participate in criminal behaviors to provide for their addiction, which can increase risks of incarceration and consequent family and employment disruptions (Nyamathi, et al., 1998; Robertson, 1991).

A homeless woman's alcohol and drug use also represents multiple risks for her children. For example, any substance ingested by a pregnant woman may affect the developing fetus (Robertson, 1991; Gelberg et al., 2008; Zima, et al., 1996). Intravenous drug use may increase the risk of prenatal exposure and infection (Nyamathi et al., 1998). There is also a significant body of research that suggests that the consequences of a homeless mother's drug use may lead her to neglect, abuse, or in extreme cases, abandon her children (Bassuk et al., 1998; Nyamathi et al., 1998; Robertson, 1991).

Additionally, inadequate parenting skills, stress, and history of abuse or violence, coupled with drug use and abuse in the mother's past, may also be a predictor of how she treats her own children (Bassuk et al., 1998; Robertson, 1991). Homeless parents deal with various stressors in addition to homelessness, causing difficulties in dealing with their children and even in developing parenting skills.

The stress of homelessness as a structure may also be the contributing force in some of the abuse and neglect. However, all of the aforementioned factors, coupled with a substance use history, results in a risky environment for the children to be raised in.

A homeless woman who is consistently abusing drugs and alcohol is at increased risk of losing custody of her children, and many studies reflected interviews with women who already experienced custody loss (Nyamathi et al., 1998; Robertson, 1991; Roll et al., 1999; Rosenheck et al., 2001). Additionally, as parenting skills are greatly influenced, separation may also occur in the instances where a homeless mother leaves

her children with housed family members or friends. This again speaks to the underreporting of accurate statistics on the hidden homeless.

Alcohol and drug use or dependencies have clearly been implicated in impairing a woman's ability to advocate for resources for herself and her family. Her dependence on substances may influence any aid she may be receiving from organizations or personal contacts (Robertson, 1991; Roll et al., 1999; Rosenheck et al., 2001). She may also jeopardize any prospects of employment due to her erratic and inconsistent behaviors. Her residential stability may be endangered due to her misappropriation of funds. There may also be reduced access to health care for herself or her children because of her lack of adherence to scheduled appointments or prescribed regimens (Nyamathi et al., 1998).

It is obvious that substance abuse can generally be considered as both an activating factor as well as a consequence of homelessness. In the United States, less than one quarter of individuals in need of substance abuse treatment actually receive it. Furthermore, personal as well as societal barriers to accessing substance abuse treatment are intensified by the limitations of homelessness (Zerger, 2002). Thus, homeless persons have a higher need for treatment than in the housed population, yet can expect to face more difficulties in accessing the resources they need.

Health and mental health issues of homeless mothers.

Homelessness has the capability to disrupt virtually every aspect of an individual's life. One such salient feature involves the physical and emotional health of those affected. Longitudinal research indicates that homeless adults have significantly higher rates of mental health and substance use disorders than the general population (Culhane, Avery, & Hadley, 1998). Specifically, homeless males tend to have greater

substance abuse issues than their female counterparts. They also tend to have a greater number of concrete diagnoses regarding drug dependence or psychoses (Culhane et al., 1998). Because homeless individuals lack health insurance, they tend not to get adequate preventive care and appropriate routine management of such chronic illnesses as hypertension, heart disease, diabetes, and emphysema (Donohue, 2004). Instead, it seems that individuals visit emergency rooms for acute illnesses, which can often be very costly for hospitals.

Common physical ailments of homeless women include asthma, ulcers, sexually transmitted diseases, and malnutrition. Unwanted pregnancy and similar gynecological ailments among homeless women also exceed those among similar and comparable groups (Hatton, Kleffel, & Bennett, 2001).

Mental health problems of homeless women commonly include depression and post traumatic stress disorder. These conditions often stem from the process of becoming homeless. Mothers who are homeless and already facing many different stressors face the additional task of protecting their children. This also adds to the pressure mothers are already feeling and can increase their psychological distress.

Health care disparities.

The disparities in access to health care between those of divergent socioeconomic as well as racial backgrounds are quite prominent. Illness and access to medical care are inextricably linked to economic status in the United States (Wenzel, Anderson, Gifford, & Gelberg, 1999). The vast majority of homeless individuals are not receiving appropriate health care, suggesting that the health problems of homeless individuals tend not to be addressed until they become severe enough to warrant costly hospitalization and

emergent care (Wenzel et al., 1999). In 2004, the number of individuals who were living without health insurance in the United States reached a staggering 44 million (Bassuk, 2004). Of these, a substantial proportion belonged to a minority race. Besides lack of health insurance, other barriers to care include denial of health problems, lack of a regular primary care provider, and lack of transportation to designated health care locations, as well as a lack of funds to cover the costs of care including required medications (Averitt, 2003; Donohue, 2004; Hatton et al., 2001) . Research also indicates that some health professionals are reluctant to provide care to the impoverished and homeless (Hatton et al., 2001).

Additionally, despite their high risk status and psychological need, women in poverty have inadequate mental health services available to them. Moreover, the services that are in place have a tendency to be underutilized for a variety of reasons, including cost, scarcity of services, difficult access, and inadequate child care (Foster, 2007). This marginalized population also reports feelings of stigmatization and discrimination, which further contribute to their lack of utilization of particular resources (Foster, 2007; Hatton et al., 2001).

Gynecological health issues.

Lack of early medical attention for gynecological problems in particular can result in unnecessary complications and more costly medical care for homeless women. A pilot study of homeless family planning clinic users discovered that 60% of homeless women had a history of sexually transmitted disease (Wenzel, Anderson, Gifford, & Gelberg, 1999). Homeless women are also at increased risk for unintended pregnancy (Gelberg, Lu, Leake, & Anderson, 2008). A study by Herndon and colleagues determined that at

any given time, 10% of the female homeless population is pregnant (Herndon, Asch & Kilbourne, 2003). This rate is twice that of all United States women of reproductive age and is markedly higher than that of low income women who are not homeless (Gelberg et al., 2008). Furthermore, researchers found that nearly 75% of pregnancies among homeless women were unintended (Herndon et al., 2003).

Data suggests that a significant number of homeless individuals engage in high-risk sexual behaviors (Herndon et al., 2003). Research is limited, however, in producing findings that address the use of contraceptives among homeless women. Contraceptive use in the general as well as homeless population is influenced by such factors as lack of awareness and accessibility (Gelberg et al., 2008; Wenzel et al., 1999). While homeless women may perceive barriers to contraceptive use that are similar to those of women in the general population, overcoming these obstacles may be more difficult for homeless women. For example, the division that exists in the structure of reproductive health care, particularly for family planning services, can result in considerable accessibility issues for homeless women who wish to practice safe sex (Gelberg et al., 2008). As a result, they may not get the adequate contraceptive tools necessary to protect themselves. Other factors that discourage contraceptive use may be unique to the homeless population, such as having no place for storage (Herndon et al., 2003; Wenzel et al., 1999). Additionally, concomitant issues such as sexual violence, substance abuse, and mental illness further compound the lack of safe sex practices in homeless women.

A study by Gelberg and colleagues suggested that the degree of perceived contraceptive deterrents varied by social and demographic backgrounds and behavioral characteristics (Gelberg et al., 2008). For instance, homeless Latina women were much

more likely than Caucasian women to report not knowing the different contraceptive methods that exist (Gelberg et al., 2008). This ignorance about their potential resources may speak to a cultural tendency wherein gender roles, religious prohibition, or the strong value placed on motherhood among Hispanics may hinder women from seeking gynecological consultation. Furthermore, language barriers may also be a notable deterrent to Latina women gaining appropriate information about effective contraception. The study also revealed that homeless African American women were more likely than Caucasian women to report that they refrained from using contraception because they did not know which method to use or felt that contraceptives were unnatural or uncomfortable. They also had an inherent fear of potential health risks from use of contraceptives (Gelberg et al., 2008). It would seem that culturally sensitive education and outreach would be greatly beneficial in assisting those women who report minimal protection due to their lack of knowledge about contraception.

Posttraumatic stress disorder.

The diagnosis of posttraumatic stress disorder (PTSD) has been used to understand the complex responses of survivors of violence. PTSD is a severe and ongoing emotional reaction to an extreme psychological trauma. This stressor may involve someone's actual death, a threat to the patient's or someone else's life, serious physical injury, or an unwanted sexual act (American Psychiatric Association, 2000). In some cases, it can also result from profound psychological and emotional trauma history.

Diagnostic symptoms of this debilitating condition include re-experiencing the trauma by way of flashbacks and nightmares, avoidance of stimuli associated with the trauma, and increased arousal such as difficulty falling or staying asleep, anger, and

hypervigilance. In order for the diagnosis to be made, the symptoms must last more than 6 months and cause significant impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2000).

While predominantly developed to apply to war veterans and disaster victims, women who have been abused and mistreated suffer from PTSD, as well (Bassuk, Melnick, & Browne, 1998). Homeless women tend to experience more traumatic events and develop PTSD at higher rates than housed women (North & Smith, 1992).

Additional research has supported the hypothesis that mothers who live in extreme poverty have a tendency to experience significantly higher lifetime rates of major depression and PTSD. More than one third of the sample suffered from PTSD, which is three times higher than the general population (Bassuk, Melnick, & Browne, 1998).

A study conducted in 1992 by North and Smith revealed that in almost three fourths of men and women, the onset of PTSD preceded the onset of homelessness (North & Smith, 1992). Unless treated, PTSD often persists, with periods of effective functioning alternating with extreme distress (Bassuk, Melnick, & Browne, 1998). This instability can result in erratic behavior and unpredictable mood shifts, which can precipitate risk factors linked to homelessness.

Research has also linked PTSD to sexual abuse in women. Individuals who have been raped or sexually molested, especially during critical formative stages, are at greater risk for developing posttraumatic disorders than those who have not experienced sexual assault (Bassuk, Melnick, & Browne, 1998). Moreover, childhood histories of abuse and family fighting were predictive of both traumatic events and PTSD. The results indicated that factors leading to PTSD in the study sample began long before the onset of

homelessness and may even overlap with factors that operate in the causal stages of homelessness (Bassuk, Melnick, & Browne, 1998; North & Smith, 1992).

It is clear that PTSD, if left untreated, has the potential to negatively influence many aspects of a woman's life. It may impede her ability to provide safety for herself and her children. She may be hindered in engaging in and maintaining constructive relationships due to her heightened levels of mistrust and depression. Competing successfully for adequate housing, jobs, and other resources may also be very difficult for her due to her instability. Finally, seeking medical or psychological services may also be impacted (Bassuk, Melnick & Browne, 1998; North & Smith, 1992) due to her PTSD, financial constraints and lack of access to care.

Depression.

Low socioeconomic status and depressive psychopathology are inextricably linked (DeForge, Belcher, O'Rourke, & Lindsey, 2008). A study by Rayburn and colleagues indicated that homeless people suffer from depression at substantially higher rates than members of the general population, with exposure to traumatic events increasing the risk for the disorder (Rayburn, Wenzel, Elliot, & Hambarsoomians, 2005). Environmental demands that are inherent to a homeless population including lack of income, unemployment, inadequate or no housing, limited food, and physical or mental health crises can have a significant impact on well-being and are widely accepted in the literature as being traumatic life events (DeForge et al., 2008; Rayburn et al., 2005; Wenzel et al., 1999).

Research has indicated that an overwhelming proportion of low income populations tend to seek assistance for depressive symptoms in a primary health care

practice rather than established mental health settings (DeForge et al., 2008; Foster, 2007; Wenzel et al., 1999). However, the depressed individual may present atypically due in part to the various symptoms inherent in a major depression diagnosis which may include multiple somatic complaints (American Psychiatric Association, 2000). Additionally, depression tends to present along with a number of comorbid diseases, leaving a significant number of patients undiagnosed and ultimately untreated for depressive states (Foster, 2007).

Interestingly, current literature shows minimal disparity between the depressive experiences of poor women who have housing and those who are shelter residents (Foster, 2007). A recent study examined the notion that greater emphasis and acknowledgement of economic, housing, and unemployment strife in the United States have begun to shift community homeless services. The trend is moving towards hurriedly establishing placements into transitional or preferred permanent housing instead of performing an initial assessment of needs in relation to mental health and stratifying the population accordingly (Foster, 2007). Therefore, the policies that have been designed to address mental health treatment concerns are currently the subject of much controversy for these marginalized individuals. Research further identified the need for successful assessment and treatment for those who do request care for depressive conditions within shelter settings (Foster, 2007; Rayburn et al., 2005).

Self-Esteem.

Financial deprivation in and of itself was found to be associated with significantly lowered self esteem (Waters & Moore, 2002). Fryer, in his agency theory, discussed the role that income plays in contributing to psychological well-being and identity (Fryer,

1995). According to his theory and research, money provides individuals with a means to control their lives and engage in spending and activities that provide them with experiences and social interactions (Fryer, 1995). These experiences and social interactions are necessary for developing identity and self-esteem. When income is extremely limited, Fryer would deem one's sense of self-worth to be congruent. Additional researchers further hypothesized that financial deprivation due to unemployment leads to poor psychological and physical health because it fosters perceptions of general helplessness and a loss of autonomy in (Waters & Moore, 2002). This is particularly so when an individual is a mother who has the added role of being a provider for minors who rely on her for their protection and well-being. When she cannot provide them with the essential comforts, including a home or adequate nutrition, her identity and self-worth become jeopardized, further compounding her psychological pathology and her relationship with her family.

Effects of homelessness on children.

Children who are homeless are more susceptible to a variety of health issues. They have more frequent ear infections, dental troubles, asthma, vision difficulties, head lice, and whooping cough. Communicable diseases seen in both adults and children include hepatitis, tuberculosis, scabies, athlete's foot, and constant cold and flu-like symptoms (Hatton et al., 2001). These ailments are often magnified by their unstable living conditions. Additionally, developmental delays related to motor skills, language, emotional expression, learning, and social behavior are not uncommon.

Chronic and acute stressors related to homelessness that impact the mental health of children have been identified as residential instability, constant school changes, poor

nutrition, exposure to family and neighborhood violence, and parental mental health (Buckner, Bassuk, Weinreb, & Brooks, 1999). These components all influence a child's capacity to cope with their current circumstance. Residential instability and constant school changes have been shown to directly impact acting-out behavior and their feelings of self-worth. Children who attend school are the subject of constant ridicule and rejection from their peers if their housing status is uncovered. Not surprisingly, then, chronic homelessness has been correlated with pervasive anxiety in children (Page & Nooe, 2002).

It is interesting to see how certain distress symptoms are associated with different aspects of the family experience. Older children who are exposed to family or neighborhood violence are at a greater risk for modeling the socially unacceptable behavior because they have the cognitive awareness that younger children may not have developed yet. Finally, research has also identified a conclusive and cyclical link between a mother's psychological distress and their child's acting out behavior (Buckner et al., 1999).

Protective factors: Reliance on social support.

A number of studies have suggested that for mothers who face the hardships associated with homelessness, the reliance on social support is great (Monroe & Tiller, 2007; Waters & Moore, 2002). Individuals who have stable support systems in place tend to have better outcomes than their mental and physical health (Monroe & Tiller, 2007; Waters & Moore, 2002). Congruently, there continues to be a marked difference in self-esteem between women who reported a low use of social support versus women who reported a high use of social support (Waters & Moore, 2002). Clearly, then, it is

apparent that mothers who do not have alternate means of support due to their personal circumstances find it difficult to adjust adaptively.

Protective factors: Faith and religion.

While specific literature on empirical studies regarding religious coping remains scarce in the homeless population, research does overwhelmingly indicate that faith-based coping is a powerful way to deal with life stressors such as natural disasters, traumatic events, mental illness, and physical illness (Cooper, 1987; Ebaugh, Pipes, Chafetz & Daniels, 2003). Since homelessness is viewed as a major life stressor, the efficacy of utilizing religious coping as a way to manage these major life disruptions warrants further review.

Additionally, as religious institutions in the United States have traditionally delivered social services to disadvantaged groups (Cooper, 1987; Ebaugh, Pipes, Chafetz & Daniels, 2003), further review is duly necessary. Studies indicate that faith-based providers of services and housing are among the most common and highly effective sources for easing the strain of homelessness on the community at large (Bass, 2009; Cooper, 1987). They are often viewed as a community solution to this pervasive and continuing problem, and they generally provide wrap-around services, ranging from alcohol and drug rehabilitation to employment and social skills (Bass, 2009; Cooper, 1987).

Research on the utilization of religious coping by homeless individuals themselves is lacking. While the effect on the community is profound, empirical data supporting the specific use by homeless individuals, namely single female heads of households, is not available (Bass, 2009; Cooper, 1987; Ebaugh et al., 2003).

Transitional living facilities.

The advent of transitional living facilities occurred in the 1980s due to a change in the traditional demographic population of the homeless (Bassuk, Rubin, & Lauriat, 1986). It became apparent that as conventional emergency shelters began to house a growing number of homeless families instead of the typical single individual, a shift in the type of living facility was also necessary (Jacobs, Little, & Almeida, 1993; Weinreb & Rossi, 1995).

The difference between emergency housing and transitional housing is in the provision of supportive services. Often, the first stop on the pathway to homelessness for families is the local emergency shelter (Grunberg & Eagle, 1990; Weinreb & Rossi, 1995). This stage of housing is referred to as crisis housing and typically provides a bed and meals while a family begins to stabilize (Grunberg & Eagle, 1990). Typically, emergency shelters have a predetermined length of stay, ranging from 30 days to several months (Grunberg & Eagle, 1990; Weinreb & Rossi, 1995). It is assumed that during this time, members of the family will obtain housing and employment (Jacobs et al., 1993). However, emergency shelters often lack support services to assist families in accessing services (Weinreb & Rossi, 1995). Families who need more time to procure housing and require more support than single individuals face a difficult set of circumstances. Instead of thriving, they are often forced to return to living with relatives or friends or to abusive relationships to avoid becoming homeless again (Bassuk et al., 1986; Jacobs et al., 1993; Kitzing, 2007). As a result, traditional emergency shelters observed the need to adapt their services to provide for the increasingly complex issues inherent and unique to a family population.

This developing trend in the homeless population ignited both political and community enterprises. Congress included the Supportive Housing Demonstration Program in the Stewart McKinney Act of 1987 (National Alliance to End Homelessness, 2008). This piece of legislation supported the development of updated housing initiatives coupled with greater wraparound support services to aid this increasingly diverse population (National Alliance to End Homelessness, 2008; National Coalition for the Homeless, 2008). In response to this legislation, a 1994 report identified transitional housing as one of the most essential factors in addressing the chronic nature of familial homelessness (U. S. Department of Housing and Urban Development, 2007).

Transitional housing is believed to act as an intermediary between crisis or emergency housing and permanent housing (Drury 2008; Weinreb & Rossi, 1995). It differs from an emergency shelter in that it offers smaller facilities, greater privacy, and more intensive services (Jacobs et al., 1993). The literature also refers to transitional facilities as second-stage housing (Grunberg & Eagle, 1990, Weinreb & Rossi, 1995). These shelters include a variety of support programs and provide housing for longer periods than emergency shelters. Services are ultimately aimed at assisting residents to achieve independence, but their approach in accomplishing this varies in several ways. These variables range from target populations (male versus female) and admissions requirements (gender, income, health) to service intensity and flexibility (Drury, 2008; Fichter & Quadflieg, 2006; Kitzing, 2007). In general, services are designed to promote independence by developing and nurturing the aptitude necessary to obtain and maintain housing.

Settings for transitional living.

Data for the present study were collected from two suburban faith-based transitional living facilities in Pennsylvania.

Inter-Faith Housing Alliance.

Since 1983, the Inter-Faith Housing Alliance (I-FHA) has served as a provider of support to homeless families in central Montgomery County, Pennsylvania. The services offered are broad and varied. They include a short-term emergency shelter, where families may stay for up to 90 days. There is also a long-term transitional housing facility, Hope Gardens, where qualifying families may stay for up to 2 years. Finally, the Graduate Program is available for families who would like to receive financial support and case management upon leaving transitional housing. I-FHA programs endow families with the skills needed to not only overcome homelessness, but also achieve self-sufficiency. In addition to housing, assistance programs are in place to provide therapeutic counseling, as well as courses on parenting, budgeting, job skills, and goal planning.

Keystone Opportunities Center.

Keystone Opportunities Center is a social services agency based in Souderton, Pennsylvania that offers a variety of services to the community, including immigration support, food bank, and transitional housing. This site is a regional affiliate of the Inter-Faith Hospitality Network. A short-term emergency shelter is offered through the Inter-Faith Hospitality Network where either two parent families or single parent families (specifically comprised of mother and children) may stay for up to 90 days. Long-term transitional housing is also available, and the program includes well-maintained rental

housing, as well as mandatory meetings with a counselor, social worker, and budget counselor. The typical lease is on a month-by-month basis, with a maximum of 24 months, and includes a comprehensive service agreement. Rent is set at 30% of adjusted household income.

Supportive services for families living in transitional housing are mandatory and include case management, mental health assessment with follow-up counseling if warranted, and financial education: budgeting, credit repair, banking services, and accountability for income and spending. The transitional program also includes linkage to many community resources.

Several criteria determine eligibility to reside in the long-term transitional living facilities at both I-FHA and Keystone. First, a family must be homeless or about to become homeless, such as residing with family or friends, leaving an abusive relationship, in a shelter, facing eviction, or in some other housing crisis. Second, the head of household must be at least 18 years of age and not in high school. Third, those with active substance abuse or untreated serious mental illness are ineligible. If the client is in recovery from drug or alcohol addiction, the individual must have been clean and sober for at least 1 year. Heads of households must have some type of income and the potential to become self-sufficient. Lastly, they must be willing and able to comply with each respective program's policies and procedures.

Research questions.

Research pertaining to the utilization of transitional housing services, is largely based on childless homeless adults. Yet there is consensus in the literature that the needs of parents with children who are homeless differ greatly from those of childless homeless

adults. Studies reveal that the underutilization of services for homeless mothers and their children was due in part to a discrepancy between the kinds of services that communities generally provided and services that the homeless families actually needed (Acosta & Toro, 2000). In general, research shows that our society has historically struggled with adequately formulating successful programs or infrastructure to meet the challenges that face such an itinerant existence. Therefore, the present study attempted to address what has been lacking in the family homelessness literature.

This study sought to gain a broader comprehension of the specific needs of homeless women with children living in transitional housing. As this study was qualitative in nature, a hypothesis was not formulated. Instead, the purpose of this research was to gain insight into the experiences of homeless mothers in transitional housing as well as to ascertain what their needs from the transitional facilities truly are. This was accomplished by posing broad and open-ended questions to the residents of Hope Gardens and Keystone Opportunities in hopes of eliciting detailed narratives.

The following chapter on methodology will detail further the derivations and justifications of research questions, specific questions used in semi-structured interviews, and an explanation of the analysis of qualitative data.

Chapter 3

Method

Research design overview: Rationale for qualitative analysis.

A qualitative study was designed to assess the needs of women living in two separate transitional living facilities. The purpose of utilizing a qualitative research methodology was to best illustrate, understand, and grasp the human experience. Additionally, qualitative research helps to expand the scope of the individual experience and to discover more profound meanings within it (Kazdin, 2003). Information and data were collected through detailed interviews of participants and observations in natural settings. Because qualitative research tends to be exploratory in nature, the interviews of participants were examined to reveal common trends and themes, which could then be interpreted and applied accordingly (Kazdin, 2003). The present study encompassed these ideologies. The current study utilizes qualitative research methods, namely semi structured interviews, in an effort to determine the common trends and themes emerging from the women's individual experiences.

Research design overview: A primer in qualitative data analysis.

Thematic analysis is a manner of investigation whereby data is scrutinized for emerging patterns of text, or themes, that reoccur. These elicited patterns or themes provide a basis for further interpretation and thesis development. Prior research supports this notion by suggesting that themes help build a broader description or manifest an overarching theory (Rubin & Rubin, 1995). The procedures used for analyzing the data obtained from the participants' interviews included: organization of the data, saturation of

the material, generating categories and themes, coding the data, ensuring validity, and, finally, offering plausible interpretations of the materials.

Organization of the data was important to avoid becoming overwhelmed or confused with the breadth of material or data elicited from the interviews. The researcher took appropriate measures to ensure that confidentiality was never breached while also maintaining orderly logs of the data collected.

In order to maximally extract thematic material from the data, the following measures were taken: primarily, the researcher became immersed in the data so as to become familiar with the details of each study participant. This was done in two separate steps. First, the interview audiotapes were reviewed several times and were manually transcribed in order to produce a written script of the interview. Then, the transcripts were thoroughly examined, read, and distributed to two research assistants in order to foster further discovery of emerging themes.

The coding team, comprised of the aforementioned research assistants, was trained in the open and axial coding system of grounded theory in order to generate categories and themes from the data. Open coding is the process of selecting and naming categories from the analysis of the data. It was the primary level of data acquisition and describes general features of the phenomenon under study (Strauss & Corbin, 1990). Variables involved in the phenomenon were then identified, labeled, categorized, and linked together with one another in an outline. The properties of the category were then described or stratified accordingly (Strauss & Corbin, 1990). Axial coding was performed after open coding and was a way of rearranging the data in novel ways. This was achieved by utilizing a coding system that sought to identify causal

relationships between categories (Strauss & Corbin, 1990). The goal of this system was to make precise associations between categories and subcategories. This process involves explaining and understanding relationships between categories in order to understand the overarching phenomenon to which they relate (Strauss & Corbin, 1990).

Enlisting a coding team served to ensure the validity of the research. This was accomplished by the method of triangulation. This method is typically used to ensure that more than one viewpoint on categorizing or coding the data is used in a study (Kazdin, 2003). The underlying premise is that the principal investigator may bring certain inevitable biases to the coding process based on his or her interpretation of the interview. The results of the interpretations can be thought of as being valid if the research assistants' explication in terms of coding or categorizing leads to similar results (Kazdin, 2003). By using three researchers to interpret the data, it is theorized that the findings would be consistent between at least two of the three. In the event that three disparate analyses were produced, the investigator would reconsider utilizing the data (Kazdin, 2003).

These series of steps began as soon as the first interview was conducted. While listening to each woman recount the story of her life, as well as her experiences with homelessness, the researcher focused on the participant's journey and transition. After all of the transcribed interviews were thoroughly read and all of the significant emerging themes were determined and coded, the researcher began to offer integrative interpretations of what the data has uncovered. Interpretation aims to bring meaning and coherence to the stratified themes and categories.

Participants.

Prior to beginning data collection, the principal researcher met with the case managers at both the Inter-Faith Housing Alliance transitional living facility in Ambler, Pennsylvania, and the Transitional Living Facility of Keystone Opportunities Center in Souderton, Pennsylvania, to explain the purpose of the study and to enlist their support in subject recruitment. Twelve respondents to the initial informational presentation met the inclusion criteria. These individuals had been prescreened for both the Inter-Faith Housing Alliance's and Keystone Opportunities Center's entry criteria.

One of the original participants was excluded from the sample due to her unwillingness to discuss her experiences with a tape recorder present, and another of the original participants was excluded due to difficulties in scheduling the interview. Data was subsequently gleaned from the taped interviews of the remaining 10 participants. Each respondent consented in writing to all conditions of the research, as approved by the Institutional Review Board of the Philadelphia College of Osteopathic Medicine.

Measures.

The qualitative design chosen for this study utilized two instruments: Semi structured questionnaire designed by the researcher and a short-answer demographic questionnaire. Both measures are included in the appendices and are identified as Appendix A and Appendix B, respectively. Interview questions were developed and generated collaboratively in a roundtable discussion format with the faculty advisor, student researcher, and an executive director from a transitional living facility. The presence of a transitional housing director of programming was valuable in order to formulate questions that were relevant and insightful to the nature and quality of their

programming and hypothesized need for program development. Subsequent questions were based largely on a review of the literature related to the experiences of homeless mothers in transitional housing. Questions are listed and elucidated as follows:

1. How long have you been homeless?

This question aimed to determine what the duration of homelessness was for each respondent. An abundance of research indicates that homelessness among women who are heads of households is consistently on the rise (Anooshian, 2005; Averitt, 2003; Culhane et al., 1998; Page & Nooe, 2002; Roll et al., 1999; Zugazaga, 2004). Further, this question will give us information regarding the chronic versus acute nature of their circumstances in an effort to help us conceptualize their individual journeys (National Alliance to End Homelessness, 2008).

2. What circumstances have contributed to you becoming homeless?

The escalation in the number of single women heads of households who are becoming homeless has been conclusively linked to a number of factors including domestic violence and unemployment and low-income employment, among others. (Anooshian, 2005; Kahne, 2004; Munoz et al., 2005; Roll et al., 1999; Rosenheck et al., 2001; Swigart & Kolb, 2004; U.S. Conference of Mayors, 2007; Vostanis, 2002). This question attempted to identify various pathways that lead to homelessness.

3. What does homelessness mean to you? What does it mean to your family?

Researchers hypothesize that financial deprivation tends to foster perceptions of general helplessness and a loss of autonomy in an individual (Fryer; 1995; Waters & Moore, 2002). This is particularly so when this individual is a mother who has the added role of being a provider for minors who rely on her for their protection and well-being.

These related research questions assisted in identifying what a homeless woman's perception of homelessness truly is. This question also provided the researcher with basic information about family dynamics and how homelessness is perceived by the family unit versus the individual unit.

4. What challenges about being homeless do you think have been the most difficult for you?

This question helped provide information about the scope of stressors that are experienced by homeless mothers. This question helped to identify what types of challenges are most salient to the research participants.

5. What were your goals when you first arrived to this shelter? Have they changed since being in here, if so, what are they are now?

These questions identified specifically what homeless mothers strive to accomplish during their time in transitional living. Additionally, as there is a temporal nature to the duration of living in transitional housing, it was assumed that achieving one's goals also occurs on a temporal schedule. Therefore, the follow-up question regarding the transient nature of goals assumes that at least a few of the goals were being met.

6. What services are you being provided with?

This question addressed the awareness and/or utilization of current programming by the mothers living in transitional housing.

7. What services would you like to be provided with?

Research by Acosta and Toro (2000) indicated that the needs of parents with children who are homeless differ greatly from those of childless homeless adults. They

reported that a significant reason for the underutilization of services by homeless mothers and their children was a discrepancy between the kinds of services that communities generally provide and services that the homeless families actually need. In general, research contends that our society has historically struggled with adequately formulating successful programs or infrastructure to meet the challenges that face such a bleak existence (Acosta & Toro, 2000). Therefore, this research question was central to the current research project and was intended to inform researchers and providers alike about the needs of homeless mothers living in transitional housing.

8. What about this program has strengthened you in coping with the challenges that contributed to you becoming homeless?

This question attempted to gauge what, if any, qualities or programs advantageous in the specific transitional living facility were. Furthermore, respondents were asked how those qualities or programs helped them cope with the various pathways that led them towards becoming homeless.

9. How has this process affected your family?

Chronic and acute stressors related to homelessness that impact the family unit have been identified as residential instability, constant school changes, poor nutrition, exposure to family and neighborhood violence, and parental mental health (Buckner et al., 1999). The responses to this question contributed to understanding what effects homelessness and the subsequent shift to transitional housing had on the family unit.

10. What is your support system?

A number of studies have suggested that for mothers who face the hardships associated with homelessness, the reliance on social support is great (Monroe & Tiller,

2007; Waters & Moore, 2002). This question attempted to gauge what impact the biggest protective factor, social support, has had on the homeless individual.

a. Has that changed since you've been living here?

This sub question aimed to determine whether the inherent and underlying nature of support that is in transitional housing is, in fact, accurate and/or recognized by the respondents.

b. How will it be when you leave?

This second sub question aimed to foster discussion about the perceptions and impressions of this protective factor as it relates to the future of respondents.

11. What role has faith had in your homelessness journey?

While specific empirical studies regarding religious coping remain scarce in the homeless population, research does overwhelmingly indicate that faith-based coping is a powerful way to deal with life stressors such as natural disasters, traumatic events, mental illness, and physical illness (Cooper, 1987; Ebaugh et al., 2003). Because each respondent was residing in faith-based transitional housing, it is important to note whether faith or religion played a protective role in their experience with homelessness.

12. Are there any questions that I have not asked which you think would be important for me to know about your experiences?

This final question attempted to gather any additional information that the respondent wanted to share.

Procedures.

Potential subjects were prescreened by transitional housing case managers and were introduced to the researcher if all criteria for participation were met. Subsequent appointment times for interviews were then set up.

At I-FHA, potential subjects were given a copy of the consent form to read and review at the time of the introductory meeting and were given an additional copy of the same consent form for further review and signature at the time of interview. At Keystone, potential subjects were given a copy of the consent form to read, review, and sign at time of initial interview, as that was also the same time as the initial meeting. This discrepancy occurred largely due to systematically inherent differences between the two programs. Consent forms explained the purpose of the research, as well as the procedures, benefits, and risks associated with participating in a 1 hour audio taped interview. Interviews were then conducted in private offices of both transitional living facilities.

A tape recorder was placed in a strategic though visible location of the office in order to optimize recording results. Before beginning the interview, confirmation of the voluntary nature of participating in such a study was reviewed and audio recording of the interview was also emphasized with the participant.

Prior to starting the semi structured interview, demographic forms were given to the participants to complete (Appendix B).

After consents were signed and demographic questionnaires were completed, the researcher began the semi structured interview of the principal data collection. Interview

questions were held constant with regard to phrasing and order for each participant (Appendix A).

At the conclusion of the interview, participants were given time for debriefing, if necessary. They were also informed that the dissertation committee and up to three additional people, the names of whom would be given upon request, would have access to the data. Additional people included two graduate research assistants to help with the coding of the data. At this time, they were given contact information for the faculty advisor of the study should they have any additional queries related to the study or for study related information.

Participants' identities were kept confidential by assigning each interview and corresponding tape recording an alias chosen by the researcher. All data was stored in a locked file cabinet when not in use.

After each participant interview was completed, transcripts of the audio taped data were generated by the researcher. This self transcribing process allowed for greater immersion with the material, as well as optimal saturation of the data. Additionally, immersion and saturation were further accomplished when the researcher read each transcript multiple times for the purpose of identifying themes within the narratives. This process entailed two sets of organized note taking. First, coding notes were made by bracketing relevant areas with coding labels. Second, memoing notes served as an ongoing collection of the researcher's impressions and thoughts regarding content in the narratives which ultimately aided in the process of building theories (Strauss & Corbin, 1990).

The transcribed copies that the two graduate research assistants received only referenced the aliases of the participants, thereby ensuring confidentiality. The transcripts were first read and coded individually by each member of the coding team, including the researcher. Coding team members then met as a group to engage in comparison of commonalities and divergences in themes, which facilitated the production of theory. This process is known as triangulation, and it produces unity of the data and subsequently supports validity (Strauss & Corbin, 1990). Emergent patterns and themes were repeatedly questioned and refined through group consensus. At this point, the most prominent themes were identified through discussion and eventual group agreement.

Lastly, categorization of themes allowed for domains, or sets, that were conceptually and empirically grounded in the data. Data that consistently emerged through repetition within transcripts were assessed and considered to be duly saturated, or colloquially, no new information was emerging (Strauss, 1996). Finally, axial coding, as defined by Strauss and Corbin (1990), was conducted as a means to map out the relationships of the constructs, from which theory was, at last, derived.

Chapter 4

Results

This study examined the themes, characteristics, and patterns of homeless mothers living in two distinct transitional living facilities in suburban Pennsylvania. Ten women were interviewed over the course of 3 months. The purpose of the interviews was to gather information about these women's experiences, pathways to homelessness, and protective factors. Their perceptions of the transitional living facilities that they were living in, as well as their specific needs from these facilities, were also explored.

Data sources and collection.

The data for this study was accumulated over a period of 3 months, during which communication with transitional facility directors and case managers generated 10 volunteer participants who met eligibility requirements for the study. Interviews were conducted in private office spaces located within the main offices of the transitional living facilities. All interviews were audio taped for later transcription, and approximately 13 hours of taping were generated. Additional sources of information included conversations with a board member and employees of the transitional living facilities.

Data analysis and interpretation.

The analysis and interpretation of the data was initiated by the investigator after the completion of all 10 interviews. Content analysis began via several readings of the transcripts. The coding process was subsequently completed with the assistance of two doctoral level research assistants, and the information was categorized. This, then, led to the formulation of themes, both within case as well as across all 10 cases. To analyze the

data further, the coding team assisted in cross-validating the categories, codes, and themes that had been elicited from the transcripts. The team then finalized the key themes that were evident across and within all 10 transcripts.

Discussion of findings.

Research findings of the study will be separated into three distinct sections: (a) demographic findings, (b) descriptive summaries and (c) analysis and interpretation of findings. The primary section will consist of the demographic variables of the volunteer participants. This will provide insight into the limitations of the generalizability of the study. The following section will provide descriptive summaries of the responses to the queries that were posed to the study participants. Throughout this and all subsequent sections, pseudonyms are utilized to maintain the confidentiality of all study participants. The final section will be utilized to present an analysis and interpretation of the responses, including cross-case differences as well as within-case variations.

Participant demographics.

The study sample consisted of seven Caucasian women, two African American women, and one woman who identified herself as an American Indian/Alaskan Native. Ages of the women ranged from 22 to 48, with the mean age being 33 years. Seven of the 10 women had never been married, two were divorced, and one was a member of an unmarried couple. The education level of these individuals varied: four women had General Equivalency Diplomas, five women had 1 to 3 years of college or technical school education, and one woman had a ninth grade education and admitted to being a functional illiterate. Employment status also differed: six of the women were employed at least part time at the time of interview, three of the women were enrolled in school at

least part time, and two women were unemployed for less than 1 year and were actively seeking employment. All 10 of the women were mothers and had one to three children ranging in age from newborn to 17 years. Religious affiliations of the women varied greatly: Baptist (2), Christian (2), Catholic (1), atheist (1), and spiritual/nondenominational (4). Nine of the women were receiving some sort of medical assistance or insurance, while only one woman reported no medical coverage. Six women indicated past experience of domestic violence. Six of the women also reported utilizing therapeutic services at some point in their lifetimes. Table 1 provides the demographic information for all participants.

Table 1

Participant Demographics

Pseudonym	Location	Age	Race	Marital Status	Employment Status	Highest Degree Earned	Children	Religious Affiliation	Therapy
Diana	Ambler	26	Caucasian	Single	Yes – FT	GED	2	Baptist	yes
Beth	Ambler	48	Afr Amer	Divorced	Yes – FT	9th Grade	3	Christian	no
Alana	Ambler	30	American Indian or Alaskan Native	Divorced	Yes – PT	Technical	3	Baptist/Methodist	yes
Cara	Ambler	22	Caucasian	Single	Yes – FT	Technical	1	None	no
Elisa	Ambler	27	Caucasian	Single	Student	Technical	2	Non denominational	yes
Janet	Keystone	37	Caucasian	Single	Unemployed > 1 year	GED	3	None	yes
Fiona	Keystone	31	Afr Amer	Single	Student -FT, Employed – PT	AA	1	Spiritual but not religious	yes
Gisele	Keystone	38	Caucasian	Single	Yes – FT	HS Diploma	1	Christian	no
Irene	Keystone	26	Caucasian	Single	Student -FT, Employed – PT	Technical	3	Catholic	No
Harriet	Keystone	46	Caucasian	Single	Unemployed > 1 year	GED	1	Non denominational	Yes

Descriptive findings.*Length of homelessness.*

The responses that the participants gave when queried about the duration of homelessness revealed two distinct types of replies: rigid, straight forward temporal accounts and less structured responses. Straight forward responses included statements such as “since July” “...probably 3 months – 4 months soon,” “Close to 2 years,” “This is my third year, third and final year.” Examples of less direct responses included participant narratives such as by Diana, “I’ve been bouncing around since my oldest son was born. He’s actually moved around 17 times now, I’ve counted.” Irene shared, “I wasn’t, I mean, I would have been homeless, but because of this place, I wasn’t.” Fiona described her journey to transitional living, “Officially, since February, well... I came here in February, so the turning of last year. Um, I actually started out at the Salvation Army, and then in February I came here...well, to the shelter program, and then I got into transitional in June.”

Evidently, the overall time that a participant had been homeless varied significantly and ranged from 4 months to 6 years. Notably, three of the 10 women indicated that they had been homeless for approximately 2 years (Table 2).

Table 2

Length of Homelessness

Inter-Faith Housing Alliance	Keystone Opportunities Center
4 months	10 months
6 months	1 year
2 years	2 years
5 years	2 years
6 years	3 years

Pathways to homelessness.

The responses to the query “what circumstances led to you becoming homeless?” yielded variably complex and multifaceted replies. Seven out of 10 women spoke about the dissolution of relationships, both familial and romantic, or even a combination of both as contributing to their current stance in life. Cara stated, “basically, my mom kicked me out for being there at 22 years old with a baby... she doesn’t think she should be responsible for me anymore, which I get, I agree with that, but wait till I get a place!” Diana shared, “I was living with my mom and she wasn’t renewing her lease.” Beth discussed the dissolution of her marriage as the catalyst for her becoming homeless, “First, I got a divorce...and I don’t think I was used to being a parent...so taking on all those responsibilities with no help.” Elisa shared a detailed account of relational conflicts, including domestic violence, with her significant other that were her personal pathway into homelessness:

...He went to Iraq, and when he returned from his third deployment...he coped by drinking a lot, and then with the drinking he would just either be verbally nasty, physically, and then some of his aggression turned towards the kids, so then I knew it was time to go. And then, I would have been able to afford to get a place, but then he cleaned out our bank account, and had my car repossessed and then you know... domino effect.

Fiona indicated that it was relational conflict with both family and a romantic partner that led her to become homeless:

My daughter's father and I broke up...he kinda just left me stranded with everything, all the bills...so that resulted in me living with my mother, which is another whole different situation. My mother suffered from addiction as well as her husband and that's not a lifestyle that I'm involved in. And to try to maintain some type of sanity, I ran to the homeless shelter.

Gisele also remarked on the combination of familial and relational difficulties:

I was living with a friend and it wasn't working out, so he kicked me and my daughter out, and we didn't really have a place to go, so then we just came to the homeless shelter...my family lives about 45 minutes from here... and I want to stay away from...that.

Notably, 6 of the 10 women indicated financial instability, including low-income wage employment, as determinants of their current transitional situation. Gisele stated, "... not having a place to go with the low income that I had" played a role in her becoming homeless. Janet also shared her account in which "I lost my job, and I couldn't pay rent,

so I got evicted.” Irene indicated that, “I’ve always had my own places, but can never afford the full amount of rent.”

Four of the 10 women also discussed the notion that while acute events may have led to their becoming homeless, they theorized that globally, a lack of education also played a role in their current living situation. Beth lamented, “That’s the battle...you don’t have the education, you don’t have the financial means to get back up on your feet.” Irene, who would eventually like to be a registered nurse said, “I have this time to get all this school...I was supposed to graduate high school in 2001...the last time I went to school was 2000, so getting back into the whole school habit is very hard, with my kids going to school, and homework...so I’m focusing this semester...I’m trying.” Fiona shared, “when I’m finished and receive my bachelor’s and hopefully receive a secure job, something that I’m going to everyday...when I have that stability under my feet, I think it’ll be much better. I’m hoping that with my degree, that’s going to change everything.”

The aforementioned themes were among the most common pathways to homelessness amongst the sample that were interviewed. Other prominent themes that were salient among the women, though less prevalent, included roommate instability (indicated by four women), landlord/eviction issues (indicated by three women), as well as maladjustment to single parenthood (indicated by three women) (Table 3).

Table 3

Pathways to Homelessness

Inter-Faith Housing Alliance	Keystone Opportunities Center
Landlord/Eviction issues	Landlord/Eviction issues
Maladjustment to single parenthood	Maladjustment to single parenthood
Dissolution of relationships – including conflict with partners or families of origin*	Dissolution of relationships – including conflict with partners or families of origin*
Financial instability/Low income employment*	Financial instability/Low income employment*
Lack of education*	Lack of Education*

* indicates most prevalent

Perception of effects of homelessness on self and family.

Self perception of homelessness among many of the study participants followed the consistent theme of lacking a stable physical environment, as well as lacking the financial means to acquire desired housing. Six participants regarded homelessness in that manner. Beth frankly stated, “Not having a place of your own and not have the financial means to get a house.” Alana shared similar sentiments of “...having no home of my own. Not being able to fend for me and mine.” Cara replied, “Not having someplace to live...” Elisa also indicated, “...we don’t have a place to call our own, I guess. It sucks.” Gisele discussed that what homelessness meant to her was, “Someone that has no place to go to put a roof over their head for just themselves or their family, too. Or someone living from place to place and not settled down.”

When these women were queried about what homelessness meant to their families, the answers they gave were often stratified by the family of origin versus their own nuclear family (i.e., self and children). When it came to their family of origin, four women indicated a variety of themes including ambivalence, abandonment, and limited support. Janet disclosed, "...and my extended family, I don't know so much if they really know anything that is going on." Irene stated, "I don't think they realize the importance of it..." and Elisa sternly stated, "They don't really care. They don't care. We've all never been that close." Cara revealed, "...it was just that feeling that I didn't have a family anymore. Like I didn't have any help."

In regards to their own nuclear family, four women explained that they wanted to protect their children from the realities of homelessness. The children's perception of homelessness was inextricably linked to their ages, as the younger children developmentally lacked comprehension. Beth explained, "I think when children are younger, I think they really quite don't understand it." Irene added, "Well, luckily, my children don't know anything about it, they just kinda look at it like, we've moved a lot." Diana also responded accordingly:

Well, my youngest kid doesn't really understand much. As long as he's with Mommy, he doesn't care. The oldest one is starting to get teased because he goes to school right across the street, so they knew the program here that he was in. There's a bully that he has that says to him, 'haha, you don't have a home!' I mean, I know its transitional housing, and he gets his own bedroom with a bed and toys, and Mommy cooks dinner every night, but I think deep down he knows what's going on.

Harriet also included her similar beliefs, “I don’t think they really know what it really means to be homeless...” (Table 4 and Table 5)

Table 4

Self Perception of Effects of Homelessness

Inter-Faith Housing Alliance	Keystone Opportunities Center
Lack of physical place to live*	Lack of physical place to live*
Lack of financial stability*	Lack of financial stability*
Powerlessness	Depressing

** indicates most prevalent*

Table 5

Familial Perception of Effects of Homelessness

	Family of Origin	Nuclear Family
Inter-Faith Housing Alliance	Limited support*	Lack of stability
	Ambivalence	Lack of comprehension
		Forced resiliency
Keystone Opportunities Center	Limited support*	Lack of stability
	Abandonment	Lack of comprehension

** indicates most prevalent*

Challenges of homelessness.

Participants identified a myriad of challenges of homelessness that had been especially difficult for them. Most often, the lack of available supports and perceived abandonment by family of origin were the most challenging as six participants indicated this as a major concern. Cara shared:

At 22 years old, I lived with my mom, and every time I had a problem, I just turned around and asked her what I had to do; so she kicked me out, and becoming independent was I guess the hardest thing for me. You know, day to day, finding food is tough...her [child's] dad isn't really in her life either...so this is tough to do it on my own, without anybody's help.

Diana explained, "The toughest part was probably not being able to have my mom. She chose not to... I mean I haven't spoken to her in 8 months. I don't know why... I'm about 7 miles away from her, and no phone call. She knows where I am. It's her choice, I've tried. I've done my part; I tried to get in touch with her." Fiona also stated that, "when I came in... I had the tools, but I just needed help to get over the hump because unfortunately, I don't have a support system or a personal support that may be able to support me with that." Irene reasoned:

You only have two years in this program, and with three kids and no fathers, you have to try to be able to do work and do what you have to do to be self-sufficient, and sometimes it takes more than just doing it while they're at school. So like, if the kids are at school, I'll be at school, so if I need to work, it has to be at nighttime, and I need to find a babysitter. I think the hardest is having, you know – you don't want to have to be depending on anybody – but sometimes you do,

sometimes you need that extra help. I think that’s the most challenging: trying to do what I want to do and finding the help.

Notably, three women also identified lack of stability as being an omnipresent struggle. Alana stated, “My kids, just not knowing where we’re going to be tomorrow... they’re just very unstable, that’s the hardest part. Every time they get a friend and then we move, they have to make friends all over again.” Beth added, “Not knowing how long you’ll have housing, and the schools, you’re always changing your children’s schools...” Finally, Harriet specified, “Mentally, the most challenging would be...the stability. No one can really, well at least I believe, no one can think straight when it’s not stable.”

Table 6

Challenges of Homelessness

Inter-Faith Housing Alliance

Keystone Opportunities Center

Lack of consistent supports*

Lack of consistent supports*

Instability*

Instability*

Lack of education

Lack of child care

Coping

Sacrificing

Fear of future/Unknown

Loss of autonomy

**indicates most prevalent*

Goals in transitional living.

Responses to the query about goals in transitional housing were overwhelmingly to: (a) obtain stable housing (indicated by eight participants), (b) procure steady employment (indicated by seven participants) and/or to (c) pursue some form of higher education (indicated by six participants). Of the ten women, only three indicated no shift and/or advancements on any goals. Alana showed progression in achieving her goals, “my goals are to sustain housing, stable housing,” then described her progress, “I now have housing, for at least 2 years [referring to time in transitional living], so now I’m looking for... maybe full-time employment.” Cara also described advances in her goals since beginning her stay at transitional housing, “...to find a place to live, that was pretty much my only real goal. I mean, I had, I wanted to get a better job, which I did that...and right before you came I was registering for classes. That was another goal, to go back to school.” Beth matter-of-factly stated, “My goal was [and is] to get my GED, make sure my kids are stable, and to find permanent housing.” Gisele indicated, “to get a job and be financially stable” as her major goals. When queried about any progress on goals, she responded, “I’m still low with the financials, but it’s the job, I’ve been with my job for over a year now and... I love it.” She further elaborated, “I guess my goals now, or looking forward, is trying to get out of transitional housing...and get into housing where I can call it my own...” Irene also stated that her goals were to “go to school full time, I like waitressing, but it’s not a job that pays the bills, especially with three kids... I want to have a house or an apartment that my kids can say, ‘hey, this is our home’, and have a career.” She also indicated that her goals had not yet been achieved nor had they changed since being in transitional living. Harriet summarized her experience:

My goals was to be able to live on my own, comfortably, by the time I got out of this program. And to get my family stable. Would I say I accomplished that? Not really, but we've come a long way. My kids feel more secure. Um, so I noticed the more they felt secure, the better they do in school... So... it may not be completely where I wanted it to be this year, but it's getting there... I just see a lot, it's improved, I'd say 80%. Living on my own? I'll be able to do it cause I've always done it, it's gonna be a struggle, and it's probably gonna be without a lot, but I'll do it.

Alternative, less frequently endorsed goals, included saving money (indicated by two women), healing (indicated by two women), obtaining a vehicle (indicated by one woman), as well as getting married (indicated by one woman).

Table 7

Goals in Transitional Living

Inter-Faith Housing Alliance	Keystone Opportunities Center
Procure stable and permanent housing*	Procure stable and permanent housing*
Obtain stable full-time employment*	Obtain stable full-time employment*
Pursue higher education*	Pursue higher education*
Saving money	Saving money
Own a vehicle	Heal
Get married	

* *indicates most prevalent*

Current services.

When participants were queried about current services, responses were consistent. Seven women indicated the usefulness of counseling services and six individuals discussed the merit in financial counseling. Diana stated, “in transitional housing I get financial assistance, counseling, budget counseling... we’re offered pretty much, like, a life counseling.” Fiona added, “Everybody has to have a counselor, a case manager, and a financial counselor. And we have to use them. It’s mandatory.” Gisele acknowledged, “I see a therapist and I see John... he’s the financial one.” Janet discussed, “Well, therapy. And John’s the financial aid guy. And they help with getting welfare help and things like that. And education, depending on what’s going on, they help you with a lot of financial education.” Harriet also added, “...the counseling, which because I don’t qualify for medical, that real helps so I can get the counsel I need.”

Four women indicated that access to the food cupboard was helpful. Beth offered, “I guess they help me with food, like food bank services we get.” Irene included, “...they have a food pantry...which you can go twice a month.” Diana explained, “If we need blankets, or toys, or soap for the kids, we have like a food cupboard downstairs, if we need something...like juice or spaghetti sauce.”

Other important services that women acknowledged receiving from their transitional living facility included employment (indicated by one woman at I-FHA), clothes assistance (indicated by two women), play room for children (indicated by one woman at I-FHA), support from church (indicated by two women), and finally, support for families during the holidays (indicated by two women).

Of note, there was one individual who denied taking part in many services that were offered. Beth stated, “Really, I don’t get a lot of services, or maybe, I don’t ask for a lot of services. So... from the shelter, I don’t come to a lot of meetings or get many services that are probably offered here. I mean, I guess they help me...”

Table 8

Current Services

Inter-Faith Housing Alliance	Keystone Opportunities Center
Therapeutic counseling*	Therapeutic counseling*
Financial counseling*	Financial counseling*
Food cupboard access	Food cupboard access
Children’s playroom	Support during holidays
Acquiring clothes	Acquiring clothes
Church support	
Employment	

* *indicates most prevalent*

Desired services.

The question “what services would you like to be receiving?” yielded a multitude of divergent responses, with no significant consistencies. Responses included: child care assistance (indicated by one woman), education regarding financial options (indicated by one woman), additional time in transitional housing (indicated by one woman), and counseling or therapeutic services for children (indicated by one woman).

Of note, two women at Keystone remarked that the need for culturally conscious, empathetic staff, as well as an individual approach to services programming and implementation, was to be desired in transitional housing. Fiona remarked,

...I just feel like sometimes, the services...has to be customized to the person's needs...the only thing I would like to probably see is more diversity for different people to relate to. Sometimes it's hard when, I don't know, I just, and it's not about color, ethnicity, I just think that sometimes with different exposures, people relate differently. This program has helped a variety of people, but for me, I would like to see different kind of diversity in terms of the case workers, case managers... I just think that just to understand the level, or experience of the culture, and I'm not saying it has to be a particular ethnicity, just some diversity.

Janet echoed similar sentiments,

The only thing is...we're not...everybody is not the same. So you have to treat everybody differently. But I think sometimes people who are in this situation, it's not because we're doing drugs or are alcoholics, and sometimes...you kinda feel like a kid. I mean, I know they're trying to help you... but sometimes, I think it just comes off the wrong way...and sometimes you get the feeling that if you say how you feel, it doesn't matter. I think, maybe they need more people [staff] to help them with this too. Maybe that would help.

Table 9

Desired Services

Inter-Faith Housing Alliance	Keystone Opportunities Center
Support with child care	Culturally conscious staff
Financial education	Individualized treatment planning
Additional time in transitional housing	Therapeutic counseling for children
Nothing	Religious education for children

Transitional living's role in coping with pathways that led to homelessness.

In coping with the challenges that contributed to becoming homeless, five women indicated that both counseling and/or support allowed them a chance to manage their hardships. Alana, who receives counseling, stated, "I get counseling. That helps a lot. She usually gives me tools to work with, especially for dealing with my son...so the strategies help me cope." Fiona also shared similar thoughts on counseling, "I know that the counselor aspect has helped me a lot because with me feeling overwhelmed, or everybody pulling at me, it's nice to have somebody to talk to because you don't share with everybody that you're homeless...or your personal life."

Cara discussed how integral her supports have been in helping her cope, "Having a friend helps me so much... that's pretty much the only thing that can really help anybody is having a friend who understands." Janet discussed supports from the transitional living facility as helping her cope, "everybody is so welcoming, they're just there, truly there...you know, you don't have to feel bad about yourself...they're very

supportive.” Diana also discussed supports from the transitional living facility, “Just the fact that [the case manager’s] door is always open...”

Of note, three women discussed assistance with financial planning as playing a significant role in their ability to cope with the stressors that led them to becoming homeless. Gisele remarked, “Getting the financial stuff...I mean trying to pay rent on time, and the cable and the phone. I mean that’s a luxury, but we just got it so...trying to manage that. I budget a lot, cause I don’t have a lot of money, so there’s some helps in there.” Harriet stated:

I’ve gotten stronger with the budgeting, with the financial... just simple things as like saving. Simple things you can do to save energy in the house and stuff...or simple things like teaching the girls not to use so much shampoo so we don’t go through it as fast, or laundry detergent, or meals and wasting food. Stronger that way.

Fiona indicated, “I know the difference between priority and necessity, between necessity and luxury...generally I’m appreciative of this.”

Table 10

Transitional living’s role in coping with pathways that led to homelessness

Inter-Faith Housing Alliance	Keystone Opportunities Center
Therapeutic counseling*	Therapeutic counseling*
Supports within facility*	Supports within facility*
Advocacy/Support for children	Assistance with financial budgeting
	Personal growth/Maturation

**indicates most prevalent*

Faith.

When the participants were queried about their stance on faith as it related to their homelessness journey, responses were mixed. Four people indicated a transitive relationship with God and their perception of faith. Irene stated, "I've been slacking on my faith... I got really lucky getting into this program...I guess you can say it's faith. I prayed for it." Harriet shared, "I don't really think it's really that I've lost, I mean I still pray to my God, and I read the Bible every once in a while...it's just that I feel like I have no time for it. I keep saying I'm going to get involved in the church, and I don't...I've just lost track of it." Cara responded:

Honestly, when I first came to this program, I was an atheist, and now I'm starting to question things. So yeah, I don't want to say that I believe any of the religions, I don't believe in religion, I think that from this, yeah, there might be a God, and I'm just starting to understand everything and that's my process...

Gisele discussed her transitive feelings on faith,

I think I do a lot for the church I go to...and then people are like, 'oh, it'll get better, things will turn around.' And I'm still waiting! I know you're supposed to pray about stuff, but you can only pray so much because it's hard. I'm still waiting for stuff to happen and it doesn't happen! It is very easy to lose faith...

Despite the hardships that these women faced, three individuals held a steadfast connection with God. Beth tearfully shared, "When you don't have a great relationship with your family, and you don't feel loved...God loves you. When the whole world seems like it, it's against you, HE loves you. I mean... there's no better gift than that." Diana shared that her faith has helped her by remaining strong, "I didn't give up. Never

give up... my mom always taught me like, it's okay if you get mad at God. So at one point, I just needed somebody to be mad at, so I chose God. I'm not going to lie, I do take the Lord's name in vain...but I know my faith, and everyone I love knows my faith, and they all respect it"

Conversely, two women felt abandoned by their faith during their time of need. Alana angrily shared, "No, none. I rely on my friends and my kids to get me by. I've had a lot of sh-t in my life, and God hasn't been there...I realize that God is not there, or that if he is, he is not fair." Elisa added:

I've been kind of a little negative about that. I just feel, I don't think anybody deserves to have to go through some of the things that we've gone through. But it's kinda like I didn't do anything to deserve this. Sometimes I feel like I'm being punished for something I did, but nobody's telling me what it was so that I can go back and fix it."

Table 11

Faith

Inter-Faith Housing Alliance

Keystone Opportunities Center

Transitive relationship*

Transitive relationship*

Faith as important source of support

Faith as important source of support

Abandonment by faith

Abandonment by faith

* *indicates most prevalent*

Summary of descriptive findings.

Narrative responses to semi structured interviews revealed that while each individual's experience of homelessness was unique, patterns emerged for each query. The overall time that a woman had been homeless varied greatly and ranged from 4 months up to 6 years. The pathways that led to homelessness most often included relationship difficulties and financial instability or low-income employment. Individuals who were homeless perceived themselves as largely residentially unstable in addition to financially insecure. They indicated that their family of origin was typically not supportive or played an ambivalent role in their lives. They further stated that their nuclear family, which included their children, depending upon child's age, lacked comprehension of what homelessness truly meant and worried about the lack of stability on their children's upbringing and future development. Women identified the overall lack of supports and pervasive instability as being the most challenging aspects of homelessness.

Overwhelmingly, the women's major goals upon arrival in transitional housing were to obtain stable housing and employment and to further their education. Accomplishment of initial goals varied with some women achieving short-term goals and others still striving to. In reference to the services that they were receiving in transitional housing, the residents agreed that counseling, financial planning, and access to a food cupboard were helpful. They recommended child care options, increased financial education, and counseling for children. Women, uniquely at Keystone Opportunities Center, recommended an increase in individual programming and culturally conscious staff.

Interestingly, women stated that the program they were living in helped them cope with the challenges that led to them being homeless through the outlets of counseling and assistance with financial planning. They also identified support from staff at their facilities as being instrumental in their abilities to cope with daily struggles. Finally, results regarding the role of faith in their homelessness journey varied. A majority of the women discussed the transitional role that faith has played in their struggles, both positively and negatively. Some women used faith as a source of light and love in their otherwise bleak existence, while others felt abandoned and disillusioned by faith. These areas will be further addressed in the Discussion section.

Chapter 5

Discussion

In this chapter, the significance of the data that was presented in the results section of this study will be examined. As this task begins, it is crucial to mention key limitations of the present study. While limitations, as a whole, will be noted in greater detail towards the end of the chapter, one important constraint, namely sample size, should be kept in mind as the analysis is reviewed. The reason for the small size of the sample is actually an inherent feature of the methodology. Due to the small sample size, as well as the limited demographic representation of the participants in this study, few generalizations of findings from this study can be made.

Nevertheless, the reader is provided with an in-depth look at the experiences of individuals who have experienced the phenomenon of homelessness personally, and therefore, it provides greater insight into what their experiences are like on a more individual level. Furthermore, we are able to glean from our data exactly what homeless mothers need from their transitional living facilities and are able to provide recommendations for future programming.

This type of study is also able to generate further hypotheses concerning the phenomenon of homelessness and may serve to provide a foundation for future research that may include large and more representative samples. Therefore, this may produce information that may be generalized to a broader population.

Throughout the previous chapter, the literal results were presented and were based primarily on how the subjects responded, when questions were posed to them, during the structured interview process. The underlying meaning of the collected data will be

explored during the subsequent analysis of the information. In addition, what was not said by the study participants may also be considered significant, and therefore, will also be discussed. This will contribute to the overall comprehensiveness of this study and provide readers with increased insight into the experiences of homeless mothers living in transitional living facilities.

The analysis process will focus on four key areas discussed during the interview process. Within these critical areas lie themes found throughout the interviews. These four areas are: (a) pathways to homelessness, (b) perceptions of homelessness including personal challenges, (c) coping, and finally, (d) the current needs of women living in transitional living facilities, discussed as a whole, then stratified according to the specific facility they resided in. The discussion of each of these areas will include information regarding the similarities and differences in the findings of this study as compared to the information currently available in the literature. Included in the analysis will be proposals concerning what the findings of the current study could mean, as well as recommendations for future programming that the transitional living facilities may opt to implement based on the needs voiced by their residents. Finally, limitations of the present study are discussed, and suggestions for future research will be presented.

Pathways to homelessness.

Domestic violence, unemployment, and substance abuse are cited as the most prevalent pathways to homelessness in the literature (Anooshian, 2005; Kahne, 2004; Munoz et al., 2005; Roll et al., 1999; Rosenheck et al., 2001; Swigart & Kolb, 2004; U.S. Conference of Mayors, 2007; Vostanis, 2002). In contrast, the current study findings vary from previous reports and may allude to an increasing complexity in the manner in

which women become homeless. For instance, in the present study, only two women mentioned domestic violence and loss of employment as a contributing factor to their becoming homeless.

Notably, however, minimum wage employment, as related to a mother's financial instability, was identified as being prevalent among the study sample, as six women discussed their struggles. Also with regard to alcohol and drug dependence, only one woman recounted a distantly remote past of abusing substances over 5 years prior to her becoming homeless. Clearly, the manner in which mothers become homeless is more complex and multifaceted than the literature may have identified.

Additionally, relationship conflicts were initially noted as being an ancillary pathway to homelessness, and likewise their presence was less abundant in the literature (Anooshian, 2005; Kahne, 2004; Munoz et al., 2005; Roll et al., 1999; Rosenheck et al., 2001; Swigart & Kolb, 2004; U.S. Conference of Mayors, 2007; Vostanis, 2002). It is precisely this pathway, however, that is found to be the most common in our study sample. Seven women discussed conflicts with their family of origin and/or dissolutions of relationships, both romantic and platonic, as directly contributing to their becoming homeless. This is a significant and unexpected finding, given the dearth of literature regarding relational difficulties as a precursor to homelessness in mothers.

This disparity between the findings of the present study and the literature may be due to the drastic shift in the population of individuals who are becoming homeless and where they are becoming homeless. The U.S. Department of Housing and Urban Development's annual survey in 2009 found that while the rates of homelessness remained steady at about 1.6 million people, the percentage of rural or suburban

homelessness rose from 23% to 32%. Furthermore, the 2009 HUD report also found that the number of sheltered homeless families grew from about 473,000 to 517,000 (U.S. Department of Housing and Urban Development, 2009). This is significant because clinicians must take into account the unique differences between the traditional homeless individual and newly suburban or rural homeless individuals. Studies of urban homeless women have linked homelessness to difficulties such as mental illness, alcohol and drug dependence, disaffiliation, and domestic violence (Hombs, 2001; Klumper, 2008). Homelessness in rural and suburban America, however, is largely attributable to the present economy, wherein home foreclosures, unemployment, minimum-wage employment, and a shortage of affordable housing are widespread (Kahne, 2004). Low-wage single-mother families are represented significantly among this population (U.S. Department of Housing and Urban Development, 2009). They are overwhelmingly affected by the state of current economy coupled with their familial responsibilities (Kahne, 2004). It is not uncommon for them to seek shelter with their families of origin, wherein conflict may likely ensue.

Perceptions of homelessness.

The homelessness literature has contended that financial deprivation has a tendency to foster perceptions of general helplessness and a loss of autonomy in an individual (Fryer; 1995; Waters & Moore, 2002). This is particularly true when this individual is a mother who has the added role of being a provider for her family. One would then expect responses of mothers in the present study to include themes of helplessness and hopelessness. Instead, the results indicated that when women were queried about their perceptions of homelessness and what being homeless meant to them,

their answers reflected very concrete and direct answers detailing the physical loss of shelter, financial instability and lack of available resources.

Perhaps a useful framework for allowing clinicians to better conceptualize and contemplate the needs of women who provide concrete responses could be accomplished through Maslow's Hierarchy of Needs. Abraham Maslow theorized that human needs can be represented as a pyramid, with the bottom level representing the most primary needs and increasingly complex needs towards the upper levels (Maslow, 1968, 1970). Furthermore, complex needs are thought to be met only once the lower levels of need are satisfied (Maslow, 1968, 1970). Once an individual's physical and immediate needs have been met (food, water, shelter, safety), they may become interested in fulfilling more complex needs, such as emotional support needs, the need for friends and relationships.

Therefore, when women were queried about their perceptions of homelessness as well as what it meant to them, many of them acknowledged that what they viewed it as, and what it meant to them, was not having a permanent living situation. It seems that even though they are in a housing facility, the women truly acknowledge the transience of it and are still seeking to fulfill their basic needs of acquiring permanent shelter.

Conversely, however, this concreteness in their thinking can also be conceptualized as the women's inability to internalize and process this difficult circumstance. Focusing on the external elements and changes allows individuals to cope on a superficial level and work towards acquiring that which is tangible in a short period. This results in the inability of individuals to truly accept accountability for their circumstances and work toward more long-term shifts within themselves in order to not become homelessness again.

Interestingly, when women were queried about what homelessness meant to their families, or what their families' perception of homelessness was, their responses were unexpectedly stratified between their family of origin, including parents and/or siblings, and their nuclear families, which included themselves and their children. Perhaps this self-directed delineation between the two types of families indicates deeper processing by these women in an effort to help them note where the support they seek is lacking.

When discussion regarded their family of origin, participants in the study generally acknowledged themes that portrayed ambivalence, abandonment and an overall sense of limited support. This is consistent with the literature which indicates that tension with the family of origin is an ancillary pathway to homelessness (Kahne, 2004; Meadows-Oliver, 2005). Additionally, these responses target more complex needs, such as social support, as determined by Maslow in his hierarchy, which cannot be met until more fundamental needs are addressed (Maslow, 1968, 1970). In further support of this notion, the mothers overwhelmingly and concretely identified that their primary goal while in transitional housing was, in fact, to acquire stable and permanent housing. This took priority over healing broken relationships with their families of origin.

In regards to their nuclear family, it was interesting to note that the same number of mothers who indicated that their children craved stability also believed that their children had difficulties comprehending the actual phenomenon of homelessness. Neither of the responses were statistically significant, but nevertheless, these were the two most commonly discussed perceptions.

The literature indicates that residential instability has been shown to directly impact a child's acting-out behavior, as well as their feelings of self worth (Buckner et

al., 1999). Additionally, children who attend school may be the subject of constant ridicule and rejection from their peers if their housing status is uncovered (Buckner et al., 1999; Page & Nooe, 2002). Past research is consistent with the findings in the present study, as women with school-age children discussed the effect that being bullied at school had on behavioral issues in their own children.

Also, related to children's perception of homelessness, mothers believed that comprehension of their circumstance related to their child's age. Developmentally, this appears to be appropriate as younger children typically do not have the mental capacity and pathways to understand complex social structures (Averitt, 2003; Barrow & Laborde, 2008; Haber & Toro, 2004). However, it appears that mothers in the present study were grateful that younger children did not understand such complexities because it allowed them to protect their young from harsh realities.

The relationship of perceptions to future programming.

With regards to developing future programming recommendations, it will be especially important to consider the perceptions of the consumers receiving services, the mothers. Because researchers have indicated that the lack of financial stability is likely to promote perceptions of general helplessness as well as a loss of autonomy in an individual (Fryer, 1995; Waters & Moore, 2002), programming recommendations should be tailored to counter such negative thinking. The predicament, however, lies in the fact that the present study revealed concrete themes as related to the mothers' perceptions of homelessness. This rigidity in cognition may indicate either acknowledgement of the transience of their current residential setting and/or a lack of internalization and insight into what this process truly means to them. Therefore, recommendations for

programming must be amended accordingly, and it would appear that the concrete themes that were raised will likely be served best by the implementation of behavioral approaches before targeting cognitive ones (Nezu, Nezu, & D’Zurilla, 2009).

Consequently, implementation of problem-solving training as well as a recovery model to homelessness is proposed among the recommendations described below (Anthony, 1993; Deegan 1998; Mahler, Tavano, Gerard, & Baber, 2001; Nezu et al., 2009).

Coping.

Given Maslow’s hierarchy of needs and self-reported conflict with the family of origin, it is not surprising that women in the present study identified lack of personal supports and pervasive instability as being among the most challenging aspects of homelessness they struggled to overcome.

When queried about what services from the transitional facility helped them in coping with the aforementioned challenges that contributed to them becoming homeless, women identified and noted the critical role that therapeutic services and financial planning assistance played. These services are consistent with the transitional living facility model, wherein the provision of such supportive services differentiates transitional housing from emergency shelters (Weinreb & Rossi, 1995). Furthermore, it is precisely these services, among select others, which promote and foster personal growth and eventual financial stability and independence for their residents (Drury, 2008; Fichter & Quadflieg, 2006; Kitzing, 2007).

Religious coping.

Specific literature and empirical studies regarding religious coping utilized by the homeless population is scarce. Instead, research does overwhelmingly indicate that faith-

based coping is a powerful way to deal with life stressors such as traumatic events (Cooper, 1987; Ebaugh et al., 2003). As homelessness is viewed as a major life stressor, utilizing religious coping as a way to manage these major life disruptions may be efficacious. Also, as both of the transitional living facilities surveyed for the purposes of this study were faith-based programs, it would be naturally assumed that the women residing in these facilities and taking advantage of the services offered by their programs would be utilizing faith as at least one way to cope.

When women in the present study were directly questioned about their faith, the results were quite divergent and unexpected. Half of the respondents discussed a transient relationship with faith and God in both positive as well as negative directions. Also of interest, three women declared that they felt as though they had been abandoned by God in their time of need, and yet another three women felt as though when they had nothing else, God was there.

These diverse responses can largely be attributed to personality and pre-homelessness differences in the individuals. For example, the individuals who stated that God had abandoned them in their time of need also had a strong sense of self-worth, exhibited by their statements that it was their own personal resiliency that allowed them to cope with homelessness.

Also, if individuals were not raised as children to ascribe to a certain faith, this usually carried over in adulthood and the reverse was also true. Still, almost every woman remarked that she felt grateful to be involved in the transitional living program that she was in, regardless of her involvement with faith. Religious coping does warrant

further research by clinicians who wish to gain further perspective on the role that faith plays on a homeless individual.

Needs of women residing in transitional living facility.

Women who are single mothers face a unique situation compared to other homeless individuals; therefore, their needs for services from their transitional housing facilities are also quite distinct. Additionally, before discussing what mothers needed from these facilities, it is important to note that because data were collected from two similar yet different transitional housing facilities, their needs varied accordingly. Therefore, the subsequent analysis will be stratified according to each of the locales. Overall, however, it should be observed that responses, while compelling for planning future programming, yielded no significant consistencies within and between sites, indicating that the homelessness journey truly is inimitable.

Child care.

At both Inter-Faith Housing Alliance and at Keystone Opportunities Center, women indicated a broad array of needs, including child care. Women at both locations discussed wanting greater assistance with child care so that they could pursue working fulltime, as their schedule with their children only allowed them to work during typical school hours. A woman at Inter-Faith noted that part-time work, coupled with her having to pay for day care, often prevented her from saving enough money to truly get ahead. This sentiment echoes the struggle that many mothers face.

Research shows that many socioeconomically disadvantaged women have limited earning power due to deficits in job skills or education, and those with children are further overwhelmed by child care responsibilities if they are employed (Levy & Sidel,

2006; Rosenheck et al., 2001). One woman at Keystone, who was currently between jobs because of this very reason, indicated that, if her child was sick and she was at work, she would have to make a choice, and it would probably be one that her employer would not appreciate.

Financial planning.

At Inter-Faith, women also indicated financial planning assistance as a major lack in their program. Specifically, individuals indicated that they would appreciate education on how to clear their credit and the steps it would take to procure a house, as well as managing and budgeting general finances. Research indicates that education about finances in transitional settings leads to appropriate management of funds and increased autonomous and positive decision making by those receiving services (Bassuk, 1993a, 1993b; Blank, 1999; Drury, 2008; Monroe & Tiller, 2007). Case managers at both Inter-Faith and Keystone indicated that financial planning is interwoven into their programming systems; however, the discrepancy in services being offered and received warrants further attention.

Another interesting need that was discussed at Inter-Faith was the opportunity to stay in transitional housing longer than the ascribed 24-month period. This is an intriguing notion. One particular woman, who was approaching her 19th month, had opted to further her educational achievements while being in transitional housing. She both rejoiced and lamented her decision to pursue a higher degree because while she was to graduate soon and would likely obtain a higher paying job than before she was in transitional housing, she had not been able to cultivate any savings for her or her children to be able to afford down payments and security deposits that would likely be necessary

for permanent housing. She felt that by the end of her stay in transitional living, she may be “getting tossed out and thrown into something that may or may not work for me” because she was “about to graduate and I’ll only have been working for a couple of months, and in that couple of months, I’m going to have to save pretty much every single penny to be able to move on from here. And it may not be enough. And I don’t want to end up in a shelter again.” While residents are made aware of the time constraints for transitional housing, and 2 years is supposed to be enough time to achieve financial stability, the implications of choosing to pursue higher education, as well as the costs associated with it, may be profound. Furthermore, given her previous history and past decision making-abilities, this level of insight and ability to express her insecurities is reflective of her personal growth.

Diversity training.

Of particular importance, at Keystone, two women discussed the need for more culturally conscious or diverse staff, as well as a more individualistic approach to training and programming. Research consistently indicates that the number of single-person households among ethnic minority women is disproportionately high (Killon, 2000). A study that compared the proportion of African Americans among the homeless in urban settings found that African Americans were twice as likely to be homeless as Caucasians in the same city (Rosenheck et al., 1996). While there are a number of factors that account for this disparity, it is clear that minority women who are referred to a transitional living facility will likely have had a different journey to homelessness than their Caucasian counterparts, and therefore, it is vital to treat each as unique individuals. Furthermore, as providers, the implication for this shift in population is compelling.

Being attuned to their cultural or ethnic backgrounds and implementing appropriate strategies serves not only to empower these women, but also perhaps will lead to better long-term outcomes.

Increased social services for children.

Another intriguing need that women at Keystone discussed involved the implementation of social and educational services for their children, specifically counseling and psychoeducation regarding homelessness. Also, the need for religious education for children was suggested.

At Keystone, counseling for the mothers is mandatory. One woman stated that she would be willing to give up one or more of her counseling sessions for her teenage daughter. Research indicates that the instability associated with homelessness for children or adolescents can be extremely confusing and difficult (Karim, Tischler, Gregory, & Vostanis, 2006; Lavesser, Smith, & Bradford, 1997; Robertson, 1991; Vostanis, 2002). Therefore, providing the children with education and counseling may become quite validating and empowering for them.

The desire for religious education for children was also an interesting one. One mother discussed how working part time and being in school prevented her from being able to take her children to church services or Sunday school. Giving her children that sort of religious exposure was important for her, but she had trouble fitting it into her already busy schedule and wondered if there was something the transitional facility could do to facilitate that. Also of note, this corroborates with study results that indicate individuals in transitional housing have a transient relationship with faith. The biggest barriers identified by this mother appeared to be time and transportation. Additionally,

perhaps the fact that this particular mother, despite her own relationship to faith, was interested in having her children receive religious education is indicative of some degree of hope that she was interested in instilling in them.

Recommendations for future programming.

Based upon the needs articulated by the women at both transitional living facilities, recommendations for future programming have been developed. These recommendations will also be stratified according to each facility because of fundamental administrative or policy differences. Furthermore, some recommendations are guided by the women's own suggestions, regarding positive changes that the transitional facilities could make to address some of their needs. Those will be presented first, followed by additional recommendations based upon researcher observations.

Child care assistance.

Women at both Inter-Faith and Keystone expressed their needs for assistance with child care. At Inter-Faith, due to the environment, there were a few options. Perhaps there could be an on-site, informal child care center for residents in the spacious playroom. Furthermore, the child care center could be staffed by the women who reside in the program, and all parents who opt to have their children attend could contribute to the hourly wage of the individual who is the caretaker. Another option may be for the transitional housing program to network with local child care agencies on behalf of their residents for affordable child care at a subsidized cost. Issues with transportation may still be an obstacle for some of the residents to be able to access this resource.

At Keystone, this would be much more difficult to accomplish because the housing is dispersed throughout the town, whereas at Inter-Faith, women all live within

the same complex where social services are also delivered. A resident at Keystone suggested that perhaps, if there were greater opportunities to network with other families or residents, they would be able to work out their own arrangements for child care. For example, she noted that teenage children of certain families may want to babysit younger children for some extra money.

Also, for an individual or a family in transition, networking with other, similar families would serve to build camaraderie with those in similar circumstances. This networking may also lead to greater accomplishments for the transitional living facility, as an environment of support and empowerment for families can only serve to improve their long-term outcomes.

Money management and financial planning.

At Inter-Faith, increased personalized financial education was also discussed as a need. This could be accomplished in a number of ways and formats. Women may be informally surveyed regarding the types of financial education or assistance that they require. Then, based upon responses or themes, groups or individual appointments could be arranged for the residents depending on their scheduling needs. For example, one woman at Inter-Faith was interested in learning how to clear her credit. Administrators may arrange guest speakers perhaps financial professionals, on a volunteer basis from the congregation, to come in and speak to the women about general procedures.

Alternatively, if guest speakers are not able to come in, perhaps phone consultations may be facilitated, wherein a more individualistic approach is utilized and applied.

Comparatively, at Keystone, all residents are mandated to have a financial counselor, in addition to other services, assigned to them for the duration of their stay in

transitional housing. While hiring additional staff to meet this need may not be appropriate for Inter-Faith, certainly utilizing community members could be an alternative and feasible solution.

Another interesting need that was discussed at Inter-Faith was the prospect of extending the 24 month stay if a resident was not ready to be on her own in stable housing. While administrative or funding constraints may prevent this from actually occurring, it does illustrate an interesting situation. Generally, the purpose of transitional housing is to promote independence by developing and nurturing the aptitude necessary to obtain and maintain housing within a predetermined period of time (Drury, 2008; Fichter & Quadflieg, 2006; Kitzing, 2007). So what happens when mothers on the cusp of ending their stay do not feel as though they have the skills or aptitudes necessary to obtain permanent housing and achieve independent living? While such assessments of readiness for independence should naturally occur on a case-by-case basis, extending stays is often not possible. Clearly, providers must then reexamine the services being provided to individuals. As a general recommendation to address these and other independent living issues that may arise, it may be beneficial to incorporate a problem-solving model of training into transitional housing.

Problem-solving training.

Problem-solving training is a cognitive-behavioral intervention that focuses on instruction in the implementation and subsequent application of adaptive problem-solving attitudes and skills (Nezu et al., 2009). The general purpose of this intervention is that it enhances psychological and behavioral functioning in order to prevent relapse and the

development of new psychological issues. It also serves to maximize overall quality of life (Nezu et al., 2009).

Ineffective problem solving has been linked to a host of physical as well as mental health issues, including, though not limited to, depression, anxiety, worry, and child-rearing difficulties (Nezu et al., 2009). Certainly, the life of a homeless mother in transition is filled with barriers, problems, and tribulations. It is easy to see how a homeless mother would be afraid to leave the supportive environment of transitional housing if not equipped with the tools, skills, and aptitudes to achieve independent living. Furthermore, not feeling ready for independent living may lead to negative or pessimistic views about herself, others, or the world. Research indicates that effective problem solving has been linked with optimism, hope, greater self-esteem and self-confidence, and improved health and emotional well-being, as well as a strong sense of overall life satisfaction (Nezu et al., 2009). Effective problem solvers do not dread the life's problems or view barriers as a threat, but instead perceive problems to be opportunities for growth or positive changes.

Implementing this intervention for the homeless population could indeed be quite constructive. While literature on the efficaciousness of problem-solving training in single homeless mothers is minimal at best, a study that examined the factors contributing to homelessness among the chronically and severely mentally ill noted disorganization and poor problem-solving abilities as a major factors in the population (Lamb & Lamb, 1990). While the study population was not comprised of individuals with chronic or severe mental illness, it nevertheless indicates problem-solving deficits as a contributing factor to homelessness. A more compelling and perhaps more applicable study on social

competency and housing instability in women aimed to determine whether respondents used problem-solving as a coping method and measured self-efficacy with regard to problem-solving skills (Hanke, 1997). The results showed that short-term housing stability was best predicted by situational variables (e.g., employment, age, number of children), but more importantly, long-term housing stability was best predicted by an individual's belief in his or her's problem-solving ability and the use of problem-solving coping strategies (Hanke, 1997).

Implementing this focused, goal-oriented, cognitive-behavioral approach with homeless single female heads of household may produce favorable long-term outcomes. This type of psychoeducational intervention may be implemented either individually or in group format. The benefits of both individual and group interventions are many. In the homeless population, where the support system is not nearly as robust as it should be, group training sessions may foster an element of encouragement that is missing. Certainly, offering this to all individuals who enter transitional living, as well as individuals who are nearing the end of their 24-month stay and are still feeling insecure about independent living, may be a challenging though rewarding endeavor. Furthermore, participation in problem-solving sessions is likely to improve perceptions of current and future quality of life.

Diversity training for staff.

Individuals at Keystone identified the need for culturally conscious staff and individualized programming. While it is inherently difficult to consider replacing current staff or reconstruct training protocols already in place, it may be beneficial to provide the current staff members with training modules in diversity and multicultural competence.

Research has consistently shown that understanding the multicultural experience is becoming increasingly important as the world's population becomes more geographically mobile and inclined to procreate across ethnic lines (Hombs, 2001; Sikich, 2008; Taylor, 2006). Clearly, then, mental health professionals and human service providers need to be cognizant not only of homelessness's presence within a multicultural community but of its complexity, as well. For example, worldviews may differ depending upon individuals' racial or ethnic background.

Furthermore, it may be hypothesized that homelessness as an entity is a culture in and of itself. Therefore, the provider who fully comprehends the unique situations and struggles of each woman living in transitional housing and takes these factors into account when implementing training protocols will likely be successful. Also, while provider matching is not always feasible, counselors and case managers who are familiar with the cultural underpinnings of their clients will be able to build increasingly significant working alliances.

Peer support.

Additional recommendations for programming at Keystone focus on increasing networking opportunities for families. Because the individuals in residential housing at Keystone are living in apartments throughout the community, rather than at one central location, many of the women indicated that they would appreciate opportunities for meeting and networking. Perhaps Keystone could hold monthly or bimonthly meetings at their central offices at which the mothers and their children would have opportunities to meet one another. This would be helpful for the children, as well, as children of

similar age would be able to relate to the experiences of each other and be able to support each other through difficult times.

A resident also expressed interest in the opportunity to meet with alumnae of the transitional living program. She believed that having the opportunity to speak to someone who had been through it would be motivating. It would allow the residents to gain valuable insights and hear stories of women who once struggled in their position, and successfully achieved independent living. This would be quite an interesting, not to mention empowering, program for members of both Keystone and Inter-Faith to implement.

Relationship of findings to the recovery model.

The recovery model may be a useful framework for transitional living facilities to better conceptualize training and program implementation for their homeless residents. This model, traditionally used for mental illness and addiction recovery, embraces many valuable tenets that may be applicable to a marginalized homeless population. The main purpose of the recovery model is to ensure that people are treated with dignity and are provided with an integrated, consumer-driven system of care (Deegan, 1988).

Recovery.

Recovery, a difficult term to define for the purposes of mental health, may be understood as both a conceptual framework for understanding mental pathology and a method of care to provide supports and opportunities for personal development (Anthony; 1993; Deegan, 1988; Mahler et al., 2001). The recovery approach emphasizes that although individuals may not have full control over the incidental occurrences in their lives, they do have full control over the choices they make in their lives (Deegan,

1988). For example, a woman who became homeless due to a series of unfortunate circumstances, including job loss and relational conflicts, may not have been able to control those occurrences. She does, however, have the ability to control the subsequent choices she makes to help herself and her family.

For an individual to adaptively recover from an addiction, mental illness, or homelessness, they may choose to utilize and include the involvement of family and other supportive advocates in making critical decisions regarding services or resources planning (Anthony; 1993; Deegan, 1988; Mahler et al., 2001). Other sources of support may include the programs such as a transitional living facility, in the case of a homeless individual, as well as supplemental services and activities developed to foster growth and independence.

Principles of the recovery model as applied to homelessness.

The fundamental principles of the recovery model include certain values and assumptions that will be subsequently altered to incorporate its use in the homeless population. The current literature and research outlines the adaptation of this methodology for primary use with the mentally ill, as well as with a substance abuse population who also happen to be homeless, perhaps as a result of these aforementioned constructs (Liberty, Johnson, Jainchill, & Ryder, 1998; Mahler et al., 2001). Nevertheless, the modifications made to fit the current study's population are certainly feasible and may actually be quite efficacious in fostering long-term residential stability among the participants in the two transitional living facilities programs. The principles of a recovery model, as applied to homelessness, are outlined as follows:

1. Recovery must be self directed: Individuals must guide, manage, and implement their right to choose and determine their own path of recovery. This may be accomplished by optimizing autonomy, independence, and a control of resources to eventually achieve what homeless mothers believe their life should resemble. Mothers should be made aware of the various resources and types of support available to them so that they may choose which path is optimal for their family circumstances. Research has overwhelmingly indicated that autonomy regarding one's programming fosters increased ownership, responsibility, and accountability over one's progress (Meadows-Oliver, 2005; Meadows-Oliver, Sadler, Swartz, & Ryan-Krause, 2007; Sikich, 2008; Tam, Zlotnick, & Bradley, 2008; Vostanis, 2002). Giving mothers this independence will allow them to transform a once shameful and upsetting circumstance into an empowering and confidence-building process. Upon admission into transitional living, mothers should be given as much control over their programming as feasible, in an effort to promote self-direction of their desired outcomes.

2. Recovery must be individualized and person-centered: Clearly, there are multiple pathways to recovery from homelessness, in either a long- or short- term format, and transitional housing facilitates that process (Toro et al., 1997). Recovery, however, seeks to ensure long-term progress and is likely to be optimal if it is based upon an individual's unique strengths and resiliencies according to their needs, preferences, experiences, and cultural backgrounds (Deegan, 1988; Ovrebro, Ryan, Jackson, & Hutchinson; 1994). As homeless mothers are a unique and heterogeneous population, it stands to reason that their recovery process will be as well. At Keystone, two women identified the need for culturally conscious and individualized programming. In addition

to diversity training for the staff members, it is imperative to let program implementation be guided on the premise that recovery must be an individualized and person-centered process. Additionally, incorporating the aforementioned problem-solving techniques will further maintain long-term changes (Hanke, 1997).

3. Recovery must take into account trauma history: It has been established that homelessness itself can be viewed as a significant life stressor akin to a trauma (Cooper, 1987; Ebaugh et al., 2003). Therefore, recovery must also take into account and process any traumas that may have been experienced. This is because unprocessed trauma history is linked to poor prognosis and has been shown to negatively impact effective recovery (Cooper, 1987; Ebaugh et al., 2003). Furthermore, individuals who have had such destructive experiences are at a greater risk of future victimization (Sells, Rowe, Fisk, & Davidson; 2004). Trauma history for homeless mothers is likely to be a prevailing factor in maintaining their overall instability, whether residential, vocational, or even emotional, especially given the high rates of relationship dissolutions. Identifying and subsequently processing their unique perceptions of traumas will likely foster increased personal and professional growth (Sells et al., 2004)

4. Recovery must empower its consumers: Mothers should have the authority to choose from a range of options and be able to participate in all decisions that will affect their lives. They must, furthermore, be educated about and supported in doing this. The literature has overwhelmingly indicated that empowering a marginalized population has been historically linked to greater autonomy and self-esteem (Meadows-Oliver et al., 2007; Sikich, 2008; Tam et al., 2008). It is thought that this empowerment will lead to increased maintenance of long-term residential as well as vocational stability, both of

which can prevent future homelessness. Allowing mothers to make concrete decisions regarding their futures is a prime example of how to empower them. This may be accomplished in a number of ways. For example, allowing them to choose whether they prefer to receive problem-solving training or financial aid workshops in an individual or a group format will allow them to feel as though their opinions are worthwhile. Case managers and other staff members may allow residents to choose appropriate times for certain meetings and give them the responsibility of making sure the agendas are reviewed and implemented in order to foster a sense of importance and autonomy that will promote increased senses of self.

5. Recovery must be comprehensive and holistic: Recovery from homelessness must encompass an individual's entire life (Deegan, 1988; Jacobson & Greenley, 2001; Mahler et al., 2001). This includes the mind, body, spirit, and community. Likewise, the recovery must embrace all aspects of the homeless mother's life including her housing, employment, education, behavioral health, and healthcare treatment and services. Also included are spirituality, social networks, and community participation, as well as any family supports, if available. This is because it is believed that if one construct is in jeopardy, then it will produce a trickle-down effect wherein other factors may also be negatively impacted (Deegan, 1988; Mahler et al., 2001). Without a doubt, families, providers, organizations, systems, communities, and society play critical roles in creating and maintaining meaningful opportunities for access to critical supports that will help homeless mothers to become residentially stable. It is recognized, however, that this is not always possible. It is an ideal situation if all of the constructs align in order to come to the aid of a woman in need. Nevertheless, providers may utilize community resources

through networking and attempt to assess a homeless woman in transition from a biopsychosocial perspective. Perhaps it will be the delicate interplay among all of these constructs that will foster autonomous growth and eventual residential independence.

6. Recovery is not linear: This is an important principle to keep in mind in the process of maintaining long-term residential stability for homeless mothers in transition. Recovery is not necessarily an incremental or sequential process, but rather one based on constant growth, intermittent obstacles, and learning from both positive and negative experiences (Davidson, Kirk, Rockholz, Tondora, & O'Connell, 2009; Jacobson & Greenley, 2001). This notion may resonate with homeless mothers in transition who have been through difficult circumstances and are accustomed to some degree of hypervigilance regarding their circumstances. Informing them that setbacks can be expected and that, similar to the problem-solving model, negative circumstances are opportunities for growth will serve to validate their experiences (Nezu et al., 2009). As recovery begins with the initial stage of awareness, it is important for mothers to recognize that positive change is achievable (Jacobson & Greenley, 2001). It appears that often they are so busy, that they lack insight into what they are doing and for what purpose. This was evidenced by their concrete and steadfast responses of aiming to obtain permanent housing, without real insight into how to go about doing so.

7. Recovery must be strengths based: Recovery focuses on finding merit and building upon the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of the mothers who are in transitional housing (Anthony, 1993; Deegan, 1988; Jacobson & Greenley, 2001). By building upon these strengths, individuals may feel empowered to engage in new and expanded life roles. Again, this will necessitate an

individualized and culturally conscious approach to programming or training and implementation by the facility providers, as each woman has a unique set of skills and experiences for which she is proud of and considers being a personal strength (Sikich, 2008; Taylor, 2006). Finally, the process of recovery moves forward through interaction with others in supportive, trust-based relationships.

8. Recovery relies upon peer support: Mutual support, including sharing experiential knowledge, skills, and social learning, plays an invaluable role in recovery (Davidson et al., 2009; Jacobson & Greenley, 2001). Mothers may serve to encourage and engage each other in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. At Inter-Faith, this was already happening due to the close proximity in which they are all housed. At Keystone, however, this was expressed as something residents desired. Networking with each other will not only serve to foster camaraderie, but will also strengthen these women's social networks, which are lacking. The facility may set up meetings wherein individuals all have an opportunity to meet one another. Additionally, implementing some of the other programming recommendations, such as problem-solving training may be accomplished in a group format, which would also promote peer relationships and support.

9. Recovery must incorporate respect: Societal acceptance, including protecting the rights of individuals and eradicating any discrimination or stigma, is crucial in recovery (Davidson et al., 2009; Deegan, 1988; Jacobson & Greenley, 2001). In transitional housing, this is likely accomplished foremost by staff and resident interactions. Staff must truly believe that the residents are capable of achieving all of their goals and must treat them accordingly. Likewise, residents should not feel as

though they are thought to be second-class citizens by staff members. Furthermore, by establishing this sort of mutual respect, residents will understand that they are perceived as capable individuals and will act accordingly (Sikich, 2008; Taylor, 2006). This, in addition to other principles of recovery, will allow mothers to eventually increase their own sense of self-acceptance and likely reaffirm their belief in themselves.

10. Recovery must incorporate responsibility: In the homeless population, it can be reliably stated that individuals have a personal responsibility for their own self-care and journeys of recovery. Mothers who are in transition may require greater support in order to manage their self-care and recovery because they are caring for not only themselves but their families as well. Therefore, taking steps toward meeting their long-term goals may require great courage because it often comes with a degree of sacrifice. Mothers in transition must aim to fully comprehend and give meaning to their experiences and, with adequate problem-solving training, will be able to identify coping strategies and healing processes to promote their own wellness (Jacobson & Greenley, 2001; Nezu et al., 2009).

Recommendations for programming based on the recovery model.

Given these principles, additional recommendations for programming are suggested for both of the transitional living facilities. The need to strengthen the support systems of the residents of the facility is paramount. This need was expressed in the narratives of the mothers, and is supported by an abundance of literature (Acosta & Toro, 2000; Averitt, 2003; Bassuk, 1993a, 1993b; Hanke, 1997; Jacobs et al., 1993; Killon, 2000; Pearce, 2001; Stainbrook & Hornik, 2008).

In addition to the within-facility resident meetings and networking opportunities already recommended, one suggestion by a resident of Keystone, regarded an opportunity to connect with past residents of transitional housing. Developing a graduate program for residents who have successfully evolved from transitional living into independent residential stability will address many of the principles of the recovery model and benefit residents and alumnae alike. Perhaps within this graduate program, a buddy system could be implemented wherein an alumna is assigned to one or more current residents and can provide support and networking. The level of commitment of the alumnae would depend upon their schedules. However, if they could be available for monthly phone consultations or scheduled check-ins with the current residents, the goal of increasing support and fostering community and peer networking would be accomplished.

Additionally, participation in this graduate program would also serve to enhance the recovery experience of the alumnae because they are taking greater responsibility, feeling empowered, and advocating for their community, which are all major tenets of the recovery model, as applied to homelessness.

Accessing broader networks in the community for support beyond that of transitional housing alumnae will also be a valuable tool in promoting long-term recovery of these individuals. This may be accomplished in a number of ways. The transitional facilities may opt to network with other transitional facilities in the area to share and compare programming and networking strategies in an effort to build a greater array of resources. The transitional living facilities may also promote outreach to local universities and high schools in an effort to recruit community volunteers to assist mothers with a variety of issues, including fund raising for supplies or tutoring services

for mothers and/or their children. Finally, utilizing the unique and established skill sets of the board members of the transitional living facilities may also provide residents with exceptional networking and resource-building opportunities.

Limitations of the recovery model.

It is imperative to note, however, that while the recovery model appears to be quite useful when considering training and program implementation in transitional living facilities, it may not be appropriate for all homeless individuals at all times. Also, as previous research is lacking regarding the functionality of the recovery model in this population, mothers who are single heads of households who currently do not struggle with sobriety or mental health issues, the efficacy of the model has yet to be demonstrated.

Nevertheless, the implementation of a recovery model in suburban transitional living programs requires that providers not simply wait for individuals to seek help. Providers must be proactive in executing such a protocol and must actively engage as well as educate their residents in this approach and consistently follow up with them regarding their progress. It is without a doubt that the recovery model will foster hope because it provides the essential and motivating message of a better future, that people can and do overcome the barriers and obstacles that confront them.

Limitations of the present study.

In the tradition of qualitative research, the sample was quite small. Thus, a major limitation of the present study is that because of the small sample size, generalizability to the population at large is intrinsically difficult. Additionally because the purpose and

focus of the study was research on a certain group of women residing in particular transitional living facilities, replication would be extremely difficult.

Additionally, one of the most challenging tasks associated with the qualitative research process is sifting through the plethora of text and detail that is the result of narrative interviewing. Subsequently, the data that was produced consisted of observational notes and transcriptions of interviews. Furthermore, in qualitative research, the interviewer serves as a test instrument during the analysis process. Therefore, the analysis of such data is unavoidably subject to human error and bias.

Implication of study for social change.

Homelessness is a chronic societal concern, and with the state of the economy, an increasing number of families are either becoming homeless or on the brink of homelessness. More is needed in the fabric of our society and provision of human services to prevent homelessness.

This study revealed dominant themes among single mothers with children striving to become self-sustaining and stably housed. Although transitional living facilities do not prevent homelessness, they are developed to stop the chronic cycle of repeated homelessness by providing supports that influence risk factors hindering success. The themes identified in this qualitative study can be utilized to motivate social service agencies to implement programming or strategies that can lead to increased personal growth within this marginalized population. Furthermore, the recommendations for programming may empower and support the women in achieving long-term residential stability.

Recommendations for future research.

Because of the small sample size of this study, more research could be conducted in larger areas or where a larger sample size can be obtained. In addition, the sample was this sample was predominantly Caucasian women and therefore does not represent all homeless women, in general. Therefore, a larger and more diverse sample could broaden the research and results.

The implications of family conflict found within this sample certainly warrant further study with women who live in poverty in order to accurately identify precipitating factors that lead to homelessness. Furthermore, the role of support systems in achieving independent living may also be an informative study within this unique population. Identification of these factors could provide an impetus for future social services programming.

In addition, conducting a similar study about transitional housing programs that provide services in urban environments may be compared to the findings of this study to reveal similarities and differences between homeless families. Additionally, examining the role that faith, religion, and spirituality play in homeless families may also be of interest to identify how individuals cope. The notion of using faith as an adaptive skill was not found in the literature on homelessness and could be explored in more detail with a similar population.

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Appendix A

Semi-Structured Interview for Mothers Living in Transitional Facilities

Interviewer's Instructions to Participant: "I want to begin by thanking you for participating in this interview. As you already know I am going to ask you a few open-ended questions during the next hour to hour and a half. These questions are going to be about your current and past experience with homelessness. It is my hope that the information that you give me during this interview will help establish what the experiences of women in similar situations are truly experiencing. Please feel free to answer as completely as possible, or ask questions if you are not sure what I am asking. Your participation will help me gain important information about other individuals like yourself and their experiences. Please answer honestly and give as much information as possible because your answers will help provide a strong basis for understanding your experiences of homelessness and what you feel you might require additional support in.

After some general demographic questions, which will allow you to talk about your own personal experience and express your real feelings, I will ask several more specific questions so that I am sure that I understand you correctly. You are allowed to decide not to answer any questions, for any reason. However, with your permission, I would like to be able to ask why you don't want to answer the question. When I finish with the questions you may tell me anything that you feel is important that I have not asked you but which you feel could add to what we have been discussing.

Remember that I will be audio taping the interview so that I can write out the interview at a later date to help me understand your thoughts, feelings, and opinions as much as I can. Do you have any questions that I can answer for you? Let's get started."

Open-Ended Questions:

- 1) How long have you been homeless?
- 2) What circumstances have contributed to you becoming homeless?
- 3) What does homelessness mean to you? What does it mean to your family?
- 4) What challenges about being homeless do you think have been the most difficult for you?
- 5) What were your goals when you first arrived to this shelter? What are they are now?
- 6) What services are you being provided with?
- 7) What services would like to be provided with?
- 8) What about this program has strengthened you in coping with the challenges that contributed to you becoming homeless?
- 9) How has this process affected your family?
- 10) What is your support system?
 - a. Has that changed since you've been living here?
 - b. How will it be when you leave?
- 11) What role has faith had in your homelessness journey?
- 12) Are there any questions that I have not asked which you think would be important for me to know about your experiences?

Appendix B**Demographic Questionnaire:**

Please complete each question by providing some brief demographic information.

1. Age

What is your age? _____

2. Race/ethnicity

How do you describe yourself? (please check the one option that best describes you)

- American Indian or Alaska Native
- Hawaiian or Other Pacific Islander
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Non-Hispanic White

3. Marital status

- Married
- Divorced
- Widowed
- Separated
- Never been married
- A member of an unmarried couple

4. Employment status

- Employed for wages
 - Current employer: _____
 - Duration of time worked: _____
- Self-employed
- Out of work for more than 1 year
- Out of work for less than 1 year
- A homemaker

- A student
- Retired
- Unable to work – why? _____

5. Education completed

- Never attended school or only attended kindergarten
- Grades 1 through 8(Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 or GED (High school graduate)
- College 1 year to 3 years (Some college of technical school)
- College 4 years (College graduate)
- Graduate School(Advance Degree)

6. Family size

How many children live in your household who are...

- Less than 5 years old?
- 5 through 12 years old?
- 13 through 17 years old?

7. Religious Affiliation

- What is your current religious affiliation? _____
- Describe any current faith-based activity that you are a participant of:

8. Health Insurance Status

- Currently insured
- Currently not insured

- 9. Have you ever experienced domestic violence/abuse? If so, how long ago and what were the circumstances?**

- 10. What has your previous or current participation in therapy been like?**