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RESEARCH ARTICLE

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Perceptions of support in shelter environments for caregivers and young children experiencing family homelessness

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Abstract

Background: Young children who stay with their families in homeless shelters face chronic challenges related to extreme poverty and acute risks from stressful events surrounding the loss of housing and move to shelter. These adversities increase the likelihood of a range of poor developmental outcomes. Consistent with the risk and resilience perspective, however, many children who experience family homelessness succeed, functioning as well or better than their non-homeless peers. As such, efforts to support resilience should consider how best to enhance protective factors, such as supportive environments within shelter settings.

Methods: With data from 60 caregivers of children ages birth to 5 years recruited from family shelters, we assessed caregivers' perceptions of community support as well as child and family well-being in terms of recent adverse experiences, parenting stress, access to social support, and child social–emotional functioning.

Results: Many caregivers experiencing family homelessness perceived negative aspects of the shelters where they were staying with their children. Furthermore, children whose caregivers had more negative perceptions of the shelter environment displayed worse social–emotional functioning, even when accounting for differences in parenting stress, recent family adversity, and other sources of social support.

Conclusions: Because young children rely on their caregivers as primary resources for nurturance and support, we encourage family homelessness service providers to work in partnership with caregivers to create more inclusive and empowering practices within the shelter context. Doing so is likely to improve children's developmental outcomes and the overall well-being of the families.

KEYWORDS
adversity, homelessness, parenting stress, resilience, risk

1 | INTRODUCTION

Among the approximately 291,000 U.S. children who stayed in emergency shelters for families experiencing homelessness in 2017, 49% were children under the age of 6 years (U.S. Department of Housing and Urban Development, 2018). These numbers are predicted to increase substantially in response to the COVID-19 pandemic (Coughlin et al., 2020). When staying in homeless shelters with their families, young children face numerous forms of adversity. These challenges include not only the chronic risks associated with extreme poverty but also acute risks from the stressful or traumatic events that precipitate or accompany the loss of housing and move to shelter (Cutuli & Herbers, 2014; Haskett & Armstrong, 2019). Together, these adversities increase the likelihood for poor developmental outcomes across domains of physical health, cognitive functioning, social relationships, academic achievement and mental health compared with

children who are stably housed (Bassuk et al., 2019; Haskett et al., 2015). Resilience research points to protective developmental processes that enable healthy, competent functioning despite considerable adversity (Cutuli et al., 2021; Masten & Palmer, 2019). Consistent with the risk and resilience perspective, many children who experience family homelessness succeed, functioning as well or better than their non-homeless peers (Herbers et al., 2020). As such, efforts to support resilience in children experiencing homelessness should consider how best to enhance their access to protective factors.

The most potent protective factors for young children experiencing adversity involve safe and nurturing care through positive relationships (Masten & Palmer, 2019). Young children are embedded in their families, which are embedded in broader systems. In the case of emergency housing, the shelter environment is that proximal system in place of a more typical home setting. Shelters thus have an opportunity to provide not only a place to live but also a context of nurturance and support for healthy development despite homelessness. Capitalizing on this opportunity requires attention to parents as caregivers, through whom the youngest children's needs are most likely to be addressed.

Children in family shelters who experience positive, nurturing relationships with their caregivers show lower levels of emotional and behavioural problems, fewer trauma symptoms and better academic functioning (Haskett & Armstrong, 2019; Herbers, Cutuli, Monn, et al., 2014; Labella et al., 2019). Within a positive parent–child relationship, young children develop a sense of trust in their caregivers as a resource for comfort, acceptance and information. They develop confidence to explore the world and tackle challenges, and they internalize experiences of co-regulation that foster their own developing capacity for self-regulation of thoughts, emotions and behaviour (Herbers, Cutuli, Supkoff, et al., 2014; Masten & Palmer, 2019). Unfortunately, episodes of homelessness and shelter stays present substantial challenges that can threaten the ability of caregivers to support child and family well-being. Homelessness occurs in the context of extreme poverty, and this chronic, poverty-related stress in addition to high rates of traumatic experiences predicts more negative parenting behaviours (Haskett & Armstrong, 2019; Labella et al., 2019).

Housing programs typically provide for basic needs like shelter and food, but they do so in settings of institutional living that can be at odds with typical family experiences. Such conditions include crowding, lack of private spaces, and exposure to 'public parenting' when staff and other residents observe and critique parent–child interactions (Bradley et al., 2018; David et al., 2012; Hausman & Hammen, 1993; Lindsey, 1998; Perlman et al., 2012). Shelters often exert social control of caregivers, most of whom are women, and restrict their choices about mealtimes, food, daily schedules and acceptable discipline techniques. This control may inadvertently compromise the caregiver's self-efficacy in the parenting role. For example, this may teach a child to believe that their mother is not competent on her own, but instead needs to be governed by rules imposed by individuals outside the family (Hartnett & Postmus, 2010).

In this challenging context, caregivers report high levels of distress due to environments lacking in emotional support. In a review of the qualitative literature on caregiver perspectives on impacts of homelessness, Bradley et al. (2018) summarized consistent themes of struggles with parent mental health, parenting authority, material resources, parenting environments and social support. Social support can be emotional or instrumental, and it can serve to alleviate parenting stress in contexts of risks (McGoron et al., 2020). Beharie (2015) showed that perceptions of negativity in shelter environments were correlated with poor mental health in caregivers with young adolescents. In qualitative studies, caregivers reported that shelter environments disrupted their family rituals and parenting through negative opinions of others, challenging their self-identification as a parent (Marçal et al., 2021; Mayberry et al., 2014). Hoffman and Coffey (2008) found that shelter conditions 'stripped [residents] of human personhood and individual identity' (p. 214) through minimal provisions and unequal power dynamics between staff and residents. Similarly, participants have expressed that case managers provided very little time for defining and understanding caregivers' needs, instead prescribing general solutions that did not necessarily apply to each individual family (Anderson et al., 2006; Marçal et al., 2021). Compounded with circumstances in which staff control residents' access to food and basic hygienic needs, this created an atmosphere of distrust, with residents believing that staff lacked compassion and abused their authority (Hoffman & Coffey, 2008).

In semi-structured focus groups, mothers in shelters with children ages 2–6 years shared their perceptions that service providers misunderstood and judged them, which prevented them from building strong working relationships (Sznajder-Murray & Slesnick, 2011). The strongest underlying theme among the mothers was distrust. When asked how they ideally would like to be treated, mothers reported a desire for service providers to understand their unique situation, consider their perspective and try to relate to their life story. Further, they wanted social support with guidance and acknowledgment of

Key messages

- Caregivers with young children experiencing family homelessness perceive restrictions and challenges within shelter environments that impact their family's well-being.
- Perceptions of challenges in the shelter environment predicted worse social–emotional functioning for children ages birth to 5 years, even when controlling for other factors.
- Parenting stress was also a strong predictor of worse social–emotional functioning for children.
- Shelter providers and other community agencies serving families experiencing homelessness can seek to better support child and family well-being by empowering caregivers, respecting their strengths and autonomy, and working collaboratively with caregivers in the design and implementation of services.

their positive progress and achievements. Overall, the mothers desired trust, confidentiality and mutual respect from providers, working on an equal platform toward a common goal (Sznajder-Murray & Slesnick, 2011). These desires are consistent with goals of Trauma-Informed Care (TIC), a strengths-based approach that seeks to understand and respond to potential impacts of trauma in social service settings, enabling people to rebuild their sense of agency and control (Guarino, 2014; Unick et al., 2019). A lack of trust and mutual respect from shelter providers may interfere with the family's progress towards more stable housing, missing an opportunity for caregivers to experience social support and TIC as protective factors (Cutuli & Herbers, 2014; Marçal et al., 2021; McDonald et al., 2016; Unick et al., 2019). Conversely, shelter providers who do establish mutual trust and respect caregivers as individuals may empower them, supporting their self-efficacy and effectiveness and, by extension, the developmental competence of their young children.

For the current study, we developed a questionnaire as a quantitative assessment of caregivers' perceptions of community support within shelter environments. We also assessed child and family well-being in terms of recent adverse experiences, parenting stress, access to social support and child social–emotional functioning among children ages birth to 5 years. We expected that caregivers' perceptions of support in the shelter environment would predict children's social–emotional functioning beyond risks associated with parenting stress, lack of social support and other adverse experiences.

2 | METHOD

2.1 | Participants and procedure

Participants were 60 caregivers recruited from five emergency shelters for families in Philadelphia. All shelters were congregate care settings. Four of the five shelters afforded families their own unit, while one shelter had two to three families share each unit. Each shelter had a communal dining space and at least one space for children to play with peers and their caregivers. Eligible caregivers were fluent in English and had at least one child under the age of 6 years. For families with more than one child under 6, the oldest was the focal child. Based upon information available from the shelter administrators, we estimated that about 75% of eligible families participated in the study. Focal children included 28 girls and 32 boys, ranging in age from 3 to 71 months ($M = 41.6$, $SD = 20.2$). Caregivers were all biological mothers, ranging in age from 18 to 47 years ($M = 28.9$, $SD = 7.0$). Fathers and other caregivers were considered eligible, but none were staying in the shelters during recruitment. As is typical in the population of mothers residing in urban family shelters, the majority were Black/African American or multi-racial (88.3%), and most were unemployed (80%). Caregivers reported having been in the shelters for an average of 17.8 weeks ($SD = 12.6$ weeks).

Recruitment and study procedures occurred onsite at the shelters. After providing informed consent, caregivers responded to a structured interview with one researcher while their children played with research assistants in an adjacent, private space. Researchers read all interview questions aloud to avoid challenges with literacy. Interviews lasted about 30 min, and caregivers received honoraria of $10 gift cards. All study procedures were approved by the Villanova University IRB. There was no missing data for the study measures reported next.

2.2 | Measures

2.2.1 | Shelter community

To assess caregivers' perception of the shelter community, we developed 14 self-report items describing sense of community within the shelter context (Vrabic, 2018). The items are listed in Table 1. The

TABLE 1 Items assessing parents' perception of the shelter community

Item	Item-total (*r*)	*M* (SE)
I feel listened to and respected when I talk about my problems to this community.	.62	2.40 (1.11)
I feel this community works to understand my needs and values.	.73	2.52 (1.08)
When helping me solve my problems, I feel this community puts my unique perspective first.	.72	2.27 (1.06)
I feel I have a voice among this community's staff (e.g., case managers, social workers, etc.)	.72	2.37 (1.06)
This community and I are working toward a common goal.	.73	3.05 (0.96)
This community provides me appropriate resources to fulfill my current goals.	.68	2.83 (1.09)
This community lets me raise my children the way I want to.	.65	2.53 (1.24)
I feel this community works to address my needs and values as a parent.	.78	2.48 (1.02)
I feel this community follows a schedule that supports my needs and goals as a parent.	.76	2.50 (1.13)
I feel this community respects my parenting style.	.69	2.86 (1.10)
This community gives me opportunities for private time with my child.	.65	3.15 (1.01)
I feel this community supports the enrichment and growth of my child.	.65	2.80 (1.07)
I feel this community prioritizes my child's health needs.	.74	2.87 (1.11)
I feel my child is safe in this community.	.43	3.15 (1.02)

content incorporates themes from a tool for self-assessment of shelter environments (ACF, 2015) and from extant qualitative research, such as themes of parenting in public and restrictive schedules (Hoffman & Coffey, 2008; Sznajder-Murray & Slesnick, 2011). The items were modelled after an existing measure of more general community support, the Sense of Community Index II (SCI-2; Chavis et al., 2008). First, participants were told: 'Now I'm going to ask you some questions about staying here at [shelter name]'. Next, we used the instructions from the SCI-2: 'How well do each of the following statements represent how you *feel* about this community?' Response options also were based on the SCI-2 as 4-point scale with anchors 1 (*not at all*), 2 (*somewhat*), 3 (*mostly*) and 4 (*completely*). We also administered the SCI-2 for convergent validity, presuming that perceptions of community specific to shelter would relate to a more general sense of community.

2.2.2 | Parenting stress

We assessed stress related to parenting and the parent–child relationship using the 12 item Parent–Child Dysfunctional Interaction subscale of the Parenting Stress Index, Fourth Edition (PSI-4-SF; Abidin, 2012). Caregivers responded to each item on a scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Example items include 'My child smiles at me much less than I expected' and 'When I do things for my child, I get the feeling that my efforts are not appreciated very much'. The subscale showed good internal reliability with $\alpha = .88$. Raw scores were converted to *T*-scores, with higher scores denoting more stress in the parent–child relationship.

2.2.3 | Social support

To account for other forms of social support, we summed affirmative responses to five questions asking whether caregivers would have access to certain types of support if they needed it. Types of support were instrumental ('someone to loan me $50', 'someone to help me if I were sick and needed to be in bed' and 'someone to take care of my child') and emotional ('someone to talk with about my problems' and 'someone to help me if I were tired and feeling frustrated with my child'). Scores ranged from 0 to 5.

2.2.4 | Adversity

To assess recent family adversity, we administered the Life Events Questionnaire (LEQ; Masten et al., 1994). Caregivers indicated whether in the past year their family had experienced 30 different life events, such as 'There were many arguments between adults living in the household during this past year' and 'a parent lost his or her job in the past year'. The number of unique negative events endorsed was summed as an index of adversity.

2.2.5 | Children's social–emotional functioning

We assessed children's social–emotional functioning using the Devereux Early Childhood Assessment (DECA: LeBuffe & Naglieri, 1999). Caregivers responded to items with options ranging from 1 (*never*) to 5 (*very frequently*). We utilized three separate forms (infant, toddler and preschooler) as appropriate. This assessment includes three subscales: attachment, self-control and initiative. Caregivers responded to statements such as: 'During the past four weeks, how often did the infant enjoy interacting with others' and 'During the past four weeks, how often did the child handle frustration well?' Raw scores were converted to *T*-scores derived from a national sample. The assessment has good internal and test–retest reliability, as well as convergent and criterion validity and has been validated for use with impoverished, ethnically diverse samples (Bulotsky-Shearer et al., 2013; Crane et al., 2011; Powell et al., 2007). Within the sample, items had an $\alpha = .78$.

3 | RESULTS

The 14 items in our novel scale of shelter community had good internal reliability, $\alpha = .93$, and the composite score was significantly correlated with scores on the SCI-2, $r = .70$, $p < .001$. Descriptive statistics and item-total correlations for each item are displayed in Table 1. The three items with average scores of 3 (*mostly*) or higher were: 'I feel my child is safe in this community', 'This community gives me opportunities for private time with my child' and 'This community and I are working toward a common goal'. The three items with the lowest scores, closer to a 2 (*somewhat*) on average, were 'I feel listened to and respected when I talk about my problems to this community', 'I feel I have a voice among this community's staff (e.g., case managers, social workers, etc.)' and 'When helping me solve my problems, I feel this community puts my unique perspective first'.

Based on norm-referenced *T*-scores, children in the sample scored below average on total social–emotional functioning ($M = 47.9$, $SD = 10.6$), with 30% of the sample scoring a full standard deviation below average. Toddlers (13–35 months old) and preschool-aged children (3–5 years old) were more likely to score below average than infants in the sample.

Perception of shelter community was significantly correlated with children's social–emotional well-being, $r = .30$, $p = .022$, showed a small but non-significant correlation with general social support, $r = .25$, $p = .059$, and was not associated with parenting stress (see Table 2). Social support was not significantly associated with children's social–emotional functioning, $r = .14$, $p = .289$. Parenting stress had a strong and significant negative correlation with children's social–emotional functioning, $r = -.62$, $p < .001$.

The multiple regression model was significant, $F(6, 53) = 8.37$, $p < .001$, accounting for 48.7% of the variance in children's social–emotional functioning. Perception of the shelter community significantly predicted children's social–emotional functioning, $\beta = .27$, $p = .010$, as did parenting stress, $\beta = -.61$, $p < .001$. Covariates of

TABLE 2 Bivariate correlations among study variables

		2	3	4	5	6	7
1	Child social–emotional	.30*	−.13	−.62**	.14	−.23	−.24
2	Shelter community	-	−.01	−.02	.25[t]	−.01	.03
3	Recent family adversity		-	.31*	−.29*	.02	.10
4	Parenting stress			-	−.05	.39**	.23[t]
5	Social support				-	.15	−0.08
6	Child age					-	0.01
7	Child gender (male)						-

*$p < .05$. **$p < .01$. [t]$p < .10$.

TABLE 3 Results of multivariate regression predicting children's social–emotional competence

	B (SE)	β
Shelter community	3.63 (1.36)	.27*
Recent family adversity	0.34 (0.42)	.09
Parenting stress	−0.81 (−0.15)	−.61**
Social support	0.40 (0.71)	.06
Child age	−0.00 (0.06)	−.00
Child gender (male)	−2.39 (2.16)	−.11
R^2	.49**	

**$p < .01$.

child age, child gender, general social support and recent family adversity did not emerge as significant predictors (see Table 3).

4 | DISCUSSION

Findings from our study affirm evidence from qualitative studies suggesting that caregivers experiencing family homelessness perceive negative aspects of the shelters where they stay with their children. Particularly, self-report items pertaining to themes of trust and empowerment were endorsed less positively than items pertaining to shared goals and children's health and safety. This suggests that, although they generally felt that their children were safe in shelter contexts, many of the caregivers in our study did not feel a sense of trust with shelter service providers. Their responses also indicated feelings of disempowerment and being misunderstood. Furthermore, differences in these perceptions were predictive of children's social–emotional functioning: Children whose caregivers had positive perceptions of the shelter environments displayed better social–emotional functioning, even when accounting for a strong effect of parenting stress and potential confounds of recent family adversity and other sources of social support.

Family homelessness is not a rare experience in the United States, and rates of family homelessness are expected to increase substantially in response to the COVID-19 pandemic (Coughlin et al., 2020; Haskett & Armstrong, 2019). Children under age 6 are especially prevalent among those who stay in family shelters, making shelters an important context for their development. Service providers at family shelters thus have an opportunity and responsibility to consider what is developmentally appropriate in those contexts and how they can best protect young children from threats associated with poverty and homelessness. Young children clearly rely heavily on their caregivers for nurturance and support, as shown in our work with the association between parenting stress and child functioning. As such, family shelters will be most successful when working in partnership with caregivers.

Our findings corroborate the need for housing providers to develop and implement methods of TIC that enhance caregivers' experience and perceptions of support. For example, housing providers can make intentional efforts and policies to include caregiver perspectives in assessments of shelter services and functioning. Creating a Participant Advisory Council is one strategy to include caregiver perspectives in decision-making. Such a council could include both current and former shelter residents to advise on what has been most helpful, and what has been lacking, in their experiences of programming and services. Housing program staff can empower caregivers by valuing their input when determining the rules for living within shelter communities. They can aid in the maintenance of each family's individual routines, supporting families' unique senses of identity and parents' autonomy as heads of household (Beharie, 2015).

Strengths of this study include the use of quantitative methods to investigate hypotheses based on extant qualitative studies. The questions we developed to assess perceptions of support in the shelter environment may be useful to future investigations seeking to better understand what factors are associated with caregiver experiences. Limitations of our study included a relatively small sample size of 60 families recruited from five different shelters. With small numbers representing each shelter, we did not have sufficient statistical power to test for shelter-level effects. Furthermore, our sample was drawn from a large urban area, and our findings may not generalize to families experiencing homelessness in suburban or rural settings. The demographics of our participants are representative of broader urban shelter populations and future research could investigate how experiences of systemic inequity affect caregiver perceptions of social support. We recommend this as a key area of future research, particularly following the COVID-19 pandemic. This study also relied on caregiver report for all measures. Future research might consider utilizing direct assessments or observational methods in addition to caregiver report

to provide more rigorous evidence. This study was also limited by its cross-sectional design, whereas future longitudinal studies could investigate whether these associations change over time.

Understanding the varied needs of families with young children experiencing homelessness, and whether and how emergency housing programs are meeting those needs, holds great potential for bolstering resilience in these high-risk, high-adversity contexts. First and foremost, there is a need to address structural issues of extreme poverty, lack of affordable housing and systemic inequality to reduce the need for families to use emergency shelters. At the same time, caregiver perspectives should be incorporated into the design and delivery of needed services. In this study, young children's social–emotional functioning was significantly associated with both caregivers' perceptions of the shelter environment and caregivers' parenting stress. Children's functioning depends on the quality of the relationships and broader contexts surrounding them. More developmentally appropriate and emotionally supportive communities within service environments could potentially support child well-being both directly and indirectly, by bolstering the resources, social support and sense of self-efficacy of the children's caregivers.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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