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Barriers to Mental Health Treatment Among Chronically Homeless Women: A Phenomenological Inquiry

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Walden University

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Rebecca Spicer

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Walden University
2017

Abstract

Barriers to Mental Health Treatment Among Chronically Homeless Women:

A Phenomenological Inquiry

by

Rebecca Spicer

MA, California School of Professional Psychology

BA, University of Washington

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

September 2017

Abstract

Homeless women demonstrate higher rates of mental illness than homeless men. The combination of complex life circumstances, stigmas related to mental illness, and homelessness may cause homeless women with mental illnesses to face unique barriers that prevent them from accessing necessary mental health services. The purpose of this phenomenological study was to expand the body of literature on homeless women's experiences with the mental health system and to understand the barriers to treatment services. Guided by Young's critical social theory of gender, this study was designed to develop a better understanding of the support that may be in place to help women overcome service access barriers related to social issues of race, class, sexuality, and gender. Study participants included 10 chronically homeless adult women in the Southeastern United States who were diagnosed with a mental illness. In-person semistructured, open-ended, phenomenological interview questions were used to explore the research questions. Thematic analysis revealed 5 main themes: (a) reasons for homelessness, (b) reasons women stay homeless, (c) mental health experiences and issues, (d) experiences with being homeless, and (e) services and supports. There were 3 subthemes associated with services and supports: (a) the shelter experience, (b) services that are needed, and (c) professionals should know. Understanding women's unique backgrounds and histories may help service providers and policy makers develop ways to make mental health services more accessible to the homeless women who need them.

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Dedication

This dissertation is dedicated first and foremost to my son, Grant D. Crabtree, and my parents, Pedro and Marion Granados. To my mother in heaven, I know you are proud of me and I thank you for your never-ending support and the kind words of encouragement you gave to me as you never questioned my ability to finish this journey. To my son, I pray you will always strive for each and every one of your goals and never give up, as there is always a way to make your dreams come true.

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Finally, and most importantly to all of my homeless participants. I acknowledge your daily struggle, trying to meet your most basic needs to the best of your abilities against a constantly changing system that has failed you. This study would have been impossible without the truth, openness, and vulnerability you shared with me.

Table of Contents

List of Tables	v
List of Figures	vi
Chapter 1: Introduction	1
Introduction.....	1
Background	2
Problem Statement	4
Purpose of the Study	6
Research Questions	6
Theoretical Framework.....	6
Nature of the Study	8
Definitions.....	10
Assumptions.....	11
Scope and Delimitations	11
Limitations	12
Significance.....	13
Summary	13
Chapter 2: Review of the Literature.....	15
Introduction.....	15
Literature Search Strategy.....	17
Theoretical Framework.....	17
Literature Review.....	20

Why Women?	20
Women With Children	21
Types of Homelessness	21
Aspects of Homelessness	24
Victimization and Violence	24
Shelters	25
Substance Abuse	26
Predictors of Homelessness	27
First Time Homelessness	30
Physical and Mental Health	31
Adaptive Behaviors and Coping	35
Barriers to Care	37
Summary	46
Chapter 3: Research Methods	47
Purpose of the Study	47
Research Design and Approach	48
Role of the Researcher	51
Methodology	52
Participant Selection Logic	52
Instrumentation	54
Procedures for Recruitment, Participation, and Data Collection	57
Data Analysis Plan	59

Issues of Trustworthiness.....	60
Ethical Procedures	62
Summary	62
Chapter 4: Results	63
Introduction.....	63
Setting	64
Demographics	64
Data Collection	66
Data Analysis	69
Evidence of Trustworthiness.....	70
Results.....	71
Theme 1: Reasons for Homelessness.....	72
Theme 2: Women Stay Homeless Because	80
Theme 3: Experiences with Being Homeless	87
Theme 4: Mental Health Experiences and Issues	97
Theme 5: Services and Supports.....	110
Summary	123
Chapter 5: Discussion, Conclusions, and Recommendations	124
Introduction.....	124
Summary of the Findings.....	125
Interpretation of Findings	129
Reasons for Homelessness.....	129

Women Stay Homeless Because.....	132
Mental Health Experiences and Issues	132
Experiences With Being Homeless.....	133
Services and Supports	134
Limitations of the Study.....	134
Recommendations.....	135
Implications.....	136
Positive Social Change	136
Theoretical Implications	137
Practical Implications.....	137
Conclusions.....	139
References.....	141

List of Tables

Table 1. Please Add Title of Table Here.....xx

Chapter 1: Introduction

Introduction

Chronic homelessness is a significant social, economic, and public health problem in the United States (Tsai & Rosenheck, 2015). A chronically homeless individual has lived in shelters or public places for at least the past year, or has experienced at least four homelessness episodes in the past 3 years (Office of Community Planning and Development, 2007). Certain individuals are at an increased risk of chronic homelessness, including those with a mental illness (Montgomery, Metraux, & Culhane, 2013). Barriers to mental health services, such as discrimination and stigma, can affect access to adequate mental care (Skosireva et al., 2014), and untreated mental illnesses can result in an escalation of the disorders (Sickel, Seacat, & Nabors, 2014). Thus, it is critical to ensure chronically homeless individuals with mental disorders have access to adequate treatment services.

Among the homeless, women are more likely than men to have diagnosed mental illnesses (Lee et al., 2010). However, because the majority of homelessness research has pertained to men, little information exists regarding the homeless experiences of women with mental disorders (Fries, Fedock, & Kubiak, 2014). Because treatment of mental disorders is critical for reducing homelessness, I explored the ways homeless women with mental illnesses access mental health services and the barriers they experience in accessing such services and resources.

This chapter includes a presentation of the background of the problem, problem statement, and purpose statement. A discussion of the theoretical framework follows the

research questions. The nature of the study, key terms, assumptions, scope, delimitations, and delimitations are also presented. I conclude with a discussion of the study's significance and a summary.

Background

Homelessness, which describes a lack of regular and adequate nighttime residence (McKinney-Vento Homeless Assistance Act, 2009), has significant social, economic, and public health consequences (Tsai & Rosenheck, 2015). In 2014, the average U.S. rate of homelessness was 18.3 out of every 10,000 individuals (National Alliance to End Homelessness, 2014). Of the homeless, women comprise 45% of the sheltered population and 29% of the unsheltered population (U.S. Department of Housing and Urban Development, 2015). Negative outcomes associated with homelessness include problems with physical health (Creech et al., 2015; Henwood, Cabassa, Craig, & Padgett, 2013; Hwang, 2001; Schanzer, Dominguez, Shrout, & Caton, 2007), substance abuse (Folsom et al., 2005; Substance Abuse and Mental Health Services Administration, 2010), premature death (Hewett, Hiley, & Gray, 2011; O'Connell, 2005), incarceration (McGuire, 2007; Tsai & Rosenheck, 2015), and high rates of hospitalization (Chambers et al., 2013; Hwang et al., 2013). The United Nations (1948, 1976) considers homelessness a violation of basic human rights.

Rates of homelessness are significantly higher among individuals with a mental illness (Montgomery et al., 2013). The Substance Abuse and Mental Health Services Administration (SAMHSA; 2003) estimated that on any given night, two-thirds of individuals experiencing homelessness in the United States have a mental illness. For

example, rates of homelessness among individuals with psychosis are as high as 42% (Fazel, Khosla, Doll, & Geddes, 2008). Common mental illnesses among homeless individuals include depression, schizophrenia, and suicide ideation (Lippert & Lee, 2015). In health care, homeless individuals with mental illnesses are among the most marginalized patient groups (Skosireva et al., 2014). Barriers, such as discrimination and stigma, create high levels of unmet health needs among homeless adults (Skosireva et al., 2014). As Skosireva et al. (2014) explained, “stigma and discrimination due to mental illness can have more devastating and long-lasting effects on the individual than the mental disorder itself and perpetuate a cycle of impoverished disability” (p. 2).

Although an extensive body of literature exists on homelessness, much of this research has focused on men (Deck & Platt, 2015; Längle, Egerter, Albrecht, Petrasch, & Buchkremer, 2005; Parker, Reitzes, & Ruel, 2015; Salem et al., 2015; Watton & Gallivan, 2013). Thus, there is a dearth of information regarding the homelessness experiences of women (Fries et al., 2014). Rates and experiences of homelessness may vary by gender (Ranieri, 2009). Researchers indicated that homeless women tend to be younger than homeless men (Novae et al., 1996), have better social connections (Brunette & Drake, 1998), report higher rates of victimization (Whitzman, 2006), are less likely to become incarcerated (Zugazaga, 2004), and are more likely to experience short-term episodes of homelessness (Zugazaga, 2004).

Homeless women “frequently face a choice between the dangers of life on the street and the hazards of overcrowded, unsafe, and poorly supervised shelters” (Goodman, Dutton, & Harris, 1995, p. 468). Homeless women with mental illnesses are

particularly vulnerable to the dangers associated with homelessness because of poor access to resources (Goodman et al., 1995). For example, homeless women who are mentally ill have more difficulty obtaining basic provisions, such as food and adequate sleep, than homeless men who are mentally ill (Rosnow, Shaw, & Concord, 1985). Homeless women are more likely than homeless men to experience mental illness. Lee et al. (2010) revealed that 73% of homeless men were mentally ill, and 81% of homeless women were mentally ill. Proper treatment for mental illness is critical to reducing homelessness; thus, research was needed on barriers, access, and use of mental health services among homeless women with mental illness.

Problem Statement

Psychiatric epidemiologists and mental health researchers have studied the complex social problem of homelessness for 4 decades (Chondraki, Madianos, Dragioti, & Papadimitriou, 2014). However, in most of the studies on risk factors associated with homelessness among adults, researchers have focused on men (Deck & Platt, 2015; Längle et al., 2005; Parker et al., 2015; Salem et al., 2015; Watton & Gallivan, 2013). Thus, a dearth of information exists regarding the homelessness experiences of women (Fries et al., 2014).

While there is a general lack of research pertaining to homeless women, a particularly problematic gap is the topic of mental health treatment among homeless women. According to SAMHSA (2011), more than 25% of homeless individuals in the United States suffer from severe mental illnesses. Although rates of homelessness are lower among women than among men, rates of mental illness are higher among the

population of homeless women (Barrow, Soto, & Cordova, 2004). Homeless women often face unique and complex life circumstances that limit their abilities to secure mental health services (David, Rowe, Staeheli, & Ponce, 2015). In addition, it is common for homeless populations to underuse the available mental health services because of various barriers (Bonin, Fournier, & Blais, 2009). Some of the potential barriers to mental health service use include stigmas related to mental illness, fears of rejection (Abe-Kim et al., 2007), poor means of communication, and unmet basic needs (Krausz et al., 2013).

Researchers have found that individuals suffering from severe mental illness die an average of 25 years sooner than the general population—a statistic largely attributed to high rates of homelessness among those with a mental illness (National Association of State Mental Health Program Directors, 2006). Understanding women’s unique backgrounds and histories may help overcome barriers to effective treatment. Bonugli, Lesser, and Escandon (2013) explained,

As research describing the prevalence, incidence, and patterns of violence among this population adds to our understanding of the risks that these women face, it is equally important to gain insight into the personal experiences as perceived by those who have lived the experience. (p. 827)

By Understanding the barriers to mental health treatment, service providers can inform initiatives and cultivate better access to services for this population.

Purpose of the Study

The purpose of this study was to expand the body of literature regarding homeless women's experiences with the mental health system and to understand barriers to treatment services. To address this gap in the literature pertaining to the availability and use of mental health services by chronically homeless women with mental illnesses, I conducted a phenomenological, qualitative study. I used semistructured interviews to gather information about mental health treatment barriers among women with histories of chronic homelessness.

Research Questions

The phenomenological study was guided by the following research questions:

RQ1: Based on their lived experiences and perceptions, how do chronically homeless women with mental illnesses residing in an urban county in the southwestern United States utilize available mental health services?

RQ2: Based on their lived experiences and perceptions, what are some of the barriers to mental health treatment and services faced by chronically homeless women with mental illnesses residing in an urban county in the southwestern United States?

Theoretical Framework

I developed the theoretical framework for the research using Young's (1994) critical social theory of gender. Young posited that social structures, such as norms, institutional rules, and embedded practices, place members of society into various positions, including those of power and subordination, according to structures of race, class, sexuality, and gender. Weldon (2008) explained, "thinking of gender, race, and

class as social structures is important because it helps to explain societal inequality; specific constellations of norms and institutions coincide to advantage certain people or characteristics and disadvantage others in certain ways” (p. 313).

Social structures can aid or disenfranchise certain members of society. Gender is one social structure that can foster social inequality. Feminist critical social theory holds that referring to something as male or female often generalizes the experience and can deprive, dominate, or exploit other groups. Multiple intersecting features, rather than gender alone, cause social inequality. Gender operates within a larger social structure, and all pieces of this structure must be considered.

When considering the use of mental health services by homeless women with mental illnesses, it is essential to acknowledge the social barriers related to race, class, sexuality, and gender that this group faces. Specifically, membership in this group brands individuals with three labels that may lead to discrimination, prejudice, inequality, or poor access to resources. These labels include (a) woman, (b) homeless, and (c) mentally ill. When individuals identify as female, issues of sexual discrimination and gender discrimination may create barriers to services. Similarly, homelessness and mental illness may create significant social barriers that prevent women in this population from accessing the mental health care they need.

When investigating the mental health services that homeless women with mental illness do access, I found the critical social theory of gender (Young, 1994) to be useful for understanding macro- and microlevel social factors involved in accessing and using those services. This theory was particularly useful for understanding why this population

uses some services more than others and how participants access such services. Essentially, by using Young's (1994) theory to explore the use of mental health services by homeless women with mental illnesses, I developed a better understanding of supports that were in place to help women overcome service access barriers related to social issues of race, class, sexuality, and gender. Chapter 2 includes further details regarding this theoretical framework.

Nature of the Study

I chose a qualitative phenomenological design to explore the experiences of chronically homeless women with mental illnesses regarding mental health services. I chose this design to explore the phenomenon from the perspectives of the study participants. Qualitative methods were inductive and the answers arose from the data. The study methods were naturalistic in that I explored phenomena in the natural setting (Creswell, 2009). This made a qualitative methodology particularly appropriate for the research because data collection was required in participants' settings because they were homeless.

Phenomenology is the study of participants' experiences with a specific phenomenon (Moustakas, 1994). The phenomenological design is recommended when the researcher wishes to investigate a number of participants sharing experiences of a phenomenon (Moustakas, 1994). In the study, I explored participants' experiences with mental health services. The nucleus of the phenomenological model is a focus on a phenomenon in the natural world (Tracy, 2013); that is, the researcher seeks to understand a phenomenon without creating intrusion. The use of a phenomenological

research method enables the researcher to explore the lived experiences of the participants and to gather information to uncover themes and subthemes (Tracy, 2013).

In qualitative inquiry, it is not necessary to have a large sample size. The goal of qualitative research is to gain in-depth understanding of the phenomenon under investigation (Burlingham, Andrasik, Larimer, Marlatt, & Spigner, 2010). To date, no standard protocol exists for estimating sample size requirements for saturation (Kerr, Nixon, & Wild, 2010). Sample sizes for phenomenological studies range from six to 10 participants (Marshall, Cardon, Poddar, & Fontenot, 2013). Other researchers recommend five to 13 participants (Cardo et al., 2013; Francis et al., 2010; Tracy, 2013). These recommended ranges were adequate in recent qualitative investigations on homelessness. For example, Osuji and Hirst (2013) achieved saturation with 12 participants during their investigation of the journey through homelessness. Similarly, Ogden and Ayades (2011) achieved saturation with eight participants in a study on use and non-use of services among homeless individuals in the United Kingdom. Based on these recommendations and past studies, I began with a sample of 10 participants. No new themes emerged during the tenth interview, so I determined data saturation had occurred. However, if another new theme emerged during the tenth interview, I would have continued to add participants and conduct additional interviews until saturation was indicated.

To be eligible to participate, individuals had to (a) be chronically homeless, as defined by the Federal government; (b) be 18 or older; (c) be medically diagnosed with a mental illness within the last 5 years; and (d) have no minor children accompanying them. Participants were recruited from local shelters, homeless service centers, and

foodbanks through flyers, word of mouth, and referral. I collected data from semistructured, open-ended phenomenological interviews conducted in participants' natural settings (i.e., not at the foodbank or shelter). I developed an interview protocol to explore how participants used available mental health resources and any barriers they experienced accessing mental health services. Prior to the study, the protocol was validated by a panel of subject matter experts to ensure the protocol was not leading and was free of bias. I anticipated each interview would last no longer than 60 minutes. The identities of all participants were protected. Upon completion of interviews, each participant received a \$10 gift card to a local food business to thank them for their time and as an appreciation for sharing their story. I used Braun and Clarke's (2006) thematic analysis to analyze the data.

Definitions

Chronically homeless: Individuals living in shelters or public places for at least the past year, or having at least four homelessness episodes in the past 3 years (Office of Community Planning and Development, 2007).

Episodically homeless: Individuals who are currently homeless and have experienced at least three episodes of homelessness in the past year. Homelessness episodes are defined as periods when an individual resides in a shelter or place not fit for human habitation (Employment and Social Development Canada, n.d.).

Homelessness: The lack of a "fixed, regular, and adequate nighttime residence" (McKinney-Vento Homeless Assistance Act, 2009).

Mental illness: All diagnosable mental disorders, which are health conditions characterized by changes in thinking, mood, and behavior, associated with distress or impairments to function (U.S. Department of Health and Human Services, 1999).

Vulnerable populations: Groups of individuals at an increased risk for poor health because of marginalized social characteristics, such as race, age, gender, socioeconomic status, mental health, or disability (Aday, 2001).

Assumptions

Several assumptions were inherent in my research. First, I assumed all participants possessed adequate experience with mental illness and chronic homelessness to provide meaningful data. To ensure participant qualification, each prospective participant was required to meet the study's inclusion criteria, discussed in Chapter 3. Another assumption was that the interview protocol used to gather study data was appropriate for a phenomenological study and could be used adequately address the research questions. To ensure the interview protocol was valid and free of bias, I had a panel of three subject matter experts review it. I assumed participants answered questions honestly and openly. The identities of all participants were protected with the hope that anonymity encouraged in-depth and truthful responses.

Scope and Delimitations

Delimitations represent the boundaries of a study (Bloomberg & Volpe, 2012). I restricted this study to 10 chronically homeless women with mental illnesses, age 18 and older. The scope of the study extended to individuals who fit the designation and were located in the southwestern United States, where the study took place. In addition, this

research only involved an exploration of participants' perceptions and experiences with mental health care; thus, perspectives and information from health care providers and other individuals who interacted with the population were not included in this analysis.

Limitations

The study was subject to limitations. First, the qualitative nature prevented generalizability. The study was also bound by time. Because data collection took place during a specific time, it is possible that participants' reported barriers to mental health services varied based on the time during which data were collected. Another limitation was the geographic location. All participants were located in an urban county in the southwestern United States. Also, only participants who were chronically homeless were eligible to participate. It is possible that women with mental illnesses who experienced episodic homelessness would report different barriers to mental health services than those who experienced chronic homelessness. This research was also limited to adult women, ages 18 and older; thus, the experiences of younger women were not investigated.

The mental conditions of participants also presented a limitation. After thorough explanation of the aims of this study, participants still may not have provided honest and forthright answers. In addition, special care was required to address concerns of confidentiality. Because of their status as mentally ill, participants may have been suspicious of well-intentioned research motives. However, despite these limitations associated with participants' conditions, I assumed participants answered interview questions openly and honestly. Mental health resources were provided to all participants, regardless of their answers to interview questions.

Significance

This study has important social implications. Untreated mental illness affects an individual's quality of life (Lam & Rosenhack, 2000; Steiner, Looney, Hall, & Wright, 1995), physical health (Jones et al., 2004), mental well-being (Ito, Morikawa, Okamura, Shimokado, & Awata, 2013), and may prolong episodes of homelessness (Patterson, Somers, & Moniruzzaman, 2012). Research has indicated that the rate of mental illness is high among homeless women (Barrow et al., 2004). Understanding the barriers to mental health treatment among chronically homeless women with mental illnesses may be an important first step in developing interventions to help this population cope with mental illnesses and reduce the rate of homelessness. In addition, the lack of affordable housing and assistance makes it difficult for women with mental illnesses living on the streets to cope with their conditions and maintain their safety. Results from this investigation may help raise awareness regarding the needs of this marginalized population. If homelessness is viewed as the failure of society to meet individuals' most basic needs, then failure appears to occur at a large scale among urban minority women (Webb, Culhane, Metraux, Robbins, & Culhane, 2003). Permanent housing is only one part of treatment and it is not always effective in resolving homelessness. Exploring other treatment and support options is important, as individuals' paths to treatment and housing may vary (Pearson, Montgomery, & Locke, 2009).

Summary

There is a gap in homelessness research on the use of and access to mental health services among chronically homeless women with mental illness. Much of the research

pertaining to homelessness has been focused on men (Fries et al., 2014), but it is important to understand the unique experiences of homeless women who are more likely than homeless men to suffer with mental illness (Lee et al., 2010). Because treatment of mental disorders is important to reducing homelessness, I explored the ways homeless women with mental illnesses accessed mental health services and any barriers they experienced in accessing such services and resources. In this chapter, I provided an overview of my study. Chapter 2 includes a review and synthesis of existing studies related to this study's research questions. In Chapter 3, I present details regarding the methodology. Chapter 4 contains study results, and Chapter 5 includes a discussion of findings.

Chapter 2: Review of the Literature

Introduction

According to the U.S. Department of Housing and Urban Development (2012), on a single night in January 2012, 634,000 people were homeless and living on the streets. Nearly 40% of those individuals were women. The United States has the highest percentage of homeless individuals of all industrialized nations (Finfgeld-Connett, 2010), and researchers have indicated that many factors may contribute to the rise of homelessness, including a shortage of affordable housing and poverty. Among women, predictors of homelessness include mental illness, domestic violence, and substance abuse (Finfgeld-Connett, 2010).

Though much of the research on homelessness has pertained to men, women comprise a significant percentage of the homeless population, and they face unique barriers (Ponce, Lawless, & Rowe, 2014). Homeless women are at high risk for mental illness, risky sexual behaviors, physical health problems, physical violence, and sexual assault (Ponce et al., 2014). Of concern are the barriers to mental health services that homeless women with mental illnesses face (Teruya et al., 2010).

As Ponce et al. (2014) explained, understanding barriers to services among homeless women “is a complicated endeavor” (p. 832). Women often face a variety of obstacles to obtaining mental health services including lack of transportation, child care problems, poverty, unemployment, and stigma (Gelberg, Browner, Lejano, & Arangua, 2004; Weinreb, Perloff, Goldberg, Lessard, & Hosmer, 2006). Women may also reject mental health services because they do not want to be labeled as “crazy” (Luhmann,

2008). Research has also shown that the severity of mental illness, substance abuse, psychosocial stress, and trauma may create service barriers for homeless women (Ponce et al., 2014).

In most studies regarding risk factors among the homeless population, researchers have focused on men (Deck & Platt, 2015; Längle et al., 2005; Parker et al., 2015; Salem et al., 2015; Watton & Gallivan, 2013). Thus, there is a dearth of information regarding the homelessness experiences of women (Fries et al., 2014). To provide homeless women with mental illnesses with the services they need, it is critical to understand their unique experiences and perceptions related to mental health services. According to Shelton, Taylor, Bonner, and van den Bree (2009), researchers must understand homeless women's experiences with mental health services to prevent poorly informed or counterproductive services. Thus, the purpose of the study was to explore experiences with the mental health system and to understand barriers to treatment services among chronically homeless women with mental illnesses.

In this review of the literature, I provide a comprehensive analysis and synthesis of the existing research on homelessness, women, mental illness, and health services. This chapter includes a contextualization of the current study and exposes the research gap that I addressed. The chapter begins with a description of the search strategies I employed to locate the literature. Next, a detailed analysis of relevant literature follows a discussion of the study's theoretical framework. The chapter closes with a summary.

Literature Search Strategy

I used many online databases to locate the studies discussed in this chapter. These databases included FirstSearch, JSTOR, LexisNexis, EBSCO, Gale InfoTrac, Academic Search Premier, and ProQuest. In addition, Google Scholar allowed me to locate seminal studies relevant to the current research. Search terms included *homelessness, women, mental illness, mental health, mental health care, homelessness stigma, substance abuse, sexual assault, physical violence, drug and alcohol abuse, homeless shelters, halfway houses, victimization, chronic homelessness, episodic homelessness, barriers to care, coping, critical theory, and critical social theory.*

Theoretical Framework

I used Young's (1994) critical social theory of gender to develop the theoretical framework for this study. According to Young, social norms, rules, and practices have the potential to place members of certain groups into positions of power or subordination. These positions are organized according to structures of race, class, sexuality, and gender. Gender is a social structure that creates inequities within society. Researchers need to recognize that multiple features of society, including gender, intersect in ways that can result in exploitation or marginalization of certain groups or individuals. The U.S. population of homeless women is an example of how race, gender, age, socioeconomic status, and stereotypes merge to create significant social barriers among a group. The interaction of many social features, not only gender, creates social inequality. Gender operates within a larger social structure, and to understand the challenges and barriers

experienced by a marginalized population such as homeless women, one must consider many social constructs and factors.

When analyzing the use of mental health services by homeless women with mental illnesses, researchers need to acknowledge the social barriers related to race, class, sexuality, and gender that this group faces. Members of this group are branded with at least three labels (i.e., woman, homeless, and mentally ill) that may lead to discrimination, prejudice, inequality, or poor access to resources. Identifying as female can evoke issues of sexual discrimination and gender discrimination, creating barriers to services. Similarly, homelessness and mental illness may create significant social barriers that prevent women in this population from accessing the needed mental health care.

The critical social theory of gender provides an exacting lens through which to challenge and deconstruct existing beliefs about social groups or structures. Within this theoretical framework, researchers use the concept of social capital to unveil additional barriers to mental health services among homeless women. In a study on social capital and health services, Wakefield and Poland (2005) used critical social theory to explore the issues of social capital and access to resources as part of their discussion of community health promotion. From a critical perspective, “social capital is seen as a resource that accrues to individuals and groups, who can leverage it to achieve particular goals that may or may not be beneficial to society as a whole” (Wakefield & Poland, 2005, p. 2822). This definition, which emerged from Bourdieu’s (1986) conceptualization of social capital, involves viewing social capital as a tool used to reinforce the prestige and power of affluent social groups to the detriment of economically disadvantaged

groups. Within health promotion, the possession of social capital is thought to facilitate self-help, access, and collaborative solutions to community problems (Wakefield & Poland, 2005).

Social capital is the product of an individual's relationships and networks; however, criticism of social capital by Wakefield and Poland (2005) demonstrated problems with this conceptualization. Although social capital has the power to improve community health and access to care resources, the possession of social capital also requires the resources individuals need to access. Social capital cannot be separate from economic and political structures because access to material resources influence social relationships. As Wakefield and Poland explained, "current conceptions of disadvantage run the risk of transforming poverty into something that is seen as the result of a lack of belongingness rather than an inability to access material and cultural resources" (p. 2828). Homeless women with mental illnesses need social capital to reduce the barriers that hinder them from care, not just in the form of inter and intrapersonal relationships, but also through economic and political resources.

An analysis of service use and barriers to accessing these services for homeless women with mental illnesses using a critical social theory of gender must include acknowledging the economic and political inequities that prevent women from accessing mental health care and obtaining stable housing. The lack of social capital these women possess has important implications not only for increasing access to mental health services, but also for resolving homelessness among individuals. The following section

contains an analysis of research pertaining to homelessness and mental illness, with a critical focus on the social challenges faced by homeless women with mental illnesses.

Literature Review

Why Women?

Because more men than women are homeless (U.S. Department of Housing and Urban Development, 2012), researchers to date have focused less on women.

Historically, a higher number of men than women have struggled with homelessness in the United States. This statistic supports the significantly large body of research that exists on male homelessness (Deck & Platt, 2015; Längle et al., 2005; Parker et al., 2015; Salem et al., 2015; Watton & Gallivan, 2013). Consequently, there is a dearth of information on the homelessness experiences of women (Fries et al., 2014). Women are becoming a larger proportion of the homeless population and are the most vulnerable (Osuji & Hirst, 2013).

The comparatively limited research on homeless women is problematic because the U.S. population of homeless women has risen rapidly in recent decades. In the 1950s and 1960s, women comprised an estimated 3% of the homeless population. Today, the homeless populations of men and women are almost equal (Lehmann, Kaas, Drake, & Nicols, 2007). Because of social factors connected to the construct of gender, it is essential that homelessness researchers acknowledge the differences between the issues faced by men and women. Thus, through this study, I specifically explored mental health care use among homeless women with mental illnesses. Most of the research reviewed in

this chapter pertains to homeless women, but when appropriate, I also discuss co-ed studies.

Women With Children

Participants selected for the study included homeless women with mental illnesses who did not have dependent children with them. I decided to limit participants in this way because differences exist in the challenges and experiences of homeless women when they have dependent children present. For example, Chambers et al. (2014) examined a representative sample of homeless women with and without dependent children to determine if risk factors for mental health problems were modified by the presence of dependent children. Although data analysis revealed that homeless women demonstrated poor mental health status regardless of the presence of dependent children, homeless participants with dependent children demonstrated higher rates of substance abuse and chronic health problems, lower access to social support, and were more likely to have been recent victims of sexual assault. Thus, to maintain the focus on mental health service use and access among homeless women, this study only included participants without dependent children to prevent obfuscating results with variables that were actually related to the presence of dependent children.

Types of Homelessness

To discuss homelessness, it is necessary to define what homelessness is. As conceptualized in this study, homelessness refers to individuals who experience excessive disadvantage, material deprivation, and persistent poverty; it does not refer to individuals who have suddenly lost their homes to fire or natural disaster (Lippert & Lee, 2015).

Many factors can increase the risk of homelessness including unemployment, job loss, personal crisis, substance abuse, mental illness, history of incarceration, and poor social supports (National Center on Family Homelessness, 2008; National Coalition for the Homeless, 2009; Zlotnick & Zerger, 2009).

Researchers studying this population also need to distinguish between the types of homelessness including episodic, transitional, and chronic. Episodic homelessness describes housing instability in which individuals frequently rotate between having housing and being homeless (Lippert & Lee, 2015). Episodically homeless individuals regularly move in and out of homelessness and often return to shelters (McAllister, Lennon, & Kuang, 2011). Episodes of high frequency and short duration characterize this type of homelessness, with a low cumulative period of homelessness (Kuhn & Culhane, 1998).

Transitional homelessness describes short and isolated periods of homelessness in which individuals move between stable housing situations (Lippert & Lee, 2015). In most cases, transitionally homeless individuals do not return to homelessness (McAllister et al., 2011). According to Kuhn and Culhane (1998), transitional homelessness is low in frequency, short in duration, and involves a maximum of two brief episodes of homelessness in total.

Chronic homelessness, the type of homelessness affecting the participants of this study, refers to a few instances of homelessness that are long lasting and persistent (Lippert & Lee, 2015). Chronic homelessness is of low frequency, but long duration (Kuhn & Culhane, 1998). According to the U.S. Department of Housing and Urban

Development (2014), 15% of the homeless population is chronically homeless. The U.S. federal government defines individuals who are chronically homeless as those who have been continuously homeless for a year, or who have experienced at least four episodes of homelessness in the past 3 years (U.S. Department of Health and Human Services, 2007).

Chronic homelessness has three categories: (a) individuals who are ineligible for Medicaid, (b) individuals who are eligible for Medicaid because of disability or health condition, and (c) individuals who qualify for Medicaid and specialized mental health services because of a mental health diagnosis (Burt & Wilkins, 2012). Participants in this study were not asked about their Medicaid status; however, because inclusion criteria required a mental health diagnosis and chronically homeless status, I assumed participants were individuals who qualified for specialized mental health services through Medicaid.

In my research, I focused on chronically homeless women because chronically homeless individuals are more likely to experience mental health issues. Kertesz et al. (2005) explored how mental- and physical-health-related quality of life varied by homelessness status. Although no differences existed in physical health related to quality of life, mental health quality of life was significantly worse among chronically homeless participants. Among the distinct vulnerabilities that accounted for the elevated rate of mental illness among these individuals were psychiatric illnesses, medical problems, poor social support, and severity of addictions. The researchers concluded that future investigators of health services and homelessness should consider chronicity of homelessness because the mental health prognoses of chronically homeless individuals

were significantly worse than the mental health prognoses of transitionally homeless individuals (Kertesz et al., 2005). Following this recommendation, in this study I included only participants who were chronically homeless as defined by the federal government.

Aspects of Homelessness

To understand the unique challenges faced by homeless women with mental illnesses, other factors that create barriers for homeless individuals must be identified. The following section includes a discussion of challenges related to victimization, violence, shelters, and substance abuse. Most of the studies discussed pertain to women; however, when appropriate, I included research on co-ed populations.

Victimization and Violence

Homeless men and women are often plagued by victimization and violence. Studies indicate most homeless individuals experience victimization in the form of theft, physical violence, and sexual assault (Huey, 2012; Jasinki, Wesely, Wright, & Mustaine, 2010). Social contexts, status, and access to resources all affect an individual's vulnerability to violence (Fraser & Craik, 2009). Roy, Crooker, Nicholls, Latimer, and Ayllon (2014) reported victimization may be even more prevalent among homeless individuals who are mentally ill. Homeless individuals are also likely to have experienced childhood physical or sexual assault and have poor mental health (Lippert & Lee, 2015).

Policy changes may be critical in addressing violence and victimization among the homeless population. Murray (2011) conducted a study on the violence against homeless women in Australia. Participants included 29 women between the ages of 19

and 52, most of whom experienced chronic homelessness. The researcher conducted interviews to understand issues related to women's homelessness and victimization and investigated policies that perpetuated the problems. Violence was pervasive among participants, and Murray reported social policy reform was critical for alleviating this violence and eradicating homelessness.

Murray's (2011) recommended policy interventions included early responses to violence and homelessness through the provision of safe and affordable long-term housing. In addition, the researcher provided recommendations for more individualized case management. In Murray's study, women were not the minority. In fact, they comprised nearly half of the homeless population and two-thirds of the individuals who sought assistance. According to the researcher, vulnerability to violence was an expected part the homelessness experience for women. Such experiences included the continuation of the violence that caused the homelessness, such as domestic abuse, as well as violence women encountered after becoming homeless. The researcher concluded, "from these women's experiences we can see the need for greater efforts to prevent homelessness, and for social policy that enhances homeless women's safety" (Murray, 2011, p. 358).

Shelters

Homeless shelters, although designed to help the homeless population, can also create barriers and challenges for homeless individuals related to institutionalization and marginalization. Hartnett and Postmus (2010) explored the function of shelter policies and practices and how they affect shelter staff and homeless women. Researchers' findings indicated shelters and programs for homeless women may not always provide

adequate safety and relief. Conversely, shelters may serve as a tool for hiding and controlling homeless women. Efforts to assist homeless women by providing them with shelter may actually marginalize and institutionalize them because such programs are based on traditional assumptions of home and culturally acceptable behavior by women.

In another study, Moe (2010) used field observations and qualitative interviews to examine the bureaucracy and institutionalization women experienced in homeless shelters by recording the typology of their survival strategies. Goffman (1961) posited that a bureaucracy operates within the total institution wherein a clear distinction occurs between those who have power and those who are dependent on the institution (us versus them mentality). Moe (2010) reported such adversarial relationships were counterproductive to the self-sufficiency goals of shelter residents. Instead, he suggested shelter workers should operate as advocates for shelter residents. Although shelters provide homeless individuals relief from the elements, they are rarely an effective means for resolving homelessness.

Substance Abuse

Substance abuse is another significant problem for the homeless population (Patterson, Currie, Rezansoff, & Somers, 2015). Heavy substance abuse is a reason some individuals become homeless in the first place (Patterson et al., 2015). Although homeless individuals often acknowledge the negative aspects of substance abuse, they usually describe drug use ambivalently, as it is used to help them cope with mental illness, stress, and boredom, or to help them “feel normal” (Patterson et al., 2015, p. 85). Issues with substance abuse often go hand-in-hand with mental illness among homeless

men and women because of self-medication and distrust toward the health care system. I discuss these problems detail in later sections of this chapter.

Predictors of Homelessness

In addition to understanding the barriers associated with homelessness, it is necessary to understand the predictors of homelessness. This section provides a discussion of homelessness predictors, as indicated from previous research. In addition, I provide a brief discussion of the experiences and causes of first-time homelessness.

Lehmann et al. (2007) explored risk factors associated with homelessness among women by comparing characteristics of newly homeless women with characteristics of women who had never been homeless. The researchers created a model to illustrate risks related to first-time homelessness and used a case control design to compare homeless women to a control group of never homeless women. Women were newly homeless if they were experiencing homelessness for the first time as an adult and had been homeless for less than 2 months. Women in the control group were those who had never experienced homelessness as an adult. The study included 50 newly homeless women and 71 never homeless women (Lehmann et al., 2007). Lehmann et al. used a questionnaire to gather basic demographic information, as well as information regarding alcohol and drug abuse, child status, marital status, social support networks, housing status, and health.

Analysis of data by Lehmann et al. (2007) supported findings of previous researchers. For example, Lehmann et al. reported that younger women were more likely to have young children, which is a risk factor for homelessness. However, other findings

were paradoxical to previous studies. Drug use was not a significant predictor of homelessness among Lehmann et al.'s sample of homeless women, but previous studies found elevated rates of drug abuse among homeless women. In Lehmann et al.'s study, fewer women were using public assistance than reported by other researchers. The homeless participants Lehmann et al.'s research also had higher levels of education than women who had never been homeless. The researchers posited some of the differences between their findings and those from previous studies could have been attributable to "restriction of this study to incident cases, suggesting that although women with low levels of education and no work experience may be at risk for chronic homelessness, education is not necessarily protective against a first occurrence of homelessness" (Lehmann et al., 2007, p. 26).

Lehmann et al. (2007) reported unemployment or underemployment, inadequate housing, and changes in geographic location increased risk of homelessness among study participants. The more of these risk factors a woman presents, the higher her risk for homelessness. Because study participants were from two locations (California and Pennsylvania), and no significant differences were noted by location, the researchers posited inconsistencies revealed across homelessness studies may be more attributable to methodology than geography. The model the researchers developed provided directions for service providers to first-time homeless women. The researchers explained service providers must be aware that most first-time homeless women need economic and housing assistance and "screening should be provided to identify those who will require

more intensive services to prevent repeated homelessness, such as substance abuse or mental health treatment” (Lehmann et al., 2007, p. 27).

Caton et al. (2005) explored characteristics of newly homeless individuals during a longitudinal study of 377 newly homeless adult men and women living in New York City shelters. The study included an 18-month follow-up period, which allowed the researchers to examine the relationship between individual demographics, family characteristics, illness history, service use, and homelessness duration. The researchers evaluated participants at 6-, 12-, and 18-month intervals. Caton et al. assessed mental health, family environments, and social factors using several inventories and several clinical scales to test for personality disorders, pathology, and psychosis. The Kaplan-Meier survival analysis showed shorter durations of homelessness were associated with younger age, current or recent employment, earned income, coping skills, adequate family support, absence of substance abuse history, and absence of arrest history. Strong predictors of longer periods of homelessness included a history of arrest and old age.

Caton et al.’s (2005) findings did not indicate an association between duration of homelessness and Axis I disorders, substance abuse disorders, posttraumatic stress disorder, antisocial personality disorder, or severe psychiatric symptoms. The researchers attributed these results to the idea that “coping skills are better indicators of one’s ability to more quickly exit homelessness than are psychopathology or diagnosed mental illness or substance use disorder” (Caton et al., 2005, p. 1758). The implications of these findings indicate individuals with mental illnesses, although predisposed to homelessness, can receive services and coping resources to help them exit homelessness.

Caton et al. explained this research underscored the need for effective mental health and substance abuse treatment among the homeless population.

First Time Homelessness

In a study of 300 homeless men and women in the Toronto area, Goering, Tolomiczenko, Sheldon, Boydell, and Wasylenki (2002) investigated the differences between individuals who were homeless for the first time and those who had been previously homeless. The study was part of the Pathways into Homelessness project and involved quantitative and qualitative interviews to estimate prevalence of mental illness, pathways into homelessness, and to identify possible policy reform. First time homeless individuals were those not previously homeless as an adult.

Goering et al. (2002) reported individuals in both groups (newly homeless and previously homeless) were predominately male and from impoverished socioeconomic backgrounds. Individuals in both groups also reported high rates of family history of mental illness and substance abuse. Childhood abuse was another common characteristic of individuals in both groups, as were high rates of unemployment and use of public assistance. First time homeless individuals had a slightly higher rate of high school completion than those who were previously homeless (42% versus 31%). The researchers also found lifetime substance abuse and rates of previous hospitalizations for mental illness were similar between the two groups (Goering et al., 2002).

Because of the striking similarities between the two research groups, Goering et al. (2002) explained, “it is incorrect to assume that the first-time homeless represent a high-functioning group of individuals who are only temporarily dislocated and unlikely

to return to shelters or the streets” (p. 1474). The researchers reported both groups had similar disadvantaged backgrounds and similar rates of physical and mental illness. Rates of psychiatric disorders and hospitalization for mental illness did not differ between the two groups. The researchers concluded the results underscored the importance of prevention strategies for individuals at risk for homelessness. Goering et al. stated, “Given the level of need that is evident among persons who are homeless for the first time, this group should receive appropriate services early” (p. 1474), and targeted interventions should be tailored to each individual’s needs.

Physical and Mental Health

Homeless individuals face physical and mental health conditions related to poor self-care, dangerous or unhealthy environments, and poor access to health care services (Bonugli et al., 2013; Chambers et al., 2014; Chondraki et al., 2014; Lippert & Lee, 2015; Speirs, Johnson, & Jirojwong, 2013). In terms of physical health, homeless women contend with a series of challenges, such as poor nutrition, exposure to the elements, drug and alcohol use, low immunity, and risky sexual behaviors (Speirs et al., 2013). Research indicates homeless women are at an increased risk for sexually transmitted diseases, respiratory illnesses, gynecological infections, hypertension, and diabetes (Speirs et al., 2013).

Although the physical health challenges faced by homeless women are significant, the focus of my study was on mental health. Further, physical health issues often correlate with mental and psychological impairments. For example, Speirs et al. (2013) conducted a systematic review of relevant literature on interventions aimed at

improving the physical and psychological health of homeless women. The researchers reviewed six studies with three main interventions, including structured group sessions, advocacy, and therapeutic communities. Most of the study interventions resulted in significant improvements to the women's psychological, behavioral, and cognitive functions. Women reported less psychological distress, less drug use, and less high-risk sexual behaviors (Speirs et al., 2013). However, not all the interventions demonstrated significant improvements. Some studies indicated poor self-esteem, increased hostility, and no improvements in AIDS knowledge at follow-up. Often, the attitudes of staff and care professionals impeded access to services if the homeless women felt judged. Speirs et al. indicated some interventions may be helpful for improving homeless women's physical, psychological, and cognitive health, but the results of the analysis were mixed. Because the researchers reviewed a variety of interventions aimed at producing improvements among homeless women, it is difficult to make conclusions about how effective interventions were at improving mental health.

Mental health and homelessness have a multidirectional relationship in that problems associated with mental health can act as predictors, as well as consequences, of homelessness (Chambers et al., 2014). Thus, homeless individuals are disproportionately diagnosed with mental health disorders compared to individuals who are not homeless (Lippert & Lee, 2015). Common mental illnesses among homeless individuals include depression, schizophrenia, and suicide ideation (Lippert & Lee, 2015). To compound these problems, high rates of drug and alcohol abuse are prevalent among homeless individuals (Lippert & Lee, 2015). Homeless individuals with disordered mental health

often lack access to adequate mental health care and have poor social support networks, making them a marginalized population (Chondraki et al., 2014).

The lifespan of homeless individuals with serious mental illness is typically 25 years shorter than that of individuals in the general population (Bonugli et al., 2013). According to SAMHSA (2012), serious mental illnesses are mental disorders that create significant functional deficits that negatively affect an individual's ability to carry out activities of daily living. Symptoms of serious mental illness include impulsivity, delusions, hallucinations, and difficulties establishing and maintaining relationships (Bonugli et al., 2013). Impairments associated with serious mental illness can make it difficult for individuals to recognize the need for treatment, placing them at a higher risk of victimization (Bonugli et al., 2013).

SAMSA (2011) estimated approximately 25% of homeless individuals in the United States suffer with some form of serious mental illness, and although the population of homeless women is smaller than that of homeless men, homeless women have significantly higher rates of severe mental illness than men do (Bonugli et al., 2013). Homeless women with serious mental illnesses that require psychiatric care are a public health concern and a social issue. An increasing number of violent acts are committed against homeless women with severe mental disorders because the population is particularly vulnerable. Bonugli et al. (2013) explained homelessness can be perilous for women with severe mental illnesses and the accumulation of traumatic experiences prevalent among this group can compound health issues, creating increased physical illness, psychiatric comorbidities, and substance abuse problems.

Bonugli et al. (2013) conducted a qualitative investigation on homeless women living with severe mental illness to increase understandings of victimization among this population. The findings indicated homeless women are disproportionately represented among populations that lack social, economic, and political resources. This lack of acknowledgment of women contributes to stigmas associated with homelessness and mental illness and reduces positive health outcomes (Finfgeld-Connett, 2010). Participants in Bonugli's et al.'s study included 15 women with self-reported serious mental illnesses. The researchers conducted in-depth, semistructured interviews to understand homeless women's experiences of traumatic events and circumstances. The researchers defined victimization as "any unambiguous act of physical, verbal, emotional, or sexual behavior perpetrated against an individual without consent, resulting in distress" (Bonugli et al., 2013, p. 829). Data analysis revealed five themes, including (a) trauma and loss, (b) addiction, (c) burdens of mental illness, homelessness, and victimization, (d) survival strategies, and (e) paradox of homeless shelters.

Relevant to the current research are the themes of mental illness, homelessness, and victimization reported by Bonugli et al. (2013). Participants reported these three factors created overwhelming feelings of distress, anger, and resentment. The three-fold stigma associated with the combination of mental illness, homelessness, and victimization resulted in increased social isolation. Managing the daily stress associated with serious mental illness was a constant struggle for women. The researchers posited providing services to support women, especially at night to further their security, is

fundamental for improving outcomes for homeless women with mental illnesses. This population must have access to safe housing and treatment for chronic mental disorders.

Adaptive Behaviors and Coping

The ability to overcome the challenges associated with homelessness is contingent on adaptation and coping mechanisms. In addition, homeless individuals, especially those who struggle with mental illness, must have access to necessary support and care resources. The concluding section provides a discussion of adaptation and service access among homeless populations with mental illnesses.

Lippert and Lee (2015) conducted a study to examine stress and coping mechanisms among homeless individuals with mental illnesses. The researchers explored how psychiatric disorders and drug or alcohol abuse varied across newly homeless, chronically homeless, and episodically homeless individuals. In addition, Lippert and Lee investigated the robustness of such differences after adjusting for early life stress, adult stress, and coping resources. The researchers used data from the National Survey of Homeless Assistance Providers and Clients (1996), which included 76 sample sites in the United States and covered an estimated 85–90% of the total homeless population in communities with sizeable service infrastructures. Stress experiences included theft and assault victimization. Coping resources included social and material assets. Data analysis revealed psychiatric disorders were most common among chronically and episodically homeless individuals, and were least common among newly homeless individuals. The researchers reported the lower incidence of mental health disorders among newly homeless individuals were because of fewer experiences of life stress (Lippert & Lee,

2015). Because rates of mental illness are higher among chronically homeless individuals than individuals who are newly homeless, I specifically examined barriers to mental health services among women who experience chronic homelessness.

Chondraki et al. (2014) conducted a study regarding homeless men and women in Athens, Greece to explore help-seeking patterns for mental disorders and psychiatric morbidity, which refers to the combination of physical and psychological deterioration that results from mental disorders. The researchers conducted unstructured interviews to gather demographic data, psychiatric information, and information on participants' help-seeking behaviors. Women had mental health disorders diagnosed at a higher rate than men across all diagnostic categories assessed, including psychotic disorders, anxiety, generalized stress, posttraumatic stress, and obsessive-compulsive disorders. The researchers noted significant differences in male and female help-seeking behaviors (Chondraki et al., 2014). For example, more female participants took medication for anxiety and depression and sought regular psychiatric treatment than men. The researchers found being female, older, more educated, experiencing longer episodes of homelessness, and receiving a diagnosis of a mental disorder increased the likelihood of help-seeking among participants. Participants reported the most significant barrier to mental health care access was the lack of medical insurance or personal finances to pay for services. Consequently, participants reported frequent use of free emergency medical services.

More than 50% of the sample from Chondraki's et al. (2014) study demonstrated psychiatric morbidity. The most prevalent mental health diagnoses included mood,

psychotic, and anxiety disorders. Because only 36.9% of participants reported recent psychiatric care, the researchers reasoned the help-seeking behaviors of homeless individuals with mental illnesses were a complex phenomenon involving economic factors, poor social support, as well as psychological attitudes and stereotypes, such as stigmatization and fears of rejection. The gap in service use among homeless individuals with mental illnesses led researchers to question whether existing mental health services effectively reach the individuals who need them most. The researchers explained “in order to better understand the underlying mechanism of these barriers, it is important to explore the views of the homeless users of services” (Chondraki et al., 2014, p. 549). Thus, I chose to explore barriers and service use among a specific population of homeless women with mental illnesses.

Barriers to Care

Research indicates homeless individuals who access care services only use them on a temporary basis (Culhane, Metraux, & Wachter, 1999). Homeless individuals with mental illnesses often experience barriers to mental health care. For example, Patterson et al. (2015) reported homeless individuals often express distrust toward the health care system, including hospitals, psychiatric care, and psychotropic medications. In general, homeless men and women avoid traditional health services. Many homeless individuals avoid psychiatric medication and choose to self-treat with street drugs (Patterson et al., 2015). Because substance abuse is linked to mental illness and homelessness, the avoidance of psychiatric care among homeless individuals with mental illnesses can

create a self-perpetuating cycle of substance abuse, homelessness, and untreated mental illness.

Krausz et al. (2013) explored the rates of mental illness, service use, and barriers to care among a sample of 500 homeless men and women in British Columbia. The researchers recruited participants from three urban areas. Krausz et al. conducted face-to-face interviews, which included a screening for eligibility, a demographic questionnaire, and a neuropsychiatric interview. The researchers reported that 92.8% of participants met criteria for at least one mental illness, and 82.6% were drug or alcohol dependent. More than half of the participants met criteria for generalized anxiety disorder, panic disorder, agoraphobia, or PTSD. The majority (63.2%) of participants reported regular medical care with a doctor or nurse practitioner; however, 34% of participants reported they felt they needed care in the previous 12 months but had not received it. Despite the prevalence of mental illness among participants, only 14.9% reported seeing a psychiatrist in the previous year. Participants reported the main barriers to care were issues related to homelessness and poor connections to the health care system.

Ponce et al. (2014) explored service barriers among 343 homeless women who experienced behavioral health problems and intimate partner violence. The researchers found homeless women with behavioral health issues demonstrated an increased need for clinical services, but life circumstances and poor relationships often created barriers to such services. Specifically, trauma related to intimate partner violence and fears of experiencing additional trauma, jeopardizing safety, or losing relationships created powerful barriers to services if participants perceived accepting services as increasing

risk. The researchers reported participants with mental illnesses desired autonomy, protection from further trauma, and help reestablishing their identities and statuses (Ponce et al., 2014).

Ponce et al.'s (2014) study is similar to this study in that the researchers explored the barriers homeless women experience with services. However, Ponce et al. studied the barriers to a wide range of services, including housing, other social services, as well as mental and physical health care. Further, the researchers did not exclusively investigate barriers for homeless women with mental illnesses, but included a large pool of participants who experienced homelessness, behavioral health, or intimate partner violence. The researchers noted that because of the challenges homeless women with behavioral health issues face, they need to have wide access to a range of social and clinical services. However, life circumstances often create barriers to access and acceptance. Thus, Ponce et al. posited, "further action-based research will reveal the prevalence of these co-occurring phenomena, the services best able to support individuals who live with them, and the resources needed to help them exit homelessness and improve their well-being" (p. 838).

Another factor that may affect the mental health of homeless women is psychological integration. According to McMillan (1996), a psychological sense of community (PSOC) involves access to several elements, including emotional safety, freedom from shame, and trust in the community. Homeless individuals often lack PSOC because of disaffiliation and disenfranchisement. To obtain a sense of psychological

integration, one must develop a sense of belonging in the community (Nemiroff, Aubry, & Klodawski, 2011).

Nemiroff et al. (2011) conducted a longitudinal study to examine the effects of physical, economic, and social integration regarding PSOC among a sample of 101 homeless women in Canada. The researchers assessed several variables, including participants' physical integration, economic integration, social integration, family status, mental health function, history of homelessness, and psychological integration. Of the sample, 49 women had dependent children, and participants' average age was 35.6. Data analysis indicated women with dependent children reported higher levels of PSOC than those without children. In addition, mental health function was not a significant predictor of PSOC; however, the researchers found higher levels of mental health were related to higher levels of integration (Nemiroff et al., 2011). Nemiroff et al. stated, "a larger sample might have provided enough statistical power to detect a statistically significant relationship between level of mental health functioning and psychological integration in this study" (p. 1014). Lifetime homelessness histories and economic integration were not significant predictors of PSOC.

In relation to the current study, Nemiroff et al.'s (2011) research has relevant implications. If homeless women do not feel comfortable in their environments through a sense of psychological integration, they may not be comfortable reaching out for assistance, such as treatment for mental illnesses. Nemiroff et al. revealed longer periods living in housing did not always improve participants' sense of integration and women in low-quality housing situated in high-crime areas may be more likely to isolate

themselves. In addition, the longer a woman experiences homelessness, the more negative outcomes she is likely to experience. Barriers to services and treatment are often related to a lack of psychological integration, but there is still much left to learn regarding these barriers (Nemiroff et al., 2011).

Patterson et al. (2015) explored factors that hindered change among homeless adults with mental illnesses. Participants included 43 homeless male and female individuals older than 19 and diagnosed with a mental illness. The researchers found barriers to services and supports were among the most significant challenges to creating positive change among participants. The researchers reported participants needed high-quality, individualized support to achieve change. Such services are “collaborative, individualized, persistent across time and place, and offer creative opportunities to promote the development of positive personal and social identities” (Patterson et al., 2015, p. 85). Patterson et al. also acknowledged the complex relationship between concurrent substance abuse and mental health disorders. Previous researchers indicated homeless individuals with substance abuse problems often face challenges obtaining and retaining housing (Johnson & Chamberlain, 2008). Patterson et al. posited the development of “a more integrated, holistic approach to service provision can reduce chances of relapse and assist in the development of meaningful activities and resources to replace substance dependence” (p. 85). However, to develop a holistic approach to services and interventions among homeless individuals with mental illnesses, a better understanding of barriers to obtaining service, as well as how individuals use existing services, is needed. Therefore, through this study, I addressed this gap in the research to

help the development of such integrated, holistic interventions among homeless women with mental illnesses.

Finfgeld-Connett (2010) conducted a metasynthesis to explore the experiences of homeless women with support services to make evidence-based inferences about optimal services for this group. The metasynthesis included an interpretation of findings from four previously published qualitative studies on homeless women and support services. Data collection methods used in the studies included interviews, focus groups, document review, and observations. The researchers found homeless women tended to assess the benefits and drawbacks of available support services before making decisions about using them. Homeless women, according to the studies analyzed, demonstrated independence, self-confidence, and defensiveness that were counterproductive to their situations.

Finfgeld-Connett explained,

They may deny their homelessness, reject assistance, be extremely self-reliant, and highly vigilant. Vigilance may take the form of maintaining a heightened awareness, scanning, and avoiding certain people and places that are deemed dangerous. All of these behaviors have the potential to accentuate attributes of pathological paranoia, and they may perpetuate the biased perception that homeless women are hopelessly mentally ill. (p. 464)

Finfgeld-Connett (2010) stated individuals who provide services to homeless women have two roles: to empower women and to provide services. Empowerment takes three forms: intrapersonal, interpersonal, and environmental. Intrapersonal factors include projecting respect and unbiased views of homeless women and encouraging self-

sufficiency through conflict resolution and problem solving. Service providers may also holistically frame assistance programs in a way that accounts for culture, gender, and women's unique situations. Interpersonal factors may include helping homeless women develop and maintain a trusting network of support with other individuals. Such empowerment "may be enhanced by promoting peer-to-peer sharing and bonding; peer-led support groups, peer exchange of babysitting services, and shared housing" (Finfgeld-Connett, 2010, p. 465). Environmental factors can be a source of empowerment for homeless women when service providers help them feel confident in their abilities to function within the structure of environments, such as shelters. In addition, service providers can help women obtain safe and clean living arrangements that respect their individual and social boundaries and promote senses of privacy, security, and self-respect.

The two types of services that provided women with the most empowerment were child care support and physical or mental health support. By providing women with adequate child care, providers could remove the threat of women losing their children, help them develop parenting skills, and help them acquire health care for their children. Most relevant to my study, Finfgeld-Connett (2010) reported the critical role of physical and mental health care services in the empowerment of homeless women. Poor access to or lack of services were primary concerns for homeless women. Although financial barriers for the women in the study were significant, women contended with several other obstacles, including bureaucracy, distrust of the system, and a lack of advocacy within it (Finfgeld-Connett, 2010). Women also had a challenging time obtaining necessary

physician referrals, setting appointments that did not conflict with their schedules, and obtaining transportation to and from appointments. Finally, adversarial and contradictory relationships between case managers, care providers, and homeless women created significant barriers. Women who struggle with chronic and unresolved homelessness often experience mental illness and substance abuse, which can prevent them from resolving their housing crisis. In addition, when they do access support services, such as mental health care, they are likely to do it on an “as-needed-basis and in a revolving door manner” (Finfgeld-Connett, 2010, p. 466).

The norms and mores of the social service system can prevent homeless women from accessing intervention and support services. Fears of losing their children, experiencing stigma, or general paranoia toward health care and other support service providers can cause homeless women to exit the social support system before they acquire the stability they need (Finfgeld-Connett, 2010). “Paradoxically, the things that homeless women fear within the social service system, such as the loss of personal integrity and unsafe living conditions, are some of the very things that they face as a homeless person” (Finfgeld-Connett, 2010, p. 466). Finfgeld-Connet (2010) concluded, “based on findings from this metasynthesis, early prevention efforts are recommended, and nurses are urged to help women develop adaptive problem-solving, decision-making, and interpersonal skills” (p. 468). Health care and other support service providers must remember that homelessness is a complex issue that requires a multifaceted approach to resolution, including providing individuals with support for mental and physical care, child care, substance abuse, and housing. Of all the areas of need discussed in the

metasynthesis, physical and mental health support were the most pressing. To connect with homeless women in a way that is empowering and allows them to use and access the support services they need to garner mental, physical, and environmental stability, service providers should use tactics that are empowering for women.

In another study on homeless women, Hamilton, Poza, Hines, and Washington (2012) explored barriers to psychosocial services among homeless women who were military veterans. The researchers held focus groups with 29 female veterans to explore proximal barriers women experienced in their current states of homelessness as opposed to barriers they may have experienced in the past. Study participants described three main barriers to services, including (a) lack of information about available services, (b) limited access to such services, and (c) poor coordination across different services (Hamilton et al., 2012). Most participants expressed a sense of isolation and abandonment when seeking services. Participants desired an integrated source of information about available services. One of the most significant challenges participants expressed was accessing services, which were often inconvenient or required significant travel.

Another finding reported by Hamilton et al. (2014) was the participants expressed a desire for women only programs, but that most available programs were co-ed. Substance abuse acted as a barrier to services; however, not in the mechanism presented by other researchers. The researchers reported, “many women found that they could only access services if they had—or claimed they had—substance abuse problems” (Hamilton et al., 2014, p. 8). This acted as a significant barrier among women who were in substance abuse recovery or who had no history of substance abuse. Although previous

researchers found homeless individuals with a history of substance abuse were more likely to use services (Wenzel et al., 2001), Murray's (2011) finding that a lack of substance abuse history could act as a barrier to attaining services was unique. Although women with mental illnesses are likely to have substance abuse disorders, not all do. Thus, homeless women with mental illnesses and without substance abuse problems may be unintentionally marginalized because most support services focus on drug abuse.

Summary

The aim of this chapter was to provide a comprehensive examination of the existing body of research on homelessness, mental illness, service access, and utilization of services among chronically homeless women with mental illnesses. A significant body of literature exists pertaining to male homelessness, but much less is known regarding the homelessness experiences of women (Fries et al., 2014). Because women represent a growing percentage of the homeless population, and because women are more likely to suffer from mental illness than men are, it is important to understand the unique experiences of mental health services among chronically homeless women with mental illnesses.

Treatment of mental disorders is critical to reducing homelessness and improving quality of life for homeless women. The aim of the current study was to explore the ways homeless women with mental illnesses access mental health services and the barriers they experience in accessing such services and resources. In Chapter 3, I present details regarding the methodology, including the current study's participant selection, recruitment, instrumentation, data collection, analysis plans, and ethical assurances.

Chapter 3: Research Methods

Purpose of the Study

Through this study, I focused on the experiences of chronically homeless women and their perceptions of barriers to treatment. I chose a phenomenological design to describe the experience through the eyes of those who experienced homelessness firsthand. Although general research on homeless women is lacking, a particularly problematic gap exists regarding the topic of mental health treatment among homeless women. According to SAMHSA (2011), more than 25% of homeless individuals in the United States have a severe mental illnesses. Although rates of homelessness are lower among women than among men, rates of mental illness are higher among the population of homeless women (Barrow et al., 2004). Homeless women often face unique and complex life circumstances that limit their abilities to secure mental health services (David et al., 2015). In addition, it is common for homeless populations to underuse available mental health services because of barriers that prevent them from accessing such services (Bonin et al., 2009). Some of the barriers to mental health service use include stigmas related to mental illness, fears of rejection (Kim et al., 2007), poor means of communication, and unmet basic needs (Krausz et al., 2013).

This chapter includes details on the study's research design and rationale, including my role in in the research process. The methodology section contains a discussion of participant selection, instrumentation, procedures for recruitment, participation, data collection, and the data analysis plan. The chapter concludes with an examination of issues of trustworthiness and ethical procedures.

Research Design and Approach

The research questions guiding this study were,

RQ1: Based on their lived experiences and perceptions, how do chronically homeless women with mental illnesses residing in an urban county in the southwestern United States utilize available mental health services?

RQ2: Based on their lived experiences and perceptions, what are some of the barriers to mental health treatment and services faced by chronically homeless women with mental illnesses residing in an urban county in the southwestern United States?

When conducting research studies, researchers typically consider using one of three methodologies: quantitative, qualitative, and mixed method designs. Quantitative methods involve the use of statistics to prove or disprove a hypothesis (Tracy, 2013). The research is deductive in nature, and quantitative researchers believe there are objective, measurable realities (Bloomberg & Volpe, 2012). The focus of a quantitative study is to measure and collect data to describe, connect, compare, or correlate information regarding a specific phenomenon and report the results using numerical data. Because I conducted an in-depth exploration of participants' experiences using their own words, I did not select a quantitative method.

Qualitative researchers use a variety of methods that can include interviews, focus groups, observations, and document analysis to gather data that aids the researcher in exploring a phenomenon (Merriam, 2014). In qualitative research, the results are inductive and arise from the data (Tracy, 2013). Qualitative research is naturalistic and used to focus on the entirety of an experience (Moustakas, 1994). Rather than trying to

measure an experience, qualitative researchers focus on understanding and exploring a phenomenon using the viewpoints of individuals who have experience with that phenomenon (Merriam, 2014). Researchers who employ mixed methods designs use both qualitative and quantitative methods. Mixed methods designs are used by researchers who wish to address a question at different levels (Tracy, 2013). This type of design helps researchers explain and interpret a specific phenomenon and triangulate the design (Stake, 2010).

For this study, I chose a qualitative method. The purpose of this study was to explore the experiences of chronically homeless women and their perceptions of barriers to attaining treatment. The quantitative method and mixed method design were not selected for this study because my goal was not to measure the phenomenon using statistical methods, but rather to explore the women's experiences using their own words.

I chose a phenomenological design to understand the experiences and perceptions of the individuals experiencing homelessness. Phenomenological research is used to study affective, emotional, and intense human experiences. At the heart of phenomenological thought is the belief that worlds and objects exist based on how individuals perceive and construct their realities. Finlay (2012) has contended that phenomenology helps people to see the world in a different way. When using a phenomenological design, the researcher composes questions to elicit information about the phenomenon under study and helps participants to describe their experiences using rich, detailed, thick descriptions that go beyond intellectual descriptions. The goal of this type of research is to describe the world as seen through the eyes of the participants.

I considered other qualitative methods, such as grounded theory, for use in this study. Grounded theory researchers aim to create a theory based on information grounded in data. This method involves several rounds of information gathering, with questions in each round based on the data gathered in the previous round. The researcher iteratively analyzes data using constant comparison (Corbin & Strauss, 2014). Because my goal was to describe participants' experiences, rather than to create a theory, I did not choose a grounded theory method.

Researchers employ case study designs when they wish to answer *how* and *why* questions (Yin, 2014). Specific features mark case study designs, including a bounded sample, a contemporary issue, and a researcher who has no control of behavioral events (Yin, 2014). Borders between the participants and their contexts are also blurred. When using this method, researchers focus on a specific case. One of the strengths of using a case study is that it allows for the use of multiple types of data to help researchers develop deeper understandings of the phenomena. Because my study pertained to understanding the experiences of the participants using only their perceptions, a case study design was not appropriate.

I considered using ethnography because this method involves direct contact with people in natural settings and the participants are an important source of data used to explain the behaviors and experiences of a group. However, this method requires multiple data collections. Because of the difficulty of repeatedly locating the same homeless individuals, ethnography was not feasible for this study. Researchers performing ethnographic studies also look at cultural theory and the roles of macro/micro and

etic/emic factors. Because my goal was to understand the experiences of individuals who are homeless regardless of ethnicity, I did not choose ethnography.

Role of the Researcher

In qualitative research studies, the researcher is an instrument (Tracy, 2013). The researcher is responsible for designing the study, creating interview questions, finding and interviewing participants, and analyzing the data. All information flows through the researcher, and the researcher becomes the medium who touches all aspects of the study (Xu & Storr, 2012). Kvale (2006) argued it is necessary to have an active researcher conducting qualitative methods and designs because a researcher is the only unit designed to understand the complexity of a phenomenon (Kvale, 2006).

I have worked with disadvantaged children, youth, families, and adults for the last 15 years in a variety of contexts. Individuals with mental illnesses and who are chronically homeless are challenging populations. I have completed more than 2,000 hours working with this specific population in the southwestern United States. My direct contact with this population has involved both individual and family counseling, facilitation of mental health treatment groups, and connecting individuals to community resources such as housing and other services based on the clients' needs and wishes.

I have also participated in the local annual homeless point-in-time count in which all homeless individuals residing outdoors are counted in an effort to secure funding for the next fiscal year. I interviewed and connected with these individuals in their natural setting and gathered personal and relevant information for the count. With my background working with this population and getting to know the individual hardships

that come with homelessness or mental illness, I understand this clientele on a more intimate and genuine level. I also made sure to suspend judgement, as everyone has their own story and reasons behind their circumstances.

Additionally, I participated in a community panel addressing the needs and concerns of the homeless population in the southwestern United States. The panel discussed what was known about homelessness and actions the community was taking to nurture change. Such changes at the local level included small community outreach efforts and changes to the local hospitals to secure funding for emergency psychiatric holds. Although members of the panel discussed funding at the federal level, members did not expect it. Thus, the community worked together to institute changes to assist homeless individuals in need.

When dealing with power differentials that occurred, I approached each participant as a cofacilitator in the study while reversing power dynamics by allowing them to be the expert in their experiences. I acted as an observer to their stories while directing their consciousness to areas they may not have considered. I made a conscious effort to follow, rather than lead, the direction of the interview and asked clarifying questions as needed. Moreover, working with this population continued to bring up questions I resolved through this study.

Methodology

Participant Selection Logic

I gathered 10 participants to discuss their experiences of the phenomenon. I used both criterion and snowball sampling to find participants who were willing to speak about

the phenomenon. By using these methods to select participants, I was able to select information-rich cases that provided thick data (see Tracy, 2013). I used criterion sampling to select informants who shared similar homeless experiences in order to gather a homogenous sample. The criterion or inclusion included (a) chronically homeless, as defined by the Federal government; (b) 18 years of age or older; (c) diagnosed with a mental illness within the last 5 years by a mental health professional; and (d) having no minor children accompanying them. Participants with current or past mental illnesses were included if their diagnosis occurred within the past 5 years. Further, women were included in the study regardless of whether they received treatment and regardless of their perceptions of the effectiveness of treatments. No stipulations existed regarding which mental illnesses an individual was diagnosed with if the individual was not actively psychotic or experiencing symptoms that would inhibit her ability to answer interview questions openly and honestly. All participation was voluntary and informants were willing to be interviewed and audio recorded. Exclusion criteria included women who felt pressured to participate, women unable to form lucid thoughts, women with children in their care, or any person who worked with me in the past through various county mental health programs.

An initial step in the interview process was establishing rapport with the informants. Within a feminist perspective, treating informants as experts and trying to minimize hierarchical relationships in the research process is essential. Research conducted from within this perspective entails a collaborative and reciprocal relationship between a researcher and the informant (Hesse-Biber, 2006).

When addressing the issue of saturation, it was essential that I considered the number of informants, or sample size. Saturation is the point at which no new information is gathered from informants. As Guest, Bunce, and Johnson (2006) explained, saturation is the key to excellent qualitative work, but there are no published guidelines or tests of adequacy for estimating the sample size required to reach saturation. Moreover, Ryan and Bernard (as cited in Guest et al., 2006) asserted that when and how a researcher reaches saturation depends on several things, such as the amount and complexity of data, investigator experience and fatigue, and the number of analysts reviewing the data. Qualitative researchers have recommended a variety of sample sizes, ranging from five to 13 participants (Francis et al., 2010; Tracy, 2013). Based on these recommendations, I set the sample size for this study at 10 participants. If saturation was not indicated, I would have added additional participants until saturation was reached.

Instrumentation

I explored the needs of homeless women with mental illnesses by investigating their narratives of homelessness. Promoting a dialogue regarding the services female participants need was more effective than applying standardized approaches to treatment. I aimed to move beyond housing issues and examine what is occurring at the heart of the crisis through thought-provoking interview questions. Feminist theorists propose researchers should treat interviewees as informants or experts, using an open-ended format to permit the emergence of new questions during the course of the interview (Flavin, 2001). Qualitative methods, especially interactive interviews, are best suited to the goals and politics of feminist analysis (England, 2006). England (2006) stated being

flexible and shifting the direction of the interview according to what the interviewee wants or is able to talk about is key for respecting the participants and producing thick and rich data.

Semistructured open-ended interviews are useful for several reasons. When performing discovery oriented research, qualitative researchers tend to construct study specific questions that are open-ended to provide openings through which interviewees can contribute their insiders' perspectives with little or no limitations imposed by more closed-ended questions (Chenail, 2011). Phenomenologist researchers often begin by asking participants to describe their experiences. Semistructured interviews help develop understanding of the ways in which people do things and reveal a hidden environment (Qu & Dunmay, 2011). Semistructured questions often begin with who, what, where, when, why, and how and encourage more expansive responses. Then, based on the responses offered by the interviewee, researchers employ follow-up questions designed to discover more details regarding the respondent's experience.

I designed the interview questions to allow informants to share their experiences while probing for further details. I developed an interview protocol to use in this study. Informants were asked to describe their experiences in detail. The interview questions used in this study include,

1. What led to your current homeless episode?
2. How has mental health played a part in your life and recovery?
3. What barriers do you face trying to get back on your feet?

4. What is one thing that you feel would help you the most, what would that be and why?
5. What do you think holds people back from successfully leaving homelessness?
6. Tell me about the experience of being homeless?
7. Was there a period of time you were not homeless and what supports did you have to make that time successful?
8. How do you make sense of your experiences?
9. What is your solution to ending homeless?
10. What services would you seek out to help you?
11. Is there anything else we haven't talked about that you feel is important to your story?

I used a three-member panel of experts to establish face and content validity of the interview questions. Each panel member received information about the study and was asked to provide feedback on the content, clarity, ease of understanding, and structure of the interview questions. The subject matter experts assessed the interview questions to ensure the protocol was not leading and was free of bias. The expert panel consisted of two mental health professionals and a director of homeless services. I addressed recommendations and modified questions based on the feedback received from the panel.

Procedures for Recruitment, Participation, and Data Collection

I distributed flyers to local homeless shelters, food banks, and homeless organizations. The flyer included a basic description of the study, the time commitment required for participation, and the criteria for inclusion. My contact information was included in the flyer. I met with potential informants to discuss the research guidelines, criteria for participation, the purpose of the interview, terms of anonymity and confidentiality, purpose of audio recorder, the format of the interview, approximate length of the interview, ways to contact me if needed, any further questions they may have, and the right to withdrawal at any time from the research without explanation. I explained the informed consent and had the participants sign the form before I conducted the interview. Participants who agreed to the interview selected a place in which they were comfortable to speak privately. I anticipated each interview would last no longer than 90 minutes. The identities of all participants were protected. Upon the completion of their interviews, each participant received a \$10 gift card to a local food business to thank them for their time and express appreciation for sharing part of their story. The procedure of thanking respondents for participating in a study with a small amount of money or gift is well established in studies that involve people who are homeless (Banyard & Graham-Bermann, 1995; Bates & Toro, 1999; Jackson-Wilson & Borgers, 1993; Smith & North, 1994, as cited in Klitzing, 2003). In similar studies, researchers used monetary gifts of small denominations (Klitzing, 2003; Nemiroff & Aubry, 2011; Patterson et al., 2015; Petrovich & Cronley, 2015).

The benefits of participation were discussed with participants, which included sharing their experiences; ways to improve the mental health system with their feedback and input; time to tell their personal story in a safe, nonjudgmental environment; and a \$10 gift card. The participants were informed of the minimal risk involved with participation in the research study. Risks included possible psychological distress from re-experiencing their homeless experiences and the boundaries they experienced from seeking treatment. The participants were offered referrals to local county clinics if needed. No safety risks were identified in the study. To provide confidentiality, participants were asked to create a fictitious name and sign all documents with this fictitious name. All interviews were completed in a naturalistic setting at the choice of the participant.

Before each interview, I took time to acknowledge my own preconceptions and enter each subject's world. I bracketed my thoughts and feelings. My goal was to be fully present and aware of the informant and to understand her story with an open and objective mindset. I began with simple introductions to establish rapport and create a positive, warm environment to elicit truthful comments from the informants. Included in this introduction was a statement of confidentiality, consent, options to withdrawal, and benefits and risks of participating in the research study.

Each interview was audio recorded with the permission of the informant and coded as "participant pseudo name, date." When more than one interview was conducted on the same date, participants were coded as "participant pseudo name, alphabetical character, date." I recorded each interview in a separate file and labeled it in accordance

with the above code. I recorded notes after each interview to assist in capturing my thoughts and feelings from the interview process.

Data Analysis Plan

I used Braun and Clarke's (2006) thematic analysis to analyze the data. One of the strengths of this method is that it is not tied to any specific research design. This analysis is intended for use with any type of qualitative methodology (Braun & Clarke, 2013). The thematic analysis is detailed, straightforward, and easy to learn and understand. To begin the analysis, I read the transcripts to gain knowledge about what the participants said. While I was reading the transcripts, some patterns, phrases, and commonly used words emerged. The transcripts were uploaded into Nvivo 11. I then began to code the data using Nvivo 11 to organize and manipulate the information. A code is a specific word or phrase used to describe the data in a clear and succinct manner. The data can consist of a word, phrase, or sentences. All interviews were coded. After coding all interviews, similar codes clustered together and similar clusters were joined together as the analysis continued (Braun & Clarke, 2013). After no further reduction was possible, I examined, described, and assigned a name the clusters. These named clusters formed the themes found during the analysis.

I collaborated with my chair and committee members to develop an interpretation of the data and to explore the reflexivity. Reflexivity is a process that challenges the researcher to explicitly examine how the research agenda, assumptions, subject locations, personal beliefs, and emotions entered their research (Hsiung, 2008).

Finally, I reflected on my perceptions throughout the process and I bracketed to prohibit interference. I engaged the phenomenological attitude to go beyond participants' words and reflections to capture something of implicit meaning and pre-reflective experiences (Finlay, 2012). I used reflective commentary to record my initial impressions of each interview and to identify patterns and theories to monitor my assumptions.

Issues of Trustworthiness

Trustworthiness has four components relevant to qualitative research: credibility, transferability, dependability, and confirmability. Credibility (similar to internal validity) refers to whether the findings accurately reflect the situation and are supported by evidence (Guion, Diehl, & McDonald, 2011). I addressed credibility by acknowledging researcher bias and writing thick narrative descriptions throughout all interviews. I established a familiarity with the homeless culture and this helped foster my credibility. Further, I acknowledged that some homeless individuals do not seek change and are comfortable with their status and experiences.

Transferability (similar to external validity) is established by providing a dense description of the population, including demographics and geographic boundaries of the study. In qualitative research, it is up to the reader to judge if the data found in the study apply to a different setting or place. Dependability occurs when another researcher can follow the decision trail used by the researcher conducting the original study. This process is explained in the data analysis plan which, along with any notes and observations I had, formed an audit trail for others to follow.

Confirmability is the qualitative investigator's comparable concern to objectivity (Shenton, 2004). To deal with this issue, I worked with my chair and committee members to determine the findings were the result of the experiences and ideas of the participants rather than my characteristics and preferences. In addition, I conducted an audit of the data to rule out potential bias.

I did not return the data, analysis, or interpretations to participants for feedback, accuracy, or review of the work. Member checks through data analysis are a verification of the overall results; however, this was not a verification strategy (see Morse, Barrett, Mayan, Olson, & Spiers, 2002). Researchers view this technique as a threat to validity. Therefore, rigor was built into the qualitative research process through methodological coherence, responsiveness, theoretical sampling, active analytic stance, and saturation. It is often through an outside viewpoint that information is gained regarding a particular experience. Therefore, I welcomed feedback, but not for validation.

Additionally, reliability is the extent to which researchers can repeat findings. The more findings repeated, the more reliable the phenomenon is. However, human behavior is never static and the qualitative researcher understands the results may change. To address this concern, I conducted an audit trail and described in detail how data were collected and categorized, and how decisions were made. Further, I conducted a multisite design to test if situations representing variation would allow the results to be generalized to similar situations. Finally, I made a conscious effort to follow the lead of the participants in the interview session and ask for clarity, if needed, to add to the thick descriptions.

Ethical Procedures

The proposal for this study was evaluated and approved by the Institutional Review Board (IRB) of Walden University. The Nuremberg Code drafted in 1947 indicates voluntary consent of the human subject is absolutely necessary (Ghooi, 2011). Similarly, the CIHR, NSERC, SSHRC: Tri-Council Policy Statement (2009) advocates the ethics of research involving human subjects must include the selection and achievement of morally acceptable ends and the morally acceptable means to those ends. This suggests that ethics in research must not only pertain to the protection of human subjects but also involve what constitutes socially responsible research (Schwandt, 2007).

It is vital that the researchers consider the participant's or guardian's competence to give consent. In addition, a participant's vulnerability to coercion, openness to lack of confidentiality, and the conflict of interest between the research ethics and the researcher's own ethics should also be considered (Beauchamp & Childress, 1989; Shamoo & Resnik, 2009). I ensured no participants were below the age of consent and they met all selection criteria.

Summary

In Chapter 3, I provided an in-depth discussion of the methodology used in this study. I selected a qualitative phenomenological framework with a feminist underpinning. Using a combination of criterion and snowball sampling, I selected 10 participants. I gathered data using a semistructured open-ended interview protocol. Interviews lasted approximately 90 minutes and the data were audio-recorded. I kept a field log to track thoughts, ideas, and observations during the study. The data were uploaded into Nvivo 11

to aid in the organization and analysis of data. I used thematic analysis (Braun & Clarke, 2013) to explore the data. I present the results of the study in Chapter 4. A discussion of the results is in Chapter 5.

Chapter 4: Results

Introduction

This study pertained to the experiences of chronically homeless women with mental illnesses and their perceptions of barriers to mental health treatment. I chose a qualitative method and employed a phenomenological design to describe the experience of homelessness of those who have experienced it firsthand. The purpose of this study was to explore the experiences and perceptions of chronically homeless women and their barriers to mental health treatment. I did not use a quantitative or mixed method design because my goal was not to measure the phenomenon using statistical methods. Rather, my goal was to explore the experiences of homeless women with mental illnesses using their own words.

I chose a phenomenological design to better understand the experiences and perceptions of individuals experiencing homelessness. Phenomenological research is often used to study affective, emotional, and intense human experiences. At the core of phenomenological thought is the belief that worlds and objects exist based on how individuals perceive and construct their reality. Finlay (2012) contented that phenomenology helps people see the world in a different way. When using a phenomenological design, researchers compose questions to elicit information about the phenomenon and help participants describe the experience using rich, detailed, thick

descriptions of the lived experience that goes beyond intellectual descriptions. The goal of this type of research is to describe the world as seen through the eyes of the participants.

Setting

I conducted interviews over a 3-month period in the southwestern United States. Using a semistructured interview format, I spent between 60-90 minutes speaking with each participant. I conducted the audio-recorded face-to-face interviews in locations selected through agreement between the participant and me to ensure each participant's comfort.

Demographics

The sample for this study consisted of 10 homeless women participants who resided in the southwestern region of the United States. Table 1 shows the demographic data of the sample.

Table 1

Participant Demographics

Characteristic	<i>n</i>	%
Age range		
18–25	0	0
26–35	2	20
36–45	2	20
46–55	4	40
56–65	2	20
66+	0	0
Marital status		
Single	4	40
Engaged	1	10
Married	2	20
Separated	1	10
Divorced	2	20
Education		
Some junior/high school	3	30
High school/GED	3	30
Some college or Associate's degree	4	40
Income		
None	2	20
Cal fresh benefits	3	30
Social security	5	50
Current number of years homeless		
Under one year	2	20
1–2	5	50
3–4	3	30
Psychiatric diagnosis		
ADHD	1	10
Bipolar	3	30
Depression	8	80
GAD/Anxiety	6	60
Psychotic disorder	1	10
PTSD	4	40
Schizoaffective disorder	1	10
Schizophrenia	1	10

The participants ranged in age from 26–65 years. All participants had at least one mental health diagnosis, with the majority reporting two or more diagnoses. Their range of years for their current episodes of homelessness was from 6 months to 3 years. Only two participants reported no form of income, and 80% reported receiving social security benefits. All participants reported some education, with 40% reporting some college.

Data Collection

I selected 10 participants for the study through snowball sampling and criterion sampling methods. I posted flyers at food banks and women's shelters, and checked back each week. Although tags with my information were removed, I did not receive one call regarding the study. One participant stated she had seen the flyer, but did not call for unknown reasons. Many of the women I interviewed thought other women would be happy to share their experiences with me and many interviews were gained in this manner. I approached women individually and in groups, and shared the goals of the study. Some politely declined, but many were willing to share their story. I noticed that a few homeless individuals appeared too mentally unstable to participate, as demonstrated by their poor appearances and actions. I offered these individuals resources and a gift card for food.

I ensured participants included into the study were (a) chronically homeless, as defined by the Federal government; (b) 18 years of age or older; (c) diagnosed with a mental illness within the last 5 years; and (d) alone, with no minor children accompanying them. All participation was voluntary and participants showed a willingness to be interviewed and audio recorded. I met one woman who wanted to

participate but did not want to be recorded. I thanked her for her time, but explained recording was necessary for transcription and other purposes. Exclusion criteria included women who felt pressured to participate, women unable to form lucid thoughts, women with children in their care, or any person who had worked with me through various county mental health programs.

Establishing rapport with the informants was complicated. With some participants, rapport was easily and quickly established. Other participants expressed a distrust with the system and felt nobody cared. I displayed a willingness to connect with them and hear their story, but also remained honest about having no direct means to change policy or secure immediate benefits for them. Working from a feminist perspective, I strove to establish a collaborative and reciprocal relationship with the participant.

I felt that after the 10th interview, the data had reached a saturation point. Saturation is the point at which no additional information can be gathered from participants. My that point, I had established metathemes, so sought no further interviews. By exploring narratives of homelessness, researchers can see the needs of such women in positions of crises. During the data gathering process, several themes emerged. Themes included substance use, death and trauma, and many crises that led to a spiral into homelessness. Except for a few participants who were in temporary shelters, many of the participants were homeless. I attempted to be flexible in the questions I asked to gather thick, rich descriptions from participants. Many of the participants

discussed the role of law enforcement and code enforcement in their daily lives and the struggles they faced living outside.

I conducted outreach by going to homeless shelters, food banks, and local parks. I discussed the inclusion criteria for the study. For those who met the criteria and wished to participate, I told them about the benefits as well as the risks of participation. I gave the participants a \$10 gift card to a local restaurant for their time and feedback. All qualifying participants I contacted completed the study. I did not experience any negative effects other than occasional tearful episodes when participants explained their fall into homelessness. Many participants enjoyed selecting a fictitious name to protect their confidentiality.

Before each interview, I took the time to acknowledge my own preconceptions and enter the subjects' lifeworld. I bracketed my thoughts and feelings, and collected these thoughts in a journal. The purpose was to be mindful of the participant in front of me and to be fully present and aware to understand their story with an open and objective mindset. I conducted interviews in natural environments the participants chose. One interview was conducted in the rain because there was no other viable place to go. I conducted the interview under my umbrella. The participants were highly detailed in their stories and willing to share their experiences. Many expressed a desire for a local support group or the need for counseling to help them deal with the day-to-day stress they were experiencing.

I audio recorded each interview with the permission of the participants and coded them as "Interview #, Participant pseudonym, date." If more than one interview was done

on one date, they were coded “Interview #, Participant pseudonym, numerical character, date.” I recorded notes after each interview to capture my thoughts and feelings from the interview process.

Data Analysis

To begin the analysis, I transcribed the audio-recording for each interview. I then read the transcripts to gain knowledge about what the participants said. When reading the transcripts, patterns, phrases, and commonly-used words emerged. I uploaded the transcripts into Nvivo 11, which helped me organize information and develop themes.

To analyze the data, I employed Braun and Clarke’s (2006) thematic analysis. To begin the analysis, I read the transcripts to gain a deep familiarity with the participants’ experiences and perceptions. Through reading the transcripts, patterns, phrases, and commonly used words emerged. Employing Nvivo 11, I organized and explored the data as the coding process began. A code is a specific word or phrase used to describe the data in a clear and succinct manner. The data could consist of a word, phrase, or sentence. The goal of assigning a code was to find a succinct way to express the meaning of the data. After I coded the interviews, I explored the codes in search of likenesses and commonalities. I clustered similar codes together. After completing this process, I explored each cluster for commonalities, relationships, or connections. I joined similar clusters together during the analysis process. After no further reduction was possible, I examined, described, and assigned a name to the clusters. These clusters were compared to the original data to ensure they accurately reflected the experiences and perceptions of the participants. After this, named clusters became the themes I found during the analysis.

Then, I wrote the results in narrative form, accompanied by selected excerpts from the data.

Evidence of Trustworthiness

To ensure credibility, I collaborated with my dissertation chair and committee members to develop an interpretation of the data and explore reflexivity. Reflexivity is a process that challenges the researcher to explicitly examine how the research agenda and assumptions, subject locations, personal beliefs, and emotions enter his or her research (Hsiung, 2008). I discuss issues of convergence and divergence in the data results.

For confirmability, I reflected on my perceptions throughout the process, and I bracketed to prohibit interference. I engaged the phenomenological attitude in order to go beyond participants' words and reflections to capture something of the implicit horizons of meaning and pre-reflective experiences (see Finlay, 2012). To monitor my assumptions, I used reflective commentary to record initial impressions of each interview and identify patterns and theories. I worked with my chair and committee members to determine that the findings were the result of the experiences and ideas of the participants, rather than my characteristics and preferences. An audit of the data helped me rule out any potential bias.

I did not return the data, analysis, or interpretations back to the participants for feedback, accuracy, or review of the work. Additionally, homeless women often do not stay in one spot long, and finding them a second time for additional feedback posed challenges that could not be surmounted. Therefore, rigor was built into the qualitative research process through methodological coherence, responsiveness, theoretical

sampling, active analytic stance, and saturation. Further, often through an outside viewpoint, researchers can gain useful information about an experience. Therefore, I welcomed feedback from my dissertation committee, but not for validation purposes.

Dependability is the extent to which findings can be repeated. The more the findings are repeated, the more reliable the phenomenon is. However, human behavior is never static, and the qualitative researcher understands that the results may change. To address this concern, I conducted an audit trail and described in detail the data collection process, categorization of the data, and how decisions were made. Further, I used a multisite design to see if situations representing variation allowed the results to be transferable or generalized to a larger range of similar situations. Finally, I made a conscious effort to follow the lead of the participants within the interview session, and I asked for clarification as needed to add to the thick descriptions.

Results

I identified five themes and three subthemes during the data analysis process. These themes were *reasons for homelessness, women stay homeless because . . . , mental health experiences and issues, experiences with being homeless, and services and supports*. Three subthemes were associated with the theme *services and supports*. These subthemes were *the shelter experience, services that are needed, and professionals should know*.

Theme 1: Reasons for Homelessness

This theme encompasses the reasons participants became homeless. This theme pertains to their personal life histories and involved exploration of the factors involved. The participants reported a variety of reasons and factors related to their homelessness.

For many of the participants in the study, their homelessness began with loss of employment. The job loss happened for reasons which included being laid off because of an illness that prevented them from returning to their employment. Mary spoke about her experience:

I was a chair side dental assistant for two dentists a total of 20 years. My second employer, may I name him or keep him anonymous? We'll just call him Dr. Anonymous. Abruptly decided in 2008 to retire, yea. Which totally took me by surprise. I had \$25,000 in savings for three years until the loss of my home, etc. I attempted to get a job, search for a job in Memphis Tennessee, which is where I am from. Um, I could not get a position.

Mary had many years of experience in her field, along with associated training and certifications. Despite her extensive experience, she was unable to find a new position. This was, for her, the first step on her way to becoming homeless. Cindy had a similar experience:

I had worked for a tax accountant for 14 years, but he passed away. So not only at that point I lost my house, my car, and my job all at once. I rented a house from him and one of my perks was a car. And um, because I would come in whenever especially during tax season, you don't just work eight hours a day.

Everything Cindy had was dependent on her employment. After she lost her position, she lost all associated benefits. Both participants had years of stable employment with one employer. They had experience and training in their fields. However, when they lost employment, they were unable to find other positions. This initial loss spiraled into eventual homelessness.

Many other participants did not give as much detail and simply stated they lost their employment. One participant, Renee, was in an accident. She spoke about her experience and said, "I was in an accident in 2013, November 21, I was in the hospital for nine days and wasn't able to go back to work." She was employed before her accident, but as a result, was unable to continue to work. Another participant lost her employment because of a death. She said, "I was her [my mother's] caregiver and when she passed away I lost my job, I lost everything." For these participants, losing their employment was the first step toward homelessness.

Some participants indicated they searched for employment but were unable to find jobs. Lisa spoke about her current situation and said, "I can't find a job." Cindy spoke about her experiences and said, "it was extremely hard to find a job. Nobody wants to hire a 53 year old woman who has, you know issues, medical issues." Mary reported similar issues and stated, "I attempted to get a job. . . I could not get a position." These participants attempted to find jobs, however, despite their effort and experience levels, they were unable to secure employment. Some participants believed people would not hire them because of age or other factors that they believed made them less desirable as employees.

Many of the participants also spoke about issues related to domestic violence. Their ability to have and maintain housing was affected by their experiences with their partners or family members. Anna said,

My ex-husband and I we just started having problems, work, you know, his work was too far away so a lot of time apart and he started cheating on me and we ended up getting arrested in May 2011, I think, for domestic violence.

Other participants reported similar histories, with Gilda stating, “my husband. . . he forgets to take his medication and he gets abusive and then he goes to jail or he gets us thrown out of places because you know neighbors don’t want to hear it.” Their experiences with domestic violence led to a loss of a house or an inability to maintain housing. Amanda reported a similar experience and said, “there was issues with me and my kid’s dad we would fight a lot and get kicked out.” The participants who stayed with abusive partners often lost housing because of disturbances, although other participants lost housing because they were fleeing domestic violence situations. Lisa dealt with a combination of domestic violence and lack of local support. She said, “I moved out to California from Virginia Beach to be with my husband who was serving in the marine corps in San Diego. Um, it was hard we struggled. There was some physical abuse in our relationship.” She reported they later divorced. She was not in a position where she could return to Virginia Beach, and knew very few people in California. A combination of these factors led her to become homeless. The first step toward homelessness, for her, was the domestic violence she experienced while married.

Other participants experienced domestic violence from family members. Minnie spoke about an incident with her son and her daughter-in-law. She was residing with them and recollected:

They kicked me out. But before they kicked [me out], me he hit me, hit me to the couch. He held me hostage and she beat me. I ran downstairs in the street and she me pulled my hair all the way up the stairs. . . So, anyway she beat me and everything and after that she kicked me out.

She had experienced homelessness in the past, but thought she had regained some stability. After that incident, she found herself living on the streets.

Another issue shared by many of the participants was addiction. Anna spoke about her substance abuse and simply stated, “I had challenges with drug use and I chose to go run amuck versus being at home.” While younger and living at home with her family she began to abuse substances. As her use escalated, she began to leave her home frequently, and finally she ended up homeless. Minnie gave the most information about her initial issues with substance abuse. She spoke at length and said,

Thirty years ago in high school, I was going to high school I was popular in high school and I was in 10th grade and around the area was a man named XXXX. . . we dated not very long, I was 17 when I met him and we dated for a couple months and then after we married, right after. . . he introduced me to the pipe and meth and we started doing it, me, him, his mom and dad, two sisters, two brothers and all of us. We had our own pipes, we had our own meth or money and we stayed out in the world and did meth all the time and everything.

Minnie began her journey when she was young. Her report indicated that up to the point she met and married her husband, she had been a high school student, focused on going to school, and doing well. After her marriage, she was influenced by those around her and began to use substances and spiral downward. She eventually lost her housing and became homeless. Several participants indicated they struggled with substance abuse: Lisa stated, “drugs”; Amanda said, “I relapsed on drugs about a year and a half ago”; and Julie said, “drinking and drug use.” Many of the participants did not offer details but were willing to attest to the effect of substance abuse on their homeless status.

Many of the participants spoke about a lack of familial support. Many of their families attempted to provide aid, but for a variety of reasons, reached a point where they could no longer provide support. Anna indicated her family attempted to proffer help, but then stopped. Anna stated,

My family had enough. . . they didn't know what to do to help me. So, they drove me, we lived in Perris, CA at the time and they drove me to what they thought was going to help me a place called Interfaith in Escondido and it turned out that Interfaith was more for veterans than anything. So, I was kinda just was left to my own devices for a long time.

The family believed they could no longer help her in any meaningful way; however, they attempted to find her services. When the services they located were not appropriate, they could not think of any resources, and left her to find support on her own.

Other participants also lived with family members. Cindy spoke about her experiences and said, “my mom passed away and I was working for my mom and living

at my nephew's house and he said I couldn't live there anymore because I wasn't paying rent so I went couch surfing basically." When she could no longer afford to pay rent, she had to move from her nephew's home. He was not willing to provide support unless she could afford to pay her own way. Cindy summarized reasons for her homelessness and said, "there are lots of reasons, like family kicking you out." Similar to other participants, she understood there were multiple reasons for her homelessness, but pinpointed lack of familial support as a primary factor.

Lisa's father did not approve of her partner. She knew that she could ask for help, but conditions were attached. She spoke about her father:

My father is really well off he lives in Encinitas he's a Navy Seal. But, he doesn't really like me with him so in order for my father to help me I have to leave him and I'm not ready to do that, you know.

She felt as if she had to make a choice between her father and her partner. As she was not willing to give up her relationship, she could not ask her father for aid. Lisa 2 spoke about her experiences with her family and said, "when you have other family members out there but they don't want to help and they want nothing to do with you. And you're out there alone and you have no support its really sad." For her, the lack of support she received from her family was an emotional topic. She did not display anger, but instead was overcome with a deep sadness. Amanda did receive some support from her sister. She said, "my sister she lives in town, but I can't stay with her because of family reasons. But, she has TV so she watches the news and lets me know what ever she can to help."

Although her sister could not provide her with a place to live, she maintained a relationship with her and tried to help by providing information.

Some participants indicated that some form of traumatic loss led to their homelessness: for many, it was the death of a family member. Lisa 2 spoke about her experiences and said, “we ended up kinda losing our kids to foster care, and then his parents died. And then from there everything just started, went from down to down.” She faced a series of losses, with each seeming to pile on top of another until she felt there was no recovery. Amanda also lost a parent and stated, “I first became homeless when my mom passed away.” Mary also said, “the traumatic loss, which I experienced 15 years ago of a beloved parent and, which was trauma.” These losses profoundly affected the participants, leaving them feeling bereft and lost. These emotions, compounded with other experiences, contributed to their homelessness.

The participants listed other reasons for their homelessness. Some participants reported losing their homes. Mary said, “I lost my home.” Renee, Anna, Gilda, and Amanda also indicated they had lost their homes to a combination of circumstances from the loss of a job to addiction issues. One of the participants, Anna, indicated that her loss of a home was directly connected to “the lack of affordable housing anywhere.” She went on to speak about this in more detail and remarked, “and if you get like an eviction on your record or something because you couldn’t pay your bills you now you can’t get into another place.” Between a lack of housing and credit issues, she found it difficult to find a place to live. She felt as if she had few options and that it would be close to impossible to end her homelessness.

Other reasons cited by the participants included a lack of money. For many of the participants, this was connected to their difficulty finding a job. Mary said, “I had \$25,000 in savings for three years . . . I ran out of money, literally.” When she first lost her job, she had a cushion of money in the bank; however, as her job search lengthened and she was unable to find a new position, she spent her funds. Cindy attempted to find a source of income and stated, “I went and applied for social security and I was denied and I filed an appeal and I’m just waiting to hear the outcome of that appeal.” She attempted to receive disability payments, but the process was long and burdensome. She was in the process and filed an appeal of her denial, but was in a position where she could do nothing but wait for the outcome. Lisa spoke about her experience and said, “it has been a struggle. I’ve never been homeless in my life until about a year ago.” She attempted to find a way out of her situation but found it challenging.

Some participants indicated they were homeless because they did not like staying in the shelter. Lisa 2 said, “I was not comfortable staying there so I come out and I stayed in the streets I stayed behind a building.” In addition, she had a pet and said, “I’m not supposed to keep the pet.” She was not willing to leave her pet alone and was afraid of losing it if she went to a shelter. Rather than giving up her pet she chose to reside on the street. Lisa 2 said,

We were staying at a shelter for a while and a lot of things were getting stolen and so, we kinda thought it weird and safer to be outside then in a building. It’s kinda weird because a lot of fights would start there and it’s kinda like, honestly, I’ve been to jail and it’s kinda worse than jail.

She did not feel safe in the shelter. Lisa 2 worried about the behavior of other residents and did not wish to have her belongings stolen. She spoke about her feelings:

We have more respect for the girls in jail then you do in the shelter I mean it was pretty bad. I was just there a couple weeks ago and I was stuck in there and I even called my Probation Officer just to pick me up just to get out of there and me and my husband go sleep in a tent. And I would rather go do that and come get food here then go be somewhere like that and that's kinda scary. Where you don't feel safe there you feel safer on the streets. It's weird.

Lisa 2 was so uncomfortable with the dynamics of the shelter that she preferred to sleep in a tent. She felt the residents of the shelter were unsafe to be around and wanted to be somewhere she felt in control of her situation. Anna spoke about other people she knew:

I met a lot of people that were homeless by choice some of them, had been on the streets for years and had been offered housing and it just blew my mind because they didn't want to move. They just didn't know how to live any other way.

Although she did not understand why some people preferred to be homeless, she acknowledged that some people seemed to prefer living without shelter.

Theme 2: Women Stay Homeless Because . . .

This theme encompasses the participants' opinions about the reasons for homelessness. The participants felt some women were afraid to ask for help and worried about judgment from others. Half the participants spoke about fear as a reason for continued homelessness. Participants indicated some women chose to be homeless, while others were comfortable and afraid of change or a loss of freedom. Participants spoke

about a focus on survival with few resources left to change circumstances. Some participants believed disabilities caused homelessness and others spoke about feelings of shame and uncertainty. Finding a job was a barrier for some women, while others spoke about lack of money, knowledge, and technology. Some participants remarked that women struggled with issues of learned helplessness, self-limiting beliefs, and a lack of self-efficacy. Other issues included physical and mental health challenges.

Some of the women in the study spoke about learned helplessness. They believed many people who were homeless simply gave up and did not believe they could change their situation. Renee believed some women remained homeless because they were not able to make the effort to change their circumstances. She said, “if somebody presented it [an opportunity] to them, but if for them to go out and make the effort it’s not there.” She observed many women she knew were no longer willing to try. Their previous experiences taught them that change does not occur and as a result they gave up trying. Julie agreed and stated, “some people just give up. . . I mean there is nothing you can do about it. They don’t want the service or don’t take medicine.” In her observations, like Renee, she felt these women had given up and believed that change was not possible. Renee concluded by stating, “I see a couple friends they just complain you know nothing will make a difference.” Cindy agreed and spoke about her observations: “people they don’t, [believe] once you’re in this situation you feel like it’s impossible to get out.”

Although the participants could identify these behaviors in others, they did not see them in themselves. Some of the participants lost their sense of self-efficacy. Renee spoke about herself and said, “I can’t do it. I don’t have the energy, the time, the

strength.” She did not believe in herself or her ability to change her life. Amanda expressed similar emotions and reported, “I think that’s why I haven’t really been working on it the last couple of months. This last year and a half, uh I have been somewhere and then something always happens.” She did not believe she had any effect on what was happening to her. She did not have an internal locus of control and felt acted upon. She did not see how she could have changed anything that happened to her.

Some participants spoke about how some people became comfortable with being homeless and did not wish their circumstances to change. Anna said, “some people get into a comfort zone of being homeless and they’ve learned how to survive they’ve learned how to manage, they learned how to cope and to them that’s comfortable.” She believed people became familiar with the routines and expectations they lived with every day. These individuals understood the rhythms of being homeless and how to survive. For them, change was fear provoking, so they preferred to stay in situations they found comfortable. Minnie spoke about this with some surprise and remarked, “Some people like to be homeless. People really like it. There are many people that like it.” She did not offer an explanation but did indicate that for her, getting a home and getting off the streets was a priority.

Lisa had similar observations to other participants as she spoke about homelessness:

You get stuck, you know, and you lose hope and you get used to living like this and you get comfortable. To the point where, I’ve talked to a lot of people out here and once they get somewhere to live they don’t feel comfortable because

they don't feel free there used to living on the streets. And I'm starting to get like that now and I don't want to get like that, you know, it's sad it really is.

She went on to say, "some people I know have chosen to be homeless. There is a couple people out here that have plenty of money every month to live in a home and they choose to be out here." Lisa spoke about people she knew with a sense of wonder. She wished to have the money she needed to find a permanent residence and did not understand why people would choose to be homeless. For other people, it was a lack of money that prevented them from finding housing. Gilda stated,

Well, trying to save up enough money to get into a place because there is first and last and then sometimes security, but basically, they want you to have three times the amount of income as the apartment or house.

Other participants indicated women remained homeless because they were focused on survival. The participants indicated being homeless can be a full-time occupation, with a focus on food, shelter, and basic survival. Lisa 2 stated, "honestly, I'm just trying to get through the day." The requirements of survival drained her energy, and left her feeling as if she did not have any energy left to consider the future. Gilda said, "sometimes you get frustrated after a while. You get some much stuff on your plate it makes you sick because stress is the number one killer." She spoke about some of the emotions associated with being homeless. The participants mentioned feelings of frustration, loss, sadness, and anger. They reported being overwhelmed by those emotions and feeling as if they had few options. Mary summarized their comments and said, "they basically dissolve into surviving literally, any way they can."

Many participants spoke about how emotions affect homelessness for women. They believed these emotions kept women from moving forward and making plans. Mary said, “what holds them back is they feel, in my word, unjustifiably ashamed of where they are.” She went on to state, “which is self-introduced and also society introduced because of the stigma [associated with homelessness].” She believed the feeling of shame connected with homelessness prevented many women from asking help or believing that they deserved to receive help. Amanda indicated many women feared success. She stated,

Fear. . . other people I have heard talk about it they’re afraid to get into a home and have everything and just lose it all again. Why get our hopes up of having something whenever there just a chance of losing it all?

Some women worried if they did find a way out of homelessness that they might someday lose everything again. They let the fear of success paralyze them. Their fear was the opposite of hope; the women feared to have hope in case things did not work out for them.

Anna spoke about how feelings of fear affected homeless women. She reported many women felt fear of the police. They did not believe the police would help them find resources. Instead, she said these women worried, “that cops are going to arrest them, they’re afraid of going to jail, they’re afraid.” They would avoid people they perceived to be social workers, police, or other professionals because they feared they would end up in a situation they perceived to be worse in some way. Gilda said,

They’re afraid their kids are going to be taken by CPS [Child Protective Services].
. . . they’re trying to help themselves sometimes and you can’t because of that. You

have to wait it out even if kids are involved. Hard to get them back when there in the system I hear.

Many women feared judgement from others. They worried about how others perceived them or what other people thought of their situation. They let these feelings of fear prevent them from reaching out for help. Lisa 2 said,

It's kinda embarrassing to, you know to be walking down the street and be judged different. You know and stuff your dirty and you don't have a shower and have enough clothes and sit there and everyone kinda looks down on you. And it's kinda, I won't ask for change. I won't do it you know, I don't feel right. I when I have asked, when I do need it and they give you looks and it kind makes you feel disgusting, you know?

Lisa said she often felt ashamed of her situation. She worried that she was being judged and wondered if she would be able to find and maintain housing. Mary said, "ironically, if they could acquire a job or jobs that's where they would go, but the stigma of homelessness is a horrible thing [which prevents many women from trying]."

Some women used finding work as a reason to explain why women were homeless. The search for a job, particularly when it was difficult to get access to a bathroom, laundry, clean clothing, address, or phone number was problematic. These barriers made an already challenging situation worse. Anna stated, "I can't go to a job interview with dirty clothes." She wished to change her circumstances, but felt limited. Gilda also said, "we don't have job skills that has a lot to do with it." She said many women who are homeless lack technological skills. They are not conversant with

computers or other electronics. Glinda said, “trying to do all these things just takes longer you know because you never feel like you’re getting ahead, one step up you go back, always something that’s stopping you.” She indicated lack of access to the Internet and telephones also hindered women’s efforts to find jobs.

The participants identified physical illness, mental illness, and disability status as other contributors to homelessness. Julie said, “most people I see, [are] sick, they have physical and mental [illness]. . . they are sick.” Lisa believed many women who were homeless had issues with mental health or substance abuse. She stated, “a lot of people out here it’s because of drugs and a mental illness.” She believed those women were not ready to receive aid and change their circumstances. Lisa remarked, “they got to want it. You got to want it. You have to want help.” She added, “you know we’re all self-medicating.” Lisa spoke about her own challenges with mental health issues:

I know I wouldn’t be where I am at if I had a doctor and my medications that I need. I would be able to go out and look for a job and be able to focus and get things done, you know. I can’t focus, I can’t do a lot of things because of it.

Lisa stated it was challenging to get the clarity and focus necessary to begin any changes while dealing with her mental health issues. Amanda had a combination of mental and physical health issues. Lisa agreed with Amanda and said, “so I mean it’s hard I’m supposed to be on heart medication and medication for my depression, anxiety, and PTSD. I haven’t had it in like three months.” She said many homeless people she knew preferred to be homeless because they wanted to use their money for drugs or alcohol.

Without the responsibilities of maintaining a home or job, they could take the funds they had and spend them how they wished.

Theme 3: Experiences with Being Homeless

The participants in this study spoke about a variety of experiences associated with being homeless. Some spoke about general experiences of life on the street. Some participants believe women experienced and felt stigma associated with being homeless. The participants spoke about assumptions of prostitution and how they believed others thought that was how they made money. Many of the participants spoke about their encounters with law enforcement. Some had histories of arrests, while others spoke about receiving tickets or harassment. Most of the participants had a negative view of law enforcement, although two participants mentioned positive encounters.

Homelessness caused issues with medication for the participants. They had difficulty maintaining their regular medication schedules. Many of the participants were the victims of violent crime, including assault, sexual assault, and robbery. Some participants mentioned issues associated with addiction, both for themselves and others. The participants believed loyalty was difficult to find and some spoke about a loss of hope. The participants believed that people did not care for them and that few programs for women existed.

Overall, the participants were divided regarding their beliefs as to differences based on gender, with half indicating gender differences existed and others speaking about how women were perceived to be weak. Other issues included encounters with CPS, difficulty with clothing, emotional challenges, and finding work. Some participants

also spoke about receiving aid, the motivation to change their situation, and mental health court.

The participants in this study indicated life on the street was often challenging. However, despite difficulties, they could speak about positive experiences. Anna said, “I stay[ed] on the streets, built camps, had friends who had campsites we would make our little campsites behind buildings um, trees and wherever, you know cuz there really wasn’t a shelter to go to.” She spoke about positive relationships she had with others and a feeling of mutual dependence she developed with the few people she trusted. For most of the others, being homeless was a negative experience. Cindy tearfully spoke about her initial time being homeless:

I stayed a couple of nights in Home Depot’s parking lot. I ended up at a drug house because it was the only shelter, they are dealing heroin, shooting up heroin and I am scared out of my mind. So they wanted my food stamps they knew when they were coming. And they would come on the 3rd of the month so on the 3rd I was at the hospital my sister works there, and she asked me what was going on and I told her and she said goes no uh, you’re spending the night at my house tonight and we will find you a shelter. So that’s how I ended up at Roy’s because there was no other shelters throughout San Bernardino, Riverside, Colton, Hemet none of them had any availability.

She was frightened by what happened to her and was able to reach out to her sister. She eventually found a shelter to stay at and was in a safer position. She reported some difficulty complying with shelter rules about staying out. Because she stayed out for more

than 72 hours, her possessions were disposed of and she was not allowed to return. Cindy said this made her feel as if she could not get ahead.

Lisa 2 also found being homeless frightening. She spent a significant deal of time worrying about her personal safety and found herself modifying her behavior. She said,

You want to speak up you can't. It's like something stops you. Because, it's like especially being out here you can't just go speak your mind and then not expect something might happen, like you may get hurt, you may say the wrong thing, as a woman. So you gotta look down and act like you don't see what you see.

She believed she needed to be careful to not put herself in an unsafe situation. Amanda summarized homelessness, stating, "It just really sucks out here, it does, it's cold and its lonely. It really is."

Most the women in the study believed homeless women faced a significant deal of stigma. Mary spoke about how women were forced to take jobs they did not want. She stated, "[people] give them a job they don't want to have, shame them into it." She felt many homeless women who reentered the workforce took jobs because they were ashamed to say they did not want to work. Mary reported many people assume homeless women make money through prostitution. Mary said, "women are stigmatized ugh. [people say] go stand on the street corner." These perceptions disgusted her but she did not see a way to change them. Even other homeless women held this perception. Gilda stated women had difficulty getting money, "unless they're going to sell their bodies or whatever to make money because they don't have any money." Anna spoke about

prostitution and said, “that’s a hard lifestyle too but, it’s they find they’re good at it.

Whether it’s a good choice, they’re good at it.”

Gilda said she was reluctant to let others know that she was homeless. She reported, “you don’t always want to say anything sometimes to people. You [are] looked down [upon].” Lisa agreed:

Because we feel, we’re embarrassed too. We’re people too, we have feelings and we get embarrassed because of our pride. We have to suck a lot up. But, I think more people should definitely play their part as an American and perhaps help. She revealed the actions of others magnified her feelings of shame and embarrassment. She noticed when people acted as if she did not exist, turned their heads away, and hurried past. Lisa indicated a “simple smile” from others could make her day better.

Amanda was emotional when she spoke about her experience. She found homelessness stigmatizing. The actions of others upset her. She said,

Not everybody out here that is homeless wants to really be here. There are a lot of people that will drive by throw things at us or call us names, they think we want to be here. I would give anything to have my kids back, my home back. I would do anything to hold my babies again and to lie in my warm bed at home.

Amanda wanted her old life back. She was living on the street, not of her own volition, and was frightened and saddened by the way she was treated as well as how much her life had changed.

The participants reported a wide variety of experiences with law enforcement. Most participants had a variety of experiences with law enforcement. Several of the participants spoke about being arrested. Amanda stated,

It's really hard though because the police in town don't really let us be anywhere. So, um, I was arrested a couple weeks ago because I had a little cart, not like a shopping cart, but a little pulley cart with my blankets in it. It was called storing private property in public. It was a site and release, they arrested me sent me to [jail] gave me a ticket and released me from there.

She had no place to keep her possessions, and because she had to keep them with her, the police arrested her. She was matter-of-fact as she spoke about the experience. Amanda did not know how she was going to pay the \$600 ticket and said she would probably end up going to jail. There were grave consequences for being arrested: "I'm still on probation for drugs. I got arrested in August for drugs. . . they have a no tolerance for drugs for a lot of stuff. I just got my food stamps back this month." Amanda had insurance to pay for medication and other health care needs. She said she would lose her food stamps and her insurance if she did not pay the ticket. Anna had also been involved with the police and said, "I got arrested for the first time at the end of 2013."

Some participants reported negative experiences with law enforcement. Renee said,

Having to deal with the police department has been rough. . . They're everywhere. You going to sleep and they are waking you up. You find a place to sleep and you know you have to be out of there at a certain time. Code enforcement is on you,

I've had so much stuff taken and having to start over so many times. It's illegal to be homeless [here]. They're arresting people [for being a] public nuisance.

She lived in a constant state of worry and never slept deeply. She was scared of getting arrested and sent to jail. Participants reported police frequently followed them and made them leave where they were. The participants worried about harassment and tried to avoid police attention.

A few participants reported positive interactions with police officers. Renee said, There is one thing I can say though, the police department when there is a situation with a female that has been attacked or something they are very discrete and sensitive to that issue. I didn't expect it for them to cuz they treat homeless like they're dirt, but when issues like that happen they're very sensitive.

Although she did not have an overall positive opinion of law enforcement, Renee believed when it came to dealing with sexual assault, they were sensitive and supportive. Anna spoke about law enforcement in her area and indicated they were attempting to be helpful. She stated,

[They are] going out to the homeless camps and taking that fear that cops are going to arrest them, if that fear is gone there are cops that actually help. They're like I'm not here to arrest you, I'm here to help you.

She believed that, in her community, the fear of police was lessening. She observed law enforcement officers were attempting to link homeless people with support and services rather than trying to arrest them and send them to jail.

The participants in the study spoke at length about being the victims of crime. They experienced sexual assault, physical assault, and robbery. Renee simply stated, “I have been attacked.” Gilda said, “the kids are on the streets trying to do whatever they can to make ends meet. Hemet used to be a retirement place, but now it’s like a crime scene you know you can’t walk down the streets.” She worried about her safety and her possessions. She believed an increased rate of poverty leads to more crime. Cindy said, “I was on the streets for one week, I did three years of couch surfing, but being on the street that’s brutal and the last time all my money was taken, my medication was taken.” Even though she had been on the street for a short time, in that period she was robbed. She lost her money and medication. She could not get her medication refilled and had to go without until her refill was due. She said robbery and assault happened often and gave an example: “that guy he got beat up last night at the bus stop in Desert Hot Springs.” Gilda also experienced a robbery and remarked, “we have people selling medication to other people. So you have to really watch your stuff. If you’re not with somebody you’re out there by yourself.”

Participants spoke about their fear of sexual assault. Gilda spoke about one of her acquaintances:

Men take advantage of that. I know this one lady, her name is Ana. And uh, she’s not all there and sometimes us, other females have to rescue her because she gets in situations where men just try to take her to their room and things like that and she doesn’t understand what is going on. That’s the extreme, but they play on your weaknesses, you know and that’s the major extreme, being female.

She believed unless people were careful it was easy to get into a situation where you could be the victim of sexual assault. Gilda was sexually assaulted and spoke about her experience:

You don't know if you will be sexually assaulted. In fact, I have an open case with Victim Witness. Yeah, when I was homeless out there in Thousand Palms I was sleeping behind McDonald's. My husband went to jail and then some guy, he mentioned someone's name and I trusted him, took me behind some bushes and he took advantage of me so he raped me.

When she was on her own, and her husband was in jail, she did not have support and found herself in a position where she was unsafe. Someone she trusted assaulted her.

A few of the participants addressed loyalty. Personal dynamics affected many people. The only stability the participants perceived was through their friendships. Renee said, "we try [to support each other]. But some of the women have issues with other women as well and loyalty is difficult to find on the street." She worried about some of the difficult personal dynamics and how they affected relationships. Gilda reported, "feeling alone and being taken advantage of." She went on to say, "you need to know who to trust and not to trust."

In addition to this lack of trust for others, the participants spoke about a loss of hope. Anna spoke about how she felt: "I lost all hope. I had people rob from me and I was like ok whatever, you know, I didn't have a reason to want to do anything." She felt as if things would never change and did not see anything to look forward to. Gilda said, "You get frustrated after a while. So people give up." When the participants did not

perceive a way to change their circumstances, they lost hope for change. Lisa 2 echoed their perceptions and said, “I feel I can’t do anything because I’m stuck in a rut, I’m homeless, I sit there and feel I can’t afford to get a house.” She did not feel any hope and felt nothing would change.

Overall, many participants felt other people did not care about them and that there were no resources for them to access. Anna felt there was more of a focus on men’s issues:

I have seen it though where there more like men’s homes and men’s programs or veteran’s homes for men because they think that’s where the needs at and it like you know guess what there are women who need it just as much if not more.

Anna believed the people who provided services perceived the level of needs differently than the women living on the streets did. She thought a level of need was not addressed because of the number of programs focused on males. She said many of the options available were co-ed and for some women, that was uncomfortable. Anna remarked,

You know there is a lot of women who because of being homeless have put themselves into precarious positions with men and then they start to feel shame so they go into a drop-in center and there are guys around and there not comfortable and they leave.

She did not want to say that all services should be separate, but rather, wanted to advocate for a variety of service delivery models. Mary and Cindy both believed people did not care about the plight of the homeless. Mary stated the message she received was, “we don’t care about you, you’re not worth [it].”

The participants spoke about issues they faced connected to addiction. The participants indicated they struggled with managing their substance abuse issues. Several participants were trying to maintain sobriety. Amanda said in her situation, “the drug addiction was a bigger part of it.” She was struggling with mental health issues, including mild agoraphobia, anxiety, and depression, but believed these issues were exacerbated by her substance use. She said, “when I was using heavily a couple years ago I was afraid they were going to test me and I would go to jail.” Many other participants reported similar issues with substance abuse intertwined with mental health issues. In addition, most participants struggled with issues regarding relapse. Anna said, “I relapsed because I had PTSD.” Amanda indicated she relapsed several times and continued to struggle with her sobriety.

The participants were divided on whether homelessness was a different experience depending on gender. Lisa stated, “I think we might handle certain situations different, but um, were all the same when it comes to that. Just how we handle it.” She believed men and women were similar; for her, the difference was how men and women react to different experiences. Lisa 2 indicated women were more vulnerable because of their gender. She said, “you gotta kinda just put your head down. And a man he can walk around and doesn’t need to worry about that as a woman does even if she is with a man or if she is alone.” She believed women attracted more attention and could be potential targets of crime. She said, “we have to be scared more than they do. And sit there and make sure we don’t cause any conflict or any attraction to us because something can happen to us.” She felt by drawing attention to herself she could become the victim of a

crime. In her perception, being homeless and a woman was dangerous. This danger was increased if a man did not accompany the woman.

Although the group did not share all the issues mentioned by individual participants, they were still significant. Anna spoke about her involvement with CPS:

I had already lost my daughter you know they totally thought, said “no, we’re not even going to help so too bad.” After I completed everything with CPS every single thing. They were ready to hand her to me when I told them I needed help with my utilities. They were like “no we’re not going to give her back to you now.” So my daughter was adopted out um, this was in 2012.

Because of her experiences, she lost custody of her children and lost her parental rights. Other women briefly spoke about CPS involvement and indicated they had similar experiences with their children or grandchildren.

Theme 4: Mental Health Experiences and Issues

The theme of mental health experiences and issues encompasses the mental health challenges the participants faced. Many had a history of anxiety, depression, or PTSD. Other psychiatric diagnoses included borderline personality disorder and bipolar depression. Participants also spoke about struggling with drug addiction. Some participants had suicidal ideation and were hospitalized after a suicide attempt. Some participants experienced difficulties in accessing care. Boundaries to care included fear, insurance issues, and lack of money. Participants had mixed emotions about using and taking medication; some believed the system was too reliant on giving patients medication. Some participants stated they could not access treatment unless they agreed

to take medication. Other participants felt they could not get the medications they needed and believed medical professionals would not listen to what they had to say about medication. Participants complained about a lack of available services and feeling as if they had no control when they could access services. Many participants had negative experiences with the mental health system. However, participants were also able to identify positive experiences with mental health care.

One of the primary concerns first mentioned by participants was a fear of diagnosis. They worried about what would happen if they received a label connected to mental health. Renee said, “not enough experience with mental health is probably my problem. The thought of them declaring me something that is incompetent you know, or actually that I am really sick.” She was aware that she had mental health issues but worried that someone would declare her incompetent or unable to manage herself in public. She feared that if people labeled her as “sick” she would be regarded differently. Anna spoke about the stigma attached to a mental health diagnosis:

There is either a stigma with them you know they're afraid “oh, mental health” and they get all freaked out and there're like I don't want to be diagnosed like da da da dah, and like for me once I started doing mental health recovery everything else was like second, you know it didn't matter, because that's where I got my help.

She understood many people feared receiving a diagnosis. However, for her, diagnosis was the first step to improve her life circumstances. Cindy also spoke about the stigma associated with a mental health diagnosis:

Well, I just basically try not to think about it just go on. It used to bother me every time I was taking a pill knowing why I was taking it. Like my husband, he was taking Lithium and stuff but, people have a hard time. I think it's the individual because if you can't accept it that you have a mental illness. You don't want to be that, because down through the years, you know, or your just out of place. People call you 5150 and say I could kill you and get away with it.

She came to terms with her diagnosis and decided not to be upset or think about the fact that she needed medication. She understood people had difficulty receiving the diagnosis because of the how others treated them.

The participants spoke about their different mental health diagnoses. These diagnoses included borderline personality disorder, ADHD, depression, anxiety, PTSD, and bipolar depression. The most common diagnoses mentioned were depression and anxiety. Some participants indicated they did not feel their diagnosis was accurate. Lisa 2 spoke about her experience:

I don't think that they don't diagnosis you correctly. I think they just do it fast by how you, cuz I've done it where you right down every symptom you had, anxiety and this and that they look at it and all you are is a piece of paper. You're not a person you're just a piece of paper. And there ok well you need this, and your anxiety then you need this. After all those yours I never heard of being bipolar my whole life and I had a lot of things happen to me and I have been to therapist and therapist to therapist and they never said anything like that.

She believed the system was ineffective because professionals did not take time to learn about their patients. Instead they relied on a self-report form, and made a diagnostic decision based on that information.

Many participants spoke of a long struggle with mental health issues that began before they became homeless. Lisa said, "I have anxiety since I was a little girl." Amanda also indicated her issues with depression began when she was a child. Mary said she struggled with depression for many years before she became homeless. Cindy stated,

Because I knew there was something wrong, but I didn't know what it was. I didn't even think it was mental, I thought it was physical, you know, but the depression I knew that was mental. Because I couldn't stop crying for days, I mean there are still days. I cried at one point in time every day I don't know how long or how I got in this position.

She struggled with symptoms for years and at times was unsure how to process what was happening to her. She was not sure if her symptoms related to her physical or mental health.

Some participants spoke about episodes when they dealt with suicidal ideation. Renee said, "depression had got to me. I took a knife and tried to cut my wrists and um, they took me. I spent 72 hours in hold and that was no fun." She did not offer detail about the experience. All she said was, "never did I think that I was going to commit suicide, but I got to that point I was trying it." Although she reported the attempt, in her mind it was not serious because she was not sure that she wished to die. Amanda spoke about her experiences and remarked, "I remember. . . I had tried to commit suicide and then that

was what opened his [the physician's] eyes to maybe this medication isn't working." She reported asking for help because of how she was feeling but was disregarded by her physician. It took a suicide attempt for her physician to listen to what she was sharing. She finished by commenting, "I wasn't doing it for attention. A friend of mine found me. I was trying to overdose on medication."

One of the issues participants connected with mental health issues was having bad days. Many of the participants struggled with depression and worried about the future.

Renee said,

It could be depression it could be just the fact that I'm hurting that bad. Today is not that bad, but when the rain comes it's really hard to get out of bed. There are days some are better than others. That's why I wrote today is a good day. And being homeless hasn't been all that bad, but I have a lot of our friends die. I'm not used to this.

Renee struggled from a combination of depression and chronic pain. The two conditions made it difficult for her to get out of bed. She did have good days and could be positive, but also indicated she was grieving for friends who had died. Anna also spoke about an inability to move and said, "I just didn't want to leave the house. I just didn't want to leave the house." She lost all motivation during her depression and retreated into herself. This inability to deal with the outside world was one of the factors contributing to her homelessness. Lisa had similar experiences because of her anxiety. She remembered, "there has been times I can't hold a job. My anxiety, I would rather not go into work because I can't deal with it. I would rather just stay in my room. Yeah, it has definitely

affected me.” She felt trapped by the anxiety she experienced and felt as if she could not face the world. Lisa 2 seemed to best summarize the experiences of the participants when she said, “I didn’t want to be here. I felt like I was just existing, cuz I had to be here, cuz God cuz I wasn’t dying. But, I didn’t want to be here.”

The participants struggled with the use of medication. Some participants believed medication helped; others did not want to be on medication and felt they were forced to make a choice between receiving treatment and taking medication. Some participants had difficulty accessing the correct medication. Minnie spoke about her experiences:

I don’t know it was a lady oriental doctor that gave it to me and I slept well on it and everything and you know for my bipolar part and stuff like that. And then see it was my old doctor that gave me my Ambien, Remeron and my Paxil. I take 40mg of Paxil and I take Ambien 5mg, 15mg Remeron at night and then at night I’m supposed to be taking 40mg of Paxil and in the morning I’m take, I’m supposed to be taking 2mg and 2mg at night of Target (?) yeah, and that’s about it, you know. But, the Latuda, you know, he had me on didn’t work. So I’m going to try to talk to my new doctor and try to get the Zyprexa too.

Minnie was on a variety of medication to manage her mental health issues. She was willing to take her medication because in her experience, those medications improved her quality of life. Cindy spoke about the other side of prescription medication:

There are some people that just don’t care. You know, even if they do see a psychiatrist and he gets them meds, oh, I don’t feel like taking meds today they

make me feel weird. Or I want to do drugs today and they interfere with the psych medicines.

She saw some people who needed medication were not willing to take their prescriptions because of side effects or interference with other activities.

Lisa 2 spoke about a negative experience with medication. She spoke about her husband:

My husband he has a disability too. They had him on so many medications that it made him go crazy where he was almost really freaked out. They had him up and down on so many medications. They don't take time to sit down and see if that's the medication you really need. They tell him, "oh, you're bipolar," here's this medication and here's this. And a month later they give him something new and up it more. And there not giving it enough time for anything to work and they're just switching it and its messing up your head more than they think.

Lisa 2 believed one of the issues with the medication was poor follow-up. She believed the physicians treating her husband were not careful and were not monitoring him appropriately. Lisa 2 felt the medication side effects her husband experienced were avoidable and his treatments should have been more carefully monitored.

Other participants reported challenges filling or keeping their medications. Many participants had been the victims of robbery: the thieves often stole the participants' medication from them. Cindy had difficulty getting refills for her prescriptions. She would have to wait for hours in her doctor's office. She would need to leave the doctor's office before her prescriptions were refilled so she did not miss the bus, which is the only

form of transportation to the shelter. Gilda spoke about difficulties she faced when her medication was stolen and said, “you can’t get some more. Well, used to be if you filed a police report then you could get some of it, but insurances don’t want to pay for that a lot of medications are expensive.”

Several of the participants spoke about their reluctance to take medication. Renee said,

The thought that I needed to be on medication did not thrill me. . . I’m not one for taking pills. That’s the barrier that I have. Anything that is going to change my mental thoughts, kinda freaks me out.

She did not like the idea that a pill could control or alter her behavior. She felt frightened by the idea and did not want to take medication. Anna also found the idea of taking medication challenging. She spoke about her experiences and said:

They’re just going to shove medication down my throat. Um, in fact I know someone right now who totally is like anti-mental health even though she has her own diagnoses, um and there pretty gnarly diagnoses, but she’s like no all they do is shove medication down my throat. It’s like that’s a choice. Yeah, so once you learn about recovery and start doing recovery versus just medication it makes a huge difference. Cuz you know there are times when I run out of medication but, I learn how to manage my symptoms.

She did not believe in taking medication in isolation. She thought that medication was a tool like any other. Anna reported medication should be taken in conjunction with other services so that medication was not the sole form of treatment. She spoke about her

friend's experiences and said how her friend felt forced to take medication with no other supportive services. As a result, her friend opposed taking any type of medication.

Lisa 2 also reported issues with the idea of taking medication. She was particularly worried about possible side effects and stated,

And you wanna give me all these pills. And it's scary cuz all these pills have long side effects. And some you may never get off of and some mess up your mind where it messes it up. I don't think it's right to just give pills right away. I don't think it's a fast track. I think you need to sit down and get to know the person and understand what they're really going through before you can help.

She also believed in having support from and a relationship with the physician who prescribed her medication. Lisa 2 did not understand how a physician with little to no relationship with the patient could prescribe psychotropic medications. She continued to state,

Especially when they put you on a new medication that you know nothing of. And you try and do your research, but you're not as smart as they are and sit there and when you tell them this medication is doing this to me I can't take it and they tell you well, don't stop it. Cuz if you stop it, it will mess you up in the head because you have been taking it for this long. And then it's like well, what am I supposed to do if you won't see me?

She felt as if her concerns were not heard by her treating physician. She worried about side effects and felt she did not understand her medication regime. She spoke about the side effects in more detail:

They had me and my husband on some pills we were so zoned, like we were stoned, high on drugs, and it's like we weren't even in the world. We were just there. We weren't able to shop, cook, nothing we were like zombies and that's mainly all the medication does for you.

She did not believe the medication was helping her mental health issues. She found the side effects prevented her from completing any activities of daily life, such as cooking or shopping.

Many participants reported negative experiences when seeking mental health services. Minnie was particularly irate. She wanted to receive mental health support but did not want to take medication. She said she could not receive counseling services without agreeing to take medication. She believed she should be allowed to determine the mental health services she wished to receive. By denying her counseling she felt as if the treating physician was attempting to coerce her into follow a course she did not believe in.

Lisa had difficulty committing to a course of treatment. Like others in the study, she indicated she faced a myriad of difficulties including cost and transportation. Lisa explained the underlying reason she could not complete any program: "I have never completely finished any program or class or anything. Cuz I don't feel like I'm getting anywhere in it. . . I just never finish anything, nothing." She did not feel the programs were helpful, and because of this, she lacked the motivation to finish.

Some participants reported negative experiences with staff while they were members of a mental health program. Amanda spoke about her experience and said:

I got transferred to something called Anka. I don't really like that program. That's the one in San Jacinto. There was problems with the doctor, I was taking my medication it wasn't working. I was feeling more depressed on it. I was feeling more anxious on it. The doctor wouldn't listen to what I was telling him. I was telling him I have been on this for two months it's not working. Is there any way we can change my medication and he just refused. If I remember right his words were, "you're the patient, I'm the doctor."

She attempted to comply with her medication regime but found it difficult. When she shared her concerns with her physician, the doctor disregarded her comments. This lack of empathy made her feel the program was ineffective.

The participants mentioned other issues related to accessing mental health care. Some participants mentioned feeling a lack of control related to mental health services. Lisa 2 explained her experiences:

The doctor's there, they were mainly not there to talk to you. . . They would come and say get in my office and we would sit down. They would say you're on this and this pill and this how are you feeling? How is this pill making you feel and I would tell him. And then he would go well maybe I need to adjust it and he would put it on the computer and they wouldn't even ask me . . . He would say come back in a month and we will see how you're doing. . . . And then when you try to call in and say this hey this medication is too much for me I can't. They would say you have to wait till your appointment time.

Although she was receiving care, she did not feel as if her opinion mattered. To her, it felt as if every decision was made for her. She did not feel a relationship or care existed between her and her doctor. When she had issues, she was told to wait until they could see her. Other participants had issues with insurance or money. Lisa said, “insurance companies not wanting to cover any mental health, any doctor psychologist, psychiatrist they don’t cover it and it gets pretty pricey . . . what homeless person has \$100 or \$75 to make an appointment?” Although she needed care, she was not always able to access it because of her insurance or lack of money. Many of the participants mentioned struggling with insurance issues including getting insurance, maintaining coverage, and having coverage that did not cover necessary services.

Some participants spoke about their positive experiences with the mental health systems. These experiences helped them make changes and deal with many of the issues they faced. Mary said,

It’s been positive, my experience has been positive. I did find people I could trust and could have a conversation with on almost any topic some are personal understandable, and fortunately they didn’t just sluff you off like “oh I have something better to do” and they do answer questions and assist you with finding resources, etc. And occasionally they will quote fix things, unquote. But, they let they leave it open for you to arrive at a conclusion/solution for yourself and that’s positive.

She was pleased with the support she received. One of the strengths of the program that she pointed out was that they let her find her own solutions. Gilda also had positive remarks to make about some of the mental health programs she experienced. She said,

What I liked about it is, there were some good things. I have been in and out of drug programs and in and out of mental health and until you get to the root of the problem of why you are having the depression or the drugs you want to numb yourself. Until you deal with why you started using in the first place you will never get better cuz its always going to be there. So I learned about different techniques and about dysfunctional families because basically that is where I come from.

Through her work in the program, she could learn about and better understand herself and her past experiences. She felt what she learned about herself enabled her to deal with her mental health and substance abuse issues. Lisa 2 also spoke about positive experiences with programs:

I had, you know some [people] went out of their way. Like Jefferson Wellness this one girl she helped me out a lot with my court and stuff and she helped me get into stuff like an apartment and everything. The place I just mentioned Victor they were really great there. They helped me out a lot got me housing, everyone there tried to help me get clean.

She appreciated the help and support she received from the people who helped her succeed. Lisa 2 aged out of the program before she was completely stable, and as a result, became homeless again.

Finally, the participants believed a gender difference related to mental health experiences existed. Overall, the participants believed women felt stigma they internalized, especially when compared to men. Mary said, “to have a mental illness and be female is extraordinary difficult because it’s a different, I guess you can say. . . they are held to [a different standard than a] man.” She believed there were different expectations for women than for men. Mary thought people looked down on women to a higher degree than men in the same situation. Minnie believed for men a mental health diagnosis was not as important, “because men don’t think it’s nothing. Because all the men that I know that are mentally ill they’re ok, it’s like not a problem.” She felt men took a mental health diagnosis more lightly and it had less of an effect on their self-image. Cindy indicated some men bragged about a mental health diagnosis and shared the information freely; women “want to keep it private and not share it.” The differences noted by the women in the study seemed to focus more on how they reacted to a diagnosis versus how men reacted to receiving a diagnosis.

Theme 5: Services and Supports

Another theme that emerged was services and supports. Within this theme, participants spoke about their experiences accessing a variety of services and supports in place to aid homeless people. The participants reported using career services, counseling, and programmatic support. They indicated issues with a lack of identification and shelter.

Participants in this study had a lot to say about the different services and supports available to them. One of the main services they talked about was counseling. The participants believed counseling was important. Mary spoke about the importance of

counseling for homeless women and stated, “they need to have communication; they need to go with some professional person. They need to be able to feel comfortable in expressing what had happened to them and how they feel.” Like others in the study, she emphasized the importance of feeling heard by others. Renee wanted to access counseling services and said, “I would like to be able to go to counseling. To see if it’s something in my head that they can change my way of thinking.” She felt as if she needed some support but was not sure where to access it. Anna spoke about how she did not realize that counseling services were available for a long time. She stated, “in Perris, there’s a huge clinic, a great clinic, I love that clinic, it had been there for a few years and I would ride my bike right by it and never even knew it what it was.” For many participants, a lack of knowledge about services, as exemplified by this statement, was one of the most significant barriers to changing their circumstances or getting aid.

Another issue participants struggled with was access to a form of identification. Renee said, “I don’t have a card, because I don’t have an address for the card to get sent to.” She had a copy of her ID but had no way to get to the DMV to get a new copy. She went on to say every piece of documentation relied on another. She remarked, “See this is where my problem lies and we’re going back to the beginning. I can’t do this without that and this without that.” Participants indicated many people lacked knowledge about available resources. Renee stated, “what do they offer? I don’t exactly know exactly what they offer. Everyone here, you know says they have been and they offer certain things, but no one has ever seen it.” Mary indicated she wanted “job or career counseling” and was unaware these services were available.

Subtheme 5A: The shelter experience. Participants described their different experiences with accessing shelter. They indicated often needing time to adjust to being in a shelter. Some experiences mentioned included learning to communicate, negative interpersonal experiences, issues with limited time in shelter and limited help available, and reintroduction to structure and life skills. Participants spoke about both having stability and a lack of stability in the shelter system. Some participants were frustrated with the long waiting lists and feeling unwelcomed. Another challenge mentioned included adjusting to shelter rules.

The participants all had a variety of experiences in the shelter system. Cindy reported the entire shelter system was stressful. She had difficulty with all the rules and stated,

In the shelters, it's the same way there are so many rules. Heaven forbid you use the use the wrong bathroom or you know, still have your locker is open at 9:00pm. You get written up for things like that and three write ups you're out. In some ways, she believed she was being set-up to fail. She thought many of the rules were pointless and worried about small infractions that could cause her to lose her placement. Julie also had difficulty with the rules. She compared the homeless services in California to her home in Guam where, in her perception, there were few rules and people received help easily. She gave an example and said, "nobody is treated that way. [People did not say] you have to be homeless like one year, oh, you have to be like this, no that's against the law." She believed that the rules and regulations interfered with people receiving the aid and support they needed easily and in a timely manner.

Participants had many issues with the structure of the shelter system. Cindy spoke about the atmosphere and said:

The food there, they don't even have a kitchen so its microwave oatmeal out of a sparkles water bottle on high, for lunch its peanut butter and jelly sandwiches. . .

they said they don't want people to get too comfortable and want to stay there.

Who would want to stay there is beyond me.

She found that the setting felt cold and unwelcoming. Even the food options were minimal and, to her, increased her feelings of not being wanted. Other participants complained about long waiting lists. Renee spoke to this, "The only shelter that we have her in town, the waiting list if forever long." Although the service was available, she did not perceive it as helpful because of the long wait time for access. She went on to state that the length of stay was limited, and when the stay was complete, if the individual did not have alternate housing, he or she would be back out on the street. Cindy agreed with this viewpoint and stated,

So there are some churches around that will help you with food or clothing, but that's it. They kick us out. If you don't feel good you can't stay in there and rest.

Um, my doctor wrote a note that I must keep my feet elevated and I asked for an extra blanket or extra pillow and oh, no we can't do that.

She felt that although she had some access to shelter, it was not the type of access that helped her in the long or short term. She felt treated badly and did not like the many different personality issues she observed.

Some of the participants liked the fact that they could learn to reach out and provide support to others. Mary said, “I became involved in the peer support system and I eventually became interested in becoming a peer support specialist.” She appreciated that she could give back. Being able to help others enabled her to give instead of taking, which was important to her. Anna felt similarly and said, “I came out here I did the peer employment training and so I worked a lot with you know people not only being a client at CVRM, but then I became, I worked in the shelter itself.” The participants spoke about learning to interact with many different people. Mary said,

this was my first time in a homeless shelter . . . The experience with the other residents was definitely transforming because I have never encountered such various personalities . . . it gave me perspective on how different people were, their situations, how they handled it.

She found it to be positive. Cindy, however, had an opposite reaction and said,

It’s difficult and every day when you’re in a room with, on one side, 40 women and 40 men on the other side there’s going to be personalities that clash. And it’s always drama. I need to stay away from the drama but, you can’t. It’s all right there.

For her, it was difficult to manage the many differing personalities and perspectives. She felt as if she had no privacy and could not escape from the “drama.”

Subtheme 5B. Services that are needed. In this subtheme, the participants spoke about the different services they saw as important to help women who are homeless. They spoke at length about services they felt were needed.

A primary concern was access to affordable housing. Many participants remained homeless because they could not find affordable housing and lacked adequate shelter space. Anna said, “The lack of affordable housing anywhere makes it really hard.” Julie agreed and spoke about the need for “cheaper housing.” Most of the participants commented on the necessity of increasing affordable housing options. For many people, the costs associated with getting into housing were prohibitive.

The participants believed more shelter space was necessary. Cindy wanted to see an increase in shelter beds. She spoke about a friend who could not get into the shelter and said, “you’re on the street and its rough out there. She [her friend] just got beat up last night at a bus stop.” She found that living on the streets was unsafe and bemoaned the limited number of safe shelter beds available. Cindy continued, “[we need] more shelters, but the problem is the city doesn’t want us.” Even though she perceived the need for shelters as significant, Cindy felt the city did not wish to deal with the homeless issue and would not support an increase in the number of shelters. Gilda wanted to see an increase in long term residential shelter and said, “if they provided some type of residential [shelter] so people could get back on their feet, you know, where you either do the program or your out. Cuz you have to want it, but everyone needs a lift up.”

Mary spoke about her experience in the shelter setting and felt it provided her some needed structure. She mentioned her experience and said, “I became involved with domestic chores, which was great because I enjoyed doing that.” She believed these simple tasks helped reacquaint herself with routines associated with daily life and prepared her to someday find stable housing again. Anna agreed, “Just something that’s

more, you know that teaches women life skills.” She went on to speak about herself and remarked, “I don’t know how to live in an apartment, I don’t know how to communicate with people because I have been homeless for so long and I just do whatever I want.”

The participants indicated they wanted better career counseling, employment support, and training. Renee added,

Job fairs [could help]. It’s not that they [homeless women] don’t want to work, it’s that for some reason it seems like an effort to [find a job] . . . If they had a job they would be going to their jobs, but the effort to get to that point seems to be blocking them.

She thought by bringing employment opportunities to the homeless women, a barrier that stood in the way of employment would be removed. Lisa indicated she would like to have a job and any training opportunities and remarked, “anything that would help me right now . . . would be great.” Another need identified by the participants was access to phones and other electronic devices to help with the job and housing search. Mary simply stated, “some people don’t have phones.” A lack of access to a telephone or the Internet made it challenging for participants to conduct any business because many services are online.

One area of importance noted by almost all participants was easy access to affordable transportation. Many of the participants indicated they did not have personal transportation, and to access services or go to medical appointments or job interviews, they had to figure out a means of transportation. Renee listed all the places she needed to access and said, “government offices, DMV, Social Security.” She did not see how to get

everywhere she needed to go and said, “how am I going to get there, transportation, you know that’s huge. And like where [the shelter] is at there’s no buses.” She was trapped by geography and unable to easily travel to where she needed to be. Cindy agreed and said, “what would be a big help if some city bus would come up here, but they won’t.”

Amanda agreed and stated,

There are a lot of places in town that are far that help with food and clothing and stuff so [having] transportation to those places [would be helpful]. I know there is one church called the Assembly of God they have gathering for the homeless people and they will make meals sometimes like once a month and its really far for a lot of us . . . it’s easily a good 15–20 minute drive. And a lot of us don’t have bikes.

It was frustrating for the participants to be aware of some resources but be unable to reach them because of a lack of transportation.

The participants felt communication was a significant issue. They believed information about possible services, programs, and support was not well distributed. Lisa believed “way more outreach” was needed. She said,

have people come out where the homeless mainly hang out, the parks you known on the weekends. Or you know, at least if you see somebody or you know, drive around, you know as they take people to the doctors, I know they sometimes they take people to the doctor’s, you know pull over give them a paper or flyer pull over and say ‘hey we’re here.’ Pull over and say if you need help and this and that. If they see someone who really needs it try to give them help. You can tell

certain people who need help really, really need it really bad and people that could wait a week or two to get into an appointment. And to just drive by and do nothing, I think is wrong.

This type of direct outreach was important. The participants felt most homeless people believed no one cared about them. They felt people who wished to offer aid need to be more assertive in communicating and explaining services. Anna believed people who offered services needed to go to where the homeless were. She suggested,

One thing that is common with homeless people, I have noticed this in all the areas I have ever been homeless. Parks attract homeless people, period. Food attracts homeless people if you put, have a lot of those booths you know, like a fair of some kind for information and you are giving out candy and goodies and bags and stuff, homeless people are going to come to it. Even if is the free food attraction, they're coming.

The participants wanted more effective outreach and a better match of program to need. Mary said, anyone who was helping place people needed to “be careful of the facilities you put them in make sure it matches their needs.” Participants reported many of the guidelines for program access were overly stringent, leaving them in a position where they could not access services they needed. Julie provided an example of this and spoke about a housing program that she was aware of in her area. She stated, “They say oh, you have to be homeless one year.” She felt positive outcomes could happen in a year, and did not comprehend why women have to experience homelessness for such a long period of time.

Other areas of need included a place to store personal items, as well as usable bathroom and laundry facilities. Being able to wash and clean their clothing was essential to the participants. They often had little money and could not afford to go to a laundromat. Anna stated, “Even if they choose to be homeless, being able to doing laundry [was important].” Amanda agreed with her and said, “laundry would be good. I think last week I wore the same outfit for like five days.” The participants wanted to be able to have clean clothes. They also wanted easy access to bathrooms. Renee stated, “having bathroom and shower facilities are probably the hardest thing to find.” Cindy agreed, “you have to have a shower someplace where you can shower and go to the bathroom and you know when you’re in a tent.” The women wanted to be able to bathe and be clean. Just because they were homeless did not mean that they did not have the desire to be as clean as possible.

Participants also felt if they had monetary support they would be able to get on their feet more quickly. Some participants ended up being homeless because when they needed some aid in paying a bill, that aid was not available. Anna said, “it’s just not available. General relief in [this] county is not an option.” Renee agreed and said that women “would need money” to be able to move forward. In addition to money, the participants spoke about having a place to store their belongings. Renee said, “we have talked about that too as homeless people we always wished someone, like a Mailbox Etc would open up some type of little lock box where we could stick stuff.” They wanted a safe place to keep the little they owned. Gilda agreed, “yes, it’s so important. You have to be able to put your medicine somewhere where you know no one is going to take it.”

Participants also spoke about wanting both individual and group counselling services. Cindy said she wanted “more counseling.” Gilda spoke about having “counseling and support groups.” Amanda agreed and said,

I think that like free counseling would be good too because a lot of people out here we don't have insurance and there's a lot that were going through like mentally and emotionally and it would be nice to have someone to talk to that's not judging us.

She felt more women would access counseling services if they were offered free of charge. An important point she made was that having empathy for the women was a key component to effective counseling. Some participants indicated churches needed to be more involved. Other possible areas of support included legal advice, safe spaces for women to rest, peer support, and free medical services.

Subtheme 5C. Professionals should know. . . Some of the participants spoke directly to their relationships with professionals in the field. They felt it was important to share their observations to improve services. Participants believed professionals should strive to create personal relationships and make real connections. They indicated professionals needed to display a lack of judgement and be genuine. Anna remarked professionals needed to have a specific attitude. She described it saying,

it's like were not here to judge you, were here to criticize you, it's like we're here to support you ok, you're having challenges with drug use or what not, we get it, we've been there it takes a while it doesn't happen overnight.

Mary stated professionals should,

Have a good conversation, put yourself in their place and that's not difficult and gently use recovery language not the precise terms in the book, parallel it, allow them to feel comfortable and not stigmatized or prejudged. They will like it. The homeless person subject to this will like it and start to trust and they will recognize they fact that somebody didn't say 'oh, you have the stigma' how do you want to handle that. Ugh, they don't want to hear that they just want the stigma to go away permanently.

Professionals needed to be aware of how they treated the homeless and not make them feel humiliated. Mary described this by stating, "gently, but firmly invite them in, the individual . . . do not present a judgmental opinion." They indicated others being helpful and trying to understanding their situation was important. The participants wanted to be treated as equals and work with people who genuinely cared about their success and survival.

Cindy shared some personal information. She spoke about a personal incident where she felt humiliated:

One night I had an accident. I stood up and I'm peeing. I had my pajama bottoms on and so you couldn't tell and I went and asked if they had a pair of underwear. And he grabs the chart and he goes I see right here your Debbie and you have an income. And I go first of all I'm not Debbie and I don't have an income. Well did you pee the bed? I said "no". Are you sure you didn't pee the bed? And I'm like "no". He's standing, did you get it all over the floor? I'm like "no" do you have

any underwear? And he gets these boy boxers ones out and throws them to me.

There like a seven bikini size, you know, I don't wear a seven, I'm a big girl.

She was disturbed by his attitude and felt disrespected and badly treated. He did not know who she was and seemed to be aggressive. Cindy wanted help and felt he treated her badly. She went on to speak further:

And then later on he called me back over there and questions me again are you sure you didn't pee the bed? And I go I'm sure. So I started walking to my bed and he comes up to me at my bed and yells so everybody can hear . . . he comes over to my bed which is in the front of the room and yells at me "as a Roy's employee I'm obligated to offer you a diaper" and I wanted to die.

The experience of losing control of her bladder was embarrassing and he made it worse by his breach of confidentiality and attitude. Cindy felt humiliated and stated,

I lost it and I couldn't stop crying he had to get me out of the room because I was gonna wake everybody up, my blood pressure went up to 186 and they called an ambulance and sent me to the hospital.

As she reflected on the experience and her emotions she said she felt, "Like your looked down upon. Like you're a burden." She was emotional as she continued to speak and concluded by remarking, "they don't realize that if it wasn't for us they wouldn't have a job. And for somebody to do that I wanted to die, I was so embarrassed."

For these participants, being treated with dignity and respect was highly important. They wanted to be acknowledged as fellow human beings who deserved to be treated like everyone else. Their situation was already challenging, and they were

sensitive to their position. All they reported wanting was to work with people who were empathetic and caring.

Summary

The goal of conducting this study was to focus on the lived experience of chronically homeless women and their perceptions of barriers to mental health treatment. Utilizing a phenomenological design, I interviewed 10 women and transcribed and analyzed the results of their interviews. The analysis resulted in five themes and three associated subthemes. The themes were (a) reasons for homelessness, (b) women stay homeless because. . . , (c) mental health experiences and issues, (d) experiences with being homeless, and (e) services and supports. The subthemes, found under the theme of services and supports, were (a) the shelter experience, (b) services that are needed, and (c) professionals should know.

This chapter contained a description of the sample demographics, participant recruitment, data collection, issues of trustworthiness, data analysis and a narrative report about the findings. Chapter 5 will contain a discussion of the results. Also, I will cover implications for practice, areas for further research, and any limitations of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Chronic homelessness is a complex social problem in the United States (Tsai & Rosenheck, 2015). A large body of literature exists on the topic, but much centers on the experiences of homeless men (Deck & Platt, 2015; Längle et al., 2005; Parker et al., 2015; Salem et al., 2015; Watton & Gallivan, 2013). Among the homeless, women are more likely than homeless men to suffer with mental illnesses (Lee et al., 2010). However, because most homelessness research has pertained to men, relatively little information exists regarding the homelessness experiences of women with mental illnesses (Fries et al., 2014). During this investigation, I employed Young's (1994) critical social theory of gender to explore homeless women's experiences with the mental health system and barriers to treatment. A significant percentage of homeless women struggle with mental illness (Barrow et al., 2004), and barriers for treatment may include stigmas related to mental illness, fears of rejection (Abe-Kim et al., 2007), poor means of communication, and unmet basic needs (Krausz et al., 2013).

I used a phenomenological design to gather insight into participants' experiences with chronic homelessness and perceived barriers to mental health treatment. Understanding the barriers to mental health treatment among chronically homeless women with mental illnesses may be an important first step in developing interventions to help this population cope with mental illness and reduce their rates of homelessness. Data I gathered from interviews with 10 chronically homeless women with mental illnesses revealed five main themes and three subthemes related to experiences with

homelessness, mental disorders, and mental health treatment. The five main themes included (a) reasons for homelessness, (b) reasons women stay homeless, (c) mental health experiences and issues, (d) experiences with being homeless, and (e) services and supports. Three subthemes were associated with the theme of services and supports: (a) the shelter experience, (b) services that are needed, and (c) professionals should know.

This chapter includes a discussion of study results. It begins with a summary of the results followed by an interpretation of the findings. I discuss study limitations and recommendations for future research. The chapter also includes practical, theoretical, and social change implications. The chapter ends with my concluding remarks.

Summary of the Findings

The participants in the study identified many causal factors for homelessness. For example, some participants identified the loss of employment and the subsequent inability to find new jobs as hurdles to housing that they could not overcome. Additionally, they spoke of the negative effects of domestic violence and abusive relationships regarding their housing situations. Others admitted to having limited social support systems to help them cope during challenging times, which was sometimes the result of deaths in the family from which participants were unable to recover. Some families were also separated because of abuse and other forms of discord, which resulted in children being placed in protective custody and resultant feelings of loss these women. Seven of the women identified such major life events as catalysts for their homelessness.

Substance abuse was also an identified struggle among participants, many of whom described substance use as a strategy for coping with homelessness and mental

illness. Eviction was a commonly identified theme, and participants struggled to find new homes after experiencing eviction. Five participants received some form of financial assistance from the government, such as social security or social security disability payments; however, they still struggled to maintain stable housing because the economic support was not adequate. Related concerns noted by participants included the lack of affordable housing in safe areas and difficulties securing housing because of (a) past evictions, (b) poor credit, (c) lack of funds for a security deposit, and (d) lack of down payment or other move-in fees. Three participants received government assistance through Cal Fresh, which is California's food stamps program. Two participants had no income of any kind to assist them during the difficult period of homelessness. The concerns they noted related to securing benefits included lack of identifying information to complete the government forms, lack of a physical address to send the paperwork, and a lack of information regarding services offered through the county.

Many participants felt living in shelters was more dangerous than living on the streets. Others identified a systemic problem in which most of the local shelters had no available spots when they needed a place to stay. At the time of this writing, one of the area's large local shelters was in the process of closing because of inadequate funding. This shelter housed upwards of 60 individuals per night; its closure will further limit the emergency shelter options available to homeless women in the area. Participants who stayed in emergency shelters often felt victimized or targeted and believed that sleeping on the streets was a safer option. The rules and regulations within a shelter were also

problematic, as the symptoms of mental illness often made it difficult for participants to comply with such rules.

Other women believed their chronic homelessness was because of stigmas related to mental disorders and homelessness. Adapting to homelessness was difficult, and many women felt they lacked the ability, motivation, or effort to change their situations. The emphasis on survival left little mental energy for participants to focus on ways to change their situations; they were caught in states of reactivity that barred productive, proactive behaviors.

Feelings of shame and failure were also common among participants, causing them to believe they did not deserve time and attention from other people who could help them change their situations. Others feared that even if they could escape homelessness, they would be unable to maintain their housing, giving them little impetus to create lasting change. Simple tasks often seemed insurmountable for the women. For example, if they could get a job interview, it was still too difficult to find professional attire, a place to get ready, somewhere to print a resume, and travel to the interview location. Meeting basic needs was a daily challenge for participants.

Substance abuse was a topic often discussed. Participants explained that taking prescribed medications for mental disorders was a challenge while living on the street. If the medication made them feel sedated, as many psychotropic medications do, the women felt more vulnerable to the dangers of living in shelters on the streets. Participants also explained sexual assault was common on the streets and they were not willing to risk this to take the psychotropic medications prescribed to them. Many reported a willingness

to comply with prescription drug schedules if they could have their medications adjusted or switch to other medications that made them less drowsy.

Participants also expressed concerns with law enforcement because of fears of arrest or ticketing, even after victimization. Similarly, the women were hesitant to seek various forms of professional help. Among individuals who did want help, securing appointments and transportation to travel to those appointments was a challenge. Many individuals did not follow set schedules and lost track of time, causing them to miss appointments. Some participants had government cell phones, but such phones were often lost, stolen, or did not work reliably, causing them to miss appointment reminders. Others felt judged by professional staff and never returned for future appointments because of those feelings. Still, other participants wanted to go to follow-up appointments, but were unable to because of lack of transportation.

When discussing mental health involvement, participants admitted to feeling dismissed or undervalued by mental health professionals. Participants who did not want to take medications often failed to follow prescribed medication protocols, which disqualified them from accessing other mental health services. Further, some of the participants felt they were improperly treated and monitored while on prescription medications. When participants raised concerns about these issues, they reported their mental health professionals often dismissed or ignored them. Participants also experienced challenges securing their medications and other personal belongings from theft. If their medications were lost or stolen, insurance providers would rarely cover a premature refill, which made it difficult to follow prescribed medication schedules. Many

women expressed a desire for traditional talk therapy, but were usually only offered medication, which they found disappointing. The lack of mental health treatment options provided to them made some of the participants feel like they had no control of the services offered to them.

Interpretation of Findings

Participants identified five main barriers to mental health treatment. I discuss each of these barriers in the following sections. In addition, I compare and contrast these themes to those described by previous investigators.

Reasons for Homelessness

The United States has the highest percentage of homeless individuals of all industrialized nations (Finfgeld-Connett, 2010). Researchers have shown that many factors may contribute to the rise of homelessness, including a shortage of affordable housing and poverty (Lenmann et al., 2007). All 10 participants discussed a lack of housing or shelter. Even participants who had social security or disability income could not qualify for housing because they did not meet the income requirements. Others had been evicted on previous occasions, impairing their abilities to secure safe housing. Long wait lists for the low-income housing was also noted, as well as difficulty saving up enough money for the security deposits, credit checks, and other move-in costs. One participant stated that most places required use of the Internet to apply for the home, but she lacked Internet access or transportation to the local library and was unable to complete this process. In addition to the lack of affordable housing options, participants noted problems getting into local shelters because of a lack of qualifying documents,

criminal backgrounds, limited beds, and short programs that provided limited access to resources.

Among women, predictors of homelessness include mental illness, domestic violence, and substance abuse (Fingeld-Connett, 2010). These findings were echoed in my study, as six participants reported a history of child or adult domestic violence. Of these six, four also experienced drug or alcohol problems. Previous scholars have reported that substance abuse is a significant problem among homeless individuals (Patterson et al., 2015). Patterson et al. (2015) noted issues with substance abuse often go together with mental illness among homeless men and women because of self-medication and distrust toward the health care system. The women in my study confirmed these findings, as they described distrust and frustration with the mental health services and professionals available to them. Chambers et al. (2014) explained that mental health and homelessness have a multidirectional relationship because problems associated with mental health can act as predictors, as well as consequences, of homelessness (Chambers et al., 2014). Lippert and Lee (2015) reported common mental illnesses among homeless individuals include depression, schizophrenia, and suicide ideation. Similarly, the mental health disorders reported by participants included posttraumatic stress disorder, depression, bipolar, ADHD, anxiety, schizophrenia, and schizoaffective disorders.

Previous scholars have discussed the unique barriers faced by homeless women (Ponce et al., 2014). Homeless women are at an increased risk for mental illness, risky sexual behaviors, physical health problems, physical violence, and sexual assault (Ponce et al., 2014). Five participants detailed fears of living on the streets and of being

physically assaulted. One participant described being sexually assaulted while her husband was incarcerated, causing her to fear returning to the streets at night. Similarly, previous researchers have reported most homeless individuals experience victimization in the form of theft, physical violence, and sexual assault (Huey, 2012; Jasinki et al., 2010).

Women may also reject mental health services because they do not want to be labeled as “crazy” (Luhmann, 2008). As Finfgeld-Connett (2010) reported, the norms and mores of the social service system can prevent homeless women from accessing intervention and support services. Participants discussed fears of mental health diagnosis and distrust toward the psychiatric medications they were prescribed. Similarly, Patterson et al. (2015) reported homeless individuals often express distrust toward the health care system, including hospitals, psychiatric care, and psychotropic medications. One participant explained she felt sedated by her medications, which was a safety concern at night. She feared if she was too sedated, she would be robbed or victimized. It appeared necessary for the women to constantly think about their security to remain safe while being homeless.

The participants noted many barriers to care. Nine of the participants were unaware of places they could go to obtain treatment and what services were available to them. This finding echoed those reported by Hamilton et al. (2012), who reported three main barriers to services among homeless women: (a) lack of information about available services, (b) limited access to such services, and (c) poor coordination across different services. Because they did not know where to seek out information on available services, participants in the study relied on information from other homeless individuals.

Women Stay Homeless Because . . .

All participants discussed their feelings regarding homelessness. Of the many feelings mentioned, the most common was hopelessness. The participants felt there was no way out of their situations, or that if they did find a way to acquire housing, they may lose it all again. Others reported feeling helpless, embarrassed, disrespected, tired of the system, frustrated, ashamed, stigmatized, ridiculed, judged, and lonely. These different feelings combined to create a general sense of hopelessness among participants. Previous researchers highlighted how feelings of being judged (Speirs et al., 2013) and stigmatized (Bonugli et al., 2013; Finfgeld-Connett, 2010) may foster homelessness and feelings of hopelessness. This lack of hope created disadvantage for the participants, especially when combined with a lack of information to access services and supports needed to end their homelessness.

Mental Health Experiences and Issues

Participants discussed their mental health experiences in detail. A problem noted by two of participants was the lack of insurance to pay for care. Similarly, Chondraki et al. (2014) reported the most significant barrier to accessing care for mental disorders was the lack of medical insurance or personal finances to pay for services. One participant in the current investigation had insurance, but was unable to verify it at the doctor's office because she had no address to have her insurance card mailed to. Thus, even *with* insurance, it can be difficult for women to prove they have insurance.

Six participants were fearful of a mental health diagnosis and the effects of prescribed medications. Similarly, Patterson et al. (2015) reported homeless individuals

often avoid psychiatric medication and choose to self-treat with street drugs instead. Participants felt out of control while on the medication, which increased their risk for assault on the street. One participant expressed frustrated because she was unable to participate in the mental health program without taking the medications prescribed by her psychiatrist. She sought other ways to cope with her mental health challenges, but failure to comply with her medication schedule disqualified her from mental health services. One participant circumvented this challenge, leaving the mental health community and working with her primary care doctor, instead. She felt the mental health professionals did not listen to her concerns or discuss treatment options with her. However, she felt her primary care doctor was a better listener and willing to compromise to find a treatment plan she was comfortable with. This participant admitted to needing a counselor, but strongly disagreed with the way services were rendered in the mental health community.

Among participants who utilized mental health services available to them, three individuals discussed long wait times to see psychiatrists or clinicians, and were unable to see providers in the event of emergency. One participant reported her doctor rushed their meeting and she did not believe he listened to her concerns. As a result, she ended treatment. All the participants discussed a desire for their care providers to listen to them, indicating a need for genuine concern from another human to provide support to make it through the day.

Experiences With Being Homeless

Homeless men and women are often plagued by victimization and violence. As noted, five participants had homeless experiences that made them feel susceptible to

violence or involved them in violent acts. Being a woman on the streets at night makes the women a target, which is why many remain in relationships that may have ended if not for being homeless. These findings aligned with those from previous researchers, who reported high rates of violence and victimization among homeless individuals (Huey, 2012; Jasinki et al., 2010; Murray, 2011).

Services and Supports

Positive and collaborative connections with mental health providers was paramount to help-seeking among participants in the current study. Feeling understood and valued was a critical first step to treatment. One participant believed she was incorrectly diagnosed but was unable to discuss this with her provider because of the limited time during her sessions. She explained mental health professionals were in charge and she had to follow their instructions, even if her treatment plan only seemed to have a limited effect on her recovery. These results are in line with the prior research. For example, Patterson et al. (2015) reported homeless individuals often express distrust toward the health care system, including hospitals, psychiatric care, and psychotropic medications. Krausz et al. (2013) found only 14.9% of homeless individuals with mental illnesses reported seeing a psychiatrist in the previous year. Ponce et al. (2014) reported homeless women with mental disorders demonstrated a need for clinical services, but life circumstances and poor relationships often created barriers to such services.

Limitations of the Study

Limitations were present in this study. First, the sample size was limited by the study inclusion criteria. Because of the limited sample size, the results may not transfer to

similar populations in other geographic locations. Because data collection took place during a specific window of time, it is possible that participants' reported barriers to mental health services may vary based on the period of data collection. I conducted interviews at various dates and times throughout the study site county, which may have precluded participation by individuals with other perspectives not revealed in this study. Also, only participants who were chronically homeless were eligible to participate. It is possible that women with mental illnesses who experience episodic homelessness would report different barriers to mental health services.

Although I posted flyers, many of which were taken, I did not have a single woman contact me for a telephone meeting. Study participants noted seeing the flyers, but their reasons for not calling are unknown. I approached many individuals throughout the course of this research and found some did not want to be audiotaped or have their interviews transcribed; thus, they were excluded from the study. Some of the women I approached were unable to form lucid thoughts and appeared to be responding to internal stimuli; these women were excused from the study, but given resources and a gift card. Other individuals avoided contact with me by walking in the opposite direction when I tried to approach them, so they too were excluded from the study.

Recommendations

Results from the current investigation indicate recommendations for future research. Future researchers may repeat this study using a larger sample to explore experiences with mental illness and mental health services among homeless women in different geographic locations. Researchers may also focus on these experiences among

the growing population of elderly homeless women. Future researchers should also conduct a larger empirical investigation using anonymous surveys to provide more generalizable data. Because of the sensitive nature of the study topic, anonymous surveys or questionnaires may provide additional information that was not revealed during this study. Another direction for future research would be for researchers to explore the effectiveness of different programs and services aimed to help chronically homeless women with mental illnesses. Because the focus of the study was on chronically homeless women with mental illnesses, future researchers may replicate the current study with episodically homeless women, or conduct a study to examine differences between chronically and episodically homeless women and perceived barriers to mental health services.

Implications

Positive Social Change

This study was valuable for many reasons. Homelessness continues to be a growing problem without a solution in the United States. By seeking information directly from those who need it most, researchers can begin to set in motion services to support vulnerable populations. I hope the results of this study will inform community leaders as well as county programs regarding services needed for homeless populations. Community leaders should establish services that are not financially exhausting and that can be accomplished with some planning and organization through homeless programs and current outreach services.

Theoretical Implications

The theoretical framework for the current research was based on Young's (1994) critical social theory of gender. Young (1994) posited social structures, such as norms, institutional rules, and embedded practices place members of society into positions of power and subordination. Critical social theory considers the structures of race, class, and sexuality, but Young posited gender was also one of these structures. When considering the utilization of mental health services by homeless women with mental illnesses, it is essential to acknowledge the social barriers related to race, class, sexuality, and gender that this group may face. Young's theory was useful for exploring how homeless women with mental illnesses accessed and utilized support services. In the current study, issues of gender repeatedly emerged, in terms of women's feelings of safety and security, their access to services, their social networks, and experiences of domestic abuse or other forms of victimization. Certainly, homeless women have unique experiences from homeless men, and addressing their challenges and improving the assistance provided to these women requires acknowledging gender differences in experiences with homelessness, mental illness, and mental health services.

Practical Implications

Several practical recommendations may be gleaned from this study. Study participants provided many valuable insights regarding their experiences with homelessness, mental illness, and mental health services. Many media stories pertaining to homelessness focus on its eradication through a "housing first" approach. However, data from participant interviews in the current study indicated this may not be the most

effective solution for homelessness among women with mental disorders. Thus, it may be more practical to help women develop strategies to overcome issues that thwart them into homelessness, such as mental disorders and substance abuse issues, than just to provide them with housing.

Participants in this study requested mental health or other treatment providers come to them because they often had limited access to transportation services. Thus, another practical implication may be to arrange systems of transportation that improve women's access to support services. Safety was a paramount concern and the need for drop-in centers was requested to seek a nap, clean and wash clothing, get a meal, see a comforting face, etc. The need for a safe place to secure their belongings was also requested; therefore, participants recommended having lockers to secure valuables. Thus, program leaders and policy makers may consider integrating support services that provide women with options for securing their personal belongings.

Participants expressed mixed feelings toward emergency shelters. Some participants opposed emergency shelters while others welcomed opportunities to stay in them. However, all women noted the lack of beds available in these shelters when they needed them. Therefore, a recommendation is to increase the number of available shelters within the county and provide the homeless with flexibility to come and go and with less restrictions for entering and exiting the shelter. Participants explained by living on the streets, having the necessary documentation needed was difficult; finding other ways to register and enroll homeless individuals into emergency programs is an important implication from this study.

Medication was also another significant topic. Women expressed a desire to seek treatment, but were concerned about medication requirements to receive support services. Thus, one recommendation is to remove this requirement and continue to work with individuals to find ways to treat them while respecting their beliefs and working to alleviate symptoms. Participants also expressed a desire to have more time with mental health professionals to discuss their concerns and explain their treatment options so they feel supported and empowered.

Conclusions

The participants in the study shared valuable information. Many had important and logical solutions to help create safety and curb homelessness. First, homeless individuals want to feel respected and valued. They understand their position in society and would accept help if offered, but they lack the hope, courage, and support to assistance. Services need to be shared with this population, out in the field or where homeless people congregate, as many are unlikely to go into a treatment center because of the feelings of shame, embarrassment, judgment, and ridicule experienced daily. Services that take place outside the office should become a regular mode of treatment for clinicians and mental health service centers. Moreover, exiting homelessness takes time and effort. Society should not dismiss those who struggle to accept services, but rather continue to engage them and show them there is hope and a way out of their situation when they are ready to accept it. These individuals desperately want help getting out of the hopelessness they have been living in. Society and community leaders need to show

these individuals compassion, encouragement, and hope so they can successfully exit homelessness and move beyond this chapter in their lives.

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