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A Comparison of Coping Strategies Among Homeless Women with Children and Homeless Women without Children

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ABSTRACT

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A COMPARISON OF COPING STRATEGIES AMONG HOMELESS WOMEN WITH DEPENDENT CHILDREN AND HOMELESS WOMEN WITHOUT CHILDREN

Committee Chair: Richard Lyle, Ph.D.

Dissertation dated May 2018

The purpose of this study was to compare the coping strategies between homeless women with dependent children and homeless women without dependent children. Of the 192 homeless women in this study, 64 were mothers who have their dependent children living with them and 132 were women who did not have dependent children living with them. The women were recruited from homeless shelters in Georgia, in the Metro-Atlanta area and several surrounding counties: Bartow, Clark, and Cobb. MANOVA analysis was used to test the differences between both groups using their scores on the Coping Strategies Inventory scales (problem solving skills, problem reframing, and ability to access social networks). Univariate analysis was used to look at each dependent variable. There was no statistical difference in coping strategies between both groups. The conclusions from this study suggest continued research regarding the benefit of coping strategies among homeless populations.

A COMPARISON OF COPING STRATEGIES AMONG HOMELESS WOMEN WITH
DEPENDENT CHILDREN AND HOMELESS WOMEN WITHOUT CHILDREN

A DISSERTATION

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

JENNIFER L. TALLEY

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

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LIST OF ABBREVIATIONS

ARRA	American Recovery and Reinvestment Act
ANOVA	Analysis of Variance
CSP	Community Support Program
EFS	Emergency Food and Shelter
FERA	Federal Emergency Relief Administration
FTS	Federal Transient Service
HCH	Healthcare for the Homeless
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing
HUD	Department of Housing and Urban Development
MANOVA	Multivariate Analysis of Variance
NIMH	National Institute of Mental Health
SNAP	Supplemental Nutrition Assistance Program
SRO	Single Room Occupancy
SSVF	Supportive Services for Veterans Families
TANF	Temporary Aid for Needy Families
VA	Department of Veterans Affairs
VASH	Veterans Affairs Supportive Housing
WPA	Works Progress Administration

CHAPTER I

INTRODUCTION

The number of homeless people in the United States has increased dramatically since the late 1970s (Wachholz, 2005). Although the rate of increase has slowed recently, homelessness remains a substantial problem in the United States. Consequently, public funding has been directed to combat this problem. According to the U.S. Department of Housing and Urban Development (HUD), January 2016, there were 549, 928 homeless people on any given night in the United States. Fifty-six percent of these homeless people stayed in residential programs for homeless people while 31% of these homeless people were found in unsheltered locations (HUD, 2016). Sadly, families with children constituted most of these unsheltered and homeless individuals.

According to the National Coalition for the Homeless (2009), families with children constitute one of the fastest growing segments of the U.S. homeless population. Women make up a small minority (28%) of homeless individuals living alone; however, women and girls represent the majority (60%) of people in homeless families (Johnson, Ribar, & Zhu, 2017). Regrettably, incidences of homelessness in the United States are the highest since the Great Depression (Finfgeld-Connett, 2010), and recent evidence confirms that the U.S. led industrialized nations in the numbers of homeless families (Finfgeld-Connett, 2010). Out of the 549, 928 homeless people reported in 2016, 194,716

were homeless females with children and 118,133 were females who reported themselves as heads of household (HUD, 2016). According to the Georgia Department of Community Affairs (2015), at least 13,790 people were homeless in Georgia in January 2015. Most of these homeless people lived in the City of Atlanta (4,317) and its surrounding areas (3,193). Remarkably, 30% of these homeless people belonged to families with children. This study investigated the coping strategies among homeless women with dependent children and homeless women without dependent children.

Homelessness, the condition of not having a permanent place to live, is a serious societal problem in the United States. Although many studies have identified the numbers of homeless individuals in the United States, these figures are often grossly understated. Most researched methodologies in this field are incapable of providing exact statistics. Studies that estimate the number of homeless individuals are alarming indeed; in fact, it has been estimated that in the United States, there were 700,000 people were homeless per night in the late 1990s and that 610,000 people were homeless per night in the early 2000s. A survey in 1994 found that 12 million Americans experienced homelessness at some point in their lives (Homelessness, 2016). The McKinney-Vento Homeless Assistance Act (1987) established federal support for the building and maintenance of emergency homeless shelters. The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (2009) placed greater emphasis on homelessness prevention and continuing efforts to eliminate chronic homelessness.

The public's outcry to end chronic homelessness has singularly and consistently been centered on one population: veterans. The presence of veterans within the general

U.S. homeless population is regarded as a point of public shame by many and a point of public concern for others (Donovan & Shinseki, 2013). In 2009, Secretary Shinseki of the Department of Veteran Affairs pledged to end homelessness among veterans in five years. Since his pledge, millions of dollars have been used to fund an expansion of VA services for homeless veterans (Tsai & Rosenheck, 2015). Indeed, serious measures are needed to combat homelessness among other groups in America, as well.

Historically, the term homelessness has been identified with people without a family and/or housing (Burt, 2002); however, definitions of the term vary depending upon the federal programs defining it. HUD and the McKinney Act, for example, define homelessness differently. HUD defines a homeless individual as a person who lacks a fixed, regular, and adequate nighttime residence (HUD, 2016). HUD's definition also emphasizes that a homeless person is someone who has a primary nighttime residence that is:

1. a supervised publicly or privately-operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for people with mental illness);
2. an institution that provides a temporary housing for individuals intended to be institutionalized; or
3. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

HUD uses this definition to determine a person's qualifications for participation in a HUD program. It does not include individuals living doubled-up or in hotels/motels, situations in which homeless children are often found (HUD, 2016).

Homelessness entails more than just the loss of a home - it also has a profound impact on the self-worth and self-efficacy of persons affected by it. For the purposes of this study, homelessness is defined according to the definition outlined in The McKinney Act of 2002. The Act defines as homeless a person who lacks a fixed, regular, and adequate nighttime residency that is supervised publicly or privately. Residential shelters operate to provide temporary living accommodations, temporary residence for individuals intended to be institutionalized, or public or private places not ordinarily used as regular sleeping accommodations for human beings. The McKinney Act of 2002 includes additional provisions related to how it defines homelessness due to loss of housing, economic hardship, living in motels, hotels, mobile homes, or camping grounds because of a lack of alternative adequate accommodations, and living in emergency or transitional shelters or abandoned in hospitals.

Causes of homelessness are linked to both macro (societal) and micro (individual) factors. The larger societal trends and changes that affect homelessness are attributable to several factors including poverty, changes in housing markets and land use, lack of affordable housing and employment opportunities, the quality and relevance of public education, institutional supports for people with disabilities, discriminatory policies of several varieties, and lack of health insurance (Anderson & Rayens, 2004; Burt, 2002; Finfgeld-Comnett, 2010; National Coalition for the Homeless, 2009; Rog & Buckner, 2007; Samuels, Shinn, & Buckner, 2010). Discriminatory practices impact access to support and resources for a segment of homeless people. North and Smith (1994) found

out that the nonwhite homeless population faced challenges based on race more than their white counterparts.

Individual factors that impact homelessness can be divided into two categories: background and on-going. Background characteristics include a history of abuse, neglect, or deprivation. On-going characteristics include physical and mental health problems that are beyond the person's control (Johnson et al., 2017). The homeless suffer disproportionately from mental health problems when compared to similarly poor but domiciled individuals (Buckner, Bassuk, & Zima, 1993; Bassuk, Buckner, Perloff, & Bassuk, 1998; Fitzpatrick, Myrstol, & Miller, 2015). Psychiatric disorders that are most common among those who experienced homelessness for more than a year were defined as chronic homelessness. Episodic homelessness was defined as those who experienced homelessness for less than a year, with more than one episode of homelessness (Lippert & Lee, 2015). One caveat to consider when examining individual factors that contribute to homelessness is that most researchers dismiss many systemic problems that contribute to homelessness within the United States, instead of focusing on injustices such as wage inequalities. Popular discourse surrounding the issue has concentrated on blaming the victims of homelessness. This kind of focus on individual characteristics only serves to blame victims and absolve society of its responsibility to alleviate homelessness. Rather than tackling the environmental context and structural underpinnings of homelessness, many have opted to take a surface view of the subject (Bogard, McConnell, Gerstel, & Schwartz, 1999).

Research has many times used the term poor to describe the homeless. Reviewing homelessness from a capitalist economic theoretical perspective, the poor are defined as an underclass whose very existence is viewed as depleting public institutions—the criminal justice system, mental institutions, foster care, and public assistance programs (Susser, 1996). Neo-Marxism provides one analogous perspective to the macro-analysis of homelessness, as it purports that the existence of underdevelopment and an underclass are direct products of capitalism. Additionally, Neo-Marxism argues that poverty and stagnation are direct byproducts of satellization, in which surpluses drain from the peripheries to metropolitan or industrialized centers. In these capitalist arrangements, multinational corporations, lured by the possibility of higher profit margins, seek cheaper labor in so-called underdeveloped countries. This behavior directly impacts employment opportunities for Americans and seriously undermines the ability of people living in underdeveloped countries to construct a sustainable living wage. This directly impacts the rise in the numbers of people who experience homelessness, in both the United States and peripheral countries.

Family homelessness constitutes a larger percentage of this societal problem. The National Alliance to End Homelessness (2015) reported that in the United States, 37% of the nearly 70,000 homeless populations on any given night were comprised of families.

The phrase “family homelessness” is typically associated with a single parent who has dependent children. Sadly, single homeless parents are typically single mothers (Haber & Toro, 2004). Rog et al., (2007) narrowed the definition of family homelessness to include a family usually headed by a single woman in her late 20s with approximately

two children, one or both under 6 years of age, with the most vulnerable members of this category belonging to ethnic minority groups. Mothers often experience homelessness following the breakdown of a relationship with a spouse or partner and they are more sensitive to economic cycles which perpetuate homelessness (Culhane, Webb, Grim, & Metraux, 2003; Tischler, Rademayer, & Vostanis, 2007).

The U.S. Conference of Mayors, Hunger and Homelessness Survey (2014) identified the main causes of homelessness among families to include the lack of affordable housing; 83% of cities surveyed noted unemployment as the primary cause, 61% noted poverty, and 52% noted low paying jobs. Additional causes included family disputes, domestic violence, eviction, substance abuse, and lack of needed services.

Many families begin their journey through homelessness staying temporarily with other people or in a motel to avoid sleeping outdoors, in public spaces, and in cars. Doubled-up situations are often overcrowded and unstable. Doubled-up refers to housing that occurs when people run into financial or social difficulties and lose their housing. They typically temporarily reside with either family or friends, in crowded domiciles (Wright, Caspi, Moffitt, & Silva, 1998). Women are more likely than men to seek these types of alternate arrangements for several reasons including: risks of physical and sexual violence associated with homelessness or their responsibilities for their accompanied children (Johnson et al., 2017).

Homeless women are comprised of a heterogeneous group of women of different race, ages, and marital and parental status who lack access to temporary housing and whose duration of homelessness places them in and out of homelessness (Milburn &

D'Ercole, 1991). Most homeless women in shelters are also mothers of minor children who live elsewhere (Barrow & Laborde, 2008). Many times, homeless mothers enter a shelter without all their children. In reviewing homelessness, the experiences and pathways of women differ from those of homeless men. Other differences between the two groups are physical and mental characteristics and homelessness-related health risks (Burt, 2002; North & Smith, 1993). The research literature has also chronicled the negative factors associated with homeless women, including higher incidences of mental health issues, substance abuse, domestic and sexual violence, pregnancy, sexual and respiratory infections, blood disorders, dermatological problems, fragmented social support, histories of child abuse, limited education, unemployment, and sole responsibility for dependent children (Buckner et al., 1993; Bassuk et al., 1998; Finfgeld-Connett, 2010; Hwang & Dunn, 2005; Wilson, 2005). Homeless women with dependent children have many of the same precipitating and contributing factors as do homeless women without children, such as substance abuse, physical and mental health problems (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013).

Homelessness is very stressful for women; it forces them to deal with negative life events and the daily hassles of living in a shelter (Klitzing, 2003, 2004; Milburn & D'Ercole, 1991; Tischler, Rademeyer, & Vostanis, 2007). Stress is defined as a relational process that occurs through the interaction of a threatening circumstance, or one that is perceived as threatening, and the psychological and social resources that one calls on to address the threat (Milburn & D'Ercole, 1991). Homeless mothers reported higher levels of stress and depressing moods than did housed women who were also low-income

(Banyard & Graham-Bermann, 1998). The stress associated with homelessness is a psychological trauma with the loss of home, possessions, and connections to one's familiar environment. Having to adjust to the daily hassles associated with life on the streets and in shelters is also a traumatic experience (Rayburn et al., 1991).

Research indicates that homelessness has an equally deleterious impact on children as it does on their mothers (Fantuzzo, LeBoeuf, Brumely, & Perlman, 2013; Haskett, Armstrong, & Tisdale, 2016; National Coalition of the Homeless, 2009). Children without a home are twice as likely as other children to have asthma, ear infections, and stomach and speech problems. Homeless children also experience more mental health problems, such as anxiety, depression, and social withdrawal, when compared to children who have homes. Additionally, they are twice as likely to experience hunger and are four times as likely to have developmental delays (Buckner, 2008).

Many homeless women are mothers who have relinquished (voluntarily or otherwise) responsibility for their dependent children. Homeless mothers who have adult children, the distinction lies in the responsibility for the care of dependent children, not in the status of motherhood per se (Buckner et al., 1993). This separation of children from their parents is another frequent consequence of homelessness among families (Samuels et al., 2010). The reasons for separation vary from shelter exclusion of boys, to mothers placing children with relatives to avoid shelters, to shelter environments magnifying familial problems and triggering the intervention of child welfare (Barrow & Lawinski, 2009).

Homelessness continues to be a problem in the United States. The causes of homelessness have both macro and micro contributing factors. Both types of factors will be discussed in this study. Despite the growing technological advancements and the wealth of the US, family homelessness is the largest group of homeless. Notwithstanding the causal factors, the impact of homelessness is devastating for both women without dependent children and families typically defined as a single woman with dependent children. This study will investigate differences in the beneficial coping strategies utilized by these two groups.

Purpose of the Study

The purpose of this study was to examine the differences in coping strategies between homeless women without dependent children and homeless women with dependent children, during their episodes of homelessness. Out of the 549,928 homeless people reported in 2016, 194,716 were homeless females with children and 118,133 were females who reported themselves as heads of household (HUD, 2016). The majority of the participants in this study were residents at homeless shelters in the metro Atlanta area. This study examined the possible differences in coping strategies between the two groups—homeless women without children and homeless women with children. Homelessness among families has increased over the past several years in the wake of the recent economic crises (Holtrop, McNeil, & McWey, 2015). The literature supports the existence of coping strategies among homeless women (Klitzing, 2003), and among homeless mothers (Tischler & Vostanis, 2007). For homeless women who become

pregnant, the unborn child is a motivator for women to exit homelessness (Ruttan, Laboucane-Benson, & Munro, 2012).

Women with dependent children may internalize stress in different ways (Welch-Lazoritz, Whitbeck, & Armenta, 2015), yet there is little research that has examined the differences in coping strategies between homeless women without dependent children and homeless women with dependent children. Research has noted that the children of homeless women are a strength, a resource, and a motivator for overcoming homelessness (Buckner et al., 1993; Culhane & Kuhn, 1998; Holtrop, McNeil, & McWey, 2015; Lindsey, 1996; Sandy, 2014; Wong, Culhane & Kuhn, 1997).

Hypothetically, there is a difference between the coping strategies employed by homeless women without dependent children and homeless women with dependent children. This difference may be attributed to the dependent children of the homeless women. McLoyd (1990) noted that the vast majority of parents in disadvantage situations yet somehow do a competent job of parenting. Homeless parents identified their priority was maintaining their role as parent during homelessness and living in a transitional shelter (Holtrop, Chaviano, Scott, & Smith, 2015). Homeless women who resided in a shelter with children identified numerous strengths and coping strategies including: reading, journal writing, maintaining focus, going to church, and talking to supportive shelter staff, family, and friends (Cosgrove & Flynn, 2005).

Coping is related to mental health outcomes in homeless individuals (Votta & Manion, 2003). Coping is defined as a multidimensional, dynamic process designed to alter an adverse, external event made intolerable by the emotional fallout that stressful

situations engender (Cwikel, Segal-Engelchin, & Mendlinger, 2010). Successful coping requires approaches that seek to avoid the problem (avoidant coping) as well as those that actively deal with it (active coping) (Roth & Cohen, 1986).

Coping strategies require solving the problem, seeking social support, and positive reframing (Morales, Rodriguez, Torres, Paez, & Ingles, 2016). Solving the problem involves: taking steps to remove the stressor or problem, considering how to cope and identifying how to best handle the problem, and seeking advice, information, and assistance to ameliorate the problem (D’Zurilla & Nezu, 1999; Nguyen, Liu, Hernandez, & Stinson, 2012; Tischler, 2009). Banyard and Graham-Bermann (1998) found that the availability of social networks was an important factor that aided the success of formerly homeless single mothers. Seeking social support includes: investing, communicating, and getting moral support from close friends and family members, seeking spiritual support through religious organizations, and seeking professional help from counselors and/or case managers. The last component of coping strategies is positive reframing which includes seeing the stressful situation from a different and positive perspective. This analysis emphasizes the strengths perspective and identification of individual factors that aid the exit strategy of homeless mothers from homelessness as opposed to the deficit model which lacks recommendations for the field of social work and other possible interventions.

Statement of the Problem

The number of homeless people in the United States continues to be a major political and socioeconomic problem. As a community health issue, homelessness

impacts multiple aspects of a society's ability to care for itself (Parker, Regier, Brown, & Davis, 2015). Homelessness impacts national healthcare; 33% of all visits to emergency departments are made by chronically homeless people, costing on average of \$45,000 annually, per person (Garrett, 2012). According to HUD, we have seen a slight decrease in the number of homeless people within the last two to three years. Women account for approximately half of the homeless population across the country and in the state of Georgia. Homeless women outnumber the available shelter beds and/or services available to regain safe, drug-free, permanent housing. Homeless women vary in race, age, marital and parental status, access to temporary housing, duration of homelessness, and their paths into and out of homelessness (Milburn, 1991). Homeless women have a high incidence of chronic health conditions, and their children suffer from higher than normal rates of physical and mental health problems and problems at school. To provide healthier living environments, mothers often relinquish care of their children to supportive agencies family, or friends (Finfgeld-Connett, 2010).

According to the 2015 Homeless Assessment Report to Congress, of the 358,422 individuals identified as homeless in the United States, 100,184 were female. Both homeless women with dependent children and homeless women without dependent children experience many of the same maladies: substance abuse, physical health disorders, and mental health disorders (Bassuk et al., 1996; Finfgeld-Conett, 2010; Guo, Slesnick & Feng, 2016; Hwang & Dunn, 2005; Wilson, 2005). These factors impact the duration of homelessness, number of homeless episodes, and successful exit from homelessness. The literature reviewed these factors, yet there has been limited research of

the impact of possible intrinsic factors that women utilize to cope with the stress of displacement and that aid in the acquisition of shelter and/or permanent housing. One strength women use is the care of dependent children. Children may be a homeless mother's stabilizing influence and only source of emotional support to enable the mother access to benefits and social services that would not otherwise be available to a single adult on the brink of or experiencing homelessness (Buckner et al., 1993; Dail, 1990). The presence of children is often the major reason homeless women receive help from a wide network of relatives and friends (Baker, 1994; Thrasher & Mowbray, 1995).

As stated earlier, homelessness is stressful (Klitzing, 2003, 2004) and, intrinsically, people employ some degree of coping mechanisms to combat the problems associated with homelessness. Identifying coping strategies among homeless women with dependent children and women without dependent children may prove beneficial in identifying exit strategies from homelessness. The lack of coping may extend women's duration of homelessness. The absence of access to social supports limits both groups of women's accesses to a number of resources that could prove beneficial to their homeless exit strategy. Often social supports provide emotional, financial, and social programmatic support for homeless women. The lack of problem-solving skills directly impacts the ability of homeless women to develop incremental plans and steps to exit homelessness. The lack of problem reframing and optimism impacts the emotional health of the homeless woman, which can be a deterrent in accessing plans to exit homelessness.

Research Questions

The research questions of the study are as follows:

- RQ1: Is there a difference in the coping strategies between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?
- RQ2: Is there a difference in the problem-solving skills between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?
- RQ3: Is there a difference in the ability to access social networks between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?
- RQ4: Is there a difference in problem reframing between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?

Null Hypotheses

- Ho1: There is no difference in the coping strategies between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia.
- Ho2: There is no difference in the problem-solving skills between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia.

Ho3: There is no difference in accessing social networks between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia.

Ho4: There is no difference in problem reframing between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia.

Significance of the Study

The societal impact of homelessness on women is multifaceted and complex, with variance dependent upon whether the women are single or have children. States and cities that do not address chronic homelessness may face substantial financial implications for their jurisdictions. These implications are primarily in the health care and legal systems (Rickards et al., 2010). The expert literature reviews several variables that impact homelessness, such as mental health, substance abuse, domestic violence, and childhood trauma (Phillips, 2015; Susser, Moore, & Link, 1993).

There is a dearth of literature focusing on the identification of internal factors such as coping strategies that account for substantial differences in the number of homeless women, in comparison to their male counterparts. There is little to no research on coping strategies among homeless women with dependent children and those without dependent children. This study explored the possible correlation and differences between the coping strategies utilized by women with dependent children and women without dependent children.

The findings of this study are likely to have an important implication for the social work profession. Coping strategies is a teachable phenomenon. They can be taught in homeless programs, without regard to gender. These coping strategies can effectively benefit all populations of homeless people, not just women but also fathers, veterans, and youth. Coping strategies can also be taught to any disenfranchised vulnerable group. Another implication for social work is a gentle reminder to employ the humanistic values found in the Afrocentric Perspective. All social work practitioners, in every field of practice, must believe that their patients have the ability and the potential to achieve their goals.

Another significant possible outcome of this study is the recommendation to change processes and/or policies that may aid in the amelioration of homelessness and empower homeless mothers with dependent children. Ultimately, by empowering homeless mothers, their children will directly reap the benefits of a stable living environment. As prescribed within the Afrocentric Perspective, human beings collectively live in an interdependent community. A valuable member of every community is its children. Policies that address ending homelessness for women with dependent children will ultimately impact the growth and potential success of those children.

Finally, this study is significant because it may suggest amendments to local, state, and federal policies addressing homelessness. One amendment to these policies is to provide case management coupled with financial resources to address problems in the homeless populations. Case management has proven successful with the homeless

veteran population. An additional amendment would be the instruction of skill building to include coping strategies. The McKinney Act provides a plethora of resources to address various barriers that would impede homeless children from accessing an education. This study suggests amendments in the direction of funding to include resources for the parents of homeless children.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of presenting this review of the literature was to synthesize and summarize the current research to provide justification for this study. This review begins with an historical review of homelessness in the United States, as well as review of current homeless interventions, homelessness and women, homelessness among women and children, coping, and homelessness. The study covers the various aspects of coping strategies including social support networks, problem solving, and problem reframing.

Historical Review of Homelessness

Homelessness has existed since the inception of America, as the settlers embarked upon a new adventure and opportunity for religious freedom and wealth. The new settlers were influenced by their former European governmental policies, with the adoption of the Elizabethan Poor Law Act of 1601. The national government consolidated various laws that had assigned welfare rolls to local parishes and it became the chief enforcer of poor relief by 1601, thus supplanting the Church of England (Jansson, 2012). A distinction existed among those who were members of the New England towns into settlers and nonmembers. Those who were members of the towns had settlement rights and by their membership they were entitled to help from the towns.

During times of adversity, the town had no responsibility to nonmembers. Newcomers could petition the selectmen at a town meeting for permission to settle in the town. Many of the applicants for membership considered at town meetings were the homeless who were often without resources (Cook, 2010). The major concern regarding the new petitioners was if they would be an additional tax burden on the town. Those who had potential to self-support were considered for town membership. Nonmembers who were likely to become town charges, especially widows and children as well as disabled or aged adults, were often “warned” to leave town (Rossi, 1989). White colonists condemned other colonists they considered undeserving to homelessness. Paupers, able-bodied men who would not work, were not assisted. Often, they were driven out of the colony to freeze or to starve (Johnson, 2010).

Local parishes would either provide outdoor relief to people or indoor relief to people in special institutions that came to be known as almshouses, poorhouses, or workhouses, which required people to become indentured servants or apprentices (Jansson, 2012). The economic conditions of women deteriorated toward the end of the 18th century. Husbands would often die before their wives and would leave most of their estates to their children. Women in the colonial period could assume the responsibility for the trades or businesses left by their deceased husbands. Although outdoor relief was afforded to women who were single heads of households in the earlier periods, women who could not fend for themselves were increasingly forced into needy, constructed poorhouses (Jansson, 2012).

In the 1640s, homelessness continued to be considered a moral deficiency, a character flaw. If one was homeless, that person was required to prove their worth to the community's elders (Cook, 2010). If unsuccessful, they were required to move onto the next town. In 1729, Philadelphia passed a law allowing locals to deport homeless people. Women continued to be counted among the homeless U.S. populations. The American Revolutionary War caused a new kind of poor and homeless person- the female camp followers of both the British and American armies (Russell, 1991). The camp followers included: washerwomen, wives, and mistresses of ordinary soldiers and prostitutes. There were also indentured female servants. When the war was over, the women returned to mainstream society.

From the 1820s to 1830s, people migrated from the farm to the city in search of employment. A new population of unattached, poor, and seasonally unemployed men appeared during the mid-19th-century due to the industrialization of the North and the conversion from farm to industrial wage labor. These men were typically native-born whites or European immigrants (Jones, 2015). Railroads and telegraphs introduced pervasive societal changes. Mill, mine, and dock work offered employment but low job security. The government responded with Public Outdoor Relief and strict vagrancy laws. Several states, for example New York and Philadelphia, had many people walking the streets causing the country's first pan-handling ordinances accompanied with fines (Lowell et al., 1900).

Slaves

Central to the fabric of the United States are the ever-present themes of separatism based on race, gender, and class. Many of the first African Americans were indentured servants before the pervasive and profitable system of slavery was established within the colonies. Technically, black slaves had shelter, however deplorable and inadequate it may have been. Slaves were considered property, as well as part of the community, which seems like an oxymoron. Whites generally considered free African Americans to be homeless and suspect. Their homelessness was tantamount to a crime - homeless black people were master-less and, with rare exception, that meant they were fugitives (Hopper & Milburn, 1996). Slaves would either commit suicide or run away, because of the deplorable and deleterious system called slavery. The large number of runaway slaves should also be considered an early example of American homelessness (Johnson, 2010). Runaway slaves were men, women, and children, singularly or in groups and pairs, who fled the abusive system of slavery, sought solace, and lived in the forests, mountains, and swamps of the South. Runaway slaves were considered by their contemporaries to be homeless. The earliest New York City poorhouses, the places that housed the white homeless in the mid-18th century, also housed runaway slaves (Hopper & Milburn, 1996).

Tramps/Hoboes

Several historical events impacted the numbers of U.S. homeless. The Civil War increased the homeless population in both the North and the South. The Depression of 1873 not only caused massive unemployment, but also impacted homelessness. Many of

these homeless followed the railroads to work as miners, loggers, and farmhands (Gimlin, 1982).

Hobo practices, specifically freeloading railway travel and an ethic of working intermittently, grew with the end of the American Civil War (Burns, 1980). After the Civil War, construction resumed on the American railroads and, in 1869, the first transcontinental railroad was completed. With this boom in the railroad construction, the hobo lifestyle of working sporadically and traveling throughout the nation fit the landscape (Tapley, 2014).

By 1873, the country encountered an economic depression, with the collapse of the banking and financial agents for the Northern Pacific Railroad. The national unemployment rate rose to 40% and the number of men on the road looking for work grew. This culminated with the advent of the tramp. The tramp became the popular and designated term for hobo. Most often, the hobo was perceived as a good man, willing to work, while the tramp was a man who refused to work (Tapley, 2014). Another definition of tramp was a man who was without home and without family. Tramp was defined as “idle persons...not having any visible means of support...wandering about...and not giving a good account of themselves” (Ringebach, 1973, p. 19). Tramping represented a distinctive and sometimes defiant form of homelessness. From 1873-1874 the American population was about 40 million people and three million of these people were thought to be tramps (Hopper & Milburn, 1996).

In most cities, tramps congregated, ate, and slept in a common area in large numbers, known as “skid rows.” The name came from Seattle, Washington, where a

street inhabited by lumberjacks was used to skid logs to a sawmill and was comprised of a community of brothels, saloons, and flophouses (Gimlin, 1982). The name came to mean a district of the city where there was a concentration of substandard hotels and rooming houses charging very low rates and catering primary to white men with no income (Russell, 1991). African-American tramps found it more difficult to find lodging in the few areas that would accommodate tramps, and it was harder for African-American men to get assistance from passersby by begging; nevertheless, it appears that African Americans were tramping in sizable numbers (Johnson, 2010).

African Americans

There was a difference between the typical ideologies associated with the American tramp, yet the white unemployed males shared the same connotation as the African-American male tramp. The white tramp was construed as the antithesis to economic progress, yet could alter his status merely with gainful employment, as opposed to the black male (Tapley, 2014), a difference that was rooted in the treatment of African Americans from arrival in slavery.

By the end of the Civil War, most newly freed slaves were basically homeless (Johnson, 2010). There were approximately 4 million slaves granted freedom from slavery that lacked a stable residence and had no source of income or provision. The South was ravaged by the war and its infrastructures, factories, cities, and businesses were rebuilt during the 12-year period known as the Reconstruction. During this period, Congress created the Bureau of Refugees, Freedmen, and Abandoned Lands, known as the Freedmen's Bureau, which was charged with the mission to help former slaves (Olson,

2005). The most urgent task of the Freedmen's Bureau was to provide for the hungry and the sick. In its first 15 months, the Bureau disseminated 13 million meals comprised of enough corn, flour, and sugar to feed one person for a week. In January 1865, Union Army General Sherman issued an order to grant former slaves 40-acre homesteads. Soon after his order, General Sherman allowed the Army to loan former slaves a mule to work the land (Darity, 2008). By the fall of 1865, President Andrew Johnson pardoned the Confederate landowners and returned their land, forcing approximately 40,000 ex-slaves to vacate the land and again become homeless (Ginapp, 2003).

Many former slaves returned to work on the plantations of former slave owners, in a contractual agreement that averaged a gross profit of \$9 to \$15 a month. With contracts, they were living in the same squalor they had been living in when they were slaves. The contracts provided no guarantee of shelter or health provisions, and many of the tenant farmers were left homeless (Johnson, 2010). In the late 19th century, available records show that African Americans were a significant presence among arrested tramps, lodging house residents, and transients in cities as diverse as Philadelphia, Kansas City and Washington, DC (Hooper & Milburn, 1996).

Even though African-American males laid most of the 3,500 railroad miles in North Carolina in the 1870s and 1880s, they are not present in the historical accounts of hobo history. African-American men took part in seasonal railroad construction, logging, and some sawmill work and it is probable that they traveled illegally on trains to get to their jobs, just like the white hobos (Tapley, 2014). Perhaps one reason for the missing accounts of railroad labor by African Americans was the practice of convict leasing.

Convict leasing, which began in Mississippi and soon spread to other Southern states, ensured that the brutality and human ownership/imprisonment continued, which was far worse than slavery, because the prisoners were expendable (Oshinsky, 1996). A steady stream of convicts was supplied when and where they were needed by simply arresting African Americans on petty charges such as vagrancy, gambling, disorderly conduct, and assault (Graff, 2016). More often and for longer periods of time, the African- American male subject was further exploited as the free labor needed to build railroads (Tapley, 2014).

Massive unemployment drew men to temporary or seasonal jobs, which caused men to drift from town to town and by 1877, tramps were perceived as a problem (Russell, 1991). Several solutions were recommended to solve the growing problem with tramps. Solutions ranged from marking the tramp body by reinstating the whipping post to legitimizing communal vigilante justice. Policy makers called for mass arrests, workhouses, and chain gangs (Tapley, 2014). The whipping post would provide a visible mark and was less costly than the penal system. The tramp chair was designed in Maine by Sandford Baker (1897), which was a device to deter tramps from inhabiting certain areas. The chair would be a padlocked cage mounted on a frame with four wheels and a drawbar for towing (U.S. Patent No. 575941A, 1897). Newcomers were padlocked into the chair and rolled onto the main street for public display. After the public degradation, the person was rolled to the town line and warned never to return. A great number of tramps ended up in New York City, where there were as many as 450,000 homeless

people lodged by the police station houses during the winters of 1874 to 1875 (Schneider, 1986).

Although a few women joined this growing group of tramps, it was generally unsafe for them. Also, whereas charities took a special interest in aiding White, native-born women and their children to keep them off the streets, able-bodied poor men who were not working were often arrested for vagrancy and forced to perform heavy labor or expelled from town (Jones, 2015). In 1889, Jane Adams founded the Hull House which provided shelter, food, and medical attention to the homeless (Schneiderhan, 2011).

The number of tramps declined during World War I when manpower on the American front was scarce, but increased after the war, when veterans returned home. Although male tramps were an established subculture of American society by World War I, women on the road were an anomaly (Russell, 1991). Homeless research began with Chicago sociologist Nels Anderson, a self-identified hobo, who lived as such before entering graduate school and publishing a series of studies on hobo culture (Anderson, 1975).

Several national events that impacted homelessness in the United States, include the Great Chicago Fire, the San Francisco earthquake, and the massive flooding of the Mississippi from Ohio through New Orleans, which displaced over 1.3 million people (Meyer, 2013). When the Great Depression began in October 1929, the number of the homeless increased significantly. The unemployment rate was 25% and families were on the move in search of work, including migrant workers from drought-ridden Midwestern states (Rossi, 1990). The civilian labor force was just over 50 million in 1932, and

approximately 12 million were homeless (Harvey, 2012). Because of the Great Depression, the number of women that rode the rails increased. Estimates of the number of women on the road ranged from 14,482 in the 1933 census to 250,000 (Crouse, 1986). African Americans suffered during the Depression, not due to the lack of equitable employment opportunities or the loss of their employment, but because of discrimination in public and private assistance which prevented them from getting their fair share of aid. Many private agencies excluded African Americans altogether from their soup kitchens and some communities gave unemployed Black families less assistance than Whites or unfairly distributed relief money (Johnson, 2010).

Homeless Women

Indicative of the patriarchal U.S. society, gender roles were governed by the notion of the Separate Spheres Doctrine in which women were divinely separated into a separate sphere that dictated female roles of remaining in the home, being protected, and being a nurturer (Ross, 2006). This doctrine was seen in the treatment of homeless women. For the most part, women were absent even in the breadlines because they had been used to relief in the almshouse or in the privacy of their homes, not in public. Homeless women have not been romanticized as have homeless men. The word tramp has a different connotation when applied to women. At the turn of the century when tramping was at its peak, women on the road were known as woman hobos or women drifters (Weiner, 1984). Women hoboos were considered unredeemable – deviants who were looking for adventure. The women adrift consisted of females who traveled the country looking for work and who were worthy of being helped. The woman hoboos had

abandoned societal roles designated to women, a place characterized by dependency, domesticity, and submission (Russell, 1991).

Federal Programs

In 1933, the Franklin D. Roosevelt administration structured the New Deal, in direct response to the country's growing unemployment because of the Great Depression. Its first legislation created a new agency—the Federal Emergency Relief Administration (FERA), to distribute \$500 million in aid over 2 years, to existing state and local public relief agencies (Harvey, 2012). FERA was succeeded by the Works Progress Administration (WPA). As a part of the New Deal package, FDR included the Civilian Conservation Corps, which provided environmental jobs for the country's unemployed during the Great Depression (Paige, 1985). Another program that was a part of The New Deal was the Federal Transient Service (FTS), which established shelters that provided food, clothing, medical care, training, and education programs. The relief also provided rooms in boarding houses as well as rent payments (Rose, 1989). A few camps were established in rural areas, but in the cities, the federal government saw the problem as a local one. The program helped many, yet it was unable to assist thousands of others in the two years of its existence. By 1935, it was phased out. The plan was then to get the homeless into work-related programs, such as the WPA; however, only about 20% of those formerly housed by the FTS could get jobs in the work programs. Though some were eligible for the Resettlement Administration camps established for migratory workers, it was still not enough.

The New Deal helped Caucasian Americans become homeowners, but African Americans were considered financial risks and not given loans or federal money to become suburban homeowners. Of the \$120 billion of government backed loans to new homeowners between 1934- 1962, 98% went to white people. The combination of evictions from land and home; seasonal, unreliable and underpaid work; and local white control of any possible federal relief made the rural black American vulnerable to starvation and homelessness (Tapley, 2014).

World War II reduced the numbers of homeless, absorbing them into the armed forces and mushrooming war industries (Rossi, 1989). In the booming postwar economy, most remained in the skilled working class or entered the middle class with help from the GI Bill and other veterans' benefits (Jones, 2015). The WPA public works employment projects were terminated after 1943 and relief programs were drastically reduced as employment opportunities increased and men went into the armed forces. Municipal lodging houses and emergency shelters were closed, and what remained of the local and transient homeless were left on Skid Row. When the war ended, employment rates remained relatively high. Accordingly, homelessness and skid row areas shrank to a fraction of the 1930's experience, but neither disappeared entirely (Rossi, 1990).

Changes in Homeless Population

The homeless population began to change with the advent of changes in US policies in the 1960s and 1970s. The number of extremely poor elderly declined in direct correlation to the increase in Social Security old age pension coverage. In addition, subsidized senior citizens' housing began to provide affordable accommodations to the

elderly and an increase in benefits for the physically and mentally ill through Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) (Rossi, 1989).

Skid row areas garnished attention by urban renewal and the efforts of its elite who wanted to renovate the central cities, which initiated social science research in these urban blighted areas. Most of the research studies (Bahr & Caplow, 1973; Blumberg, Shipley, & Shandler, 1973; Bogue, 1963) cite similar findings. Skid Row was mostly comprised of White males who experienced extreme poverty from unemployment or underemployment, low benefits (Social Security pension), and disability resulting from advanced age and alcoholism. The white male Skid Row residents also suffered with mental and physical illness and lack of social connectedness, many who had tenuous family and kin, with few or no friends. The remnants of the Skid Row populations (along with tens of thousands of African-American, Puerto Rican, and white urban residents) had been displaced by the urban renewal and slum clearance (Jones, 2015). Many of the Skid Row residents were placed in single-room occupancy (SRO) hotels.

The homeless population continued to change in the late 1970s and early 1980s. The once segregated Skid Row residents were now more visible in diverse public locations. The new homeless could be seen sleeping in cardboard boxes, or in train and bus stations (Rossi, 1990). The demographic of the homeless also began to change, from the once male dominated enclaves to a larger female presence. The bag lady began to appear in the media - a woman surrounded by her shopping bags, rummaging through the trash containers, strangely dressed (Russell, 1991). Not only were women without

dependent children visible, but also the genesis of family homelessness became apparent. Women and children began to appear at the doors of public welfare offices asking for aid to find shelter. The shelter arrangements evolved from the SRO hotels to accommodations that provided quasi-private quarters for families.

With the rise of feminism, sex roles of females began to change. Women began to step out of the separated sphere of the home and became active participants in the work force. They began taking a more dominant role within the family structure. Bahr and Garrett (1970) concluded that occupational roles for women had little correlation with homelessness, but the more salient cause was the dissolution of marriages. Stephen Crystal (1984) studied the gender difference among the homeless. He concluded that women were more likely to have been married previously, to have had psychiatric treatment, and to have had family difficulties in childhood. Women were also less likely than men to have been in prison or to have been employed.

Deinstitutionalization

Another phenomenon that impacted the numbers of the homeless, directly and indirectly, was deinstitutionalization. Richard Wyatt, Chief of the Neuropsychiatry Branch of the National Institute of Mental Health (NIMH), reported America's homeless crisis began in 1963, when deinstitutionalization became law through the enactment of the Mental Retardation Facilities and Community Mental Health Centers Act, in which, by law, the former residents of institutions became the homeless (Wyatt, 1986).

There were several court cases that challenged this country's practice of placing those with a mental retardation or mental illness diagnosis in long-term psychiatric

facilities. The 1971 *Wyatt versus Stickney*, a federal district court case that defined the quality of care for the mentally ill and retarded. It also stipulated the least restrictive residences needed to be staffed with qualified person who initiated individualized treatment plans (French, 1987). Another pivotal court case was *Halderman versus Pinehurst State School and Hospital*. In 1977, the court ordered the first closing of a U.S. mental facility. The court stipulated that if a state takes away the responsibility of providing habitation for a retarded person, it must do so in the least restrictive environment consistent with the individual's needs. The court ordered the immediate removal of the retarded residents from Pinehurst (Chemerinsky, 1984).

The emphasis of deinstitutionalization was based on the premise that people would thrive in the least restrictive environment and have a better quality of life. There was a second gain: the cost effectiveness of providing services in the community rather than in an inpatient setting. Many state psychiatric hospitals either downsized or closed throughout the country (Kamis-Gould, Snyder, Hadley, & Casey, 1999). Community mental health centers were established and were ill equipped to provide comprehensive care to the mentally disabled. Hall (1987) posited that the result of deinstitutionalization was a rise in the mentally ill homeless. Dickey (2000) notes that the lack of community-based services for the mentally-ill and the difficulty in coordinating social and medical services were factors that contributed to the increase in the mentally ill homeless. The NIMH Community Support Program (CSP) was launched in 1978 in response to the massive discharge of mentally ill and retarded individuals from long-term inpatient care. The initial demonstration project funded local agencies to provide comprehensive support

to individuals with mental illness and who were inappropriate for 24-hour long term care. Sources noted, in 1978, there were approximately 1.5 million people who met this criterion (Turner & TenHoor, 1978). In 1979, Baxter and Hopper's research changed the terminology used to describe this population by using the description of the homeless instead of a vagrant or a bum.

Lack of affordable housing was uncovered as a primary cause of homelessness in the 1982 lawsuit against New York City. Baxter and Hopper, along with Robert Hayes successfully sued and forced the city to provide emergency shelter to all who demanded it. This trio formed the National Coalition for the Homeless (Jones, 2015). The trio had evidence that the city, in the 1970s, strategically encouraged owners of SRO and cheap rooming houses to convert their properties into condominiums and rental properties for middle and upper income residents in exchange for short term tax incentives. Enticed by the offer, owners of SRO's and cheap properties began to evict the marginally poor, which further increased the homeless population (Linhorst, 1991).

Changes in Federal Policy

The country's homeless policies were closely regulated and impacted by the political agenda of the White House. President Reagan, in 1981, proposed \$47 billion in budget cost to domestic social spending, of which \$37 billion was approved. As a result, major cuts in funding to federally-funded social programs' local agencies began an increase in requests for aid. The United Way and local agencies successfully lobbied Congress to pass a \$50 million appropriation for Emergency Food and Shelter (EFS) program that they would jointly administer (Jones, 2015).

The NIMH sponsored several research projects to address homelessness. One project was the statewide Ohio Longitudinal Study (1983-1985), whose results showed that less than one third of the 979 sample had behavioral health diagnoses (Roth, 1985). Another study, Bassuk's project in Boston of 78 homeless, cited 46% of respondents with a mental illness, 29% who had issues with alcoholism and 21% had personality disorders. Approximately one-third had a previous psychiatric hospitalization. Bassuk postulated that shelters had become alternative institutions to care for the mentally ill (Bassuk, Rubin, & Lauriat, 1984).

Policy is impacted by research. Policy administrators and state and federal legislators began to rally and advocate for increased funding to address homelessness. The federal agencies that provided support to eradicate homelessness were the Federal Emergency Management Agency (FEMA), Department of Defense (DOD), Health and Human Services (HHS), and HUD. Under the Emergency Jobs Appropriation Act of 1983, FEMA distributed \$100 million to groups providing food and shelter (Fogel, 1985). In 1984, DOD appropriated \$900,000 of the \$8 million budgeted by Congress to make military facilities and incidental services available to the homeless. The \$900,000 was appropriated for two shelter projects (Spar & Austin, 1984). In 1983, a Federal Interagency Task Force on Food and Shelter was created in HHS to cut red tape and act as a broker between the federal government and the private sector when an available federal facility or resource was identified (Fogel, 1985).

Prominent public legislators and officials like Republican Senator Pete Domenici and Senator Al Gore's wife, Tipper, were two of the advocates for policy to support the

homeless. The Robert Wood Johnson Foundation and the Pew Charitable Trust launched a 4-year, \$18 million project that established demonstration healthcare projects for the homeless in 19 cities, called Healthcare for the Homeless (HCH) (Zlotnick & Zerger, 2009). HCH advocates convinced legislators to include in legislation a federally funded expansion of the program. Because of their advocacy, in July 1987, President Regan signed the Stewart B. McKinney Homeless Assistance Act, the first federal homeless legislation (Jones, 2015).

U.S. Homeless Policies

McKinney-Vento Act

Homelessness has been a socioeconomic issue since the inception of the United States. In 1984, in response to community advocates, the Robert Wood Johnson Foundation and Pew Charitable Trusts launched a 4-year \$18 million national demonstration project called HCH to establish healthcare for the homeless and unstably housed individuals in 19 U.S. cities (Zlotnick & Zerger, 2009). This project was adopted as part of the first major legislation on homelessness, the McKinney Act of 1987. It was passed both by the House and the Senate with large bipartisan majorities. It was named after Representative Stewart B. McKinney, the chief Republican sponsor from Connecticut, who died from Acquired Immunodeficiency Syndrome (AIDS) in May of that year. It appropriated \$442 million for the homeless in fiscal year 1987 and \$616 million in 1988. The money was channeled through a group of agencies, providing some housing for the homeless, subsidies for existing shelters, and subsidies for a variety of rehabilitation programs including vocational training and medical care and services for

the chronically mentally ill (Rossi, 1989). The McKinney Act was later changed to the McKinney-Vento Act in 2000, and provided funds not only for emergency shelter, transitional housing, and permanent housing, but also for job training, primary health care, mental health care, drug and alcohol treatment, education programs, and other supportive services. The most significant programs are the supportive housing program; the shelter plus program, and the single room occupancy program, which were consolidated into one program known as the Continuum of Care Program in 2009. The Continuum of Care Program gives Section 8 housing through the single room occupancy program in which the homeless receive transitional housing along with supportive services such as childcare and case management. The Act also contains the Emergency Shelter Grant Program. In 2009, the McKinney-Vento was reauthorized as part of a larger federal homelessness policy effort, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (Cunningham, 2014).

Supportive Services for Veterans Families

In 2009, the Department of Veterans Affairs established the goal of preventing and ending homelessness among veterans, Supportive Services for Veterans Families (SSVF) was created (Byrne, Treglia, Culhane, Kuhn, & Kane, 2015). The program provides services for veterans experiencing crisis homelessness. It provides temporary financial assistance and a range of services to prevent homelessness and to rapidly stabilize those who do become homeless by affording them permanent housing.

Housing and Urban Development Veterans Affairs Supportive Housing Program (HUD-VASH)

The Housing and Urban Development Veterans Affairs Supportive Housing Program combines Housing Choice Voucher (HCV) rental assistance from the Department of Housing and Urban Development (HUD) with intensive case management and clinical services provided by the Department of Veterans Affairs (VA). The primary goal of the HUD-VASH program is to move chronically homeless veterans and their families from homelessness to housing stability (Patterson, Nochajski, & Wu, 2014). The provision of case management services has proven to be an integral service for the veterans. Veterans receive assistance with housing location that accommodates the voucher. Once housed, case managers continue to follow the veterans for the duration of their possession of the housing voucher. The findings show that HUD-VASH participants have a higher percentage of nights housed and fewer nights homeless, and have generally better housing outcomes than groups receiving intensive case management alone or those receiving standard VA care (Patterson, Nochajski, & Wu, 2014).

The Homelessness Prevention and Rapid Re-Housing Program

The American Recovery and Reinvestment Act of 2009 (ARRA) was Congress's response to the economic downturn, or financial crisis, that began approximately in 2007 and continued several years thereafter. The act, essentially a government spending bill, was primarily designed to create new jobs, to save existing jobs, and to provide financial resources to federal, state, and local government programs that had been adversely impacted by the protracted economic downturn (Steinbrook, 2009). The ARRA allocated

\$1.5 billion dollars to the Homeless Prevention Fund, which spends its money primarily on housing first programs like HUD-VASH and the McKinney Act programs. Now the ARRA has been renamed and is called the Homelessness Prevention and Rapid Re-Housing Program (HPRP). This initiative provides financial assistance and services to either prevent individuals and families from becoming homeless or to help those who are experiencing homelessness to be quickly re-housed and stabilized.

City of Atlanta

In Title VIII of the 2009 ARRA, money was allocated to states to fund departments, including the Department of Labor and the Department of Health and Human Services. The City of Atlanta has used these ARRA funds to support new projects under the Homelessness Prevention and Rapid Re-Housing Program. In the city of Atlanta, the HPRP provides financial assistance and services to prevent individuals and families from becoming homeless.

Current Homeless Interventions

Research regarding homelessness in the United States continues to tackle this national epidemic and offer potential innovations to public policy to reduce the large number of Americans that are unhoused. The first intervention is a shelter; an establishment that provides food and shelter to the homeless. There are five types of federally funded shelter or housing assistance programs: emergency shelters, transitional housing programs, permanent supportive housing, permanent subsidies, and temporary subsidies to promote rapid exit from shelters (Fisher, Mayberry, Shinn, & Khadduri,

2014). Culhane, Kane, and Johnston (2013) noted advances to include the U.S. Interagency Council on Housing and their call for a Housing First approach across homeless programs. The Council has also urged federal agencies, their state and local agencies, and state and local partners to prioritize housing interventions to address homelessness with the necessary services and supports to follow.

The Housing First Program comes from research and its outcomes from various programs that include the Collaborative Initiative to End Chronic Homelessness, the Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) program, and the Homelessness Prevention and Rapid Rehousing (HPRP) programs. The federal HUD HPRP program provided \$1.5 billion through the American Recovery and Reinvestment Act which has provided a national demonstration model. The outcome of these programs has provided an evidence base that indicated most of families and non-chronically homeless single adult households can resolve their homelessness with timely, intensive, but also relatively brief financial and social assistance. A major thrust of the future research agenda will need to focus on why these interventions do not always work for everyone, and what more needs to be done to make housing attainable and sustainable for all (Culhane, Kane, & Johnston, 2013).

Another program funded by the HPRP is community-based rapid re-housing (CBRR). CBRR provides short-term subsidies for a maximum of 18 months. The goal of the program is to provide homeless families with the minimum level of assistance until they can pay market value rent.

Patterson, Currie, Rezanoff, and Somers (2015) conducted interviews with 43 homeless adults with mental disorders 18 months after random assignment to Housing First with intensive supports or to a treatment as usual subgroup. Most of the participants assigned to Housing First reported positive change as a result of stable housing. Factors that impacted change were clustered into four themes: services and support from service providers, experience of cumulative trauma and loss once alone, social support of new friendships and romantic relationships, and reducing and controlling substance abuse.

Williamson (2015) discussed several innovative collaborations between housing authorities and school districts to address homelessness. One such collaboration is the pilot program at an elementary school in Tacoma, Washington. The partnership was between the school, the local housing authority, the Bill and Melinda Gates Foundation and several other local agencies. The project brought 50 families to the school, attending conferences, volunteering and working with caseworkers. In return, these families received vouchers to help cover the cost of housing. Several other similar demonstration projects occurred in Colorado, at the Boulder Valley School District and the St. Vrain Valley School District, and in California at the San Francisco Unified School District.

Another housing intervention has been the creation of Habitat for Humanity (HFHI), the nonprofit Christian organization, founded in Americus, Georgia in 1976. Its mission to build decent homes for low-income families grew with the endorsement of Mr. and Mrs. Jimmy Carter in 1984. The organization has rehabilitated or built approximately 200,000 homes across the globe. However remarkable the accomplishments of HFHI are, Smith (2013) contended that there is a concentration of poverty in the Habitat for

Humanity communities and questions if the neighborhoods and subdivisions are doomed to become the next generation of substandard housing.

Homelessness and Women

The homeless are not a monolithic or homogenous group. Out of the 564,708 people who were homeless on a given night, 206,286 were people in families with children, typically headed by females; of the 356,422 homeless individuals, 100,184 were female (HUD, 2015). Homeless men and women have different characteristics (Lee, Tyler, & Wright, 2010). Women without children and women with children have different characteristics and needs. Many times, for women with children, the defining variable is the existence of the children, which may be a very important variable in determining what needs exist, what support may be available to these women, and how soon they can transition out of homelessness (Ruttan et al., 2012).

Upshur, Weinreb, and Bharel (2014) conducted 461 alcohol screenings of homeless women within a healthcare homeless primary care program in Boston, Massachusetts. There were a greater number of women housed in shelters who reported problems with drinking than women who were homeless, living in the streets. Interestingly, however, rates of problem alcohol use were lower among sheltered women who provided care for dependent children. More generally, there was a strong correlation between risky alcohol use and street and shelter living, while women who reported having housing had lower rates of risky drinking.

Osuji and Hirst (2013) found that experiencing homelessness and working to exit it represented, for women, a journey through that began with losing oneself to

experiencing self-discovery and hope. In this study, convenience and snowball sampling techniques were used to recruit 12 women in an urban center in Canada. Participants described their experiences of living on the streets as an inevitable and consequential journey – not a choice but a consequence of their decision to leave unacceptable living circumstances at home.

Exiting homelessness encompassed more than placing participants in a sheltered environment. For the participants of this study, having a home and feeling at home signified a strong and intimate relationship with their environments, and when this relationship was weakened or broken, they felt disconnected and ostracized and distanced themselves from support networks.

Homeless women are vulnerable to multiple forms of interpersonal victimization, including sexual and physical assault at the hands of strangers, acquaintances, pimps, sex traffickers, and intimate partners on the street, in shelters, or in precarious housing situations (Goodman, Fels, Glen, & Benitez, 2006). The homeless definition—residence in a homeless shelter, on the street, or in other settings not intended for human habitation—leaves out a much larger population of the hidden homeless: women and children who may stay with friends, neighbors, family members, on couches night after night (couch surfing), or who return to their abusers when emergency shelters are full, especially women in rural areas where no shelters are available, and women who trade sex for a place to sleep (Evans & Forsyth, 2004). Goodman and colleagues (2006) urged that changes to the system are required to provide adequate care and support to homeless women who have experienced a sexual assault that includes trauma-informed homeless

services, collaboration between providers and rape crisis advocates, and training for direct care staff.

Fordham (2015) provided a reflexive narrative study of homeless women in which several key points are identified. Homeless women are a heterogeneous group of people of varying ages that include professional women. Mainstream health services are often “hard to reach” for homeless groups. This prevents complex health issues from being effectively addressed. Service development for homeless women should include dialogue around the prevalence of childhood trauma and support for mothers who have had their children taken into foster care.

Homelessness experienced at any age has deleterious effects on the lives of those affected. Waldbrook (2013) contended that formerly homeless, older women contend with both financial and social barriers to planning for their elderly years. Fifteen were surveyed and 11 were interviewed in Toronto, Canada. The participants were recruited using three types of convenience sampling methods: agency-based, street-based, and recruitment flyers. The participants were at a life stage when older people begin to seriously plan for their retirement, and were preoccupied with maintaining their housing, dealing with their current financial troubles, and struggling to meet their daily needs. The women had little capacity in their daily lives to plan for their futures in terms of finances, housing, health and social care, and their other needs. They also had long histories of unemployment and homelessness, suggesting these women will have minimal financial resources to support them in their old age.

Older homeless adults not only have financial and social barriers, but also are inept at working with the social service system, struggling to negotiate the system that could help them exit homelessness. Davis-Berman (2011) conducted interviews with 10 women over the age of 50 who resided at an overnight homeless shelter. In depth interviews were conducted and analyzed. Older adults typically fall through the cracks when they seek public assistance. Adults between the ages of 50 to 62 are too young to access Social Security benefits. Within the study, women had a difficult time accessing disability benefits. Even though the majority of the participants had a serious physical or mental health disability, they did not qualify for benefits.

Older adults in the shelter were not comfortable with the younger women. Noise, disruption, and physical and verbal violence were discussed as problems. Many older women felt that the younger women were not doing what they were supposed to do to get out of the shelter system. There seemed to be a real generation gap between the younger and older women at the shelter. Although some of the older women tried to serve as mother figures, all of the older women talked about the stress of being housed with younger women.

Most of the women surveyed were estranged from their families. Most of the women had children with whom they were not in touch. Some women actually had family members in the area who knew they were living at a homeless shelter. Past hurts, pride, stubbornness, and other dynamics kept these families apart. Sadly, every woman expressed her pain at this estrangement from family, especially during her later years. Recommendations included training for shelter staff regarding the nuances of the aging

process and training with regards to accessing resources from the social service system. Lastly, consideration should be given to separate older adult females from the younger ones, to reduce noise and chaos.

Finfgeld-Connett (2010) found that many of the problems that lead to and sustain homelessness appear to be related to poorly-developed problem-solving and decision-making skills. Nonadaptive thinking patterns are made worse by feelings of anger, betrayal, and helplessness, plus, in some instances, the emergence of mental health and substance abuse problems.

Homelessness among Women and Children

The stress of homelessness impacts women without children differently from women who are caring for dependent children. The literature reviews the differences associated with caring for dependent children while homeless and homeless women who are without children. There is also literature that reviews parental stress.

Tein, Sandler, and Zautra (2000) noted the relationship among life stress, psychological distress, coping, and parenting behaviors among divorced mothers. Small stressors were as impactful as major stresses. Parental coping strategies were found to decrease parental stress. Parental coping strategies that were avoidant in nature, provided temporary respite yet no real resolution of the problems and eventually created an increase in psychological distress.

Johnson and Kreuger (1989) conducted interviews with 240 homeless women as part of the medical screening protocol developed by the Homeless Coalition of Greater

St. Louis. The women were residents of six participating shelters (a one-day shelter and five overnight shelters) over a period of 2 years. The sample was a nonprobability selection of cases in which the homeless women answered a question concerning whether they were accompanied to the shelter by dependent children. Of the 240 women participants, 176 were with dependent children and 64 were without dependent children; 184 were black and 56 were white. A greater number (40%) of women without children had experienced mental health diagnoses. Women without children reported being without a residence for an average of 14.03 months, while women with children reported being without a place to live for an average of 4.71 months.

Welch-Lazoritz, Whitbeck, and Armenta (2015) conducted 148 interviews with women from three mid-sized U.S. cities, 24.3% of whom were caring for at least one child. There were differences between women who were experiencing homeless episodes with minor children and women who were experiencing homelessness alone. Their findings indicated that homeless women with children and women who are homeless on their own may deal with stress in different ways. Both groups were equally likely to be victimized on the street and both groups had experienced a comparable amount of stressful life events, health problems, and substance abuse problems. Women with dependent children may internalize stress in ways that are detrimental to their mental health, specifically with regards to Bipolar Personality Disorder. Opposed to Johnson and Kreuger's (1989) findings, the two groups were comparable with regards to mental health diagnoses and alcohol and substance abuse disorders when accounting for shelter status, age, and length of homelessness. Nearly one-third of women with children met past-year

criteria for PTSD almost one-half were currently depressed, and more than one-fourth met past-year criteria for bipolar disorder.

Holdrop and colleagues (2015) found that despite the stress associated with homelessness, women were dedicated to their role as caregiver. The study employed a multi-method, descriptive study to acquire an understanding of the psychosocial status and life experiences of homeless parents residing in transitional housing. Quantitative data were collected from 69 parents and primary caregivers living in a transitional housing community, combined with in depth qualitative interviews from a cohort of 24 participants. Parents in this study reported levels of depressive symptoms approaching clinical significance and parenting stress in the clinical range. In their current living situation, parents felt restrained by the rules of the housing community. Participants remained dedicated to their role as parents, despite facing the challenges of homelessness. Participants reflected on the joys they continued to experience as parents and how their children constituted strong sources of motivation as they sought to improve their living situation and employment contexts. Participants reported the transitional community was like a family in several ways.

In a study by Sandy (2014), mothers also reported their children as inspiration to exit homeless. The study conducted qualitative focus groups with 14 formerly homeless women with underage children in diverse neighborhoods in Milwaukee, Wisconsin. A qualitative hermeneutic analysis served as the theoretical frame for analyzing these data. The participants described securing more stable housing as a satisfying outcome, noting the benefits of privacy, security, the end of the drama of group living situations, and the

satisfaction of being able to provide for their children. They reported a key motivator for change included wanting a better life for their children.

From the macro level, participants emphasized structural opportunities that needed improvement, such as policies that continue to deter access to housing based on credit history and criminal records. There is a need for the creation of policies that promote payee incentive programs, access to emergency shelters and rebuilding family connections. One recommendation to address this problem included offering payee incentive programs; at least six women reported the instability of having a social security payee was a factor for becoming homeless.

Guo, Slesnick, and Feng (2016) compared housing and supportive services to community-based housing and support services among 60 homeless mothers from June 2010 to January 2011 following a Housing First approach, in which time-limited rental support (3 months) was given for an apartment of the mother's choosing. In addition, up to 6 months of support services including substance abuse and mental health treatment were provided. Women were randomly placed in either Ecologically-Based Treatment (EBT) or non-treatment or Treatment as Usual (TAU) groups. EBT integrated independent housing, strengths-based case management services, and substance use/mental health counseling. Families who received TAU were housed more slowly, often following participation in various community programs. In contrast, EBT families were housed quickly and in an apartment of their choosing and within 3 weeks of their shelter stay.

Samuels, Fowler, Ault-Brutus, Tang, and Marcal (2015) also tested the effects of time-limited case management targeted for homeless mothers who were experiencing mental health problems. The Family Critical Time Intervention (FCTI) was used to support mothers as they moved from homeless shelters into affordable housing. The 210 homeless mothers that who were referred to FCTI experienced greater declines in psychopathology compared with those receiving homeless services as usual. Results suggested that all homeless mothers reported significant and clinically meaningful declines in mental distress over time, regardless of intervention condition. The treatment effects did not vary by prior homelessness experiences or receipt of mental health services.

Williams and Merten (2015) also noted the benefit of therapeutic interventions. The study involved weekly group meetings during a 3-month period with seven single mothers who were homeless and living in transitional housing. Each week, participants shared stories from their pasts, current experiences and future goals which were recorded using researcher field notes. There were several prevailing themes. All the maternal relationships discussed were reported as being intensely negative, the effects of childhood abuse also endured into the women's adult lives and affected their emotions, behaviors and choices, and their sense of self was a mediator between their adverse childhood experiences and their current emotions.

Hryniewicz and Fthenus (2014) noted that homeless women were rarely asked to provide a complete history that included experiences of violent victimization and its effects. Semi-structured qualitative interviews with 79 homeless women were conducted,

and 60 reported experiences of violent victimization. The study drew from participants' experiences in nine shelters (four in Detroit and five in Chicago).

Tobin and Murphy (2013) reviewed existing literature regarding homeless people in the United States with the goal of providing insight into understanding the phenomenon of child and family homelessness and evaluated various strategies used to address it. The impact of homelessness includes chronic and acute health problems. Homeless children contract four times as many respiratory infections and twice as many ear infections. Policy and program changes were recommended that included interventions for homeless families to increase their income and decrease the effects of poverty. The funding of public programs that support income for homeless families include: Temporary Aid to Needy Families (TANF), Section 8 or public housing, Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Medicaid. Comprehensive programming for homeless women needs to include changes to job training, transportation, and child care. Social services are warned to be careful to form well matched, comprehensive, adaptive, and responsive service plans that provide opportunities for dialogue to allow family members to identify and make plans to achieve their own goals.

Grant, Gracy, Goldsmith, Shapiro, and Redlener (2013) also conducted a review of the literature on child and family homelessness during the past 25 years. It revealed several discordant trends. Income inequality increased, child poverty remained virtually the same, and there was no change of the government disinvestment in affordable

housing. Housing costs consumed an unmanageable proportion of the income of poor and low-wage earning families and have been steadily rising. Family homelessness has become more prevalent and has affected poor and low-income families more generally than in the 1980s when the homeless heads of households frequently had personal vulnerabilities such as depression or other mental illness. There has been less attention to the issues of child and family homelessness than in the two previous decades. This is reflected in fewer research studies, government reports, print, and broadcast stories and less political attention to children and families in poverty.

As Goodman, Fels, Glen, and Benitez (2006) recommended an amendment to the definition of homelessness. Zlotnick, Tam, and Bradley (2010) also recommended revisions to the definition. This challenge arose due to the verbiage of the 2003 federal definition of homelessness that defined chronic homelessness as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. This definition excludes those persons who have experienced episodic periods of homelessness, either with less than four episodes within three years or with a duration of less than three years.

Zlotnick et al. (2010) used data from the National Survey of Health Assistance Providers and Clients. The data used a sample of 849 homeless women which calculated the prevalence rates and profiles of long-term homelessness. The relationship between two sets of variables was explored: adverse childhood events and the dwellings used for overnight stays. Common to both groups of women who experienced two of the three

criteria of chronic homelessness was having experienced childhood sexual or physical abuse. Factors that impacted the length of homeless episodes included adverse childhood events (such as histories of living in foster care or group homes or other out-of-home placements) or running away from home.

Barrow and Laborde (2008) offered a qualitative study of mothers who were staying in homeless shelters for unaccompanied women without dependent children and had minor children living elsewhere. Interviews were conducted with a convenience sample of 20 mothers in two shelter programs, 10 kin caregivers, and 17 case workers. The women had assumed major roles in parenting their children either alone or with the help of relatives. Many of the women were at family shelters before residing at a single adult shelter. In some cases, incidents in family shelters lead to the removal of their children by child welfare authorities; others had previously used family shelters to stabilize their situations following a housing crisis; and two were suddenly reunited with children, but in the absence of viable family housing appeared to be headed to family shelters. Women talked about mothering as a significant identity and major life project. Many women counted on family care giving traditions and when their needs exceeded what families could provide, women found themselves under the jurisdiction of public welfare agencies.

There are challenges for women who have children seeking shelter placement to exit homelessness, even for the short term. The homelessness of women alone and that of women with children are difficult to disentangle from one another; as often the two overlaps, even when there are no children present. Women are daughters, and many of

them are also mothers, even if their children are not alongside them. Dotson (2011) reviewed data obtained from physical intake files and a computerized database from a homeless shelter in southeastern United States to determine the predictors of entering a shelter with or without children and predictors of being separated from one or more children. The sample of 359 included adult women staying at a shelter in 2007. There was a prevalence of child separation among the homeless; one third of women in the shelter were separated from at least one child. One fourth of families entering with children were separated from at least one other child and one third of women entering as “single” were in fact separated from one or more children. Those children who were separated from their homeless mothers were in healthier and safer situations than they would have been in remaining with their mothers; nonetheless the women were upset and wanted to be reunited with their children.

Klitzing (2003) explored if women who are homeless face chronic stress and how the women cope with living in a shelter. The data were collected primarily through semi-structured interviews with a convenience sample of 10 women who lived in a transitional homeless shelter with their children in a Midwestern university city. When the women discussed how they coped with stress, various strategies were identified with a primary strategy consisting of being with others. The women also noted that they engaged in diversionary leisure activities to help them relax. It could be that diversionary activities have become so much a part of the women’s lifestyles that these activities unconsciously assist with coping, and that, therefore, diversionary leisure activities are critical to coping with chronic stress, even though not recognized as coping strategies. The most frequently

used coping strategy was being with others, their children, other women in the shelter, friends, family, or staff.

Tischler and Vostanis (2007) also examined aspects of coping. Their study investigated the relationship between coping, mental health, and goal achievement among homeless mothers. Seventy-two women took part and 44 were re-interviewed 4 months later. The Family Crisis Oriented Personal Evaluation Scales (F-COPES) were used to identify their coping strategies at the time of homelessness. The General Health Questionnaire (GHQ) measured mental health problems, and a semistructured questionnaire identifies their goals. Outcome measures at follow-up were goal achievement and mental health. A variety of coping strategies were used, with some differences influenced by the reason for homelessness and respondent age. Despite exposure to major stressors and poor mental health, consistent with Klitzing's (2003, 2004) findings, mothers experiencing homelessness can maintain their ability to cope effectively to achieve their goals.

Coping and Homelessness

According to Lazarus (1990), psychological stress refers to the relationship between a person and his/her environment. The way an individual cope with stress does not only have a short-term effect on his/her feelings but, in the long run, also affects his/her somatic health and social functioning. Within the homeless population, the quality of coping with stress affects the level of mental health and consumption of psychoactive substances, which translates into the chances of transitioning out of homelessness (Opalach et al., 2016).

Coping with homelessness has been studied by a myriad of other researchers. Banyard (1995) conducted some of the first research pertaining to homeless women with children and coping in a qualitative study of 64 mothers who lived in temporary emergency shelters. These women used a variety of coping strategies and used more than one strategy to cope. Strategies utilized included: confronting of problems, getting social support, using activities to keep their mind off problems, thinking positively, getting distance from problems, letting feelings out, prayer, and focusing on children or the future. There were instances of avoidant coping, when children acted as a diversion or distraction to help women to stop thinking about their problems.

The cognitive-behavioral responses that control or reduce emotional stress in the face of externally imposed life stress is known as coping. Ward and Heidrich (2009) examined African-American women's beliefs about mental illness and their preferred coping behaviors if faced with mental illness. Participants were 185 community-dwelling African-American women 25 to 85 years of age. Results indicated the women believed that mental illness was caused by several factors, including family-related stress and social stress due to racism, and that it was cyclical. Major preferred coping strategies included praying and seeking medical and mental health care.

Cosgrove and Flynn (2005) confirmed the existence of coping within the homeless population. They found from the 17 women interviewed in their study who lived in shelters in the northeast United States, that all of the participants identified numerous strengths and coping strategies to include such skills as reading, writing in a journal, staying focused, going to church, and talking to supportive shelter staff, friends,

and family. Shelter participants were also able to identify their strengths and how their strengths helped them to survive hardships and negotiate the red tape associated with social service agencies.

Broussard and colleagues (2012) also noted disparate methods of coping. They investigated a purposive sample of 15 poor women from a large urban area, and 12 of the 15 interviews were reported along with a literature review of stress and coping for single mothers in the context of poverty. The participants reported high levels of stress that were associated with their low-income status and documented both mental and physical illnesses. The participants reported an array of coping methods, including emotional support from family members and friends, faith-spirituality, pets, exercise, internal strength, and resourcefulness, hope, neighborhood supports, humor, therapy, creative endeavors (such as drawing), volunteering, and combinations of these methods.

Johnson and colleagues (2017) identified several coping strategies among homeless women. The first strategy was an attempt to reduce household expenses by turning to soup kitchens, and gaining assistance from food pantries and charitable organizations. Another strategy was to access their support networks to find friends and family members with whom they might double up. One strategy associated with longer-term homelessness, which is risky for women, involves moving in with men in exchange for sex, a practice commonly known as shacking up. Shacking up enables homeless women to avoid sleeping on the streets where they are much more vulnerable to physical and sexual violence than men. Opalach and colleagues (2016) conducted a study among 78 homeless individuals. Coping styles were defined as dealing with stressful situations

for which the study employed the Coping Inventory for Stressful Situations. When dealing with stressful situations, the homeless individuals in this study relied upon avoidance-oriented and emotion-oriented styles. Although the frequency of using emotion-oriented coping strategies decreases with age, alcohol consumption is associated with the tendency to rely upon the poorly effective emotion and avoidance-oriented strategies.

Coping also exists among homeless youth. Ferguson, Bender, and Thompson (2015) examined the gender differences among young homeless adults' coping strategies and homelessness stressors. A sample of 601 homeless young adults were recruited from three cities Los Angeles, California; Austin, Texas; and Denver, Colorado. Using purposive sampling, youth were recruited from three different service programs at three host agencies: (a) street outreach/drop-in centers (non-residential); (b) residential short term and mid-length shelters (30 days to up to 6 years); and (c) transitional housing (long-term housing). Researchers administered a 45-minute quantitative, semi-structured interview. Four dimensions of coping strategies were assessed using the Coping Scale (Kidd & Carroll, 2007).

All coping items used a 5-point scale from 1(Never) to 5 (Almost Always) in response to a prompt. Problem-Focused Coping was assessed using two items: (a) Concentrate on what to do and how to solve the problem, and (b) Think about what happened and try to sort it out in my head. Avoidant Coping was assessed with two items: (a) Try not to think about it, and (b) Go to sleep. Social Coping was assessed with two items: (a) Go to someone I trust for support, and (b) Go off by myself to think,

indicating social withdrawal, both of which were derived from qualitative work by Kidd (2003). Lastly, Other Ways of Coping was comprised of eight additional coping strategies including “Use my anger to get me through it” and “Do a hobby.”

Findings included specific coping strategies such as a problem-focused coping, and functioned as protective factors, buffering the youth from the effects of well-established risk factors among homeless young people, including criminal behavior, transience, mental illness, and substance use. That homeless young people relied on positive coping techniques is important to note, given that coping skills are often learned in the context of family upbringing. Greater use of problem-focused coping strategies was associated with legal and illegal income in females. It was suggested that high cognitive functioning, self-reliance, and problem solving (characteristic of problem-focused coping) not only help females manage homelessness stressors but also constitute assets in legal (formal) employment as well as in informal (illicit) work.

Mental illness compounds the degree of in the coping of the homeless. Lippert and Lee (2015) examined how the accumulation of life stress is associated with the distribution of mental health problems across different categories of people who are homeless. Data from the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC) evaluated to how stressors and coping resources throughout the life course are implicated in differences among homeless people with psychiatric disorders and alcohol and other drug abuse disorders. Psychiatric disorders were most common among people who were chronically homeless and least common among the new-entry homeless. There was also a lower prevalence of mental health problems among the new-

entry group and this is related to the group's fewer encounters with life stress. Select stressors experienced in childhood and during adult homeless incidents raise the odds of poor mental health.

The existence of trauma was studied to determine a possible relationship between its impact on a homeless person's ability to cope during the stressful episodes of homelessness. Rayburn and colleagues (2005) surveyed 810 women (402 sampled from shelters, 408 sampled from low-income housing) from the central region of Los Angeles County. The study examined the relationship between trauma, coping, and depression and mental health service-seeking behaviors. The findings support the argument that the condition of homelessness itself represents an extremely stressful, potentially traumatic condition. The experience of a trauma may contribute to an unhealthy, avoidant style of coping, which, in turn, may enhance the risk of experiencing symptoms of depression. Active coping was a predictor of mental health service-seeking among women who had experienced trauma, and avoidant coping did not influence mental health service-seeking. Traumatized women who used a proactive, problem-approach style of coping were more likely to seek treatment for their psychological problems. Coping was found significantly more important than their inability to access medical care or assistance from a social worker).

Narayan (2015) reviewed all the quantitative studies on positive parental functioning in homelessness and provided a comprehensive, integrated summary of the basic research on the promotive and protective factors for positive parental functioning in homelessness. Findings suggested that positive parental functioning in homelessness

most likely is observed in individuals with strong educational and vocational resources, who possess effective strategies to reduce or ameliorate symptoms of psychopathology and stress despite current hardships, exhibit warm parenting with children and placing themselves in favorable positions to secure stable housing. Many parents experiencing homelessness display positive outcomes and many factors support positive functioning.

Different variables were combined and studied to determine possible correlations that impact coping and homelessness. Galaif, Nyamathi, and Stein (1999) examined risk and protective factors associated with three qualitatively different drug use constructs describing a continuum of drug use among a sample of 1,179 homeless women.

Relationships among positive and negative sources of social support, positive and negative coping strategies, depression, and the drug constructs of current drug use and drug problems and physical drug dependence were assessed using structural equation models with latent variables. Positive social support from nondrug using friends or family did not protect a homeless woman from more drug use; however, utilizing active coping strategies significantly protected these homeless women from drug use, drug related problems, and physical drug dependence.

Sammuel-Dennis (2007) examined the relationship between employment status, stressful life events, and depressive symptoms among single mothers, with a special focus on the potential mediating and moderating roles of coping. A cross-sectional survey design was used on a sample of 96 single mothers (48 employed and 48 single mothers on social assistance) who were the primary caregiver for at least one child. The coping repertoire—use of problem solving, seeking support, and avoidance coping strategies—

was not a mediator through which employment status or stressful encounters explain depressive symptoms in single mothers. The employed single mothers predominantly used problem-solving strategies while their social assistance counterparts predominantly used avoidance coping strategies.

Social Support Networks

The weakening of already limited social networks may impair the well-being of individuals who are homeless. Social support networks have been proven to assist in the reduction and management of stress and bear a direct correlation to the psychological and physical symptoms of the homeless and act as a buffer between stressful life events and symptoms (Bates & Toro, 1999; Carton, Young, & Kelly, 2010; Zimet, Dahlem, Zimet, & Farley, 1988). Members of social networks may help in maintaining housing or provide emotional support to bolster the family's coping resources (Shinn, Knickman, & Weitzman, 1991).

The literature has several different definitions of social support. Barrera (1986) organizes social support into three concepts: social embeddedness, perceived social support, and enacted support. Social embeddedness is the social support that refers to the connections that individuals have to significant others in their social environments. Perceived social support has emerged as a prominent concept that characterizes social support as the cognitive appraisal of being reliably connected to others. Social support can also be viewed as enacted actions that others perform when they render assistance to a focal person.

Bates and Toro (1999) defined social support as those interactions in which one group or individual directly provides another with a sense of connection, resources, and/or affirmation. Rowe and Wolch (1990) defined social network as an individual's social interactions with a finite set of people those individuals know and from whom one obtains material, emotional, and/or logistical support (e.g., kin, friends, work associates, neighbors, and service providers). The breakdown of traditional social networks and changes in daily/life paths leads homeless people to develop ways to acquire resources which do not depend on either a home or job base site. The social networks formed within the homeless community differ in both composition and spatial organization from those formed within the homed community.

For the purposes of this study, there are four different kinds of social support: tangible, advice, self-esteem, and belonging (Reitzes, Crimmins, Yarbrough, & Parker 2011). Tangible support is aid defined as shelter, income or financial assistance, clothing, and food. Advice is information and assistance in finding or acquiring available shelter, jobs, food, clothing, and health care. Self-esteem refers to a positive feeling of self-worth generated about oneself through the social interactions. Belonging is a sense of attachment and community, offsetting a sense of isolation, loneliness, and anomie. There are three kinds of networks homeless people may rely on for social support: non-kin networks, associates, and normal social service networks.

Reitzes and colleagues (2011) conducted a 2-year-long observation study of homeless men and women who frequent a downtown Atlanta public park. Findings

posited the four types of social support and that the homeless combined support provided by social networks in the attempt to address their substantial needs.

Social supports among the homeless have been studied for several decades. Dail (1990) found that family and social or emotional support systems were lacking among a sample of 124 homeless women interviewed. Of the 124, 53 were mothers with children under 18 years of age. Mothers often reported there were only one or two people with whom they felt safe enough to confide, and almost all indicated a strong distrust of others and a reluctance to make friends. Most often the person they felt the closest to was one of their children (usually the oldest one, even if this child was very young). Mothers' coping mechanisms included the stabilizing effects of their children, which gave them something outside of themselves to focus on and divert their attention from the overwhelming magnitude of their problems, comparable with avoidant coping.

Shinn and colleagues (1991) also compared homeless mothers with housed mothers in New York City. Both samples were comprised of mothers who were currently receiving Aid to Families with Dependent Children (AFDC) or received benefits within the last six months. The total sample size was 701 participants. Contrary to Dail's (1990) findings, the results of this study revealed that participants seeking shelter were in greater contact with their social networks than their housed counterparts. Shelter seekers perceived themselves less likely able to stay with family or friends than did housed respondents. More than three-fourths of the shelter seekers had previously stayed with their network within the past year and had worn out their welcome.

Hill (1991) conducted an ethnographic case study with 90 homeless women at a shelter run by an order of Roman Catholic sisters. The findings included first that the poverty experienced by the guests reduced their attachment to typical consumer goods. These tended to value sacred items, such as memories, relationships, and religious beliefs, in which physical ownership and tangible items that symbolized these intangible possessions were irrelevant. Secondly, a lack of strong bonds to family and friends combined, with their inability to support themselves, led to a childlike dependence on the sisters and the shelter. Finally, the study included the fact that the women appeared to have used fantasies about future home life as a coping mechanism.

Again, Dail's (1990) findings were refuted by research by Thrasher and Mowbray (1995) who found a wide range of social supports among homeless women. In 1995, they conducted ethnographic interviews with 15 homeless female-headed families from three Detroit shelters. Many of the women in the study lived intermittently with relatives and friends for weeks and months before arriving at a shelter. Many women reported frustration due to their diminished parental authority with regards to child-rearing, due to the stress of homelessness and shelter rules. Despite the stress of the shelter and its problematic structure undermining their authority, women expressed parenting concerns and a desire to improve their children's wellbeing. Women had a wide variety of social contacts, which ranged from immediate family such as mothers, fathers, and sisters to relatives of their children's fathers. Women were often in conflict with their children's fathers yet kept in touch with the father's families, such as grandparents, aunts, and uncles.

Anderson and Rayens (2004) expounded upon this research, yet found lower existence of family support. Their study examined families of origin and the support systems of women who experienced homelessness. A comparison of 225 homeless women and women who have not experienced homelessness from the greater Portland area were interviewed to determine levels of intimacy, autonomy, social support, reciprocity, and conflict in childhood relationships. The study results revealed that the homeless group was significantly lower in support and reciprocity and significantly higher in conflict than the never homeless group. Anderson and Rayens purported that the absence or lack of developing a social network may lead to an increased vulnerability to the development of homelessness as an adult. The lack of relationship with the homeless person's family of origin, as well as a weakness in the ability to develop and access support from one's social network may limit a protective factor available to those who did learn how to establish relationships in their childhood.

Bassuk, Mickelson, Bissell, and Perloff (2002) continued to research the phenomenon of familial support versus support from non-relatives. They compared the support of kin and non-kin among a sample of 220 sheltered homeless single mothers and 216 women who received AFDC who had not experienced homelessness. Conflict with one's support network was predictive of negative mental health outcomes. Sibling support and, to a lesser degree, support from the participant's mother also predicted mental health outcomes. Emotional support was greatest from professionals and friends rather than from kin, whereas conflict was greatest with partners and family.

Social support presents itself in many forms, kin and non-kin, as Bassuk and colleagues (2002) discovered. One form of non-kin support can be staff from various programs. Meadows-Oliver (2003) conducted 18 qualitative studies on homeless women living in shelters with their children. Six themes of caring for homeless children were identified: on becoming homeless, protective mothering, loss, stressed and depressed, survival strategies, and strategies for resolution. The most common strategies used were praying and getting support from others. Receiving support from others in their environment helped mothers deal with homelessness. The shelter staff provided social support to the homeless mothers in the form of individualized counseling services, parenting classes, and support group meetings. Other mothers in the homeless shelters were significant providers of support for study participants.

Carton and colleagues (2010) also reviewed the impact of the relationship with staff for the homeless focusing on the outcomes of formerly homeless persons and their relationships with accessing normal social service networks, assertive community treatment (ACT), and staff. Twenty-two formerly homeless women comprised the sample of the study participants. The sample was racially diverse with 62% Caucasian, 24% African American, 9% Latino, and 5% Asian. Two inventories were adapted for the purpose of the study: (a) Relationship Inventory and (b) the Social Support Questionnaire. The findings indicated that participants reported the quality of their relationships with ACT staff members was significantly better than the relationships maintained before and during their homelessness.

The existence of social support has proven beneficial for homeless women. Building upon Bassuk and colleagues' (2002) findings, Neale and Brown (2015) explored the role of friendship in the lives of homeless drug and alcohol users living in hostels, using the concepts of "social capital." Thirty residents (9 females, 21 males) who self-reported drinking and/or drug problems, were interviewed twice, with an initial and follow up interviews. Only 21 reported current friends at the initial interview, yet all desired friendships. Eight categories of friends emerged: family-like friends, using friends, homeless friends, childhood friends, online-only friends, drug treatment friends, work friends, and mutual interest friends. Routine and regular contact was highly valued, with family-like friends appearing to offer the most constant practical and emotional support. The use of information technology was key to maintaining a connection with social support.

Klitzing (2004) continued to examine the impact of stress experienced by women who lived in transitional homeless shelters and to explore the ways women coped with stress. Photo-elicitation (the use of pictures the women took with disposable cameras) was utilized to supplement and clarify data obtained through traditional interviews with 11 women who lived in a shelter for at least one week prior to the initial interview. Five of the women had children with them in the shelter and six were women without dependent children. The women utilized a variety of coping strategies such as diversionary activities, getting away, and social support. The results of the study suggest that women who are homeless use social support as a coping strategy and that leisure may or may not be a part of the strategy.

Tischler and colleagues (2007) conducted a qualitative study aimed at describing mothers' experiences of homelessness in relation to their mental health, support, and social care needs. Twenty-eight homeless women with dependent children residing in hostels, in Birmingham, UK, were interviewed. Homeless mothers employed a variety of coping methods including: avoidance of problems and not addressing problems more often than actively dealing with them. The experience of homelessness was stressful, but viewed as a respite for many of the participants because they had experienced violence and harassment prior to their stay in the hostels. Many described poor mental health, which they related to the conditions in the hostels and traumas that they had experienced before becoming homeless. Although many of the participants saw it as a respite, most women had difficulty with homelessness and several said that support from other homeless women was an important source of help.

Fitzpatrick and colleagues (2015) also explored the possible relationship between mental health and aspects of homelessness. This study explored factors related to depressive symptomology associated with homeless people living in two communities – 161 homeless from Birmingham, Alabama and 103 from northwest Arkansas. The study focused on the impact of place (location) and the influence of social capital on the depressive symptomology of homeless persons. Results found that being homeless transcends location and is stressful regardless of where it is experienced and that capital, if available, can make a real difference, regardless of where it was obtained and if it is used. Specifically, the study found that the everyday negative experiences of life in a shelter or on the street are clearly important to homeless people and their overall mental

health regardless of location. Both social ties and psychological resources had negative effects with depressive symptoms. Despite differences in support and coping between the two groups of homeless, these resources made a difference and were not location specific.

Toro, Tulloch, and Quelette (2008) measured the effects of social support and the stress buffering effects in two samples of 468 homeless adults. The limitations of previous research regarding social support systems were addressed, as well as differences in the assessments. The homeless showed high stress, low social support, and poor outcomes in most areas.

Accessing social supports as a coping strategy has a beneficial impact upon a person experiencing homelessness. Marra, McCarthy, Lin, Ford, Rodis et al. (2009) studied a sample of 234 women who were recruited from 12 Connecticut homeless programs for women, examining the impact of conflict and social support on the parenting behaviors of the participants.

Homelessness is a stressful event that impacts parenting (DeGarmo & Forgatch, 1997). This study found that women who reported high emotional and instrumental social support self-reported greater improvements in parenting consistency over time than those who reported lower levels of support; however, conflict in support networks was a risk factor for harsh parenting practices among participants who reported lower levels of instrumental social support.

Eyrich-Garg (2010) examined mobile cellular phone possession among 100 homeless men and women who did not have shelter in Philadelphia, Pennsylvania.

Participants used their cellular phones to increase their sense of safety, responsibility, and social connectedness. Forty-four percent of the study participants had at least one person within their network with whom they speak, and 27% had at least one person within their social networks that they would text. Eyrich-Garg postulated that the reason homeless persons have smaller social networks is because of the lack of ability to maintain contact with his/her supports. Excluding those homeless people with substance abuse issues who have severed their relationships with family and friends, it is possible that others have small social networks because of the lack of access to landlines, money for pay phones, transportation, or physical ability to walk and visit with family and friends.

Brown and Mueller (2014) examined factors that enabled homeless women to secure employment and re-enter mainstream society among a sample of 68 residents of a women's homeless shelter in the Midwest region. All participants had at least one child, were currently unemployed, and 78% reported income below \$10,000 and received primarily public assistance funding. Findings indicated that perceived social support, specifically social integration, assumes a more critical role in homeless women's self-efficacy for securing employment than do social psychological variables and the intrapersonal process of hopeful thinking.

Building upon perceived social support, homeless women still reported feelings of isolation. Gültekin, Brush, Baiardi, Kirk, and VanMaldeghem (2014) conducted focus groups with homeless mothers and their caseworkers in a qualitative, descriptive design with participants from an agency in Detroit, Michigan. The majority of the women reported feelings of isolation and few friends or reliable relatives to which they could

turn. Many women noted that family dysfunction started with their families of origin and included violence and substance abuse. Many women noted generations of homelessness and poverty and difficult mother-daughter relationships. Nearly all of the women reported involvement in abusive relationships and all defined themselves as single or divorced. Several women noted they were unable to turn to family for financial support due to their family's ongoing financial struggles. Doubling up with family members was a common practice.

Forlan (2016) provided recommendations for homeless service providers to intervene with the aspirations of homeless women. A secondary analysis of 20 transcribed interviews revealed that all the women in the study had a positive perception of the future. Some spoke of the near future and resolving their current homeless situation, whereas others described their future in post-homeless terms. Participants described multiple sources of connectedness including service providers, homeless peers, and family. Recommendations for service providers included offering and referring homeless women to support or social groups with shared interests, attempts to reconnect them with family/friends, or assisting with the development of surrogate familial relationships.

The presence of social supports has proven to aid those coping with the stress associated with life, as well as with homelessness (Bassuk, Buckner, Weinreb, Browne, Bassuk et al., 1997; Goodman, 1991; Tischler, Rademayer, & Vostanis, 2007). Research has proven that the existence of social supports has been beneficial for both cohorts of homeless women with dependent children and homeless women without dependent

children (Klitzing, 2004; Marra et al., 2009; Rowe & Wolch, 1990; Toohey, Shinn, & Weitzman, 2004).

Problem-Solving Coping

One of the coping strategies to deal with stress is problem solving coping, which is an action designed to eliminate stress. It is more likely present in situations in which one determines that something constructive can be done to eliminate the stressor (Scheier, Weintraub, & Carver, 1986; Tischler & Vostanis, 2007). Human beings are not always creatures of habit. We have the ability to think flexibly about situations we have never encountered and come up with innovative ways to solve problems (Goldstone & Pizlo, 2009). There have been links throughout the literature referencing problem solving as a solution and an aid in combating emotional distress associated with homelessness.

Nyamathi (1992) completed a comparison study that examined how 460 Black homeless women categorized as high, moderate, or low risk for the human immunodeficiency virus (HIV) differed in environmental, demographic and personal factors, appraisal of threat, resources, coping responses, and outcomes. The results showed that homeless, intravenous-drug-addicted women reported greater environmental concerns, appraisal of threat, emotional distress, depression, and use of emotion-coping than homeless non-intravenous-drug-addicted women. Based on results, Nyamathi made recommendations for future programming to focus on substituting emotion-focused (i.e., use of drugs, alcohol, withdrawal) with problem-solving skills may lead to decreased emotional distress and depression.

Nyamathi, Stein, and Swanson (2000) examined the causal model of personal, cognitive, behavioral, and demographic predictors of two coping mediators, the outcome variables of HIV testing and return for test results, and a recent STD infection among a sample of 621 homeless women. Predictors of problem-focused coping strategies included less drug use, more self-esteem, more social support, more AIDS knowledge, and less risky sexual behavior.

Meadows-Oliver (2003) also noted that the study participants searched for solutions to their problems and that would improve their current situation and prevent future incidents of homelessness. Tischler and Vostanis (2007) also found that homeless mothers used problem-focused and cognitive coping strategies, despite most recently having been exposed to violence and trauma.

Barrow and Lawinski (2009) conducted a qualitative study of 210 sheltered mothers with mental health or substance abuse problems; approximately half of the women were entering shelter placements within Westchester County. The study explored mother-child separation in homeless families and identified precursors of separations which included precarious housing, turbulent relationships, substance abuse by mothers and others, institutional confinement, and children's needs. They also documented mothers' problem-solving efforts in an attempt to find the best choices for their children, often among a set of undesirable alternatives.

Finfgeld-Connett (2010) found, in conjunction with the challenges that accompany residing in shelters, a lack of privacy, loss of personal and parental freedom, and diminished self-respect, and that homeless women have limited problem-solving,

decision-making, and interpersonal skills. The study concluded that many of the problems that lead to and sustain homelessness appear to be related to poorly-developed problem-solving and decision-making skills. Non-adaptive thinking patterns are made worse by feelings of anger, betrayal, and helplessness, and in some instances, the emergence of mental health and substance abuse problems.

Nguyen, Liu, Hernandez, and Stinson (2012) examined attributes of role conflict, attitudes towards seeking professional help, and psychological stress and problem-solving appraisal among a sample of 126 homeless men in a rural city in the Midwest. Participants who scored higher with regards to gender role conflicts also reported negative appraisals of their problem-solving skills, attitudes, and confidence. The concept of problem-solving included three aspects: problem solving confidence while solving problems, tendency to approach or avoid the problems, and ability to control emotions while solving the problem.

Problem Reframing

Cognitive reframing focuses on altering maladaptive, self-defeating, or distressing cognitions and makes them more adapted to the situation. This, in turn, is assumed to improve coping, reduce burden and psychological morbidity, and improve quality of life, as noted by Vernooij-Dassen, Draskovic, McCleery, and Downs (2011). Reframing the problem is an essential component of Cognitive Behavioral Therapy, which is an evidenced-based therapy used with various populations. Simply put, change the way you think, you change your behavior which directly impacts your outcomes. Problem reframing as a coping strategy is beneficial for people experiencing homelessness.

Wagner and Menke (1991) examined and compared the life events of coping behaviors of homeless families, poor domiciled families, and low-income domiciled families. The sample consisted of 86 mothers divided into three different groups: 28 homeless mothers, 23 poor domiciled mothers, and 35 low-income domiciled mothers. The subject's scores on the F-COPES indicated that all three groups reported using a variety of coping strategies. The possible ranges of scores for the reframing coping subscale was 8 to 40 with the sample's range being 13 to 40. The mean score for each group indicated that they used a variety of reframing coping strategies.

Tischler and colleagues (2007) conducted interviews with 28 homeless women with dependent children living in three local authority run hostels, in Birmingham, England. The aim of the study was to describe the experience of homelessness in relation to the mental health, care, and support needs of mothers. Many of the participants relayed their struggle with the stress of homelessness. These women coped in several ways: avoidance, seeking social support as well as reframing their problems, and comparing their situation favorably to others.

Schuster, Park, and Frisman (2011) conducted a study of 70 homeless women from the Connecticut Homeless Family Program. Study participants provided information about previous trauma history and post-traumatic stress disorder (PTSD) symptoms at baseline. Coping and psychological symptoms were assessed 15 months later. Coping was assessed with the Brief COPE. One of the factors was conceptualized with the Active Coping factor; subscales included active coping, seeking instrumental and social support, planning, and positive reframing. Findings suggested that Active Coping (positive

reframing) was unrelated to either number of lifetime traumatic events or PTSD symptom severity.

Carver and Schier (2014) define optimism as being focused on positive versus negative expectations for the future about how such outcomes occur. If a person is confident about eventual success in the face of obstacles, effort towards goal attainment continues. If a person is doubtful there is a tendency to disengage effort. Optimism is synonymous with the variable problem reframing used in this study. A person can view a problem (i.e., homelessness) and reframe it or focus on the positive versus the negative outcomes with regard to exiting homelessness. The ability to view life positively has positive impacts on both psychological and physical health. Research demonstrated that for many health-related outcomes (e.g., heart disease, cancer, and pregnancy), optimism lowers vulnerability to emotional distress and improves the overall functioning of patients (Park, Moore, Turner, & Adler, 1997; Trunzo & Pinto, 2003).

Taylor and Conger (2017) discussed the impact of optimism among single mothers. More optimism was correlated with lower levels of internalizing distress and higher levels of positive parenting. Higher levels of internal resources had a positive effect on boosting coping strategies that inadvertently effect mental effect and eventually positive parenting. Reframing negative mental cognitions was directly linked to benefiting single mothers.

Brown and Mueller (2014) referenced the concept of hopeful thinking in relation to a study of homeless mothers living in a shelter. Hopeful thinking was defined as the powerful cognitions within oneself that propel one to move beyond one's present

situation and to envision a better tomorrow. This is synonymous with problem reframing. A hypothesis included hopeful thinking and its prediction of the participant's ability to obtain employment. The findings failed to reveal a predictive relationship between hope and homeless women's job procurement.

The participants in Holdrop and colleagues' (2015) study were able to maintain a positive outlook. It may be that the supports provided by the transitional housing program and other residents of the community helped bolster these families and promoted optimism.

Fitzpatrick (2016) conducted a study using intensive interviews with 168 homeless adults in northwest Arkansas and examined the role that social support and optimism played in lessening the negative impact of homeless circumstances/experiences on mental health symptomatology. Despite the conditions of homelessness, people with higher levels of optimism and social support reported lower depression and anxiety symptoms. Findings focused on the importance of maintaining a positive outlook for the future among homeless persons.

Theoretical Framework

The theoretical framework used to guide this study and the analysis of the variables was a mixed approach. Three perspectives were incorporated to explain the relationship between the variables in this study: the Afrocentric Perspective, the Transactional Stress Theory, and the Ecological Approach.

Afrocentric Perspective

The Afrocentric Perspective is a worldview that incorporates the mores and values of African people in scholarly research. When applying Afrocentric patterns of thought to intellectual and scholarly activity, the goal is to maximize an understanding of all people's potentialities and to gain an understanding of people's talents. In Afrocentric social work, everyone is believed to have civil rights but, more importantly, a right to work, to acquire decent housing and adequate food and clothing (Schiele, 1997).

The fundamental assumptions of the Afrocentric Perspective, especially those assumptions relate to macro level analyses of economic markets, are applicable to this study's research on homelessness in America. The Afrocentric Perspective assumes increases in wealth would result in the satisfaction of all human needs, in particular, those of African Americans. According to this perspective, homelessness should not exist in America, since America is among the world's richest countries (Gregson, 2017), yet America has an enormous number of people who are poor and without shelter, among whom are a great majority of African Americans. One of the main tenets of this perspective is that poverty is an intolerable consequence of society's lack of commitment to collective welfare (Schiele, 1997). The Afrocentric Perspective maintains that homelessness is a solvable problem, considering America's wealth. This idea is the basis and driving thought of this study: that homelessness in this country is solvable. It began with this view and gave light to identifying possible solutions to eradicate its presence, with an emphasis on the micro level.

An application of Afrocentrism to a macro analysis of U.S. homelessness would require that U.S. policymakers adopt a communitarian outlook, which would diminish polar extremes between the rich and poor in America. Unfortunately, capitalism is the mother of creativity in the United States and is rooted in a worldview that valorizes individualism over communitarian concerns; whereas Afrocentrism has its grounding in humanistic values that are inherently communitarian. One value germane to the Afrocentric Perspective is that all people are created with equal ability and potential. Considering this value, the Afrocentric Perspective argues that all people should have access to basic inalienable rights such as shelter. This continues to support the premise for studying this population, those who do not have shelter in this country, which should be their basic right.

Consequently, an application of the Afrocentric Perspective to this study's research questions suggests the notion that homelessness can be mitigated by identifying the strengths and resources of individuals who fall victim to homelessness, especially mothers and their children. In this view, children can be identified as a strength and a motivating force for mothers to exit homelessness (Lindsey, 1996). Research indicates that homeless women who have been separated from their children exercise determination to mitigate separation and sustain their parenting roles (Barrow & Laborde, 2008).

Transformed into practice, identifying the strengths and resources of individuals who fall victim to homelessness would require active listening in order to help social workers gather a comprehensive psycho-social profile of homeless mothers and their

children. Social work practitioners, with cooperation from homeless women, would identify communal resources for homeless women, including interpersonal resources such as family, friends, and social organizations. The transmutation of Afrocentric theory into practice would allow women to exit homelessness, built on the collaborative efforts between social work practitioners and homeless women (Saleebey, 1996). This creates a collaborative approach to the eradication of homelessness that would be both Afrocentric and effective.

Transactional Stress Theory

The Afrocentric Perspective provides the foundational framework for this research, that all human needs should be met, in particular shelter, and that every individual arrives at an adverse situation with their own set of strengths and resources. Transactional Stress Theory provides a view to address the stress of mitigating homelessness by way of coping and supporting the rationale for the operationalization of coping, specifically problem solving and problem reframing.

Transactional Stress Theory purports that people experience stimuli and engage in thoughts to create processes called cognitive appraisals. Cognitive appraisals include primary appraisals. These primary appraisals include negative stressors, which result in harm or that offer people an opportunity to grow. On the other hand, secondary appraisals include stressors that dictate how a person responds to a situation or how they can be controlled by it. This appraisal process generates emotions, which influence the coping phases of cognitive appraisals. In this theory, coping is defined as a person's desire to constantly change their cognitive and behavioral efforts to manage external or internal

stimuli that proves taxing to the person (Lazarus & Folkman, 1984). Lazarus and Lazarus (2006) described two main classes of coping strategies: problem solving and regulating emotions. Other examples of coping include: maintaining favorable morale under stress, sustaining or restoring positive self-regard, and taking a break from the demands of chronic stress.

In problem-focused coping, a person's attention focuses on what can be done to change the situation or decrease the stress associated with it, whereas, in emotion focused-coping, a person focuses on dealing with emotional distress. Another aspect of emotion-focused coping is that a person reframes negative attributes of the stressful situation to find its positive corollaries. In these instances, situations can be reappraised to reduce or eliminate the amount of stress in a given situation. Lazarus and Lazarus (2006) purport that most stressful situations depend on two functions of coping: regulating feelings and trying to change the stressful situation. These functions are rarely separated. According to the Transactional Stress Theory individuals use both problem-focused and emotion-focused strategies to cope with stress.

Homelessness is stressful (Klitzing, 2003, 2004). It impacts women both psychologically and physically (Bassuk, Buckner, Perloff, & Bassuk, 1998; Finfgeld-Conett, 2010; Hwang & Dunn, 2005; Wilson, 2005). The stressful experience of homelessness causes women to negotiate and employ coping strategies to ameliorate their circumstances. Homeless women traverse the stages of coping to mitigate the traumatic effects of homelessness. Homeless women with children and women who are homeless on their own may deal with stress in different ways. Women caring for dependent

children may internalize the stress in different ways and have shorter histories of homelessness (Welch-Lazoritz et al., 2015).

Ecological Approach

The third applicable theory is the Ecological Approach. This theory emphasizes how the social context in which individuals live helps shape individual behavior. While the ultimate responsibility for problems such as homelessness may lie in structural inequalities, both structural and individual factors must be addressed. This approach also assisted with the operationalization of the third aspect of coping: accessing social supports.

Toro, Trickett, Wall, and Salem (1991) synthesized the definition of the ecological approach for evaluating homelessness, and contains: (a) an emphasis on describing the ecological context that surrounds individual behavior; (b) the assertion that the ecological environment can be conceptualized at different levels of analysis, each of which may independently and in interaction influence behavior; (c) an understanding that even environments of the same type (e.g., shelters for homeless people) differ greatly from one another; (d) the notion that individual behavior is transactional and cannot be understood without reference to context; and (e) the belief that interventions must be tailored to the specific ecologies in which they are implemented.

Bronfenbrenner's (2009) ecological systems theory presents subsystems that include macro system levels, legal and political systems such as health and public policy; mesosystems that include the school, community, and local institutions; and the microsystems that include relationships with family, friends, and neighborhoods.

Exploration of the existing relationships of homeless persons is essential when developing exit strategies from homelessness. This idea drove the inclusion of accessing social supports as one of three parts of the definition of coping for this study. The family system is an important system in mediating the resource losses that result in or manifest as homelessness (Haber & Toro, 2004).

Homelessness is a social problem comprised of macro factors that include: lack of affordable housing, poverty, and lack of employment opportunities. The impact of a lack of societal resources needs to be included in the conversation about homelessness. Although the present study does not address this phenomenon, it is crucial not to delete it from this discourse, to ensure that possible solutions incorporate all relevant factors rather than focusing on the personal pathology of those affected by homelessness, as it is the best predictor of successful long-term adaptation among people who are homeless (Haber & Toro, 2004).

CHAPTER III

METHODOLOGY

Chapter III presents the methods and procedures that were used to conduct the study. The following are described: research design, description of the site, sample and population, instrumentation, treatment of data, and limitations of the study.

Research Design

A descriptive quantitative research design was employed using data to describe the difference in coping strategies among homeless women (i.e., women with dependent children and women without dependent children) at several shelters throughout the state of Georgia. A descriptive study examines some phenomenon (Singleton & Straits, 2005). Most of the shelters utilized in this study allowed direct access to both populations: homeless women with dependent children and homeless women without dependent children.

The design allowed for descriptive analysis of the demographic characteristics of the participants, which facilitated the explanation of the statistical relationship of social support systems, problem solving, and problem reframing skills between the two groups of homeless women without dependent children and homeless women with dependent children. The Transactional Stress Theory was used to explain coping methods employed by both groups of women, homeless women without dependent children and homeless

women with dependent children, during their period of homelessness. The extra stress of parenting requires additional coping strategies employed by homeless mothers in contrast to the coping employed by homeless women without dependent children. Homeless women with dependent children were likely to have greater usage of access to social support systems, problem solving, and problem reframing skills than homeless women without dependent children.

The null hypothesis is that there is no difference between homeless women without dependent children and homeless with dependent children regarding coping strategies that include problem solving, accessing social supports, and problem reframing. The nondirectional alternative hypothesis is that there is a difference between the two groups of homeless women—with children and without children—regarding coping strategies they employ.

Description of the Sites

There are 26 shelters in Georgia that provide services to homeless women with and without dependent children. Of the 26 shelters, 8 provide homeless shelters in the Metro Atlanta area. This research study was conducted at 11 different shelter locations in Georgia. The survey was administered in the group setting area at each site during the evening hours.

The first site has housed women since 1993 within the city in a 200,000+ square foot warehouse in the heart of Atlanta, Georgia. The shelter offers comprehensive onsite services to both homeless women and children and includes housing, healthcare, vocational programs, educational programs, youth programs, childcare, and other social

service resources. There are several programs that include the Kitchen Meal Program that feeds the residents three meals per day. This shelter collaborates with a local health system in Atlanta that provides general medical, dental, vision, and mental health services at the facility. There are 32 hotel-style rooms designed exclusively for mothers with children. The shelter also provides housing for 80 women without children.

The second site, since 1997, has provided temporary shelter for homeless men and women within a 100,000-square-foot building, in the heart of downtown Atlanta. The only program surveyed was the female side, which housed up to 40 women without dependent children. These women were surveyed prior to its closing on August 28, 2017.

The third site provides temporary shelter for homeless women without dependent children and families, in downtown Atlanta. Their emergency housing program provides shelter for up to 40 women without dependent children, up to a 30-day stay, once within a 365-day period, night time only. Shelter residents here must leave Mondays through Saturday mornings by 8:00 a.m. Shelter residents receive a bed, locker, and two meals per day; breakfast and dinner. The program offers shelter for up to 21 parents and/or guardians with their children up to 60 days, once per calendar year. This program is also a night shelter. Participants receive a private room and weekly case management services. All family rooms are furnished with a private bathroom. Participants receive two meals per day along with financial and parenting classes.

The fourth site, since 1982, provides temporary shelter to homeless families of any size, in the metro Atlanta area. This shelter does not prohibit the placement of adolescent male children. The shelter is a Victorian home that can house up to 12

homeless families, which includes accommodations for a family of 10. The program provides case management services that begin with development of individualized treatment planning to assist with establishing long-term goals. Twice-weekly evening courses cover various topics to include interview skills, resume writing, budgeting, debt management, computer use, and parenting and stress management skills. The shelter also provides after-school programming, summer camp, and evening activities.

The fifth site provides emergency residential housing for homeless families originating from the North Fulton area of Georgia, with 16 fully furnished, private one or two-bedroom apartments in which to live rent-free for 90 to 180 days. The shelter provides food and an after-school program for its residents. This shelter allows male adolescent children to stay with their families. This is an exception, as most female shelters do not allow adolescent male children. Families are defined as a mother and her dependent children. Mothers are assigned a case manager who assists with developing a personalized empowerment plan. Residents are assigned a career coach who meets weekly with them, to assist with the development of job search skills and employment opportunities. Mothers also attend weekly workshops addressing areas such as personal finances, health and wellness, organizational skills, parenting, and nutrition. Childcare is provided and mothers are matched with mentors.

The sixth site is in Cartersville, Georgia, 44 miles northeast of Atlanta. The shelter opened in 1996 and is housed in a 4,600-square foot, 24-hour facility that provides temporary housing for men and women. It is a 30-bed facility, with two dormitories for men and two for women. Upon admission, each shelter resident has a session with a goal

coordinator to assess the resident's situation and create of plan of action. The plan of action focuses on several areas to include: employment, budgeting, savings, and planning for permanent housing. The first phase of the shelter program requires residents to obtain employment within the first four weeks of their stay. Once employment is ascertained, residents are encouraged to save their income, which is monitored by staff. Extended housing is the final phase of the programming and assists with locating permanent housing.

The seventh site is a nonprofit organization that assists community providers with the following services; housing assessments, housing counseling, housing advocacy, housing locator services, landlord liaison services, financial assistance, and case management. The agency assisted 1,291 homeless people move into permanent housing in 2016.

The next shelter site provides emergency housing services for individuals and families. It was established in 1971 and provides services for people who live in Marietta, Smyrna, and Canton/Cherokee County areas. This emergency shelter is a 72-bed facility that provides shelter for single individuals as well as families. The program also provides for basic needs: food, clothing, hygiene items and assistance to obtain income. Residents are paired with a case manager who assists residents in creating a Housing Stability Plan.

The ninth site provides shelter for 6 homeless women and children for residents of the Athens/Clarke County area. Parents are required to engage in employment, school, or training. The program provides job training, referral, education and case management. It

assists mothers with interviewing skills, constructing resumes, and financial assistance for transportation and training certifications.

The 10th site also provides shelter for residents in the Athens/Clarke County area. This female shelter was established in 1980. The shelter has 34 beds for women without dependent children and two-family rooms that have 4 beds in each room. The shelter provides case management for its residents.

The last site is a 130-bed residential facility for homeless women and their children. The site was established in 2014 and is located in metro Atlanta on one acre of park space which includes a playground, a basketball court, and walking trails. The shelter offers wraparound services for families for up to six months. Each family is given a dormitory-style room, furnished with beds and dressers. Families are empowered in the areas of financial literacy, parenting, job readiness, health and wellness, and social activities.

Sample and Population

In any large city hospital for indigent patients, there are always a substantial number of homeless patients seen in the emergency department. Homeless men may consistently request services in physical health and housing resources, while the numbers of homeless women would be marginal and scanty; these numbers of women with dependent children are always small. The numbers of women with children were small because, women often utilized various methods and means of coping to either prevent or reduce homelessness. This contrasts with national research statistics that identify family homelessness; women with dependent children, as a growing population within U.S.

homelessness. This situation has sparked inquiry into the differences between data derived from social work practice and nationally published data.

The societal impact of homelessness among women is multifaceted and complex, with variance dependent upon whether the female is single or has children. States and cities that do not address chronic homelessness may face substantial financial implications for their jurisdictions. These costs are primarily in the health care and legal systems (Rickards et al., 2009). The literature reviewed identified several variables that impact homelessness such as mental health, substance abuse, domestic violence, and childhood trauma. There is a lack of literature on the role that internal factors and coping strategies have in the numbers of homeless women, in comparison to their male counterparts

The target population for this research is residents of the women's shelters in Georgia, consisting of homeless women. The unit of analysis is homeless women. Quota sampling was employed to ensure that an equal number of women without dependent children and women with dependent children were represented in the sample. A quota sample is a nonprobability sampling, in which units are selected into a sample based on predetermined characteristics, so that the total sample will have the same distribution of characteristics assumed to exist in the population being studied (Babbie, 2007). The sample is dependent upon the voluntary participation of shelter residents, who may or may not be willing to complete the survey without any incentive. G*Power was used to perform a power analysis to determine the desirable sample size (Faul, Erdfelder,

Buchner, & Lang, 2009). With a medium effect size ($f^2 = .0625$), an alpha of .05, power ($1-\beta$) of .80, two groups, and three variables, the estimated sample size would be 180.

The initial plan included quota sampling with the entire sampling frame to be drawn from the entire population of shelter residents at Site I: 120. Only 60 shelter residents agreed to participate in the study. The sampling frame was extended to include additional shelter sites from Georgia. A second sample was generated, using convenience sampling, which generated 136 participants. Four cases responded “never” to all the questions on the coping inventory and were excluded from the study, leaving the total sample size for this study at 192.

This researcher had access to the first site from a previous professional relationship but was denied access to the largest female shelter in the Metro Atlanta area, by the vice president of women’s programs. To expand the sampling frame, this researcher attended the Atlanta Continuum of Care meeting and met with the Continuum’s director to gain support for this study. The director contacted several shelter directors and solicited interest in speaking with this researcher about this study. This researcher then contacted the shelter directors that were amenable to possible participation in this study. The contact included an introduction of this study, a copy of the questionnaire, and the letter to the participants regarding confidentiality. After review of documentation and permission was granted, this researcher scheduled a time and date to visit these shelters to administer the questionnaire. This researcher also conducted cold calls to additional shelters in the metro Atlanta and neighboring counties. After speaking

with shelter directors who were amenable to this study, this researcher employed the same method.

Instrumentation

The survey questionnaire was comprised of questions that attempt to measure the constructs of coping. Nine statements were chosen from the Coping Strategies Inventory, created by Rory C. Reid (2007). The survey was divided into two sections: demographics and characteristics of coping. Section I of the survey contained 12 questions regarding age, ethnicity, education, marital status, income and sources of income, mental health diagnosis, children, ages and location of children, religious preference, and substance abuse. Section II contained 12 questions regarding coping regarding coping were: seeking advice from others, talking with professional people, enlisting support of others to assist with an issue, requesting a loan, addressing and analyzing the issue, efforts addressing issue in different ways, evaluating options to resolve issues, developing strategies to deal with issues, positive outlook, positive self-talk, learning something about self through issues, and promising self a different outcome in the future. The scale was: 1=Always, 2=Often, 3=Rarely, and 4=Never. The score was the sum of the responses to the 12 questions and dividing the score by 12 to give the mean response for each scale. A pilot test of the survey instrument was administered to a convenience sample of the population to test the questionnaire for clarity with regard to the instructions, formatting, and possible typographical errors.

Cronbach's alpha, which measures internal consistency, was used to measure the reliability of the overall Coping Survey and the three scales (problem solving skills, ability to access social networks, and problem reframing). An alpha between .7 and .8 is considered acceptable. The overall coping score which consisted of 12 items ($\alpha = .782$), the ability to access social networks which consisted of four items α ($\alpha = .787$), and problem reframing which consisted of four items ($\alpha = .762$) all have acceptable reliability. The alpha for problem solving which consisted of four items ($\alpha = .595$) is considered of questionable reliability. As the reliability of the Overall Score and the scores for the other two scales were all acceptable, this analysis was continued (see Table 1).

Table 1

Reliability of Coping Strategies

Scale	Reliability
Overall coping score	.782
Problem solving skills	.595
Ability to access social networks	.787
Problem reframing	.762

Participants voluntarily completed surveys after reviewing and completing informed consents. Surveys incorporated components of the Coping Strategies Inventory comprised of 24 questions, of which 12 were demographic in nature. Statistical analysis used is the MANOVA independent variable (dependent children – yes, no) and three

dependent variables (problem solving skills, ability to access social networks, and problem reframing). The advantage of utilizing questionnaires is the efficacy of gathering data from a sample of people to hopefully generalize about the larger population of homeless women.

Data Collection Procedures

The survey was administered in person to shelter participants by a licensed clinical social worker. Shelter participants were informed about the purpose of the study, confidentiality, and review of participation consent. Surveys were numbered and administered to participants.

Treatment of the Data

The Statistical Package for the Social Sciences (SPSS) Version 24 was used to analyze the data. The analysis included two parts: (a) description of the sample – n and % of responses to the demographic questions and (b) MANOVA and ANOVA to examine the relationship between the independent variable (dependent children – yes, no) and three dependent variables (the problem-solving skills, ability to access social networks, and problem reframing). MANOVA was used to determine if there is a difference between the two groups when there is more than one dependent variable. Coping skills were comprised of three variables (the problem-solving skills, ability to access social networks, and problem reframing). After the MANOVA has been calculated, individual ANOVAs used were conducted for each dependent variable.

Prior to evaluating the differences between homeless women without dependent children and women with dependent children, the data examined whether the assumptions

for MANOVA were supported. The first assumption is that the observations are independent. The women filled out the survey independently; therefore, this assumption was supported. The second assumption is that the dependent variables (coping strategies operationalized as problem solving skills, accessing social networks, problem reframing), are moderately correlated. The intercorrelations between the dependent variables were calculated. If the intercorrelations were at least moderate, this assumption will be supported. The third assumption is that the variables are normally distributed. This assumption was tested using the skewness statistic. If the variable distribution skewness statistic is between -1 and +1 the distribution is approximately normally distributed. If the skewness statistics for the dependent variables fall between -1 and +1, the third assumption will be supported. The fourth assumption is homogeneity of variance. Levene's test for equal variances was used to test the null hypothesis that the variances are equal. If the *p*-values for all the variables are greater than .05, the null hypothesis will not be rejected and the assumption of homogeneity of variance will be supported. The fifth assumption is that the covariance matrices are equal. This will be tested using Box's test. Box tests the null hypothesis that the covariance matrices are equal. If the *p-value* is greater than .05, the null will not be rejected, indicating the covariance matrices are equal and this last assumption will be supported.

Limitations of the Study

There were several limitations of this study. First there was a lack of reliability among the questions used in the coping inventory. The sample size (196) did not allow the researcher to generalize regarding the overall population of homeless women

with/without dependent children. Another limitation is the hypotheses have not been studied in previous research studies. This study used a nonprobability sampling which excludes the ability to estimate the probability of any one element being included in the sample. There is no assurance that each item has a chance of being included, making it impossible either to estimate sampling variability or to identify possible bias.

CHAPTER IV

PRESENTATION OF FINDINGS

The purpose of this chapter is to present the findings of the study in order to describe and explain the coping strategies among homeless females with and without dependent children. The findings are organized into two sections: Demographic profile of participants and analysis of research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to analyze the age, gender, ethnicity, education, marital status, income, government benefits, mental health diagnosis, substance use, religious preference, and number and ages of children of the study group ($n=192$).

The target population for the research was composed of residents of homeless shelters within metro Atlanta and several surrounding counties: Athens, Bartow, Clark and Cobb. There were 11 shelters surveyed with a combined census of 1,806 residents. One hundred and ninety-six responded (64 mothers who have their dependent children living with them and 132 women who did not have dependent children living with them). Of the 196 respondents, four responded “never” to all the questions on the coping inventory. These four were eliminated from the study.

The total sample size for the analyses therefore was 192. There were 12 questions on the first part of the survey which dealt with respondents' demographic information. The 12 questions were divided into four sections: Personal (#1, #2, #3, #9); family (#4, #5, #6); children (#10, #11); and health (#7, #8).

Age

Women whose children lived with them: the highest percentage of respondents was 50 or older (36.5%), followed by the percentage of respondents between 30 and 39 (28.6%), and those between 30 and 40 (20.6%). The smallest percentage of the respondents was less than 30 (14.3%). Among women who did not have dependent children living with them: the highest percentage of respondents was 50 or older (38.0%), followed respondents less than 30 (23.3%), those between 30 and 39 (20.2%), and between 40 and 49 (18.6%). The percentages of respondents were about the same for all the age groups, except that there were a higher percentage of the women who did not have children living with them than those who have children living with them who are less than 30 years old.

Ethnicity

Of the women whose children lived with them, the majority of the respondents were African American (47.6%) followed by Caucasian (28.6%) and Asian (15.9%). The smallest percentages of respondents were Hispanic (7.9%). Of the women who did not have dependent children living with them, the majority of the respondents were African American (65.9%) followed by Caucasian (24.0%) and Asian (7.0%). The smallest percentages of respondents were Hispanic (3.1%). The percentage of African-American

women who did not have children living with them is higher than African-American women who did have children living with them. The percentages for the other three ethnicities were about the same for both groups of women.

Education

Of the women whose children lived with them, the majority of the respondents with some college education was (38.1%), followed by high school graduates (27.0%). The smallest percentage of respondents had some high school (17.5%) and a college degree (17.5%). The majority of the women who did not have dependent children living with them had some college education (39.5%), followed by high school graduates (26.4%), and those with some college degree (25.6%). The smallest percentage of the respondents had some high school education (8.5). A greater percentage of women without dependent children had graduated from college, some college (91.5) in contrast to women who did not have dependent children (82.6).

Religious Preference

Most of the women whose children lived with them were Christian (71.4%), followed by Other (14.3%) and no preference (11.1%). The smallest percentages were Jewish (1.6%) or Muslim (1.6%). Of the women who did not have dependent children living with them, most of the respondents were Christian (62.8%) followed by no preference (20.9%). The smallest percentages were Other (10.1%), Jewish (0.8%) or Muslim (5.4%). The percentages of the religious preference categories were about the same for both groups. Of interest is the fact that there was a higher percentage of women with no children living with them who have no religious preference (see Table 2).

Table 2

Personal Demographic Characteristics of Respondents, n = 192

Variable	<u>Dependent children live with her</u>		<u>No dependent children with her</u>	
	N	% ^a	n	% ^b
Age				
Less than 30	9	14.3%	30	23.3%
30-39 years	18	28.6%	26	20.2%
40-49 years	13	20.6%	24	18.6%
50 years or older	23	36.5%	49	38.0%
Ethnicity				
African American	30	47.6%	85	65.9%
Caucasian	18	28.6%	31	24.0%
Hispanic	5	7.9%	4	3.1%
Asian	10	15.9%	9	7.0%
Education				
Some High School	11	17.5%	11	8.5%
High School Grad	17	27.0%	34	26.4%
Some college	24	38.1%	51	39.5%
College degree	11	17.5%	33	25.6%
Religious Preference				
Christian	45	71.4%	81	62.8%
Muslim	1	1.6%	7	5.4%
Jewish	1	1.6%	1	0.8%
Other	9	14.3%	13	10.1%
No preference	7	11.1%	27	20.9%

^aPercents represent respective variable levels for women with dependent children living with them.

^bPercents represent respective variable levels for women who do not have dependent children living with them.

Marital Status

Of the women whose children lived with them, most of the respondents were never married (45.3%) followed by divorced (34.4%). The smallest percentages of the respondents were married (12.3%) or widowed (7.8%). Of the women who did not have dependent children living with them, most the respondents were never married (51.2%) followed by divorced (30.2%). The smallest percentages were of the respondents who were married (14.0%) or widowed (4.7%). The percentages for both groups were similar. Most of both respondent groups were never married or divorced (see Table 3).

Last Annual Income

Of the women whose children lived with them, most of the respondents' income was \$25,000 or less (82.5%). A smaller percentage of the respondents' income was between \$25,000 and \$34,999 (12.7%) or between \$35,000 and \$44,999 (4.8%). None of the respondents' income was over \$45,000. The majority of the women who did not have dependent children living with them have an income of \$25,000 or less (78.3%). A smaller percentage of the respondents' income was between \$25,000 and \$34,999 (13.2%) or between \$35,000 and \$44,999 (3.9%) or greater than \$45,000 (4.7%). The percentages for both groups were similar. Most of both groups had an annual income of less than \$25,000. Although none of the women who had children living with them had an income greater than \$45,000, a small percentage of the women who did not have children living with them did have an income greater than \$45,000 (see Table 3).

Table 3

Family Demographic Characteristics of Respondents, n = 192

Variable	<u>Dependent children live with her</u>		<u>No dependent children with her</u>	
	<i>n</i> = 63		<i>n</i> = 129	
	N	% ^a	n	% ^b
Marital status				
Married	8	12.5%	18	14.0%
Never married	29	45.3%	66	51.2%
Divorced	22	34.4%	39	30.2%
Widow	5	7.8%	6	4.7%
Last annual income				
Under \$25,000	52	82.5%	101	78.3%
\$25,000-\$34,999	8	12.7%	17	13.2%
\$35,000-\$44,999	3	4.8%	5	3.9%
\$45,000 or more	0	0.0%	6	4.7%
Government Benefits ^c				
SNAP	37	58.7%	73	56.6%
TANF	7	11.1%	8	6.2%
SSI	11	17.5%	14	10.9%
Social Security	4	6.3%	5	3.9%
None	14	22.2%	36	27.9%

^aPercents represent percent of respective variable levels for women with dependent children living with them.

^bPercents represent percent of respective variable levels for women who do not have dependent children living with them.

^cRespondents may choose more than one benefit.

Government Benefits

Of the women whose children lived with them, most receive SNAP (58.7%) followed by no benefits (22.2%). Smaller percentages of the respondents received SSI (17.3%), TANF (11.1%), or Social Security (6.3%). Of the women who did not have dependent children living with them: most of the respondents received SNAP (56.6%) followed by no benefits (27.9%). Smaller percentages of these respondents received SSI (10.9%), TANF (6.2%), or Social Security (3.9%). The percentages of both groups who received government benefits were similar. More than half of both groups received SNAP benefits (see Table 3).

Number of Children

Regarding women with dependent children, the majority of the respondents had one or two children (58.7%) followed by three or four children (28.6%), or five or more (12.7%). Most women did not have dependent children living with them had one or two children (45.0%) followed by no dependent children (31.0%), three or four children (14.7%), or five or more (9.3%). Most women of both groups had one or two children (see Table 4).

Children's Ages

Of the women whose children lived with them, many of the respondents had children five years old or older (79.4%), followed by two through five years (17.5%), seven through 12 months (9.35%), and six months or less (7.9%).

Table 4

Children's Demographic Characteristics of Respondents, n = 192

Variable	<u>Dependent children live with her</u>		<u>No dependent children with her</u>	
	<i>n</i> = 63		<i>n</i> = 129	
	N	% ^a	n	% ^b
Number of children				
None	0	0.0%	40	31.0%
1 – 2	37	58.7%	58	45.0%
3 – 4	18	28.6%	19	14.7%
5 or more	8	12.7%	12	9.3%
Children's Ages ^c				
6 months or less	5	7.9%	1	7.8%
7-12 months	6	9.5%	17	13.2%
2-5 years	11	17.5%	21	16.3%
5 years and older	50	79.4%	61	47.3%
NA	0	0.0%	42	32.6%

^aPercents represent percent of respective variable levels for women with dependent children living with them.

^bPercents represent percent of respective variable levels for women who do not have dependent children living with them.

^cRespondents may choose more than one benefit.

Of the women who did not have dependent children living with them, most of the respondents had children five years old or older (47.3%), followed by two through five years (16.3%), seven through 12 months (13.2%), and six months or less (7.8%). There were respondents with no children (32.6%). The percentages in the children's age groups of both groups who had children were about the same. Most of both groups had children who are five years old or older (see Table 4).

Mental Health Diagnosis

Of the women whose children lived with them, many of the respondents were diagnosed with depression (54.0%), followed by no diagnoses (34.9%). Smaller percentages were diagnosed with anxiety (25.4%), bipolar disorder (19.0%), or schizophrenia (4.8%). Most of the women who did not have dependent children living with them were not diagnosed with any mental disorder (57.4%), followed by depression (30.2%). Smaller percentages were diagnosed with anxiety (14.7%), bipolar disorder (10.1%), or schizophrenia (6.2%). Of interest is that many of the women with children living with them were diagnosed with depression, whereas the majority of the women who did not have children living with them were not diagnosed for any mental disorder (see Figure 1).

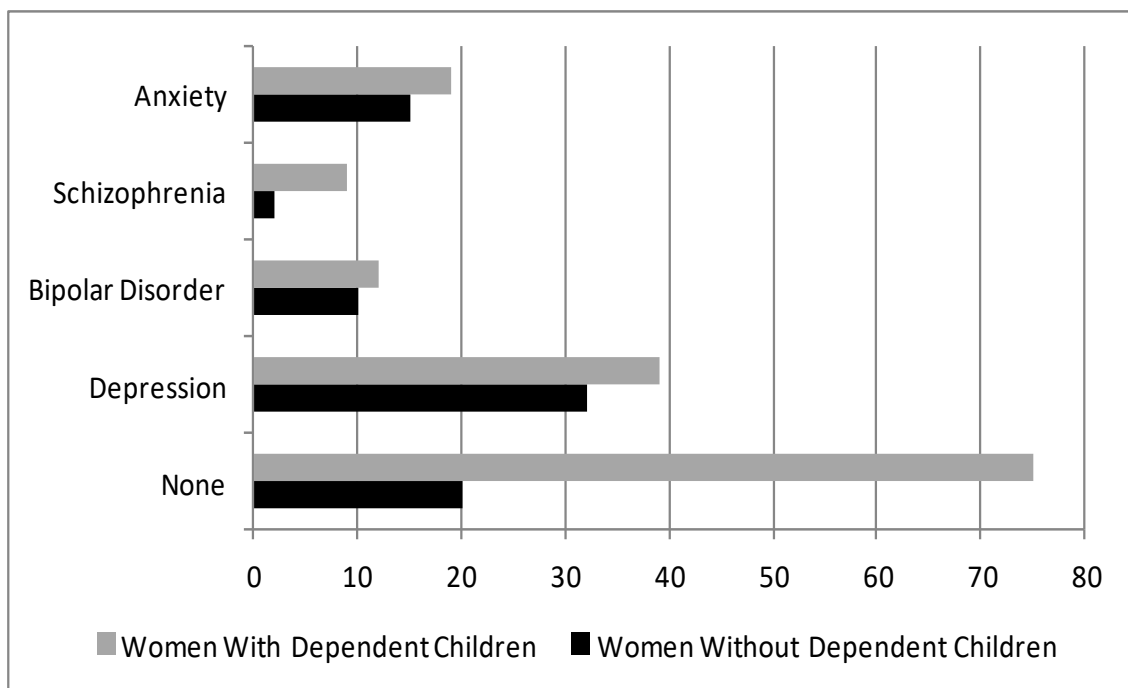


Figure 1. Mental health characteristics of respondents, $n = 192$.

Alcohol/Substance Abuse

Women whose children lived with her: 19% of the respondents indicated they use alcohol or substance. Women who did not have dependent children living with her: only 5.4% of these respondents indicated they use alcohol or substances. A higher percentage of women who had children living with them indicated they use alcohol or substances (see Figure 2).

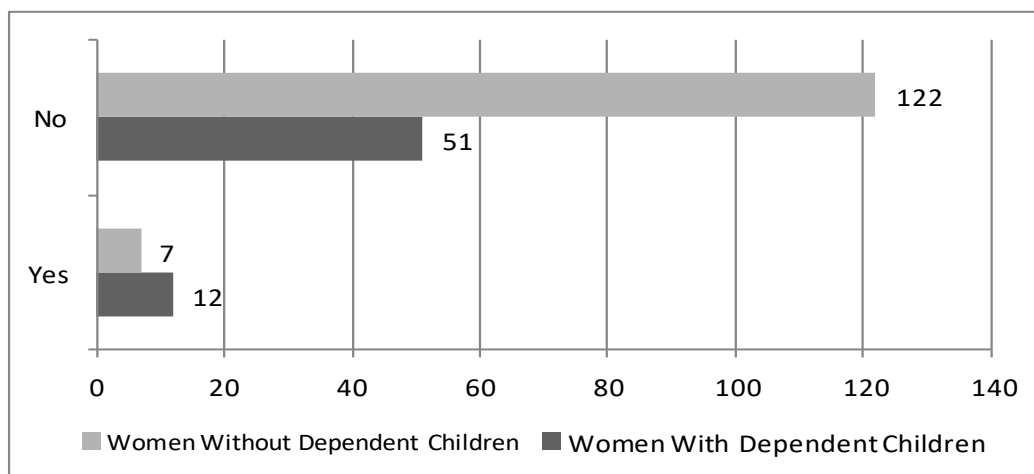


Figure 2. Alcohol and drug use of respondents, $n = 192$.

Summary of Findings

Research Questions and Hypotheses

RQ1: Is there a difference in the coping strategies between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?

Ho1: There is no difference in the coping strategies between homeless women with children and homeless women without children in Atlanta, Georgia.

- H_{A1}: There is a difference in the coping strategies between homeless women with children and homeless women without children in Atlanta, Georgia.
- RQ2: Is there a difference in the problem-solving skills between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?
- H₀₂: There is no difference in the problem-solving skills between homeless women with children and homeless women without children in Atlanta, Georgia.
- H_{A2}: There is a difference in the problem-solving skills between homeless women with children and homeless women without children in Atlanta, Georgia.
- RQ3: Is there a difference in the ability to access social networks between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?
- H₀₃: There is no difference in accessing social networks between homeless women with children and homeless women without children in Atlanta, Georgia.
- H_{A3}: There is no difference in accessing social networks between homeless women with children and homeless women without children in Atlanta, Georgia.

RQ4: Is there a difference in problem reframing between homeless women with dependent children and homeless women without dependent children in Atlanta, Georgia?

Ho4: There is no difference in problem reframing between homeless women without children and homeless women without children in Atlanta, Georgia.

H_A4: There is a difference in problem reframing between homeless women without children and homeless women without children in Atlanta, Georgia.

Statistical Analysis

For Ho1, MANOVA was used to test for differences between homeless women with children and homeless women without children in their scores on the Coping Strategies Inventory scales (problem solving skills, problem reframing, and ability to access social networks) (see Table 5). There were three dependent variables for this study. Following the calculation of the MANOVA to see how the composite of the three dependent variables differs between the two groups of women, Univariate ANOVAs were conducted to look at each dependent variable individually (H2, H3, H4).

Table 5

MANOVA Test for Coping Scales

Scale	<i>F</i>	Df	<i>Sig</i>	Wilk's Λ	η^2
Children live with participant	1.333	3,188	.265	.979	.021

Mean and Standard Deviation

The mean and standard deviation was determined for all three dependent variables: the ability to access social networks, problem solving, and problem reframing. The mean for the variable ability to access social networks was gathered from mean responses to items #13 – #16 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never. The minimum response was 1.00 indicating some of the women are always able to access social networks. The maximum response was 4, indicating some of the women are never able to access social networks. The mean for the women who did not have children living with them was 2.66 (SD = .66) and for the women who did have children living with them the mean was 2.52. Both groups' means fell between often and rarely able to access social networks (see Table 6).

The mean for problem solving skills was derived from responses to items #17 – #20 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never. The minimum response was 1.00 indicating some of the women always use problem-solving skills. The maximum response was 4 indicating some of the women never used problem-solving skills. The mean for the women who did not have children living with them was 1.74 (SD = .66) and for the women who did have children living with them the mean was 1.65 (SD = .63). Both groups' means fell between always and often use problem-solving skills.

Table 6

Means/Standard Deviations: Overall Coping Scores

Scale	Min	Max	Mean	SD
No dependent children live with the respondent, $n = 129$				
Access social support	1.00	4.00	2.66	0.66
Problem-solving	1.00	4.00	1.74	0.66
Problem reframing	1.00	4.00	1.70	0.66
Overall	1.00	3.67	2.03	0.49
Dependent children live with the respondent, $n = 63$				
Access social support	1.00	4.00	2.52	0.64
Problem-solving	1.00	3.50	1.65	0.63
Problem reframing	1.00	4.00	1.73	0.75
Overall	1.33	3.58	1.97	0.47

The mean for problem reframing was calculated from responses to items #21 – #24 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never. The minimum response was 1.00 indicating some of the women always use problem reframing. The maximum response was 4 indicating some of the women never use problem reframing. The mean for the women who did not have children living with them was 1.70 (SD = .66) and for the women who did have children living with them the mean was 1.73 (SD = .75). Both groups' mean fell between always and often use problem reframing.

The mean for the overall coping score reframing was calculated from the mean response to items #13 – #24 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the twelve items were summed and divided by 12. The response scale was 1=always, 2=often, 3=rarely, 4=never. The minimum response was 1.00 indicating some of the women always used coping strategies. The maximum response was 4 indicating some of the women never used coping strategies. The mean for the women who did not have children living with them was 2.03 (SD = .49) and for the women who did have children living with the mean was 1.97 (SD = .47). Both groups' means fell within the often use coping strategies category.

Inferential Tests

There were several assumptions that required support to continue with prescribed inferential tests. The first assumption was that two or more dependent variables should be measured at the interval or ratio level (i.e., when they are continuous). The scores for the dependent variables were the mean response to the questions. The mean response was a continuous variable. Thus, this assumption was supported. The second assumption was that the independent variable should consist of two or more categorical, independent groups. The independent variable was whether the women have dependent children living with them. The responses were *yes* or *no*, which made this variable a categorical variable. Thus, this assumption was supported. The third assumption was that the independence of observations, which means that there was no relationship between the observations in each group or between the groups themselves. The women completed the questionnaire independently. Thus, this assumption was supported. The fourth assumption required an

adequate sample size. G*Power was used to do a power analysis to determine the desirable sample size. With a medium effect size ($f^2 = .0625$), alpha of .05, power ($1-\beta$) of .80, two groups, and three variables the estimated sample size would be 180. The sample size was 192 which was adequate. Thus, this assumption was supported. The fifth assumption required that there were no univariate or multivariate outliers. The Outlier Labeling Rule (Hoaglin & Iglewicz, 1987) was used to determine if there were any outliers in the coping strategy scale distributions. The minimum and maximum values for all three subscales and the overall score of the distributions were within the lower and upper lower limits calculated using the outlier labeling formulas. Therefore, there are no outliers in these distributions. Thus, this assumption was supported (see Table 7).

Table 7

Outliers in the Distribution for Overall and Subscale Scores

Score	Q1	Q3	Min	LL	Max	UL
Problem-solving	1.25	2.50	1.00	-1.50	4.00	5.25
Access social support	2.25	3.00	1.00	.60	4.00	4.65
Problem reframing	1.00	2.00	1.00	-1.20	4.00	4.20

Note: Q1 = 25th percentile or first quartile, Q3 = 75th percentile or third quartile, Min = minimum, LL = lower limit, Max = maximum, UL = upper limit.

The sixth assumption required multivariate normality. Three of the variables (overall coping score, problem-solving skills, and ability of access social networks) had a skewness statistic between -1 and +1. Problem reframing had a skewness of 1.080, not large. As skewness for three of the variables were within the desired range, the

assumption of approximate normality was supported for these three variables. Overall, the F test was robust to non-normality, if the non-normality is caused by skewness rather than by outliers (see Table 8). As problem reframing did not have outliers, the analysis will continue.

Table 8

Skewness of the Coping Strategies Inventory

Scale	Skewness
Overall coping score	.810
Problem solving skills	.989
Ability to access social networks	-.376
Problem reframing	1.080

The next assumption required a linear relationship between each pair of dependent variables for each group of the independent variable. Most of the intercorrelations were significant indicating the variables are related. For the group who did not have dependent children living with them the correlation of ability to access social networks and problem-solving skills ($r = .154$) was significant. For the group who did have dependent children living with them the correlations of ability to access social networks with problem solving ($r = .059$) was insignificant and problem reframing ($r = .112$) was significant. This assumption was not completely supported. The power of the test was reduced slightly. The next assumption required that there was no multicollinearity. As shown in Table 9, none of the correlations were greater than .9. This assumption was supported.

Table 9

Intercorrelations among the Coping Inventory Scales

Scale	1	2	3	4
No dependent children living with the woman				
1. Ability to access social networks	---	0.154	.234**	.615**
2. Problem solving skills		---	.661**	.803**
3. Problem reframing			---	.840**
4. Overall coping score				---
Dependent children living with the mother				
1. Ability to access social networks	---	0.059	0.112	.536**
2. Problem solving skills		---	.527**	.747**
3. Problem reframing			---	.810**
4. Overall coping score				---

** . Correlation is significant at the 0.01 level (2-tailed).

The Box's M test of equality of variance-covariance matrix was used to test the homogeneity of variance-covariance matrices. The Box M tests the null hypothesis that the observed variance-covariance matrices of the dependent variables are equal across groups. As the p value is greater than .05 the null hypothesis that there is homogeneity of the variance-covariance matrix is retained (see Table 10).

Table 10

Box's Test of Homogeneity

Statistic	Value
Box's M	7.078
F	1.156
df1	6
df2	100399.160
Sig.	0.327

Dependent Variables

For the ability to access social networks, the mean response was from items #13 – #16 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never. For problem solving skills the mean response was from items #17 – #20 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never. For problem reframing the mean response was from items #21 – #24 on the Coping Strategies Inventory. To calculate the mean response, the participant responses to the four items were summed and divided by 4. The response scale was 1=always, 2=often, 3=rarely, 4=never.

MANOVA

Ho1: There was no difference in the coping strategies between homeless women with children and homeless women without children in Atlanta, Georgia.

This hypothesis was retained.

There was no statistically significant difference in coping skills based on if dependent children live with the participant, $F(3, 188) = 1.333, p = .352$; Wilk's $\Lambda = 0.979$, partial $\eta^2 = .021$.

Univariate (ANOVA)

There was no statistically significant difference in any of the coping scales between women who had dependent children living with them and those who did not. Access to social networks, $F(1, 190) = 1.986, p = .160$, partial $\eta^2 = .010$; problem-solving, $F(1, 190) = 0.735, p = .392$, partial $\eta^2 = .004$; problem reframing $F(1, 190) = 0.095, p = .759$, partial $\eta^2 = .000$ (see Table 11).

Table 11

Univariate Test of Coping Scales

Scale	df	MS	F	Sig.	η^2
Source: Dependent children living with participants					
Access social support	1	0.843	1.986	0.160	0.010
Problem-solving	1	0.310	0.735	0.392	0.004
Problem reframing	1	0.045	0.095	0.759	0.000

Table 11 (continued)

Scale	df	MS	F	Sig.	η^2
Source: Error					
Access social support	190	0.424			
Problem-solving	190	0.422			
Problem reframing	190	0.472			

Ho2: There was no difference in the problem-solving skills between homeless women with children living with them and homeless women without children living with them in Atlanta, Georgia.

This null hypothesis was retained: $F(1, 190) = 0.735, p = .392$. The mean response for the women who did not have children living with them was 1.74 ($SD = .66$) and for the women who did have children living with them was 1.65 ($SD = .63$). The response scale for the Coping Strategies Inventory was 1=always, 2=often, 3=rarely, 4=never. A mean of 1.74 or 1.65 indicated the women used the problem-solving skills between always and often (see Table 12).

Table 12

Means/Standard Deviations for Coping Subscale Scores

Scale	Mean	SD
No dependent children live with the respondent, $n = 129$		
Access social support	2.66	0.66
Problem-solving	1.74	0.66
Problem reframing	1.70	0.66

Table 12 (continued)

Scale	Mean	SD
Dependent children live with the respondent, $n = 63$		
Access social support	2.52	0.64
Problem-solving	1.65	0.63
Problem reframing	1.73	0.75

Ho3. There was no difference in accessing social networks between homeless women with children and homeless women without children in Atlanta, Georgia.

This null hypothesis was retained: $F(1, 190) = 1.986, p = .160$. The mean response for the women who had children living with them was 2.52 ($SD = .64$) and for the women who did not have children living with them was 2.66 ($SD = .66$). The response scale for the Coping Strategies Inventory was 1=always, 2=often, 3=rarely, 4=never. A mean of 2.52 or 2.66 indicated the women access social networks between often and rarely.

Ho4. There was no difference in problem reframing between homeless women with children living with them and homeless women without children living with them in Atlanta, Georgia.

This hypothesis was retained: $F(1,190) = 0.095, p = .759$. The mean response for the women who had children living with them was 1.73 ($SD = .75$) and for the women who did not have children living with them was 1.70 ($SD = .66$). The response scale for

the Coping Strategies Inventory was 1=always, 2=often, 3=rarely, 4=never. A mean of 1.70 or 1.73 indicated the women use problem reframing between always and often.

CHAPTER V

DISCUSSION AND IMPLICATIONS OF FINDINGS

This research study was designed to answer four questions concerning coping strategies among homeless women with and without dependent children living with them. The discussion and implications of the findings are presented in this chapter. Implications of findings are proposed for future discussion for policymakers.

Literature Comparison

There are several significant findings from the literature review. There is limited literature that compares the two groups of homeless women with dependent children living with them and homeless women without dependent children living with them. There is no study that has addressed the variables surveyed in this research—that is, comparing homeless women with and without children regarding coping strategies (accessing social networks, problem solving, and problem reframing). There are several studies that partially review elements of this research. The existing studies have compared both groups as it relates to problems with health, mental health, and accessing social supports (Chambers et al., 2014; Page & Nooe, 2002) and issues of victimization, stress, mental health, and accessing social supports between similar groups; homeless and housed mothers (Anderson & Koblinsky, 1998; Banyard & Graham-Bermann, 1998; Glick, 1996; Letiecq et al., 1998; Goodman, 1991; Welch-Lazoritz et al., 2015).

In some of these studies, most of the women with children living with them were diagnosed with depression, whereas most of the women who did not have children living with them were not diagnosed for any mental disorder. This contradicts the findings of this study; both homeless women with dependent children and those without dependent children are likely to have poor mental health status (Chambers et al., 2014). Other studies state that both groups cluster together around mental health issues (Page & Nooe, 2002). The current study found that women who did not have dependent children had a smaller (5.4%) amount of alcohol and substance abuse problems than did women with dependent children (19%). The current literature cited women with dependent children living with them as having lower substance use than did women without dependent children (Chambers et al., 2014).

There were also literature comparisons as it relates to age and depression. The number of women who are on the brink of homelessness or become homeless (often for the first time) in middle to older ages has been increasing in most developed economies (Davis-Berman, 2011; Johnson & Kreuger, 1989; Travia & Webb, 2015). This is supported by the current study; most of the women surveyed from both groups, women with children and women without dependent children living with them, were 50 years of age or older. Homeless mothers experience disproportionately high rates of major depressive disorders compared to the general population (Bassuk & Beardslee, 2014), which is consistent with this current study that found women whose children lived with them were diagnosed with depression (54%), greater than women who were without children living with them.

Children have been cited as being a source of support and emotional motivation and can provide access to benefits and social services for their homeless mothers; homeless women are also committed to their parental role (Buckner et al., 1993; Holtrop, McNeil & McWey, 2015; Ruttan, Laboucane-Benson, & Munro, 2012;). In this study, there was no difference in the coping strategies between homeless women with dependent children and homeless women without dependent children.

Study Limitations

Several limitations of this study are evident. First, this study was exploratory with no previous substantive research to provide direction. There was no statistical difference in the coping strategies between homeless women with dependent children and homeless women without dependent children. Second, the number of homeless women without dependent children were more than two thirds compared to the number of homeless women with dependent children. Third, for homeless women who did not have dependent children living with them, there was a greater correlation between ability to access social networks and problem-solving skills ($r=.154$). For homeless women who did have dependent children living with them, there was less of a correlation between the ability to access social networks with problem solving ($r=.059$) and problem reframing ($r=.112$). This assumption was not completely supported and the power of the test was reduced. The fourth limitation is the use of a nonprobability sampling technique in which the entire population of the female homeless population in Georgia was not sampled. This decreases the ability to generalize its results to the entire population. Despite these limitations, this study sheds light on an issue that had not been studied by experts, yet

assumptions were made regarding the differences and/or similarities between both groups of women. This study addresses a gap in the literature regarding comparison of both homeless mothers with dependent children and homeless women without dependent children. The study had an adequate sample size of 192, which was beyond the recommended power analysis of 180.

Conclusions

The current findings indicate that there is no difference between the coping strategies employed by homeless women with dependent children and homeless women without dependent children. There were several differences between the two groups with regards to demographic factors. The percentages of respondents were closely similar for all the age groups except that there was a higher percentage of the women who do not have children living with them than those who have children living with them, who were less than 30 years old. This was contrary to national statistics that documented 8% of the homeless population was under the age of 24 (HUD, 2016). This is an opportunity for future research to investigate causal relationships that impact this conclusion.

Several of this study's results were consistent with current literature. One similarity was with the number of women with dependent children with high school through college education was higher than for women who did not have children living with them during homelessness. This was consistent with a recent study where two-thirds of the sample where homeless women with dependent children and 85% of sample had secondary education (Vuillermoz, Vandentorren, Brondeel, & Chauvin, 2017).

There was a higher percentage of women with no children living with them who have no religious preference. A small percentage of women who did not have children had an income greater than \$45,000. More than half of both groups received SNAP benefits. This was indicative of the current restrictive U.S. policies that have placed term limits for TANF benefits, absent from current program requirements for SNAP. Both groups of homeless women access SNAP as the only existing governmental aid available for this disadvantaged population.

The United States has embraced entitlement programs dating back to the Revolutionary War, when the government guaranteed and aided soldiers who were disabled by injuries sustained during wartime. The New Deal and Great Society social insurance and welfare entitlements were created to provide a safety net to aid the elderly, single mothers, the disabled, the unemployed, and people suffering from ill health (Cogan, 2017). This phenomenon of caring for the disadvantaged is not new for this country. Yet the numbers of poor in this country continue to increase. In 2014, 46.7 million people were living in poverty (Varghese, 2016). From an Afrocentric Perspective, this country's current situation requires a balance between providing for the less unfortunate while requiring a sense of personal responsibility, self-sufficiency, and self-improvement.

The current macro level programs, the Earned Tax Credit (ETC), SNAP and TANF that assist with poverty are not sufficient. The \$2.4 trillion the federal government currently spends annually on entitlements equals \$7,500 for every man, woman, and child living in the United States, an amount that is five times the money necessary to lift every

poor person out of poverty (Cogan, 2017). There is a need for the creation of policies that define the needy and programs that limit the provision of supplemental support for the able bodied. A review and reform of one of our country's beloved entitlement programs, Social Security and Medicare is required, as is a revamping of programs based on means, to redefine its requirements that include a review of income. This is a fiscal as well of value laden requirement, to ensure the programs' long-term viability. Social Security beneficiaries who have accumulated financial wealth throughout their lives are entitled to receive for some, up to \$50,000 per year in additional income, while the U.S. poverty rate continues to grow. Most seniors receive, with the combination of Social Security and Medicare benefits, more than what they contributed to the system during their working years.

Social Work Profession

The profession of social work advocates for practitioners to engage in research. Although this study noted no difference in coping between the two groups of homeless women, further research is warranted. Parenting is a crucial function of a society; providing for the socialization of children who will eventually function as productive citizens. This difficult and complex task is performed in often demanding situations with limited personal and physical resources, which can lead to parental stress (Abidin, 1990). Parental stress is a motivational variable which catapults parents to seek and utilize resources to support them in their parenting (Abidin, 1992). This supports the hypothesis construction that homeless women with dependent children would be motivated and exercise greater coping skills for the sake of their children. Additional research is needed

to study the factors that alter this phenomenon—possibly unresolved, unmentioned trauma. Social workers can engage in additional research to explore the benefits of coping strategies training among various underserved populations. The profession can also encourage policy makers to look at entitlement programs and create additional policies to fund homeless resources, in addition to the current McKinney Vento legislation and increase funding for HUD and Section 8 Housing vouchers.

Georgia policy makers would benefit from an assessment of resource allocations and review current policies that prohibit access to female homeless shelters during the weekend. Policy makers need to address the evolving change in the composition of homeless families that now includes single fathers and their children. This small but growing phenomenon was observed at several of the metro Atlanta family shelters during this study. With the recent closing of one of the largest homeless shelters in Atlanta, policymakers need to formulate action plans to address the vast numbers of homeless in the city and provide shelter, which is a basic human right, as outlined in the Afrocentric Perspective. Georgia, specifically the city of Atlanta, needs to address the lack of access of homeless shelters for women with and without children during the weekend hours.

APPENDIX A

Questionnaire

A Comparison Study of Coping Skills among Homeless Single Women and Women with Children

Jennifer Talley, LCSW-School of Social Work PhD Program-Clark Atlanta University

Section I: Demographic Information:

Instruction: Place a mark (X) next to the item which best describes you. Choose only one for each question.

1. Age Group: 1) Under 30 2) 30-39 3) 40-49 4) 50 & Over
2. Ethnicity: 1) African-American 2) Caucasian 3) Hispanic 4) Asian 4) Other
3. Education: 1) Less than High School 2) High School Grad 3) Some College
4) College Degree
4. Marital Status: 1) Married 2) Never Married 3) Divorced 4) Widow
5. Last Annual Income: 1) Less than \$25,000 2) \$25,000-\$34,999 3) \$35,000-\$44,999
4) \$45,000 and up
6. Government Benefits: 1) SNAP 2) TANF 3) SSI 4) None
7. Mental Health Diagnosis: 1) No Mental Health Diagnosis 2) Depression
3) Bipolar Disorder 4) Schizophrenia 5) Anxiety
8. Alcohol/Substance Use: 1) Yes 2) No
9. Religious Preference: 1) Christian 2) Muslim 3) Jewish 4) Other
5) No Religious Preference
10. Children: 1) 0 2) 1-2 3) 3-4 4) 5 or more
11. Ages of Children: 1) Less than 6 months 2) 7-12 months 3) 2- 5 years
4) 5 and older
12. Are Your Children with You: 1) Yes 2) No

Please turn over

Section II: People respond in different ways when they are faced with a difficult or stressful issue in life. The questionnaire invites you to respond how you cope when you experience a stressful event. Place an (X) in the box that represents your response. Please respond to all questions.

	Always	Often	Rarely	Never
13. I seek advice about the issue from people close to me.				
14. I talk to professional people for help with the issue (therapist, doctor, minister, social worker).				
15. I ask for help from others to tackle the problems associated with the issue.				
16. I have asked others to loan me money.				
17. I tried to analyze the problem in order to understand it better.				
18. I make several efforts to address the issue in different ways.				
19. I spend time evaluating my options for resolving the issue.				
20. I made a plan of action and followed it.				
21. I try to be positive and look on the bright side of things in spite of the issue.				
22. I talk to myself in ways that help me see the issues less negatively.				
23. I seek to learn something about myself from the issues.				
24. I made a promise to myself that things would be different next time.				

Thank you !

APPENDIX B

Letter to Participants



Whitney M. Young, Jr.
School of Work

CLARK ATLANTA UNIVERSITY

June 15, 2017

Dear Research Participant,

I am a doctoral student at the Whitney M. Young, Jr., School of Social Work, and I am studying the coping strategies utilized among homeless women; women with children and women without children.

I am requesting access to the homeless women at your shelter/agency. I am asking that female shelter residents complete the attached survey form. Completion of the survey form will only take about two - five minutes of their time. There is no compensation for your participation. **HOWEVER, ALL RESPONDENTS WILL RECEIVE A COPY OF THE FINDINGS ONCE THE STUDY IS COMPLETED.**

All responses will remain anonymous. Residents **DO NOT** write their name on the survey. There is no identifiable information on the survey, aside from some very general demographic questions. All surveys will be held in locked files by the Doctoral Program Chair for a period of three years, consistent with federal regulations. After this time, all data will either remain locked or will be destroyed. Locked data may be used for future publications or research only and no identifiable data on individual participants will be retained.

There are no risks or consequences should you choose to participate in this study. You can discontinue completing the survey at anytime if you choose to do so. Additionally, if you wish to speak with someone about this study, please feel free to contact Dr. Richard Lyle, Chair of the WMYJSSW Doctoral Program at the address, phone number or email address below.

BY COMPLETING AND RETURNING THIS SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS. RETURNING THIS QUESTIONNAIRE INDICATES THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

Jennifer Talley, Doctoral Student
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Formed in 1988 by the consolidation of Atlanta University, 1929, and Clark College, 1929

APPENDIX C

IRB Approval Letter



CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

September 23, 2017

Ms. Jennifer Talley <jennifer.talley@students.cau.edu>
School of Social Work
Clark Atlanta University
223 James P. Brawley Dr. SW
Atlanta, GA 30314

RE: A Comparison of Coping Skills Among Homeless Single Women and Women with Children.

Principal Investigator(s): Jennifer Talley

Human Subjects Code Number: HR2016-8-665-1

Dear Ms. Talley:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Extended Approval Code is HR2016-8-665-1/RA2
Type of Review: Expedited.

This permit will expire on September 23, 2018. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office.

The CAU IRB acknowledges your timely completion of the CITI IRB Training in Protection of Human Subjects – “Social and Behavioral Sciences Track”. Your CITI certification expires on August 3, 2018.

If you have any questions, please contact the IRB Office or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

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