

SUCCESSFUL LONG-TERM OUTCOMES OF
PREVIOUSLY TRANSITIONALLY-HOUSED
FEMALE-HEADED FAMILIES

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To Angela, for your constant encouragement, enduring patience and unwavering faith.

SUCCESSFUL LONG-TERM OUTCOMES OF
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by

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Melody Moore-Betasso

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Despite efforts on the part of federal, state, and local government as well as concerned community organizations, homelessness, especially among female-headed families, has continued to increase. Despite the need for outcome studies and an increased understanding of how to serve these families, few research studies have attempted to determine what factors contribute to long-term success. The current study explored the impacts of therapy, substance abuse, domestic violence, mental illness, and social support on long-term success for women who were previously transitionally housed. In addition, the children's self-esteem, self-efficacy, substance abuse, and mental illness were also taken into account. Success was defined as either six months or more stable housing or six months or

more stable employment. The majority of the participants met criteria for success by at least one definition, and half of the participants were successful by both definitions. It was found that the optimal length of stay in a transitional housing center is one year, with longer stays being less likely to contribute to permanent housing. Women who were successfully housed reported more psychological symptoms than those who were not, identifying the need for follow-up services for past-residents of shelters and transitional housing centers, who are likely experiencing increased stress as they attempt to live independently. Overall, there was a low prevalence of substance abuse among both women and children. Further, children were not found to be likely to report psychological symptoms. Children whose mothers were successfully housed were found to have greater personal and social self-esteem as well as consider academics more important than those whose mothers were not successfully housed. The results of the current study indicate the effectiveness of a specific transitional housing center located in Dallas, Texas, the Shared Housing Center.

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LIST OF ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
CFSEI	Culture Free Self-Esteem Inventory
CNSE	Child of a mother with Non-Stable Employment
CNSH	Child of a mother with Non-Stable Housing
CSE	Child of a mother with Stable Employment
CSH	Child of a mother with Stable Housing
GIFT	Generations in Family Therapy
GT	Group Therapy
ISA	Index of Spouse Abuse
ISA-NP	Index of Spouse Abuse-Non-Physical
ISA-P	Index of Spouse Abuse-Physical
IT	Individual Therapy
NP	Non-Participant Past-Residents
NSE	Non-Stable Employment
NSH	Non-Stable Housing
PRQ	Personal Resource Questionnaire

PS	Participant Sample
SA-45	Symptom Assessment-45
SASSI-3	Substance Abuse Subtle Screening Inventory-Third Edition
SASSI-A	Substance Abuse Subtle Screening Inventory-Adolescent
SE	Stable Employment
SH	Stable Housing
SHC	Shared Housing Center
SSCS	Student Self-Concept Scale
TANF	Temporary Assistance for Needy Families

SUCCESSFUL LONG-TERM OUTCOMES OF PREVIOUSLY TRANSITIONALLY-HOUSED FEMALE-HEADED FAMILIES

I. Introduction

A. Homelessness

Homelessness is a serious and complex social problem in almost all modern societies. Today, homelessness in America is a dynamic force that requires vigilance and persistence by those who determine to understand its causes and advocate its eradication.

Despite efforts to obviate homelessness in America, the homeless population continues to increase. The amount of money that the federal government spends on housing, along with the number of academic publications on homelessness, has increased substantially in the past fifteen years. Following the creation of the first federal task force on homelessness in 1983, the active participation of the federal government in addressing the needs of homeless families, rather than simply rely on individual programs to do so, has been evident. The Stewart B. McKinney Homeless Assistance Act (Public Law 100-77) was signed into law by President Ronald Reagan in 1987, and has been repeatedly reauthorized by both Congressional houses. This act, which contains legislation regarding emergency relief provisions for shelter, food, mobile health care, and transitional housing, was subsequently renamed the McKinney-Vento Homeless Assistance Act following the death of its foremost advocate, republican Representative Stewart B. McKinney. Federal spending called for by the McKinney-Vento Act has exceeded \$1.0 billion every year since 1994 (Toro

& Warren, 1999). According to the act, a person is considered homeless who “lacks a fixed, regular, and adequate night-time residence and has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations...(B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Toro and Warren (1999) list government officials, advocates, and social scientists as the three prominent groups that have become engaged in the policy debates over homelessness. They describe the tension among the three groups in defining homelessness and estimating its prevalence. Social scientists, as a rule, determine their definitions of homelessness based on the methodological circumstances surrounding their particular study’s need. For example, in their 1990 study, Boxill and Beaty define homelessness for a woman with children as “having to find a shelter that will temporarily/momentarily house her children. Homelessness means that mothers must always carry all of their belongings and those of their children.” This particular definition most likely would not generalize to other studies.

Additional barriers to facilitating definitions for homelessness among social scientists are disagreements about the nature of what living arrangements constitute homelessness and the length of time one must live in said arrangements to be considered homeless (Toro, et al., 1999). Burt and Cohen (1989) explain that most often studies define homelessness based on a one-night period of persons who are in a shelter, but that these estimates leave out the non-sheltered, or “street” population. Some studies have attempted to correct for this problem by

including individuals who use day-shelters and soup kitchens. However, it is likely that many persons that are in need of shelter do not use any of these services. Further, there are differences in prevalence and in the characteristics among the chronically homeless and currently homeless. Point-prevalence studies use the currently homeless as their sample, which introduces bias. According to Phelan and Link (1999), point-prevalence studies suggest that homelessness is a persistent problem affecting a relatively small group of significantly disabled and deviant individuals from particular subgroups, whereas studies of formerly homeless individuals indicate that a much larger and heterogeneous population have experienced homelessness and that it is not always a chronic state resulting from illness or disability.

In addition to the various attempts at defining homelessness among the social scientists, there is a major policy debate between advocacy groups and government officials over the prevalence of homelessness. Advocacy groups consistently provide larger estimates than those provided by the federal government (Reyes & Waxman, 1987, 1989, Burt & Cohen, 1989). For example, in 1984, estimates of the total number of homeless Americans ranged from three-hundred thousand, according to the U.S. Department of Housing and Urban Development, to three-million, according to the National Coalition for the Homeless (Edelman and Mihaly, 1989). The advocacy groups accuse government agencies of undercounting in order to decrease the amount of federal funding required to address the needs of the homeless. Government officials, for their part, accuse lobbyists of intentional exaggeration for political purposes. Burt & Cohen (1989) point out that those advocacy groups would estimate the rate of homelessness to be about 80 to 120 per 10,000 people,

however, they have consistently refused to describe their methodology. In their own stratified, random sample of homeless persons in 20 cities across the U.S., Burt and Cohen estimated that in 1989 there were 229,000 service-using homeless individuals in large U.S. cities. They broke this number down into subgroups of adults (194,000) and children (35,000). This number translates into a rate of 37.4 homeless persons per 10,000 people in the population for these cities. When making projections for both service-users and non-users, these numbers jump to a range of 500,000 to 600,000 homeless people in a single day in March 1987 (Burt & Cohen, 1989). These estimates would transfer into rates of 20.6 to 24.9 per 10,000 people. The figures produced by these authors suggest that the number of homeless individuals almost doubled during the 1980's, but that homeless advocates' estimates were indeed too high.

The National Coalition for the Homeless (1992) reported that the largest increase in demand for services for homeless persons was by families with children. By 1994, the U.S. Conference of Mayors estimated that families with dependent children made up 39 percent of the homeless population (Waxman, 1994). In 2001, the U.S. Conference of Mayors' survey of homelessness found that 25.3 percent of the homeless population was made up by children under the age of 18 (U.S. Conference of Mayors, 2001). This estimate utilized 27 large cities, where thousands of people are homeless. On a national level, including more urban areas, the Urban Institute found in 2000 that 39 percent of the homeless population is made up of children. In rural areas these proportions are even higher. Vissing (1996) found that families, single mothers, and children make up the largest group of people who are homeless in rural areas.

According to the U.S. Conference of Mayors (2001), homeless adults are more likely to be male than female. This same survey found that the homeless population was 50 percent African-American, 35 percent Caucasian, 12 percent Hispanic, 2 percent Native American, and 1 percent Asian. Commensurate to the total population, the homeless population in rural areas is more likely to be white, whereas the homeless population in urban areas is more likely to be African American or Hispanic. In the 27 cities studies by the U.S. Conference of Mayors in 2001, 11 percent of the homeless population were veterans, while 22 percent of the single adult homeless population suffered from chronic and severe mental illness. Further, 34 percent of the homeless population met criteria for an addiction disorder.

II. Review of Literature

A. Factors Related to Homelessness in Women with Children

The systematic study of homeless women has been minimal (Johnson & Kreuger, 1989). In order to develop preventative interventions that would help women with children avoid or minimize the impacts of homelessness, more must be known about the characteristics of different subgroups among the homeless (Burt & Cohen, 1989).

In the 1980's, two schools of thought emerged on the cause of family homelessness. One theory attributed fiscal and social welfare policies as the root cause. This theory attempted to solve the homeless "problem" by looking for increased housing opportunities, higher wages, and welfare-to-work programs. Proponents of this school pointed to the fact that family homelessness was rare before the aforementioned changes in housing and welfare policies that took place in the 1980s. The other theory looked primarily at problems within the individual, rather than within society as a whole, to determine the causation of homelessness. This school advocated mental health and other support services to "cure" homelessness, and believed that multi-problem families were destined to remain homeless (Zorza, 1991).

Since then, social scientists have integrated these two theories of causation. Bassuk (1986) attempted to combine the two rationales in her description of the "tangle of pathology," pointing to the pernicious outcome of poverty coupled with a breakdown of family structure and values. She argues that poverty erodes a person's self-esteem and confidence, while at the same time creates feelings of despair and alienation. Many within both schools of thought underestimate the role of racism and the contribution of racism to

poverty. As social scientists construct theories and legislators create laws that assume the poor are to blame for their poverty, the discriminatory behavior of institutions is ignored in favor of the “deviant” behavior of the poor themselves (Sabol, 1991, Paradis, 2000).

Sullivan & Damrosch (1987) determined multiple factors that are commonly associated with situationally homeless women (those who are not chronically homeless), including the scarcity of affordable housing, unemployment, the feminization of poverty, teenage pregnancy, domestic violence, and family disruption. Dail (1990) describes the complicated etiology of homelessness by pointing to three common pathways. The first is a relationship with a man that dissolves for reasons associated with physical violence. Women who take their children and leave the perpetrator are considered to have taken a positive step toward independence. However, once these women have taken this brave step, they have few options for successful independent living. Second, Dail lists major disruptions in the early family of origin as a common precursor to homelessness. Examples of such disruptions include an absent father, parental death, mental illness or alcoholism of parent, and physical abuse. Dail argues that these disruptions contribute to a socially isolative lifestyle where family support is lacking. In addition, the social skills required to function effectively in society are never developed due to these early developmental disruptions. Third, Dail points to mental health and drug abuse problems, which in her estimation characterize at least 25 percent of homeless mothers. Most of the homeless women in Dail’s 1990 study (n = 53) come from circumstances of poverty, acute social disadvantage, and difficult and deprived childhoods.

Although she points out relevant and evident forerunners of homelessness, Dail ignores the economic conditions that commonly result in a family becoming homeless. Koegal et. al. (1995), for example, find that poverty and a lack of affordable housing are consistently related to homelessness. Edelman and Mihaly (1989) delineate three trends that have led to a growing number of low-income families being pushed into homelessness. They describe falling family incomes among the poor, especially those headed by single parents under 25, a rapidly decreasing amount of affordable low-income housing, and cuts in federal low-income housing assistance. The combination of these factors results in statistics such as the following: among the poorest low-income households, over 25 percent spent more than 75 percent of their incomes on rent alone. Further, 35 percent of poor single mothers with children under six spent over 75 percent of their incomes on rent (Edelman & Mihaly, 1989).

According to the National Low Income Housing Coalition (2001), inadequate income leaves many people homeless. Although at least 20 percent of the urban homeless are employed (U.S. Conference of Mayors, 1998), declining wages have resulted in unaffordable housing. For example, in the average American state, a minimum-wage worker would have to work 89 hours each week to afford a two-bedroom apartment at 30 percent of his or her income, which is the federal cutoff for “affordable housing” (National Low Income Housing Coalition, 2001). To put this in perspective, the hourly wage that would be required in Texas in order to make “fair market rent,” at 30 percent of income, would be \$13.84 per hour. Even so, the minimum wage in Texas remains only \$5.15 per hour (Texas Workforce, 2005).

LaVesser, et al. (1997) reported that more homeless mothers (30 percent) than continually housed mothers (19 percent) grew up in homes that received welfare income. In

addition, more homeless mothers (18 percent) than housed mothers were placed in a foster or group home as a child. In regard to sexual abuse, many more homeless mothers had experienced sexual molestation (34 percent), physical abuse (44 percent), and emotional abuse (70 percent) during their childhood than their housed counterparts. Suffering this abuse may have been one of the factors that led to the increased likelihood that the homeless women (27 percent), compared to the housed women (14 percent), left their parents' homes before the age of 17. There were no significant differences found between the two groups of women in family histories of homelessness, substance abuse, or psychiatric disorders (LaVesser, et al, 1997). Using the stepwise logistic regression model, these authors identified the most significant risk factors for homelessness. The factors included greater number of children, cocaine use, single parenthood, a diagnosis of Post Traumatic Stress Disorder (PTSD), and dropping out of high school. Two factors decreased the odds of becoming homeless: being married and demonstrating average cognitive skills.

Many homeless women with children have kept their families together despite the trauma of homelessness (Johnson and Kreuger, 1989). Although these women are likely to be struggling financially, socially, and emotionally, they clearly have distinct strengths. Some studies have attempted to identify the factors leading to homelessness by directly asking the homeless mothers. For example, Vostanis, et al. (1997) found that of 113 mothers, 82.3 percent had moved to the homeless shelter from rented accommodations. The most frequent reason for moving out of their homes was domestic violence (55.8 percent) and violence from neighbors (29.1 percent). These authors also found that 45 percent of their

sample reported a history of sexual abuse, compared to only 3 percent of the comparison group, which was made up of housed low-income single mothers.

B. Homeless Female-Headed Families

The first published reports of the increasing numbers of homeless women appeared about twenty years ago (Bufkin & Bray, 1998). Ellen Bassuk, who has since become one of the most prolific writers on homeless women, wrote in 1986 that “the alarming increase in numbers of female-headed families on the streets suggests that we are witnessing the “feminization of homelessness.” She explains that after ten years of stable numbers of homeless families in the caseloads of New York social workers, between 1981 and 1984 the number of homeless families increased 150 percent (Bassuk, 1986). By 1993, the U.S. Conference of Mayors, which annually surveys 29 major cities in the United States, found that families with children accounted for 43 percent of the homeless population. Bassuk lists various economic factors as the cause for this explosion, including the breakdown in family structure and its association with poverty, the housing crisis, and reduced welfare benefits. However, Bassuk goes on to explain that it is not only the economics of poverty that has created the new phenomenon of homeless families. She attributes the interconnected effects of poverty, violence, and profound deprivation of a person’s development and self-esteem as likely causes.

Using a sample of 115 homeless families in San Jose, California, Winkleby and Boyce’s (1994) findings supported their hypothesis that homeless female-headed families are specifically vulnerable to the recent economic and social trends that have led to increases in

the homeless population. These mothers, when compared to males with and without children and females without children, were the youngest, the least educated, and had the least amount of full-time employment. However, these homeless mothers were also the least impaired by psychiatric problems and alcohol and drug abuse.

In 1990, Dail published finding from a sample of fifty-three homeless mothers with children under the age of eighteen. She found that the most acute needs for assistance, according to the mothers, were money (28 percent), housing (24 percent), employment (12 percent), and greater welfare benefits (8 percent). Fifty-one percent were receiving food stamps and/or Medicaid, 28 percent were receiving Aid to Families with Dependent Children (AFDC) benefits, and 22 percent received Social Security (SSI). Of the 53 women in the sample, 25 percent were employed in part-time and minimum wage jobs. Similarly, 82 percent of the female-headed families studied in Los Angeles (Wood, Valdez, Hayashi & Shen, 1990), and 89 percent of those in Atlantic City, New Jersey (Steinbock, 1995) were receiving AFDC. The policy of AFDC, which was originally established during the Great Depression under the Social Security Act, is to enable children to remain in the home of their parents. With the help of this federal funding, it is assumed that the adult recipients are making attempts to stabilize their lives and retain self-sufficiency (Steinbock, 1995). The Welfare Reform Law of 1996 allocated the funding through a different channel. The new funding, titled Temporary Assistance for Needy Families (TANF), has been overseen by the Office of Family Assistance in the United States Department of Health and Human Services Administration for Children and Families since July 1, 1997.

In an effort to examine predictors of positive and negative parenting among homeless families, Torquati (2002) used a sample of thirty-eight families who were residents of temporary shelters. Each family in the sample had at least one child between the ages of six and twelve. Thirty-six of the thirty-eight families in the sample were female-headed families. Using a number of measures, the authors were able to identify what specific stressors contributed to the negative and positive parenting in the homeless families. It was found that 70.3 percent of parents identified having insufficient money and moving to new residences as stressors. In addition, 43.2 percent identified “not enough food for family” and “a lot of problems unsolved” as being stressors. The authors found that stressors were associated with more negative affectivity, more physical health problems, and less positive self-esteem. They concluded, therefore, that stressors significantly predicted negative parenting, but not positive parenting. Contrary to Torquati’s (2002) hypothesis, social support was not correlated with personal resources or parenting behavior. Negative affect did not significantly predict positive or negative parenting, but was significantly correlated with physical health problems and lower self-esteem. Poor physical health, however, did significantly predict negative parenting.

C. Demographic Variables of Homeless Women with Children

In 1989, Burt and Cohen released the findings from their study of 1,704 in-person interviews with homeless persons. This research was the first national study that used three-stage probability sampling and utilized 20 cities across the US in an effort to obtain a representative sample. These authors found that 73 percent of homeless persons were single

men, 9 percent were single women; another 9 percent were women with at least one child, 1 percent were men with at least one child. The remainder of the population was made up of men (7 percent) or women (2 percent) who were with a spouse, partner, or relative, but without children. The women in the sample had an average of 2.2 children each, making a total of 32,000 children. Sixty-eight percent of these female-headed families had either one or two children; 22 percent had three children, and 11 percent had four or more children. Further, Burt and Cohen (1989) found that 10 percent of homeless households were homeless families with children. This finding is consistent with the Department of Housing and Urban Development's 1989 shelter survey (HUD, 1989), which found that 36 percent of beds in U.S. shelters were occupied by homeless family members. Demographic variables differed amongst subgroups in Burt and Cohen's sample. They found that 83 percent of the women with children in their sample were non-white. However, of the entire U.S. population, based on the 1987 U.S. Census, only 22.5 percent are non-white. (Bureau of the Census, 1987). Women with children were the youngest subgroup in the study, with 61 percent of these women being between the ages of 18 to 30 and 37 percent between the ages of 31 to 50 (Burt & Cohen, 1989).

Of the 268 women with children surveyed by Burt and Cohen, about 50 percent of them had never been married, indicating that a sizeable portion of female-headed families are "the result of out-of-wedlock childbearing" (Burt & Cohen, 1989). In addition, educational attainment was the lowest among women with children, with only 32 percent having a high school education or greater, compared with 45 percent of homeless single men and 58 percent of homeless single women without children. The length of the current spell of

homelessness also differed among the subgroups, with women with children having spent an average of 15 months homeless, compared with 34 months for single women without children and 43 months for single men without children. Burt and Cohen (1989) point out that periods of joblessness are longer than periods of homelessness. They suggest that this finding indicates that, next to not having a job, a lack of resources, such as no family or government assistance, likely contributes to becoming homeless. However, the authors note, for women with children, the gap between joblessness and homelessness is longer than for other subgroups. This suggests that reliance on welfare programs or the incomes of other household members may have prolonged or temporarily prevented homelessness for many of these female-headed families. In fact, they found that homeless women with children relied less on working than the other two subgroups. This was likely due to their more frequent receipt of welfare. Aid to Families with Dependent Children or General Assistance was utilized by 69 percent of the women with children, compared with 18 percent of single women and 11 percent of single men. In addition, women with children were more likely to get Supplemental Security Income (SSI), which indicates that either a higher proportion had disabilities or were more likely to have access to the benefits system. A homeless person who receives assistance from the government (AFDC, SSI, etc.) is much more likely to also receive food stamps than is someone who does not receive other government assistance (58 percent versus 8 percent), according to Burt and Cohen (1989). Further, women with children were more likely to receive financial assistance from friends and family than were single women and men without children. However, single men and women were much more likely to obtain cash from handouts on the street. Total financial income during the 30 days

preceding the interviews of these 1,047 homeless persons differed among subgroups, with single women reporting \$183, single men reporting \$143, and women with children receiving \$120 per person. “Per person” estimates were used because of the assumptions built into the public benefit programs in the U.S. that the second and third family member will not require as much money as the first.

Burt and Cohen (1989) also looked at service utilization differences among the three groups. They reported that women are much more likely than men to be consistent users of shelters, with 70 percent of women with children, 53 percent of single women, and only 29 percent of single men spending seven nights in a row in shelters, versus sleeping on the streets. The authors point out that this pattern of shelter utilization is reflective of the availability of services for women with children as compared to those for single women and single men. Compared with the average American who eats three meals per day, 41 percent of homeless women with children reported eating three meals per day. In the seven days prior to being interviewed, 17 percent of women with children, compared to 40 percent of single men had gone at least one entire day without eating any food. Women with children were most likely to eat foods from groceries stores, which is likely due to their greater access to food stamps, whereas single women were most likely to eat food at shelters serving meals.

Using a sample of 240 homeless women who were residents of six shelters in St. Louis, Johnson and Krueger (1989) found that 73 percent were with dependent children and 27 percent were without dependent children. Of the women with children, approximately 66 percent were single, versus 28 percent of the women without children. Regarding ethnicity, 77 percent of their sample was African-American, while only 23 percent was Caucasian.

Johnson and Krueger (1989) found significant differences between groups of homeless women with and without children. In a study of 240 women, the authors found that women with children tend to be younger (median age = 26 years) than those without (median age = 31.5). In addition, they found a significant difference between the groups in length of time they reported being without residence. For women with children, the average number of months they had no place to live was 4.71, compared with 14.03 months for women without children. Interestingly, the authors found no correlation between length of time without residence and length of time living in shelters for either group. Similarly, the length of shelter stay did not differ between the groups. One reason for this finding, however, may be that many shelters place limits on the number of days any one individual can stay.

LaVesser, Smith, and Bradford (1997) also studied homeless women in St. Louis. They used a matched sample of previously homeless women with dependent children and comparison women who had never been homeless. The comparison women were within five years of age and lived in the same neighborhoods as the homeless women. Although the women were similar in age, the previously homeless mothers had more children than their matched counterparts, were less likely to be married, and less likely to have completed high school. Of the previously homeless women, twenty-one (10.4 percent) were still homeless. On the Kaufman Brief Intelligence Test (K-BIT), significantly more previously homeless mothers scored below the average range.

In 1990, Dail published findings from a sample of fifty-three homeless mothers with children under the age of eighteen. Of her sample, 67 percent was Caucasian and 33 percent African-American. The mean age was 27.2 (SD = 6.3) and the average years of formal

education was 11.6 (SD = 2.0). The average number of children per mother was 1.9 (SD = 1.2), with a range of one to six children. Of the fifty-three women, thirteen were employed (25 percent). For 100 percent of these women, employment was part-time or temporary, and most had been in their present job for less than two weeks. Before becoming homeless, however, 82 percent of the women had been employed for a sustained period of time. Prior to entering the shelters, 50 percent of the women had been living in an apartment or house, while the other 50 percent had been living with relatives or friends for periods of up to one or more years. Seventy percent of the sample listed a personal crisis as their reason for becoming homeless. These crises most often included domestic violence and drug or alcohol abuse. Another reason listed was financial crisis due to losing a job, resulting in eviction.

Bassuk (1986) described a sample of 51 mothers and 78 children living in six different Boston shelters. She found that the typical homeless mother was single (60 percent), African-American (63 percent), young (median age = 29), and a mother of 2.4 children who had completed several years of high school. In addition, 96 percent of the women were supported by Aid to Families with Dependent Children (AFDC), and 41 percent had received this support for more than four years. On average, the age of the mother at the birth of her first child was 20.4 years.

North and Smith (1994) compared white and nonwhite homeless men and women, pointing out that despite the well-known fact that the majority of homeless people are people of color, there has been little study of racial differences among the homeless population. Using a sample size of 900, 300 of whom were female, these investigators found that non-white men and women were significantly less likely to have ever married than their white

counterparts. More nonwhite (91.3 percent) than white (77.8 percent) women were mothers. There were no racial differences among the women in terms of frequency of employment. Similarly, there were no racial differences among the women in amount of income. However, almost half (47.3 percent) of nonwhite women depended primarily on welfare for support, while more white women depended on their own earnings. In addition, more white (6.9 percent) than nonwhite (0.8 percent) women reported no source of income whatsoever. In terms of length of time being homeless, white women had experienced more years of homelessness than nonwhites, and were more likely to have been living on the streets during the past year (8.8 percent) than the nonwhite women (1.5 percent). The two racial groups of women did not differ in the reasons they identified for becoming homeless. However, the difficulties underlying homelessness for white women were more internal, reflecting psychopathology, while for nonwhite women the reasons were more external, relating to socioeconomic problems.

More nonwhite (76 percent) than white (44.8 percent) women reported that their family had been close and that they had felt loved as a child. Despite this, 16.4 percent of nonwhite women reported physical abuse and 20.9 percent reported sexual abuse as children. Higher levels of both types of abuse were reported by the white women, with 37.9 percent reporting physical abuse and 41.4 percent reporting sexual abuse during their childhoods. Similarly, more white than nonwhite women reported a maternal history of psychiatric illness (North & Smith, 1994). In terms of psychiatric diagnoses of the respondents themselves, the white women had higher rates of all Diagnostic Statistical Manual (DSM) non-substance abuse Axis I diagnoses except for Post Traumatic Stress Disorder. White women were more

likely to have an alcohol use disorder (25.7 percent) than nonwhite women (15.6 percent), whereas nonwhite women (24.1 percent) were more likely to have a drug use disorder than white women (15.2 percent). Differences were found between racial groups in terms of psychiatric help received. Nonwhite women with a lifetime non-substance abuse Axis I diagnosis received less inpatient and outpatient psychiatric treatment, and had more often desired but been unable to obtain psychiatric treatment in the past year than their white counterparts.

As has been shown, many homeless mothers have not graduated from high school, have very inconsistent work histories, access government subsidies, and are likely to be of minority ethnic groups. Common reasons for becoming homeless include job loss, followed by the inability to pay for housing, fleeing an abusive partner, and conflict with the family member or friend with whom one was living prior to becoming homeless. Although substance abuse and mental illness are much less common causes contributing to homeless mothers as compared to homeless single men and women, there is evidence that the conditions of homelessness have a significant negative impact on mental health (Lindsey, 1998; Bassuk, 1986, 1987; McChesney, 1990, Zima, et al., 1996).

D. Victimization among Homeless Women with Children

Women's greatest risk of both physical and sexual abuse is from their intimate partners (Browne, 1993). As a group, low-income and minority women are at high risk for experiencing victimization through violence and homelessness. It follows that impoverished women will become homeless when fleeing abusers. Most victims of domestic violence have

an extremely low self-concept, are socially isolated, are extremely dependent on others and have a history of impoverished early relationships (Ryback & Bassuk, 1986). According to Zorza (1991), domestic violence is the precipitating factor for approximately one-half of homeless women with children seeking shelter in New York, Massachusetts, Pennsylvania, and Oregon. Despite this, Steinbock (1995) points out that due to battered women's shelters often being excluded from studies of the homeless, there has been an undercount of this population. One St. Louis study (LaVesser, 1997) that compared previously homeless mothers to a matched group of continually housed mothers found that 31 percent of homeless women and 28 percent of housed women had reported physical injury caused by a partner. In addition, 40 percent of the homeless women, compared with 32.5 percent of their housed counterparts, reported that their partners had threatened them with violence. Goodman, Dutton, and Harris (1995) found that of 99 mentally ill homeless women, 87 percent had suffered some form of adult physical assault and 80 percent had been assaulted by an intimate partner.

Goodman (1991) found no significant differences between homeless and housed low-income mothers on the prevalence of current and childhood abuse. Sixty-four percent of the homeless and 70 percent of the housed respondents had experienced some form of partner physical abuse in adulthood. Of the whole sample, 37 percent had experienced adult sexual abuse as well. Further, 57 percent of the total sample had experienced some form of physical abuse in childhood, and 46 percent had experienced sexual abuse in childhood. Notably, only 11 percent of the women had not been physically or sexually abused during their lifetimes. In an attempt to identify predictors of shelter use among low-income families,

Weitzman, Knickman, & Shinn (1992) used a sample of 701 families requesting shelter and a comparison group of 524 families randomly drawn from the public-assistance rolls in New York City. They found that indicators of victimization were significant predictors of shelter use. Specifically, the families who included mothers who had been sexually or physically abused as children or physically abused as adults had double the risk of shelter use.

E. Mental Illness among Homeless Women with Children

For the general homeless population, mental illness is thought of as a leading contributor to homelessness. However, for mental illness in homeless women with children, the literature reflects a more bidirectional causation. Clearly, the stress that surrounds becoming homeless is likely to cause any number of emotionally distressful reactions. Whether depression, for example, is a cause linked to the prevalence of homelessness, or a likely reaction to losing one's housing, is less well understood. Zima, et al. (1986) assessed 110 homeless mothers using the Diagnostic Interview Schedule. The authors estimated that 16 percent of the women had probable lifetime depression and 10 percent had a probable lifetime psychotic disorder. Further, 55 percent of the women reported high psychological distress. Despite the need for such services, only 11 percent of the mothers had used any mental health services in the past year. Women were more likely to use mental health services if they had probable lifetime depression or a psychotic disorder (Zima, et al., 1986).

Torquati (2002) included mental illness as a factor in her examination of thirty-eight homeless families, thirty-six of which were headed by women. Torquati (2002) found that in her sample, 19 percent of parents scored above the clinical cutoff for depression on the Beck

Depression Inventory (Beck, 1967), and 43 percent scored in the clinical range for anxiety on the State-Trait Anxiety Inventory (Spielberger, 1983). Furthermore, 21.6 percent of respondents were hospitalized during the previous year, for either physical or mental symptoms.

In a sample of 53 homeless mothers, Dail (1990) found that 80 percent indicated emotional difficulties on measures of self-report. In contrast, using a sample of 1,047 homeless persons across the U.S., Burt and Cohen (1989) found that both single women and single men are more likely to have histories of mental hospitalization and of suicide than are women with children. Although homeless women with children are less likely to be chronically and severely mentally ill, they are nonetheless likely to be experiencing emotional distress, either due to homelessness itself or a combination of becoming homeless combined with other premorbid factors. Burt and Cohen (1989) found that on a measure of depression/demoralization (CES-D), 59 percent of homeless women with children scored above the clinical cutoff, indicating the need for immediate clinical attention.

Johnson and Krueger (1989) found that only 13 percent of the women with dependent children in their study ($n = 176$) reported an outpatient mental health contact within the past year. Compared to the 25 percent of homeless women without children, only 6 percent ($n = 10$) of women with children reported psychiatric hospitalization within the past five years (Johanosn and Krueger, 1989). These finding are especially noteworthy because there were no significant differences in current psychiatric diagnoses for homeless women with children and homeless women without children. Bassuk (1986) reported similar findings. Of 51 homeless mothers in her study, only 16 percent ($n = 8$) were connected with the mental

health system within the year of becoming homeless, despite the fact that 60 percent ($n = 31$) had been connected with the mental health system at some point in their lives. Similarly, Burt and Cohen (1989) found that 80 percent of homeless women with children in their study had no involvement with any mental or chemical dependency institution, compared with only 25 percent of single men.

Bassuk, Rubin, & Lauriat (1986) found that among 75 homeless mothers in Massachusetts, psychoses were not overrepresented among homeless mothers. About one-fourth of their sample suffered from a major psychiatric clinical syndrome. In contrast, 71 percent of homeless mothers were assigned Axis-II diagnoses of personality disorders. The authors attempt to explain this extremely high percentage by pointing out that personality disorder is a diagnosis of social dysfunction and that the DSM criteria do not take into account environmental factors such as poverty, racism, and gender-bias. They go on to warn that “the labels should primarily be used to indicate severe functional impairment and the need for help rather than implying strict causality” (Bassuk, et al, 1986). Taken as a whole, it seems that there is indeed a bi-directional causation between mental illness and homelessness for women with children who become homeless. Overall, women with children have less chronic or severe mental illness, however, those who are currently suffering from depression, anxiety, or a myriad of other Axis I or II disorders, are less likely than homeless single men, homeless single women, or poor women with children who are housed, to be receiving treatment.

F. Substance Abuse and Dual Diagnosis among Homeless Women with Children

Zlotnick, et al. (1998) point out that there is a strong relationship among homelessness, substance use, neglect of children, and placement of children in foster care. Bassuk and colleagues (1996) found that substance abuse among homeless parents is more common than among low-income, housed single parents. Johnson and Krueger (1989) found that among homeless women without children, 40 percent (n = 25) indicated that they consume alcohol and 31 percent (n = 39) had been told they have a drinking problem. Among homeless women with children, however, 23 percent (n = 39) currently consume alcohol and only 5 percent (n = 8) had been told that they have a drinking problem. Similarly, Burt and Cohen (1989), in their sample of 1,047 homeless persons from across the U.S., found that women with children had the lowest reported experiences with chemical dependency treatment, which the authors used as an indication of substance dependence, among subgroups of homeless persons. In their study, single women without children had double the rate of chemical dependency than women with children, and single men had four times the rate of women with children.

Zima, et al. (1986) assessed 110 homeless mothers using the Diagnostic Interview Schedule. They found that 16 percent of the homeless mothers had an alcohol abuse problem, 18 percent had a drug abuse problem, and 6 percent had both a substance abuse problem and a severe mental illness.

G. Social Support among Homeless Women with Children

Social support is believed to facilitate positive coping, augment subjective well-being, buffer the maladaptive effects of stress, and strengthen family functioning (McLoyd, 1990, Weinert, 1998). Support networks are imperative in the lives of women struggling with poverty, loss, and the stress of raising children without permanent shelter (Bassuk, et al., 1997). Often, mothers rely on their social support networks for housing and food in order to stave off an episode of homelessness. Those who are homeless and perceive themselves as disconnected from their support networks may, in addition to being isolated, suffer from depression, substance abuse, or be victims of domestic violence. These problems may further debilitate a mother's ability to "mobilize networks of support" (Leticq, et al., 1996). The loss of such support, especially for African American women who have traditionally relied on extended family members and close friends to provide a variety of goods and services, is extremely devastating (Leticq, et al., 1996).

Torquati (2002) examined the social support networks of thirty-eight homeless families, thirty-six of which were female-headed. The mean number of people that the parents named as being participants in their social support networks was 5.2 (SD = 1.8), with agency personnel, friends, and siblings being the most commonly nominated, in that order. Torquati (2002) found that social resources had no significant impact on the process of parenting, however, she explains these findings by pointing to the fact that subjects listed agency personnel and newfound friends as their support systems. These persons, she says, are not likely to have been of much benefit due to their lack of familiarity and acceptance of the nominees. Furthermore, the author warns, "pernicious relationship difficulties in the

context of other risks and changes can potentiate a housing crisis. Once people are homeless, relationship difficulties may function to maintain housing instability” (Torquati, 2002).

Mothers in this sample clearly had minor amounts of social capital and lacked information about resources and opportunities.

In Johnson and Krueger’s 1989 sample of 176 homeless women with dependent children, 74 percent of them reported having family in the immediate area. Bassuk (1986) asked the 51 homeless mothers in her study to describe three major supports. One fourth listed their children as their support, while another fourth said they had no supportive relationships. Even more poignantly, Dail (1990) found that in a sample of 53 homeless mothers, without exception, they reported that they were unable to trust anyone at any time. It was therefore determined that the mothers were severely socially isolated and alienated. Although many of the women in this study identified that a relative lived within 25 miles, this person was not likely to be viewed as part of an ongoing support system. Zima, et al. (1986) had similar results. Out of 110 homeless women in their study, over half (53 percent) had two or fewer persons to whom they could turn for support. Further, fifteen of the women (14 percent) reported their own children as their only source of social support. Twenty-five percent of the women in the sample reported that they had had no contact with any family member in the last sixty days (Zima, et al., 1986).

A study in St. Louis using a sample of 202 previously homeless women found that 76.7 percent reported at least one dependable support. They defined support as being someone who could help with food, money, shelter, childcare, or other everyday needs (Lavesser, et al, 1997). Letiecq, et al. (1998) compared the social support of 92 homeless

and 115 poor housed mothers. The investigators compared the social support of predominantly African-American homeless families residing in emergency shelters, transitional housing, and doubled-up arrangements with that of low-income permanently housed families. The authors looked at three categories of support: social embeddedness, perceived availability of support, and enacted support. Findings of social embeddedness questions revealed that housed mothers saw or talked to significantly more friends and relatives ($M=4.5$) on a weekly basis than mothers residing in emergency shelter ($M=1.4$) or transitional housing ($M=3.1$). In addition, housed mothers perceived that they could rely on significantly more people during times of need ($M = 4.4$) than either transitionally housed ($M = 2.7$) or emergency sheltered mothers ($M = 2.1$). Further, transitionally housed ($M = 1.5$) and emergency sheltered ($M = 1.2$) mothers reported that their families had provided significantly less help than was reported by the housed mothers ($M = 1.9$).

The authors hypothesize that shelter policies may contribute to the lack of social support by friends and family by prohibiting male visitors, limiting the use of public phones, and providing very little transportation assistance (Leteicq, et al., 1998). The relationship of social support to homelessness has been clearly demonstrated in the literature. Obviously, isolation and alienation are barriers to successful outcomes in homeless women with children, and the impact of positive social support cannot be underestimated in terms of intervention and treatment planning.

H. Effects of Homelessness on Children

In 1988, the National Academy of Sciences estimated that 100,000 children under that age of 18 were homeless on any given night (Institute of Medicine, 1988). This estimate did not include those who have been forced to leave their parents' homes. By 1995, the U.S. Department of Education estimated that 744,000 school-age children and adolescents were homeless in the course of a year (as cited in Buckner & Bassuk, 1997). The experience of being without a home is traumatic to children as well as to parents. Becoming homeless results in tremendous feelings of loss, fears about safety and security, and changes in family functioning. Homelessness takes a measurable toll on the physical, emotional, and mental development of children (Edelman & Mihaly, 1989). In fact, homelessness negatively impacts children before they are even born, according to a 1987 study of the New York City Department of Health (Chavkin, Kristal, Seabron & Guigli, 1987). In that study of 400 pregnant women in welfare hotels, over 39 percent had not received any prenatal care, a rate nearly three times that of women in low income housing projects (15 percent). After birth, homeless children become part of a family whose problems include a lack of housing and food, but also a lack of social supports and means to sustain the family. Specifically, homeless children are at great risk for being placed in foster care – not due to homelessness itself, but to the contextual features of parents' lives, features which are often secondary to substance abuse and the transient nature of homelessness (Zlontick, et al., 1998).

Buckner and Bassuk (1997) investigated the mental health of homeless children according to established diagnostic criteria. They administered the National Institute of Mental Health's (NIMH) Diagnostic Interview Schedule for Children (DISC) to a sample of

41 homeless children and a comparison group of 53 poor housed children and each of their mothers. These investigators used the Vineland Screener to assess adaptive functioning in three areas: communication, daily living skills, and socialization. The homeless youths had experienced more stressful life events in the prior year than their continually housed peers. In fact, 39 percent of homeless youths, compared with 17 percent of housed youths, had witnessed violence in their home or community within the past twelve months. The homeless children had moved an average of 3.7 times in the previous year, compared with an average of .7 times for the housed peers. Moreover, 70 percent of the homeless youth, compared with 32 percent of the housed youths, had changed schools in the past year. According to their mothers, 17 percent of homeless children had been physically abused and 22 percent had been sexually abused in the past, compared with 15 percent and 6 percent for housed children. Finally, 24 percent of the homeless children, compared with 4 percent of housed children, had been placed in foster care.

Dail (1990) found that mothers of younger children manifest significantly less difficulty with impulse control and psychopathology than those with older children (greater than 10 years of age). She attempts to explain this by offering that worries that accompany having older children, such as school, drugs, and violence, are not as acute for mothers of younger children. No matter what the age of the child who becomes homeless, this status is a traumatic and stigmatizing one that has far-reaching effects in both the current and future life of the child.

I. Homeless Children's Education

A child's ability to succeed in school is undoubtedly diminished by the stress of homelessness (Rafferty, 1995). Significant educational issues for homeless children include developmental delays and behavioral disorders, problems with transportation and attendance due to frequent school changes, low academic achievement, poor parental education, poor nutrition, untreated physical illness and high levels of drop-outs (Zima, Bussing, Forness, & Benjamin, 1997). The Texas Education Agency (as cited in Rafferty, 2005), delineated a few of the issues:

Homeless children suffer the loss associated with separation from their home, furniture, belongings, and pets; the uncertainty of when they will eat their next meal and where they will sleep during the night; the fear of who might hurt them or their family members as they live in strange and frequently violent environments; the embarrassment of being noticeably poor; and the frustration of not being able to do anything to alleviate their (or their family's) suffering. To assume that a child could push all of such suffering aside to adequately focus on academic tasks may in many cases be unrealistic.

According to the McKinney Act of 1987, as well as the McKinney-Vento Act which followed, homelessness alone is not a sufficient reason to separate students from the mainstream school environment. Therefore, provisions require states to ensure the same free access to a public education, including services provided under federal education programs,

to homeless children as are provided to any other child. The law allows for the best interests of the child to determine whether the child should remain in the school which he or she attended before becoming homeless or change schools to the area where he or she currently stays. Homeless students' schools of origin are mandated to provide transferred schools with academic, immunization, guardianship, and special education evaluation records in a timely manner (Rafferty, 1995). For states receiving funds from the U.S. Department of Education, their local education agencies are required to do the following: (a) designate a homelessness liaison to ensure that children and youth receive the educational services for which they are eligible (including referrals to health care services, dental services, and mental health services), (b) inform school personnel, service providers, and advocates working with homeless families of their services, and (c) coordinate with local social service agencies, and other agencies or programs providing services to such children or youth and their families (Rafferty, 1995). Despite these protections, homeless children's ability to obtain a successful education is severely mitigated by numerous factors.

The first of these factors is academic underachievement, coupled with an unmet need for services. Bassuk (1986) found that of 78 homeless children, 54 percent had repeated a grade and 29 percent were in special classes. Using the Denver Developmental Test, an instrument that is used to identify gross developmental delays, Bassuk and Gallagher (1987) found that almost half of the 81 preschoolers they tested suffered from developmental lags. In addition, one-third of these children manifested more than two developmental lags in the four areas tested, including language development, fine motor coordination, gross motor skills, and personal/social development. Similar findings were reported by Rescorla, Parker,

& Stolley (1991), who found preschool-aged sheltered children were significantly delayed in receptive vocabulary and visual-motor development than comparison group children. These children were much less likely to be enrolled in any kind of early childhood education program than were those in the domiciled comparison group. Despite such developmental lags, it is unlikely that these children, if they are to remain homeless, would receive special education services that are generally offered to publicly schooled children.

Using a sample of 169 homeless children in Los Angeles County, Zima, et al. (1997) found that almost one-half (45 percent) of school-aged sheltered children merited a special education evaluation. Despite this overwhelming need for services, only 23 percent of those with any disability had ever received special education testing or services. It is no surprise that school achievement among homeless children is low. According to 80 homeless parents of 151 children assessed by Bassuk, Rubin, & Lauriat (1986), 21 children were performing below average or were failing their courses, 43 percent had already repeated one grade, and 25 percent were in special classes. Similarly, of 60 African-American homeless children living in Minneapolis (Masten, Sesma, Si-Asar, Lawrence, Miliotis, & Dionne, 1997), 80 percent of the scores on the Wechsler Individual Achievement Test (WIAT), a nationally standardized achievement test, fell in the bottom quartile. In addition, teacher ratings of academic performance on the Teacher Report Form were also significantly below average. Of the sixty children, 20 percent had repeated a grade.

A second, but related, barrier to homeless children's education is poor school attendance. The National Law Center on Homelessness and Poverty reported that 23 percent of homeless children in America do not attend school during their course of homelessness

(NLCHP, 1995). For example, Vostanis, et al. (1997) found that of the 249 homeless children they assessed, 180 children (72 percent) had been attending mainstream primary schools, 4 (1.6 percent) had been attending special schools, and 33 (13 percent) were attending day care or preschool prior to their becoming homeless and being admitted to a shelter. After their admission, however, only 72 children (29 percent) were attending mainstream schools, 3 (1.2 percent) special schools, and 12 (5 percent) remained in day care or preschool. In comparison to the control group of low-income housed children, which all (100 percent) remained in school, these results are significant for all age groups. Similarly, a study in Los Angeles of 78 homeless students and 90 poor housed children found that the homeless children had missed an average of eight to nine days of school in the past three months, compared with five to six days missed by poor housed children. In addition, 42 percent of homeless children had missed more than one week of school, compared with only 22 percent of their housed peers (Wood, et al., 1989). Using a sample of 151 children from 80 families, Bassuk, Rubin, & Lauriat (1986) found that despite parents' reports that their school age children were attending school, shelter directors gave different indications. According to directors, attendance was irregular.

One factor contributing to the decrease in school attendance for homeless children is likely the school's insistence on their residency requirements, which allow only children living within a school's district to attend that school. The National Law Center on Homelessness and Poverty (NLCHP) reported that despite the federal law's mandates to forego this requirement for homeless children, ten out of twenty states surveyed in 1990 continued to impose the residency requirement (NLCHP, 1995). In addition, there are

barriers to parental involvement in school, including a lack of compliance with the McKinney Act's stipulation that school officials take into account the parent's requests to place a child in a particular school (Rafferty, 1995). However, 71 percent of the 244 homeless families in New York are sheltered in a different borough than their last permanent home, which means that the children are forced to change schools (Rafferty & Rollins, 1989). Some parents attempt to get around this problem by allowing their children to stay with relatives that live in the school district of origin. If found out, however, it is likely that children are not allowed to remain at their schools because their legal guardian must reside in the school's district, creating a catch-22 for parents and children alike, despite such laws to override such situations. Unfortunately, school mobility is associated with loss of educational services, poor school attendance, academic failure, school dropout, alienation, low self-esteem, and poorer mental health (Rafferty, 1995).

For students allowed to attend their schools of origin despite being temporarily housed in another school's district, transportation to school becomes a barrier. In fact, 74 percent of respondents in the NLCHP's 1995 survey listed transportation as a significant barrier to school attendance for homeless children. Most homeless families do not own cars, and for those who live outside of the school district, taking the bus is no longer an option. Rafferty & Rollins (1999) found that most children do transfer schools upon becoming homeless, with 33 percent having transferred between two and six times. Transferring schools poses various setbacks for children, one being uneven patterns of learning due to changes in curricula (Walsh & Buckley, 1994). Finally, shame and embarrassment become an issue for homeless children who have difficulty obtaining school clothes and supplies.

They become stereotyped and labeled by peers and likely become further isolated. In addition, homeless children often have no quiet and safe place to do homework after school, which negatively impacts their ability to keep up with assignments (Davey, 1998).

It is clear that despite federal attempts to minimize the barriers to school attendance and success for homeless children, myriad problems remain. Schools alone are not likely to resolve the issues that keep homeless children from being afforded the same educational rights as housed children. Coordinated service delivery provided by the various agencies that serve homeless families, homeless parents, and local and federal policies must improve in order to address the long term cost to the children and to society.

J. Mental Illness among Homeless Children

According to Vostanis, et al. (1997), there have been few studies on the mental health problems of homeless children. It has been well documented, however, that mental illness among homeless children is correlated to mental illness in their caregiver (Zima, et al., 1996, Rafferty, 1991, Vostanis, et al., 1996). Considering that homeless families are less likely than poor families to have stable social support, and are commonly victims of domestic violence, stigmatization, and poverty, it follows that a high rate of adjustment and mood difficulties would be prevalent in homeless children. Upon moving into shelters, it is not unusual for children to demonstrate regressive behaviors, including eating and sleeping difficulties as well as bed wetting (Bassuk & Gallagher, 1987). Bassuk postulates that the regressive behaviors reflect a child's current state of overwhelming stress coupled with his wish for nurturance and protection. In addition to this regression, other mothers reported that

their children's behavior deteriorated in the direction of aggression, hostility, and defiance. These subjective statements were corroborated by scores on the Child Behavior Checklist (CBCL), where the homeless children scored equal or higher than the mean of emotionally disturbed children on the factor scales of sleep problems, aggression, shyness, and withdrawal. One explanation for an increase in aggressive, acting-out behaviors could be that the homeless children are expressing anger at their current situations as well as attempting to gain attention from their depressed and anxious mothers, from whom they are not certain of protection. Davey (1998) reported that of the 52 homeless children he assessed using the CBCL, almost 50 percent of the sample fell into the borderline or clinical range, indicating poorer social functioning than normal children. In addition, 42 percent of the children fell into the clinical range on the CBCL's profile of behavioral problems.

Using Becks's Childhood Depression Scale on a sample of 78 homeless children, Bassuk (1986) found that of the children older than age five, 51 percent ($n = 35$) were depressed and required further clinical evaluation. Most children in the sample also acknowledged suicidal ideation, although most denied having a plan. Their overall depression scores were higher than those found among poor, non-homeless children and those registered in psychiatric clinics. In addition, 60 percent of the children in the sample demonstrated intense anxiety. In a sample of 52 homeless children, Bassuk, Rubin, & Lauriat (1986) found that approximately half required further psychiatric evaluation based on their scores on the Children's Manifest Anxiety Scale. Similarly, two-thirds of the boys and almost one-half of the girls whose parents filled out the Achenbach parent checklist required further psychiatric evaluation.

Zima, et al. (1996) found similar results in their study of 157 children living in homeless shelters in Los Angeles. More than one-third (38 percent) of these children required psychiatric evaluation for clinical depression. Further, clinical depression in children was most likely if their mothers reported chronic psychotic symptoms than if they did not. Twenty-two percent of the children required further clinical evaluation for internalizing behavior problems. Children were more likely to have internalizing behavior problems if their mothers were depressed or had histories of alcohol abuse. More than 25 percent of the children screened positive for externalizing behavior problems, such as aggression and delinquency. The children were more likely to have externalizing behaviors if their mothers had a history of depressive symptoms.

Vostanis, et al. (1997) investigated the psychosocial characteristics of 249 homeless children ages two through sixteen ($M = 11.4$). Using the Child Behavior Checklist (CBCL), they found that 65 homeless children (28 percent), compared with 15 housed controls (18 percent), had scores within the clinical range. The homeless children had significantly higher externalizing and internalizing scores. The best predictor of the children's scores on the CBCL was the mother's General Health Questionnaire score, which accounted for 15 percent of the variability (Vostanis, et al., 1997). Buckner and Bassuk (1997) investigated 41 homeless youths and a comparison group of 53 poor housed peers. Out of the entire sample, 31.9 percent of the children had one or more disorder, based on the Diagnostic Interview for Children (DISC), while 12 percent appeared to be seriously emotionally disturbed, based on meeting criteria for at least one disorder, had impairment associated with that condition, and had low scores on the Vineland-ABC. The most prevalent conditions were disruptive

behavior disorders, including oppositional defiant disorder, for which 14 percent of the sample met criteria. Other prominent disorders included anxiety disorders and affective disorders. Of the 16 children who met criteria for at least one disruptive behavioral disorder, five (31 percent) had received mental health services within the past six months. Of the seven “seriously emotionally disturbed children,” only one had received mental health treatment in his/her lifetime. However, five out of the seven mothers perceived a need for their children to receive such treatment. None of the children or adolescents met criteria for a substance abuse or dependence disorder or for mania or hypomania, while homeless children had moderately higher rates of co-occurring disorders.

K. Stress, Coping, and Self-Efficacy among Homeless Children

Homeless children experience a tremendous amount of stress. Loss of mostly everything that is known to them, including belongings, familiar people, and even a parent at times, results in a lack of knowing what to expect. Davey (1998) investigated 52 homeless children between the ages of six and eleven. He found that homeless children experienced a significantly high level of stress as measured by the Stress Response Scale. More than 95 percent of the children evidenced possible maladaptive coping patterns, with 65 percent falling into the clinical range. In addition, 64 percent of the sample had experienced an at-risk number of stressful events, as measured by the Life-Event Scale, during the three months prior to coming into a shelter, without factoring in homelessness itself as a numerical value. Davey concluded that elementary school-age homeless children of both genders clearly

indicated that they were experiencing greater amounts of stress than would be expected for their age group.

Menke (2000) compared currently, previously, and never homeless children ages eight to twelve on measures of coping. Three types of coping behaviors were analyzed: social support (seeking out another person such as a parent or friend), behavioral (physical activity used to handle stressors), and cognitive (mental processes used to manage stressors). Results revealed that significantly more previously homeless and never homeless children identified more social support compared to the homeless children. They also identified more individuals as sources of support. For the homeless children, the most frequently used behavioral coping strategy categories were aggressive activities (verbal or motor activities such as screaming or hitting) (20 percent), behavioral avoidance (a deliberate attempt to keep away from a stressor, such as sleeping or walking away) (14 percent), behavioral distraction (behavior other than isolating or avoiding that delays dealing with the stressor) (13 percent), and spiritual support (8 percent). The homeless children's most frequent cognitive coping strategy was avoidance, which refers to deliberate attempts to avoid acknowledging the existence of a stressor, such as not thinking about or ignoring it.

Davey (1998) found that total scores for six to eleven year old homeless children (n=52) on the CBCL's social competence scales indicated that homeless children are involved in significantly fewer social activities and organizations, have fewer friends, and perform below average in school. On the Coopersmith Self-Esteem Inventory, almost 70 percent of the homeless children in Davey's 1998 study scored below average.

L. Interventions for Homeless Female-Headed Families

The most basic intervention for homeless female-headed families is to provide them with stable housing. Clearly, none of the problems of poor mothers can be addressed without the “successful revamping” of federal housing policies (Dail, 1990). Safe and stable housing is necessary in order to set the stage for addressing the psychosocial needs of these families. Findings from their 1989 study of 240 homeless women with and without children led Johnson and Krueger to conclude that compared with homeless women without children, “homeless minority women with children need more extensive socioeconomic supports, such as subsidized low-income housing, public entitlements, parenting skills training, job training, and day care services.” Similarly, Dail (1990) defined one critical cause of homelessness as being the “paucity of low-income housing.” Burt and Cohen (1989) address the common assumption that homeless persons’ problems must be “fixed” before they can maintain stable housing by providing an alternative solution to transitional housing. They postulate that moving people into permanent housing while providing flexible supportive services might enable an individual or family to maintain their housed status.

However, even provided room and board, these families are faced with myriad difficulties and deficits. In 1986, Bassuk asserted “our major goal should be to rescue these families, particularly the children, from a lifetime of deprivation and violence and to interfere with a newly emergent cycle of intergenerational homelessness.” Dail (1990) purports that findings from her study of homeless mothers indicate that attention to the unique educational needs of homeless children are necessary. In addition, she advocates parental education for mothers in order to promote healthy parent/child relationships. Close parent-child

relationships and high parent involvement in the child's education have been shown to predict school success among sheltered children (Miliotis, Sesma, & Masten, 1999). Bassuk and Gallagher (1987) urge that special programming be creatively developed. They propose that children's distress can be alleviated by the provision of structure, routine and supportive limit setting, and a safe space in which they can engage in age-appropriate behaviors.

Either due to lack of services, barriers to treatment, or failures in recognizing needs, the mental health needs of homeless children and adolescents are not being met (Buckner & Bassuk, 1997). Potential barriers to service for children include mothers' own mental health or substance abuse problems, lack of transportation, language barriers, lack of communication among social service agencies, and, of course, financial means. It has been shown that case management, regardless of what type, is important in initiating change in family support. Wood, Hurlburt, Housgh, and Houghstetter (1998) found that clients in stable housing, compared with those without stable housing, improved in relationships and social support.

M. Transitional Housing Shelters

Most shelters for the homeless consist of barrack-style accommodations and single-room occupancy dormitories or hotels. Many of these shelters are located in dangerous neighborhoods where mothers with children would likely be frightened to expose their children to the criminal activity surrounding their temporary homes. Most often, families are crowded into one single room, likely sharing living room and kitchen facilities with many other families (Dail, 1990). Boxil and Beaty (1990) spent six-months observing the parent-

child relations of 40 women in an Atlanta shelter in an effort to understand the impact of shelter-life on the quality of mother/child interactions. The investigators utilized qualitative methodology in an attempt to gain insight about the experiences of the families, which they refer to as “public families, because they are forced to engage in each and every task of daily living in full public view.” The authors describe specific themes that emerged through their observations, with the overarching topic being the “difficulty mothers and their children as family units face in establishing and maintaining ordered mother/child relationships in this circumstance.” Boxill and Beaty (1990) explain that the time children spend in shelters is mostly unstructured and the activities are random. Children indicated that they were uncertain about everything, from where they would live the next day to whether they would accept food prepared by volunteers. Nothing was predictable. In addition, children were observed to have conflict over their need for attention/dependence and their own autonomy.

Themes that emerged for the mothers included the difficulty of mothering in public, which caused most mothers to feel judged and exposed. The “unraveling” of the mother role was observed as a consequence of homelessness. The authors use the word “unraveling” to describe a process of the oldest children taking over the role of mother, caretaking not only younger siblings, but also the mother herself. The final theme that emerged from the six months of observations was external control. Many of the mothers in the shelter reported not being able to control anything. Shelter rules usurped the traditional role of mother as “provider, family leader, organizer, and standard setter” (Boxill & Beaty, 1990). The authors’ recommendations include providing private time and space to homeless families

staying in shelters, reassessing the use of volunteers, and “re-ordering” mother/child relationships.

Only two of the six shelters participating in Bassuk’s (1986) Boston study provided childcare or parenting groups. However, McChesney (1990) reported that most transitional housing programs offer “life skills” training, including teaching parenting skills and money management. He also explains that many of these programs provide job training, educational programs, substance abuse treatments, and assistance in locating permanent employment and housing opportunities (McChesney, 1990).

There is a dearth of information regarding the recidivism of homelessness for female-headed families. Culhane and Kuhn (1996) used public administrative data to conclude that virtually all single adult users of homeless shelters in both Philadelphia and New York had left the system in a two-year period. Long-term shelter use was uncommon in both cities, with only 10 percent of both genders’ shelter stays lasting six months or more in New York, and three months or more in Philadelphia. Although individuals tended to leave the shelter system relatively early, the investigators also found that one-third of the women and approximately one-half of the men experienced readmission to shelters within a two-year period (Culhane & Kuhn, 1996).

N. Shared Housing Center

Shared Housing Center (SHC) was founded in 1984 as a Texas-based social service organization in a national network promoting “shared housing” as an affordable and compassionate alternative housing option for elderly homeowners seeking to remain in their

homes despite debilitating medical, social and economic circumstances that often accompany later years in life. Within four years of incorporation, Shared Housing Center recognized an unmet need beyond its original mission of providing “homeshare” arrangements for the elderly: the need to provide transitional housing to single-parent, homeless women with young dependent children. In 1989, Shared Housing Center’s first “transitional intergenerational group residence” was established in a rehabilitated duplex in the Oak Cliff section of Dallas as a second model alternative housing program. The housing accommodation and coordinated program were designed to serve both the aging population and an underserved, but growing, population of single mothers with children among Dallas’ new homeless. Since that time, Shared Housing has refined and successfully implemented its distinctive mission: To provide housing options and comprehensive supportive services to a critically at-risk, multi-cultural, intergenerational population, who are seeking to elevate themselves from homeless or near homeless situations to lifestyles of relative self sufficiency.

The Group Residence Program, as it is now called, offers transitional, intergenerational housing for single women with young children and for older adults. Currently, Shared Housing Center owns and operates four homes with a total of eighteen units available to clients in need of transitional housing while working toward self-sufficiency. The average stay for most clients who complete the program is twelve to fifteen months and the maximum stay for any client or family is twenty-four months. Individuals interested in the group residence program must complete an application and are screened for criminal histories and substance abuse at intake, and at any time there is suspicion of abuse

throughout their stay. There is a rental fee of \$100.00 per month per family, or 30% of their monthly income, whichever is the least amount. In order to stay in the program, single parent families must be employed, employable, or attend school. The older adult may volunteer or work, depending on the source of income. During their stays, residents are required to apply for public housing and any other assistance they need, such as medicare, food stamps, and TANF. The maximum number of children any one woman can have living with her at SHC is three, because each family has only one room and one bathroom to themselves. Further, the maximum age limit for girls is 12, and for boys it is 10.

The intergenerational approach provided by Shared Housing is unique among transitional housing available in Dallas. The family dwellings have a common kitchen area and common living areas. The two client populations served, the elderly and single parent families, create an environment of mutual support and a network for self-help and independent living. This program serves twenty-five or more homeless families and older adults each year. During their stay, residents are offered and provided, as needed, an array of direct services. Among these are case management, job skills training, employment counseling, and educational tutoring. Educational and cultural enrichment programs are provided for the children as well. Staff supervises the group residence to assure maintenance, sanitation, and safety. In addition, staff is responsible for the delivery of case management regarding screening new applicants and placing exiting residents in a more permanent living situation.

The Group Residence program has entered its sixteenth year of service, and has consistently evolved in an effort to reflect the fluctuating and increasing needs of the client

families. By 1995, the small staff at Shared Housing experienced a more difficult and increasingly needy homeless client family, due in part to the decline in community supportive services. After five years of transitional housing with basic case management services and volunteer driven programs, the board and executive director agreed to evaluate the program. The review committee at that time concurred that it was not enough to offer employment and education opportunities for the women. Instead, what became apparent was a growing need to address the dysfunctional behaviors of the clients. This evaluation was the key in addressing a major gap in services - the need to identify mental health providers as partners in order to provide therapeutic services to the families. Therefore, the creation of the Generations in Family Therapy (GIFT) program emerged. For the past ten years, GIFT has served as the mental health counseling component that deals with the less tangible, but highly valuable, needs of Shared Housing's client population: psychological awareness, emotional stability, and parenting and social skills.

Over the years, Shared Housing Center has utilized a number of partnerships in an effort to develop the curriculum of the GIFT program and in order to carry out therapeutic tasks. These collaborators have included the Beavers Family Studies Center at Southern Methodist University and the Child and Family Guidance center. Currently, a clinical psychology intern from the University of Texas at Southwestern Medical Center performs the therapeutic duties of the GIFT program, which focuses on the delivery of non-traditional therapy. All adult and child clients of the Group Residence program at Shared Housing are offered individual therapy sessions. Rather than requiring clients to come to an office to discuss their feelings and experiences, therapists at Shared Housing go into the clients'

residences. This modification decreases the “no-show” problem in clinics, which is often due to an alienating environment and a system too reminiscent of other bureaucracies. In addition, the GIFT therapist visits the group homes once per week to facilitate a group therapy session with the adult women. This group therapy session is often the place where, as one resident put it, “we learn to believe in each other...and in ourselves too.” While this group meeting is taking place, a similar group session is conducted for the children.

For the past twenty years, Shared Housing has offered myriad services to female-headed families. Until now, however, formal assessment of the outcomes of such services, including the addition of the GIFT component, has not been performed.

III. Aims of Study and Hypotheses

A. Purpose of Current Study

Despite the best efforts of federal, state, and local private and public sectors, social and economic indicators suggest that homelessness is here to stay for the foreseeable future. Although the effects upon families are not fully understood, concern about the long-term consequences of homelessness is justified. This concern includes the question of whether the children in these families are likely to become a generation of homeless and socially dependent adults. (Dail, 1990, Bassuk, et al., 1986). Many authors (LaVesser, et al, 1997, Letiecq, et al., 1998) have pointed out the need for impact studies and program evaluations in an effort to identify antecedents and consequences of homelessness. Specifically, Letiecq, et al. (1998) pointed out that few studies have assessed the effectiveness of transitional housing programs in helping homeless families transition into permanent housing. Clearly, none of the problems of poor mothers can be addressed without the “successful revamping” of federal housing policies (Dail, 1990). Safe and stable housing is necessary in order to set the stage for addressing the psychosocial needs of these families. Findings from their 1989 study of 240 homeless women with and without children led Johnson and Krueger to conclude that compared with homeless women without children, “homeless minority women with children need more extensive socioeconomic supports, such as subsidized low-income housing, public entitlements, parenting skills training, job training, and day care services.” Similarly, Dail (1990) defined one critical cause of homelessness as being the “paucity of low-income housing.”

Burt and Cohen (1989) address the common assumption that homeless persons' problems must be "fixed" before they can maintain stable housing by providing an alternative solution to transitional housing. They postulate that moving people into permanent housing while providing flexible supportive services might enable an individual or family to maintain their housed status. The current study is an attempt at identifying long-term successful outcomes of previously transitionally housed female-headed families. It is our hope to be able to identify what internal and external factors contribute to long-term success.

Data collection for the current study began several years ago, however; this data was not obtained in a controlled fashion or with specific output variables in mind. Due to the variation in terms of data collection, efficacy for the therapeutic outcomes of the GIFT program is limited. Instead, factors that do contribute to the long-term success of past clients will be derived, including whether or not participation in individual and/or group therapy accounts for any variance in outcome.

B. Hypotheses

Success can be measured in a number of ways. For the purpose of the current study, "success" is operationally defined as 1) stable housing, defined as equal to or greater than six months of living independently in one's own apartment, condominium, or home where one is not relying on a shelter network or friends and family to pay for the rent or mortgage. However, those who are receiving Section 8 government assistance in order to make their rent are not excluded from being successful, nor are those who live with husbands,

boyfriends, or other roommates in their own property. Secondly, “success” is operationally defined as 2) stable employment, defined as equal or greater than six months of working, without interruption between or within a job, for at least minimum wage at least twenty hours per week. Women who have reached retirement that are receiving Social Security were not excluded.

Each of the dependent variables were examined separately using both definitions of success. A great deal of overlap was expected between these two definitions; however, it was hoped that discrepancies between the two might lead to a unique perspective regarding contributors to positive outcomes.

Hypothesis 1. Women who have successful outcome will be more likely to have participated in the therapeutic GIFT program during their stay at Shared Housing Center.

Hypothesis 2. Women who have successful outcome will report more social support.

Hypothesis 3. Women who have successful outcome will report less mental illness.

Hypothesis 4. Women who have successful outcome will report less domestic abuse.

Hypothesis 5. Women who have successful outcome will report less drug and alcohol use.

Hypothesis 6. Children whose mothers had successful outcomes will be more likely to have participated in the therapeutic GIFT program during their stay at Shared Housing Center.

Hypothesis 7. Children whose mothers had successful outcomes will report less mental illness.

Hypothesis 8. Children whose mothers had successful outcomes will report higher self-esteem and self-efficacy.

Hypothesis 9. Children whose mothers had successful outcomes will report less drug and alcohol use.

IV. Method

A. Subjects

Participants for this study will be recruited from the past residents of the Shared Housing Center (SHC). These past residents consist of adult females and their male and female children, who range in age from zero to adult. Participation in Shared Housing Center's transitionally housed program, as well as in this research, has been and will be strictly voluntary. Furthermore, no rigid inclusion or exclusion criteria will be in place for participation in this study. Participants will be notified of the current study in multiple ways. First, a flyer will be created and left around SHC for the past residents to see when they come to the center to pick up groceries, use computers, or for any other reason (see Appendix A). Secondly, a letter requesting their participation in the study will be sent to each potential participant (see Appendix B). In addition, for those potential participants with known telephone numbers, phone calls will be given in an effort to obtain voluntary participation by the past residents. Past residents of SHC include over two-hundred women with as many children. Of those, seventy-five women with over one-hundred children have remained in contact with or left contact information with the staff of SHC. Demographic differences between these two groups, those who can and cannot be contacted, will be addressed. Participants will likely range in age from five to eighty years and will represent various ethnicities and education levels. Furthermore, it will be likely that diagnostic issues will be broad, with a number of participants likely meeting criteria for one or more diagnoses delineated in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), including significant difficulties with substance abuse. The literature (Goering, et

al., 1992) suggests that due to the transient nature of this population, it is likely that data gathering will produce many unforeseen challenges.

B. Materials

1. Diagnostic Measures

a.) Informed Consent Form

Following explanation of the study by this researcher, each subject will be asked to sign a consent form prior to participation in the study. Each child's parent or guardian will be asked to sign a consent form prior to their participation as well. Information provided in the consent form will include a brief description of the study, the purposes of conducting the research, the risks and benefits involved, and the precepts of confidentiality (see Appendix B).

b.) Demographic Survey

After informed consent has been obtained, this researcher will interview each adult female past resident using a set of structured questions. Demographic data gathering using a unique personal history form has been repeatedly performed (Goering, et al., 1998).

c.) Personal Resource Questionnaire-85 (PRQ-85)

The Personal Resource Questionnaire-85 (PRQ-85) is a two part instrument that was developed by Brandt and Weinert based on Weiss's (1974) model of relational functions. He defined social support as comprising the following dimensions: (a) provision for attachment/intimacy (intimacy), (b) being an integral part of a group (social integration), (c)

opportunity for nurturant behavior, (nurturance) (d) reassurance of worth as an individual and in role accomplishments (worth), and (e) the availability of informational, emotional, and material help (assistance).

The PRQ-85 is a norm-referenced paper and pencil instrument. Part one consists of descriptions of ten situations in life in which one would need assistance. This section requires the respondent to determine their resources as well as the satisfaction with the help that they may have received from these resources within the past six months. The eight life situations were derived from a review of the literature and include the domains of (a) immediate help, (b) extended help with an ill family member, (c) help in the event of short-term illness, (d) problems regarding family/friends, (e) problems with spouse or partner, (f) feeling lonely, (g) financial problems, and (h) global concerns with everyday life (Weinert, 1998).

Part two is a twenty-five item Likert scale that measures the respondent's perceived social support. Scores on this section range from 25 to 175 with higher scores indicating higher levels of perceived social support. By means of numerous studies, the alpha reliability of Part 2 has been demonstrated to be around .90 (Phillips, 2004).

d.) Index of Spouse Abuse (ISA)

The Index of Spouse Abuse (ISA) is a short-form scale that was designed for use in clinical settings. It can be used to measure the severity of both physical and non-physical abuse as perceived by female respondents. The ISA is a 30-item self-report scale that has high face validity and can be completed in about five minutes. The ISA scores for both

physical and non-physical abuse range from 0 to 100. The ISA was originally validated on a sample of 398 female university students, 198 other students and faculty members, and a third sample made up of 64 women who were victims of spouse abuse, most of whom were obtained through protective shelters, and 43 who were not victims of spouse abuse. The factorial validity of the ISA was evaluated by means of a principal components procedure with a varimax rotation. In this way, Hudson and McIntosh (1981) found that the ISA has discriminant validity when compared to the Index of Marital Satisfaction, which measures the severity of a problem in the marital relationship (Hudson and Glisson, 1976). In addition, the ISA was able to successfully discriminate between the two groups of known abused versus known non-abused women. The coefficient of discriminant validity for the physical scale (ISA-P) was .73 and for the non-physical scale (ISA-NP) was .80 (Hudson & McIntosh, 1981).

In terms of reliability, the ranges given for the ISA-P scale were .90 to .94 and for the ISA-NP scale were .91 to .96, using coefficient alpha (Hudson & McIntosh, 1981). The cut scores given for the ISA scales were determined in terms of their ability to minimize the sum of false positives and false negatives. In this way, results from a cumulative frequency distributions showed that an ISA-P score of 10 and an ISA-NP score of 25 are the most reliable. Using these cut-off scores, the ISA scales were able to correctly classify 90.7 of the sample as abused versus non-abused (Hudson & McIntosh), 1981). In an effort to investigate the reliability and validity of this scale when used as a research instrument with African-American women, Campbell and colleagues (2001) recruited a sample of 504 African-American women from four urban locations. These women ranged in age from 14 to 42

years. The mean education level for this sample was 12.5, SD=2.9, and 68% of the women qualified for the Medicaid and WIC programs within their states. Campbell, et al. (1981) report that the alpha reliability coefficients on the ISA-P and ISA-NP are “certainly impressive”. These authors also found that the factorial division between the two scales was also valid for their sample of African-American women.

e.) Symptom Assessment-45 (SA-45)

The Symptom Assessment-45 consists of forty-five items that require the respondent to rate from 1 (Not at all) to 5 (Extremely) according to their level of distress in the past seven days. The SA-45 is a shortened form of the original 90-item checklist developed by Derogitis, Lipman, and Covi (1973). These authors used cluster analysis to produce nine five-item scales based on their original Symptom Checklist-90 (SCL-90). The SA-45 consists of the following nine scales: Anxiety, Depression, Hostility, Interpersonal Sensitivity, Obsessive-Compulsive, Paranoid Ideation, Phobic Anxiety, Psychoticism, and Somatization. In addition, there are two global scales, the Global Severity Index and the Positive Symptom Total. The SA-45 can be scored by hand. T-scores based on age and gender are provided in the manual. Cutoff scores (T-score of 60) are based on scores that are one standard deviation or more away from the nonpatient mean in the direction of impairment (Maruish, Bershadsky, & Goldstein, 1998).

Scale development was based on a sample of adults, both female (n = 690) and male (n = 829), and adolescents, both female (n = 466) and male (n = 400) ages thirteen to eighteen. Five additional samples were given the SA-45 in order to run cluster analysis.

These consisted of 1,307 adult inpatients, 736 adolescent inpatients, 994 adult and adolescent inpatients, 1,082 adult and adolescent inpatients, and 1,649 adult and adolescent nonpatients (Viswesvaran, 2001).

Internal consistency reliability of the nine scales, using coefficient alpha, ranged from .74 to .87 (Median = .81) for adult nonpatients (n = 57) and from .73 to .91 (Median = .86) for adult patients (n = 4,000+). For adolescents, internal consistency ranged from .71 to .87 (Median = .79) for nonpatients (n = 64) and from .74 to .90 (Median = .86) for inpatients (n = 866) (Reynolds, 2001). Test-retest reliability estimates for the SA-45 were based on samples of 57 adult and 64 adolescent nonpatients. A two-week test-retest interval revealed acceptable stability estimates (.70s and .80s) for eight of the nine scales. The Anxiety scale (.42), however, had an abnormally low consistency score. The test-retest estimates were higher for the adult sample than for the adolescent sample (Viswesvaran, 2001). In addition, construct validity was found to be good, based on high intercorrelations with the SCL-90 (9:1082) and the Brief Symptom Inventory (BSI) (10:35) (Viswesvaran, 2001).

f.) Substance Abuse Subtle Screening Inventory-Third Edition (SASSI-3) and Substance Abuse Subtle Screening Inventory for Adolescents (SASSI-A)

The Substance Abuse Subtle Screening Inventory-Third Edition (SASSI-3), developed by Miller (1988), was designed to “indicate the risk of substance dependence using items that are less likely to elicit suspicion and untruthful answers” (Pittenger, 2001). One side of the paper and pencil questionnaire asks clients to answer true or false to questions that are not obviously related to substance abuse. These 67 subtle items are

intended to indicate those respondents with substance abuse problems that would not be open to disclosing them directly. The other side of the questionnaire lists 14 face valid questions that are quite obvious in their relationship to substance dependence. These items are rated on a four point Likert scale according to how often the proposed circumstances have occurred during the past six months, ranging from 0 “never” to 4 “repeatedly”.

The face-valid questions make up two of the SASSI-3’s subscales, Face Valid Alcohol (FVA) and Face-Valid Drugs (FVD). Objective scoring produces a yes or no answer as to the probability that the client does or does not have a substance dependence disorder. The true-false subtle items produce eight subscales and the Random Answer Pattern (RAP), which is a measure of validity (Pittenger, 2001). Three clinical scales measure the presence of symptoms of substance abuse: Symptoms (SYM), Obvious Attributes (OAT), and Subtle Attributes (SAT). There is also a Defensiveness scale (DEF), a Supplemental Addiction Measure (SAM), a Family vs. Controls scale (FAM), and a Correctional scale (COR) (Fernandez, 2001).

The SASSI-3 is scored by hand, and raw scores are plotted on a graph. Following this step, nine “decision rules” must be followed in order to determine whether the respondent is likely to have a substance abuse or dependence disorder (Pittenger, 2001). Normative data have been established for both males and females. The normative sample was made up of 2,015 respondents found in various addiction treatment facilities, general psychiatric hospitals, a vocational rehabilitation program, and a sex offender treatment program (Fernandez, 2001).

Lazowski, Miller, Boye, and Miller (1998), using the development sample (n = 2,015), found a 95% concordance between the SASSI-3 inference scores and clinical diagnoses of substance dependence. These authors also found a test sensitivity of 96% and a specificity of 93%. Test-retest reliability of the SASSI-3 development sample (n = 40), using a two-week interval, ranged from .92 to 1.00 (Lazowski, et al., 1998). In addition, Concurrent Validity with the Michigan Alcoholism Screening Test and the Drug Abuse Screening Test has been found (Fernandez, 2001).

g.) Culture-Free Self-Esteem Inventory (CFSEI)

The Culture-Free Self-Esteem Inventories, Third Edition (CFSEI-3) were designed to assess the self-esteem of children ages 6 to 18 using a self-report inventory. This is the latest edition of the culture-fair test developed by James Battle. There are three forms of the inventory: The Primary Form (ages 6-8), The Intermediate Form (ages 9-12), and the Adolescent Form (ages 13-18). Battle's theory of self-esteem, from which he derived the CFSEI-3's assumptions, was based on Harter's (1998) neo-Piagetian stages of development of self-esteem (Garcia, 2003). According to the CFSEI-3 manual, self-esteem is defined as "the perception the individual possesses of his or her own worth, which develops gradually and becomes more differentiated with maturity and interaction with others" (Battle, 2002).

The Primary Form consists of 29 items which are read by the examiner to the child, who must respond with a yes or no answer. A Global Self-Esteem Quotient (GSEQ), as well as a Defensiveness score to predict validity, are derived from normative tables, where the mean score is 100 (SD=15). The Intermediate form consists of 64 items that must be read

and answered either yes or no by the respondent. It yields four subscales: Academic (an individual's perception of his or her ability to perform academic tasks), General (an individual's overall perceptions of self-worth), Parental/Home (an individual's perceptions of his or her status at home), and Social (an individual's perception of the quality of his or her relationships with peers). Like the Primary Form, it also yields a Global Self-Esteem Quotient and a Defensiveness score. The Adolescent form is similar, in that it too produces the same scaled scores based on normative data. The 67 items that make up the Adolescent form yield one additional score, the Personal Self-Esteem Score (an individual's most intimate perceptions of anxiety and self-worth). All scaled scores have a mean of 100 and a standard deviation of 15). GSEQs from 90 to 110 account for almost 50% of the population (Battle, 2003). According to the manual, the GSEQ is the most useful value derived from the CFSEI-3. Very low GSEQs (below 90) indicate a problem such as poor self-esteem, immature behavior patterns, negative feelings, or unsatisfactory adjustment is present (Battle, 2003). The manual identifies use in research studies in which self-esteem is a variable as one of the intended uses of the CFSEI (Brunsman, 2003).

The CFSEI-3 was normed on a sample of 1,727 children in 17 states, one of which was Texas. The sample was made up of a representative group based on the projected characteristics of the school-age population by the U.S. Bureau of the Census (Battle, 2003). According to the normative group, internal consistency for the GSEQ ranged from .77 to .93, with greater values correlating to higher ages of respondents. Test-retest reliability, based on a sample of 77 students from Austin, TX and an interval of two weeks between tests ranged from .72 to .98 (Battle, 2003). Concurrent Validity of the CFSEI-3 was demonstrated by

comparing the normative sample's GSEQ scores to their scores on other valid and reliable measures. Coefficients of .61 and .72 ($p < .01$), respectively, were found when comparing GSEQ scores to those on the Self Esteem-Inventory Self-Esteem Quotient and the Piers-Harris Self-Esteem Inventory Total Score (Battle, 2003). Differential item functioning (DIF) analyses were conducted to detect bias based on gender and ethnicity, and effect size for items with potential biases were examined (Brunsman, 2003). The DIF analysis indicated minimal detectable bias for gender and ethnicity (Garcia, 2003).

h.) Student Self-Concept Scale (SSCS)

The Student Self-Concept Scale (SSCS) was designed as a multidimensional self-report measure of self-concepts and related psychological constructs for use with students in grades 3 through 12 (Gresham, et al., 1993). The measure is made up of 72 items, which are rated on a three point Likert scale. The SSCS assesses students across three rating dimensions: Confidence, Importance, and Outcome Confidence. In addition, a Lie scale is included to detect faking. The authors of the measure define self-concept as “the level of confidence students have in the Self-Image (whether or not they possess culturally valued attributes), Academic skills, and Social skills” (Gresham, et al., 1993). Self-Image, therefore, is a measure of self-esteem, while Academic and Social skills is a measure of self-efficacy. A global Self-Confidence score encompassing all three of these domains can also be calculated. Gresham (1995) lists one of the five uses of the SSCS to be “a component of research projects designed to measure the self-concept characteristics of defined populations...or longitudinal aspects of self-concept in children and adolescents”.

The standardization sample for the SSCS consisted of 2,151 elementary students and 1,435 secondary students from 19 states. The sample was stratified by ethnicity, gender, region, and community size, based on U.S. census data and was collected in Spring of 1998 (Benson, 1998).

Internal consistency estimates for each subscale ranged from .55 to .92. The internal consistency estimates for the composite scores of Self-Confidence and Outcome Confidence were .90 and .81, respectively (Benson, 1998). Test-retest reliability scores were based on a four week interval and ranged from .35 to .72 (median = .58) for elementary students and .52 to .82 (median = .73) for secondary students. The authors examined the concurrent validity of the scale by correlating it with measures such as the Coopersmith Self-Esteem Inventory, the Piers-Harris' Children's Self-Concept Scale, and the Achenbach Child Behavior Checklist (Leong, 1998). In a sample of 102 elementary students, SSCS total scores correlated .54 with the Coopersmith Self-Esteem Inventory. Similarly, in a study using 44 secondary students, the SSCS composite score correlated .64 with the Piers-Harris Self-Concept total score. Similar validity estimates were found between the SSCS and the Tennessee Self-Concept Scale (Gersham, 1995).

C. Procedure

The assessments of female past residents and their children took place either at Shared Housing Center or in the women's homes. Upon making contact with each participant, the researcher set up an appointment with each woman and/or family for a face-to-face meeting, at the convenience of the participant. The participant was informed at this

time that the interview would consist of both verbal and paper and pencil measures and would take between sixty and ninety minutes. Prior to the assessment, the researcher obtained written consent from each adult participant and for each child participant by their adult guardian. At this time, the researcher asked the participant whether they could read and write in English at or above a seventh grade level of understanding, and every participant answered yes to this question. Further, no participant had less than nine years of education. Due to the length of the self-report tests, the researcher felt that an additional test of reading would be too burdensome to the subjects.

The researcher individually interviewed each past resident participant using the Demographic Survey form (Appendix D). In addition, the researcher was available to assist the adult women and/or children in understanding the directions to any of the assessment instruments. During this meeting, the researcher distributed all of the pertinent measures to each participant. Measures given to each participant depended on his or her age, with every past resident adult receiving the Informed Consent, Demographic Survey, Index of Spouse Abuse, Symptom Assessment-45, and Substance Abuse Subtle Screening Inventory. Adolescent children of past residents were asked to fill out the Symptom Assessment-45, the Substance Abuse Subtle-Screening Inventory for Adolescents, the Culture-Free Self-Esteem Inventory (Adolescent version), and the School Self-Concept Scale (Secondary). Children of past residents that are ages six through eleven were asked to fill out the Culture-Free Self-Esteem Inventory (Primary for ages six to eight and Secondary for ages nine through eleven) and the School Self-Concept Scale (Primary).

D. Statistical Analyses

All data were analyzed with the Statistical Package for the Social Sciences for Windows, version 12.0 (SPSS, 2003). The following statistical analyses were conducted to explore the hypotheses.

Hypothesis 1. Women who have successful outcome will be more likely to have participated in the therapeutic GIFT program during their stay at Shared Housing Center.

Hypothesis 1 was evaluated with four two-sample Chi-Square tests. Subjects were divided into two categories, the successful and non-successful groups for both outcomes, employment and stable housing. Separate Chi-Square analyses were conducted to determine the relationship between participation in therapy and successful or non-successful outcome.

Hypothesis 2. Women who have successful outcome will report more social support.

Hypothesis 2 was evaluated by using independent samples *t*-tests that compared the mean score of each group's ratings on the Personal Resource Questionnaire. The groups compared were the successful employment and non-successful employment groups and the successful housing and non-successful housing groups. A mean score was considered statistically significant if the coefficient alpha (*p*) was $< .05$. In addition, social support was measured by using Chi-Square analyses to determine the relationship between the number of people listed as supportive during and after transitional housing and successful or non-successful outcome.

Hypothesis 3. Women who have successful outcome will report less mental illness.

Hypothesis 3 was evaluated by using independent samples *t*-tests that compared the mean score of each group's ratings on the each of the ten scales of the Symptom Assessment-45. The groups compared were the successful employment and non-successful employment groups and the successful housing and non-successful housing groups. A mean score was considered statistically significant if the coefficient alpha (*p*) was $< .05$.

Hypothesis 4. Women who have successful outcome will report less domestic abuse.

Hypothesis 4 was evaluated by using independent samples *t*-tests that compared the mean score of each group's ratings on the each of the two scales of the Index of Spouse Abuse. The groups compared were the successful employment and non-successful employment groups and the successful housing and non-successful housing groups. A mean score was considered statistically significant if the coefficient alpha (*p*) was $< .05$.

Hypothesis 5. Women who have successful outcome will report less drug and alcohol use.

Hypothesis 5 was evaluated with four two-sample Chi-Square tests. Subjects were divided into two categories, the successful and non-successful groups for both outcomes, employment and stable housing. Separate Chi-Square analyses were conducted to determine the relationship between substance abuse, based on mean scores from the Substance Abuse Subtle Screening Inventory-Third Edition, and successful or non-successful outcome. A difference between groups was considered statistically significant if the coefficient alpha (*p*) was $< .05$.

Hypothesis 6. Children whose mothers had successful outcomes will be more likely to have participated in the therapeutic GIFT program during their stay at Shared Housing Center.

Hypothesis 6 was evaluated with four two-sample Chi-Square tests. Subjects were divided into two categories, the children of successful mothers and the children of non-successful mothers groups for both outcomes, employment and stable housing. Separate Chi-Square analyses were conducted to determine the relationship between the children's participation in therapy during their stays at SHC and their mothers' successful or non-successful outcome. A difference between groups was considered statistically significant if the coefficient alpha (p) was $< .05$.

Hypothesis 7. Children whose mothers had successful outcomes will report less mental illness.

Hypothesis 7 was evaluated by using independent samples t -tests that compared the mean score of each group's ratings on the each of the ten scales of the Symptom Assessement-45. The groups compared were the children of mothers with successful employment and children of mothers with non-successful employment groups and the children of mothers with successful housing and children of mothers with non-successful housing groups. A mean score was considered statistically significant if the coefficient alpha (p) was $< .05$.

Hypothesis 8. Children whose mothers had successful outcomes will report higher self-esteem and self-efficacy.

Hypothesis 8 was evaluated by using independent samples *t*-tests that compared the mean score of each group's ratings on the each of the self-esteem quotients from both the Culture Free Self Esteem Inventories and the Student Self-Concept Scales. The groups compared were the children of mothers with successful employment and children of mothers with non-successful employment groups and the children of mothers with successful housing and children of mothers with non-successful housing groups. A mean score was considered statistically significant if the coefficient alpha (*p*) was $< .05$.

Hypothesis 9. Children whose mothers had successful outcomes will report less drug and alcohol use.

Hypothesis 9 was evaluated with four two-sample Chi-Square tests. Subjects were divided into two categories, the children of successful mothers and the children of non-successful mothers groups for both outcomes, employment and stable housing. Separate Chi-Square analyses were conducted to determine the relationship between the children's likelihood of having a substance abuse problem according to the Substance Abuse Subtle Screening Inventory-Adolescent Version and their mothers' successful or non-successful outcome. A score was considered statistically significant if the coefficient alpha (*p*) was $< .05$.

V. Results

A. Description of Sample

Demographic Information

Table 1 provides the demographic information for the sample. The sample consisted 25 women, ranging in age from 25 to 75 years, with a mean age of 39 years ($SD = 12.2$). Sixty-four percent ($n = 16$) of the sample were African-American, 16 percent were Hispanic ($n = 4$), 12 percent ($n = 3$) were Caucasian, and the remaining 8 percent were made up equally of one woman who was Native American and another who was one-half Hispanic and one-half Caucasian. The average number of children among the women was 2.2, with a range of 0 to 5 children ($SD = 2.2$). The average years of education in the sample was 12.9 years, with a range of 9 to 18 years ($SD = 2.2$).

Regarding income, the average monthly income of the sample was \$1,275.52, with a range of 0 to \$3,000.00 ($SD = \841.29). Of the sample, 76 percent ($n = 19$) spoke English as their first language, with 16 percent ($n = 4$) speaking Spanish as their first language, and eight percent ($n = 2$) speaking tribal languages as their first language. The entire sample ($n = 25$) spoke and read proficiently in English.

Table 2 provides information about the women's experiences prior to and during their stays at Shared Housing Center. The women who participated in this study had left the Shared Housing Center an average of 63 months ago, with a range of 7 to 161 months ($SD = 46.9$) since having moved away from the Center. Their average stay at Shared Housing Center was 14.3 months, with a range of 3 to 47 months ($SD = 11.6$). Shared Housing Center designed its program for women to stay from twelve to fifteen months. However,

women may be evicted if they do not comply with program rules or may choose to move out for any reason at any time prior to completion of the program. Prior to entering Shared Housing, 80 percent of the sample ($n = 20$) had lived with relatives at some point in their adult lives. Fifty-two percent of them had at some point previously lived in a shelter ($n = 13$), while 36 percent had previously been homeless ($n = 9$) before their entry to SHC. Similarly, thirty-six percent of the sample ($n = 9$), had ever previously lived in a transitional housing center, while 32 percent had ever previously been evicted ($n = 8$). Only 8 percent ($n = 2$) of the sample had ever lived on the streets prior to entering SHC. Table 2 also includes information regarding the women's living situations since their exit from SHC. Of the entire sample, 36 percent ($n = 9$) had lived with relatives, while 12 percent ($n=3$) had stayed in a shelter. Since leaving SHC, only 8 percent ($n=2$) of the sample had been homeless and only 4 percent ($n=1$) had been evicted. While 16 percent ($n=4$) of the sample had lived in a transitional housing center other than SHC after their departure from SHC, none of the sample had lived on the streets ($n=0$).

When the sample of 25 women was divided into two groups, based on criterion for success, thirteen women (52 percent) met criteria for both successful housing and successful employment. Five women (20 percent) met criteria for successful housing, but not successful employment. Five other women (20 percent) met criteria for successful employment, but not successful housing. Two of the women (8 percent) in the sample did not meet criteria for successful housing or successful employment. These distinctions will be important to keep in mind when considering data, because the groups have the same number of persons for successful housing (SH, $n = 18$) and for successful employment (SE, $n = 18$),

but these 18 people are not the same in each group. It is also important to note that there were significantly more women that met criteria for success defined by stable housing ($n = 18$) than those who did not ($n = 7$), $\chi^2(1) = 4.84, p = .028$. In the same way, there were significantly more women that met criteria for success defined by stable employment ($n = 18$) than those who did not ($n = 7$), $\chi^2(1) = 4.84, p = .028$. It is also important to point out that of the women who did not meet criteria for successful employment, none of them were working at all. Therefore, they did not simply miss the six-month cut-off for stable employment, but in fact were not employed at all at the time of assessment (Table 3).

Comparison between Participating Sample and Other Past-Residents

This pilot study sample was compared to the entire population of past residents of SHC to determine if there were differences between the sample and past-residents who did not participate in the study. Student *t*-tests and Chi-square analyses were conducted to examine potential differences in demographic variables between participants and non-participants. All demographic variables that were available from the database at SHC were used to examine differences between the past-residents that did not participate in the study (NP) ($n = 124$) and those that did participate (PS) ($n = 25$). There was not a significant difference found between the two groups on age, with PS having a mean age of 34.5 ($SD = 12.6$) and NP having a mean age of 35.36 ($SD = 14.9$), $t(147) = .01, p = .99$ at the time of their stays at SHC. Similarly, no significant difference was found between the groups on amount of education obtained, with 80 percent ($n = 20$) of the PS group having earned a high school diploma 65.3 percent ($n = 81$) NP group having earned a high school diploma $\chi^2(4, n$

$= 149) = 11.23, p = .024$. However, the 25 participants in the PS group ($M = 12.92, SD = 8.78$) stayed at Shared Housing Center for a significantly longer amount of time than those in the NP group ($M = 6.68, SD = 6.05$), $t(147) = 4.33, p = .00$ (Table 4).

Further, Chi-Square analysis revealed a significant difference between the groups with respect to Ethnicity. The PS group was made up of 64 percent African American women ($n = 16$), while the NP group was made up of 44.4 percent African American women ($n = 55$). While both groups were made up of roughly 16% Hispanic women, the PS group had 12 percent Caucasian women ($n = 3$), while the NP group was made up of 37.1 percent ($n = 46$). Clearly, Caucasian women were underrepresented in the sample (PS), and African American women were overrepresented, $\chi^2(4, n = 149) = 11.23, p = .024$.

An additional significant difference was found between the groups on housing choice following their stays at SHC, with 25 percent ($n = 31$) of the NP group, compared to zero percent of the PS group ($n = 0$) returning to the streets or to a shelter directly after their SHC stay, and a significantly higher number of the PS group (80 percent, $n = 20$) choosing to live in their own apartment or home after leaving SHC, compared to only 44.4 percent ($n = 55$) of the NP group, $\chi^2(5, n = 149) = 18.57, p = .002$. Additional results show that there was not a significant difference between the groups with regard to who referred them to SHC, whose decision it was for them to move out of SHC (whether they chose to leave or were evicted), nor in which residence they lived while at SHC. These results can be found in Table 5.

B. Analysis of Hypotheses

Hypothesis 1. The first hypothesis predicted that the mothers who had a successful outcome defined by either successful employment (SE) or successful housing (SH) would be more

likely to have participated in individual and/or group therapy as part of the GIFT program. Participants were divided into two categories, those who met criteria for successful housing (SH) and those who did not (NSH). In addition, participants were divided into two categories based on whether they met criteria for successful employment (SE) or not (NSE). Participants were also divided according to whether or not they participated in individual therapy and whether or not they participated in group therapy. The dichotomous variables were then compared by separate Chi-Square tests.

As can be seen in Table 5, no significant results were found for the SH and NSH groups. Specifically, in the SH group, 94.4 percent ($n = 17$) participated in group therapy compared to 5.6 percent ($n = 1$) who did not. For the NSH group, 85.7 percent ($n = 6$) participated in group therapy, compared to 14.3 percent who did not ($n = 1$). Regarding participation in individual therapy, 55.6 percent ($n = 10$) of the SH group and 85.7 percent ($n = 6$) of the NSH group received individual therapy.

Results for SE and NSE are shown in Table 6. Regarding the women who met criteria for successful employment (SE), 94.4 percent ($n = 17$) of them participated in group therapy, while only 5.6 percent ($n = 1$) did not. Of those who were not successfully employed (NSE), 85.7 percent ($n = 6$) had participated in group therapy, while 57.1 percent ($n = 4$) did not.

Hypothesis 2. The second hypotheses predicted that women who have successful outcome in employment and/or housing would report more social support. This hypothesis was examined using an independent samples *t*-tests. Participants were divided into both SH and

NSH groups and SE and NSE groups. Each set of the two independent groups were compared using the mean score of the Personal Resource Questionnaire, part B. Potential scores on this measure range from 25 to 175, with higher scores indicating higher levels of perceived social support. No significant results were found (see Table 7) between SH and NSH or SE and NSE on this measure.

In addition, using Chi-square analyses, groups were compared based on the average number of people that they listed as being supportive, both during their stays at SHC, and currently. For the SH group, they listed an average of 1.67 people ($SD = 1.46$) during their stay at SHC, and an average of 2.50 people ($SD = 2.88$) who they could currently rely on for support. Although the results were not significantly different, the opposite trend was found for the NSH group, where during their stays at SHC they listed an average of 2.71 people ($SD = 3.35$) who they could rely on for support, versus a current average of 1.43 people ($SD = 2.15$) they considered supportive. A Chi-Square analysis was performed using an increase, decrease, or no change in supportive people and the impact on successful housing, but no significant difference was found, $\chi^2 (2) = 3.56, p = .169$. For the SE group, they listed an average of 1.67 people ($SD = 1.46$) as supportive during their stays at SHC, which grew to an average of 2.00 people ($SD = 3.01$) currently. For the NSE group, however, they listed an average of 2.71 people ($SD = 3.35$) as supportive during their stay at SHC, and the same number, on average, of people currently supportive ($M = 2.71, SD = 1.70$). A Chi-Square analysis was performed using an increase, decrease, or no change in supportive people and the impact on successful employment, but no significant difference was found, $\chi^2 (2) = .254, p = .881$.

Hypothesis 3. The third hypothesis stated that women who have successful outcome would report less mental illness. This hypothesis was tested using independent samples *t*-tests, which compared the SH and NSH and the SE and NSE groups' mean scores on the Symptom Assessment-45 scales. Results for SH and NSH are shown in Table 8, and for SE and NSE in Table 9. Notably, the clinical cutoff for significance on the SA-45 is a scaled score of 60.

Contrary to what was hypothesized, the SH group had a significantly higher mean score ($M = 63.11$, $SD = 7.83$) than the NSH group ($M = 55.00$, $SD = 6.11$) on the Global Severity Index (GSI), $t(23) = -2.46$, $p = .020$. Similarly, the SH group had a significantly higher mean score ($M = 63.11$, $SD = 7.83$) than the NSH group ($M = 55.00$, $SD = 6.11$) on the Positive Symptom Total (PST), $t(23) = -2.60$, $p = .016$. On the Anxiety (ANX) scale, the SH group had a significantly higher mean score ($M = 60.33$, $SD = 9.39$) than the NSH group ($M = 52.29$, $SD = 6.75$), $t(23) = -2.46$, $p = .051$. Also on the Somatization (SOM) scale, the SH group had a significantly higher mean score ($M = 61.94$, $SD = 8.47$) than the NSH group ($M = 55.29$, $SD = 6.37$), $t(14.6) = -2.13$, $p = .051$. On the Phobic Anxiety (PHO) scale, the SH group had a significantly higher mean score ($M = 65.50$, $SD = 6.78$) than the NSH group ($M = 60.14$, $SD = 4.18$), $t(17.9) = -2.29$, $p = .028$, although both groups' mean scores on the PHO scale were elevated to the clinical cutoff score, which is 60. Further, on the Hostility (HOS) scale, the SH group had a significantly higher mean score ($M = 61.94$, $SD = 7.05$) than the NSH group ($M = 56.43$, $SD = 4.24$), $t(18.4) = -2.39$, $p = .028$. On the Interpersonal Sensitivity (INT) scale, the SH group had a significantly higher mean score ($M = 60.06$, $SD = 7.29$) than the NSH group ($M = 52.71$, $SD = 5.80$), $t(13.8) = -2.64$, $p = .020$. Finally, on the Paranoid Ideation (PAR) scale, the SH group had a significantly higher mean

score ($M = 62.67$, $SD = 7.86$) than the NSH group ($M = 57.14$, $SD = 4.41$), $t(19.47) = -2.22$, $p = .039$.

A logistic regression was run on all variables that were significant or that approached significance in discriminating between groups of SH and NSH. The factor that was found to account for the greatest amount of variance in predicting stable housing was the score on the SA-45 General Symptom Index scale. This finding (Table 25) is discussed further in the Exploratory Analyses Section.

Only one scale was significantly differed between the SE and NSE groups: the Hostility (HOS) scale. The mean score for the SE group ($M = 61.89$, $SD = 7.26$) was significantly higher than that of the NSE group ($M = 56.57$, $SD = 43.36$), $t(21.99) = -2.50$, $p = .021$.

Hypothesis 4. The fourth hypothesis stated that women who have successful outcome would report less domestic abuse. This hypothesis was tested using Chi-Square analyses, which compared the SH and NSH and the SE and NSE groups based on the clinical cut-off scores on the Index of Spouse Abuse Non-Physical (ISA-NP) and Physical (ISA-P) scales. No significant results were found (see Table 10 for SH and NSH and Table 11 for SE and NSE). The clinical cutoff score is 25 for the ISA-NP scale and 10 for the ISA-P scale.

Hypothesis 5. Hypothesis five stated that women who have successful outcome would report less drug and alcohol use. To examine this hypothesis, participants were divided into SH and NSH groups, as well as into SE and NSE groups. Participants were also divided according to

whether or not they were likely to have a substance abuse disorder, according to their scores on the SASSI-3. The dichotomous variables were then compared by separate Chi-Square tests. None of the Chi-Square tests were statistically significant, which was likely attributable in part to the small sample size. Of the SH group, 5.6 percent ($n = 1$) of the SH group participants were likely to have a substance abuse disorder, and 94.4 percent ($n = 17$) were not. For the NSH group, 28.2 percent ($n = 2$) were likely to have a substance abuse disorder, compared to 71.4 percent ($n = 5$) who were not (see Table 12). For the SE group, 11.1 percent ($n = 1$) were likely to have a substance abuse disorder, whereas 88.9 percent ($n = 16$) were not. In the NSE group, 14.3 percent ($n = 1$) were likely to have a substance abuse disorder, as opposed to 85.7 percent ($n = 6$) who were not. Results for the SE and NSE groups are shown in Table 14.

Hypothesis 6. The sixth hypothesis predicted that children whose mothers had successful outcomes would be more likely to have participated in the therapeutic GIFT program during their stay at Shared Housing Center. This hypothesis was examined using four separate Chi-Square analyses. Children of mothers who met criteria for successful housing (CSH) and children of mothers who did not meet criteria for successful housing (CNSH) were divided into two groups. Similarly, Children of mothers who met criteria for successful employment (CSE) and children of mothers who did not meet criteria for successful employment (CNSE) were divided into two groups. The child participants were also divided according to whether or not they participated in individual therapy and whether or not they participated in group therapy. The dichotomous variables were then compared by separate Chi-Square tests,

results of which can be found in Table 15 for CSH and CNSH and Table 16 for CSE and SNSE. None of the Chi-Square tests were statistically significant. Contrary to what was expected, there was not a significant difference between the groups with regard to participation in group therapy. Seventy five percent of the SH group ($n = 15$) and 83.3 percent of the NSH group ($n = 5$) participated in group therapy during their stays at SHC. Similarly, 35 percent of children in the CSH group ($n = 7$) received individual therapy, whereas 67 percent of those in the CNSH group had received individual therapy ($n = 4$). Overall, this trend is the opposite of what was hypothesized (see Table 15).

The statistical trends are slightly different with regard to the CSE and CNSE groups, where 79.2 percent of the CSE group ($n = 19$) received group therapy, compared to 50 percent of the CNSE group ($n = 1$). Similarly, 45.8 percent of the CSE group ($n = 11$) received individual therapy, compared with 0 percent of the CNSE group ($n = 0$). There are no significant differences between groups, although the trends here do suggest that group therapy for children was more common among those in the CSE group (see Table 16).

Hypothesis 7. Hypothesis 7 predicted that children whose mothers had successful outcomes would report less mental illness. This hypothesis was tested using independent samples *t*-tests, which compared the CSH and CNSH and the CSE and CNSE groups' mean scores on the Symptom Assessment-45 (SA-45) scales. Results for CSH and CNSH are shown in Table 17.

Although there are no significant findings, it is worth noting that for the CNSH group, multiple scales were elevated at or above the cutoff score of $T = 60$, based on scores

that are one standard deviation or more away from the nonpatient mean in the direction of impairment (Maruish, Bershadsky, & Goldstein, 1998). Specifically, the CNSH ($n = 3$) had mean elevations on the following scales: Postiive Symptom Total (PST) ($M = 60.00$, $SD = 20.3$), Anxiety (ANX) ($M = 65.00$, $SD = 12.53$), Depression (DEP) ($M = 60.33$, $SD = 12.58$), Obsessive-Compulsive (OCD) ($M = 61.33$, $SD = 16.86$), Somatization (SOM) ($M = 62.33$, $SD = 17.01$), Phobic Anxiety (PHO) ($M = 65.67$, $SD = 9.71$), and Paranoid Ideation (PAR) ($M = 61.67$, $SD = 14.05$). Table 18 shows the results for the CSE and CNSE groups. No significant differences were found between these groups, likely because of the small sample size. Specifically, only one participant was in the CNSE group. This participant elevated scores on the PST ($M = 62.00$, $SD = 0$), ANX ($M = 60.00$, $SD = 0$), OCD ($M = 61.00$, $SD = 0$), and HOS ($M = 60.00$, $SD = 0$) scales, whereas the only elevated mean score of the ten participants in the CSE group was on the PHO ($M = 60.10$, $SD = 7.09$) scale.

Hypothesis 8. Hypothesis eight stated that children whose mothers had successful outcomes would report higher self-esteem and self-efficacy. This hypothesis was tested using independent samples *t*-tests, which compared the CSH and CNSH and the CSE and CNSE groups' mean scores on the Culture-Free Self-Esteem Inventory (CFSEI) and Student Self-Concept Scale (SSCS). For success defined by stable housing, no significant results were found (see Tables 19 and 20). However, for success defined by stable employment, significant results were found, but they were counter to the research hypothesis. Two scores on the CFSEI were found to be statistically significant. A significant difference between the mean scores of the CSE ($M = 6.67$, $SD = 2.24$) and NCSE ($M = 14.00$, $SD = 0.00$) was found

on the Personal Self-Esteem Score, $t(8) = 3.11, p = .014$. However, caution should be taken when considering this result due to the small sample size, particularly in the NCSE group ($n = 1$). An additional significant difference, also in the opposite direction of what was predicted, was found between the mean scores of the CSE ($M = 88.92, SD = 15.56$) and NCSE ($M = 108.50, SD = 71$) on the Global Self-Esteem Quotient, $t(23.82) = 6.06, p < .001$. Again, because of the small sample size, particularly of the NCSE group, where $n = 2$, caution should be taken when considering these results, which can be found on Tables 21 and 22.

Hypothesis 9. The final hypotheses predicted that children whose mothers had successful outcomes would report less drug and alcohol use. To examine this hypothesis, participants were divided into CSH and CNSH groups, as well as into CSE and CNSE groups. Participants were also divided according to whether or not they were likely to have a substance abuse disorder, according to their scores on the SASSI-3. The dichotomous variables were then compared by separate Chi-Square tests. None of the Chi-Square tests were statistically significant, which was likely attributable in part to the small sample size ($n = 12$). Results for the CSH and CNSH revealed that 11.1 percent ($n = 1$) of the CSH group was likely to have a substance abuse disorder, compared to 33.3 percent ($n = 1$) in the CNSH group. Similarly, 88.9 percent ($n = 8$) of the CSH group was not likely to have a substance abuse disorder, compared to 66.7 percent ($n = 2$) of the CNSH group. Results are shown in Table 23. As for the CSE and CNSE groups, 18.2 percent of the CSE group ($n = 2$) was likely to have a substance abuse disorder, compared to 0 percent ($n = 0$) of the CNSE group.

Eighty-one percent ($n = 9$) of the CSE group was not likely to have a substance abuse disorder, compared with 100 percent ($n = 1$) of the CNSE group (see Table 24).

C. Exploratory Analyses

In order to understand more fully the predictors of Successful Housing and Successful Employment amongst the sample, Chi-Square and independent samples *t*-tests were performed. A multiple regression analysis was conducted to evaluate how well any of the predetermined significant variables could predict stable housing. Logistic Regression analysis revealed that 33 percent of Successful Housing Outcome could be predicted by SA-GSI score (Table 25). Participants who scored higher on the SA-45 GSI scale were more likely to be successfully housed for six months or more ($OR = 1.22$, $95\% CI = 1.01-1.48$). In an effort to determine if there was a potential outlying score amongst the SH group, the participant with the highest scores on the SA-45, including the SA-45 GSI scale, was removed. The *t*-tests were then run comparing the groups of SH to NSH on these SA-45 scales. However, even without the woman with the highest scores considered, the significant differences between groups were still found on each scale.

Further investigation into understanding the differences between groups on the report of psychological symptoms led to the discovery that within the SH group, 33.3 percent ($n = 6$) were currently receiving therapy and 66.7 percent ($n = 12$) were not currently receiving therapy. Student's independent samples *t*-tests were run to explore differences between these two groups in mean scores of scales on the SA-45. However, no significant differences were found between the groups.

Another issue that called for additional inquiry was the length of stay at SHC. Although the length of stay at SHC between the SH and NSH groups was not found to be of statistical significance ($t(23) = 1.28, p = .213$), there is clinical value in noting that of the women in the SH group, their average length of stay at SHC was 12.5 months ($SD = 7.8$). In contrast, the women in the NSH group stayed at SHC an average of 19.0 months ($SD = 18.0$), indicating that these women, even while residents at SHC, may have had greater needs for support. The policy at SHC to offer extended housing for those women that are not yet able to make it independently and continue to have need for such services may be one explanation for this difference.

In an effort to further explore potential predictors of successful employment, student's t -tests and Chi-square analyses were performed by comparing the SE and NSE groups for all of the variables available. Regression analysis showed that 54 percent of the variance in Successful Employment Outcome can be accounted for by the amount of government assistance received for housing (Table 26). Participants who received more government assistance for housing were less likely to be successfully employed for six months or more ($OR = .99, 95\% CI = .988-.999$).

VI. Discussion

The lack of an adequate understanding of what predicts long term success of women and their families who have been homeless and transitionally housed prompted interest in examining this hard to reach population. The goal of this particular research was to examine the effectiveness of the Shared Housing Center's (SHC) Intergenerational Group Residence program, specifically that of the Generations in Family Therapy (GIFT) program. In determining what factors would lead to successful outcome, consideration of the common pathways leading to homelessness was necessary. Research has shown that the five primary indicators of homelessness in general are mental illness, substance abuse, domestic violence, lack of social support, and underemployment and poverty. These factors were well represented amongst the past residents of SHC. Literature on the particular plight of homeless female-headed families has also pointed to factors such as the scarcity of affordable housing, unemployment, domestic violence, disruptions in family of origin, and teenage pregnancy, to name a few (Sullivan & Damrosch, 1987, Dail, 1990). This study attempted to assess each of these variables in an effort to determine how much each of them significantly predicts successful outcome in previously transitionally housed women.

This study also set out to determine ways to break the cycle of homelessness by assessing not only mothers, but also their children. Adhering to the advice of Ellen Bassuk, who in 1986 asserted "our major goal should be to rescue these families, particularly the children, from a lifetime of deprivation and violence and to interfere with a newly emergent cycle of intergenerational homelessness", this study attempted to explore the ways to best protect the children from repeating the cycle of homelessness.

A. Characteristics of Sample

Description of Sample

The 25 women who participated in the current study are similar to sample groups described in the literature on a number of factors. The average age of the sample in 2005 was 39 years, and their average age while residents of SHC was 35.4. The average age of women in other studies include 29 (Bassuk, 1986), 27.2 (Dail, 1990), and 26 (Johnson and Krueger, 1989), making the current sample slightly older, on average, than other reports in the literature.

The average number of children for the women in the current sample was 2.2, the same average number of children found by Burt and Cohen (1989) in their study of 1,704 homeless people. Similarly, Bassuk (1986) found that the average number of children was 2.4 in her sample of 51 mothers, and Dail (1990) found the average number of children was 1.9 in a study of 53 homeless mothers. Therefore, it is assumed that the current sample is representative of the general population of homeless mothers in terms of number of children.

The majority of participants in the current sample (64 percent) were African-American ($n = 16$), with 16 percent ($n = 4$) being Hispanic, 12 percent ($n = 3$) Caucasian, 4 percent ($n = 1$) Native American, and 4 percent ($n = 1$) Mixed Race. Other studies have reported similar ethnic breakdowns for their samples. Johnson, and Krueger (1989)'s sample was 77 percent African-American and 23 percent Caucasian. Similarly, Burt and Cohen's (1989) sample was 83 percent non-white. The 2001 Conference of Mayors found that the homeless population was 50 percent African-American, 35 percent Caucasian, 12 percent

Hispanic, 2 percent Native American, and 1 percent Asian. The current sample accurately represents the nation's homeless in terms of ethnicity.

In the current sample, the average years of education was 12.9 ($SD = 2.2$), with 80 percent ($n = 20$) of the women having earned a high school diploma. In Burt and Cohen's 1989 sample, only 32% of homeless women with children had a high school education. Dail (1990), however, found that the average years of education in her sample of 53 homeless women was 11.6.

Regarding receipt of TANF (previously AFDC), the current sample is reflective of other studies cited in the literature. In Burt and Cohen's (1989) sample, 69 percent of the women with children received AFDC. Similarly, Dail (1990) found that 28 percent of the women in her study were receiving AFDC benefits. In the current sample, 40 percent ($n = 10$) of the women received TANF while they were residents of SHC, while currently, only 12 percent ($n = 3$) receive TANF.

In the current sample 40 percent ($n = 10$) reported domestic violence as the reason that they came to SHC, while 20 percent ($n = 5$) reported that they were evicted from their apartments and could not afford the rent. Further, 32 percent ($n = 8$) reported that they were thrown out of a friend's or relative's house and had no where else to go. Four percent ($n = 1$) left another shelter to find more stable housing, and another 4 percent ($n = 1$) listed another reason for seeking transitional housing. The reasons given for homelessness in the current sample are consistent with Dail's findings that 70 percent of her sample listed a personal crisis, such as domestic violence, financial crisis resulting in eviction, and substance abuse as their reasons for homelessness. Similarly, the current sample reported that immediately prior

to living at SHC, 24 percent ($n = 6$) had been living in their own apartment, while 32 percent ($n = 8$) had been staying in a shelter. Another 4 percent ($n = 1$) of the current sample had been living with friends, while 24 percent ($n = 6$) had been staying with a family member, and 4 percent ($n = 1$) had been living with her abusive husband in their shared apartment.

The current sample was no exception to the common finding of high prevalence of abuse amongst homeless women. By means of self-report, 60 percent ($n = 15$) of the sample indicated that they had experienced physical abuse as children, 48 percent ($n = 12$) indicated that they had experienced sexual abuse as children, 64 percent ($n = 16$) indicated that they had experienced verbal abuse as children, and 60 percent ($n = 15$) indicated that they had experienced emotional abuse as children. Perhaps due to the overall sample's high likelihood of abuse, this factor did not predict successful outcome in the current study. However, the prevalence of abuse reported by the current sample are consistent with LaVesser, et al.'s (1997) report of 34 percent of her sample having experienced sexual molestation, 44 percent experienced physical abuse, and 70 percent having had experienced emotional abuse. This study found that significantly more homeless women than their housed counterparts had experienced such abuse. A similar study by Vostanis, et al. (1997) found that 45 percent of 113 homeless mothers reported a history of sexual abuse, compared to only 3 percent of the housed peer comparison group. Further, North and Smith (1994) found that of nonwhite women in their sample, 16.4 percent reported physical abuse and 20.9 percent reported sexual abuse as children. In addition, for the white women, 37.9 percent reported physical abuse and 41.4 percent reported sexual abuse during their childhoods. Therefore, it is

assumed that the high prevalence rate of all types of childhood abuse found in the histories of the current sample is consistent with the literature on homeless mothers.

Exploratory analysis of the current sample revealed that the women who were currently successfully housed had been residents at SHC for an average of one year, which is the recommended time allotted by SHC for completion of their GIFT program. In contrast, the women in the unsuccessfully housed group stayed in transitional housing at SHC for an average of nineteen months. The policy at SHC to offer extended housing for those women that are not yet able to make it independently and continue to have need for such services may be one explanation for this difference. It appears that the maximum benefit in terms of long-term successfully stable housing can be gained during the first twelve months of residency at a transitional housing center. Attempts to grant the residents more time at the center do not coincide with a greater chance of being successfully and permanently housed.

Comparison of the Sample Group to the Non-Participating Past Residents

The obstacles in reaching an adequate sample of previously homeless persons are well documented, and were anticipated in this study (LaVesser, et al., 1997). Due to the difficulties with obtaining volunteer participants from the pool of potential past-residents at SHC, the participant (PS) and non-participant (NP) groups were compared on a number of demographic variables to ensure that the sample was representative of all past-residents of the center. One of the most qualitatively significant findings was that the majority of the PS were successful, which should have been expected considering volunteer bias. Indeed, from their departure from SHC, the PS group had spent significantly more time at Shared Housing

than the NP group. Although the two groups did not differ with regard to whose decision it was for them to leave, meaning whether they were evicted or chose to exit, they did differ in the length of stay at Shared Housing. The transitional housing program at SHC is set up so that women can live there for twelve to fifteen months, and it is therefore meaningful that the PS average length of stay was within this time period, compared to the much shorter length of stay of the NP group. This suggests that the participating sample, as a group, received much more benefit from services offered at SHC than those who either could not be reached or chose not to volunteer. Further, the participating sample was significantly more likely to move into a home or apartment on their own than was the non-participating sample. This finding is clinically significant because it indicates that from the gate, the PS group was much more likely to be successful, and, therefore, to leave a current phone number and/or address where they could be reached with SHC staff.

Other studies have found that as many as one-third of women who stayed in a shelter for six months or longer experienced readmission to shelters within a two-year period (Culhane & Kuhn, 1996). Similarly, LaVesser, et al. (1997) reported that 10.4 percent ($n = 21$) of the previously homeless women in their sample were still homeless. Similar estimates could be made for the NP group in the current study, as 55 percent ($n = 69$), upon leaving SHC, went back to the streets, to a friend's home, back to their abuser, or to another shelter. All of these options are not permanent, stable situations. It is likely that many of these families continue to live marginal lives or are currently staying with relatives, friends, or in shelters.

Another significant finding when comparing the PS to the NP is that the NP was significantly more likely to be Caucasian. Specifically, 37.1 percent ($n = 46$) of the NP group was Caucasian, compared to only 12 percent ($n = 3$) of the PS. Similarly, participants in the PS were more likely to be African-American (64 percent, $n = 16$) than those in the NP group (44 percent, $n = 55$). One potential way to understand this difference is to consider that African-American women may be more open to communal living than their Caucasian peers. The family dwelling offered by SHC may serve as a support for African American women, who, according to Letiecq, et al. (1996) have traditionally relied on extended family members and close friends to provide a variety of goods and services. In this way, it is possible that African American women were more successful at SHC than their Caucasian peers. It follows, then, that African Americans may have been more likely to participate in the study, which was made up of mostly successful past-residents.

The two groups did not differ on age or amount of education obtained, which means that the sample is representative of all past-residents of SHC on these two variables. Similarly, the two groups did not differ in regard to who referred them to SHC, with most referrals for each group coming from other shelters. Further, the groups did not differ in terms of which physical residence they lived in during their stays at SHC.

B. Discussion of Findings

Impact of Therapy on Mothers' Success

It has been shown in the literature that case management, regardless of what type, is important in initiating change in family support (Wood, et al., 1998). McChesney (1990)

reported that most transitional housing programs offer “life skills” training such as parenting skills and money management. He also explains that many programs provide services such as job training, educational programs, substance abuse treatments, and assistance in locating permanent employment and housing opportunities. Shared Housing Center is no exception.

Although there were no significant differences found between the successful and non-successful groups, it is qualitatively significant that so many of the women in what has been shown to be an overall successful sample did participate in therapy. Although having 92 percent ($n = 23$) of respondents having participated in group therapy, and 64 percent ($n = 16$) in individual therapy makes it very difficult to discriminate between the groups statistically, it does point out that receipt of therapeutic services is not only common at SHC, it likely promotes a sense of community and belonging amidst the women, who were more likely to stay in touch with SHC and to have volunteered for a study such as this. In future studies, the utility of knowing the specific type, duration, and involvement with therapy that each of the women received would be of significant clinical value. Perhaps if records such as these were available in future studies, other contributing factors regarding the quality of the therapy could enlighten service providers as to how to have the most meaningful impact. What has been shown, however, is consistent with the literature and supports SHC’s GIFT program and flexible supportive services.

Impact of Social Support on Mothers’ Success

The literature has shown that isolation and alienation are barriers to successful outcomes in homeless women. In an attempt to assess social support in the current sample,

two separate methods were used. The first was a standardized measure, the Personal Resource Questionnaire-Part B (PRQ-B). Scores on the PRQ-B, which measure perceived level of social support, did not significantly differ between groups. However, it is noteworthy that out of a range of 25 to 175, with higher scores indicating greater levels of perceived social support, the mean scores in the entire sample ranged from group were 121 to 141, indicating an overall above average perception of social support amongst the sample.

In order to understand more fully the impact of social support, the participants in the current study were asked to list the first names of those individuals whom they could rely on for support both during their stays at SHC and currently. In Johnson and Krueger's 1989 sample of 176 homeless mothers, 25 percent listed their children as support, while another 25 percent said they had no supportive relationships. Dail (1990) found that 100 percent of the 53 women in her study said that they had no supportive relationships, while Zima found that over half of the women in her study had two or fewer persons to whom they could turn for support. The current sample's average number of supportive persons listed did not significantly predict successful outcomes for stable housing or employment, however, qualitatively, certain trends are evident. For the SH group, they named an average of 1.67 people ($SD = 1.46$) as being supportive during their stays at SHC, but that number grew to 2.50 ($SD = 2.88$) when asked to name people who are currently supportive. In contrast, the NSH group named more people as supportive during their stays at SHC ($M = 2.71$, $SD = 3.35$) than those who can currently be relied on ($M = 1.43$, $SD = 2.15$). Similarly, the SE group named an average of 1.67 people ($SD = 1.46$) that could be relied on during their stays at SHC, but an average of 2.00 people ($SD = 3.01$) currently, as opposed to the NSE group,

who named the same number of people as supportive during their stay at SHC ($M = 2.71$, $SD = 3.35$) as they did currently ($M = 2.71$, $SD = 1.70$). This trend indicates that for the successfully housed and successfully employed groups, their average number of supportive people has grown since their departure from SHC, a finding that is not shared by the Non-Successfully Housed and Non-Successfully Employed groups.

Impact of Mental Illness on Mothers' Success

With regard to successful housing, it was found that the SA-45 General Symptom Index, along with six other scales on the measure (Positive Symptom Total, Anxiety, Somatization, Phobic Anxiety, Hostility, Interpersonal Sensitivity, and Paranoid Ideation, were significantly higher for the stably housed group than for the non-stably housed group. Even when removing the highest score, in the event that an outlying score might account for the difference, the statistical significance between groups was still found. This indicates that there was a true difference in the groups assessed on self-report of psychological symptoms. In an effort to understand what other factors may have contributed to this difference, the group of women that were successfully housed were divided into two groups based on whether they were ($n = 6$) or were not ($n = 12$) currently receiving therapy. It was found that these two groups did not significantly differ on their mean scores of the Symptom Assessment-45 on any scale. Therefore, it can be concluded that the difference between the successfully housed and non-successfully housed groups on self-report of psychological symptoms is not due to whether or not one is currently receiving mental health treatment.

The findings that successfully housed women endorse clinically significant amounts

of psychological symptoms are not surprising in light of the prevalence of mental illness described in the literature. The U.S. Conference of Mayors (2001) found that 22 percent of the homeless population suffered from chronic and severe mental illness. However, Phelan and Link (1999) pointed out that point-prevalence studies such as the U.S. Conference of Mayors' tend to suggest that illness or disability cause chronic homelessness, versus their findings of looking at previously homeless populations, such as the current sample, which indicate that a much more heterogeneous population has experienced homelessness, and that it is not necessarily chronic or resulting from mental illness. Bassuk (1986) postulated that the interconnected effects of poverty, violence, and profound deprivation of a person's development and self-esteem are likely causes of homelessness. Taken one step farther, it could be assumed that women who have managed to provide stable housing for themselves and their families are more likely to be burdened by the challenge of having to do so. These women do not receive significantly more social support or significantly more government assistance than the women who scored lower on the SA-45 scales. It is possible that the added stress of having to provide shelter increases a woman's awareness of her symptoms. Perhaps future studies could attempt to further investigate this clinically valuable hypothesis. Certainly, women who are attempting to remain stably housed are under a great deal of psychological duress and could benefit from meaningful and appropriate mental health services.

An additional explanation could be that those who are successfully housed are more likely to have gained a therapeutic impact during their stays at SHC of learning to identify and express their feelings. This group could have been less likely to underreport their

symptoms, based on their level of comfort with acknowledging their problems. In addition, it is useful to consider that the clinical scales that were not clinically elevated by the SH group were the Depression and Psychotic scales. This finding is even greater evidence that the women in the SH group may be under more stress due to having to rely on themselves to provide shelter for their families, but they are neither more depressed nor more psychotic than the NSH group. According to Zima et al., (1986), 55 percent of the women in her study reported high psychological distress, but only 11 percent of the mothers had used any mental health services in the past year. These authors report that women were more likely to use mental health services if they had a probable lifetime depression or a psychotic disorder. These two specific scales are the only two that were not significantly higher for the successfully housed group. Further, it is important to keep in mind that the difference found is in self-reported symptoms versus observer or clinician rated symptoms, for which there may have been a very different picture.

Regardless, the women in the current study endorsed, and therefore could be assumed to experience, a clinically significant number of symptoms. Currently, there is a dearth of research regarding the specific benefits of different types of follow-up or continual psychological supportive treatments for this population. It would be extremely beneficial to service providers and recipients if future studies looked more carefully at the specific mental health needs of women who were once homeless or living in transitional housing.

Impact of Domestic Abuse on Mothers' Success

Vostanis, et al. (1997) found in her study of 113 homeless mothers that the most frequent reason for moving out of their homes was domestic violence (55.8 percent). This incidence rate is found throughout the literature, and was certainly true in the current sample. Of the 25 women studied, 40 percent ($n = 10$) reported domestic violence as the reason for which they entered SHC. There was not a significant difference found between those who are now successfully housed or employed and those who are not when considering domestic violence, likely due to the overall lack of current victimization amongst the participants. Perhaps a better testimony to the effectiveness of SHC and the GIFT program is the fact that compared to the 40 percent of women who fled to the center due to domestic violence, only 8 percent ($n = 2$) scored above the clinical cut-off for Non-Physical Abuse on the Index of Spouse Abuse, and only 4 percent ($n = 1$) scored above the clinical cut-off for Physical Abuse. This lack of victimization amongst the participants as a whole made it nearly impossible for a clinical or significant difference to be found amongst the groups. It is therefore a testament to SHC, and to the women, that they, for the vast majority, have managed to flee and keep away from their abusive partners.

Impact of Substance Abuse on Mothers' Success

A similar scenario to what was found in comparing the two groups on victimization is found when looking at substance abuse. Many studies cite the prevalence of substance abuse in the population of homeless mothers to be significant, including Zima, et al. (1986), who found that of the 110 mothers in her sample, 16 percent had an alcohol abuse problem and 18

percent had a drug abuse problem. Similarly, the U.S. Conference of Mayors (2001) found that 34 percent of the homeless population met criteria for an addiction disorder. The rates were not as prevalent in the current sample. Specifically, only 12 percent ($n = 3$) of the entire sample is likely to have a substance abuse disorder, as defined by the SASSI-III. Therefore, it was impossible to have found a clinical or significant difference between the groups of successful versus non-successful women on this variable. However, viewed in another light, this is an extremely positive finding for SHC, because although substance abuse is rampant in the homeless population, it is scarce within this sample of past-residents.

In fact, one mother of three that was interviewed went into great detail about her previous addiction to crack cocaine. She described what it was like to crush her glass pipe under the palm of her hand into the kitchen floor of the apartment from which she had just been evicted. Her children, she had two at the time, had been removed from her home by Child Protective Services. She turned to Shared Housing Center for help. After being allowed a place to stay, therapeutic services, and the support from the staff, this woman was able to stop using the crack cocaine and has not returned to the drug since. She now has successfully worked at a bottling plant for over five years, lives in government subsidized housing, and cherishes the two high school diplomas of her daughters that are displayed on her living room shelf. Her oldest daughter, who also participated in the study, is now a college sophomore, and will be the first person in her extended family to graduate from college. Their story is just one of the many that could be used to explain the lack of statistically significant findings using the SASSI-III to predict outcomes between groups of women that, for the most part, do not use drugs or alcohol.

Children's Therapy

Although, similar to the findings amongst their mothers, participation in therapy by the children did not significantly predict successful outcomes, this is likely due to the fact that of the entire sample ($n = 26$), 77 percent ($n = 20$) participated in group therapy, and 42 percent ($n = 11$) participated in individual therapy during their stays at SHC, making it difficult to statistically discriminate between the groups on this factor. Therefore, it is perhaps most clinically significant to note that of the largely successful sample ($n = 26$), the vast majority of the children did participate in therapy, especially in group therapy, during their stays at SHC. Based on the literature, mental health services of any kind are extremely rare for this population to have received. Specifically, Buckner and Bassuk (1997) found that only 31 percent of the children of homeless mothers who met criteria for at least one disruptive behavioral disorder in their study had received mental health services within the past six months. Shared Housing Center residents, therefore, have an advantage in that the GIFT program offers each for each child to be seen in both group and individual therapy.

Children's Mental Illness

The Symptom Assessment-45 was used to measure mental illness amongst the children in the current sample, however, due to the fact that there were only eleven participants that met the minimum age cutoff, which is 13 years of age, it is difficult to capture whether mental illness amongst the children can predict successful outcome for the mothers. Likely due to the small sample size, none of the results were statistically significant. However, when comparing the children of successfully housed mothers ($n = 8$)

(CSH) and those of non-successfully housed mothers (CNSH) ($n = 3$), certain trends are evident. Specifically, the CNSH group's mean scores on a number of scales met or exceeded the clinical cut-off for the SA-45 ($t = 60$). These include the Positive Symptom Total, Anxiety, Depression, Obsessive-Compulsive, Somatization, Phobic Anxiety, and Paranoid Ideation Scales. In contrast, none of the CSH group's mean scores were above the clinical cut-off for significance, indicating that the children of non-successfully housed mothers were more likely to report psychological symptoms.

Comparing the CSE and CNSE groups on this measure must be proceeded with caution, because of the eleven adolescents in the sample, only one is in the CNSE group. That being said, that adolescent's scores, which independently made up the group means, were above the clinical cutoff for significance ($t = 60$), including the Positive Symptom Total, Anxiety, Obsessive-Compulsive, and Hostility Scales. In contrast, the CSE group ($n = 10$) mean score was at the clinical cutoff only on the Phobic Anxiety Scale. Although none of the results were statistically significant, it is noteworthy that for success defined by either stable housing or employment, the children in these groups reported surprisingly low amounts of psychological symptoms. The literature states that mental illness among homeless children is correlated to mental illness in their caregiver (Zima, et al., 1996, Rafferty, 1991, Vostanis, et al., 1996), rendering the finding of so few psychological symptoms especially poignant. Contrary to studies that report the prevalence of mental illness in currently homeless children has being as high as 42 percent for behavioral problems (Davey, 1998), 51 percent for depression (Bassuk, 1986), and 60 percent for anxiety (Bassuk, 1986), children in the Successful Housing group did not demonstrate any mean scores above

the clinical cutoffs. Similarly, for the children of Successfully Employed mothers, the only mean score that reached the clinical cutoff was on the Phobic Anxiety Scale. Overall, it can be seen that the children of the SH and SE groups are much less likely to report psychological symptoms than are currently homeless children as well as children of NSH and NSE mothers.

Children's Self-Esteem

The current study attempted to measure children's Self-Esteem and Self-Concept using both the Culture-Free Self-Esteem Inventory (CFSEI) and the Student Self-Concept Scales (SSCS). Again due to the fact that significantly more children were in the CSH and CSE groups than the CNSH and CNSE groups, it is difficult to accurately discriminate between the groups. Certain trends, however, within the CSH group ($n = 15$), compared to the CNSH group ($n = 5$) were found to be qualitatively valuable. The CSH group had mean scores that approached significance when compared to the CNSH group on the CFSEI. These were the Social and Personal Self-Esteem Scales. This finding is valuable because the literature shows that homeless children are involved in significantly fewer social activities, have fewer friends, and perform below average in school (Davey, 1998). That the children of SH mothers have more Social and Personal Self-Esteem indicates that they are most discriminant from homeless children such as described by Davey (1998) and Bassuk and Gallagher (1987), who found that more than one-third of the homeless preschoolers they tested manifested developmental lags in personal/social development. Another qualitatively valuable finding is that children in the CSH group ($n = 20$) had a much higher mean score on

the Academic Importance scale of the SSCS, indicating that academic achievement is more valuable to them than to the CNSH group ($n = 6$). This finding is valuable in light of the fact that “low academic achievement” is listed as one of the significant educational issues for homeless children in the literature (Zima, et al., 1997, Rafferty, 2005).

The only significant findings upon comparing the groups of CSE and CNSE on the self-esteem and self-concept measures were on the CFSEI and must be taken with extreme caution, due to the fact that the sample sizes are made up of an n of 1 for the Personal Self-Esteem Scale and an n of 2 for the Global Self Esteem Quotient. The reason the number in the samples are different is because the Personal Self-Esteem Scale is only available on the adolescent version of the CFSEI, whereas the Global Self-Esteem Quotient is available on the primary, intermediate, and adolescent versions. With those caveats in mind, it can be noted that the respondent in the CNSE group did have a higher scaled score than the average scaled score of the respondents ($n = 9$) in the CSE group on Personal Self-Esteem. In addition, the two respondents in the CNSE group did have a higher mean score on the Global Self-Esteem Quotient than the CSE group ($n = 24$). However, due to the extremely small sample sizes of the children of Non-Successfully Employed mothers, these results are not considered meaningful. Similarly, there were no significant differences found between the CSE and NCSE groups on the SSCS, which is in large part attributable to the negligible sample size of the NCSE group ($n = 2$), especially compared to the CSE group ($n = 24$).

Children's Substance Abuse

The impact of children's substance abuse, as measured by the Substance Abuse Subtle-Screening Inventory-Adolescent version, did not significantly predict successful outcome. However, this finding is most likely attributable to two factors, 1) the extremely small sample size in the CNSH ($n = 2$) and CNSE ($n = 1$) groups, and 2) the fact that so few of the participating adolescents had a substance abuse disorder. Viewed in this way, it is qualitatively significant to point out that of the eleven adolescents in the entire sample, only two of them are likely to have a substance abuse disorder (18 percent). When considering that one of the goals of SHC is to "break the cycle of homelessness", this finding indicates that the large majority (72 percent) of adolescents in the sample ($n = 12$) do not, at this point, meet criteria for substance abuse, which is clearly demonstrated in the literature to be a risk factor for homelessness (Zlotnick, et al., 1998, Bassuk, 1996, Johnson and Krueger, 1989).

Impact of Government Assistance

The logistic regression revealed that the greatest amount of variance in successful employment outcome could be accounted for by the amount of government assistance received for housing. In many ways, this finding is intuitive, because those who are not earning as much money working at a job are more likely to receive government assistance for housing. As Burt and Cohen (1989) pointed out, periods of joblessness are longer than periods of homelessness, especially for homeless women with children. Their findings revealed that homeless women with children relied less on working and more on welfare programs or incomes of other household members than did single women and single men

who were homeless. A careful look into the current sample revealed that this assumption does hold up with regard to Section 8 and other housing programs, but not when considering other government assistance. Specifically, within the SE group of the current sample, 38.9 percent ($n = 7$) receive food stamps, while 42.9 percent ($n = 43$) of the NSE group receive food stamps. Similarly, 11.1 percent ($n = 2$) of the SE group was receiving TANF, compared to 14.3 percent ($n = 1$) of the NSE group. Neither receipt of food stamps nor TANF significantly predicted successful employment outcome in the current sample.

In light of the literature, North and Smith (1994) found that almost half (47.3 percent) of the nonwhite homeless women in their study depended primarily on welfare for support, while more white women depended on their own earnings. However, in the current sample, there was not a significant difference found among ethnicities in the SE and NSE groups. Specifically, of the African Americans ($n = 16$) in the current sample, 31.3 percent ($n = 5$) were not stably employed, but 68.8 percent ($n = 11$) of them were. Therefore, North and Smith's findings are not replicated here.

C. Clinical Implications

The current study shows that the GIFT program at Shared Housing Center has been effective in numerous ways, while also revealing ways to enhance benefit of services to clients. One finding that suggests that SHC is promoting stable living situations is with regard to changes in living situations from before entry to SHC and since exiting from the program. After living at SHC, women are much less likely to be living with family or friends, in shelters, in transitional housing centers, or on the streets than before they entered

SHC. Similarly, since exiting SHC, women are much more likely to rent or own their own apartment or home.

Another pattern emerged regarding the optimal length of stay at SHC. For the women who were most successful in terms of housing, they stayed at SHC for an average of one year. Women who were not successfully housed stayed at SHC for an average of 19 months, whereas women who could not be contacted for participation in the study had stayed at SHC for an average of 6 months. Results suggest, but do not conclude, that one year is the optimal length of stay at SHC. For the women that request additional services after the first year, granting them longer stays may result in their becoming dependent on the services provided, and, more importantly, decrease their chances of being successfully and independently housed long-term. However, women who required longer stays may have also needed more help and were possibly at greater risk for unsuccessful outcomes.

The SHC past-residents are, by an overwhelming majority, not likely to be abusing substances or to be victims of domestic violence. Although almost half of the women sought services at SHC because of domestic violence, a very small percentage is currently victimized. This finding implies that SHC is doing a good job of providing women who are taking a brave step in leaving abusive situations with alternative, safe options to staying with their abusers. Additionally, it is likely that the therapy provided by the GIFT program impacted the once victimized women's long-term housing and partner choices, because only one of the participants is currently living in an abusive situation.

The finding that successfully housed women were more likely to report psychological symptoms is one of the most clinically relevant, and suggests that follow-up mental health

care should be provided to past-residents. It is likely that women who are exiting SHC, and therefore burdened with the added stress of finding and maintaining housing, could strongly benefit from therapeutic and supportive services during and following this time of transition back into independence. In fact, women exiting SHC are as likely as women entering SHC to benefit from therapy. Those coming into the program may be overwhelmed with concern of having their fundamental needs met, such as provision of shelter and food, and therefore may not be able to fully engage in the therapeutic task of insight and self-acceptance. Those who are exiting the program, however, would likely be able to find therapy supportive during their transitions back to independence.

This study also found that the greatest predictor of successful employment was the amount of government assistance received for housing. Although the direction of the relationship between these variables is unknown, it is clinically relevant to note that women who are not working do receive more government funding for housing than those who are working.

Children who once lived at SHC are, by a large majority, not likely to be substance abusers or to be experiencing psychological symptoms. Those who are successfully housed are more likely to have high personal and social self-esteem, and are highly concerned with their academic performance. These findings imply that SHC is well on its way to “breaking the cycle of homelessness”, because substance abuse, mental illness, and low academic achievement are known risk factors for homelessness.

D. Limitations

Many of the limitations in the current study are a result of this having been a “real life” look at a transient population that was extremely difficult to recruit for participation. These women were not placed in experimental groups and there were no baseline data available to describe what their relationships to the dependent variables involved might have been before their stays at Shared Housing Center. This study had a huge undertaking, and certain advantage, in that the participants were simply open to sharing their unique stories. However, because of the nature of field research, many confounds do exist. Included in these is the length of time since being a resident at Shared Housing. Not only practice effects, but also a variation in impact of experiences undoubtedly potentially corrupts the data. Some experiences that might have taken place since the women’s stays at SHC include stays at other shelters or transitional housing centers, therapy outside of what was received at SHC, and treatment for substance abuse.

An additional major flaw in this study is the lack of available baseline data. Fortunately, SHC has kept records of demographic data for most one-time residents. However, the lack of access to pre and post-testing forbids the current research from drawing any causal interactions between variables. Most studies of homeless families cited in the literature compare low-income housed mothers to currently homeless mothers (LaVesser, et al., 1997, Goodman, 1991). This study took a novel approach and instead compared two groups of currently housed mothers, both of which had previously been homeless. Although this perspective provided a unique understanding of the differences between these two groups, significant differences were few. It is likely that as a result of volunteer bias, with

more successful past-residents volunteering for the study, the differences between groups were minimized. In contrast, if the two groups had been made up of more disparate populations, such as a currently homeless group compared to a previously transitionally housed group, more significant differences would have been found.

Another possibility would be to begin a similar study by having a common intake for women entering a transitional housing center, where all of the measures used herein are given to participants before their stay, during their stay, and at an exit interview. An even better strategy would be to find some way to ensure that follow-up interviews and assessments would be possible with all of the women who leave, whether they are evicted or complete the program and depart on good terms with the center. In this way, follow-up data is not confounded by a successful volunteer bias.

Another limitation to this study was that the “snapshot” assessment of these participants in time was somewhat arbitrary and could have been or could be a different picture had the study been conducted even six months earlier or later. For this reason, a follow-up study using the same sample is highly recommended in one or two years. However, due to the difficulty in obtaining the current sample, this follow-up may be beyond what is feasible. Indeed, the small sample size of the current study serves as perhaps the most severe limitation. Despite various and numerous attempts at contacting the potential pool of past-residents, a number of obstacles forbade a larger sample. The greatest deterrent was the difficulty with locating the past-residents, due to their having left phone numbers and addresses that were no longer relevant. For those who were contacted, either by phone, flyer, or mail, most did participate in the study. Therefore, it is recommended for future research

that a great emphasis be placed on finding ways to keep in contact with past-residents so that long-term outcome research such as this can be possible.

E. Conclusions

The primary aim of this study was to delineate successful long-term outcomes of previously transitionally-housed female headed families. A specific population, the past-residents of Shared Housing Center, was chosen as the sample group. Success was defined in two ways, as stably housed for six or more months, and as stably employed for six or more months. The voluntary sample of previously transitionally housed women was assessed on a number of variables, based on results from a literature search regarding the causes of homelessness. These assessments included the variables of mental illness, substance abuse, victimization, social support, and participation in therapy. Further, the children of the previously homeless women were also included in the study, and they were assessed by looking at the variables of mental illness, substance abuse, participation in therapy, self-esteem, and self-confidence. Due to the limited sample size obtained ($n = 25$ adults and $n = 26$ children), few statistically significant results were found between groups. Descriptive analyses of the sample group revealed that the average participant is African American, has 2.2 children, and a high school education. In addition, the average participant received AFDC (now TANF) while staying at SHC, but currently does not. Further, consistent with the literature on this population, the average participant was likely to have sought shelter due to domestic violence and to have suffered physical, sexual, verbal, and emotional abuse as a child.

In addition, many of the most qualitatively significant findings came from comparing the group of past residents who chose to participate in the study to those who did not. Research participants spent more time in the SHC program, suggesting that they received much more benefit from the services offered than those who did not participate. Further, participants were more likely to move into a home or apartment on their own upon leaving SHC, and were more likely to be African American. The participant sample did not differ from the non-participant past-residents in terms of age, amount of education obtained, nor referral source to the SHC.

In terms of the impact of specific variables, it was found that most of the sample of both women and children had participated in both group and individual therapy while residents at SHC, making it difficult to significantly discriminate between these two groups by successful outcome. The same is true for Substance Abuse and Domestic Violence, where so few of the overall sample ($n = 25$) were found to be currently impacted by these risk factors. On measures of social support, the trends do suggest that women in the successfully housed and successfully employed groups did tend to have increased the number of social supports that they could rely on since their stays at SHC, which was not true for the non-successfully housed or employed groups. One counter-intuitive finding was that the non-successfully housed group scored lower, on average, on a measure of mental illness, the Symptom Assessment-45's General Symptom Index, along with six other symptom scales. It is possible that women who have managed to obtain stable housing for themselves and their families are under significantly more stress than those who are not stably housed, and therefore reported more psychological distressing symptoms. Similarly, it was found that the

successfully employed women scored higher on the Symptom Assessment-45's Hostility Scale.

Trends found on measures of self-esteem amongst the children indicate that children of successfully housed mothers have higher social and personal self-esteem than children of non-successfully housed mothers. This finding is valuable because it further discriminates the successfully housed children from homeless children, who are involved in few social activities, have few friends, and perform below average in school (Davey, 1998). Further, children whose mothers are successfully housed were more concerned with Academic Achievement than were children of non-successfully housed mothers. This finding is clinically relevant because it indicates that these children are not being impacted by the "low academic achievement" amongst homeless children in the literature (Zima, et al., 1997). Similar to the findings of substance abuse amongst the mothers, the children in the sample were, overall, highly unlikely to have a substance abuse disorder. Therefore, it was difficult to discriminate between the groups on this factor. However, the finding that the children were unlikely to have a substance abuse disorder is relevant, as substance abuse would significantly increase the likelihood of this generation becoming homeless.

Other findings revealed that the greatest amount of variance in successful employment outcome could be accounted for by the amount of government assistance received for housing, with more government assistance indicating less likelihood of being successfully employed.

Limitations to the study included a small sample size, lack of baseline data, volunteer bias, and historical effects. Due to the dearth of long-term outcome studies of previously

homeless families, the current study attempted to capture a here-and-now viewpoint of this hard to reach population. The results can be used not only to increase the benefit of services at Shared Housing Center for their particular clients, but for a broad array of service providers and advocates for the homeless. The findings that few of the past-residents are impacted by Substance Abuse, Domestic Violence, and Mental Illness speak volumes for the success of the Generations in Family Therapy program at Shared Housing Center. Future research can elaborate on these findings by performing follow-up assessments, or using a population for which more baseline data are available. Perhaps the most valuable findings in the current study are those qualitative variables that account for a great deal of the long term success of the families who have, with the assistance of a program like Shared Housing Center, overcome the potentially debilitating effects of homelessness.

Appendix A

Institutional Review Board Approval

Appendix B
Informed Consent Form

Informed Consent for Participation
In the Shared Housing Center GIFT Evaluation Project

You are being asked to consent to participate in a research project that will evaluate the effectiveness of the GIFT program at Shared Housing. As a research participant, you will be asked to complete a series of paper and pencil questionnaires and to provide information to a research assistant about your experiences as a resident at Shared Housing.

This research involves little potential for personal risk, although some participants may find answering confidential, personal questions may create some temporary discomfort. The benefits of participating in this research include monitoring your progress in the treatment program and helping the research and clinical staff to better understand how the GIFT program and Shared Housing staff may better serve future clients.

As a research participant, any data collected from you will remain confidential. To protect your identity, all data will be assigned a research number to insure that your data will not be identifiable by name or any other recognizable information. The results of this research project will be used to validate and improve the current treatment model and to help other programs to develop similar treatment options for their clients. This will be accomplished by publishing the overall results of this project in reputable professional journals and presenting these findings at scientific meetings.

Your participation in this project is completely voluntary. If you should choose not to participate, or decide to withdraw from the research project at any time for any reason, there will be no penalty, denial or change in services that you may be receiving or waiting to receive from the staff or organization of Shared Housing. If you have any questions about this research project at any time, you may contact:

Melissa Black, Ph.D.
6330 LBJ Freeway, Ste. 150
Dallas, TX 75240
(972) 991-8855

By signing this consent form, you are agreeing to participate in the Shared Housing GIFT evaluation project outlined above and acknowledge understanding and agreement with the information provided.

Participant or Participant's Parent/Guardian

Date

Project Director

Date

Appendix C

Materials



Calling all Past Residents!

You have a chance to contribute your
opinions to
SHARED HOUSING CENTER!

A study is being conducted about how to best
serve our clients.

Your participation is completely voluntary.

To find out more, contact:

Melody Moore-Betasso, Research Intern

214-912-8693

Melody.Moore@utsouthwestern.edu

Dear _____,

I am writing you because you are a past resident of Shared Housing Center, and therefore have a wonderful opportunity to give back something to Shared Housing Center and staff. How can you help? Well, Shared Housing is doing some research in order to help them gain access to government and private funding, the much needed money they use to provide housing and services to women and their families. Not only will the outcomes of this research help Shared Housing Center to provide services, but also, it should help Maria and Jacquie know how to best help the clients of Shared Housing—what works best, what is not helpful, what should be changed? Only those of you who have lived at Shared Housing Center really know the answers!

I have met many of you at various events and in Level II groups, but for those who do not recognize my name, allow me to introduce myself. I am Melody Moore-Betasso, and I have been hired to conduct research on behalf of Shared Housing and a grant from the University of Texas at Southwestern Medical School, where I am a student.

If you would be willing to talk with me about participating in the study, I would very much appreciate it. I will need all of the participation I can get in order to help out Shared Housing.

Your participation is completely voluntary and will cost you absolutely nothing. You will not be penalized by Shared Housing in any way if you refuse to participate. Participation will involve only one hour of your family's time. Please call me to set up an appointment or to find out more. I would be happy to answer any questions you may have.

I can be reached the following ways:

Phone: 214-912-8693
 Email: melodymoore05@yahoo.com
 US Mail: Melody Moore-Betasso
 c/o Shared Housing Center
 402 N. Good Latimer Expressway
 Dallas, TX 75204

I wish you and your families a wonderful holiday season.

Sincerely,

Melody Moore-Betasso

Past-Resident Survey

1. Your Age: _____
2. Your Ethnicity: _____
3. Please list the ages and genders of each of your children:
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
4. When was your stay at Shared Housing Center? How many months did you stay?

5. How many children did you have living with you while you were living at SHC?

6. Prior to living at Shared Housing Center, had you ever:
 - Lived with relatives/friends because you had no housing? _____
 - Lived in a shelter? _____
 - Been homeless? _____
 - Lived on the streets? _____
 - Been evicted? _____
 - Lived in a transitional housing center? _____
 - Owned your own home/condo/townhouse? _____
- 6B. If you answered yes to any of the above questions, please list the year in which your living arrangements took place.
7. Where did you live just before you moved into Shared Housing Center?

8. How did you find out about Shared Housing Center?

9. What circumstances led you to live at Shared Housing Center?

10. Which residence did you and your children stay in? (ex. Grigsby, Gaston, Haines)

11. How many other families lived in the house with you? _____
12. Did you attend group therapy sessions while living at Shared Housing Center? _____
13. Did you attend individual therapy/counseling sessions while living at Shared Housing Center? _____
14. Did your children attend group therapy while living at Shared Housing Center? _____
15. Did any of your children receive individual counseling/therapy while living at Shared Housing Center? _____
16. To the best of your knowledge, what was your monthly income during the time you lived at Shared Housing Center? _____
17. Were you employed during the time you lived at Shared Housing Center? If yes, where and what was your job? How many hours per week did you work?

18. While at Shared Housing Center, did you receive financial support from the government, such as:
- Social Security Yes ___ No ___ Amount \$ _____
 - Unemployment Yes ___ No ___ Amount \$ _____
 - Disability Yes ___ No ___ Amount \$ _____
 - Temporary Assistance for Needy Families Yes ___ No ___ Amount \$ _____
 - Food Stamps Yes ___ No ___ Amount \$ _____
 - Other _____
19. While at Shared Housing Center, were you receiving any child support? If yes, for how much? _____
20. While at Shared Housing Center, were you single/married/divorced/ separated/ widowed/partnered? _____
21. While at Shared Housing Center, did you own or lease a car? _____
22. While at Shared Housing Center, were your children enrolled in school?

23. Did your children have to change schools when you moved into SHC?

24. Did your children have to change schools when you moved out of SHC?

25. To the best of your ability, name the people in your life who you could rely on for support during the time you were living at Shared Housing Center. Please list their first names and their relationship to you, such as friend, neighbor, sister, etc.

26. Before living at Shared Housing Center, what was the highest level of education that you had obtained? (Highest grade completed) _____

27. Did you pursue more education while at Shared Housing? If yes, where? _____

28. Whose decision was it for you to move out of Shared Housing Center?

29. Under what circumstances did you move out of Shared Housing Center?

30. Where did you go immediately following your stay at Shared Housing Center?

31. How long did you stay at that place?

32. How many times have you and your children moved since you moved out of Shared Housing Center?

CURRENT SITUATION

33. How long have you lived at your current residence?

34. How many children do you have now? _____

35. What are the ages of everyone living in your home?

36. Are you single/married/divorced/separated/widowed/partnered? _____

37. Do you own or rent your current space? _____

38. How much is your current monthly rent or mortgage? _____

39. Of that amount, how much do you pay? _____

40. How much does the government pay (Section 8 or other program)? _____

41. For the following questions, please answer yes or no and, if yes, give a date as to when this occurred. Since moving out of Shared Housing Center, have you:

- Lived with relatives/friends because you had no housing? _____
- Lived in a shelter? _____
- Been homeless? _____
- Lived on the streets? _____
- Been evicted? _____
- Lived in a transitional housing center? _____
- Owned your own home/condo/townhouse? _____

42. Are you currently employed? _____

43. If yes, what is your current position? _____

44. How long have you been employed? _____

45. What is your current monthly income? _____

46. Currently, do you receive financial support from the government, such as:

- Social Security Yes ____ No ____ Amount \$ _____
- Unemployment Yes ____ No ____ Amount \$ _____
- Disability Yes ____ No ____ Amount \$ _____
- Temporary Assistance for Needy Families Yes ____ No ____
Amount \$ _____
- Food Stamps Yes ____ No ____ Amount \$ _____
- Other _____

47. Do you receive child support? If yes, how much? _____

48. What are your other sources of income, if any? _____

49. To the best of your ability, name the people in your life who you currently rely on for support. Please list their first names and their relationship to you, such as friend, neighbor, sister, etc.

50. What is the highest level of education that you have obtained? (Please list what grade you got to in school, GED, or how many years of college, trade, or graduate school that you have completed).

51. Are you currently in school or in training? If so, where?

52. Do you currently own or lease a car?

53. Are you currently seeing a mental health professional, such as a therapist, counselor, or psychiatrist?

54. Are any of your children currently seeing a mental health professional, such as a therapist, counselor, or psychiatrist?

55. Is English your first language?

56. Are you currently involved in any legal battles or do you currently have any involvement with the court system? If yes, please explain:

57. For each of your children, please list their ages and the highest grade level that they have achieved in school:

1. Age: _____ Highest Grade Completed: _____
Ever Repeat/Fail a grade? Yes ___ No ___ Drop out from school ? Yes ___ No ___
2. Age: _____ Highest Grade Completed: _____
Ever Repeat/Fail a grade? Yes ___ No ___ Drop out from school ? Yes ___ No ___
3. Age: _____ Highest Grade Completed: _____
Ever Repeat/Fail a grade? Yes ___ No ___ Drop out from school ? Yes ___ No ___
4. Age: _____ Highest Grade Completed: _____
Ever Repeat/Fail a grade? Yes ___ No ___ Drop out from school ? Yes ___ No ___
5. Age: _____ Highest Grade Completed: _____
Ever Repeat/Fail a grade? Yes ___ No ___ Drop out from school ? Yes ___ No ___

HISTORY

58. What was the highest level of education achieved by each of your parents?

Mother _____ Father _____ if unknown, leave blank

59. What language was spoken in your home when you were growing up? _____

60. With whom did you live when you were growing up?

61. As a child, were you ever physically abused? _____

62. As a child, were you ever sexually abused? _____

64. As a child, were you ever verbally abused? _____

65. As a child, were you ever emotionally abused? _____

66. When you were a child, to the best of your knowledge, did your family ever:

- Live in a shelter? _____
- Become homeless? _____
- Live on the streets? _____
- Get evicted? _____
- Live in a transitional housing center? _____
- Own your own home/condo/townhouse? _____

QUESTIONS FOR MOTHERS WITH CHILDREN OLDER THAN 18

67. Do any of your children hold a job? Yes ____ No ____

If yes, what are their ages and how much income do they make per month?

1. Age _____ Income _____

2. Age _____ Income _____

3. Age _____ Income _____

68. Do any of your children rent their own apartment or own their own home? _____

If yes, what are their ages and genders?

1. Age of child with apartment or home _____ gender _____

2. Age of second child with apartment or home _____ gender _____

3. Age of third child with apartment or home _____ gender _____

69. Have any of your children, as adults, ever been homeless or lived in a shelter or transitional housing shelter? Yes ____ No ____

Appendix D

Results and Tables

VII. Tables

Table 1

Demographic Variables of Sample

Variable	Past-Resident Participant Sample			
	<u>n</u>	<u>Mean</u>	<u>SD</u>	<u>Range</u>
Age (years)	25	39.0	12.55	25-75
Education (years)	25	12.9	2.2	9-18
Children	25	2.2	2.2	0-5
Income (monthly)	25	\$1,275.52	\$841.29	\$0-\$3,000.00
	<u>n</u>	<u>%</u>		
Gender (female)	25	100		
Ethnicity				
African American	16	64		
Hispanic	4	16		
Caucasian	3	12		
Native American	1	4		
Other/Mixed Races	1	4		
First Language				
English	20	80		
Spanish	4	16		
Other/Tribal Language	2	8		

Table 2

Variables of experiences at and since Shared Housing Center

Variable	Past-Resident Participant Sample			
	<u>n</u>	<u>Mean</u>	<u>SD</u>	<u>Range</u>
Months post SHC	25	63	46.9	7-161
Months living in SHC	25	14.3	11.6	3-47
	<u>n</u>	<u>%</u>		
Prior to SHC				
lived with relatives	20	80		
lived in shelter	13	52		
been homeless	9	36		
lived in another THC	9	36		
been evicted	8	32		
lived on the streets	2	8		
After SHC				
lived with relatives	9	36		
lived in shelter	3	12		
been homeless	2	8		
lived in another THC	4	16		
been evicted	1	4		
lived on the streets	0	0		

Table 3

Chi –Square Comparisons of Successful Employment and Successful Housing Within Sample

Variable	Percentage of Sample within Each Group			
	Yes	No		
	<u>% (n)</u>	<u>% (n)</u>	<u>χ^2</u>	<u>p</u>
Successful Housing	72 (18)	28 (7)	4.84	.028*
Successful Employment	72 (18)	28 (7)	4.84	.028*
Both Successful Housing and Successful Employment	52 (13)			
Neither Successful Housing or Successful Employment	8 (2)			

Table 4

T-test Comparisons of Participant Sample(PS) and Non-Participant (NP) Past-Residents

	Group (<u>n</u>)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
Age at SHC (in years)	PS (25)	35.4 (12.58)	.01	.990
	NP (124)	35.36 (14.90)		
Time at SHC (in months)	PS (25)	12.92 (8.78)	4.33	.000**
	NP (124)	6.68 (6.05)		

p* ≤ .05, two-tailed. *p* ≤ .01, two-tailed.

Table 5

Chi –Square Comparisons of Participant Sample (PS) and Non-Participants (NP) on Demographic and Treatment Variables

Variable	Group		χ^2 11.2	p .02*
	PS	NP		
Ethnicity	<u>% (n)</u>	<u>% (n)</u>		
African American	64 (16)	44.4 (55)		
Hispanic	16 (4)	16.9 (21)		
Caucasian	12 (3)	37.1 (46)		
American Indian	4 (1)	0 (0)		
Biracial/Other	4 (1)	1.6 (2)		
Referral Source			6.60	.159
Non-shelter agency	20 (5)	22.1 (27)		
Another shelter	48 (12)	58.2 (71)		
Self	0 (0)	5.7 (7)		
Friend/Coworker	32 (8)	13.1 (16)		
Other	0 (0)	.8 (1)		
Education			2.05	.152
High School Graduation	80 (20)	65.3 (81)		
Less than 12 years	20 (5)	34.7 (43)		

Table 5 (continued)

Variable	Group		χ^2	p
	PS	NP		
	<u>% (n)</u>	<u>% (n)</u>		
SHC Residence			2.08	.353
Grigsby	56 (14)	62.1 (77)		
Gaston	36 (9)	23.4 (29)		
Haines	8 (2)	14.5 (18)		
Decision to leave SHC			6.20	.102
Resident's	60 (15)	38.7 (48)		
SHC's	28 (7)	53.2 (66)		
12 mos. Completed	12 (3)	6.5 (8)		
Other	0 (0)	1.3 (2)		
Housing Choice			18.57	.002**
Apartment/Home	80 (20)	44.4 (55)		
Treatment Center	4 (1)	0 (0)		
Back to Street/Shelter	0 (0)	25 (31)		
Friend/Family's Home	8 (2)	12.1 (15)		
Back to Abuser	4 (1)	4 (5)		
Other Transitional Housing	4 (1)	14.5 (18)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 6

*Chi –Square Comparisons of Successfully Housed (SH) and Non-Successfully Housed (NSH)
Women and participation in Individual Therapy and Group Therapy*

Variable	Group		χ^2	p
	SH	NSH		
In Group Therapy	<u>% (n)</u> 94.4 (17)	<u>% (n)</u> 85.7 (6)	.52	.47
No Group Therapy	5.6 (1)	14.3 (1)		
In Individual Therapy	55.6 (10)	85.7 (6)	1.9	.16
No Individual Therapy	44.4 (8)	14.3 (1)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 7

Chi –Square Comparisons of Successfully Employed (SE) and Non-Successfully Employed (NSE) Women and participation in Individual Therapy (IT) and Group Therapy (GT)

Variable	Group		χ^2	p
	SE	NSE		
In Group Therapy	<u>% (n)</u> 94.4 (17)	<u>% (n)</u> 85.7 (6)	.52	.47
No Group Therapy	5.6 (1)	14.3 (1)		
In Individual Therapy	66.7 (12)	57.1 (4)	.19	.65
No Individual Therapy	33.3 (6)	42.9 (3)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 8

T-test Comparisons of Social Support Measures for SH, NSH, SE, and NSE

	Group (<u>n</u>)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
PRQ B	SH (18)	127.39 (29.39)	1.36	.192
	NSH (7)	141.57 (20.55)		
Number during SHC	SH (18)	1.67 (1.46)	.798	.451
	NSH (7)	2.71 (3.35)		
Number currently	SH (18)	2.50 (2.88)	-1.01	.327
	NSH (7)	1.43 (2.15)		
PRQ B	SE (18)	135.39 (26.23)	-1.107	.295
	NSE (7)	121.0 (30.25)		
Number during SHC	SE (18)	1.67 (1.46)	.789	.451
	NSE (7)	2.71 (3.35)		
Number currently	SE (18)	2.00 (3.01)	.745	.465
	NSE (7)	2.71 (1.70)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 9

T-test Comparisons of Mean Scores on SA-45 Clinical Scales for SH and NSH Groups

SA-45 Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
GSI Global Severity Index	SH (18)	63.11 (7.83)	-2.45	.022*
	NSH (7)	55.00 (6.11)		
PST Positive Symptom Total	SH (18)	65.56 (8.62)	-2.60	.016*
	NSH (7)	55.00 (7.07)		
ANX Anxiety	SH (18)	60.33 (9.39)	-2.06	.051*
	NSH (7)	52.29 (6.75)		
DEP Depression	SH (18)	59.44 (8.32)	-.92	.373
	NSH (7)	56.71 (5.94)		
OCD Obsessive-Compulsive	SH (18)	60.94 (9.68)	-1.50	.153
	NSH (7)	55.86 (6.64)		
SOM Somatization	SH (18)	61.94 (8.47)	-2.13	.051*
	NSH (7)	55.29 (6.37)		
PHO Phobic Anxiety	SH (18)	65.50 (6.78)	-2.39	.028*
	NSH (7)	60.14 (4.18)		
HOS Hostility	SH (18)	61.94 (7.05)	-2.39	.028*
	NSH (7)	56.43 (4.24)		

Table 9 (continued)

INT Interpersonal Sensitivity	SH (18)	60.06 (7.29)	-2.64	.020*
	NSH (7)	52.71 (5.80)		
PAR Paranoid Ideation	SH (18)	62.67 (7.86)	-2.22	.039*
	NSH (7)	57.14 (4.41)		
PSY Psychoticism	SH (18)	65.17 (6.78)	-1.14	.272
	NSH (7)	62.43 (4.76)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 10

T-test Comparisons of Mean Scores on SA-45 Clinical Scales for SE and NSE Groups

SA-45 Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
GSI Global Severity Index	SE (18)	61.06 (7.48)	-.18	.862
	NSE (7)	60.29 (10.36)		
PST Positive Symptom Total	SE (18)	63.00 (8.70)	-.89	.391
	NSE (7)	59.00 (10.46)		
ANX Anxiety	SE (18)	57.44 (9.13)	.50	.625
	NSE (7)	59.71 (10.47)		
DEP Depression	SE (18)	57.78 (7.59)	.91	.383
	NSE (7)	61.00 (8.09)		
OCD Obsessive-Compulsive	SE (18)	60.72 (8.90)	-1.03	.327
	NSE (7)	56.43 (9.55)		
SOM Somatization	SE (18)	59.78 (7.86)	.25	.807
	NSE (7)	60.86 (10.25)		
PHO Phobic Anxiety	SE (18)	64.33 (6.32)	-.37	.721
	NSE (7)	63.14 (7.58)		
HOS Hostility	SE (18)	61.89 (7.26)	-2.50	.021*
	NSE (7)	56.57 (3.36)		

Table 10 (continued)

INT Interpersonal Sensitivity	SE (18)	59.00 (6.14)	-.84	.427
	NSE (7)	55.43 (10.58)		
PAR Paranoid Ideation	SE (18)	60.67 (7.28)	.46	.659
	NSE (7)	62.29 (8.24)		
PSY Psychoticism	SE (18)	64.22 (5.52)	.18	.860
	NSE (7)	64.86 (8.53)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 11

Chi –Square Comparisons of Successfully Housed (SH) and Non-Successfully Housed (NSH) Women and scores on ISA-P and ISA-NP

Variable	Group		χ^2	p
	SH	NSH		
	<u>% (n)</u>	<u>% (n)</u>		
ISA-Physical				
Above cut-off (Abused)	15.6 (1)	0 (0)	.405	.524
Below cut-off	94.4 (17)	100 (7)		
ISA-Non-Physical				
Above cut-off (Abused)	5.6 (1)	0 (0)	.845	.358
Below cut-off	94.4 (17)	100 (7)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 12

Chi –Square Comparisons of Successfully Employed (SE) and Non-Successfully Employed (NSE) Women and scores on ISA-P and ISA-NP

Variable	Group		χ^2	p
	SE	NSE		
	<u>% (n)</u>	<u>% (n)</u>		
ISA-Physical				
Above cut-off (Abused)	0 (0)	14.3 (1)	2.68	.102
Below cut-off	100 (18)	85.7 (6)		
ISA-Non-Physical				
Above cut-off (Abused)	5.6 (1)	14.3 (1)	.522	.470
Below cut-off	94.4 (17)	85.7 (6)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 13

Chi –Square Comparisons of Successfully Housed (SH) and Non-Successfully Housed (NSH)

Women and scores on SASSI-3

Variable	Group			
	SH	NSH		
	<u>% (n)</u>	<u>% (n)</u>	<u>χ^2</u>	<u>p</u>
Substance Abuse Disorder	5.6 (1)	28.6 (2)	2.53	.112
No Substance Abuse Disorder	94.4 (17)	71.4 (5)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 14

Chi –Square Comparisons of Successfully Employed (SE) and Non-Successfully Employed (NSE) Women and scores on SASSI-3

Variable	Group			
	SE	NSE		
	<u>% (n)</u>	<u>% (n)</u>	<u>χ^2</u>	<u>p</u>
Substance Abuse Disorder	11.1 (2)	14.3 (1)	.05	.83
No Substance Abuse Disorder	88.9 (16)	85.7 (6)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 15

Chi –Square Comparisons of Children of Successfully Housed (CSH) and Non-Successfully Housed (CNSH) Women and children's participation in Individual and Group Therapy

Variable	Group		χ^2	p
	CSH	CNSH		
In Group Therapy	<u>% (n)</u> 75 (15)	<u>% (n)</u> 83.3 (5)	.181	.671
No Group Therapy	25 (5)	16.7 (1)		
In Individual Therapy	35 (7)	67 (4)	1.90	.17
No Individual Therapy	65 (13)	33.3 (2)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 16

Chi –Square Comparisons of Children of Successfully Employed (CSE) and Non-Successfully Employed (CNSE) Women and participation in Individual Therapy (IT) and Group Therapy (GT)

Variable	Group		χ^2	p
	CSE	CNSE		
In Group Therapy	<u>% (n)</u> 79.2 (19)	<u>% (n)</u> 50 (1)	.89	.35
No Group Therapy	20.8 (5)	50 (1)		
In Individual Therapy	45.8 (11)	0 (0)	1.59	.21
No Individual Therapy	54.2 (13)	100 (2)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 17

T-test Comparisons of Mean Scores on SA-45 Clinical Scales for CSH and CNSH Groups

SA-45 Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
GSI Global Severity Index	CSH (8)	54.00 (4.11)	.85	.420
	CNSH (3)	59.67 (19.55)		
PST Positive Symptom Total	CSH (8)	55.38 (3.89)	.67	.518
	CNSH (3)	60.00 (20.30)		
ANX Anxiety	CSH (8)	54.00 (6.63)	1.45	.263
	CNSH (3)	65.00 (12.53)		
DEP Depression	CSH (8)	51.13 (5.84)	1.22	.332
	CNSH (3)	60.33 (12.58)		
OCD Obsessive-Compulsive	CSH (8)	55.63 (8.62)	.56	.624
	CNSH (3)	61.33 (16.86)		
SOM Somatization	CSH (8)	52.63 (8.52)	.95	.430
	CNSH (3)	62.33 (17.01)		
PHO Phobic Anxiety	CSH (8)	57.88 (4.36)	1.34	.297
	CNSH (3)	65.67 (9.71)		
HOS Hostility	CSH (8)	55.38 (8.85)	.03	.975
	CNSH (3)	55.67 (13.61)		

Table 17 (continued)

INT Interpersonal Sensitivity	CSH (8)	52.13 (3.44)	.88	.401
	CNSH (3)	55.00 (7.94)		
PAR Paranoid Ideation	CSH (8)	53.38 (5.04)	1.00	.415
	CNSH (3)	61.67 (14.05)		
PSY Psychoticism	CSH (8)	56.13 (5.99)	.39	.723
	CNSH (3)	58.33 (9.02)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 18

T-test Comparisons of Mean Scores on SA-45 Clinical Scales for CSE and CNSE Groups

SA-45 Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
GSI Global Severity Index	CSE (10)	55.60 (10.27)	-.06	.957
	CNSE (1)	55.00		
PST Positive Symptom Total	CSE (10)	56.10 (10.25)	.55	.596
	CNSE (1)	62.00		
ANX Anxiety	CSE (10)	56.70 (9.87)	.32	.757
	CNSE (1)	60.00		
DEP Depression	CSE (10)	54.50 (8.55)	-1.06	.317
	CNSE (1)	45.00		
OCD Obsessive-Compulsive	CSE (10)	56.80 (11.22)	.36	.731
	CNSE (1)	61.00		
SOM Somatization	CSE (10)	55.10 (11.97)	.15	.883
	CNSE (1)	57.00		
PHO Phobic Anxiety	CSE (10)	60.10 (7.09)	-.15	.886
	CNSE (1)	59.00		
HOS Hostility	CSE (10)	55.00 (9.98)	.48	.644
	CNSE (1)	60.00		

Table 18 (continued)

INT Interpersonal Sensitivity	CSE (10)	53.10 (4.98)	-.40	.697
	CNSE (1)	51.00		
PAR Paranoid Ideation	CSE (10)	55.40 (8.92)	.28	.787
	CNSE (1)	58.00		
PSY Psychoticism	CSE (10)	57.20 (6.66)	-.74	.476
	CNSE (1)	52.00		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 19

T-test Comparisons of Mean Scores on CFSEI Scales for CSH and CNSH Groups

CFSEI Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
A Academic	CSH (15)	8.80 (2.46)	.00	1.00
	CNSH (5)	8.80 (3.35)		
G General	CSH (15)	8.93 (3.50)	-.64	.536
	CNSH (5)	8.00 (2.55)		
P/H	CSH (15)	8.07 (3.45)	-.04	.967
	CNSH (5)	8.00 (2.83)		
S Social	CSH (15)	9.80 (2.24)	-1.79	.134
	CNSH (5)	6.60 (3.78)		
P Personal	CSH (7)	8.43 (3.10)	-1.76	.116
	CNSH (3)	5.00 (1.73)		
GSE Global Self-Esteem Quotient	CSH (20)	90.90 (14.96)	-.23	.82
	CNSH (6)	88.83 (20.01)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 20

T-test Comparisons of Mean Scores on SSCS Scales for CSH and CNSH Groups

SSCS Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
Self-Confidence Self-Image (SCSI)	CSH (20)	103.85 (14.12)	1.00	.346
	CNSH (6)	110.17 (13.47)		
Self-Confidence Academic (SCA)	CSH (20)	95.15(22.10)	.58	.572
	CNSH (6)	100.00 (16.42)		
Self-Confidence Social (SCS)	CSH (20)	97.65 (22.86)	1.05	.315
	CNSH (6)	105.83 (14.53)		
Self-Confidence Composite (SCC)	CSH (20)	99.05 (17.86)	.91	.389
	CNSH (6)	106.17 (16.58)		
Importance Self-Image (ISI)	CSH (20)	105.05 (17.45)	1.20	.257
	CNSH (6)	113.50 (14.29)		
Importance Academic (IA)	CSH (20)	119.50 (12.82)	1.35	.199
	CNSH (6)	110.20 (19.89)		
Importance Social (IS)	CSH (20)	106.60 (20.01)	.01	.991
	CNSH (6)	106.67 (9.11)		
Outcome Confidence Composite (OCC)	CSH (20)	102.45 (16.40)	1.15	.275
	CNSH (6)	109.67 (12.47)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 21

T-test Comparisons of Mean Scores on CFSEI and Scales for CSE and CNSE Groups

CFSEI Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
A Academic	CSE (18)	8.56 (2.55)	1.17	.425
	CNSE (2)	11.00 (2.83)		
G General	CSE (18)	8.33 (3.20)	2.93	.080
	CNSE (2)	12.00 (1.41)		
P/H Parental/Home	CSE (18)	7.83 (3.35)	.89	.383
	CNSE (2)	10.00 (0.00)		
S Social	CSE (18)	8.78 (3.04)	1.01	.326
	CNSE (2)	11.00 (0.00)		
P Personal	CSE (9)	6.67 (2.24)	3.11	.014*
	CNSE (1)	14.00 (.)		
GSE Global Self-Esteem Quotient	CSE (24)	88.92 (15.56)	6.09	.000**
	CNSE (2)	108.50 (.71)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 22

T-test Comparisons of Mean Scores on SSCS Scales for CSE and CNSE Groups

SSCS Scale	Group (n)	Mean (<u>SD</u>)	<i>t</i>	<i>p</i>
Self-Confidence Self-Image (SCSI)	CSE (24)	104.25 (13.41)	.96	.502
	CNSE (2)	118.00 (19.80)		
Self-Confidence Academic (SCA)	CSE (24)	95.71 (20.85)	.39	.756
	CNSE (2)	103.00 (25.46)		
Self-Confidence Social (SCS)	CSE (24)	98.75 (21.72)	.86	.510
	CNSE (2)	109.00 (15.56)		
Self-Confidence Composite (SCC)	CSE (24)	99.75 (17.21)	.71	.601
	CNSE (2)	112.00 (24.04)		
Importance Self-Image (ISI)	CSE (24)	106.54 (17.40)	.72	.568
	CNSE (2)	112.50 (10.61)		
Importance Academic (IA)	CSE (24)	112.04 (19.31)	.44	.712
	CNSE (2)	116.00 (11.31)		
Importance Social (IS)	CSE (24)	106.63 (18.67)	-.02	.987
	CNSE (2)	106.50 (7.78)		
Outcome Confidence Composite (OCC)	CSE (24)	103.54 (15.86)	.65	.619
	CNSE (2)	111.00 (15.56)		

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 23

Chi –Square Comparisons of Children of Successfully-Housed (CSH) and Non-Successfully Housed (CNSH) Women and scores on SASSI-A

Variable	Group			
	CSH	CNSH		
	<u>% (n)</u>	<u>% (n)</u>	<u>χ^2</u>	<u>p</u>
Substance Abuse Disorder	11.1 (1)	33.3 (1)	.80	.371
No Substance Abuse Disorder	88.9 (8)	66.7 (2)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 24

Chi –Square Comparisons of Children of Successfully Employed (CSE) and Non-Successfully Employed (CNSE) Women and scores on SASSI-A

Variable	Group		χ^2	p
	CSE	CNSE		
Substance Abuse Disorder	<u>% (n)</u> 18.2 (2)	<u>% (n)</u> 0 (0)	.22	.64
No Substance Abuse Disorder	81.8 (9)	100 (1)		

*p ≤ .05, two-tailed. **p ≤ .01, two-tailed.

Table 25

Logistic Regression Analysis of SA-45 General Symptom Index predicting Stable Housing Outcome

	B	Wald	<i>p</i>	OR	95%CI
SA-45 GSI	.200	4.16	.041*	1.22	1.01 -1.48

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

Table 26

Logistic Regression Analysis of Amount of Government Assistance predicting Stable Employment Outcome

	B	Wald	<i>p</i>	OR	95%CI
Government Assistance	-.008	7.88	.005**	.99	.987-.998

* $p \leq .05$, two-tailed. ** $p \leq .01$, two-tailed.

VIII. References

- Adams, C. E., Pantelis, C., Duke, P. J., & Barnes, T. R. E. (1996). Psychopathology, social and cognitive functioning in a hostel for homeless women. *British Journal of Psychiatry, 168*, 82-86.
- Anderson, E. A., Koblinsky, S.A. (1995). Homeless policy: The need to speak to families. *Family Relations, 44*(1), 13-18.
- Averitt, S. S. (2003). "Homelessness is not a choice!" The plight of homeless women with preschool children living in temporary shelters. *Journal of Family Nursing, 9*(1), 79-100.
- Bachrach, L. L. (1992). The urban environment and mental health. *The International Journal of Social Psychiatry, 38*(1), 5-15.
- Baggerly, J. (2003). Child-centered play therapy with children who are homeless: Perspective and procedure. *International Journal of Play Therapy, 12*(2), 87-106.
- Banyard, V. L., Graham-Bermann, S. A. (1995). Building an empowerment policy paradigm: Self-reported strengths of homeless mothers. *American Journal of Orthopsychiatry, 65*(4), 479-491.
- Banyard, V. L., Graham-Bermann, S. A. (1998). Surviving poverty: Stress and coping in the lives of housed and homeless mothers. *American Journal of Orthopsychiatry, 68*(3), 479-489.
- Bassuk, E. L., Rubin, E., & Lauriat, A. S. (1986). Characteristics of sheltered homeless families. *American Journal of Public Health, 76*(9), 1097-1101.

- Bassuk, E. L. (1986). Homeless Families: Single mothers and their children in Boston shelters. *New Directions for Mental Health Services*, 30, 45-53.
- Bassuk, E. L. (1987). The feminization of homelessness: Families in Boston shelters. *The American Journal of Social Psychiatry*, VII(1), 19-23.
- Bassuk, E. L., & Rosenberg, L. (1988). Why does family homelessness occur? *A case-control study*. *American Journal of Public Health*, 78(7), 783-788.
- Bassuk, E. L., & Gallagher, E. M. (1990). The impact of homelessness on children. *Child & Youth Services*, 14(1), 19-33.
- Bassuk, E. L. (1990). Who are the homeless families? Characteristics of sheltered mothers and children. *Community Mental Health Journal*, 26(5), 425-434.
- Bassuk, E. L. (1993). Homeless women-economic and social issues: Introduction. *American Journal of Orthopsychiatry*, 63(3), 337-339.
- Bassuk, E. L. (1993). Social and economic hardships of homeless and other poor women. *American Journal of Orthopsychiatry*, 63(3), 340-347.
- Bassuk, E. L., Buckner, J. C., Weinreb, L. F., Browne, A., Bassuk, S. S., Dawson, R., & Perloff, J. N. (1997). Homelessness in female-headed families: Childhood and adult risk and protective factors. *American Journal of Public Health*, 87, 241-248.
- Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry*, 155(11), 1561-1564.
- Bates, D. S., & Toro, P. A. (1999). Developing measures to assess social support among homeless and poor people. *Journal of Community Psychology*, 27(2), 137-156.

Battle, J. (2003) *Culture-Free Self-Esteem Inventories-Third Edition*. Austin, TX:

Pro-Ed.

Benson, J. (1998). Student Self-Concept Scale. In B.S. Plake & Impara, J.C. (Ed.), *The Thirteenth Mental Measurements Yearbook* (Vol. 13, pp.). Lincoln, NE: Buros Institute of Mental Measurements.

Bogard, C. J., McConnell, J. J., Gerstel, N., & Schwartz, M. (1999). Homeless mothers and depression: Misdirected policy. *Journal of Health and Social Behavior*, 40, 46-62.

Bogard, C. J., Trillo, A., Schwartz, M., & Gerstel, N. (2001). Future employment among homeless single mothers: The effects of full-time work experience and depressive symptomatology. *Women & Health*, 32(1-2), 137-157.

Boxill, N. A. & Beaty, A.L. (1990). Mother/child interaction among homeless women and their children in a public night shelter in Atlanta, GA. *Child & Youth Services*, 14(1), 49-64.

Bridgman, R. (2001). A safe haven for chronically homeless women. *International Journal of Mental Health*, 30(2), 79-89.

Brooks, M. G., & Buckner, J. C. (1996). Work and welfare: Job histories, barriers to employment, and predictors of work among low-income single mothers. *American Journal of Orthopsychiatry*, 66(4), 526-537.

Browne, A., & Bassuk, S. S. (1993). Family violence and homelessness: The relevance of trauma histories in the lives of homeless women. *American Journal of Orthopsychiatry*, 63(3), 370-384.

- Browne, A., & Bassuk, S. S. (1997). Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. *American Journal of Orthopsychiatry*, 67(2), 261-278.
- Browne, A., Salomon, A., & Bassuk, S. S. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women*, 5(4), 393-426.
- Brunson, B. A. (2003). Culture-Free Self-Esteem Inventories, Third Edition. In B. S. Plake, & Impara, J.C. (Ed.), *The Fifteenth Mental Measurements Yearbook* (Vol. 15, pp. 274-276). Lincoln, NE: Buros Institute of Mental Measurements.
- Buckner, J. C., Bassuk, E. L., & Zima, B. T. (1993). Mental health issues affecting homeless women: Implications for intervention. *American Journal of Orthopsychiatry*, 63(3), 385-399.
- Buckner, J. C. & Bassuk, E. L. (1997). Mental disorders and service utilization among youths from homeless and low-income housed families. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(7), 890-900.
- Bureau of the Census, U.S. Department of Commerce (1997). *Statistical Abstracts of the United States*: 1988, Washington, D.C.: Bureau of the Census.
- Bufkin, J.L. & Bray, J. (1998). Domestic Violence, criminal justice responses and homelessness: Finding the connection and addressing the problem. *Journal of Social Distress and the Homeless*, 7, 227-240.
- Burg, M. A. (1994). Health problems of sheltered homeless women and their dependent children. *Health and Social Work*, 19(2), 125-132.

- Burt, M. R., & Cohen, B. E. (1989). Differences among homeless single women, women with children, and single men. *Social Problems, 36*(5), 508-524.
- Camasso, M. J. (2003). Quality of life perception in transitional housing demonstration projects. *Brief Treatment and Crisis Intervention, 3*(1), 99-118.
- Campbell, D. W., Campbell, J., King, C., Parker, B. & Ryan, J. (2001). The Reliability and Factor Structure of the Index of Spouse Abuse With African-American Women. In K. D. M. O'Leary, R.D. (Ed.), *Psychological Abuse in Violent Domestic Relations* (pp. 101-118). New York: Springer Publishing Company.
- Chavkin, W., Kristal, A., Seabron, C. & Guigli, P. (1987). The reproductive experience of women living in hotels for the homeless in New York City. *New York State Journal of Medicine, 87*, 10-13.
- Clarke, P. N., William, C.A., Percy, M.A., & Kim, Y.S. (1995). Health and life problems of homeless men and women in the southeast. *Journal of Community Health Nursing, 12*(2), 101-110.
- Clarke, P. N., Pendry, N. C., & Kim, Y.S. (1997). Patterns of violence in homeless women. *Western Journal of Nursing Research, 19*(4), 490-500.
- Coll, C. G., Buckner, J. C., Brooks, M. G., Weinreb, L. F., & Bassuk, E. L. (1998). The developmental status and adaptive behavior of homeless and low-income housed infants and toddlers. *American Journal of Public Health, 89*(1371-1374).
- Conrad, B. S. (1998). Maternal depressive symptoms and homeless children. *Archives of Psychiatric Nursing, 12*(2), 50-58.

- Coughey, K., Feighan, K., Cheney, R., & Klein, G. (1998). Retention in an aftercare program for recovering women. *Substance Use & Misuse, 33*(4), 917-933.
- Craig, T. K. J., & Hodson, S. (2000). Homeless youth in London: II. Accommodation, employment, and health outcomes at 1 year. *Psychological Medicine, 30*, 187-194.
- Crockett, D. (2003). Critical Issues children face in the 2000s. *School Psychology Quarterly, 18*(4), 446-453.
- Crystal, S. (1986). Psychosocial rehabilitation and homeless youth. *Psychosocial Rehabilitation Journal, 10*(2), 15-21.
- Kuhn, R. & Chulhane, D.P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: results from the analysis of administrative data. *American Journal of Community Psychology, 26*, 207-232.
- Curtis-Boles, H., & Jenkins-Monroe, V. (2000). Substance abuse in African American women. *The Journal of Black Psychology, 26*(4), 450-469.
- Dail, P. W. (1990). The psychosocial context of homeless mothers with young children: Program and policy implications. *Child Welfare, 69*(4), 291-308.
- Daniels, J., D'Andrea, M., Omizo, M., & Pier, P. (1999). Group work with homeless youngsters and their mothers. *Journal for Specialists in Group Work, 24*(2), 164-185.
- Davey, T. L. (1998). Homeless children and stress: An empirical study. *Journal of Social Distress and the Homeless, 7*(1), 29-40.
- Davey, T. L. Neff, J. A. (2001). A shelter-based stress-reduction group intervention targeting self-esteem, social competence, and behavior problems among homeless children. *Journal of Social Distress and the Homeless, 10*(3), 279-291.

- Davidson, B. P. J. (1989). Class diversity in shelter life. *Social Work*, 34, 491-495.
- Davies-Netzley, S., Hurlburt, M. S., & Hough, R. L. (1996). Childhood abuse as a precursor to homelessness for homeless women with severe mental illness. *Violence and Victims*, 11(2), 129-142.
- Davison, M. L., Bershadsky, B., Bieber, J., Silversmith, D., Maruish, M.E., & Kane, R.L. (1997). Development of a brief, multidimensional, self-report instrument for treatment outcomes assessment in psychiatric settings: Preliminary findings. *Assessment*, 4(3), 259-276.
- Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale-preliminary report. *Psychopharmacological Bulletin*, 9, 13-25.
- Douglass, A. (1996). Rethinking the effects of homelessness on children. *Child Welfare*, 75(6), 741-751.
- Eddowes, E. A., & Hranitz. (1989). Educating children of the homeless. *Childhood Education*, 65(4), 197-200.
- Edelman, M. W., & Mihaly, L. (1989). Homeless families and the housing crisis in the United States. *Children and Youth Services Review*, 11, 91-108.
- Fernandez, E. (2001). The Substance Abuse Subtle Screening Inventory-3. In B. S. Plake, & Impara, J.C. (Ed.), *The Fourteenth Mental Measurements Yearbook* (Vol. 14, pp. 913-916). Lincoln, NE: Buros Institute of Mental Measurements.
- Flouri, E. B., A. (2004). Childhood families of homeless and poor adults in Britain: A prospective study. *Journal of Economic Psychology*, 25, 1-14.

- Flynn, L. (1997). The health practices of homeless women: A causal model. *Nursing Research, 46*(2), 72-77.
- Fogel, S. J. (1997). Moving along: An exploratory study of homeless women with children using a transitional housing program. *Journal of Sociology and Social Welfare, 24*(3), 113-133.
- Galaif, E. R., Nyamathi, A. M., & Stein, J. A. (1999). Psychosocial predictors of current drug use, drug problems, and physical drug dependence in homeless women. *Addictive Behaviors, 24*(6), 801-814.
- Garcia, Y. E. (2003). Culture-Free Self-Esteem Inventories, Third Edition. In B. S. Plake, & Impara, J.C. (Ed.), *The Fifteenth Mental Measurements Yearbook* (Vol. 15, pp. 276-279). Lincoln, NE: Buros Institute of Mental Measurements.
- Geissler, L. J., Bormann, C. A., Kwiatkowski, C. F. Braucht, G. N., & Reichardt, C. S. (1995). Women, homelessness, and substance abuse. *Psychology of Women Quarterly, 19*, 65-83.
- Goerning, P., Wasylenki, D., St. Onge, M., Paduchak, D., & Lancee, W. (1992). Gender differences among clients of a case management program for the homeless. *Hospital and Community Psychiatry, 43*(2), 160-165.
- Goodman, L. A. (1991). The prevalence of abuse among homeless and housed poor mothers: A comparison study. *American Journal of Orthopsychiatry, 61*(4), 489-500.

- Goodman, L. A., Dutton, M. A., & Harris, M. (1995). Episodically homeless women with serious mental illness: Prevalence of physical and sexual assault. *American Journal of Orthopsychiatry*, 65(4), 468-478.
- Goodman, L. A., Dutton, M. A., & Harris, M. (1997). The relationship between violence dimensions and symptom severity among homeless, mentally ill women. *Journal of Traumatic Stress*, 10(1), 51-70.
- Gresham, F. M. (1995). Student Self-Concept Scale: Description and relevance to students with emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 3(1), 19-26.
- Gresham, F. M., Elliot, S.N., & Evans-Fernandez, S.E. (1998). Review of the Student Self-Concept Scale. *Journal of Psychoeducational Assessment*, 16, 181-186.
- Guerney, B., Coufal, J., & Vogelsong, E. (1981). Relationship enhancement versus a traditional approach to therapeutic/preventative/enrichment parent-adolescent paradigms. *Journal of Consulting and Clinical Psychology*, 49(6), 927-939.
- Guerney, L. G., B. (1987). Integrating child and family therapy. *Psychotherapy*, 24, 609-614.
- Guerney, L. F. (1991). Parents as partners in treating behavior problems in early childhood settings. *Topics in Early Childhood Special Education*, 11(2), 74-90.
- Gunning, M. P. D. A., R.C. (1998). Review of the Student Self-Concept Scale. *Journal of Psychoeducational Assessment*, 16, 181-186.

- Harter, S. (1998). The development of self-representations. In W. Damon (Editor in Chief) & N. Eisenberg (Vol. Ed.), *Handbook of child psychology: Social, emotional, and personality development* (5th ed., Vol. 3, pp. 553-617). New York: Wiley.
- Hartman, A. (1989). Homelessness: Public issue and private trouble. *Social Work, 34*, 483-484.
- Hatton, D. C., Kleffel, D., Bennett, S., Gaffrey, E.A.N. (2001). Homeless women and children's access to health care: A paradox. *Journal of Community Health Nursing, 18*(1), 25-34.
- Hausman, B., & Hammen, C. (1993). Parenting in homeless families: The double crisis. *American Journal of Orthopsychiatry, 63*(3), 358-357.
- Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health, 87*, 449-255.
- Herrman, H., McGorry, P., Bennett, P., Van Riel, R., McKenzie, D., & Singh, B. (1989). Prevalence of severe mental disorders in disaffiliated and homeless people in inner Melbourne. *American Journal of Psychiatry, 146*, 1179-1184.
- Hodnicki, D. R. H., S. D. (1993). Homeless mothers' caring for children in a shelter. *Issues in Mental Health Nursing, 14*, 349-356.
- Holleman, W. L., Bray, J. H., Davis, L., & Holleman, M. C. (2004). Innovative ways to address the mental health and medical needs of marginalized patients: Collaborations between family physicians, family therapists, and family psychologists. *American Journal of Orthopsychiatry, 74*(3), 242-252.

- Homeless, N. C. f. t. (1999). The McKinney Act. Retrieved 10/31/2004, 2004, from <http://www.nationalhomeless.org/mckinneyfacts.html>
- Hudson, W. W. Glisson, D.H. (1976). Assessment of marital discord in social work practice. *Social Service Review*, 50, 293-311.
- Hudson, W. W. & McIntosh, S.R. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the Family*, 873-888.
- Imam, H., & Redd, S. (1985). The Elizabeth Stone House: A residential mental health program for women. *SAGE: A Scholarly Journal of Black Women*, 2(2), 65-68.
- Ingram, K. M., Corning, A. F., & Schmidt, L. D. (1996). The relationship of victimization experiences to psychological well-being among homeless women and low-income housed women. *Journal of Counseling Psychology*, 43(2), 218-227.
- Institute of Medicine, Committee on Health Care for Homeless People. (1988) *Homelessness, health and human needs*. Washington, DC: National Academy of Sciences.
- Israelstam, K. (1988). Contrasting four major family therapy paradigms: Implications for family therapy training. *Journal of Family Therapy*, 10, 179-196.
- Jainchill, N., Hawke, J., & Yagelka, J. (2000). Gender, psychopathology, and patterns of homelessness among clients in shelter-based TCs. *American Journal of Drug and Alcohol Abuse*, 26(4), 553-567.
- Johnson, A. K., & Kreuger, L. W. (1989). Toward a better understanding of homeless women. *Social Work*, 34(6), 537-540.

- Khanna, M., Singh, N. N., Nemil, M., Best, A., & Ellis, C. R. (1992). Homeless women and their families: Characteristics, life circumstances, and needs. *Journal of Child and Family Studies, 1*(2), 155-165.
- Koblinsky, S. A., Morgan, K.M., & Anderson, E.A. (1997). African-American homeless and low-income housed mothers: Comparison of parenting practices. *American Journal of Orthopsychiatry, 67*(1), 37-47.
- Koegel, P., Melamid, E., & Burnam, M.A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health, 85*(6), 1642-1649.
- Korittko, A. (1991). Family therapy with one-parent families. *Contemporary Family Therapy, 13*(6), 625-640.
- Lam, J. A., & Rosenheck, R. (1998). The effect of victimization of clinical outcomes of homeless persons with serious mental illness. *Psychiatric Services, 49*, 678-683.
- Lamb, H. R. L., D.M. (1990). Factors contributing to homelessness among the chronically and severely mentally ill. *Hospital and Community Psychiatry, 41*(3), 301-309.
- LaVesser, P. D., Smith, E. M., & Bradford, S. (1997). Characteristics of homeless women with dependent children: A controlled study. *Journal of Prevention & Intervention in the Community, 15*(2), 37-52.
- Lazowski, L.E., Miller, F.G., Boye, M.W., & Miller, G.A. (1998). Efficacy of the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) in identifying substance dependence disorders in clinical settings. *Journal of Personality Assessment, 71*, 114-128.

- Leal, D., Galnter, M., Dermatis, H., & Westreich, L. (1999). Correlates of protracted homelessness in a sample of dually diagnosed psychiatric inpatients. *Journal of Substance Abuse Treatment, 16*(2), 143-147.
- Leong, F. T. L. (1989). Student Self-Concept Scale. In B. S. Plake, & Impara, J.C. (Ed.), *The Thirteenth Mental Measurements Yearbook* (Vol. 13, pp. 968-969). Lincoln, NE: Buros Institute of Mental Measurements.
- Letiecq, B. L., Anderson, E., A., & Koblinsky, S. A. (1998). Social support of homeless and housed mothers: A comparison of temporary and permanent housing arrangements. *Family Relations, 47*(4), 415-421.
- Lindsey, E. W. (1998). The impact of homelessness and shelter life on family relationships. *Family Relations, 47*(3), 243-252.
- Lines, S. (1992). Educational disadvantage in teh promary shcool: Children living in temporary accommodation. *Support for Learning, 7*(1), 8-13.
- Maruish, M. E., Bershadsky, B., & Goldstein, L. (1998). Reliability and validity of the SA-45: Further evidence from a primary care setting. *Assessment, 5*(4), 407-420.
- Masten, A. S., Sesma, A., Si-Asar, R., Lawrence, C., Miliotis, D., & Dionne, J. A. (1997). Educational risks for children experiencing homelessness. *Journal of School Psychology, 35*(1), 27-46.
- Maurin, J. T., Russell, L., & Memmott, R.J. (1989). An exploration of gender differences among the homeless. *Research in Nursing & Health, 12*, 315-321.
- McCarty, D., Argeriou, M., Huebner, R. B., & Lubran, B. (1991). Alcoholism, drug abuse, and the homeless. *American Psychologist, 46*(11), 1139-1148.

- McChesney, K.Y. (1990). Family homelessness: A systematic problem. *Journal of Social Issues, 46*(4), 191-205.
- McChensney, K. Y. (1992). Absence of a family safety net for homeless families. *Journal of Sociology and Social Welfare, 19*(4), 55-72.
- McGloin, J. M. W., C.S. (2001). Resilience among abused and neglected children grown up. *Development and Psychopathology, 13*, 1021-1038.
- McKinney-Vento Homeless Assistance Act, Subtitle VII-B. (2002). Retrieved from http://www.nlchp.org/FA_Education/mckinneyText.cfm
- McLoyd, V.C. (1990). The impact of economic hardship on black families and children: Psychological distress, parenting, and socioemotional development. *Child Development, 61*, 311-346.
- Meadows-Oliver, M. (2003). Mothering in public: A meta-synthesis of homeless women with children living in shelters. *Journal for Specialists in Pediatric Nursing, 8*(4), 130-136.
- Menke, E. M. (2000). Comparison of the stressors and coping behaviors of homeless, previously homeless, and never homeless poor children. *Issues in Mental Health Nursing, 21*, 691-710.
- Metraux, S. & Culhane., D.P. (1999). Family dynamics, housing, and recurring homelessness among women in New York City homeless shelters. *Journal of Family Issues, 20*(3), 371-396.

- Miliotis, D., Sesma, A., & Masten, A. S. (1999). Parenting as a protective process for school success in children from homeless families. *Early Education & Development*, 10(2), 111-133.
- Mills, C. & Ota, H. (1989). Homeless women with minor children in the Detroit metropolitan area. *Social Work*, 34, 485-489.
- Moe, A. M. & Bell, M. P. (2004). Abject Economics. *Violence Against Women*, 10(1), 29-55.
- Molnar, J. M., Rath, W. R., & Klein, T. P. (1990). Constantly compromised: The impact of homelessness on children. *Journal of Social Issues*, 46(4), 109-124.
- National Coalition for the Homeless. (1992). *Over the edge: Homeless families and the welfare system*. Washington, D.C., National Coalition for the Homeless. Retrieved February 25, 2005, from <http://www.nlihc.org/oor98/appenda.html>
- National Law Center on Homelessness and Poverty. (1995). *A Foot in the Schoolhouse Door: Progress and Barriers to the Education of Homeless Children*. Washington, DC: Author.
- National Low Income Housing Coalition. (October, 1998). *Out of Reach: Rental Housing at What Cost?* Retrieved February 20, 2005, from <http://www.nlihc.org/oor98/appenda.html>
- National Low Income Housing Coalition. (2004). *Out of Reach 2004: State Ranks Based on Two Bedroom Housing Wage*. Retrieved February 4, 2004, 2004, from www.nlihc.org/oor2004/table9.htm

- Neiman, L. (1988). A critical review of resiliency literature and its relevance to homeless children. *Children's Environments Quarterly*, 5(1), 17-25.
- North, C. S., & Smith, E. M. (1994). Comparison of white and nonwhite homeless men and women. *Social Work*, 39(6), 639-668.
- North, C. S., Pollio, D. E., Smith, E.M., & Spitznagel, E.L. (1998). Correlates of early onset and chronicity of homelessness in a large urban homeless population. *The Journal of Nervous and Mental Disease*, 186(7), 393-400.
- Nyamathi, A. M. (1991). Relationship of resources to emotional distress, somatic complaints, and high-risk behaviors in drug recovery and homeless minority women. *Research in Nursing & Health*, 14, 269-277.
- Nyamathi, A. M., Bayley, L., Anderson, N., Keenan, C., & Leake, B. (1999). Perceived factors influencing the initiation of drug and alcohol use among homeless women and reported consequences of use. *Women & Health*, 29(2), 99-114.
- Nyamathi, A., Galaif, E. R., & Leake, B. (1999). A comparison of homeless women and their intimate partners. *Journal of community Psychology*, 27(4), 489-502.
- Nyamathi, A. M., Stein, J. A., & Bayley, L. J. (2000). Predictors of mental distress and poor physical health among homeless women. *Psychology & Health*, 15(4), 483-500.
- Nyamathi, A., Leake, B., Keenan, C., & Gelberg, L. (2000). Type of social support among homeless women: Its impact on psychosocial resources, health and health behaviors, and use of health services. *Nursing Research*, 49(6), 318-326.

- Nyamathi, A. M., Leake, B., & Gelberg, L. (2000). Sheltered versus nonsheltered homeless women: Differences in health, behavior, victimization, and utilization. *Journal of General Internal Medicine*, 15, 565-572.
- Nyamathi, A. M., Longshore, D., Keenan, C., Lesser, J., & Leake, B. D. (2001). Childhood predictors of daily substance use among homeless women of different ethnicities. *American Behavioral Scientist*, 45(1), 35-50.
- Page, T., & Nooe, R. M. (2002). Life experiences and vulnerabilities of homeless owmen: A comparison of women unaccompanied versus accompanied by minor children, and correlates with children's emotional distress. *Journal of Social Distress and the Homeless*, 11(3), 215-231.
- Paradis, E. K. (2000). Feminist and community psychology ethics in research with homeless women. *American Journal of Community Psychology*, 28(6), 839-858.
- Phillips, L. (2002, 5/29/2002). Psychometric Information. Retrieved 2/3/2004, from <http://www.montana.edu/cweinert/instruments/PRQ85/psychinfo.html>
- Phillips, L. (2003, 5/19/03). PRQ85. Retrieved 11/24/2003, 2003, from <http://www.montana.edu/cweinert/instruments/PRQ85/PRQ85.html>
- Pittenger, D. J. (2001). The Substance Abuse Subtle Screening Inventory-3. In B. S. Plake, & Impara, J.C. (Ed.), *The Fourteenth Mental Measurements Yearbook* (Vol. 14, pp. 916-918). Lincoln, NE: Buros Institute of Mental Measurements.
- Pool, M. L. F., J.R. (1973). Family therapy: A review of the literature pertinent to children and adolescents. *Psychotherapy: Theory, Research and Practice*, 10(3), 256-260.

- Punukollu, M. (2003). Domestic violence: screening made practical. *Journal of Family Practice*.
- Rafferty, Y. (1989). Learning in limbo: The educational deprivation of homeless children. Long Island City, NY: Advocates for Children of New York, Inc.
- Rafferty, Y., & Shinn, M. (1991). The impact of homelessness on children. *American Psychologist*, 46(11), 1170-1179.
- Rafferty, Y. (1995). The legal rights and educational problems of homeless children and youth. *Educational Evaluation and Policy Analysis*, 17(1), 39-61.
- Rafferty, Y., & Shinn, M., & Weitzman, B. C. (2004). Academic achievement among formerly homeless adolescents and their continuously housed peers. *Journal of School Psychology*, 42, 179-199.
- Rescorla, L., Parker, R., & Stolley, P. (1991). Ability, achievement, and adjustment in homeless children. *American Journal of Orthopsychiatry*, 61(2), 210-220.
- Reyes, L.M., & Waxman, L.D. (1987). The continuing growth of hunger, homelessness, and poverty in America's cities: 1987, Washington, DC: U.S. Conference of Mayors.
- Reyes, L.M. & Waxman, L.D. (1989). A status report on hunger and homelessness in America's cities: 1989, Washington, DC: U.S. Conference of Mayors.
- Reynolds, W. M. (1989). Student Self-Concept Scale. In B. S. Plake, & Impara, J.C. (Ed.), *The Thirteenth Mental Measurements Yearbook* (Vol. 13, pp. 966-968). Lincoln, NE: Buros Institute of Mental Measurements.

- Reynolds, W. M. (2001). Symptom Assessment-45 Questionnaire. In B. S. Plake, & Impara, J.C. (Ed.), *The Fourteenth Mental Measurements Yearbook* (Vol. 14, pp. 1207-1209). Lincoln, NE: Buros Institute of Mental Measurements.
- Rog, D. J., Holupka, C. S., & McCombs-Thornton, K. L. (1995). Implementation of the homeless families program: 1. Service models and preliminary outcomes. *American Journal of Orthopsychiatry*, 65(4), 502-513.
- Rog, D. J., McCombs-Thornton, K. L., Gilbert-Mongelli, A. M., Brito, M. C., & Holupka, C. S. (1995). Implementation of the homeless families program: 2. Characteristics, strengths, and needs of participant families. *American Journal of Orthopsychiatry*, 65(4), 514-528.
- Roll, C. N., Toro, P. A., & Ortola, G. L. (1999). Characteristics and experiences of homeless adults: A comparison of single men, single women, and women with children. *Journal of community Psychology*, 27(2), 189-198.
- Rollins, J. H., Saris, R. N., & Johnston-Robledo, I. (2001). Low-income women speak out about housing: A high-stakes game of musical chairs. *Journal of Social Issues*, 57(2), 277-298.
- Rossi, P. H. (1990). The old homeless and the new homelessness in historical perspective. *American Psychologist*, 45(8), 954-959.
- Ruffolo, M. C., Evans, M. E., & Lukens, E. P. (2003). Primary prevention programs for children in the social service system. *The Journal of Primary Prevention*, 23(4), 425-450.

- Ryback, R. F., & Bassuk, E. L. (1986). Homeless battered women and their shelter network. *New Directions for Mental Health Services*, 30, 55-61.
- Sabol, B. J. (1991). The urban child. *Journal of Health Care for the Poor and Underserved*, 2(1), 59-73.
- Salomon, A., Bassuk, S. S., & Brooks, M. G. (1996). Patterns of welfare use among poor and homeless women. *American Journal of Orthopsychiatry*, 66(4), 510-525.
- Sarason, I. G., Levine, H.M., Basham, R.B. & Sarason, B.R. (1983). Assessing Social Support: The Social Support Questionnaire. *Journal of Personality and Social Psychology*, 44(1), 127-139.
- Shinn, M., Knickman, J. R., & Weitzman, B. C. (1991). Social relationships and vulnerability to becoming homeless among poor families. *American Psychologist*, 46(11), 1180-1187.
- Smith, E. M., North, C. S., & Spitznagel, E. L. (1993). Alcohol, drugs, and psychiatric comorbidity among homeless women: An epidemiologic study. *Journal of Clinical Psychiatry*, 54(3), 82-87.
- Smith, E. M., North, C. S., & Fox, L. W. (1995). Eighteen-month follow-up data on a treatment program for homeless substance abusing mothers. *Journal of Addictive Diseases*, 14(4), 57-72.
- Smolen, A. G. (2001). Connecting with Sara; Facilitating attachment. Smith College. *School for Social Work*, 72(1), 53-75.

- Stein, J. A., Leslie, M. B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect*, 26, 1011-1027.
- Steinbock, M. R. (1995). Homeless female-headed families: Relationships at risk. *Marriage and Family Review*, 20(2), 143-159.
- Stephen, D. E. (2000). Young women construct themselves: Social identity, self-concept and psychosocial well-being in homeless facilities. *Journal of Youth Studies*, 3(4), 445-460.
- Stevens, S. J., Erickson, J. R., Tent, J. C., Chong, J., & Gianas, P. (1993). A therapeutic community model for treatment of homeless alcohol and drug users in Tucson, Arizona. *Alcoholism Treatment Quarterly*, 10(3-4), 21-33.
- Stojanovic, D., Weitzman, B. C., Shinn, M., Labay, L. E., & Williams, N. P. (1999). Tracing the path out of homelessness: The housing patterns of families after exiting shelter. *Journal of community Psychology*, 27(2), 199-208.
- Strawser, S., Markos, P. A., Yamaguchi, B. J., & Higgins, K. (2000). A new challenge for school counselors: Children who are homeless. *Professional School Counseling*, 3(3), 162-171.
- Tessler, R., Robenheck, R., & Gamache, G. (2001). Gender differences in self-reported reasons for homelessness. *Journal of Social Distress and the Homeless*, 10(3), 243-254.

- Texas Workforce (2003, June 19, 2003). *Summary of Texas Minimum Wage Act*. Retrieved February 20, 2005, from www.twc.state.tx.us/ui/lablow/tmwsu.html.
- Thrasher, S. P., & Mowbray, C. T. (1995). A strengths perspective: An ethnographic study of homeless women with children. *Health & Social Work, 20*(2), 93-101.
- Toohey, S. M., Shinn, M., & Weitzman, B. C. (2004). Social Networks and homelessness among women heads of household. *American Journal of Community Psychology, 33*(12), 7-20.
- Toro, P. A. (1999). Advances in research on homelessness: An overview of the special issue. *Journal of community Psychology, 27*(2), 115-117.
- Toro, P. A., & Warren, M. G. (1999). Homelessness in the United States: Policy considerations. *Journal of community Psychology, 27*(2), 119-136.
- Torquati, J. C. (2002). Personal and social resources as predictors of parenting in homeless families. *Journal of Family Issues, 23*(4), 463-485.
- United States Department of Housing and Urban Development (1989). A report on the 1988 national survey of shelters for the homeless, Washington, D.C., Department of Housing and Urban Development, Office of Policy Development and Research.
- United States Conference of Mayors. A Status Report on Hunger and Homelessness in America's Cities: 1998. Available for \$15.00 from the U.S. Conference of Mayors, 1620 Eye St., NW, 4th Floor, Washington, DC, 20006-4005, 202/293-7330.
- Urban Institute, The. A New Look at Homelessness in America. February 01, 2000. www.urban.org. February 25, 2005.

- Van der Ploeg, J. D. (1989). Homelessness: A multidimensional problem. *Children and Youth Services Review, 11*, 45-56.
- Vissing, Yvonne. (1996). Out of Sight, Out of Mind: Homeless Children and Families in Small Town America. Lexington, KY: University Press of Kentucky.
- Viswesvaran, C. (2001). Symptom Assessment-45 Questionnaire. In I. B. S. Plake, J.C. (Ed.), *The Fourteenth Mental Measurements Yearbook* (Vol. 14, pp. 1209-1211). Lincoln, NE: Buros Institute of Mental Measurements.
- Vostanis, P., Grattan, E., Cumella, S., & Winchester, C. (1997). Psychosocial functioning of homeless children. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(7), 881-889.
- Vostanis, P., Tischler, V., Cumella, S., & Bellerby, T. (2001). Mental health problems and social supports among homeless mothers and children victims of domestic and community violence. *International Journal of Social Psychiatry, 47*(4), 30-40.
- Walsh, M. E., & Buckley, M. A. (1994). Children's experiences of homelessness: Implications for school counselors. *Elementary School Guidance & Counseling, 29*(1), 4-15.
- Waxman, L. (1994). A status report on hunger and homelessness in America's Cities. Washington, D.C.: United States Conference of Mayors.
- Weinert, C. (1998). Revision and further development of a social support measure: The Personal Resource Questionnaire. *Measurement of Nursing Outcomes, 1*(309-327).
- Weinreb, L., & Buckner, J. C. (1993). Homeless families: Program responses and public policies. *American Journal of Orthopsychiatry, 63*(3), 400-409.

- Weitzman, B. C., Knickman, J. R., & Shinn, M. (1992). Predictors of shelter use among low-income families: Psychiatric history, substance abuse, and victimization. *American Journal of Public Health, 82*, 1547-1550.
- Weltner, J. S. (1982). A structural approach to the single-parent family. *Family Process, 82*, 203-210.
- Wenzel, S. L. (1992). Gender, ethnic group, and homelessness as predictors of locus of control among job training participants. *The Journal of Social Psychology, 133*(4), 495-505.
- Wenzel, S. L., Koegel, P., & Gelberg, L. (2000). Antecedents of physical and sexual victimization among homeless women: A comparison to homeless men. *American Journal of Community Psychology, 28*(3), 367-390.
- Winkleby, M. A. B., W.T. (1994). Health-related risk factors of homeless families and single adults. *Journal of Community Health, 19*(1), 7-23.
- Wong, Y. I., Piliavin, I., & Wright, B. R. E. (1998). Residential transitions among homeless families and homeless single individuals: A comparison study. *Journal of Social Service Research, 24*(1-2), 1-27.
- Wood, P.A., Hurlburt, M.S., Hough, R.L., Hofstetter, C. R. (1998). Longitudinal assessment of family support among homeless mentally ill participants in a supported housing program. *Journal of Community Psychology, 26*(4), 327-344.
- Woods, L. J. (1988). Home-Based Family Therapy. *Social Work, 33*, 211-214.

- Ziefert, M., & Brown, K. S. (1991). Skill building for effective intervention with homeless families. *Families in Society: The Journal of Contemporary Human Services*, 72, 212-219.
- Zima, B. T., Wells, K.B., Benjamin, B., & Duan, N. (1996). Mental health problems among homeless mothers: Relationship to service use and child mental health problems. *Archives of General Psychiatry*, 53(4), 332-338.
- Zima, B. T., Bussing, R., Forness, S. R., & Benjamin, B. (1997). Sheltered homeless children: Their eligibility and unmet need for special education evaluations. *American Journal of Public Health*, 87, 236-240.
- Zlotnick, C., Kronstadt, D., & Klee, L. (1998). Foster care children and family homelessness. *Journal of Public Health*, 88, 1368-1370.
- Zorza, J. (1991). Woman battering: A major cause of homelessness. *Clearinghouse Review*, 421-429.

VITAE

Melody Moore-Betasso was born in Arlington, Texas on January 20, 1977, the daughter of Carolynn Elaine Moore and Don Lewis Moore. After graduating from Lamar High School in 1995, she entered Pepperdine University in Malibu, California. She spent her sophomore year studying abroad in Florence, Italy, where she solidified her interest in psychology. In April of 1999, she received her Bachelor of Arts in Industrial/Organizational Psychology from Seaver College at Pepperdine. Subsequently, Melody returned to Texas, where she worked for two years at Bryan's House, a non-profit setting for children impacted by HIV/AIDS. In August of 2001, she entered the Clinical Psychology doctoral program at the University of Texas at Southwestern Medical School in Dallas. Melody married Angela Erin Betasso on September 5, 2004. That year, she enrolled in a two-year post-graduate training in psychoanalytic technique and theory and continued her participation in a three-year seminar in Infant Observation. Melody Moore-Betasso was awarded the degree of Doctor of Philosophy in Clinical Psychology in August, 2005.

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