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Mother-to-Mother: Creating A Peer Mentor Program for Mothers in Homelessness

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Mother-to-Mother: Creating A Peer Mentor Program for Mothers in Homelessness

by

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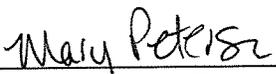
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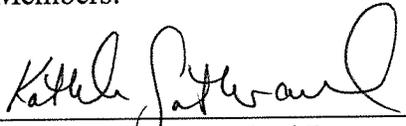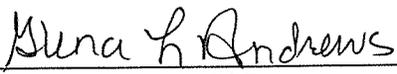
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Abstract

Mothers with children represent a growing segment of the homeless population. The American Psychological Association (APA) responded to the problem by initiating a task force in 2009 calling psychologists to step forward and enhance the treatment and services available for this population. However, providing treatment is often a challenge for this population because of the power differential and other barriers that negatively impact the potential relationship between mental health providers and the person living in homelessness (Hoffman & Coffey, 2008). The use of a peer mentor to mitigate the risk factors for a specific population has been an effective intervention used by multiple support and advocacy groups (e.g. NAMI, AA). Building on research supporting the effectiveness of a peer-mentoring model, this study explored the impact of a mentoring program on the self-efficacy, self-esteem and self-perception of overall functioning for mothers experiencing homelessness. Using a repeated measures ANOVA design, this study compared the effectiveness of two mentoring approaches. One group of mentors were trained to incorporate a structured, brief intervention model (5A's) into the meetings with their mentees versus a group of mentors using an unstructured approach for mentee meetings. Results showed that a four-session peer mentoring program significantly improved perceived overall functioning for both groups of mentees. However, the study did not

find a statistical differences between the structured versus unstructured groups. Discussion and

implications for future studies are included.

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Chapter 1

Introduction

The Issue: Homelessness in the United States

Methodological and financial constraints contribute to the difficulty in gathering an

accurate understanding of homelessness in the United States. According to the U.S. Department

of Housing and Urban Development (HUD) Annual Homeless Assessment Report for 2013

(AHAR) presented to Congress, estimates indicate that homelessness within the United States is

assumed to be on the decline. On a single night in January 2013, it was approximated that

610,042 people in the United States were experiencing homelessness (counting only people in

homeless shelter or the street conditions). This was a 4% decrease from the previous years'

report and an overall 13% drop from 2007. Of that estimate, 222,197 of the individuals were

accompanied by family members (The U.S. Department of Housing and Urban Development,

2013). However, many believe that this estimate grossly underestimates the number of homeless

Americans because the report fails to factor in people who are "doubling up" with friends or

relatives in their homes, individuals living in short-term motels, or people who simply evade

being counted.

Although these data suggest homelessness is declining, other data suggest that

homelessness has, in fact, been increasing in specific regions within the United States. For

example, in 2015, King County, Washington reported a 21% increase in the number of people

living on the streets from the previous year (Seattle/King County Coalition on Homelessness,

2015). Most recently in November 2015, Seattle declared a State of Emergency on

Homelessness. Whether the data show homelessness to be increasing or decreasing, a vast

number of people experience homelessness in a given year. Of all those experiencing

homelessness, mothers with young children represent an especially vulnerable segment of the

homeless population. With the rates of homelessness still unquestionably high, cost of living

surpassing what minimum wage earners can afford, and the number of affordable housing

options becoming more scarce, the need to equip homeless mothers with the effective skills and

resources to manage their homeless status is crucial.

Homelessness and how it Impacts the Mother and Child

According to a meta-analysis by Finfgeld-Connett (2010), becoming homeless is a

gradual process, often stemming from early childhood experiences such as abuse, neglect,

abandonment, transience, poverty, and parental mental health issues, which initiates a sequence

of thoughts and behaviors that place women at further risk. Larkin and Park (2012) studied

Adverse Childhood Experiences (ACEs) among people experiencing homelessness and in their

research it was found that 87% percent of the homeless respondents reported at least one of the

10 ACEs prior to age 18, and over half (53%) reported experiencing more than four ACES. As a

result of growing up in a life where abuse, neglect, and family disorganization is prevalent,

young women may be vulnerable to subsequent trauma along with a sense of powerlessness and

shame (Lewinson, Thomas, & White, 2014; Padgett, Hawkins, Abrams, & Davis, 2006). The

worldview of powerlessness and shame limits the development of protective factors including

problem solving and/or trust in a system to provide accessible resources or support. The lack of

protective factors creates a cycle in which women may become increasingly vulnerable to a

myriad of risk factors including homelessness. An example of such a cycle occurs when a

woman's sense of isolation and powerlessness increases her vulnerability to exploitation and

unhealthy attachments with men who may be violent and abusive (Finfgeld-Connett, 2010). Not surprising, the cycle of abuse and trauma exacerbates the feeling of isolation and shame, which reduces the opportunity to learn more adaptive coping skills. As stress increases, women may turn to maladaptive coping strategies including substance use, or criminal activity in order to fulfill the needs for their family (Fischer, Shinn, Shrout, & Tsemberis, 2008; Torchalla, Strehlau, Li, & Krausz, 2011; Upshur, Weinreb, & Bharel, 2014). Unfortunately, these maladaptive strategies may be passed onto their children, creating a generational cycle of powerlessness.

Beyond relational trauma, the physical and mental health of homeless mothers may be compromised, leaving them more susceptible to harm than their housed counterparts. Bassuk and Beardslee (2014) found that homeless mothers are at a disproportionately higher risk for depression than the general population. Depression increases the difficulty for effective parenting, which may compromise the child's growth, developmental progression, and school readiness (Knitzer, Theberge, & Johnson, 2008). Depression can also be a risk factor for early attachment troubles between the child and mother. Literature suggests that early attachment ruptures are related with negative medical, social emotional, and educational outcomes later in life (NRC & IOM, 2009a). Along with depression, homeless women are also at a much greater risk of mortality, poor health status, mental illness, substance abuse, victimization, and poor birth outcomes (Schanzer, Dominguez, Shrout, & Caton, 2007). Despite the increased health risks that come from being exposed to homelessness, homeless women experience a greater disparity in access to healthcare. Disparities include a decreased likelihood of having a primary care provider, health insurance, early cancer care screenings, prenatal care, ambulatory care, and specialty care (Teruya et al. 2011).

Understanding the vast and perilous effects that homelessness has on mothers and children increases the sense of urgency to identify sufficient and effective resources to mitigate the effects of homelessness.

The Mental Health Contribution: Is it effective?

As the number of people living in poverty with subsequent homelessness continues to be a problem in the United States, the American Psychological Association formed the 2009 Presidential Task Force on Psychology's Contribution to End Homelessness (American Psychological Association, 2010). This task force was commissioned by former APA president James Bray to identify the psychosocial factors associated with homelessness as well as to define effective strategies and treatment interventions that may be helpful to this population. Recommendations included: psychologists should contribute through increasing the body of research targeted towards helping this underserved population; advance training and curricula to improve competence in working with diverse and underserved populations at risk for homelessness; include more marginalized patients in client case loads; and advocate in legislature to increase funding and support.

Current research suggests that direct intervention by psychologists may not be the best method to support individuals in homelessness. Hoffman and Coffey (2008), interviewed 500 individuals experiencing homelessness and asked them to report their perceptions and opinions of mental health service providers. Results from the qualitative analysis were less than promising, as a theme of mistrust emerged towards mental health providers. This mistrust stemmed from the feeling of being "objectified" and "infantilized" by service providers, and not feeling respected as an equal. Research from Sznajder-Murray and Slesnick (2011) indicated that homeless mothers view service providers as misunderstanding and unsupportive. Additionally,

homeless mothers reported a lack of trust in service providers' ability to understand the traumatic circumstances they and their children experienced before seeking services. On top of feeling misunderstood, many homeless mothers perceived that providers were unable to hear or meet their needs. Lastly, homeless mothers expressed fear toward providers because of the potential risk of being reported to child protective services and having their children removed from their care. As a result of all these negative perceptions, many homeless mothers avoid seeking treatment, and those who do seek treatment tend to drop out at alarmingly high rates (up to 85%) (Nuttbrock, Ng-Mak, Rahav, & Rivera, 1997; Sznajder-Murray & Slesnick, 2011).

Taking into account that service providers are not fully trusted by homeless mothers, and people living in homelessness view services as inadequate and inaccessible, it's crucial that mental health providers identify more accessible and familiar resources. Although linking every homeless mother with an experienced therapist/case worker might be the ideal scenario, limited resources as well as the service provider stigma within this population negate this as a possible option.

Peer Mentoring as a Viable Option

Since direct therapeutic intervention is neither feasible nor is it very beneficial because of the service professional stigma, we need to identify alternative strategies to reach this population. One currently available resource that is not being utilized is the population of women who have recovered from homelessness.

Peer support is defined as the "giving of assistance and encouragement by an individual considered to be equal" (Dennis, 2003). Peer support programs are designed to help populations who have been marginalized in the past such as gay males, low SES mothers who suffer from post partum depression, and victims of domestic violence (Taft et al., 2011). Alcoholics

Anonymous (AA), which is renowned for it's utilization of "sponsors", has shown that peer mentoring is the most effective intervention for helping substance-using individuals sustain sobriety (Kingree & Thompson, 2010; Tonigan & Rice, 2010). Peer mentoring has been very effective within the National Alliance on Mental Illness (NAMI), as families support one another to cope with loved ones being diagnosed with mental illness. Their Family-to-Family education program is effective for enhancing coping skills and empowerment in the family members (Dixon et al, 2011). Given that the mentor and mentee have shared familiar experiences, peer-mentor programs have an opportunity to reduce the power differential in the relationship and create more impacting change.

Peer Mentoring with Homeless Mothers

Mothers and children new to homelessness often have extensive unmet needs. New homeless mothers face incredible challenges and stigma with their newly homeless status. Such challenges include, but are not limited to; dealing with feelings of failing their children, balancing the stress of their children's education demands while confronting their own needs for employment/education, dealing with fears of their children being bullied at school because of their homeless status, and searching for emergency, transitional, or permanent housing options. An extensive body of literature highlights the risks and seemingly insurmountable challenges faced by women in homelessness (Finfgeld-Connett, 2010; Knitzer et al., 2008; Lewinson et al., 2014; Padgett et al., 2006; Schanzer et al., 2007; Teruya et al., 2011), however research has failed to identify many successful, brief, and affordable interventions. Creating opportunities for homeless women to mentor their peers through their homelessness may be an empowering, affordable, evidenced-based intervention. It utilizes the best resource, the women themselves, and empowers a community on a relational and personal level.

As positive as peer mentoring has the potential to be, this form of intervention also runs the risk of potentially producing negative or harmful effects with mentees as well. Research on contagious negative behaviors suggests that harmful negative behaviors such as rudeness, aggression, and even antisocial traits, can be spread within organizations and between individuals (Foulk, Woolum, & Erez, 2016; Robinson & O'Leary-Kelly, 1998). In order for peer mentoring to be an effective intervention versus a harmful one, the mentors must embody positive attitudes, beliefs, and behaviors that they desire to promote in their mentee.

Utilizing Brief Interventions

According to the National Alliance to End Homelessness (2014), approximately 75% of homeless families who enter homeless shelters are able to quickly exit through family members, motels, or emergency housing. However, 25% of families may require additional assistance. Since the goal is to help individuals exit homelessness quickly, it makes sense to utilize effective and brief interventions. Brief interventions are evidence-based practices designed to help individuals make changes in short-term settings (Fleming & Manwell, 1999 p.128-137). Originally designed to help treat substance use and primary care health issues, brief interventions have not yet been integrated in peer mentor interventions. The structure offered through a brief intervention model may be helpful in a short-term, peer-mentoring relationship because the structure may mitigate the potentially harmful negative contagions as well as maximize the outcome in a time-limited relationship.

The "5 As" is a behavior change model which is frequently used in primary care medical settings (Hunter, 2009). The 5A's is a collaborative problem-solving approach designed to support the client's ability to determine a goal and strategy that is most relevant to their desired change. The 5-stage intervention can be conducted in the span of 15 to 30 minutes. The first

stage is Assess, during which the provider gains an understanding of the symptoms, environmental factors, and level of agency experienced by the patient. Once enough information is gathered, the provider and the client move to the Advise stage which the provider explains intervention options. The third stage, Agree, is when the client decides and communicates agreement to pursue a specific intervention. Once the intervention is decided upon, the client enters the Assist stage and the provider helps the client by introducing new skills, resources, or relevant referrals. In Arrange, the fifth and final stage, the provider and client arrange a specific follow-up plan. Follow-up plans could include setting the next appointment, calling referral agencies, or providing additional, specific resources.

Purpose of Research

The current literature highlights the risks and seemingly insurmountable challenges faced by women in homelessness, but fails to identify successful and/or affordable interventions. The application of a peer-mentoring model in which women who have overcome homelessness have the opportunity to mentor women currently living in homelessness has the potential to be an empowering and effective intervention. In an effort to address the potential problem of negative contagion and the limited time available for mentor-mentee meetings, this study incorporated the use of the 5A's to maximize the impact of the mentor-mentee relationship. I wanted to know if the use of a structured intervention within the mentoring relationship increased the impact of the relationship when compared to the impact of a more traditional non-structured mentoring relationship. In an effort to assess the application of a peer-mentoring model for women living in homelessness, including a comparison of a structured vs. unstructured mentoring relationship, this research proposed the following hypotheses:

Hypothesis 1: Fostering a peer mentor relationship between a formerly homeless mother and a current homeless mother would increase the self-efficacy, self esteem, and subjective perception of overall functioning as measured by the Outcome Rating Scale (ORS) for the currently homeless mothers (regardless of whether the mentees participated in an unstructured or structured intervention).

Hypothesis 2: Homeless mothers who were mentored by peer mentors who were trained in a structured brief intervention (5 A's) would report greater levels of change in self-efficacy, self-esteem, and subjective perception of overall functioning than the women assigned to the control group who receive mentoring from the non-trained mentors.

Hypothesis 3: The mentors themselves will also increase in self-efficacy, self-esteem, and subjective perception of overall functioning.

Chapter 2

Methods

Participants

The participants were 20 mothers (4 mentors, 16 mentees), all women reported English to be their primary language. All four of the mentors in the program were formerly homeless, and all 16 of the mentees were currently homeless (range of 10 days to 1.5 years). Top reported reasons for entering homelessness included loss of employment, prohibitive cost of housing, recent move, or fleeing domestic violence.

The average age of the mentees in the study was 34.25 years (SD=7.64), the average age of the mentors was 36.5 years. Race of the mentees included African-American (56%), Caucasian (32%), Latina and Multi-racial (6% each), with mentors identifying as African-American (75%) or Caucasian (25%). Marital status of the mentees included single (56%), married/partnered (31%), and separated (13%), and marital status of the mentors included married/partnered (50%), and single and separated (25% each). The average number of children currently cared for by mentees was 2.19 (SD=1.68). A history of domestic violence was reported by 44% of the mentees and 31% reported a history of mental health or substance abuse problems. No participants reported current substance abuse or presence of a severe and persistent mental illness.

Apparatus

New General Self-Efficacy Scale (NGSES)- The NGSES is a self-report 8-item measure developed to assess the general self-efficacy of an individual. General Self-efficacy is described

as "one's belief in one's overall competence to effect requisite performances across a wide variety of achievement situations" (Eden, 1988). Studies done in two different countries indicated that the NGSES has higher construct validity and is shorter to administer than the Scherer et. Al General Self Efficacy Scale (SGSES), while also having high reliability.

Rosenberg Self-Esteem Scale (RSE)- The RSE (Rosenberg, 1965) is a self-report 10-item measure developed to assess an individual's subjective evaluation of personal worth. The measure is on a 4-point Likert-type scale with responses including: Strongly Agree, Agree, Disagree, and Strongly Disagree. Internal consistency ranges from .77 to .88 and the test-retest reliability ranges from .82 to .85.

Outcome Rating Scale (ORS)- The ORS was developed as a brief alternative to the Outcome Questionnaire 45.2 (Lambert et al., 1996). The ORS is an ultra-brief 4-item self-report measure used to assess and track client progress from session to session. The questionnaire assesses four areas including; Individually (personal well being), Interpersonally (family, or close relationships), Socially (work, school, friendships), and Overall (general sense of well being). Reliability for the ORS has a coefficient alpha of .87 to .96. The ORS has an overall concurrent validity with the Outcome Questionnaire 45-item (OQ-45) of a .59 (Miller, Duncan, and Brown, 2003).

Procedure

Mary's Place is a day shelter in King County, WA that serves homeless women and women with children. In 2014-2015, Mary's Place provided basic needs (showers, laundry, medical, food) to 3,194 women and children at their day center. Mary's Place agreed to help in the implementation of the peer-mentoring pilot program. The director of Mary's Place identified four formerly homeless mothers who participated in the program as mentors and selected 16-

women currently living in homelessness to be the mentees. The criteria for selection of the

mentors included perceived openness to mentoring, no obvious impairment or evidence of

symptoms indicating a lack of ability to participate (e.g. intellectual disability, acute mental

illness), English speaking, and perceived interpersonal warmth. Criteria for inclusion for the

mentees included perceived openness to being mentored, no symptoms indicating lack of ability

to participate, English speaking, and currently a homeless mother. The mentors were recruited

and hired with the help of the Mary's Place Director and staff.

The mentees were assigned to either the structured peer mentoring relationship or the

unstructured peer mentoring relationship based on the convenience factor of availability. The

intervention for the structured peer mentoring relationship occurred August 2015 and the pairs in

the non-structured mentoring relationships met during February, 2016. Mary's Place staff

recommended the implementation of the unstructured mentoring relationships occur after the

holiday season to avoid the high levels of stress, which might interfere with the mentoring

relationships. The mentors in the structured intervention condition participated in a 90-minute

training based on the adaptation of the 5A's behavior change model. The training was developed

and delivered by the primary researcher of this study. The trained mentors received a manual

and resources based on the 5A's in addition to the core mission values of Mary's Place. The

trained mentors individually contracted with each "mentee" for four 30-minute sessions over the

course of 2 weeks. The mentors assigned to the unstructured (non-intervention) relationship did

not be receive the training, but also contracted with each of their mentee's for four 30-minute

sessions over the course of 2 weeks. The unstructured contol group mentors had the freedom to

decide how they wanted to format their sessions.

Upon starting, each mentor reviewed and attained informed consent with each mentee. Following informed consent, the mentor and mentee each completed a New General Self Efficacy Measure (NGSES) questionnaire, a Rosenberg Self-Esteem questionnaire (RSE), and a Outcome Rating Scale (ORS) questionnaire. After every meeting, each mentor asked the mentee to complete an Outcome Rating Scale Measure, as well as completing their own. All mentors had the opportunity for consultation, questions and referrals with the trainer and Mary's place staff. After the four sessions of mentoring, post-intervention data were collected and analyzed. It was then determined whether the use of a structured intervention (5A's) had an actual impact on the mentee, or whether any differences could be attributed to the support offered in a peer mentoring relationship, regardless of structured intervention. If the mentees in the structured intervention relationship groups showed significant improvement over the mentees in the non-structured mentoring relationship, the non-trained mentors and mentees would also receive the training and have the opportunity to establish another series of mentoring experiences. Mentors had the opportunity to debrief their experiences and provide feedback for quality improvement in the future.

Chapter 3

Results

This study explored the impact of a peer-mentoring program on the subjective perception of overall functioning, self-esteem and self-efficacy of women mentors and mentees experiencing or recently emerged from homelessness. The study used repeated measures ANOVA design as the main statistical analyses.

Hypothesis 1 stated that fostering a peer mentor relationship between a formerly homeless mother (mentor) and a current homeless mother (mentee) would increase the self-efficacy, self-esteem, and overall functioning of the mentees as measured by the New General Self Efficacy Scale (NGSES), Rosenberg Self-Esteem Scale (RSE), and the Outcome Rating Scale (ORS), and the. This hypothesis was partially met as the results of the ORS showed significant positive change over time for all mentees (those in both the structured and un-structured conditions) $(F (1, 14) = 14.73, p = .002)$ from pre $(M = 29.17, SD = 6.04)$ to post $(M = 33.99, SD = 6.82)$. In contrast, the results of the RSE $(F (1, 14) = 1.38, p = .28)$ and NGSES $(F (1, 14) = 0.88, p = .36)$ did not significantly change over time. Refer to Figure 1 and Table 1 for mean change for each assessment measure over time.
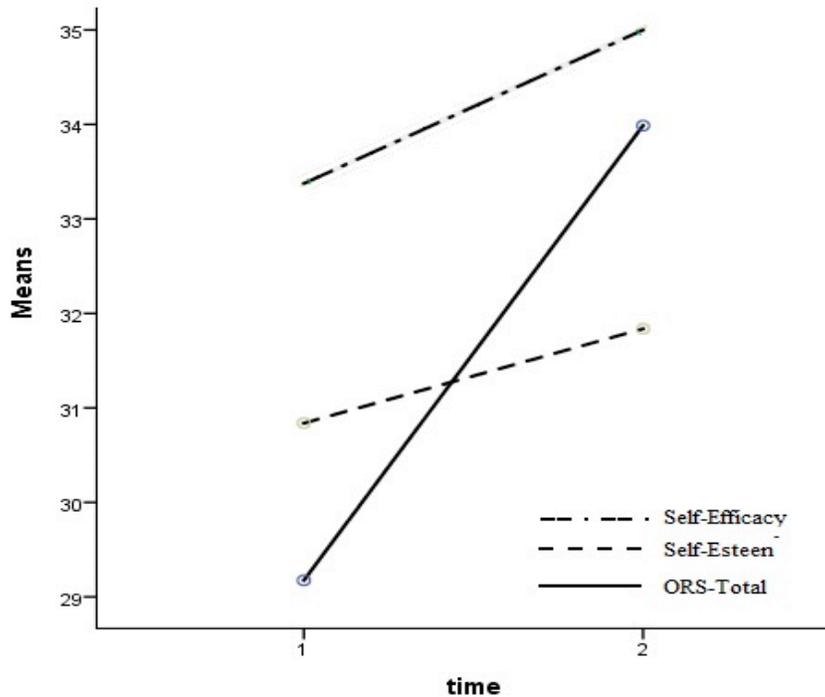
Figure 1. The change in test scores over time.

Table 1
Descriptive Statistics, ORS, NGSES, RSE for Unstructured vs Structured (5As) groups over time

Assessment Measure	Group	M	SD	n
NGSES	Unstructured	33.00	4.69	8
Pre-Test	Structured (5As)	33.75	4.83	8
	Total	33.38	4.62	16
RSE	Unstructured	31.59	4.81	8
Pre-Test	Structured (5As)	30.10	5.46	8
	Total	30.84	5.03	16
ORS Total	Unstructured	27.72	7.21	8
Pre-Test	Structured (5As)	30.63	4.62	8
	Total	29.17	6.04	16
NGSES	Unstructured	34.63	4.72	8
Post-Test	Structured (5As)	35.38	4.66	8
	Total	35.00	4.55	16
RSE	Unstructured	32.09	6.91	8
Post-Test	Structured (5As)	31.59	6.51	8
	Total	31.84	6.49	16
ORS Total	Unstructured	32.95	7.53	8
Post-Test	Structured (5As)	35.03	6.37	8
	Total	33.99	6.82	16

Hypothesis 2 stated that the mothers who were mentored by peer mentors trained in the structured intervention (5As) would report greater levels of change in the NGSES, RSE and ORS, than the women assigned to the unstructured peer-mentoring relationship. Results of the analyses did not support this hypothesis, as there was no significant difference between the groups for the NGSES ($F(1,12) = 2.23$, p= .16), RSE ($F(1,14) = .127$, p=.73) and ORS ($F(1,14) = .68$, p=.42),

Hypothesis 3 stated that mentors themselves would show significant improvement across all measures. Due to insufficient data gathered, this hypothesis was unable to be tested.

Supplementary Analysis

Given the above reported differences in the ORS over time, and lack of similar differences in the other measures, RSE and NGES, a supplemental analysis explored whether there was a statistically significant difference or sensitivity between the measures in the ability to detect changes over time. A 2x2x3 repeated measures ANOVA analyzed the interaction of three variables, group assignment (unstructured mentoring program vs. structured mentoring), time (pre-post), and the sensitivity of three assessment measures (ORS, RSE, and NGSES) to detect change over time. Mauchly's test of sphericity indicated that the assumption of sphericity had not been violated for either the comparisons between tests ($\chi2(2) =2.67$ p= .262) or test changes over time ($\chi2(2) =3.032$ p= .220). The results of the Levene's test confirmed the statistical assumptions were met in the ANOVA. Results showed the three assessment measures varied in their ability to detect differences over time ($F(2,28)= 4.47$, p=.02), with the ORS as the only measure able to detect differences over time. Refer to Table 2 for a summary of the ANOVA results.

Table 2

ANOVA Summary Table

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Eta Squared	Observed Power
time	147.41	1	147.41	6.74	.021	.48	.68
time * Group	.02	1	.02	.001	.98	<.001	.05
Error (time)	306.37	14	21.88				
test	159.69	2	79.84	3.84	.03	.27	.65
test * Group	48.58	2	24.29	1.17	.33	.08	.24
Error(test)	582.53	28	20.81				
time * test	66.96	2	33.48	4.47	.02	.32	.72
time * test * Group	3.33	2	1.67	.22	.80	.02	.08
Error (time*test)	209.82	28	7.49				
Group	13.38	1	13.38	.11	.75	.01	.06
Error	1721.30	14	122.95				

Additional analyses were conducted to determine which of the four subscales or combined total score of the ORS was most sensitive to change. Results of a 2(groups) x 2(times) x 4(ORS subtest) repeated measures ANOVA indicated the ORS Total scores changed significantly over time (F (1, 14) = 14.73, p = .002), but the individual subscales did not significantly differ (F (3, 42) = 1.82, p = .16). The ORS subtest scores all evidenced a medium effect size ($\eta^{2=}$ .13) change over time. Refer to Table 3 for a breakdown of ORS scores by subtest for each group.

Table 3
ORS Subscale and Overall Mean Differences, Pre-Post intervention for the Unstructured and Structured peer mentoring relationships.

ORS Scale	Group	M	SD	n
Individually Pre	Unstructured	6.99	2.74	8
	Structured (5As)	8.04	2.27	8
	Total	7.51	2.49	16
Interpersonally Pre	Unstructured	7.75	3.28	8
	Structured (5As)	7.85	2.07	8
	Total	7.80	2.65	16
Socially Pre	Unstructured	5.85	1.92	8
	Structured (5As)	7.01	1.65	8
	Total	6.43	1.75	16
Overall Pre	Unstructured	7.14	1.92	8
	Structured (5As)	7.73	1.65	8
	Total	7.43	1.75	16
Individually Post	Unstructured	7.66	2.56	8
	Structured (5As)	8.75	1.50	8
	Total	8.206	2.10	16
Interpersonally Post	Unstructured	8.65	1.62	8
	Structured (5As)	9.03	1.32	8
	Total	8.84	1.44	16
Socially Post	Unstructured	7.70	2.59	8
	Structured (5As)	8.59	1.67	8
	Total	8.14	2.16	16
Overall Post	Unstructured	8.94	1.55	8
	Structured (5As)	8.66	2.17	8
	Total	8.80	1.83	16

Chapter 4

Discussion

The purpose of this study was to explore the potential benefit of a peer-mentoring program for vulnerable women experiencing homelessness. Specifically, the research proposed that the implementation of a peer-mentoring program for women currently experiencing homelessness would positively impact self-efficacy, self-esteem and subjective perception of overall functioning, and that these differences would be greater for those women participating in the structured peer mentoring intervention protocol (5A's) than for those women assigned to the non-structured peer meetings. Results of this study converged with current literature (Kingree & Thompson, 2010; Taft et al., 2011; Tonigan & Rice, 2010) showing peer mentoring to be an effective intervention, specifically in participants' subjective perception of overall functioning. Results failed to support the expectation that including a structured brief intervention model within the peer-mentoring relationship would increase the impact of the relationship on the perception of overall functioning, self-esteem or self-efficacy as compared to the unstructured peer meetings. Nor did the results show significant differences in self-efficacy or self-esteem, regardless of group assignment.

The study contributed to the growing body of literature showing the positive impact of peer mentoring. Although no significant changes were discovered in regards to self-efficacy or self-esteem, there were significant changes founded in regards to increasing subjective overall sense of well-being as measured by the total score on the Outcome Rating Scale (ORS). Furthermore, the study showed high statistical power, suggesting that peer mentoring for both groups was a very effective intervention for creating change within current homeless mothers. These findings are promising as peer mentoring is a cost effective approach to supporting the

rising homeless population, and represents an important step forward in circumventing the power differential between homeless individuals and professional service providers.

Most important, this study implies that through relationship, growth and change can occur. As described in chapter one, the literature highlights a consistent theme around the negative spiral of unhealthy attachments and the intergenerational cycles of powerlessness commonly occurring with women who experience an excessive amount of risk factors (Finfgeld-Connett, 2010; Lewinson, Thomas, & White, 2014; Padgett, Hawkins, Abrams, & Davis, 2006). As a result of feeling disempowered, shame can often develop, leading these women to believe that their needs are no longer worthy and therefore are reluctant to ask or have positive expectancy that their needs will be met even if they do seek help. It is through the process of forming relationship and beginning to express their need, ask for, and receive help do these intergenerational patterns become disentangled. A peer mentor has the possibility to interrupt this negative cycle and provide an approximation of a corrective experience by showing an individual their needs matter and change is a possibility. By creating a place of safety and hope, which in this context, was offered through the form of a mentor relationship, the mothers in this study were able to take a step forward and improve their perception of their overall well-being.

Contrary to expectations, this study found no significant changes between the mothers who received mentoring from mentors trained in the 5A's intervention versus mentors who were not trained in the intervention model. The lack of a difference is likely due to two potential explanations. The first is the 5A's training might not have been thorough or long enough for the mentors to acquire mastery of the model. Maybe with additional training and practice and continued refinement of the 5a's framework, a change could occur. The second explanation, which appears more likely, is that the real mechanism of change was the mentors' ability to

create a safe and supportive relationship for the mentees. The experience of feeling listened to and understood by someone who had overcome homelessness may be far more important than the skills and techniques emphasized in a brief intervention model. Although the literature suggests that a lack of problem solving abilities exacerbates ones homeless status (Fischer, Shinn, Shrout, & Tsemberis, 2008; Torchalla, Strehlau, Li, & Krausz, 2011; Upshur, Weinreb, & Bharel, 2014), there may be another more important need going unmet and that is the need for human contact. Instead of equipping women with problem solving skills, perhaps the opportunity to talk, express oneself to another, and connect may be the primary need before any action plan or strategy can be implemented. The impact of relationship has been well documented in the psychological literature (Lambert & Barley, 2001) and the unexpected results may underscore the importance of relationship in this vulnerable population.

The supplementary analyses revealed unexpected outcome assessment information that may be helpful to future researchers and providers of service for women experiencing significant psychosocial stressors. When comparing between measures, results indicated that the ORS was the most sensitive measure for detecting change through out the study. The ORS was unique when compared to the New General Self Efficacy Scale (NGSES) or the Rosenberg Self-Esteem Scale (RSE) because not only was the ORS the most sensitive, it was also the shortest scale to administer and required the lowest reading ability. The measures of self-efficacy and self-esteem may have been impacted by social desirability, whereas the demand characteristics of the ORS were not as obvious. Future researchers looking to do field research with women of this population need to take into account the importance of brevity in administration, education level of the participants, and impact of demand characteristics for women to present themselves as competent.

Limitations

Given this study was a pilot project, the number of participants (N=16, 20 including

mentors) was quite small. Utilizing the G*Power program, inferential statistics predicted that

there would need to be 92 participants (46 in each group) to detect a statistically significant

change between the unstructured and structured intervention groups. A second limitation was the

lack of random assignment due to scheduling and mentor/mentee availability, thus this study was

quasi-experimental. Lastly, attrition also played a role in the study, as four participants (three

from the structured intervention group, and one from the unstructured mentoring group) were

unable to complete the entire program. In one circumstance, the staff was required to call child-

protective services, which disrupted the mentee's involvement. Due the unpredictability and

stressful nature of homelessness, these challenges are to be expected when working with this

population.

Future Research

This study is the first documented attempt to explore peer-mentoring interventions with

mothers living in homelessness, thus there are numerous opportunities for future research.

Potential opportunities include, but aren't limited to; furthering the development of ecologically

valid training protocols for mentors, increasing the number of participants, incorporating random

assignment of groups, and also studying the subsequent impact that peer mentoring can have on

the mentor.

Conclusion

As psychosocial stressors continue to increase, more families are at risk of facing the

hardship of homelessness. In a society where the threat of poverty is ever prevalent, there is an

urgent need to create effective and affordable interventions. The results of this study suggest that

a peer-mentoring program may be a promising intervention. While using minimal financial

resources, peer mentoring was shown to be an effective intervention for improving the subjective

well being of mother's currently experiencing homelessness.

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Appendix A

Outcome Rating Scale (ORS)

Name _____

Date: _____

Looking back over the last week, including today, help me understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I--I

Interpersonally
(Family, close relationships)

I--I

Socially
(Work, school, friendships)

I--I

Overall
(General sense of well-being)

I--I

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Appendix B

NGSES
(Chen, Gully & Eden, 2001)

	strongly agree	agree	No Preference	disagree	strongly disagree
1. I will be able to achieve most of the goals I set for myself	☐	☐	☐	☐	☐
2. When facing difficult tasks, I am certain I will succeed	☐	☐	☐	☐	☐
3. In general, I think I can achieve outcomes that are important to me	☐	☐	☐	☐	☐
4. I believe I can succeed at most tasks in which I set my mind	☐	☐	☐	☐	☐
5. I will be able to successfully overcome many challenges	☐	☐	☐	☐	☐
6. I am confident I can manage well on many different tasks	☐	☐	☐	☐	☐
7. Compared to other people, I can do tasks very well	☐	☐	☐	☐	☐
8. Even when things are tough, I can manage quite well	☐	☐	☐	☐	☐

Appendix C

Rosenberg Self-Esteem Scale (Rosenberg, 1979)

1. On the whole, I am satisfied with myself.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

2. At times, I think I am no good at all.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

3. I feel that I have a number of good qualities.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

4. I am able to do things as well as most other people.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

5. I feel I do not have much to be proud of.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

6. I certainly feel useless at times.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

7. I feel that I'm a person of worth.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

8. I wish I could have more respect for myself.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

9. All in all, I am inclined to think that I am a failure.

   Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

10. I take a positive attitude toward myself.

Strongly Disagree   *Disagree*   *Agree*   *Strongly Agree*

Appendix C

MARY'S PLACE

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Participant Name:_____   Date:_____

Taylor Hartman
Graduate Student Researcher
George Fox University

414 N. Meridian St. #332
Newberg, OR 97132
thartman12@georgefox.edu
(206) 234 7233

Study Title:
A Pilot Study: Implementing and Evaluating a
Brief Peer Mentoring Program for Newly Homeless Mothers.
Mentee Form

You are invited to participate in a research study conducted as a part of my graduate student dissertation at George Fox University. The purpose of this study is to find out more information about helping mother's take steps towards exiting homelessness.

INFORMATION
If you agree to take part in the study, you will be paired with a "Mentor", and meet for four meetings that will last 50 minutes each.

In conjunction with the meetings, you will also be asked to complete a demographic survey with information about yourself, A 10 item questionnaire, and a short four-item questionnaire about your mentoring process. The questionnaires are expected to take around 5 to 10 minutes to complete, and will be completed at the end of the meetings. Responses will be kept confidential.

BENEFITS
While there may or may not be direct benefits to you, we hope that the information we learn will help with the support of homeless mothers in the future.

RISKS
There are no physical risks associated with this study. There is, however, the potential risk of loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. Some of the questions we will ask you as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions and you may take a break at any time during the study. You may stop your participation in this study at any time.

CONFIDENTIALITY

Individual participants will not be identified. Please do not write your name or any other identifiable information anywhere on the surveys. We will not use your personal information in any reports about this study, such as journal articles or presentations.

WHAT ARE THE COSTS OF TAKING PART IN THE STUDY?
There will be NO cost to you.

WILL I BE PAID TO PARTICIPATE IN THE STUDY?
As a token of appreciation, you will receive a gift card worth $50.

WHAT ARE MY RIGHTS AS A RESEARCH PARTICIPANTS
- Your participation in this study is voluntary. You do not have to join this study. You are free to say yes or no.
- If you get sick or hurt in this study, you do not lose any of your legal rights to seek payment by signing this form.
- If you do decide to withdraw, we ask that you contact Taylor Hartman at (206) 234-7233 to let her know that you are withdrawing from the study.

WHO CAN ANSWER MY QUESTIONS ABOUT THE STUDY?

If you have questions about:	Contact:
This study (including complaints and requests for information)	(206) 234-7233 (Taylor Hartman) thartman12@georgefox.edu or Dissertation Supervisor, George Fox University Mary Peterson, PhD mpeterso@georgefox.edu
	You can always talk with your mentor as well.

You will get a copy of this form.
If you want more information about this study, please ask the researcher.

STATEMENT OF CONSENT

By signing my name below, it means that I have decided to participate in this study as a research participant. I read and understand the information on this consent form, I understand the purpose of this research study and what my participation in it will involve, and that all my questions are answered to my full satisfaction. I understand that I will be given a signed and dated copy of this consent form.

_____
Printed Name of Participant

_____   Date_____
Signature of Participant

SIGNATURE OF THE PERSON CONDUCTING THE INFORMED CONSENT DISCUSSION

I attest that all elements of informed consent described in this consent form have been discussed fully in non-technical terms with the participant. I further attest that all questions asked by the participant were answered to their satisfaction. The participant will be provided with a fully signed copy of this consent form.

_____   Date_____
Signature of Principal Investigator

<div align="center">Appendix D</div>

<div align="center">**MARY'S PLACE**
CONSENT TO PARTICIPATE IN A RESEARCH STUDY</div>

Participant Name:_____   Date:_____

<div align="center">

Taylor Hartman
Graduate Student Researcher
George Fox University

414 N. Meridian St. #332
Newberg, OR 97132
thartman12@georgefox.edu
(206) 234 7233

</div>

<div align="center">

Study Title:
A Pilot Study: Implementing and Evaluating a
Brief Peer Mentoring Program for Newly Homeless Mothers.
Mentor Form

</div>

You are invited to participate in a research study conducted as a part of my graduate student dissertation at George Fox University. The purpose of this study is to find out more information about helping mother's take steps towards exiting homelessness.

INFORMATION
If you agree to take part in the study, you will be paired with 4 "Mentees", and meet with each of them for four meetings that last 50 minutes each. The overall time commitment will be approximately 16 hrs of mentoring over the four days, plus a few extra hours for consultation with the researcher and the Mary's place supervisors.

In conjunction with the meetings, you will also be asked to complete a demographic survey with information about yourself, A 10 item questionnaire, and a short four-item questionnaire about your mentoring process. The questionnaires are expected to take around 5 to 10 minutes to complete, and will be completed at the end of the meetings. Responses will be kept confidential.

BENEFITS
While there may or may not be direct benefits to you, we hope that the information we learn will help with the support of homeless mothers in the future.

RISKS
There are no physical risks associated with this study. There is, however, the potential risk of loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. Some of the questions we will ask you as part of this study may make you feel uncomfortable. You may refuse to answer any of the questions and you may take a break at any time during the study.

CONFIDENTIALITY
Individual participants will not be identified. Please do not write your name or any other identifiable information anywhere on the surveys. We will not use your personal information in any reports about this study, such as journal articles or presentations.

WHAT ARE THE COSTS OF TAKING PART IN THE STUDY?
There will be NO cost to you.

WILL I BE PAID TO PARTICIPATE IN THE STUDY?
As a token of appreciation, you will receive a gift card worth $250.

WHAT ARE MY RIGHTS AS A RESEARCH PARTICIPANTS
- Your participation in this study is voluntary. You do not have to join this study. You are free to say yes or no.
- Once committed to the study, We do ask that you complete your comittment.
- If you do decide to withdraw, we ask that you contact Taylor Hartman at (206) 234-7233 to let him know that you are withdrawing from the study.

WHO CAN ANSWER MY QUESTIONS ABOUT THE STUDY?

If you have questions about:	Contact:
This study (including complaints and requests for information)	(206) 234-7233 (Taylor Hartman) thartman12@georgefox.edu or Dissertation Supervisor, George Fox University Mary Peterson, PhD mpeterso@georgefox.edu
	You can always talk with your mentor as well.

You will get a copy of this form.
If you want more information about this study, please ask the researcher.

STATEMENT OF CONSENT

By signing my name below, it means that I have decided to participate in this study as a research participant. I read and understand the information on this consent form, I understand the purpose of this research study and what my participation in it will involve, and that all my questions are answered to my full satisfaction. I understand that I will be given a signed and dated copy of this consent form.

_____
Printed Name of Participant

_____   Date_____
Signature of Participant

SIGNATURE OF THE PERSON CONDUCTING THE INFORMED CONSENT DISCUSSION

I attest that all elements of informed consent described in this consent form have been discussed fully in non-technical terms with the participant. I further attest that all questions asked by the participant were answered to their satisfaction. The participant will be provided with a fully signed copy of this consent form.

_____   Date_____
Signature of Principal Investigator