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Experiences Associated with Intervening with Homeless, Substance-abusing Mothers: The Importance of Success

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Abstract

This article documents the experiences of providing housing and supportive services, or ecologically based treatment, to shelter-recruited, substance-abusing homeless women with young children in their care. Among clients, observed experiences related to housing, substance abuse, and health and mental health care are discussed. Among therapists, experiences related to managing the chaotic nature of the client's lives, wanting to manage the client's lives, and frustration with client's life trajectories are reviewed. Observations related to the therapeutic process include the client's relationship to the therapist, balancing the client's independence and need for assistance, and unrealistic expectations among the clients. Recommendations for successfully approaching these clinical situations and experiences are offered. The purpose of this article is to document these therapy experiences to facilitate the work of future teams seeking to intervene in the lives of homeless families through homeless shelters or other settings.

Keywords

homeless families; substance abuse; treatment

Shelters in 88 percent of 24 major cities have to turn away homeless families because of lack of resources (U.S. Conference of Mayors, 2005). The majority of homeless families are headed by single mothers, with rates ranging from 85 percent to 94 percent (Bassuk, Rubin, & Lauriat, 1986; National Center on Family Homelessness, 2006; E. M. Smith, North, & Fox, 1995). Most research on homelessness focuses on mothers instead of fathers because mothers are more likely than fathers to have their children with them when experiencing homelessness. Homeless mothers are also substantially more likely to experience drug and

alcohol problems than are housed mothers (Bassuk, Buckner, Perloff, & Bassuk, 1998), and many studies have noted that homeless substance abusers are underserved by the substance abuse treatment system (Koegel, Sullivan, Burnam, Morton, & Wenzel, 1999; North & Smith, 1993; Robertson, Zlotnick, & Westerfelt, 1997). Even though the Institute of Medicine concluded that substance abuse represents the predominant public health problem of people who are homeless, little research has assessed what types of treatment are effective with homeless mothers (Stahler, 1996). Substance abuse treatment is imperative because substance abuse disorders can exacerbate the severity of homelessness, which has many personal, social, and economic costs (Robertson, 1991).

In addition to substance abuse problems, homeless mothers often have histories of victimization, including childhood and partner abuse; lack of social support from family and friends; and multiple financial, legal, physical, and mental health problems (Connors et al., 2004). For example, studies indicate that 28 percent of homeless mothers report having had a suicide attempt; 57 percent report having had multiple attempts; and 50 percent meet Axis I diagnostic criteria for at least one clinical or major mental disorder, such as a mood, anxiety, or psychotic disorder (LaVesser, Smith, & Bradford, 1997; Rog, Holupka, & McCombs-Thornton, 1995). Homeless parents and children become sick and go hungry twice as often as do members of non-homeless families and typically lack a regular source of medical care (National Center on Family Homelessness, 2006). Homeless mothers report fewer people they can count on in times of need and fewer people who would be able to care for their children than do housed mothers (Letiecq, Anderson, & Koblinksy, 1996).

The experiences described in this article arose from a pilot intervention study whose primary goal was to develop and evaluate a treatment intervention to stabilize homeless mothers and their children. Therefore, treatment occurred within the context of a stage 1 treatment development grant award from the National Institutes of Health and is part of an ongoing project. This article is based on experiences during a nonrandomized pilot conducted between September 2009 and July 2010. Fifteen homeless families participated; all of them were engaged through a local shelter for homeless families. All mothers met diagnostic criteria for an alcohol or other psychoactive substance abuse disorder and had at least one biological child from two to six years of age in their custody. The intervention was provided by three master's level PhD students in a couple and family therapy program. All therapists were female and white (non-Hispanic). Therapist experience ranged from two to four years. The intervention, ecologically based treatment (EBT), included three months of rental assistance for independent housing and six months of intensive case management and substance use/mental health treatment (the community reinforcement approach [CRA]) (Meyers & Smith, 1995). The intervention began at the shelter, in private offices, but once women obtained housing, services were provided in their homes. Each case management session ranged from 15 minutes to two hours, and CRA sessions lasted, on average, one hour. The intervention was well received, with homeless mothers completing an average of 33.1 ($SD = 7.6$) sessions and 49.7 ($SD = 13.6$) contact hours across six months. No guidance for therapists was found in the literature regarding how to work with substance-abusing homeless families. The information presented in this article is meant to inform those who work with such families in the future. (As such, when we speak in the present tense of

“women” or “therapists,” for example, we are referring strictly to members of the target demographic, those serving them in such an intervention setting, and so on—not *all* women or therapists.) Our experiences may facilitate future teams' efforts to successfully intervene with homeless families and be better prepared for potential barriers as well as successes.

Conceptual Framework

Based on Bronfenbrenner's (1979) theory of social ecology, the most efficacious type of intervention for marginalized populations is one that changes dynamic relationships between individuals in interconnected activity settings in a way that fosters positive linkages and engenders constructive activities. One mechanism that serves as a linkage between these ecological systems of interaction is self-efficacy. According to Bandura's (1977 Bandura's (1986) social-cognitive theory, *self-efficacy* is the major mechanism of change in human behavior, and it is defined as “people's beliefs about their capabilities to exercise control over their own level of functioning and over events that affect their lives” (Bandura, 1993, p. 118). In accordance with Bandura's theory, once an intervention enhances clients' expectations of personal efficacy, self-efficacy beliefs trigger behavioral change through cognitive, motivational, affective, and selection processes. Bandura (1993) argued that once an individual has had a new experience of successfully engaging in a specific behavior, this enhances self-efficacy and the likelihood that the individual will engage in similar behaviors to achieve the next goal. Therefore, one of the primary goals of the intervention described in this article was to increase the success experienced by women. Marginalized individuals must feel empowered to participate in the types of activity settings that will engender more positive life relationships (for example, educational settings, social service/mental health settings, health care settings). For these women, success in these settings can occur through direct experience and through positive discourse and encouragement from a therapist familiar with their situation and the positive role that these activity settings can play in their lives (Bandura, 1993). Every success experienced while dealing with an activity setting associated with housing, substance use, and mental health can help these women continue to build both their general and specific senses of self-efficacy. It was expected that the integrated housing, case management, and the substance use/mental health intervention (EBT) would increase their levels of self-efficacy in addressing all of these issues. Using EBT as a framework, this article discusses experiences that arose during the intervention study in regard to the clients, therapists, and therapeutic process along with recommendations for addressing those experiences and situations.

Observed Client Experiences

Here, experiences observed among clients in the targeted domains (housing, substance abuse, and health and mental health) are discussed. Barriers to achieving therapeutic goals in these areas and guidance for overcoming barriers are also presented.

Housing

In most cases, a primary need and goal of women with young children residing at a homeless shelter is occupancy of some permanent or semipermanent dwelling. Therefore, housing was the first focus of therapists. This section is written with the assumption that the

program or agency is able to provide rental assistance. Our program provided three months of rental assistance, with the lease signed by the client.

Because this was our initial entry into the lives of these women and the most important goal in many of their lives, we concentrated on maintenance of the domicile as a key building block of self-efficacy. Most of the women had an urgent need to leave the shelter and reside in their own place with their children and had difficulty focusing on anything other than accomplishing this goal. Because we wanted these women to experience obtaining housing as their own achievement, we tried to ensure that they chose their own apartment. Because the women had little prior experience with or knowledge about apartment hunting, a therapist helped them consider such things as safety of the area, affordability of the apartment given their budget, availability of public transportation, and proximity to support networks. However, affordable housing tends to be in less safe neighborhoods, somewhat limiting neighborhood choice. Furthermore, women's support networks may reside in affordable but unsafe neighborhoods, which may influence their decisions to also choose those neighborhoods. And consideration needs to be given to cases in which a mother's identified support network may not be safe. Women need to be aware that if they are unable to maintain their housing on their own once project support ends, they will be evicted from their apartment, and this will appear on their FABCO report (a screening instrument of tenants used by property managers and owners). An eviction can destroy self-efficacy; therefore, therapists spent a significant amount of time helping women maintain their apartments independently.

When working with women to identify suitable housing, several common experiences were observed. First, some women wanted apartments that were more expensive than they could reasonably manage once rental assistance ended. It is important to help women identify reasonably priced housing so that they can afford to pay the rent once housing assistance ends. Also, therapists often need to address women's disappointment associated with the housing options that are in the range of \$400 to \$600 a month. In other words, the available housing for low-income families within this price range represents very "basic" housing situations. The apartments might be old, small, poorly maintained, or in low-income areas. Thus, the experienced self-efficacy associated with choosing an apartment could be limited as some women might even view the apartment itself as a failure. To address this, therapists can frame the apartment as a "stepping stone." If the woman has job stability and has experienced some success in maintaining her apartment, she will be able to find a better housing situation when her lease is up (usually in six to 12 months). But for the idea of a "stepping stone" to work, discourse with, and encouragement from, the therapist is vital.

Barriers to Housing—Women's criminal records, poor credit histories, prior evictions, and lack of employment negatively affect the number of housing choices available, especially given that some landlords will not rent to individuals with one or more of those problems. Also, past-due amounts for utilities are a significant housing barrier. Most women have accumulated hundreds (sometimes thousands) of dollars of unpaid utility bills, and utility companies will not turn the electric or gas on until a payment is made. This can be especially problematic because many landlords will not allow tenants to move into their

property until the utilities have been switched to the tenant's name. Finally, lack of transportation and furniture can constitute daunting barriers to housing.

Overcoming Housing Barriers—One key strategy used by shelters to overcome many of housing barriers is to meet with landlords and identify those landlords willing to offer families experiencing homelessness a second chance. Therefore, the therapist might also be able to negotiate with landlords to overlook poor credit, minor criminal convictions, and spotty rental histories. Several landlords in the community are interested in providing a second chance to homeless families, especially knowing that mothers will be supported in maintaining their apartments. Once the program or agency has obtained a list of landlords who are willing to house the homeless families, appointments can be set up with women to show them available properties in the area of the city in which they prefer to reside.

Unpaid utility bills are a difficult barrier to overcome. Most women residing in a shelter do not have income to make the initial payment for their utilities to be turned on. Agencies can “pledge” for the individual or pay the down payment, but ability to pledge depends on the agency's or program's available funds. There may be community agencies that can make a pledge; however, because of the high need for assistance, it can take considerable time to obtain an appointment at an agency. Therefore, if a program is planning to provide rental assistance, setting aside monies for utility company pledges might be necessary. Once the utilities are turned on, there are programs available to assist with the monthly payment. Most states apply for grants from the federal Low Income Home Energy Assistance Program to help low-income families pay energy bills. Funds are distributed on the basis of each state's weather and number of low-income individuals. This program offers one month's utility payment in the winter months. In Ohio, the Percentage of Income Payment Plan is an extended payment arrangement based on a percentage of the household income. If payments are made consistently, credits are given toward the arrearage, or leftover portion, between the income-based payment and the actual amount due.

For women to view rental apartments, transportation by a therapist is usually needed. Also, furniture can be obtained from furniture banks. Some cities have programs that offer gently used furniture to low-income individuals and families for a small amount of money. For example, in Columbus, Ohio, \$60 can cover a bed, couch, stuffed chair, dresser, lamps, and several tables. For an additional \$40, the Columbus furniture bank offers curbside delivery. Some cities may not have a furniture bank. An alternative is to request furniture donations from the public (through e-mail to a university community or newspaper and radio announcements). A storage shed can be rented to store the furniture for future families if donations exceed current demand. Women can identify those items that they want from the storage shed, and movers can be arranged to deliver the items to a woman's home. Success in each of these critical microsystems—landlord negotiation and utility company offices—is expected to increase the woman's level of comfort and engagement with the setting. These successes are then expected to increase the likelihood that women will return to talk with landlords (to address problems that they may experience with their apartment or to sign future leases) or utility companies on their own when they need to.

Substance Use

Substance use was a targeted outcome of our intervention. CRA (Meyers & Smith, 1995) was used to treat substance use and negative emotional experiences among the women. This treatment is associated with significant reductions in alcohol and drug use among individuals experiencing homelessness (Slesnick, Prestopnik, Meyers, & Glassman, 2007; J. E. Smith, Meyers, & Delaney, 1998) and is considered an evidence-based practice (Substance Abuse and Mental Health Services Administration, 2008). Functional analyses are conducted so that triggers for alcohol or drug use are recognized as well as positive and negative short- and long-term consequences. The goal of this therapeutic intervention is to identify alternative activities that compete with the functional outcome of drug use in a woman's life. Ultimately, this is so she can achieve more positive outcomes that do not involve the use of alcohol or drugs. Therefore, the core session topics include a functional analysis of using and nonusing behaviors, refusal skills training, and relapse prevention. Sessions also focus on social skills training (including communication and problem-solving skills), job skills training, social and recreational counseling, anger/stress management, and support with parenting.

Barriers—Most substance abuse treatment interventions, including CRA, were developed using treatment-seeking populations. However, the women served through this project were not seeking substance abuse treatment, and many had little motivation for change. Therefore, the most common barrier was that women were uninterested in addressing or discussing their substance use.

Overcoming Barriers—Service providers have noted that attitudes and motivation to change influence an individual's ability to exit homelessness and access financial, educational, and food resources (Lindsey, 1998). When the client was uninterested in discussing her alcohol or drug use, the therapist addressed other goals of counseling. Often, other goals of counseling overlap with substance use (for example, meeting employment goals). Once the therapeutic relationship develops, the therapist should be able to make gentle connections between substance use and meeting life's goals. In general, some women connect quickly with their therapist, whereas others develop trust more slowly. As trust develops, women are more likely to divulge sensitive matters, such as childhood abuse histories, substance use problems, and parenting stressors. Therefore, engaging mothers through the development of trust, addressing those issues that are important to women (even if they do not include substance abuse), and displaying unconditional positive regard are likely integral to addressing the most difficult issues with which women struggle. If the therapeutic relationship is not strong and trust has not been established, even gentle connections between goals and substance use can alienate the client.

Another consideration is that homeless mothers experience higher levels of stress and depression than do housed mothers (Banyard & Graham-Bermann, 1998). Many homeless mothers residing at shelters experience stress associated with feelings of being stigmatized and judged (Cosgrove & Flynn, 2005; Lindsey, 1998). Lacking coping self-efficacy, some women may perceive alcohol and drug use as the only means of dealing with their stress. Once women move into an apartment and their basic needs are met, coping self-efficacy

should increase (especially given the successful experiences of negotiating their lease with a landlord and working with the utility company to turn on their power), and they might be more open to addressing substance use. In sum, women will experience early successes as they move out of their homeless crisis, the stress related to living at a shelter will have lessened, and self-efficacy that they can successfully cope with life's challenges will be increased.

Health/Mental Health Care

Most of the women and children engaged through homeless shelters have untreated medical, dental, or psychiatric problems, so this was another targeted outcome for this project. The therapist works with the client to clarify the untreated problems and identify programs that will serve the client. Dental problems are common, as are needs for prenatal care and detoxification from drugs or alcohol, including maintenance medication for heroin use.

Barriers—Consistent with prior research, barriers to receiving medical care reported by the women in our study were not knowing where to go, long office waits, and being too sick to seek care (Lewis, Andersen, & Gelberg, 2003). Other barriers included not having insurance and being fearful of seeking medical care because of prior negative experiences. Because navigating the health care system can overwhelm some women, many do not receive needed care. There were generally few constructive linkages between the women's primary activity settings (for example, shelters) and decent health care settings, and attempts to acquire care often ended in failure or, worse, humiliation. Several women refused psychiatric assistance because they believed that others would think that they were “crazy.” Psychiatric evaluations can be difficult to arrange and obtain. Pursuing this service requires long waits at a local triage center for low-income or indigent individuals and families, and some women refuse to wait. Even once a referral is obtained, the actual psychiatric evaluation might not occur for weeks or months because of waiting lists. In cases when success is achieved and clients receive needed care and prescriptions for medical or psychiatric conditions, they do not always consistently take their medications.

Overcoming Barriers—Health care for homeless people, public health clinics, and university clinics can offer medical and psychiatric services for indigent and low-income individuals and families. Therapists are encouraged to drive clients to these appointments and, if possible, stay with them while they await treatment. At times, a therapist may need to advocate on a client's behalf so that she receives the necessary services. If medication is prescribed, identifying strategies to increase medication compliance, such as setting alarm reminders or creating a routine by always taking the medication with breakfast or at night, may be useful. Alternatively, the client may have mixed feelings about taking her medications; this should be discussed so that fears or other concerns can be addressed and resolved.

Observed Therapist Experiences

Therapists' experiences were also observed and reported during weekly supervision. These experiences included managing the chaotic lives of the clients, wanting to manage the clients' lives, and frustrations experienced by the therapists.

Managing Chaos

The women's lives were chaotic, with little routine. Their future was unclear in terms of where they would live and how they would support themselves. The women were in a crisis state, and for many, their coping self-efficacy was continuously depleted by stress, lack of support, and feelings of loneliness. When therapists enter the lives of homeless women, they should recognize the chaos in these women's lives and must intervene. For therapists to succeed, without being paralyzed or overwhelmed, they can attempt to break down therapeutic goals into smaller, more manageable steps. For example, during the first session, women might state that they need housing, transportation, child care, medical care, psychiatric evaluation, and cash assistance and that they also have pending court appearances and so on. Women might then list the barriers to dealing with any of these challenges (for example, no identification, no transportation, lack of friends or family to help with child care). Crises (for example, interruptions of cash assistance, arrests, relapses) can quickly derail progress toward goals. In most cases, the steps toward reaching therapeutic goals can be resumed once a crisis has been resolved, but damage to general and coping self-efficacy may have already occurred. When therapists help women manage the chaos in their lives by breaking down their goals, they should use realistic time frames for meeting their goals so that the women do not become overwhelmed and have a good chance of experiencing success. A therapist needs to structure and lead this discussion (in other words, manage the chaos) or he or she may not be able to successfully help a woman reach her goals.

Wanting to Manage Women's Lives

Some therapists may become especially connected to certain mothers and want to actually solve their problems. Or therapists may be easily swayed to offer rides and goods that should not be offered because they are not directly related to the client's therapeutic goals and offer little in the way of development of the types of self-efficacy that will allow the client to experience continued success. Therapists described feeling badly for the mothers and worrying about them frequently. It might not be possible for therapists to change how they feel toward their clients, and evaluation of their feelings in supervision (that is, whether it is good or bad to feel this way toward the women, good boundaries versus bad boundaries) should be avoided. However, it is important that therapists acknowledge their feelings and discuss them with their supervisor and that their behaviors and the intervention remain professional and consistent for each woman. It is possible to have strong feelings of wanting to care for a client and also only intervene appropriately, within the limits set by the intervention, by not acting on desires to "take care of" the client. It can be useful for the therapist to focus on the primary intervention areas: housing, substance use, and mental health. In the face of multiple unmet needs, this focus can be experienced as less overwhelming to therapists and can be helpful in focusing their intervention efforts more effectively.

Frustration

Another common experience among therapists is frustration. It is not uncommon for clients not to follow through on tasks or homework, such as obtaining job applications, making

appointments, or completing workforce requirements for maintaining cash assistance. Women may note that they are very motivated to work but then not follow through on any of the agreed-on goals for obtaining employment. Some women may be called for a job interview but, for various reasons (forgetting, oversleeping, lack of transportation), miss the interview. If the therapist spent a significant amount of time helping the client complete applications, transported her so that she could submit her applications, helped her acquire work clothes, and practiced (using role plays) the job interview, frustration is understandable. Just as mothers' self-efficacy is restricted or nonexistent in areas where they do not experience success, therapists may lose self-efficacy in their ability to change their clients' behaviors or situations if they also experience little or no success. If the therapist withdraws from the client or becomes hopeless and gives up, he or she joins the client's experience (that is, they both give up). Many homeless women have experienced letting other people down. This is accentuated for therapists whose primary goal is to set these women on a positive behavioral trajectory. The therapy session becomes one more activity setting where the women feel like failures, and the frustrated therapists begin to feel that they are not capable of helping the women. The therapy microsystem becomes a descending spiral. There is little opportunity for a therapist in this type of relationship to serve as a positive link to other critical activity settings in a woman's life. The therapist in this situation would benefit from examining the attributions he or she has regarding the client's apparent lack of progress or movement forward. This allows the therapist to restart the therapeutic relationship on a more positive trajectory. Perhaps the therapist assumes that the client is being lazy or oppositional when she is actually immobilized by fears of failure. Or perhaps the client is fearful of independence and the responsibility that it entails. Processing of this might be helpful for the client, but it is also helpful for the therapist, allowing both to see that lack of success is context dependent and that relationship barriers can be overcome through shifts in perspective.

Therapists might experience frustration because they feel as if they are wasting their time or that the women do not appreciate their efforts. For example, it is not uncommon for a therapist to travel to a woman's apartment for a scheduled appointment and find that she is not home or, worse, is home but will not answer the door (because, for example, she is sleeping or not in the mood for therapy). The role of the therapist in the relationship with the client is to be available for the client. Clients may not thank the therapist for the work that he or she does. In fact, the therapist may be insulted, yelled at, or blamed for the problems that the client experiences, but this is not a failure of the therapist–client relationship (although it may be symptomatic of one). In these situations, the therapist can be reminded during supervision that the attacks or apparent lack of gratitude are not personal but are, instead, representative of an accumulation of significant past wounds and betrayals. In every such actual case, women who were given time contacted their therapist to request additional assistance. The prior negative interaction was discussed again, creating a successful resolution of a negative interpersonal interaction rather than reinforcement of interpersonal failure. When such a thing happens, it may be one of the few times in a client's life that negative interactions with service providers did not almost immediately lead to unrecoverable loss. Reestablishing the relationship between the client and the therapist then may actually have a strong impact on the client's behavior. The client learns that if she is

able to reestablish connections (through her own work or the work of the therapist), she can ameliorate the pain and loss of previous negative behavior. The client learns that negative interactions do not necessarily lead to the loss of a positive relationship. This would help explain why sometimes those clients who do not appear to appreciate the therapist's efforts are those who feel most connected to the therapist and are the most vulnerable. As noted earlier, even if it seems that the therapist's efforts are not resulting in observed behavioral changes in client behavior, the therapeutic relationship itself is unique. It may be one of the first times in the client's life that someone has not criticized, judged, or given up on them and has not allowed himself or herself to be pushed away by the client. By maintaining the therapeutic relationship, despite multiple missed appointments or anger directed toward him or her, the therapist is offering the client a positive relational experience in a positive activity setting. The therapist can then parlay that positive experience into links to other positive activity settings (such as health/mental health clinics).

Process Experiences

Therapeutic process includes those factors that occur during therapy that may influence change (Pinsof & Wynne, 1995). Through our work with these families, the following three processes were identified: (1) the development of a trusting therapist–client relationship, (2) a balancing of the client's needs for independence and assistance, and (3) the prompting of realistic expectations among clients.

Development of a Trusting Relationship

When project therapists enter a woman's life, they might be the only, positive, supportive person in that woman's life. As the relationship develops and fears regarding betrayal and trust subside, the connection with the therapist becomes strong. Often, women will call their therapist several times throughout the day. The topic of the phone call might be to share good news, to ask for a ride or assistance completing employment or school paperwork, or to seek support during a crisis.

Consistently, women become very connected to their therapist. As noted, sometimes trust develops over several weeks. Once the therapist is perceived as safe, he or she becomes a primary source of support. In the beginning, on average, therapists received two calls each day from each client, with some clients calling more frequently. The number of calls across therapists diminished significantly over time, so by three months, therapists received only a few client calls (two per week per client). This might have been due to the resolution of the housing crisis and also the fact that, as stabilization and therapy progressed, coping strategies increased and the need for therapist support diminished. The role of the therapist in the woman's life is significant, likely representing one of her few truly positive, stable relationships.

Balance between Women's Independence and Providing Assistance

A balance must be achieved in which the therapist offers help, support, and assistance as needed but, over time, the client is able to process events that occur independently or with the support of those in her social network. This is especially important given that the

therapeutic relationship is temporary. If a social network does not exist or is dysfunctional, then the therapist needs to work with the client to develop a dependable one. The question might arise as to what is considered too much help. For example, therapists using EBT sit with clients as they make calls to other agencies to set up appointments. Therapists transport and accompany clients to various appointments or court appearances or to pick up job applications because the clients fear going alone or want the support of a therapist. In conducting this pilot, we determined that if during the beginning stages of therapy the therapist does not provide significant time and assistance to the client, many appointments and other important activities will not be completed, making the development of self-efficacy and the instantiation of positive links that much more difficult.

Should women experience the “natural consequences” of not following through with their appointments or other activities associated with improving their situation? Our stance is that women have already experienced the natural consequences of not following through with their social obligations or responsibilities by virtue of residing in a homeless shelter with their children. The lack of positive experiences in the women's lives has already had devastating effects on their ability to positively navigate their worlds. Experiencing “natural” negative consequences leads to a negative or unproductive learning experience in the behavioral model, not only for these women, but for anyone. These types of experience can further throw these women into a state of despair and learned helplessness. Our approach is to provide hands-on assistance with daily stressors and responsibilities. In fact, therapists spend a significant amount of time at the beginning stages of treatment helping women with nearly every aspect of their lives.

One concern is that if the therapist provides a high level of support to the client, the client might not learn how to complete tasks independently. The goal of the EBT therapist is to assess the skills and abilities of clients and to help them develop the skills so that they can approach and resolve situations independently. In other words, some women might require a significant amount of technical assistance (for example, with how to identify and complete paperwork requirements) and moderate levels of emotional support at the beginning stages of therapy, whereas other women will only need a moderate level of technical assistance but a significant amount of emotional support. The key is working toward positive behavioral experiences in critical, positive settings that these women can then build on.

Realistic Expectations among Women

A common experience observed during therapy is that mothers have unrealistic expectations regarding housing and services that the project therapist can provide. For example, some women protest vehemently if their therapist does not provide transportation for nonessential errands (for example, providing a ride to the Laundromat or grocery store) or if they want a household item (such as a television or computer) and the project cannot purchase this for them.

A practical strategy that can be used to circumvent this disappointment is for the therapist to present a list of those items and services that the project can offer, including the limits of transportation by the therapist. During the first session, the therapist should review the list and provide a copy to the client. If the client later complains about transportation or items

that the project cannot purchase, she can be reminded of the list of services and items that the project covers.

Conclusion

This article described experiences and recommendations associated with providing housing and supportive services to homeless mothers with young children in their care. The intervention, EBT, uses an ecological systems approach (Bronfenbrenner, 1979), with the goal of increasing success experiences so that self-efficacy is increased among women (Bandura, 1993). In most cases, a primary need and goal of women with young children residing at a homeless shelter is housing, and housing is therefore the first focus of EBT therapists. Once housing has been obtained, women generally become more interested in and open to assistance in other life realms (for example, substance use, health/mental health).

Homeless mothers require different levels of support from a therapist to accomplish agreed-on tasks. At first, some therapists interpreted perceived lack of follow-through on tasks (making calls, picking up applications) as lack of motivation or laziness. However, the philosophy of the EBT intervention is that no matter the motivation of the participant or the reason for lack of follow-through, the therapeutic goal is for the client to experience success in positive activity settings. Any success can be built on. In this intervention, therapists strived to withhold judgment and focused instead on the behavioral activity of the clients, seeking to increase confidence and self-efficacy with the successful accomplishment of very small tasks so that independence across tasks and domains could ultimately be achieved. Also, therapists were available to women for emergencies at all times, and women's connection to their therapist was exemplified by a high number of contact hours. The relationship between the therapist and the client appeared to be unique and powerful. Future research should further explore the role of the relationship between the therapist and the homeless mother in outcomes. Shared goals and trust are important (for example, therapeutic alliance), but, anecdotally, the reparation of past betrayals (whether by family or human service workers), as well as the alleviation of existential loneliness, appeared to be significant factors in this intervention's success.

And, finally, the role of the children in the intervention process must be considered. Separation of family members is a significant issue for homeless families, as fear of having a child taken away from the mother's care has been reported as preventing homeless mothers from having contact with social services providers (National Alliance to End Homelessness, 2006; E. M. Smith et al., 1995). One report noted that 62 percent of children in families seeking emergency shelter were currently placed, or had a history of placement, in foster care (National Alliance to End Homelessness, 2006). In addition, inadequate housing is a major contributing factor to the placement and retention of children in foster care (National Alliance to End Homelessness, 2006). The average annual cost of placing the children of a homeless family into foster care is \$47,608, whereas the average annual cost for a permanent housing subsidy and supportive services for a family is \$9,000 (National Alliance to End Homelessness, 2006). Mandatory reporting laws provide guidance on which cases require reporting to Child Protective Services (CPS). In our work, most women were

familiar with these reporting laws and with CPS. Therapists must adhere to reporting laws, but they must also develop a trusting relationship with mothers. The goal of therapists is to ensure the safety of children and to address risk factors associated with child abuse and neglect (substance use, mental health, and housing), successful resolution of which may reduce generational foster care involvement as well as individual, family, and societal costs. It is hoped that the experiences and recommendations provided in this article offer practical assistance and facilitate the work of those who seek to serve these vulnerable families in the future.

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