Homeless African-American Women and Their Families: Coping With Depression, Drugs, and Trauma

Sheryl Brissett-Chapman, Ed.D., A.C.S.W., L.I.C.S.W.

INTRODUCTION

Child welfare and public social service systems recently have been confronted with a growing problem of homelessness for women and their children, yet specific concerns about homeless women and their difficulties have been inadequately discussed in the literature (Milburn and D'Ercole 1991). Within this population, African-American women are disproportionately likely to be homeless; race appears to be a risk factor for homelessness (Breakey et al. 1989; D'Ercole and Struening 1990; Shinn et al. 1991). In addition, African-American women may find themselves homeless for a variety of reasons, such as poverty, residential instability, work and employment problems, or histories of victimization. These acute and chronic problems within the women's environments produce extreme stresses and challenge their adaptive responses (Pearlin et al. 1981).

This chapter addresses qualitative observations about homeless African-American women who, along with their children, received emergency family shelter services within an affluent, highly educated, semiurban community in the Northeast. The author, an African-American child welfare professional, uses concepts of resiliency and coping as a way of understanding African-American women, their homelessness, and their abilities to adapt. Existing analytical research models are compromised by cultural constraints that fail to capture either the subtle but powerful perceptions of these women or their subjective experiences. There is an urgent need to promote research efforts and methodologies that synthesize information and formulate substantive inquiry and thus relevant practice development. Most interesting is the examination of how current theory and systematic observations might come together to ensure more effective programmatic responses and policy direction.

STRESS: A CONTEXT FOR DEPRESSION

Several definitions of stress have been put forth in the psychological literature (Milburn and D'Ercole 1991). Some researchers have viewed stress in terms of a "general adaptation syndrome" with an extreme response (Selye 1956). In this instance homelessness could be viewed as trauma in and of itself (Goodman et al. 1991) that warrants an acute reaction. Others have pointed to the importance of the individual's perception and judgment as a key to whether particular life events are stressors. This perspective is concerned with the interface between life events and the individual's cognitive appraisal or perception of what has happened to her or him (Lazarus and Launier 1978, pp. 287-327). Essentially, stress results neither from the situation nor the person but rather from the person's recognition of an event and her or his subsequent adaptation to it (Belle 1990; Taylor 1990; Lin and Ensel 1989; Vitaliano et al. 1987).

Several risk factors for homelessness in women have been described in the research literature. For example, homeless families have been found to move their lodging more frequently than other poor families (Wood et al. 1990), and African-American women are more likely to live temporarily with family members or friends before becoming homeless (Kreuger et al. 1987). Continued instability and poverty are also known to prolong homelessness for families. Wood and colleagues (1990) described how a sudden drop in income for chronically poor families can result in homelessness. The vast majority of homeless families had incomes, including public assistance payments, beneath the poverty line before they lost their homes. Long-term poverty can be viewed as a major and chronic risk factor because it reflects a life of subsistence in which much energy is spent seeking food, clothing, housing, and transportation as well as protecting oneself from crime and violence (McLloyd 1990).

Many homeless women are unemployed because they have young children and few or no alternatives for child care. As a result, women often have less experience in the workplace and are more likely than men to be unsuccessful in finding work. Homeless women also may be subjected to work-related stresses such as sexual harassment, demotions, reductions in the work force, firings, menial employment, or jobs "off the books" (Milburn and D'Ercole 1991). Furthermore, the literature suggests that homeless women are more likely than average women to

have experienced abuse both as children and as adults (Bassuk and Rosenberg 1988; D'Ercole and Struening 1990). In fact, Kreuger and colleagues (1987) indicated that abuse is a primary factor leading to homelessness for African-American women, second only to the disruption of multiple family occupancy in temporary housing arrangements.

The transactional stress model, which focuses on the power of the individual's perceptions of life stressors on subsequent life circumstances, allows for the examination of external supports that might be provided to homeless African-American women who are coping with depression, drugs, and child-rearing responsibilities at a critical point in their family's exposure to and involvement with the formal helping systems. The components of a stress model include exposure to acute and chronic stressors, interaction of these stressors, and social and psychological resources that mediate their impact (Milburn and D'Ercole 1991, p. 1161). It is important to understand both the diversity of the experiences of homeless African-American women who have been confronted with multiple acute and chronic life events and their unique perceptions of these events and of homelessness itself. Homelessness can become the very stressor that ultimately damages a woman's coping style and may create a nearly insurmountable challenge. A transactional stress model views these women as "actors," not as "objects" or powerless victims. Therefore, homeless women are viewed as bringing adaptive and tailored coping strategies to the family's crisis with housing. This model becomes an effective framework for examining the strengths of homeless women, their perceptions of their homeless status, the implications for depression and feelings of hopelessness and inadequacy, their motivations to act, and the most appropriate responses by human service systems (Milburn and D'Ercole 1991; Belle 1990).

GREENTREE SHELTER

The Greentree Shelter began as a pioneer model program in 1983 and is currently known in Montgomery County, MD, for serving homeless families whose situations are most difficult. The shelter provides 46 beds each night, primarily to single mothers and their children, and also delivers a comprehensive set of services that includes meals, housing, laundry facilities, parent education, medical care and referrals, assistance with job placement and employment counseling, substance abuse education and prevention, social services referrals, assertiveness

training and self-esteem building, individual and group counseling, computer and other employment skills training, general equivalency diploma (GED) classes, a full-range child-care center and afterschool care, recreation, and transitional housing with intensive case management. The average stay for a family in residential shelter care is approximately 5 months. The shelter turns away four or five families weekly because of a lack of available beds for this growing population.

The Greentree Shelter serves an estimated average of 200 individuals, or 50 families, annually. The parents have an average of two children; typically, 80 percent of the children are younger than 6 years old. The mothers are not young teen parents; the age range is 18 to 35 years with a mean of 25. Many of the families are repeat motel and shelter residents. Nearly half have moved from shelter to shelter in the past. Eighty percent of these homeless women are African-American parents.

During the past year, 60 percent of the families served by the Greentree Shelter worked or went to school during their stay. Forty percent moved into permanent housing on their own on discharge; 22 percent moved into transitional housing; 24 percent moved into shared housing with a family member or a friend; and 14 percent remained at the shelter for an extended period or were referred to an inpatient drug treatment center.

Housing Instability

Most families are referred to the shelter by the local department of social services after being evicted from public or private housing. Often they have been rejected by their own extended families or friendship networks. Domestic violence plays an important role because many of the women are escaping abusive relationships with spouses or partners. Others had jobs that were tenuous, and when they lost them, there were no savings or other reserves to fall back on.

In addition, some mothers lose their housing because a partner suspected or known to be a child molester has his name on the apartment lease or is providing financial support for the home. Child Protective Services (CPS) will threaten to take the child away if the mother does not separate from the alleged offender, often a child sexual offender. This is a growing challenge, not only because homelessness may be the reason why children are removed but also because CPS interventions may force the mother to move if she plans to maintain

physical custody of her children. Overcrowded housing, more common with the Latino families served, is also a visible issue for African-Americans and results in a substantial number of referrals to the shelter.

The full impact of society's inadequate investment in affordable housing is felt by these women. They also are increasingly vulnerable to the impact of inflation and their lack of employment skills as society moves into an age of information technology in which computer literacy is an essential skill. These women are not able to generate living wages with the initial level of skills and preparation they bring to the work-place. As a result, housing instability becomes a chronic and relentless barrier that must be overcome.

Substance Abuse

Forty-five to fifty percent of these homeless women have problems with substance abuse. Although some are in recovery for addiction, others range from experimental users, to more frequent users and abusers, to addicts. An estimated 70 percent of these women are codependent with family members or partners, and approximately 40 percent of this group also report being abused by their partners. There is never a history of adequate drug treatment for these women. Their families are not a resource because extended family members generally are also involved in substance abuse. Moreover, these extended families have limited financial and emotional resources.

One reason these women are referred to the Greentree Shelter is because, unlike other shelters and service systems, families are not evicted routinely because of an alcohol- or other drug-related relapse. The mothers receive services and support until they are able to move into permanent community housing. Transitional case management supports are important in this process. Other shelter or transitional housing programs in the community often do not forgive women who use drugs and, fearing the likelihood of drug relapse, will not give them a chance. Simply put, these women often are viewed as inherent failures.

Traditional Alcoholics Anonymous and Narcotics Anonymous programs generally do not offer sufficient treatment because these women often lack the commitment and trust needed to use a community support model. They are often socially isolated and lack the sophisticated interpersonal skills and confidence to learn new behaviors and engage others in mutual and effective ways.

Victimization

Bassuk and Rubin (1987) described most homeless mothers as having only a few supportive relationships: 43 percent had no support or minimal support, and about 24 percent viewed their child as their major emotional support. In addition, 33 percent reported that they had been abused during childhood, 33 percent said they never knew their fathers, 66 percent described a major family disruption, and 40 percent had lost a parent when they were younger than 5 years old (Bassuk and Rubin 1987, p. 281).

Most children living in family shelters suffer developmental delays, severe anxiety and depression, and learning difficulties (Bassuk and Rubin 1987, p. 284). The Greentree Shelter has known or suspected that a significant number of shelter children have been sexually or physically abused by the mother's boyfriend or spouse. Depression or posttraumatic stress disorder symptoms often are present, and widespread substance abuse by family members and friends becomes a particularly difficult issue because these mothers generally are not able to "divorce" these significant persons. Clearly, women are challenged in their ability to recover from the ravages of addiction and abuse while separating from the limited natural family or friendship network they have.

The boyfriend or spouse is a substance abuser in 95 percent of the domestic violence cases known to the Greentree Shelter. Violence may also accompany the family to the shelter, where staff members must be vigilant regarding child protection issues, especially physical abuse, emotional neglect and abuse, and failure to appropriately supervise children. Consequently, these issues may affect the mother's functioning, resulting in poor judgment, self-centeredness, a sense of hopelessness, an increase in risk of child abuse and neglect, and a slow response to a child's health and educational needs.

OBSERVATIONS: DEPRESSION, TRAUMA, AND THE FAMILIES

The stigma for all women who show up needing shelter, but especially for African-American women who use substances or who fail to care for and adequately nurture their children, is enormous. For African-American women, substance abuse by the maternal figure violates a culturally transmitted pattern for families of descendants of slaves, whose males are targeted by society in a different way than

females. Females are socialized to rear their children at *all* costs and despite *all* odds. The stigma and the cultural taboo are awesome and overwhelming when the female submits to her own neediness and immaturity, hence the strong correlation with depression and its powerful sense of inadequacy, resignation, and failure.

It is important to rethink trauma as a construct. In the lives of these women, trauma may not result from a series of events or the nature of specific events; in fact, trauma may not result from intrusive assaults as much as from the chronic, nagging, unmitigated life circumstances confronting these women.

Depression then becomes an adaptive, coping response to overwhelming circumstances and perceptions of life. It serves to (1) blunt the visceral impact of life's harsh realities to cope with overwhelming feelings of impotence or (2) channel anger into an energizing, if not also rigid and controlling, impulse to motivate oneself through another day and another series of affronts. There are serious implications here for concepts of family and community, particularly estrangement, violence, and victimization in the family; abandonment; unmet personal needs; and most importantly, unresolved grief and loss issues. The repressed question by the time an African-American female is 4 or 5 years old may be, as one song asks, "Is this *it*?" Many African-American females, particularly those who are poor, increasingly perceive early on that they have limited choices.

A theme from another song asks, "What's love got to do with it?" The notion of survival is prominent with these women—*not* expecting to be connected or to be validated but learning to survive. Not only is depression a coping response used to shield one against harsh truths, but it also becomes normalized as an adaptation. Indeed, it is quite challenging to resolve grief and loss issues if you are receiving the brunt of societal rage for your failure to take care of the next generation.

ROLE OF EXTERNAL SUPPORTS

These African-American mothers need external supports: Careful and "caring" confrontation regarding depression (which may be normalized coping) via an authentic relationship; incentives; recognition; and a redefined sense of community and understanding of the family. They also need research and systematic inquiry that will help clarify the need for external supports so that substance-involved parents no longer

self-medicate or seek or accept artificiality in relationships and can solicit, experience, tolerate, and celebrate genuine and mutual relationships.

How can we foster the woman's acknowledgment that love does have something to do with it and that there is more than this? How do we build incentives? How do we validate, recognize, encourage, support, and facilitate a redefined sense of community and family?

There are some factors that need consideration. First, histories of pervasive sexual abuse in childhood as well as codependency in adulthood create major personal boundary problems for these mothers as they interact with others. They tend to experience poor self-esteem, heightened perceptions of dependency, and vulnerability to exploitation by family, friends, and strangers. These personal boundary problems often are modeled on their parents' relationships and constitute major obstacles to effective parenting. Multiple motel-shelter placements further damage the family's natural boundary formation, creating psychological as well as physical instability.

Second, these women are challenged by the limits set by the Greentree Shelter. They struggle with and manipulate the structure of the program, and they are skeptical of or resistant to requirements such as savings and curfew. Nevertheless, they are capable of fighting for their children's safety and avoiding the child welfare system. Enormously persistent and tenacious in their struggle to hold on to their children, they believe their children are all they have left. In fact, all these mothers have when they come to the Greentree Shelter with their shopping bags is their children, their most valuable resource.

The Greentree Shelter's mission is to establish family sufficiency and support family reintegration into the community. Despite the tension and difficulty, mothers do respond to reasonable structure. The myth is that they will not, but the Greentree Shelter has become a "kibbutz" for families with special needs. These vulnerable parents do respond to this milieu, this beautiful place isolated somewhat from the community but laden with structure and staffed with professionals who will support parents with the needs described above.

Many of these homeless women minimize their involvement with alcohol or other drugs and its impact on their family's functioning and their own health. The concept of health initially appears disassociated from their personal needs and their vulnerability. They can address the denial regarding substance abuse and its impact on their health only

when they gain confidence from concrete accomplishments such as gaining a GED, a course certificate, computer skills, or a lease on an apartment or having a successful encounter with a teacher. They can then internalize effective problemsolving that may be modeled by others in their community.

The shelter structure involves reworking unresolved adolescent and even early childhood issues for these women. They must comply with curfews; develop case management goals, including savings and employment plans that they must execute themselves; and take care of their children—put them to bed in a timely fashion, make certain they eat properly, and manage all their parental responsibilities. Shelter staff members *insist* that *they* do it. Results are monitored through a performance system, with points, rewards, incentives, and recognition of the mother. The mothers also volunteer to work in the onsite child-care center with other children and participate in a 12-week "family nurturing" program.

In a community sense, treatment compliance is paramount. Eviction from the Greentree Shelter results from continued refusal to comply with drug treatment demands, although the treatment approach can be negotiated by the mother. Relapses are understood to be a potential aspect of the treatment process and journey to recovery, but subsequent treatment requirements, including hospitalization or step-ups in care, must be met. There are various phases and types of treatment located in the community that parents must participate in, based on the level of intensity required to stabilize their recovery.

The key components of the shelter structure are parenting education and conflict resolution. Parenting education is important to reinforce parental self-esteem and build on parents' investment in their children and a sense of importance. Conflict resolution teaches parents how to live in a community, participate in community group meetings, resolve conflicts with each other, and experiment with how they are going to resolve conflicts with their estranged family systems (because they rarely let go of those family systems). These women learn how to say, "I love you, Mom, but I'm not letting my brother and his five kids move into my new transitional apartment because I will be put out. I love you, but I will not do that."

Interagency planning and collaboration are also a key to success for these women. At intake, Montgomery County Department of Social

Services workers sit down with the program staff and the families to jointly come up with a plan so that there is no confusion, inappropriate manipulation, or secrecy. Acting together, all agree on a vision and a plan for the families.

CASE ILLUSTRATION

This author encountered two of the women from the shelter in the parking lot. One was pursuing an 18-month-old child between the parked vehicles. The 22-year-old mother screamed profanities at the child, who laughed and ran underneath a vehicle. The second mother grabbed her 3-year-old son and reprimanded him by threatening to beat him severely. This child looked dejected and depressed. Both parents glanced sideways at the author as she drove away.

The next evening, the author requested a meeting with all the mothers in the shelter and directly confronted them with her concerns about unsupervised children, emotional and physical abuse of children, and the perception of a general sense of disregard for the children's safety and well-being. After she shared her strong feelings and sense of personal responsibility, the author asked the mothers about their own experiences in childhood. More than half indicated that they had been verbally, physically, or sexually abused during childhood. The mothers reported that some of them had tried to intervene with other shelter parents but were threatened with physical violence or were told to mind their business. All the mothers concurred that they had either retreated from the community's problem or had contributed to the problem with their irresponsibility and frustration.

Each mother was asked to propose a strategy either for herself or for the community that would address the problem of children's vulnerability at the shelter. The strategies included establishing appropriate boundaries between the parents rather than rigid or hostile ones regarding parenting, providing and reaching out for support, engaging in appropriate play activity with children, and supervising them on the basis of their developmental needs.

The Greentree Shelter's parent educator specialist captured the energy of the mothers and their commitment to change. This was incorporated in the following creed, which has become part of the culture and ritual of the shelter.

GREENTREE SHELTER PARENT'S CREED

WE THE PARENTS AT GREENTREE SHELTER AFFIRM THAT:

We are a community of caring people.
We believe that a nurturing environment requires parents to be responsive to every child at Greentree.
We will not use offensive language with each other or with our children.
We will keep our children ten and younger away from physical harms such as secondary smoke [or] unsupervised time on the blacktop and on Greentree Road. We will organize supervision and appropriate playtime for children ten and younger on the playground.
We will freely and generously respond to each other's pleas for help, whether by bathing a child, providing child care, or allowing a mother to take a break from the intensity of a child's need.
We firmly believe in holding each parent accountable for his or her actions in the community. Moreover, as a caring, nurturing community, we strive to be open to accept suggestions in the spirit that they are offered. Most important, we are a community ever striving to learn and grow as parents and as individuals!
September 26, 1996

Homeless women frequently resist the shelter structure at first because it requires energy and investment and forces them to confront depression. Yet confrontation in a community context, and with consistent, reasonable, and authoritative structure, results in a lifting of depression. Eventually, rules and standards are internalized and serve to buffer the families from the insidious aspects of racism, addiction, and poverty. Mothers often leave with rules that they will post on the walls of their new apartment because they say to their precious children, "We're going to live with rules, like we did in the shelter!"

SUMMARY

Families are referred to the shelter because of homelessness, not substance abuse or depression, and yet a disproportionate majority have problems in these areas. The Greentree Shelter's focus is to directly address and promote the families' resiliency and adaptation, which may be "normalized" depression, and to promote expanded dreams and expectations of success.

Innumerable exciting stories abound of women who have recovered from cocaine, or are in recovery from cocaine and alcohol abuse or polydrug abuse, and what they have been able to do with their lives. Family supports that have promoted their recovery include church members and volunteers in the larger community who get involved with these families so that they can move into extended family systems. Intensive case management for 18 months and subsidized private housing are critical resources. Yet success is dependent on the notion of real investments in these families as well as the expectation that these women can address their depression effectively. The depression is adaptive, but in reality, it costs these women. The Greentree Shelter offers to form a partnership with these women so that they can better structure their lives, lead their families, and sustain their futures.

In conclusion, the author promotes the need to understand qualitatively the specific coping styles of homeless African-American women who are rearing children. Alcohol and other drug abuse must be viewed as a symptom of a far-reaching and normalized depression that serves both as protection and motivation during difficult life journeys involving poverty, racism, sexual exploitation, workplace discrimination, domestic violence and betrayal, and child victimization. Future research efforts should measure the positive results of a highly structured community setting and comprehensive supports that focus on the intertwined effects of homelessness, alcohol and other drug use, and depression on African-American women and their families.

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AUTHOR

Sheryl Brissett-Chapman, Ed.D., A.C.S.W., L.I.C.S.W.
Executive Director
Baptist Home for Children and Families
6301 Greentree Road
Bethesda, MD 20817
(301) 365-4480, ext. 115 (Tel)
(301) 365-2536 (Fax)
bhcf1@erols.com (E-mail)

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