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## Characteristics of Mothers Caring for Children During Episodes of Homelessness

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### Abstract

This study provides a description of the physical, psychological, and substance use problems of adult homeless women who are and are not caring for children. We also examined differences in the characteristics of these two groups of women. Interviews were conducted with 148 homeless women from three mid-sized U.S. cities, 24.3 % of whom were caring for at least one child. Our results showed that women caring for children were more likely to be sheltered and have health insurance. Homeless women caring for children and solitary homeless women were generally similar in terms of substance abuse problems. However, rates of Borderline Personality Disorder were higher among women caring for children than among solitary homeless women. Our results are somewhat consistent with previous research, with the exception of substance abuse problems and mental health problems, which were shown to be equally problematic for all women, regardless of current caregiving status.

### Keywords

Homeless mothers; Substance use; Mental health; Caregiving

### Introduction

Women make up the fastest growing segment of the U.S. homeless population. Of the nearly 1.6 million individuals estimated to have experienced homelessness in 2008, 36 % were women (U.S. Department of Housing and Urban Development 2009). Homeless women differ from homeless men in their circumstances, pathways to homelessness, physical and mental health characteristics, and homelessness-related health risks (Burt and Cohen 1989; Crystal 1984; Hagen 1987; North and Smith 1993; Maurin et al. 1989; Smith and North 1994). The difference between women and men who are experiencing homelessness is

perhaps most pronounced in their attachment to children and families. The number of homeless families increased 9 % between 2007 and 2008, and 81 % of adults in homeless families were women (U.S. Department of Housing and Urban Development 2009).

Homeless women are typically divided into two subgroups: *solitary* and *with children* (Burt and Cohen 1989; Johnson and Krueger 1989; Smith and North 1994). Estimates of homeless women with children range from 65 to 84 % (Zlotnick et al. 1999). Pregnancy and caring for dependent children complicates risk factors and enhances the stress associated with episodes of homelessness and finding housing (Webb et al. 2003). This report documents these risks and stressors by providing a descriptive account of pregnancy, child caregiving, physical health, mental health, and substance use disorders among 148 homeless women aged 19–54 years in three U.S. cities (Portland, OR, Pittsburgh, PA, and Omaha, NE).

## Pregnancy, Children, and Homelessness

Homeless women are more likely to be pregnant than housed women living in poverty (Weinreb et al. 1998) and homeless mothers who are caring for children are more likely to be pregnant or have experienced a recent birth than homeless women who are living without children (Shinn and Weitzman 1996). There is evidence that women who have become homeless, regardless of their caregiving status, lack knowledge about contraception and reproductive health (Gelberg et al. 2004). Additionally, perceived discrimination and judgment from health care practitioners due to homeless status is a substantial barrier to homeless women receiving any medical care (Gelberg et al. 2004). This issue is likely magnified when seeking care for reproductive health because of the especially sensitive nature of this health domain (Gelberg et al. 2004).

Homelessness is traumatic in itself (Goodman et al. 1991), but it could be even more stressful for homeless women with children. These women deal with additional responsibilities associated with protecting, caring for, and maintaining custody of dependent children (Averitt 2003; Cowal et al. 2002). Homeless mothers also experience depressive symptoms and loss of privacy (Meadows-Oliver 2006). Additionally, 37 % of children of mothers who had experienced an episode of homelessness were involved in the child welfare system (Culhane et al. 2003).

## Health

Many researchers report dramatic health disparities associated with homelessness among women (Arangua et al. 2005; Gelberg et al. 2004). Homelessness can affect health via stress (Goodman et al. 1991), victimization (Wenzel et al. 2001b), poor nutrition (Wehler et al. 2004; Whitbeck et al. 2006), access to regular health care (Lewis et al. 2003; Gelberg et al. 2004; Stovall and Flaherty 1994), and access to regular hygiene and other preventive health behaviors (Rosengard et al. 2001). Homeless women have poor access to health care, particularly for contraception (Wenzel et al. 2001a), prenatal care (Webb et al. 2003; Weitzman 1989), perinatal care (Little et al. 2005), and gynecological problems (Wenzel et al. 2001a).

## Mental Health and Substance Abuse

Fear of harm and actual victimization associated with homeless environments create continual distress for women. Psychological repercussions in the form of depressive symptoms, anxiety, self-medication or other stress-related symptoms are to be expected. The most recent large diagnostic study that included homeless women (Smith et al. 1993) in St. Louis indicated that rates of major depression (MD) and posttraumatic stress disorder (PTSD) among homeless women were about twice that of comparable general population samples; approximately one-quarter of homeless women met criteria for MD and about one third met criteria for PTSD. Seventy-two percent met criteria for a least one lifetime psychiatric diagnosis (Smith and North 1994). In the Bassuk et al. (1998) study, homeless women with children were 2.5 times more likely than the general female population to meet criteria for major depressive episode and three times more likely to meet criteria for PTSD.

Prior mental health research comparing subgroups of homeless women with and without children has produced mixed results. Rates of self-reported psychiatric hospitalization appear to be lower for homeless women with children in their care than for homeless women without children (Robertson and Winkleby 1996). Similarly, Smith and North (1994) reported that homeless mothers caring for their children had lower rates of MD, schizophrenia, and panic disorder than did non-mothers and mothers who did not have custody of their children. However, other studies have estimated that homeless women with children have higher levels of depressive symptoms than single homeless women (Burt and Cohen 1989; Robertson and Winkleby 1996). Prior substance use research comparing subgroups has produced a relatively clear picture. Estimated rates of alcohol use, alcohol abuse or dependence, and drug abuse or dependence are lower among homeless women with children than they are among single homeless women (Johnson and Krueger 1989; Shinn and Weitzman 1996; Smith and North 1994).

## Present Study

In this paper we provide descriptive details for a sample of homeless women aged 19–54 years. We also compare the history of homeless episodes, health, and mental health and substance use problems between homeless mothers caring for children and homeless women who are not caring for children. In line with prior research, we expected that in comparison to homeless women who were not living with a child, homeless women caring for a child would report greater levels of stress but lower levels of substance abuse. Given the mixed results from previous studies, we did not forward any hypotheses regarding mental health differences.

## Methods

### Participant Recruitment

Data were collected from homeless women via in-person interviews in three mid-sized U.S. cities (i.e., Omaha, NE, Pittsburgh, PA, and Portland, OR) between August 2010 and May 2011. We utilized a multiple frame sampling approach (Sudman et al. 1988), which has been used to study both regional and national homeless populations in the U.S. (Koegel et al. 1996; Burt and Cohen 1989; Burt et al. 1999; Iachan and Dennis 1993; Rossi et al. 1987;

Smith et al. 1993). In each of the cities, shelters, meal kitchens, and high concentration outdoor areas were enumerated and an estimated measure of population size was obtained. In each of the three sampling frames, locations were selected with probabilities proportional to size to achieve a desired sample size of 100 women in Omaha, 50 women in Portland, and 50 women in Pittsburgh after accounting for eligibility and nonresponse rates. Within selected locations a systematic random sample was taken from lists of bed occupants in shelters, of persons exiting the meal locations, and of persons numbered (left to right, front to back) using a predetermined random start and a skip interval.

Contact letters were sent to selected bed occupants in *shelter locations*, which explained the purpose of the study, included an invitation to participate, and provided contact information for project staff. In *meal* and *outdoor locations*, selected women were approached by a project staff member who explained the purpose of the study and invited them to participate. Individuals were first screened to determine whether they met our definition of homelessness. We defined homelessness based on the criteria used in the Stewart A. McKinney Act of 1987 (HUD 1995), supplemented with the addition of individuals who were “doubling up” (Burt 1996). All homeless women between the ages of 19–54 years were eligible to be selected from shelters; women at meal locations were eligible if they were between the ages of 19–54 years and if they had not stayed in a shelter during the previous week; and women in outdoor locations were eligible if they were between the ages of 19–54 years and had not utilized shelter or meal services during the previous week. This eligibility criterion prevents women from being present on more than one sampling frame and therefore maintains an equal probability of selection. Detailed information regarding participant response rates can be obtained by contacting the authors.

Four survey instruments (World Health Organization-Composite International Diagnostic Interview (WHO-CIDI), personal interview, Event History Calendar, and self-administered questionnaire) were administered in two interview sessions. Each session lasted approximately 2 h and respondents were reimbursed with a \$20 gift card to a local store for each session. The University of Nebraska-Lincoln’s Institutional Review Board approved this study and the authors have no known conflicts of interest. All authors certify responsibility for this manuscript.

## Measures

*Caregiving status* was assessed by asking the woman how many children total she is currently caring for (range 0–5). If she reported that she was caring for at least one child, she was then asked how many were her biological children.

Several health outcomes were measured. First, women were asked whether they had (coded as 1) or had not (coded as 0) experienced twenty different *health problems* (e.g., diabetes or high blood sugar, a stroke, a heart attack, seasonal allergies) during the past year and composite health problems scores were derived by computing the sum of the responses. The women also were asked whether they had *health insurance* coverage during the past month. *Sex work* was assessed by asking the women whether they had or had not ever traded sex in exchange for money. Stress was measured in two ways. First, *victimization on the street* was assessed by asking the women how many times they had been beaten up, robbed, sexually

assaulted or raped, threatened with a weapon, or assaulted with a weapon while homeless and composite victimization on the street scores were derived by computing the sum of the responses. Seven respondents reported that they had experienced victimization on the street “too many times to count” and those responses were recoded to 25, which was the highest numeric response for victimization questions. *Stressful life events* was assessed by asking women if they had or had not experienced 24 stressful events during the past year (e.g., personal injury or illness, death of a family member, arrest) and composite stressful life events scores were derived by computing the sum of these responses.

Mental health outcomes were measured primarily using standardized measures for DSM-IV-TR criterion, with the exception of one variable which measured whether or not the woman had seen a psychiatrist, psychologist, or any other mental health counselor within the past 12 months. Lifetime, past year, and past month Axis I disorders were assessed with the Composite International Diagnostic Interview (CIDI; Kessler et al. 2005a). We report on the following diagnoses: *Post-Traumatic Stress Disorder (PTSD)*, *Major Depressive Episode (MDE)*, *Major Depressive Disorder with hierarchy (MDD)*, *Dysthymia with hierarchy*, and *Bipolar I-II-Sub-threshold Disorders*, *Alcohol Abuse Disorder (without dependence)*, *Alcohol Dependence Disorder*, *Drug Abuse Disorder (without dependence)*, *Drug Dependence Disorder*, and *Nicotine Dependence*. The hierarchy is used for MDD and Dysthymia in order to better align with DSM-IV-TR criteria and for comparisons to nationally representative estimates (Kessler et al. 2005a, b). The Bipolar I-II-sub-threshold variable includes women who met criteria for Bipolar I, Bipolar II, or Bipolar sub threshold disorders, which are mutually exclusive diagnostic categories.

Criteria for two DSM-IV-TR Axis II disorders were assessed; specifically, *Borderline Personality Disorder (BPD)* and *Antisocial Personality Disorder (APD)*. We used a standardized version of the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV; Zanarini et al. 1996), which was developed for the present study to be administered by lay-interviewers (DIPD-IV-S; Armenta et al. 2012). In order to be consistent with the DSM-IV-TR, our standardized adaptation of the DIPD-IV also includes a module to assess adolescent criteria for Conduct Disorder (CD) with onset prior to the age of 15 years. The standardized adaptation of the DIPD-IV assesses past 2-year criteria for BPD and past-year criteria for APD and CD. Given that our study represents the first use of the DIPD-IV-S, diagnostic classifications were derived using a combination of item response theory and latent class analyses (for full details, see the technical report by Armenta et al. 2012). In line with the DSM-IV-TR, final APD diagnoses required classification into the CD and APD diagnosis categories.

In addition, we included a measure of *attempted suicide*, which specifically asked respondents whether they had ever attempted to commit suicide and whether they had attempted to commit suicide within the past 12 months.

## Missing Data and Analytic Approach

The sample for this paper included 148 women (33 sampled from Portland, 36 sampled from Pittsburgh, and 79 sampled from Omaha), all of which completed paper and pencil

interview, which provided full pregnancy and caregiving status information, and the WHO-CIDI instrument which provided diagnostic information. Only 134 women completed our structured adaptation of the DIPD-IV. The results reported in this paper are based on one way ANOVA (for continuous outcomes) and Chi-square tests (for categorical outcomes) to evaluate differences between women caring for dependent children and women who are not currently caring for dependent children. Results of ANOVA or Chi-square tests that indicated statistically significant differences were further examined using ANCOVA or logistic regression, using the control variables of age (in years), number of months homeless, and sheltered status.

## Results

### Demographics and Homeless Experience

The age of the women ranged from 19 to 54 years ( $M = 38.89$  years;  $SD = 10.2$ ). Of the women, 24.3 % ( $n = 36$ ) were caring for at least one dependent child. Caregivers and non-caregivers were equally distributed in all three cities (where 79 women were sampled from Omaha, 33 from Portland, and 36 from Pittsburgh)—the percentage of current caregivers ranged from 21.2 % in Portland to 26.5 % in Omaha ( $\chi^2(2) = 5.63$ ,  $p = .75$ ). Women who were caring for dependent children were significantly younger ( $M = 33.65$  years) than were non-caregiving women ( $M = 40.5$  years),  $F(1, 143) = 12.7$ ,  $p < .001$ . The majority of the women who were interviewed were from shelter locations (89.4 %). All of the caregiving mothers were sampled from shelters while 86.6 % of the non-caregiving women were sampled from overnight shelters,  $\chi^2(1) = 5.31$ ,  $p = .02$ . On average, the entire sample of women had been homeless for 35.9 months ( $SD = 47.94$ ; range 1–333). Women who were caring for children had been homeless for significantly fewer months ( $M = 18.4$ ) than their non-caregiving counterparts ( $M = 41.6$  months),  $F(1, 146) = 6.58$ ,  $p = .01$ . The most highly endorsed reasons for the current homelessness episode included “your drug or alcohol use was causing problems”, “you couldn’t pay the rent”, and “the people you were living with asked you to leave” and these reasons were not statistically different between caregivers and non-caregiving women ( $\chi^2(10) = 6.599$ ),  $p = .76$ .

### Caregiving

Of the 36 women who were caring for dependent children, 18 women (50.0 %) were caring for one child. Eleven women (30.5 %) were caring for two children, 3 (8.3 %) were caring for three children, 3 (8.3 %) were caring for four children, and 1 (2.8 %) was caring for five children. All of the women who were caring for children at the time of interview were caring for their biological children. Due to limitations with the dataset, we do not know whether women who weren’t caring for children at the time of interview ( $n = 113$ ) are women who never had children, mothers with grown children, or mothers whose children are not in their custody. We recognize this limitation, but our focus was on women were caring for children while experiencing homelessness.

### Health and Stress

The average number of health problems that the women reported was 3.28 ( $SD = 2.47$ ; range 0 = 9) and the number of health problems were not significantly different by caregiving

status,  $F(1, 147) = .88, p = .35$ . About one-half of the women (53.2 %) were covered by some type of health insurance within the past month (the majority of this health insurance coverage was from Medicaid). Women who were currently caring for children were significantly more likely to be covered by insurance (82.9 %) than were women who were not caring for children (43.5 %),  $\chi^2(1) = 16.4, p = .000$ . When controlling for age, number of months homeless, and shelter status, women currently caring for children were still significantly more likely to have health insurance ( $\text{Exp}(B) = 4.752, p = .003$ ). Nearly 18 % of the women reported that they had traded sex for money at some point in their lives. Women caring for children and those not caring for children were not significantly different in their lifetime histories of sex work,  $\chi^2(1) = 1.33, p = .25$ . On average, the women reported being victimized 3.19 times while homeless ( $SD = 8.25$ ) and caregiving mothers were equally likely to experience victimization while homeless as solitary women,  $F(1, 147) = .765, p = .38$ . There were no significant differences in the average number of past year stressful life events that the women reported ( $M = 5.99, SD = 3.88, \text{Range} = 0\text{--}15$ ),  $F(1, 147) = .66, p = .42$ .

### Mental Health

The rate of lifetime MDE in the total sample was 47.3 %, the rate of lifetime MDD was 28.4 %, and the rate of lifetime PTSD was 41.9 %. More than one-tenth of the women met diagnostic criteria for BPD (12.4 %) and 7.1 % of the sampled women met diagnostic criteria for APD. Forty percent of the women had attempted suicide at some point in their lives. Rates of these disorders from the past year were also high: 41.2 % of the sample met criteria for MDE, 23.0 % met criteria for MDD, and 29.1 % met criteria for PTSD. About 7 % of the women had attempted suicide within the past year. Nearly two-thirds of the women reported visiting a mental health professional within the past year (65.1 %).

Chi-square tests were performed on each mental health diagnosis to test for significant differences between care-giving mothers and non-caregiving women. The only statistically significant difference in prevalence rates of mental health diagnoses between caregiving mothers and non-caregiving women exists for BPD. Caregiving mothers (24.1 %) were significantly more likely to meet criteria for BPD than non-caregiving women (9.0 %),  $\chi^2(1) = 4.74, p = .03$ . This finding remains robust even after controlling for age, number of months homeless, and shelter status ( $\text{Exp}(B) = 4.473, p = .026$ ).

### Substance Use

For the entire sample of women, the rate of lifetime alcohol abuse was 28.4 % and lifetime alcohol dependence was 26.4 %. More than half (53.4 %) of the women met criteria for lifetime nicotine dependence, 14.9 % met criteria for lifetime drug abuse, and 43.2 % met criteria for lifetime drug dependence. Rates of past year alcohol dependence were 10.8 % and past year drug dependence were 17.6 %. Chi-square tests were performed on each substance use diagnosis to test for significant differences between caregiving mothers and non-caregiving women. There were no statistically significant differences across subgroups for alcohol abuse, however, women who were not caring for dependent children were more likely to meet criteria for lifetime alcohol dependence (30.1 vs. 13.9 %),  $\chi^2(1) = 3.71, p = .05$ , past year alcohol dependence (13.4 vs. 2.8 %),  $\chi^2(1) = 3.18, p = .06$ , and for lifetime

drug dependence (46.9 vs. 30.6 %),  $\chi^2(1) = 2.98, p = .08$ , than were women who caring for their children. However, when controls for age, number of months homeless, and shelter status are included in the logistic regression, no significant differences between women caring for children and solitary women exist for substance use.

## Discussion

Although the majority of the women in our study had experienced at least one pregnancy (91.9 %), most (75.7 %) were not currently caring for dependent children at the time of their interview. Nearly one quarter (24.3 %) of these homeless women were caring for dependent children—this statistic is higher than in other studies (Crawford et al. 2011; Johnson and Krueger 1989; Zlotnick et al. 1999) and may be attributable to a sample design that employed probability selection methods and the wide age range of the women we interviewed. We found that in some ways women who are experiencing homeless episodes with minor children were dissimilar from women experiencing homelessness on their own, though not necessarily better off. The situation of homelessness is undeniably stressful, and our findings indicate that homeless women with children and women who are homeless on their own may deal with stress in different ways. Both women with children and women without children were equally likely to be victimized on the street and they had experienced a comparable amount of stressful life events, health problems, and substance abuse problems.

In dealing with these stresses and other stresses related to experiencing homelessness, women caring for dependent children may internalize the stress in ways that are detrimental to their mental health, specifically in regards to BPD. Our finding that these two distinct groups of women were far more alike than different in regards to mental health diagnoses contradicts some previous findings (Burt and Cohen 1989; Johnson and Krueger 1989; Robertson and Winkleby 1996; Smith and North 1994). These differences may be attributed to our use of the WHO-CIDI diagnostic interview, based on DSM-IV criteria. Prior research has utilized self-reported hospitalization into a mental health facility (Burt and Cohen 1989; Johnson and Krueger 1989; Shinn and Weitzman 1996), visits to a mental health professional (Johnson and Krueger 1989), and distress (CES-D) (Burt and Cohen 1989). While women caring for children were more likely to suffer from BPD than solitary women, for the most part we found that mental health is equally problematic for all the women in this sample.

In contrast to previous studies, we found that both solitary women and women who are caring for dependent children are equally likely to meet criteria for alcohol and substance use disorders, when accounting for shelter status, age, and length of homelessness. Women with children were significantly more likely to be sheltered and be covered by health insurance, both of which could be direct results of the responsibility of caring for the basic needs of a child. Other studies (Lim et al. 2002), have reported similar health insurance coverage, which is a protective factor associated with obtaining preventative care and regular healthcare. The women caring for children had shorter histories of homelessness than solitary women. This may be a function of age and circumstance surrounding becoming homeless.

## Limitations

Our study is limited by the small sample size. Of the 148 women who provided data on their life histories and completed the WHO-CIDI mental health assessment only 36 were caring for at least one dependent child at the time they were interviewed. The resulting lack of statistical power may explain our failure to detect mental health differences between solitary and caregiving women. The study is further limited because it was only administered in English and excluded non-English speaking women and that it did not include any measures of schizophrenia. It is also important to emphasize that the vast majority (89.4 %) of this sample was sheltered and it is possible that unsheltered women have very different experiences of homelessness and of caregiving. Although the study utilized three sampling frames (shelters, meal locations, and outdoor areas), only one woman was sampled from an outdoor area. Other women who were selected in outdoor areas were utilizing meal locations or shelters and thus ineligible. Outdoor areas were also sampled during daylight hours for safety reasons and were not as populated with homeless women as they may have been after dark. This obviously limits the study's generalizability to women who are experiencing homelessness and accessing services (like shelters or meal locations). Finally, our findings are limited in that we could not further differentiate women who weren't caring for children into more distinct groups—these women may have lost custody of their children through divorce or Child Protective Services, they may be mothers to grown children, or they may never have had children.

## Conclusions

Pregnant and childrearing women who are experiencing episodes of homelessness must cope with different responsibilities than women experiencing homelessness on their own. The finding that women with children do not differ in terms of substance abuse disorder or psychiatric diagnosis is noteworthy. Typically, solitary women do not fare as well as those with children (Burt and Cohen 1989; Haber and Toro 2004 for a review; Johnson and Krueger 1989). This coupled with what we view are very high rates of psychiatric disorders is a cause for concern. 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 a bipolar disorder. An additional few were alcohol or drug dependent. Given the immense difficulty of caring for children under the conditions of homelessness, these mental health issues are an enormous liability and provide the “take away” message of the study. These findings have important policy implications—mental health and substance use support should be a priority for service providers, as it affects the health and well-being of these women and the well-being of their children. It really doesn't matter whether these mental disorders are a cause or a consequence of homelessness, it is important for the sake of the children involved that they be addressed.

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