

4-17-2014

Women's Discourse on the Homeless Experience: It's About Love and Loss

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Women's Discourse on the Homeless Experience:
It's About Love and Loss

Ruthanne Marcus, PhD

University of Connecticut, 2014

Physical Health, Abuse, Mental Illness, Loss, Instability, and Substance Use; the lives of homeless women are shaped by multiple interwoven domains. They confront extreme loss and destructive relationships throughout their lives. This dissertation addresses this syndemic (PHAMILIS) through an ethnography of homeless women staying at a rural emergency shelter in Northeastern Connecticut.

My aim was to understand, through narratives, the life trajectories of homeless women, the experiences leading to their current state, and their perceptions of the impact of structural, psychological, and intervening events on their lives.

Based on two theoretical models that provide the foundation for the analysis, I first explore how critical medical anthropology (CMA) examines the broader social, economic, and political factors that shape individual health, health-related behavior, and the social and physical conditions that impact health. I then use Mary Douglas' theory of risk to explore more personal or individual factors that affect homeless women.

My research involved interviewing 30 homeless women staying at the emergency shelter and 13 housing service providers throughout Connecticut. The purpose of the interviews was to hear and share the women's stories and to gain insight into their conceptualization of homelessness. The provider interviews further contextualized the perception of homeless women.

The research illuminated predisposing, exacerbating, and intervening factors that the women shared. They led complex, unstable lives growing up in various levels of poverty with dysfunctional families often rife with abuse and frequent relocation. Multiple, complex issues such as mental illness, substance use disorders, and abuse (sexual, physical, or emotional) exacerbated their homeless situation. Other factors intervened to interrupt their lives, such as early parenthood, lack of education, Department of Children and Families involvement, custody battles, incarceration, and disability.

Coupling the emic perspective with CMA theory, which examines how social inequalities are experienced by homeless women in their everyday realities, provides a better understanding of the culture of homeless women. The PHAMILIS syndemic elucidates the interrelatedness of factors that create the homeless experience and will help to inform how we strive to address the complex

Ruthanne Marcus - University of Connecticut, 2014

issues that affect the health and well-being of homeless women and the issue of homelessness.

Women's Discourse on the Homeless Experience:
It's About Love and Loss

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A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of Doctor of Philosophy

at the

University of Connecticut

2014

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2014

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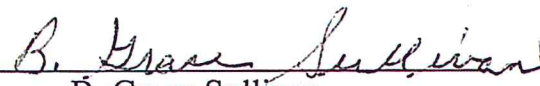
Doctor of Philosophy Dissertation

Women's Discourse on the Homeless Experience:
It's About Love and Loss

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Acknowledgements

For this dissertation I listened to 30 homeless women and 13 housing providers tell their stories. As I walked through the women's lives with them I identified common themes that formed their history and shaped their outlook on the future. The women weren't all open with me and they shared only what they felt comfortable discussing. For some, their discourse was full of pain and suffering but the interviews contained many humorous moments. Although some of the women held their stories close inside, others were willing to share their lives and we were able to cry and laugh together. At the end of every interview we both honestly thanked each other for talking and listening. I am indebted to these women whose lives have touched mine.

I would like to thank my advisors, Grace Sullivan, who first introduced me to the women at the shelter and encouraged me to expand my biomedical gaze; Merrill Singer, whose contribution to the field of medical anthropology is an inspiration to any budding anthropologist; and Pam Erickson, whose support, friendship, and confidence in me was unwavering. I am also grateful that Tracey Andrews was always there to listen and to share in my achievements.

This road has been long and I am fortunate to have had the backing of colleagues at Yale University in the Emerging Infections Program and Clinical and Community Research Program. And I could not have gone through this process without encouragement from my children, Alejandro and Cristina, for whom I tried to set a good example. I am so appreciative for my husband, John, whose love and encouragement kept me grounded and determined. I am thankful for my role model, my mother, Marcia Bok, who provided endless support and guidance and listened to my every complaint and even read my entire dissertation. My extended family

provided endless encouragement and support. And I am grateful for Cyndi Frank's unconditional friendship. She was there by my side enduring all the challenges and growth I experienced during this process and I could not have accomplished this without her.

As a side note, I would like to thank Carol Walter, former Executive Director of the Connecticut Coalition to End Homelessness who died December 27, 2012. She was a champion for the homeless and despite being so busy she took time to let me interview her as one of the providers of housing services.

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Chapter 1 – Homelessness: *“It’s not something that you plan.”*

“It’s a whole new experience for me. I didn’t get up one morning and say, “All right. I’m 39. I wanna be homeless.” It’s not something that you plan. It just goes to show that it can happen to anybody. No matter what your situation and that’s the biggest thing that people out there don’t understand. They [think] because they got this nice, cushy job and everything that it can’t [happen to them] —with the economy now, guess what? You’re just as vulnerable as anybody else.” Margaret (W026)

“Short-term I want a good job back. I want that. I wanna be happy again. I want to be in love with somebody again. I don’t wanna be alone anymore. I’ve been alone for years. I don’t wanna feel angry, and that’s what I feel, is anger.” Mary (W013)

Homelessness is multifactorial and complex, complicated by cognitive, cultural, social, political, and economic factors that may, in part, explain why an individual or a family initially becomes homeless and perhaps whether they remain in that situation. Homeless women, like housed women, want simple things in life: a place to call their own, their children to be happy, and to be able to share their love. Whether being homeless is a chronic condition or a transitory period in their history, they are all striving for similar goals. They must get past the losses and stumbling blocks and tragedy in their lives to move forward into the future with hope.

In my study of homeless women, I found that they experience their lives in a dynamic present in which they face daily struggles as well as a constant past-present that centers on their social relationships and the losses they confront. It is these two constructs, I found, that shape their existence. Moreover, it is these facets of their lives that affect their health and wellbeing in the broadest sense. I elicited narratives about homelessness from women because they are useful for both identifying the risk factors that lead people into homelessness as well as better understanding of the struggle and vulnerability homeless women experienced that led them to their current situation. They are also a vehicle to understand their expressed resilience and agency to overcome their current situation. To appreciate their point of view we must first

understand who is homeless, the causes of their homelessness, how homelessness affects them, and how homelessness influences their overall health. Understanding these issues from the perspective of homeless women themselves can shed light on how homelessness can be prevented and the kinds of interventions and programs that are needed to address it.

In this thesis I will give voice to homeless women and allow them to illustrate their own lives through their own life stories. These stories provide insight into their lived experience, inner thoughts, perceptions, and the cultural construction of their lives. It is within the context of a rural homeless shelter that I explored the voices of homeless women. I conducted my research at a rural emergency homeless shelter in northeastern Connecticut over the course of several years from 2007 to 2012 to gain an understanding of factors that influence homeless women's lives and affect their everyday health and well-being.

I first arrived at the shelter in March, 2007. The shelter is located just off the Main Street in a residential area of a small town of about 4000 people in north-eastern Connecticut. The town has one main street with historic buildings and some tired-looking shops including a pizza parlor, a dress shop with elegant prom and wedding dresses, and a furniture store. There's a gas station on the corner. It was once a mill town whose mills are long gone, having closed in economically hard times.

After I drove past the commercial blocks and past the churches and banks, I came to a small town green with a gazebo, some benches, and some trees that looked like they would be decorated in a quaint way at Christmas. I turned right before the green and went one block past the church that serves as a soup kitchen on Wednesday evenings for residents of the town. On the left hand side of the street was a pharmacy and a health clinic. I parked my car and went inside. I asked where the *Entré* shelter was and some nurses and a receptionist told me the

shelter was across the street. I left my car, careful to lock it. I was in unfamiliar territory and a bit nervous about the area and the unknown. I walked across the street where a young man and woman were sitting on a stoop in front of the housing shelter, a three-story large white residential building with an old-fashioned porch in front. The man looked no more than 20 years old with a stocky build, wearing jeans and a black sweatshirt. The woman was also young but I couldn't tell her age. I asked if this was the shelter and told them I was looking for my professor, a nurse practitioner who was working with some nursing students. They said, "Yes, she is inside, but you need to enter around the back." I walked to the back of the house where there was a fairly large parking lot with 6-8 parked cars. Across the parking lot were a shed and a garage. I could see a playground in the backyard and a picnic table near the edge of the parking lot. I would ultimately spend numerous hours sitting at that picnic table, talking to shelter residents, listening to them argue, encouraging one another, disciplining their children, rolling cigarettes, and gossiping.

On this day there were several men standing outside. They watched me as I approached. I smiled at them and said "hello" but they seemed unsure about this stranger entering their space. New people come and go at the shelter all the time. I carried a notebook – not suitcases or plastic garbage bags with my belongings, so I was different; perhaps a new staff member or an inspector or worse, someone from DCF (Department of Children and Families). I really don't know what they were thinking. It was I who was imagining the worst. Thus, I entered the "field" where I would do my research, somewhat unnerved and through the back door.

The entryway at the shelter was small with a pay phone on the wall, stairs to the upstairs directly in front of the door, the main office to the right, and an open doorway to the kitchen, dining room, and main living area on the left. The house was old and in need of a fresh coat of

paint on the walls, but it felt warm and busy with people talking and children crying. I went in the office and was met by one of the staff. She welcomed me with a warm smile, the same smile I saw her show to residents many times after that. She had a gentle face, somewhat worn, experienced, comforting to people who (like me) were coming into the unknown. She told me that my professor, Grace, and her students were in the main dining room. They met me as I walked through the door.

Grace is a seasoned nurse practitioner, an expert in child health, who has been volunteering in the homeless shelter and proctoring nursing students from the University of Connecticut who do a clinical rotation there. When I came in she was with a young woman who was holding a baby girl. The mother looked like a teenager and the baby looked about a year old. The mother had long, straight dark hair to her waist. She could not have weighed over 90 pounds. She had the baby on her hip, shifting her up and down possibly because she was heavy or fussy. I found out later that the mom was 24 years old and had been at the shelter herself with her own mother 20 years earlier. When I learned this I made a mental note to explore the cycle of homelessness. One of the nursing students was going to examine the baby, who wasn't feeling well, in an office upstairs. The students wore nursing uniforms like real nurses that separated them from the shelter residents. Was this attire a symbol of the power the non-residents (staff and volunteers alike) had over the residents or a requirement of their academic status? As they ascended the steep stairs, I went with one of the other nursing students to the dining room.

The dining room was being set-up for dinner with long fold-up tables with attached stools. Three men and several women were walking in and out of the room. Some had coats on to show they weren't staying long; this was a transitory station in their lives. One woman picked up a clipboard hanging on the wall. She signed herself out to record that she would not be

present for dinner. I could smell food cooking in the kitchen but I couldn't tell what it was – possibly something baked like pork chops or chicken. I sat at one of the three long tables that had been pulled out for dinner. A pre-schooler approached the student and me to see what we were doing. She, too, was wearing a winter coat with faux fur around the hood. The coat was old, used, and dirty. The girl was inquisitive, eager for attention. She brought along a lunch box with Dora the Explorer on it. She climbed up on an adjacent stool and spoke in an animated tone about her lunch box, explaining who Dora, and Diego, and Boots, the monkey, were. Her conversation was random with no direction. Two other young children approached us, also eager to see what we were doing there. One was a small girl who wanted to use my pen, and I suggested she go find some paper. She immediately went to look in a small wooden desk in the corner of the room. She returned to the table where I was sitting with some recycled white paper with numbers on the back. She took my pen and began scribbling on the page. I couldn't tell her age but her language skills were limited. The boy, who had the same coffee complexion and looked like her brother, found some crayons to use. He used his left hand to scribble on the paper, not saying a word, with his head bent low over the paper, just being part of the experience. The nursing student drew faces on the paper and outlined the children's hands for them to color in. This was truly a family shelter with almost a dozen children of all ages, all homeless.

In this dissertation I present the stories of 30 homeless women's lives. In this first Chapter I described my introduction to the *Entré* shelter where I met the women I interviewed and was introduced to their lives and the broader issues facing homeless women. For several years I was a participant observer at the shelter, spending time with the women and their children and getting to know their routine and some of the challenges they faced. In Chapter 2 I present a review of the literature on homelessness, focusing particularly on how homelessness affects

people in rural areas. My focus was on women whose lives were further complicated by their relationships with their children, since they were generally the primary caregivers for their children.

In Chapter 3 I lay out the theoretical models and the methods I used to undertake this work. I developed my research combining different theoretical models relevant to the study of homelessness. I use the work of Mary Douglas (1992; Douglas & Wildavsky, 1982) because of our shared interest in the social construction of risk. I used Critical Medical Anthropology (CMA) to examine the social, political, and economic factors that affect the health and well-being of homeless women in the United States (Baer, Singer, & Susser, 2003). CMA was useful in explaining a host of relevant issues permeating homelessness in America at the structural level such as poverty, unemployment, and a lack of affordable housing to more micro level factors such as substance abuse and mental illness. I use these theoretical perspectives to structure my written ethnography of homeless women in New England. This chapter also describes the methods I used in my research, including two sets of interviews, one among women staying at an emergency shelter and another among housing service providers throughout the State.

Chapter 4 illustrates how the women and the providers conceptualize homelessness. This chapter serves as a framework for the location of my research as well as a concise introduction into their thoughts about being homeless. In this chapter I present some of the findings from the semi-structured interviews with housing providers. These heuristic interviews better informed my understanding of homeless women. During the interviews with providers I asked them what they think homeless women think about being homeless. This unique perspective provides further insight into the conceptualization of the culture of homeless women from various vantage points.

In Chapter 5 I present circumstances that may occur prior to coming to the shelter when some of the women had been unstably housed, “doubling-up” with family or friends and some were forced from their homes through eviction. I then explore the structural and personal factors of the shelter experience, including housing issues and employment, and individual factors that affect the women on a personal level, such as shame, embarrassment, and a need for respect and dignity. In Chapter 6 I focus on the narratives of the women discussing their lived experience coping with love and loss, the two major themes of this research. Chapter 7 presents a positive outlook on life once the women leave the shelter in which their agency and inner strength is developed. Chapter 8 presents the findings I identified in my analysis of the in-depth interviews. Here I present the crosscutting domains of homelessness: predisposing factors including poverty and dysfunctional families; exacerbating factors of physical health problems, mental illness, substance use, and physical, emotional, and sexual abuse; and intervening factors that further complicate their lives, such as early pregnancy, custody battles, and incarceration. A synopsis and summary is provided in the Discussion and Conclusion in Chapter 9, with presentation of a syndemic approach to homelessness.

Chapter 2 – Background

In the nineteenth century, discourse on homeless women revolved around the issue of prostitution (May, Cloke, & Johnsen, 2007) since homeless women had been rejected by polite society, which normally accommodated homeless relatives or employers in domestic service. Hence, they became part of an underground society that was publicly stigmatized but variously tolerated. In the 1950s and 1960s only 3% of the homeless population were women (Bassuk, 1993). In the 1970s, economic stagnation, rising inflation, decline in real wages, the significant loss of manufacturing jobs, and high unemployment levels led to a rise in homelessness (Glasser & Bridgman, 1999). Moreover, many patients, among them a growing number of women, were deinstitutionalized from mental health facilities without sufficient social support and housing services (Hopper, 1988; Rossi, 1989). By the 1980s, state and federal welfare programs were reduced, real estate prices rose, lower-paid service-industry jobs and part-time work increased, affordable housing decreased, and the departure of manufacturing industry reduced available work (Burt, 1992). Due to the convergence of all these factors, by the 1980s there was a large increase in the number of visibly homeless men and women on the streets and they were much harder for polite society to ignore. During the period 1985-1990, unlike in earlier decades, the proportion of homeless women equaled the number of homeless men (Lehmann, et al. 2007).

These historical factors have set the stage for the current situation in which the volume of single women and women with minor children seeking shelter has increased substantially. In general, the factors that cause homelessness today are structural in nature (i.e., social, political and economic) rather than individual. According to Baer, et al (2003), reductions in the federal budget for social services, changes in real estate regulation and taxes, and the increasing cost of housing, rather than individual issues such as mental illness and substance abuse make people

more vulnerable to homelessness in a worsening economic situation. Little has changed in the past decade (National Coalition to End Homelessness, 2013). This is particularly relevant in rural areas where rural poverty has been affected by a loss of manufacturing jobs and there has been an influx of people moving from urban areas to more hospitable environments (First, Rife, & Toomey, 1994; Vissing, 1996). Moreover, tax incentives for second home owners has inflated the cost of rural housing and price increases in the rental market have made it more difficult to "double-up" with relatives who don't own their own home (Glasser & Bridgman, 1999). Often people in rural areas resort to moving from "one unaffordable rent to another, occasionally interspersed with time in a motel or shelter." (Glasser and Bridgman 1999:10)

Literature Review

The face of homelessness has changed since the images of the bowery and skid row were etched in the public's eye during the early twentieth century, depicting homeless, drunk men on the streets (Hopper, 2003; Rossi, 1989; Wagner, 1993). This vision was replaced in the 1960s when mental health reforms closed many psychiatric facilities and forced mentally ill persons onto the street, leaving them to sleep in the cold, in doorways, on park benches or culverts, under bridges, or in other outdoor or nonpermanent locations. Welfare reform in the 1980s and 1990s further altered this image as younger women, mothers and their children, were forced to seek residence on the streets, in shelters, subway stations, bus stations, and other public places (Glasser & Bridgman, 1999; Rossi, 1989). Women who are living without shelter represent a growing proportion of the homeless population. Of the approximately 3.5 million people who are homeless; one third are women. More than two thirds of homeless mothers have a mental illness, including post-traumatic stress disorder (PTSD), substance abuse and depression

(Desmond, 2006). According to the National Alliance to End Homelessness Point-in-Time count (National Coalition to End Homelessness, 2013) in 2012, 38% of the homeless population (approximately 77,157 households) were families. The percentage of homeless families has increased 20% between 2007 and 2010 (Craft-Rosenberg, Powell, Culp, & Team, 2000; U.S. Department of Housing and Urban Development, 2011). The proportion of homeless people in shelters who are part of a family has increased from 30% to 35% during this time period. Sixty percent of homeless women have children under the age of 18 years, but many do not have custody of their children (Desmond, 2006).

Homeless women pose a particularly challenging and complex group to study since they represent a diverse and heterogeneous population. For many, their multifaceted lives are compounded by their array of problems and their responsibilities as caretakers of their children. The dichotomy between single women and mothers with children is blurred by the fact that women who appear to be single may have children not living with them. Moreover, the health issues of single women and women with children in their custody differ. As Page and Nooe (2002) indicated, “Compared to homeless women accompanied by minor children, unaccompanied women have been shown to be older, more likely to have histories of mental illness and substance abuse, to have been homeless longer, to have served time in jail or prison, to be poorer, and to have more health problems”.

Issues facing homeless women relate to their relationships with men, their families, and the perception of them by society. Homeless women are frequent victims of domestic violence (Anderson & Rayens, 2004; Browne, 1993; Coker et al., 2009; Goodman, Dutton, & Harris, 1997; Lown, Schmidt, & Wiley, 2006) and they deal with often insurmountable economic struggles. Physical and mental health problems among homeless women are pervasive (Bassuk,

Buckner, Perloff, & Bassuk, 1998; Benbow, Forchuk, & Ray, 2011; Lillian Gelberg & Arangua, 2006; S. Hwang et al., 2011; S. W. Hwang, 2001; Kilbourne, Herndon, Andersen, Wenzel, & Gelberg, 2002; Levy & O'Connell, 2004; O'Campo et al., 2009; Rabiner & Weiner, 2012; Strehlau, Torchalla, Li, Schuetz, & Krausz, 2012; Teruya et al., 2010).

According to Gelberg (1990) homeless people in their forties and fifties often develop health disabilities that are more commonly seen only in people who are decades older (L. Gelberg et al., 1990; S. W. Hwang, 2001). Medical problems include seizures, chronic obstructive pulmonary disease (e.g., emphysema and chronic bronchitis), arthritis and other musculoskeletal disorders (First et al., 1994; Lillian Gelberg, Linn, Usatine, & Smith, 1990; Raoult, Foucault, & Brouqui, 2001). Chronic diseases such as heart and circulatory problems (e.g., hypertension), diabetes, and anemia are often inadequately controlled and may go undetected for long periods.

Living in group homes, missions, shelters, or prisons increases the risk of communicable illnesses, such as HIV/AIDS, tuberculosis, influenza, and other respiratory and enteric infections (Levy & O'Connell, 2004; Raoult et al., 2001; E. Susser et al., 1995). Harsh environmental conditions are also a factor in the health of homeless persons with exposure to extreme weather leading to dehydration, sunburn, frostbite, ulcers, and hypothermia (Lillian Gelberg & Linn, 1989; Raoult et al., 2001).

Health issues in women in particular include pregnancy, sexual and reproductive health issues, including sexually transmitted infections (gonorrhea and chlamydia are the most prevalent) (Desmond, 2006; S. W. Hwang, 2001). Mental health problems of homeless women include depression, anxiety, stress, cognitive impairment, behavioral issues, and developmental

delays (Bassuk et al., 1998; Lillian Gelberg & Linn, 1989; Schanzer, Dominguez, Shrout, & Caton, 2007).

Definitions of homelessness vary depending on the source. The concept of homelessness has been defined as a continuum ranging from being precariously housed to literally homeless (Homelessness, 2013; Toomey & First, 1993). However, May and colleagues (2007) found that among the women they interviewed, homelessness was episodic, rather than progressive (May et al., 2007). Sharon, a 32 year-old mother of teenaged twin girls and a 9 year-old son, who was staying at the shelter with her husband and children told me, “This is my first rodeo [laughs] and it’s not ever going to happen to me again --- ever.” Policymakers, in general, agree on the definition of literally homeless, which includes people with no access to a conventional dwelling or the “visible” homeless who live on the streets or in a shelter (May et al., 2007; Rossi, 1989; Toomey & First, 1993). There is less consensus on the definition of the precariously, marginally, or unstably housed. This would include people with tenuous or temporary claims to conventional dwelling or housing, such as a person who, with his or her own limited resources or at public expense, stays in hotels, motels, or rooming houses on a short-term basis. Even more controversial is the crowding phenomenon of “doubling up” (Ahrentzen, 2003; Glasser & Bridgman, 1999). “Doubling up” refers to people staying together with friends or family in their homes or apartments. When resources are not available for a woman to pay her own rent she may need to stay with someone else. This may result in housing displacement, more common in rural than urban areas (Vissing, 1996). Families in rural areas may not experience literal homelessness but instead may find themselves living in “housing distress” (Vissing, 1996). This is especially problematic when the individuals who are providing the shelter, whether on a couch or in a room, are receiving housing subsidies. It is a violation of Section 8 and other housing

programs or subsidies to allow others who are not included on the lease to stay in the apartment and this can lead to eviction of all parties. “Doubling up” is often a precursor to homelessness for women and children living in poverty (Ahrentzen, 2003; Danseco & Holden, 1998; Glasser & Bridgman, 1999).

Women who are homeless are often described as “invisible” (Glasser & Bridgman, 1999; Whitzman, 2006) or “hidden” (Singer, 1999). They may avoid the streets due to fear of vulnerability to violence and environmental conditions and resort to staying in shelters. They also use more informal strategies, such as staying with friends and family or attaching themselves to housed men, to avoid the streets or emergency shelters (Klodawsky, 2006; May et al., 2007; Whitzman, 2006). In addition, homeless women are often considered “invisible” because, historically, their numbers have been fewer than those of men. They are often hidden from public view, and they are more apt to engage in “sofa/couch surfing” where they stay for short periods of time with friends or family (Glasser & Bridgman, 1999; May et al., 2007; Whitzman, 2006).

The “invisibility” of homeless women and families is even more evident in rural areas (Cloke, Milbourne, & Widdowfield, 2001; First et al., 1994; Vissing, 1996; Whitzman, 2006). Women with children have a more difficult time relying on the social support of family and friends because of the burden of the children staying with them who may not be welcomed by their hosts, who are likely themselves be impoverished or have other children for whom to care. In addition, their housing subsidy usually caps the number of people that can live in their household making their ability to extend assistance to someone else nearly impossible.

Epidemiology of Homelessness

Homelessness taken at face value constitutes an individual or family without a home. The number of homeless people in the United States varies from year to year and the numbers change depending on the definition. The accuracy of the number of homeless people is debatable since until 1990 homeless people were not included in the U.S. census. This was even more pronounced in rural areas where the homeless population is more invisible (Vissing, 1996). Many communities conduct a Point-in-Time (PIT) (Pollio, North, Eyrich, Foster, & Spitznagel, 2003) count on a single day in January to determine the number of homeless people living in a community. In 2012 the U.S. PIT assessment identified 633,782 homeless individuals (Homelessness, 2013; U.S. Department of Housing and Urban Development, 2011); 62% (n=390,155) were sheltered in an emergency shelter or in transitional housing and 38% (n=243,627) were unsheltered. Of the sheltered individuals, 38% were women (U.S. Department of Housing and Urban Development, 2011). Of the total number of homeless, 62% (n=394,379) were individuals alone and 38% (n=239,403) were individuals in families. These individuals in families comprise 77,157 family households (at least one adult and one child).

While there has been a steady decline in the number of people who are homeless, there has been an increase in the number of families experiencing homelessness. Since 2005 the number of homeless people decreased 0.34% from 763,010 to the current figure of 633,782 in 2012; the number decreased 6% in Connecticut during this time period. From 2007 to 2010 there was a 6% decline in the number of homeless individuals and 20% increase in the number of sheltered families. Focusing just on sheltered homeless people, we find that 78% of all sheltered homeless people are adults, 38% are women, and 58% are members of a minority group. Sixty-three percent are in one-person households, but the proportion of homeless people who are using

emergency shelters and transitional housing as part of a family has increased from 30-35% during this same period.

Rural homelessness has increased since 2007 with the number of people using homeless shelters in suburban and rural areas increasing by 57% (from 367,000 to 576,000), while that number decreased 17% in principal cities (from 1.22 million to 1.02 million) (U.S. Department of Housing and Urban Development, 2011). The largest increase in homelessness in small towns and rural areas is among single women with children and families (Homelessness, 2012). The majority of homeless families consist of a young single mother with young children, typically two young children. Nearly half of the young mothers are under the age of 30 and the children are under five. They have very low incomes, generally below 50% of the poverty level, which in 2012 was \$9,545 annually (\$795 monthly) for a family of three (U.S. Department of Housing and Urban Development, 2011).

The macro or structural factors that affect homelessness include poverty, unemployment, and a lack of affordable housing. In 2011, the median household income in the US was \$50,502, a 1.3% decrease below the previous year. The poverty level for a single person household was \$10,830 and \$22,350 for a family of four. The number of persons living in poverty increased 4.8% (from 46,215,956 to 48,452,035) and the national poverty rate was 15.9%. The overall unemployment rate in the US was 8.9%; a 0.6% decline from 2010 to 2011. The Fair Market rent for a two bedroom unit was \$937 per month (U.S. Department of Housing and Urban Development, 2011). Over 7 million poor people in the US were living “doubled-up” in 2011, a 9.4% increase over the previous year (National Alliance to End Homelessness, 2013).

These factors are paralleled in Connecticut where the median household income was \$65,753 in 2011. The number of persons living in poverty in 2011 was 377,856; almost an 8%

increase over the previous year. The poverty rate was 10.9%. The unemployment rate in CT was 8.8% in 2011, a 0.5% decrease over the previous year. The Fair Market rent for a two bedroom unit in CT was \$1,235 per month (U.S. Department of Housing and Urban Development, 2011). An estimated 49,398 poor persons in CT were living “doubled-up”, a 28.6% increase over 2010 (National Alliance to End Homelessness, 2013).

Homeless Women

Addressing homeless families must begin with a focus on women since 78% of homeless families are headed by single women (Nunez & Fox, 1999). Homeless women include a heterogeneous group comprised of women who are alone or solitary and women who are mothers; with or without their minor children living with them (Bassuk, 1993; North & Smith, 1993). Single women encompass a variety of women with a wide array of needs. "[They]...may include women who have never been married, young women without children, women whose children are living in foster homes or with other family members, elderly women, heterosexual women, and lesbian women." (Glasser & Bridgman, 1999:20) According to Bassuk, et al, (1998) solitary women have higher rates of schizophrenia, bipolar disorder, and substance use disorders than homeless mothers. They are also more apt to live in unsheltered environments and to need access to health care (Nyamathi, Leake, & Gelberg, 2000). Mothers with children present tend to have experienced violence in their lifetime (Bassuk et al., 1998; Nunez & Fox, 1999), to be pregnant or with small children (Nunez & Fox, 1999), and they tend to stay in shelters not on the street (Metraux & Culhane, 1999).

Women in rural areas are a unique population (Craft-Rosenberg et al., 2000). In rural areas, there are a higher percentage of homeless females than in urban areas, a larger number of families, they are more likely to be residing in the county of their birth, and they may be

homeless for shorter periods of time. The ethnicity of the rural homeless population is predominantly Caucasian compared with greater ethnic diversity in urban areas. Homeless persons in rural areas may be more invisible than urban homeless due to a scarcity of social services and shelter programs that forces them to rely on relatives, friends, and self-help strategies (First et al., 1994; Fitchen, 1996).

Homeless Families

No one would argue that periods of homelessness in an individual's life are disruptive and unsettling and, with few exceptions, not by choice. Homeless children are particularly concerning, as the consequences of homelessness are detrimental to their development and mental and physical health (Danseco & Holden, 1998). Families may become homeless after many attempts to stay with family or friends or to "double-up". After becoming unstably housed for a period of time they may become homeless and opt to stay in a mission, emergency shelter, or transitional housing, or in unsafe locations, such as cars, on the streets, or in campgrounds. Fortunately, homeless families do not remain homeless for long periods of time and they generally do not remain homeless for more than three to six months and many do not return to homelessness. According to the National Alliance to End Homelessness 2012 report on Family Homelessness (2012), approximately 20% of homeless families have a longer stay in transitional housing combined with extensive social services and housing subsidies. Some experience multiple episodes of homelessness; these families utilize the majority of homeless services (Culhane, Metraux, Park, Schretzman, & Valente, 2007),

Researchers who have explored the lives of homeless women have found that homeless mothers face particular challenges, especially when forced to parent their children within the

congregate shelter setting (Bassuk, 1993; Craft-Rosenberg et al., 2000; David, Gelberg, & Suchman, 2012; Friedman, 2000; Hausman & Hammen, 1993; Narayan, Herbers, Plowman, Gewirtz, & Masten, 2012; D. K. Padgett, Hawkins, Abrams, & Davis, 2006; Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012; Steinbock, 1995; Tischler, Karim, Rustall, Gregory, & Vostanis, 2004; Tischler, Rademeyer, & Vostanis, 2007; L. Weinreb, Nicholson, Williams, & Anthes, 2007). The struggles may depend upon whether the woman is alone (“solitary”) versus with her children. Homeless families deal with a double crisis of the disruptive and traumatizing experience of losing a home as well as impediments to the parent's ability to function as a consistent and supportive caregiver (Friedman, 2000; Hausman & Hammen, 1993). Compared to other women, mothers with children in their custody face more “social vulnerabilities (dependent children; lack of employment) and fewer personal vulnerabilities (substance abuse and other psychiatric problems) to homelessness” (Smith & North, 1994:609). They deal with more feelings of failure and self-blame when they are responsible for their children’s, as well as their own, well-being. “Helping children to get through the difficulties, keeping the family together, and holding onto a sense of self-worth as parents were the core parts of the survival and healing process” faced by homeless mothers with children (Friedman, 2000:91) They may perceive themselves as in “perpetual risk of losing their children, and they must constantly struggle to provide the financial and emotional support, physical care and safety, and developmental stimulation that domiciled children receive” (North & Smith, 1993:430).

Homelessness may cause mothers to experience feelings of powerlessness, loss, distress, fear, anxiety, worthlessness, depression, loss of parental authority ("public parenting"), and loss of family relationships. In turn, the children may exhibit behavioral, emotional, or academic problems (Hausman & Hammen, 1993; Steinbock, 1995; Tischler et al., 2007). One evening

when I was at the shelter, a 9 year-old girl was repeatedly standing on a small table and jumping off it to the floor. She was the same girl who asked a visiting nursing student why she wanted to spend time with “us losers.” Issues like these in their lives caused mothers to experience increased physical and mental stress, associated with having to keep their lives and their families' lives together (Hausman & Hammen, 1993; Whitzman, 2006).

What are the causes of homelessness?

There is a wealth of literature on the causes of homelessness from the etic perspective, with fewer in-depth explorations of the roots of homelessness from the insider's view (Kozol, 1988; Liebow, 1993; Moxley, Washington, & Calligan, 2012; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; D. K. Padgett et al., 2006; Sargent, 2011; Waterston, 1999). From the outsider's vantage point, one can describe at least three broad causes of homelessness: 1) the micro or individual level; 2) the macro or structural level; and 3) the social and family network level. These levels are inextricably intertwined (E. Susser, Struening, & Conover, 1987). The levels are neither discrete nor hierarchical. There is often a synergistic or cascade effect among the causes of homelessness (Mathieu, 1993). For example, a young mother with diabetes may not be able to work due to her health problems and her boyfriend may need to stay home to care for the children; his inconsistent work attendance may result in the loss of his job which results in the family not being able to pay their rent.

The causes of homelessness may not be acute; they may have developed over the woman's lifetime through her childhood experiences. Some issues, such as loss of a job or eviction, may result in current or immediate homelessness but often people who are homeless have suffered in childhood (Shelton, Taylor, Bonner, & van den Bree, 2009). Many authors have

identified adversity, such as trauma and abuse, in childhood as precursors to homelessness (Bassuk, Perloff, & Dawson, 2001; Davies-Netzley, Hurlburt, & Hough, 1996; Goodman et al., 1997; Green Jr et al., 2012; Hamilton, Poza, & Washington, 2011; North, Thompson, Smith, & Kyburz, 1996; Shelton et al., 2009; Stein, Leslie, & Nyamathi, 2002; Swick, 2008). Liebow (1993) notes that “For the great majority of the woman I came to know, life had never been easy. Their childhoods were often punishing and painful. They came into homelessness by many different paths, almost all of which, one way or another, had to do with being poor and powerless.” (Liebow, 1993:16). Studies of homeless female veterans have also identified trauma as a contributing factor to homelessness (Hamilton et al., 2011). Trauma may contribute to homelessness but it is not the sole cause. There are many factors from the individual, structural, and societal level that contribute to personal or family homelessness.

Micro Level Factors Associated with Homeless Women

Individual or personal level factors explain some aspects of homelessness with 34.7% of the sheltered homeless population having a history of substance abuse, 26.2% having a serious mental illness, 12.3% being domestic violence survivors, and 3.9% living with HIV/AIDS (National Alliance to End Homelessness, Ending Family Homelessness – National Trends and Local System Response, Oct 2012). Abundant research has been conducted on the mental and physical health issues experienced by homeless women (Bassuk, 1990; Benbow et al., 2011; Craft-Rosenberg et al., 2000; Tischler et al., 2007; L. F. Weinreb, Buckner, Williams, & Nicholson, 2006; Whitzman, 2006).

Mental illness and drug abuse are well documented among homeless women (Hopper, 1988; E. Susser, Betne, Valencia, Goldfinger, & Lehman, 1997; E. Susser, Moore, & Link, 1993;

I. Susser, 1996). Strehlau and colleagues (2012) found that 63% of homeless women had some type of mental illness: 39% had anxiety, 28% a post-traumatic stress disorder, 19% an obsessive-compulsive disorder, 17% a depressive disorder, 10% a manic disorder, and 7% a psychotic disorder. Moreover, 58% had concurrent substance dependence and mental illness. Paul Koegel (1992) provides a unique lens that stresses the need to examine the strengths of mentally ill homeless individuals from an anthropologic aspect instead of relying on the more negative blaming viewpoint of the epidemiologist or clinician. He feels that we know little about what is “right” with mentally ill homeless individuals, the strengths that enable them to survive in inordinately hostile environments, the creative strategies people devise to meet their needs, and their resilience in the face of adversity. He further emphasizes that we know nothing about their ability to adapt to a specific set of circumstances and therefore, we are “left with the perception of them as defective human beings.” (Koegel, 1992)

Substance abuse, including drug use and alcoholism, contribute substantially to homelessness. Homeless women with substance abuse problems often have the most difficulty getting into stable housing and remaining there (Aubry, Klodawsky, & Coulombe, 2012; Caton et al., 2005; Finfgeld-Connett, Bloom, & Johnson, 2012). Women with substance use issues may also struggle to maintain custody of their young children (Steinbock, 1995).

Personal factors such as mental illness and substance abuse are one aspect of the problem. Mental illness and substance abuse are also prevalent in the housed population and not all of them become homeless; therefore, it is prudent to explore the risk factors for poor families becoming homeless that go beyond mental illness and substance abuse (Bassuk, 1993; Glasser & Bridgman, 1999; Lehmann, Kass, Drake, & Nichols, 2007; North & Smith, 1993; D. K. Padgett et al., 2006; Plumb, 2000; L. Weinreb, Goldberg, & Perloff, 1998). Many agree that the most

common risk factors include: 1) single mother as head of household; 2) African –American ethnicity; 3) young age of the head of household; 4) substance abuse by the mother or her male partner; 5) childhood victimization of mother; 6) adult victimization (e.g., intimate partner violence); 7) pregnancy or recent childbirth; 8) and lack of (or having exhausted) social support, particularly housing support. Lehmann and colleagues (2007) also found recent relocation, ceasing work in the prior year, and overcrowded or marginal housing in the prior year to be important factors that result in homelessness (Lehmann et al., 2007). Weinreb et al. (1998) reported that homeless mothers were less likely to have completed high school, had lower annual incomes, and were less likely to have received welfare in the prior year than housed mothers. They were also more likely to have ever injected drugs (L. Weinreb, Goldberg, & Perloff, 1998).

While some might describe these putative risk factors as personal traits, they simply provide an epidemiologic description of who is homeless. These factors do not provide an understanding of the women themselves or the culture of homelessness. People who are homeless face deep personal issues that affect their cognitive perception of themselves. These may include feelings of stigmatization, low self-esteem, low self-efficacy, marginalization, vulnerability, and limited internal resources. Mary, a 55 year-old woman at the *Entré* shelter, who had not told her family where she was, said, “[My sister] knew that I was staying in my car but I didn’t tell her the whole story about it. Figured she didn’t need to know. I don’t know, I don’t like to tell my story.” Davis (1996) speaks of the desperation, loss of hope, and powerlessness of homeless persons. Poor self-image and low motivation to affect change are also common. On the other hand, some researchers have studied the resilience or resistance factors that assist homeless individuals in identifying their personal strengths and overcoming obstacles for survival (Benbow et al., 2011; Tweed, Biswas-Diener, & Lehman, 2012).

Padgett et al. (2006) interviewed 13 formerly homeless mentally ill women and identified trauma and victimization as the major factors affecting their life trajectory. Interestingly, she focused on the stigma experienced by homeless women as compared to homeless men. The authors point out that, "For comparable men, the loss of life opportunities (a job or career) and the impact of stigma can also be profound, but such losses still leave open compensatory roles on the margins of society, for example, pimp, drug dealer, gambler, or hustler. Such activities, often valorized in movies, hip-hop, and country music, enable men to earn income as long as they can avoid getting arrested (although serving prison time is also viewed favorably in youth culture as conferring 'street credibility')." They go on to say, "In contrast, women's options for earning money off the books were largely confined to prostitution and shoplifting - or to assisting male partners in their illegal activities." They note the difference between the positive images of men as "outlaws" and the negative imagery of female "outcasts" as defining the vulnerability of these women (D. K. Padgett et al., 2006:464).

Despite the stigma and low self-esteem experienced by homeless women, they also exhibit resilience and hope that is sometimes not recognized. Homeless women may have positive attitudes and they tend to persevere despite their hardships (Benbow et al., 2011). Women with substance use disorders can also display competency beyond what is expected of them (Fingeld-Connett et al., 2012).

Macro Level Factors Associated with Homeless Women

The second level of homelessness, the broad societal level, which would include, among other issues, lack of affordable housing, unemployment and poverty, comprises the macro or structural causes of homelessness. "In the midst of much concern about alcoholism,

deinstitutionalization, physical disabilities, social disaffiliation, and the like, one must remember that homelessness is a housing problem" (Rossi, 1989:31). Simply stated the two biggest reasons for homelessness are lack of accommodations and unemployment or underemployment (Baer et al., 2003; Farrin, Dollard, & Cheers, 2005; Shinn & Gillespie, 1994). Even if a woman is employed she often has to work more than one minimum wage job to support her family. Sometimes these multiple jobs still don't pay enough to provide for housing and basic needs. This is a national crisis. In essence these factors stem from political factors that cause poverty. "Poverty robs or blocks a person's ability to access the resources necessary for her family's needs. These resources include safe affordable housing, adequate food, a safe family life, solid education, employment that pays an adequate wage, good health care, and appropriate child care. Without these supports a family is not able to fulfill societal expectations of self-sufficiency and self-support. These are systemic needs, not only personal issues." (Friedman, 2000:36)

Rhodes and colleagues (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005) discuss "risk environments" which comprise all risk factors exogenous to the individual. Rhodes et al.'s work revolves around risk of HIV transmission but is applicable to the study of homelessness since it focuses on the social situations, structures and places in which risk is produced rather than a reliance on a conception of risk as endogenous to individuals' cognitive decision-making and immediacy of interpersonal relations (Rhodes & Simic, 2005; Rhodes et al., 2005). These authors believe that the physical environment is socially constructed in two senses: "human actions shape the physical environment, and human conceptions filter the experience of it" (Rhodes et al., 2005:1027). The notion of the "risk environment" provides some conceptualization of the complexity and the interrelatedness of the three broad causes of homelessness. The socioeconomic factors converge with the familial and individual

determinants of homelessness. It is the intermingling of the social and structural factors that produces risk (Rhodes et al., 2005). People with mental illness have difficulty maintaining employment, paying their bills, or keeping supportive social relationships. People with substance abuse problems find their financial resources may be drained or their social relationships may be eroded. Poverty, on the other hand, is a major underlying factor in homelessness; the concepts are synergistic and interrelated (Baer et al., 2003; Lillian Gelberg & Arangua, 2006; Levy & O'Connell, 2004).

Poverty is pervasive throughout the country, yet some unique attributes are present in rural America. Fitchen (1992) has identified three intersecting trends in rural poverty: erosion of rural employment and earnings, increase in single-parent families, and migration of low-income urban people to small towns (Fitchen, 1992). The relationship between homelessness, poverty, unemployment, and depressed rural economies more than mental illness or drug/alcohol abuse is the source of most rural homelessness (First et al., 1994). These authors found that the reasons for homelessness in rural areas were primarily economic with 45% of people in their study reporting eviction, problems paying rent, and unemployment as the primary factor resulting in homelessness. Family problems were cited by 30.4% of respondents (First et al., 1994). Fitchen (1992) conducted research in rural upstate New York among people who, while not actually homeless at the time of their interview, were deemed to be on the edge of homelessness. "This approach has an advantage in that it contextualizes homeless people within their communities, connects their past or anticipated homelessness with other facets of their lives, and sets the whole issue of rural homelessness within the context of the poverty that drives it" (Fitchen, 1992:178).

The distribution of rural housing trends makes poor people vulnerable to homelessness. Urban gentrification, suburban residential development, a limited supply of cheap rentals,

increase of second homes in rural areas, and the collapse or condemnation of old neglected buildings all impact the availability of affordable housing in rural areas. Fitchen (1992) suggests increasing the number of small-town scattered-site public housing, providing federal rent subsidies, and protecting and encouraging home ownership as solutions to ending rural homelessness.

Political factors also unjustly affect poor women and their risk of becoming homeless. Many become homeless when they leave an abusive family situation. One study found domestic violence cited by more than half (57%) of homeless parents as a reason for homelessness (Nunez & Fox, 1999). Maintaining custody of children is a major challenge for homeless mothers when poverty, homelessness, and substance abuse are considered by some courts as negligence or dangerous living conditions (Steinbock, 1995). Placing children in foster care has often been the child welfare system's response to family homelessness and substance abuse when the goals of federal safety net programs fail. The manner in which these structural factors shape the culture of homelessness needs further exploration.

Social Factors Associated with Homeless Women

Finally, the social and family network appears to further frame the complex nature of the issues faced by persons who are homeless. Rossi (1989) claims that "...the network of kith and kin is the last line of defense against homelessness; the homeless, in turn, are apparently those for whom this network has been destroyed in a process no doubt strongly tied to disabilities such as alcoholism or mental illness." (Rossi, 1989:29) Homeless mothers, in particular, are generally isolated and alone and lacking a social network. Social support includes the number of people they have available to help them and also the strength of that support (Tischler et al., 2007). They

have limited support from family and friends and are less likely to use them for assistance. Anderson and Rayens (2004) found that "...the family of origin provides a basis for the development of future interpersonal relationships and support networks" (Anderson & Rayens, 2004:20). According to Metraux (1999), family instability, defined as households in which either parents or children are absent from the household for extended periods of time, contributes to homelessness among young mothers. Their research supported the notion that provision of stable housing was one of the most important solutions for preventing subsequent shelter stays: "Although housing cannot remediate problems such as experience with domestic violence, for example, it can provide an atmosphere more suitable to addressing these problems, and it can prevent a single homeless episode from becoming a series of repeat stays." (Metraux & Culhane, 1999:392) Bassuk (1990, 1993) and Shinn (1998) concur that many women who are now homeless may have been abused or severely deprived as children and come from disrupted families, therefore, as adults they are less able to depend on parents, siblings, or extended family.

The women's relationships with partners may involve intimate partner violence, comprised of physical or emotional abuse (Baker, Billhardt, Warren, Rollins, & Glass, 2010; Browne, 1993; Wesely & Wright, 2005). Nunez and colleagues (1999) found that "Among [homeless] parents who lived with a spouse or partner, more than three-quarters (76 percent) left for domestic violence, overcrowding, or disagreement reasons." (Nunez & Fox, 1999:293). Children in foster care present a particular challenge when they "age out" of the foster care system, leaving the young adult vulnerable to homelessness with few, if any, family or social support networks (Fowler, Toro, & Miles, 2009; Steinbock, 1995).

Sara, a talkative, 32 year-old woman at the shelter, explained to me that she had been diagnosed as manic-depressive at the age of 15. She had been very close to her chronically ill

mother until her death in 2001. Of her father, she said, “We just don’t get along.” Of her relatives living in the area, she lamented, “I’m homeless. All these relatives and I’m homeless.” When homeless mothers were asked to name three persons they can turn to during times of personal crises, only a third were able to name at least three people who they could depend on and 22% were unable to name any supports. The remainder named one or two persons and many in this group mentioned a recent shelter friend or professional contact (Bassuk, 1990). The lack of positive and enabling social networks (Bassuk, 1993) coupled with extreme poverty, isolation, and residential instability may contribute to relationships in which homeless women are more economically and socially dependent on men and more apt to remain in dysfunctional and abusive relationships (L. Weinreb, Goldberg, & Perloff, 1998). The role social networks play in framing the ideas, beliefs, and concerns of homeless women and their children is essential in understanding the culture of homelessness.

Shelters

Throughout this chapter I have mentioned that some homeless women are in shelters and others are unsheltered, either staying on the streets, in their cars, or “doubling-up” with friends or relatives. The focus of my research was on sheltered women since I conducted interviews among women staying at an emergency shelter. Shelters vary; some only allow single men or single women, others accept families. Some require the residents to leave early in the morning and to return daily to wait in line for a bed, and others operate on a “first come-first served” basis with a stay limit. There are “no-freeze” shelters that are open only during cold periods of time in the winter to assure that homeless people are not on the streets and at risk for hypothermia. Shelters also vary in their tolerance of the use of substances. Some are completely “dry” shelters

and no one is allowed to stay there under the influence of drugs or alcohol; they can be sent for random drug tests or given a breathalyzer test to assure that they are not using substances and they can be dismissed from the shelter if they are caught using. Most shelters that allow families are “dry” shelters. There are also “wet” shelters that permit people to be using drugs or alcohol if they are not disruptive to the other residents. One provider I interviewed called the shelter where he works a “damp” shelter. That means they follow a harm reduction model and they tend to allow people to stay for the night under the influence if they are not causing problems for the other residents, are not violent, and are not harmful to themselves or others.

Needless to say, shelters are classic examples of institutions. Post-Modern theorists such as philosopher John Searle provide an architectural framework that is useful for understanding the concept of institutions (Searle, 1995). In his 1995 book entitled, *The Construction of Social Reality*, Searle pointed out that institutions have certain universal characteristics that make them distinct. For example, they have an impact on individuals through their use of power. The staff at shelters has significant power over the residents and the ability to enforce rules. Institutions are formed by collective thought and intention. They have intentionality, meaning they have a purpose. They are systematically related to each other. Some have physical properties such as a physical building, offices, and employees; such as a homeless shelter. These are often called corporate institutions; they have agency versus distributed institutions, such as marriage or religion. Members of the same institution speak a common language. I found the language of the shelter revolved around housing terms like HUD or Section 8. They often have objective status. Searle describes institutions as a social reality. By this he means that a fusion occurs when people collectively get together and create norms for society. These norms fuse the relationship between something and an idea resulting in an institution. Thus, the power comes

from the agreement among people or the norm of what people think they “should” do. This relationship creates a social reality that is an institution. Institutions are social phenomena that are based on the combined intentionality of those who make use of them. Therefore, when groups of people work together with the same ideas, goals, and thoughts they form a collective and a social reality. A homeless shelter is an ideal construction of an institution with its normative values, power structure, and social and behavioral activities of the staff and residents.

Homeless families are more apt to stay in shelters than on the streets (Bassuk, 1990; Glasser & Bridgman, 1999). Only 4% of homeless families have stayed on the street at some point in time (Nunez & Fox, 1999). At times being in a shelter is a comforting, safe option, away from violence or domestic disruptions, while on the other hand, staying in a shelter provides its own stressors and possible damaging effects on families (Tischler et al., 2007). Being sheltered may affect a woman’s identity (Sargent, 2011) but women who are sheltered are less likely than unsheltered women to have mental illness and substance abuse problems and reports of physical assault (Nyamathi et al., 2000). Since 2007, the annual number of people using homeless shelters in principal cities has decreased 17 percent (from 1.22 million to 1.02 million), and the annual number of people using homeless shelters in suburban and rural areas has increased 57 percent (from 367,000 to 576,000) (U.S. Department of Housing and Urban Development, 2011). Emergency shelter stays in suburban and rural areas have decreased, allowing for more people to utilize services in a shorter span of time.

Wasted time, unsupervised activity, lack of privacy and of opportunity to establish a family routine are all cited by homeless mothers as effects of staying in a shelter (Friedman, 2000; Hausman & Hammen, 1993; Perlman et al., 2012). Homeless mothers feel they lack control over their own lives and the lives of their children.

Shelters can evoke mixed emotions and serve discrepant purposes. In Alisse Waterston's (1999) account of women at Woodhouse, a facility for women with mental illness, she describes:

"The contradictions are dizzying. Woodhouse women are at once vulnerable and strong, failures and survivors. They are at once in need of 'help,' 'healing,' and 'teaching,' a paternalistic and infantilizing approach, and at the same time they need respect, freedom and autonomy, independence. Woodhouse is at once a home that nurtures, heals, cares, embraces, and a precarious institution that names and labels, constructing otherness and essentializing women's experiences with poverty, homelessness, mental illness. Just as the women signify our social problems, Woodhouse is emblematic of our social solutions, always fragmented and partial" (Waterston, 1999:142).

Relationships between residents and among residents and staff are also both positive and negative, resulting in struggles of power and social control. Residents of shelters may develop strong attachments to other residents, often relying on each other for services (i.e., transportation, babysitting) or resources (i.e., money, cigarettes). Despite feelings of powerlessness over shelter staff, a lack of social support networks may result in childlike dependence on the staff (Hill, 1991). On the other hand, shelters have been described as institutions, with a strict set of rules, regulations and standard procedures (Searle, 1995; Waterston, 1993). Staff maintain social control and power over residents with authority to inspect rooms, evict residents, enforce strict curfews, assign chores, and reward and discipline actions (Waterston, 1999). Susan said, "I feel like I'm treated like a child like I can't be trusted, you know. Um, like locking the doors at 8 o'clock...they know that you have no place to go so and they got these three warnings and you're out. You feel like you can't speak up and say 'I don't think this is right' but you're never going to change the system either so what do you do?"

Health Issues

One can ask whether health problems cause homelessness or whether homelessness causes health problems? I would argue that housing is health; persons who are adequately

housed are healthier than homeless persons. Much has been written about both the physical and mental health issues of homeless persons (Baer et al., 2003; Daiski, 2007; Lillian Gelberg & Arangua, 2006; Lillian Gelberg & Linn, 1989; S. W. Hwang, 2001; Levy & O'Connell, 2004; Lewis, Anderson, & Gelberg, 2003; Schanzer et al., 2007; Wright, 1990). Susser and colleagues (1993) claim that homeless persons have physical health problems but no data suggest that poor physical health is a risk factor for homelessness. In general, the physical health issues among urban and rural homeless persons are similar, with both groups having more health problems than their poor, housed counterparts (Post, 2002; Trevena, Nutbeam, & Simpson, 2001; L. Weinreb, Goldberg, & Perloff, 1998; L. Weinreb et al., 2007; Whitzman, 2006). Health issues, including pregnancy, sexually transmitted infections, and domestic abuse, among homeless women are particularly prevalent (Bassuk et al., 1998; Craft-Rosenberg et al., 2000; Lewis et al., 2003; L. F. Weinreb et al., 2006; Whitzman, 2006). Mental health and substance abuse has been reported less often among homeless persons in rural areas than in urban areas and women with children in shelters are less likely to have mental health and substance use problems than solitary women (Bassuk et al., 1998; Smith & North, 1994; Winkleby & Boyce, 1994).

Self-reported health status among homeless women and children has consistently found reports of fair to poor health (Roth & Fox, 1990; Schanzer et al., 2007; Trevena et al., 2001; L. Weinreb, Goldberg, & Perloff, 1998). Some authors (Levy & O'Connell, 2004) found that when homeless persons are asked about their physical problems they tend to focus on their feet, teeth, and eyesight rather than on acute or chronic illness. Weinreb and colleagues (1998) conducted a case-control study of 293 homeless and 334 low-income housed children aged 3 months to 17 years and their mothers in Worcester, MA. Homeless children were reported to experience a higher number of acute illness symptoms, including fever, ear infection, diarrhea, and asthma.

They are also more likely to exhibit behavior problems, poor academic achievement, mental illness, and trouble sleeping (Danseco & Holden, 1998; Steinbock, 1995).

Health problems differ for persons living on the streets compared with those staying in shelters. In general, homeless persons who stay in shelters have fewer health problems than unsheltered (Lillian Gelberg & Arangua, 2006; Lillian Gelberg & Linn, 1989). Living on the streets introduces health problems such as nutritional deficiencies and exposure to harsh environmental conditions including extreme weather and pollutants leading to dehydration, sunburn, frostbite, ulcers, and hypothermia (Lillian Gelberg & Linn, 1989; Raoult et al., 2001; Whitzman, 2006). Foot and skin problems such as peripheral vascular disease and leg ulcers caused by excessive walking, sleeping upright, being on their feet for long durations, inappropriate footwear, and poor hygiene may also occur in persons living on the streets (Raoult et al., 2001). On the other hand, living in shelters can increase the risk of acquiring communicable diseases such as tuberculosis, influenza, and other respiratory and enteric infections (Levy & O'Connell, 2004).

Poor physical or mental health may adversely affect social and structural aspects of the homeless person's life. For example, an individual with rheumatoid arthritis may not be able work or an individual with mental health problems may have worn out their welcome in a family member's household. Health problems are magnified many times by lack of social support, lack of housing, poor nutrition, lack of economic support, and lack of access to medical services (Baer et al., 2003). Over two thirds of women with disabilities or chronic health problems live below the poverty line (Whitzman, 2006).

Access to Health Care

Homeless people are plagued by multiple internal and external barriers to obtaining effective health care, including primary care (Plumb, 2000; Rabiner & Weiner, 2012). Among the external barriers are a lack of or insufficient medical insurance, lack of transportation to medical providers, limited availability of providers, clinicians who provide inconsistent, incomplete, and insensitive medical care, long waiting lists, not knowing where to obtain services, low-quality social services, lack of coordination of services, language barriers, and health literacy (Craft-Rosenberg et al., 2000; S. W. Hwang, 2001; Lewis et al., 2003; L. Weinreb, Goldberg, Bassuk, & Perloff, 1998; Whitzman, 2006).

Health services in rural areas are often scattered and physical access is a problem (e.g., lack of transportation, no family or social networks to rely on, and lack of access to a telephone)(First et al., 1994; Whitzman, 2006). Internal barriers include the denial of health problems and the intense pressure to fulfill competing needs, such as caring for their children, obtaining food, clothing and shelter and maintaining safety (Plumb, 2000). Nonadherence to therapy and delays in seeking care also result in poor health. One quarter of homeless persons reported needing to see a doctor in the past year but they were not able to do so. Moreover, many seek care where there is no continuity (e.g., emergency departments, outpatient clinics, community health clinics). Women put off non-emergency medical care which leads to chronic problems being neglected (Whitzman, 2006). Often they feel they have too many other financial or time priorities. A regular source of care -- a "medical home" -- was found to be more important than health insurance (Lewis et al., 2003). Schanzer et al. found that homeless persons who remained in the system had poorer health status than those who moved out of the system (Schanzer et al., 2007).

Prevention

In recent years there has been a shift in homelessness prevention efforts from a focus on providing temporary housing, such as emergency shelters, to rapid re-housing through provision of upfront rental assistance and transitional case management (Culhane, Metraux, & Byrne, 2011). Legislation signed by President Obama in 2009 entitled, The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, was enacted to amend and reauthorize the McKinney-Vento Homeless Assistance Act

(<https://www.onecpd.info/resource/1717/s-896-hearth-act/> accessed September 2, 2013). One of the purposes of the HEARTH Act is to consolidate the various homeless assistance programs that were available under the previous McKinney-Vento Homeless Assistance Act; this includes programs such as supportive housing programs, safe havens program, Section 8 for single-room occupancy, and shelter-plus care programs. The HEARTH legislation develops three homeless assistance programs: the Continuum of Care (CoC), Emergency Solutions Grant Program (ESG), and Rural Housing Stability Assistance Program (RHSP). HEARTH also changes the Housing and Urban Development (HUD) definition of homelessness and chronic homelessness and establishes a HUD goal of getting individuals and families who become homeless into permanent housing within 30 days.

One example of an attempt to rapidly re-house individuals and families was a component of the American Recovery and Reinvestment Act of 2009, called “Homelessness Prevention and Rapid Rehousing Program” (HPRP) which allotted funding in homelessness prevention to decrease the need for shelters and quickly relocating individuals and families back into rental properties as soon as possible with minimal economic assistance. Although no longer available,

HPRP funds were developed to provide financial assistance to States and housing agencies to enhance their ability to prevent homelessness.

As National efforts to prevent homelessness are developed and implemented, some effective interventions to end homelessness and improve health are ongoing. Most of these begin with provision of, and assistance with, housing. The “Housing First” methodology is designed to move homeless families into permanent, affordable, rental housing as quickly as possible, then provide time-limited support services after they have been relocated out of the homeless services system (Henwood, Stanhope, & Padgett, 2011; McNaughton Nicholls & Atherton, 2011; Tull, 2004). The philosophy is that if an individual has a place to live then other factors in their lives will also improve. First, and foremost, is preventing loss of housing, and second would be minimizing recurrent bouts of homelessness. Some prevention strategies that have found to be effective are: 1) housing subsidies; 2) supportive services coupled with permanent housing; 3) mediation in housing courts; 4) cash assistance for rent or mortgage arrears; and 5) rapid exit from shelter (Burt, Pearson, & Montgomery, 2007; Shinn et al., 1998) and community support (Nemiroff, Aubry, & Klodawsky, 2011). Families with short-term problems could be offered solutions that could be resolved with minimal resources such as cash assistance to prevent eviction and cover rent, mortgage, or utility arrears, also in-kind services and budget counseling (Burt et al., 2007). These actions, and the provision of support services for persons with personal or individual needs, such as mental health or substance abuse issues, will also benefit from these supports.

Interventions

The goal of interventions to end homelessness is an improvement in overall health and wellbeing of persons at risk for homelessness. Research has been conducted to determine

whether provision of housing was associated with improvements in social support, community integration, meaningful activity, and other aspects of quality of life of formerly homeless people with mental illness (Nelson et al., 2005; Slesnick & Erdem, 2012). Nelson and colleagues (2005) found that after supportive housing, individuals reported greater feelings of independence and well-being, development of strengths and a better vision for the future. They had positive change in the quality of their relationships, improved community participation, more feelings of independence, more stable lives, and better access to resources such as food and clothing (Nelson et al., 2005).

Summary

Much is known about homelessness including who becomes homeless and why they become homeless, from the point of view of researchers. Although many have studied homeless persons and their experiences, little is known about the personal fears, risks, and vulnerabilities of homeless women and children and how these are impacted by social, economic, and political factors. Narratives of homeless women's lives will provide insight into the cultural context in which they live and their own personal lived experiences with homelessness. Knowledge of these factors will assist professionals to help homeless persons improve their living situation and the lives of their children. In turn, prevention efforts can be instituted.

In terms of what we know about homeless women, we know there are at least two kinds of homeless women: solitary women who suffer with more mental health and substance abuse problems and mothers with or without their children. Most of the women with custody of their children tend to stay in shelters and experience episodic homelessness. Their reasons for homelessness are more often due to economic, political, and social factors such as poverty,

unemployment, or domestic violence. These women experience common feelings of powerlessness and loss of social control in their own family relationships as well as in their relations with shelter staff. They are at the mercy of the shelter staff with numerous rules, policies and procedures imposed upon them but yet they are grateful for a roof over their head and a safe place to stay. Homeless women and their children may have health problems that facilitated their homelessness and these may cause concern, worry, and fear in their daily lives, but it may not be the sole focus of their being. Their perceived risks and vulnerabilities are not known. For example, is their fear that they will not find housing? Will they get sick? Will they not be able to care for their children? Will they lose custody of their children?

Based on the synthesis of information of what is known about homeless women and their families, I believe that there is a gap in our knowledge of what women, themselves, believe to be the issues affecting their lives and their health. Only a clear understanding of the impact of structural and social factors on homeless women and their children, from the emic perspective, can assist in alleviating this national crisis.

Chapter 3 – Theory and Methods

Using ethnographic methods, this research employs a critical medical anthropology theoretical perspective to contextualize the lives of homeless women. Their stories provide the trajectory of their lives in their own words and set the stage for understanding their perceptions, beliefs and concerns about being homeless, as well as how they experience homelessness. This research further seeks to understand what homeless women perceive as their risks and vulnerabilities associated with being homeless and how this affects their physical and mental health. My research utilizes the discourse of homeless women to frame a research question within the theoretical context of critical medical anthropology and Douglas and Wildavsky's theory of risk (Douglas & Wildavsky, 1982).

Theoretical Background

To guide my research, I draw from two theoretical perspectives that create a basis for my work. These theoretical models, while potentially conflicting when combined, can be layered to better contextualize the risk associated with homelessness. I first explore the structural level of risk using critical medical anthropology which examines how broader social, economic, and political factors influence and shape individual health, health-related behavior, and the social and physical conditions that impact health (Baer et al., 2003). Then I utilize Mary Douglas' theory of risk to explain the experiential level of perceived risk which includes the more personal or individual factors that affect homeless women (Douglas, 1992; Douglas & Wildavsky, 1982).

This research is an ethnography of the lives of homeless women residing at the *Entré* emergency homeless shelter in rural northeastern Connecticut from their perspective. My aim is to understand, through life stories, the trajectories the women have taken, the experiences that have led to their current situation, and the impact of structural factors on their lives. Coupling

the emic perspective with critical medical anthropology theory that examines how social inequalities experienced by homeless women in their everyday realities are influenced by social, political, and economic factors provides a better understanding of the culture of homeless women. Although much has been written about the causes of homelessness they are primarily constructed from the etic perspective and less is known about the actual lives of homeless individuals and the impact their history has had on their ideas, beliefs, and concerns and how this influences their overall physical and mental well-being. Likewise, incorporating stories from their own perspective provides important insight into the effects their mental and physical health has on their life course and their outlook on the future. On the structural level, these perceptions are influenced by the social, economic, cultural and political factors, including poverty, unemployment, and a lack of affordable housing, that affect their lives. On the individual level, these perceptions will be based on their lived experience and the challenges of their everyday lives. Individual level factors such as physical health problems, mental illness, substance use disorders, and interpersonal violence and abuse put the women at risk for homelessness. Thus, the interaction between the macro and micro issues is explored. In particular, I examined the predisposing factors that uniquely influence their life histories: poverty, instability, and dysfunctional natal families. These factors are exacerbated by their own personal and familial struggles with poor physical health, substance abuse, mental illness, and violence. The specific structural factors unique to rural areas, including less access to medical care, transportation and isolation are described.

Interested in the inequalities that arise from relations of power, I build from Mary Douglas's theories of risk, to provide a unique lens through which we can begin to better understand homeless women's lived realities (Douglas, 1992; Douglas & Wildavsky, 1982).

Douglas and Wildavsky (1982) in their book entitled, *Risk and Culture*, describe their cultural theory of risk perception which revolves around social processes. They construct their model by creating a dichotomy between what they term the “center” and the “borders”. The center includes the institutions that hold power and influence. The borders are more vulnerable and they hold less power. This typology is useful in our discussions of the social factors that affect risk perception because we can explore what constitutes the social reality that forms the institutions of power and how this affects those at the borders.

Douglas’ discussion of risk and vulnerability explores the culture of homelessness because it integrates what homeless women experience as the risks in their lives on the structural level (i.e., risk in not finding employment or risk of being evicted) with their vulnerability to individual social exclusion and isolation (Beck, 1992; Rhodes & Simic, 2005).

Although homelessness is brought on by poverty, not all poor people are homeless. Asking ‘what are the factors that put an individual living in poverty at risk for homelessness’ explores their vulnerabilities. Risk is a dynamic process and women who are at risk for homelessness are confronted with risky situations throughout their lives, particularly in their social interactions and their relationships. Their ability to challenge the risks and face certain obstacles or power dynamics can define how they deal with homelessness. A woman who is poor may be able to pay her rent, keep her children fed and in child care, and get to work but if she is living with a partner who abuses her, she may be at risk for homelessness. Furthermore, she may be relying on a partner to assist her financially but if he has a substance abuse problem or gets incarcerated, she and her children may be left without shelter.

The notion of risk is apparent when considering the past, present, and future of the women’s lives. For example, in their past during childhood many of the women experienced

serious risk from alcoholic parents or physical or sexual abuse. At the present time while living at the shelter they risk not finding a place to live or being unable to secure a job. Their future risks revolve around their worries or concerns about returning to their former friends and rejoining a negative way of life. According to Douglas' theoretical perspective, the manner in which the women experience these periods in their life form emic risk.

The issue of power is also evident in personal relationships or in a structural sense, stemming from a hierarchy created by societal processes of entitlements, education, class, or individual factors such as gender, race, or ethnicity. Women may be dominated by a partner and suffer from interpersonal violence at home. Structurally, women of color or lacking in education are subjected to a multitude of subordinate roles and discrimination in any number of circumstances, including employment and housing. Their ability to cope with oppression and power differentials in society depends on their agency and resilience. Through my interviews with women who had already faced numerous risks and losses throughout their lives, in childhood and adulthood, I am able to explore their vulnerabilities and resilience.

To thoroughly understand the "risk" perception of homeless women and the culture of homelessness requires an expansion of knowledge beyond the epidemiological exploration of risk factors. According to Inhorn (1995), "epidemiology 'blames victims' for their 'risky' behaviors; anthropology examines the macro-level conditions giving rise to those behaviors. Epidemiology generates 'risk' and medicalizes life; anthropology critiques 'risk' and attempts to alleviate human suffering." It is the anthropological construction of risk that will be explored in this research.

In my research, in addition to exploring the perspectives of the homeless women, who constitute the "borders" in Douglas' view, I also solicited the views of the providers of shelter

services including the staff and housing service providers who are at the “center”. The providers are in decision-making roles and have the ability to influence the future of the women’s lives. They can exert power over the women and control whether or not they receive a housing subsidy or get on a waiting list for Section 8. They can make them vulnerable to oppressive demands while staying at the shelter or in their quest for employment or receipt of social services, such as mental health care. Understanding the emic perspective of both the homeless women and the staff is important because the relationships between these groups and their perceptions of homeless women are quite different and warrant understanding for a more balanced and contextualized view of the culture of homeless women.

Aims

My aims are to 1) provide an ethnographic depiction of the lived experience of homeless women in rural northeastern Connecticut from the emic perspective; 2) identify the constructs that put them at risk for homelessness throughout their lives; 3) describe the themes that define who homeless women are on an individual level; and 4) contextualize their lives within the domain of structural influences of social, economic, and political factors. Secondary aims are to explore the themes in their lives that affect their ability to cope with their situation and to identify the power inequalities and vulnerabilities among the women staying at the shelter and the shelter staff. These aims will provide an understanding of the specific cultural domains that the women themselves ascribe to the causes of homelessness. Interviews with the women residing at the emergency shelter and those who influence their lives in terms of their basic housing needs will further enhance our appreciation of the culture of homeless women and the dynamic of power that exists among these groups. Moreover, there may be aspects of

homelessness among women living in rural areas that are specific to the geographic setting and may require in-depth exploration.

Methods

Study Population

The study population included women staying at the *Entré* Emergency Shelter located in a town of over 4000 people in northeastern Connecticut, near the Massachusetts and Rhode Island borders. The area is often referred to as “the Quiet Corner” of the State. Shelter residents primarily include single men and women, and parents and children (6 months to 21 years of age) from a 14 town rural area in Northeast Connecticut (population approximately 90,000 persons; 2006 census estimate). Interviews were also conducted among a convenience sample of housing providers from a variety of shelters and agencies in the State.

Setting

The Shelter is an emergency facility with 60 beds and a 60-day stay limit. It is a family shelter with rooms on the second floor for single men and single women. The third floor is for families. If couples are not married, they need to stay in separate rooms. Even if they come with children, only the biological parent, usually the mother, can stay with the children. A few times there were fathers there alone with their children. This is one of the few shelters in the State where single fathers can stay with their children. Each floor has one shared bathroom with a tub. One resident is assigned to clean the bathroom every day as their chore so it is spotless. The single rooms each have two sets of metal bunk beds and dressers. The rooms were small and confined, but not untidy. They looked like college dorm rooms. The windows were closed and covered with a shade to block the light making it feel smaller and more closed in. The family rooms were much larger with plenty of space for the children to play. They seemed airy and

bright with large windows. They also had bunk beds and dressers and closets and dirty walls. The family rooms were cluttered with suitcases, clothing, and toys. There were no pictures on the walls but the families brought many familiar possessions with them so the children would feel better about being in a strange, unfamiliar place. Some brought stuffed animals, pillows, or their child's favorite toy. There were no locks on the doors.

Preliminary Studies

In March 2007 I began to visit the *Entré* Emergency Shelter with B. Grace Sullivan, PhD, APRN. At that time, Dr. Sullivan was a clinical nursing professor in the UCONN School of Nursing and her nursing students were participating in one of their clinical rotations at the Shelter. The purpose of my visits was to become familiar with the facility and to get to know the staff and residents. I went to the shelter at dinnertime to eat and talk with the informants. I did not take notes while speaking with residents but wrote field notes after each visit. Between March and November, 2007, I spoke with at least 20 women; 11 who were at the Shelter with children and 9 who were either single or with a partner. Of these, 14 were White, 4 were African-American, and 2 were Latina. Eight of the women were at the Shelter alone (two of the women were partners). Many of the women had children living elsewhere. One woman was at the Shelter with her husband and they did not have any children. Six of the women were there with their minor children and no partner, and five were at the Shelter with their spouse and children.

Pilot Interviews

After gaining some trust and familiarity with the facility, its policies and procedures, and the staff and residents, I began informal interviews with a convenience sample of female

residents. These interviews were audio taped. The audio taped interviews were conducted in a private office on the second floor of the Shelter to avoid noise and disturbances. The participants were provided with an information sheet describing the purpose of the research, that the interviews were voluntary, and telephone numbers to call for further information. The women were not compensated for the interview. The participants were encouraged to talk about their lives, how they became homeless, and their health issues. During the interviews, they were prompted with questions about their experience in the Shelter, with the staff, as well as inquiries into their health and their relationship both with family at the shelter and the other residents. The interviews each lasted approximately one hour. The interviews were transcribed verbatim. This project was approved as a student research project through the University of Connecticut Institutional Review Board (IRB).

This preliminary work provided a basis and laid the groundwork for my dissertation research. Several broad themes were identified that support the current literature on homeless women and provide a framework for identifying cultural domains during the informal and semiformal interviews. Specifically, women I met were concerned about housing, employment, children, partners, health, access to health care, and issues at the shelter. These themes were intertwined in the women's physical and mental health; some women were unable to work or had lost custody of their children due to their physical or mental conditions. Many were at the shelter after leaving a violent home situation. These initial topics needed further exploration among a larger group of women to assure they represent cultural consensus among the women. No interviews were conducted with shelter staff or policy makers during this preliminary work.

Research Design & Methods – Homeless Women

I used qualitative research methods to create an ethnographic account of the descriptions homeless women have of their shared ideas, beliefs, and concerns (Handwerker, 2001). Using a cultural consensus model for informant agreement, I was able to identify the shared culture of the homeless women I studied (Handwerker, 2002; Romney, Weller, & Batchelder, 1986). First, I was a participant observer, spending time in the shelter among the community of homeless women. Second, I conducted 30 in-depth interviews with women to contextualize their life histories. These interviews were guided by a set of questions that explored the women's family life as a child, school years, teenage experiences, relationships with partners or spouses, work experiences, motherhood (if appropriate), goals and desires for their lives, and factors that led to their current homeless situation. The residents' views of staying at the shelter, the shelter rules, and shelter staff were also incorporated into the interviews. All the women were asked if they considered themselves to be homeless and about their perceptions of homelessness. Informal and semi-formal interviews were also conducted with a sample of shelter staff and housing services providers from several different homeless shelters and agencies in the State. I also used systematic cultural assessment methods including free-lists to explore what the term homelessness meant to the women and which terms apply to their lives (D'Andrade, 1995; Handwerker, 2002).

The guides for these interviews (discussed later in the chapter) were developed based on the interviews of the women and their perspectives of the shelter, but it included a discussion of how the facility functions, the staff and residents' roles and responsibilities, as well as their perceptions of the risks associated with homeless women. These data were used to identify the cultural domains of the informants (Handwerker, 2002; Romney et al., 1986).

Research Sample

This study utilized non-probability sampling since the data to be collected were cultural data (Bernard, 2002; Handwerker, 2001). According to Handwerker (2001) selection of informants can be subjective, arbitrary, and non-random; a random sample is not necessary for cultural data collection because all individuals who participate in a shared social world are cultural experts and can provide reliable cultural data. The selection of the sample was one of convenience, based on the availability of the women at the time I was at the shelter and their willingness to be interviewed.

Field Notes and Participant Observation

Throughout the years that I went to the *Entré* shelter I recorded notes after each visit. These notes were either hand-written or audio recorded on a digital recorder. The notes were reviewed for content to enhance or contextualize events and conversations that transpired during the visit or the interview. During these visits I conducted informal, unstructured interviews with shelter residents (men and women), which were not audio recorded.

In-depth Interviews

The purpose of the 30 in-depth interviews was to identify cultural domains shared among the homeless women (Culhane et al., 2007; Handwerker, 2001; Romney et al., 1986). The interviews were conducted with a convenience sample of women staying at the shelter with a partner or alone, including those who had children and those who didn't, and women staying at the shelter with their children. Only women over the age of 18 years were included. The women who participated were approached either by the shelter staff or by me and asked if they would be

willing to be interviewed. It was explained that I was a student conducting research on homeless women and I was interested in hearing about their lives. Because I had been going to the shelter as a participant observer for several years, I was familiar to many of the residents and they were willing to speak with me. Although the shelter has a 60-day limit, I went to the shelter every week for several months in a row and I saw the same people repeatedly. Moreover, often someone who had left the shelter returned a few months later. Once they had left, they could not return for 90 days. During my preliminary work on one or two occasions I had interviewed women on their first day at the shelter and I found they were quite upset and not very willing to talk. Thus, during the formal research period I often waited until I had seen the woman more than once at the shelter before I approached her and asked her if she wanted to participate in my study. This increased the likelihood that she would feel comfortable and would be willing to talk to me.

The interviews were conducted in one of the offices or activity rooms on the second floor of the shelter at a time that was convenient for the participant. These were private rooms where other residents could not hear our conversation and the interview could be kept confidential. Several times the woman's child was in the room during the interview. Depending on the age of the child, this affected the interview's flow and continuity. At times it was disruptive but the women had little choice but to have the child in the room with them during the interview since the shelter rules prohibited the woman from leaving her child with any other resident. The child always had to be with the mother. There were a few exceptions to this, for instance, if one of the staff members was leading an activity for the children at the shelter, then the child could participate in the activity and the staff person would be responsible for them. In general, the child returned to the mother before the interview was completed and interrupted the interview. If

the woman was at the shelter with her husband or boyfriend, then he would watch the child or children while she participated in the interview. If the children were teenagers they were able to be left alone in their rooms or in the main living area of the shelter and the woman could participate in the interview without interruptions. Children who were in the room during the interview usually were entertained with toys, crayons, books, pipe cleaners, or other activities that were in the room where the interview took place. There were breaks in the conversations when the children needed attention or were speaking to their mother. For the most part, the children who remained in the room during the interview were under the age of 5 and the women were able to speak freely without concern that the child would understand what they were saying or be disturbed by the conversation. One of the women had her 12 year-old son in the room and she did not seem to open-up and discuss much about her life. I asked her several times if she would prefer to talk without him in the room and she declined saying she had no secrets from him. Her interview was quite short and she did not discuss her family or any details about her life, leaving me to believe that she was not comfortable talking in front of him. It is also possible that she did not want to discuss personal issues and her son, as her excuse, made that easier. Two of the interviews were conducted on the third floor where the families stay. One was conducted in the woman's room with her young daughter present. The other was in the hallway because her son was asleep in their room and she needed to stay nearby. This interview was very difficult to understand on the audiotape because there were so many disruptions and so much noise.

Each woman was asked to provide informed consent to be interviewed (Appendix B). The interviews were digitally audio recorded. The women were assigned a unique code number

and only the code number was used to identify the woman on the audio-recording and in the transcriptions.

Protecting the Women's Identity

It was my intent to protect the identity of the women to the greatest extent possible. They had all provided consent to be interviewed and they were aware of the purpose of the interviews. I found during my analysis that if I described a particular woman or contextualized a quote in too much detail, I could potentially identify the women. The town in which the shelter is situated is a small community and it is possible that details could expose an individual person. Therefore, I have omitted some potentially informative background information or I slightly altered the facts in the quote or description to minimize the likelihood of identifying anyone. I have attempted to maintain the women's anonymity as much as possible without losing the gist of the story.

Although only the code number was used in the interviews and transcriptions, after all the analysis was complete I debated whether or not to assign each woman a pseudonym. The code numbers alone can be quite impersonal and I wanted the reader to get a feeling for who the women were. I recognized that the false name that I assigned to each woman was based on my own unique perspective of who the woman was, what she looked like, how she behaved, as well as her nationality or race. No one reading the narrative should be able to identify the women since their identity was to be kept confidential. My bias was introduced in the naming scheme I used. So for instance, most of the women were White. Is it possible that I selected names that sounded too "White"? For the few Latina women did I select traditionally Latina or Spanish-sounding names or not? I made an effort to assign names that did not reflect my bias but this was not possible. Each woman was given a pseudonym that I use throughout the ethnography.

Simply assigning a familiar, common name, I hope, gives the reader a feeling of closeness or familiarity with the woman and not an impersonal identity.

Topic Guide

The in-depth interviews were based on the following topic guide (Tischler et al., 2007), domains were identified during unstructured interviews, literature review, and discussions with my doctoral committee (Appendix D). The topic guide included:

1. Events leading to homelessness
2. Experience of homelessness – environment/staff/other residents
3. Mental health
4. Social network and support
5. Coping with homelessness
6. Service needs
7. Shelter experience

The first domain, ‘events leading to homelessness,’ required some participant-led discussions of the woman’s life history including life as a child, school years, teen years, and work experience. ‘Experience of homelessness’ included probing about life at the shelter and ‘Coping with homelessness’ focused on goals for the future. The other topics, such as ‘social network and support’, encompassed women's relationships with their partners, family, and children. The discussion about ‘Service Needs’ included asking the women about what they need to get out of their current situation and what services they have been receiving. All the women were also asked about their perception of homelessness and whether they considered themselves to be homeless. Their perspective was compared to the U.S. Housing and Urban Development (HUD) definition of homelessness to identify whether their own beliefs and

feelings were aligned with a standard definition. This query was important to gain an understanding of the women's view. Specifically, I phrased the question by saying, "Society has this idea of homeless people, do you consider yourself to be homeless? Why or why not?" The general categories in the Topic Guide were used to provide a better understanding of the context in which their current state of homelessness is framed (Appendix D).

Free Listing

In between in-depth interviews, I met with 21 female residents of the shelter, either one-to-one or in a small group, and asked them to provide me with a free listing of their perceptions of homelessness (Bernard, 2002; D'Andrade, 1995; Handwerker, 2001). Specifically, I asked each informant to tell me what homelessness means to her. The women were each given a piece of paper and a pen and were asked to make a list of all the words or phrases they could think of. These lists were used to identify the domains to be studied. The words/phrases they wrote down were analyzed using AnthroPac® (Borgatti, 1992), which generated a list by frequency and alphabetical order (Appendix F). The 21 respondents listed 153 different items. I ran frequencies on the lists created by all the participants to determine how often each item was mentioned. I reviewed the list and regrouped some of the items on the lists if they were similar. The list of terms identified in the Free Listings included words and phrases that the women recorded to describe what homelessness means to them. These terms can be classified into those that describe their feelings and those that they believe other people would use to describe homeless people.

Data Analysis

The audio-recorded interviews were transcribed into Microsoft Word text documents and uploaded into MAXQDA (Version 10; MAXQDA, software for qualitative data analysis, 1989-

2013, VERBI Software - Consult - Sozialforschung GmbH, Berlin, Germany) for analysis. Of the 30 in-depth interviews conducted, 19 were transcribed by Landmark Associates, Inc (Tempe, AZ; www.thelai.com). I transcribed the remaining 11 interviews. The interviews that were transcribed by Landmark Associates were sent to Landmark Associates via email as .mp3 files; 4-5 files were sent as a batch at any one time. These were transcribed by the company into Word documents and returned to me. I reviewed the transcriptions before sending another set of files. Landmark used a pre-agreed upon format (I for Interviewer; P for Participant) for the transcriptions. The transcribers (Bernard, 2002) highlighted and recorded the minute in the audio recording where names were used by the women in the interview so these could be omitted or changed to a pseudonym during analysis. The names the women used were either their own name when they spoke in the third person or if they were quoting someone speaking to them, or the spoken names were of family members, friends, or staff members. These names were removed in the quotes that are used in this dissertation.

Data analysis consisted of qualitative ethnographic descriptions of the semi-structured interviews. The transcribed text files were uploaded into MAXQDA and reviewed for content. Analysis was conducted using a modified grounded theory technique (Bernard, 2002), focusing on patterns and themes that arose from the textual data, as well as from pre-established codes that were identified as constructs from the review of the literature (Bernard, 2002). The codes were developed as an iterative process upon review of the transcribed interviews. After the coding process began, I identified additional codes that I added based on reviewing the interviews. The text files were reviewed and coded at least twice using the code book I developed during analysis (DeCuir-Gunby, Marshall, & McCulloch, 2011) (Appendix G).

Research Design and Methods - Providers

Between October 2010 and October 2011, I conducted semi-structured, open-ended interviews with 13 staff members from shelters, housing agencies, and homeless service organizations. The providers were selected as a convenience sample from the *Entré* shelter and other agencies throughout the State. Providers were contacted and arrangements were made to interview them at a mutually convenient time and place. The interviews were conducted at their work site in a room or office that they selected. Each provider provided written informed consent to be interviewed and to have the interview audiotaped (Appendix C). The length of the interviews was from one hour to several hours. If the interview was conducted with shelter personnel at shelters other than the *Entré* shelter, I was given a tour of the facility and provided with details and information about the shelter. These discussions were informal and not audiotaped.

Topic Guide

A topic guide was used to elicit information on what the providers believe is needed by homeless women, the barriers they face, and what they think homeless women think about being homeless. The questions were open-ended and included the following (Appendix E):

1. What services help them the most?
2. What services are most needed by them?
3. What are the barriers they face to getting these services?
4. What are the primary concerns on the minds of homeless women?
5. How can homeless women change their situation?
6. What specific steps can society take to most help homeless women end their homelessness?

7. In your experience, what do homeless women think about homelessness?

Study Population

A total of 13 providers were interviewed. They included shelter directors, agency executive directors, shelter staff (e.g., case managers, program managers), Housing First for Families staff, Connecticut State Department of Social Services staff, and policy makers at the Connecticut Coalition to End Homelessness. Of the 13 providers, 9 (69%) were women. They represented six different shelters throughout Connecticut, and not-for-profit and State governmental agencies.

Data Analysis for Provider Interviews

I listened to the audiotapes of the provider interviews multiple times and took detailed, copious notes to identify themes and responses to the questions asked on the topic guide. I copied quotes from the interviews verbatim. I categorized the providers' responses to the open-ended questions and identified themes. I present the findings to the question "What do homeless women think about homelessness" in Chapter 4 when I describe the provider's conceptualization of homelessness.

Shelter Visits

During my interviews with providers I visited five different shelters throughout the State. Each was different and unique. Some provided housing services such as transitional housing, housing for veterans, single rooms, dormitory style rooms, rooms for single men or women only, and some were family shelters. One of the family shelters located in the same area of Connecticut as the *Entré* shelter was particularly interesting and the woman I interviewed was

enthusiastic about showing me the shelter and describing their services. Although perhaps not representative of all the shelters I visited, I found it worth describing here. The shelter was located on a busy street in a tired, once thriving, industrial city. In the 1800s, the city was home to a half dozen cotton factories, which have since moved to the South. Unemployment and drug use are the current themes in the local papers. There was a wrought-iron fence around the premises and grass in the front yard that needed to be mowed. The building that housed the shelter was an immense three-story brick structure attached to a church. It had originally been a hospital and then a home for the aged. The provider I interviewed was an experienced nun dressed in habit; but she made it clear the shelter was not part of the church, nor was it funded by the church.

I entered the shelter through a huge wooden door that led into a hallway cluttered with pictures drawn by children, strollers, and boxes of donated clothing. The ceiling was high with wood half way up the walls. Her small office off the main corridor was piled high with stacks of papers. Her desk was so full of papers I could barely see her face behind a desktop computer. She got up to look for some paperwork to share with me only to knock over piles and disrupt the balance of the clutter. I sat on a metal chair next to small desk with a bookcase on it but there was no place to write or lay down my notebook. I put the audio recorder on one of the piles of paper. I kept moving it closer to hear her over the noise of the air conditioner in the room; it was the summer and the tiny office was sweltering. Our interview was interrupted several times by staff asking about documents, bringing the Sister some soup for lunch (despite the heat this provoked a lengthy discussions about the food they served at the shelter), and the phone ringing with calls from people asking if there were any beds available at the shelter.

This particular shelter provides rooms for families; women and children only. There is no maximum length of stay and some families stay for up to two years. They provide food and shelter and other basic needs including clothing received as donations, over-the-counter medications, and diapers. The staff consists of the Executive Director, the Public Relations and Volunteer Coordinator, three Case Managers, an Education Coordinator, tutors to help with homework, a cook, and a social worker who comes to the shelter weekly to provide on-site services and presentations on topics such as parenting and budgeting. The staff makes referrals to local agencies for health care, dental, and mental health services.

The Sister was proud to mention the in-house activities they provide for the families, especially the children, such as after-school time and field trips. They own a mini-van to transport residents to activities, medical and social service appointments. She claims, “there’s no straight line for people in need; they need to go here and there.” After the interview was complete, she took me on a tour of the facility. The ceilings were high throughout the first floor. There were long, narrow rooms with cubicles set-up inside for each family. The families were separated by partial wooden walls and sheets or blankets hanging from the ceiling to separate their area and provide much-needed privacy. Light from a high window could barely make its way into the room through the shroud of the material covering it. There were beds for the women and children to sleep on but the spaces were cramped and full of their meager personal belongings. There were boxes of clothes and other things lining the rooms.

There was a large common area that served as a dining area and a place to congregate. There were two girls in the room, perhaps about 8 or 9 years old, looking at books. There was an old computer on a table for use by the residents, perhaps for the children’s homework or for the women to look for employment or housing. The walls were littered with artwork done by the

children. A board contained a list of the week's activities. We took an old, creaky elevator to the second floor; it looked like a hospital ward in an old movie with a wide hallway and rooms on both sides. The doors were all painted white but they showed age with dirty, peeling paint. I expected to see many more rooms for residents but there weren't many. They have room for 27 occupants (maximum 32 if they add some cribs). Some rooms down hallways were empty except for metal old-fashioned hospital beds with plastic mattresses.

There was a room at the end of the hall that was cluttered with art supplies, paints, puzzles, toys, and dress-up clothes that is used for activities for the children; it was bright and colorful but looked like a child would be overwhelmed and overstimulated by the tight quarters and the abundance of items to choose from. On the third floor there were multiple rooms for storage and the rectory. The chapel could be entered from the shelter or from another door that went into the church. It had once been used by the nuns. It was sunny and bright in this room but dusty and quiet like it hadn't been used in years. Each storage room contained a different type of donation neatly organized in boxes; one room had toys for boys and one for girls, one had wrapping paper and Christmas decorations; one entire room had party supplies that had been donated when a party supply store went out of business. We also toured the kitchen and the pantry in the basement with the food supply; dozens of donated, labeled canned and boxed goods in storage on metal shelves in a tiny, cramped room. The highlight of the tour was the machine room, which housed the original heating system from the 1800s – it was a monster that took up almost half of the basement with a mass of pipes and gauges. The Sister was very proud to show this to me; her excitement about this treasure eluded me.

Summary

The theoretical frameworks I selected provided structure to the interviews and a method to examine the lives of homeless women. Together these methods and interviews with women and providers gave me a personal understanding of the experience of homelessness for women in Connecticut, which I describe in the following chapters.

Chapter 4: Conceptualization of Homelessness: Thoughts from Women and Providers

[I: Do you consider yourself to be homeless?] Yeah, absolutely. You have to maintain reality here, okay. Reality is that I am homeless. That keeps you motivated.

-Audrey (50 year-old)

I went to the *Entré* Emergency Shelter in the northeastern corner of Connecticut to explore how women at the shelter think about being homeless and to better understand their risks and vulnerabilities identified through their life histories and lived experience. In this chapter I present their conceptualization of being homeless, describe the shelter where they are staying, and provide some details about the women themselves. Some of the women said they hadn't thought about being homeless until I asked them the question. I conducted in-depth interviews with women and providers to identify their thoughts on what homeless women believe about being homeless. I also elicited Free Listings from some women at the shelter to further understand their thoughts about homelessness.

The Shelter

The *Entré* shelter is a large three-story, white house on a quiet residential street in a small town in rural northeastern Connecticut that blends into the neighborhood with the other houses. It is surrounded by churches and private residences. Across the street is a small health clinic where the residents go to be checked for tuberculosis prior to entering the shelter, one of the many requirements placed on those who wish to stay at the shelter. It presents an obstacle to entering the shelter for those who arrive in the evening or on weekends after the clinic has closed. The proximity of the clinic provides a false sense of relief that medical care is nearby when in reality it is difficult to get appointments at the clinic, the shelter residents rarely have medical records with them which limits the care they can receive, and their health insurance is often not up-to-date, preventing them from being seen by a provider. When I first began my

doctoral research with Dr. Sullivan she was running a weekly clinic at the shelter called “Bridge to Health Care” which she staffed with RN and nurse practitioner students from the University of Connecticut. This highly sought after service provided much-needed health care assessments, referrals, and treatment to numerous residents each week. The clinic was successful in decreasing expensive and frequent emergency department visits by shelter residents.

The shelter is an emergency shelter with a limit of a 60-day stay. When I first began going to the shelter there was a 90-day stay limit but on October 1, 2010, this was reduced as politics and philosophies changed to focus on a national trend of a rapid rehousing model. All residents staying at the shelter need to accomplish numerous tasks during that short time period. For example, they need to develop an action plan, meet with the Service Coordinator, look for housing, jobs, school placement for their children, and they may need to complete paperwork for entitlement programs, such as Social Security disability insurance or health insurance. Once in a while the residents may be granted an extension on their stay, but it’s rare. These exceptions may be if they are waiting to sign a lease for an apartment in a short time and they need some place to stay for a few days and they have a job or entitlements. The shelter director decides whether or not an extension is granted.

Upon arrival at the shelter, the individual is given a list of rules. The seven page document they receive says across the top of the first page, “Welcome to the ‘*Entré*’ Emergency Shelter; this is a non-smoking facility.” The enumeration of rules is daunting. Specifically, rooms in the shelter are closed between 10am and 4pm; only open for an hour for lunch. Residents need to leave for the day to look for employment, meet with counselors, or search for housing. Many residents go to the public library for the day to use a computer, stay warm and dry, or to read. Staying outside during the day presents challenges on cold winter days or when

the library is closed. Other rules include: no alcohol or drugs, no food in your room, no visitors in your room, stay with your children at all times, no smoking, no violence, and no sexual harassment. All medications, prescription or over-the-counter, must be kept in the staff office and they are dispensed according to the health care providers' orders. If any medication is found in a residents' room they get "written up." Any violation of the rules results in being "written up." If a resident is "written up" three times they must leave the shelter and they cannot return for 90 days. Children must be bathed and in bed by 9pm. Doors are locked at 9pm. One of the women once said to me, "I'm 34 years old and I can't even watch [Jay] Leno". This control and power over the daily activities of the women affected their lives by causing chronic frustration, poor self-determination, and decreased self-esteem. It also contributed to their personal concept of homelessness.

The residents complained tirelessly about the rules. There were often tense house meetings for the residents to air their frustrations or to present important information or new rules. Sometimes there were house meetings with presentations given by staff from the shelter or another community agency on topics such as money management, employment, or life skills. Not all the sessions were relevant to the residents' situation. After one of these meetings I heard some of the residents bemoaning the fact that they had to listen to a presentation on gardening that they felt was not at all pertinent to their current housing arrangement. One evening there was a meeting while I was there. The residents were yelling at each other, blaming one another for neglecting their chores, accusing the staff of using their money (15% of their income was supposed to go to the shelter) frivolously, poor quality food, and the problem of working third shift (i.e., 11pm to 7am) and having to leave the shelter during the day. This misconception was

discussed frequently and the staff insisted that anyone who worked third shift could sleep during the day.

The shelter provided a strict institutional structure that required the women to conform to the rules but it also provided a safe, stable environment for them to work on improving their lives. There were complex group dynamics at the shelter developed during their shared homeless experience. Although I heard most residents at the shelter complaining about the rules and the staff and "drama" at the shelter, there were, nevertheless, strong bonds developed among the residents, either with the staff or with each other. There were both positive and negative relationships formed at the shelter, and it was these experiences that provided the social context of homelessness. This sense of communal suffering and camaraderie was possibly one of the factors that affected how well the residents adjusted to life outside the shelter in their own apartments, sometimes living alone for the first time with little support. They tended to lean on each other for the short time they were at the shelter. Some relationships and friendships continued after they left the shelter. Still others believed it wasn't worth the effort to befriend someone who they would only relate to temporarily while staying at the shelter.

The Women – who are they?

The 30 women I interviewed were staying at this rural family shelter in northeastern Connecticut (Appendix A). They were a heterogeneous group with many similarities. The common factors were more abundant than the differences. Specifically, most came from poor families who struggled to make ends meet. They came from difficult and unstable families and they were limited by personal challenges. Based on the literature on homelessness I expected the majority of the women at the shelter to have mental illness or a substance use disorder. But since

there has been less research on homelessness in rural areas than in urban areas, I had wondered if these issues would be less prevalent in a rural area: perhaps this would be what makes rural homelessness distinct. Unfortunately, this was not the case. There were groups of women with mental illness, substance use disorders, or a history of domestic violence, and there were others who had not experienced these issues but they had suffered in other ways, such as economically or through destructive romantic relationships. Although the literature attributes much of the struggles of homeless women to trauma in early childhood, hearing it directly from the women was alarming. The prevalence of violence and abuse experienced by the women was by far the most disturbing finding. I don't believe this is unique to rural areas but it warrants further exploration. The confluence of all of these factors: poverty, dysfunctional family relationships, mental illness, substance use, and violence, among homeless women is the basis of this ethnography.

Characteristics of the Women

The women ranged in age from 19 to 58 years, with an average age of 36.2 years. They were overwhelmingly White (77%) with fewer Blacks (13%) and Latinas (7%); one woman was of mixed race. I did not specifically ask the women what they would report their race or ethnicity to be so these data may not accurately reflect their self-identified heritage. One of the two Latinas self-reported Puerto Rico as her birthplace. Seventy percent of the women had a high school education; an additional 20% had a GED.

Structural Typology

The women I met could be divided into groups in various ways. One categorization could be based on family structure. Some of the women were at the shelter alone, either because their children were grown and no longer in their care, or they had been taken away by DCF or

were staying with other relatives, or the woman had no children. There were also women at the shelter with a boyfriend or husband, with or without children, and some of the women were there as a single parent with their children. This categorization appeared to differentiate the types of women. At first I thought this might be useful in relation to the services they use but upon further examination it seemed that other factors were more useful for creating a typology of the women. The personal characteristics of mental illness, substance use disorders, or violence and abuse, more clearly defined the women. These issues were identified in the majority of the women and defined who they were personally.

Mental Illness

Approximately 73% of the women self-reported a mental illness diagnosis. Many had been coping with their illness since childhood. Some were currently receiving treatment and others were not, either by choice or because they had moved to the area and follow-up with their mental health provider was one thing they had not gotten around to securing in their new location. Caring for children or other competing activities like job and apartment hunting often took precedent. Others needed to resume health insurance to obtain mental health services, including refilling medication prescriptions. Several of the women mentioned being under the care of a psychiatrist but the doctor was in another city where they lived before coming to the shelter and they were logistically unable to get an appointment or get there to see the provider. At least two of the women had come to the shelter directly after hospitalization for a psychiatric admission. I frequently heard the women talk about self-medicating to deal with their mental health conditions or their childhood trauma and hardships.

Substance Abuse

Abuse of drugs and alcohol was pervasive among the women with almost half (47%) mentioning some type of substance use in their life. Many spoke about alcoholic or drug addicted parents and the toll that took on their childhood and their siblings. Others turned to substances themselves early in their lives to escape from the pain of destructive family relationships. Often the women blamed a boyfriend or a bad decision on their use of drugs or alcohol. I found that due to unhappy childhoods or poor family relationships many of the women had low-esteem which they tried to bolster by using substances to temporarily ease the pain or give them confidence. This started a vicious cycle of substance use to alleviate bad feelings in relationships and detrimental relationships due to substance use disorders. Stuck in this loop exposed the women to additional vulnerabilities in their lives, including abusive relationships, conflicts with the Department of Children and Families (DCF), eviction, and dealing with the criminal justice system or incarceration.

These factors negatively affected all aspects of the women's lives, including maintaining a job and relationships. Many had struggled with drug or alcohol use throughout their lives and some were coping with their children's use. This was often the most painful. There were women who spoke freely about their substance use and others who never mentioned it to me, even if it was a major part of their personal or family life. The shame or embarrassment and stigma associated with these addictions made it controversial and difficult to discuss so they hid it. Some of the women had made numerous attempts at recovery, seeking rehabilitation services in a range of settings: court mandated, in-patient, or out-patient programs. One option while at the shelter was to attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings.

In fact, if a shelter resident was known to have an addiction problem they were required as part of their support plan to attend AA and NA meetings in the evenings.

One evening I attended an AA meeting with three of the shelter residents. The meeting was held in a church around the corner from the shelter. It was a crowded room of about 30 men and women of all ages and races or ethnic background. Some people came alone and others came with a partner, friend, or family member. They sat at long tables with plastic table cloths. Coffee and cookies were available for free in a corner for anyone who wanted some. The room seemed dark but full of a strange energy. Some members were living sober lives and had rekindled detrimental relationships, had jobs, and other positive aspects to their lives. Others continue to struggle with their disease and they appeared serious, quiet, perhaps depressed, or ashamed. Many had been attending AA meetings for years while others mentioned it was their first meeting. I saw several men and women from the shelter in attendance. When the meeting started everyone read the 12 steps out loud and said a prayer. The group secretary introduced a man who was the leader for the evening and said, "This is Jim [pseudonym]." Refrain from the group in unison, "Welcome, Jim". Jim began to speak, "My name is Jim. I'm an alcoholic. I'm grateful to be here today. Nice to see everyone here. I've been sober for 12 years." Then he told his story providing the group with words of strength and hope that he shared through his experience. He talked about the sign-posts (like a DUI) in his life which he ignored that were warning signs for his addiction. He said, "like any good drunk, I was the last one on the block to find out." His mother gave him the AA Big Book for Christmas when he was 21 years old. At first he resented it then he was grateful. This book contains the philosophy of AA and the steps needed to stay sober and manage life without the use of substances; it is a spiritual doctrine. Like all group teachings or recovery models, it works for some people but not others. I was told that

the only thing you need to be in AA is the desire to stop. It does take a great deal of determination. I was impressed with the perceived strength of the people in attendance. In my interviews with women at the shelter some mentioned their AA sponsor who had been a part of their recovery for years. Jim finished his story and he said, "If I'm working the steps, my spiritual condition is good." Everyone clapped and said together, "You're a good man, Jim." This group cohesion, built on a common bond, was one of the building blocks of AA. It was encouraging and uplifting to witness. After Jim spoke they went around the room and others spoke about how they were tackling sobriety. It was optional to speak and tell your story. None of the shelter residents who accompanied me shared during that meeting. Being with them was reassuring. They made me feel at ease going to the meeting. It was a great experience for me to better understand the AA philosophy and what people who attend AA meetings experience.

Abuse

A third, and very large, group of women was those who had been subjected to some form of trauma in their lifetime. This included women who were abused as children, either sexually, physically, or emotionally, and those who were victims of intimate partner violence in their adult lives. During the interviews I did not specifically ask about abuse in the women's lives but sixty percent of the women reported at least one type of abuse (i.e., 43% reported physical abuse, 33% reported emotional abuse, and 27% reported sexual abuse). The scars left by this abuse were very difficult for the women to speak about. Childhood beatings by parents were frequent and mentioned matter-of-factly; often at the hand of an alcoholic parent. Some relayed the information about childhood sexual abuse with ease, as if they had to retell the story, perhaps to a therapist, numerous times in the past. Others found it hard to even utter the words and they seemed to mention this deep secret reluctantly. The subject was difficult to speak about for all

the women and some provided more detail than others. Sexual abuse by a family friend or relative was also mentioned but sometimes it had been repressed or not discussed within the family. Several of the women mentioned attempting to tell someone, often their mother, about the sexual abuse and they were not taken seriously or not believed. Situations of intimate partner violence were also common. Several of the women had left a violent, abusive relationship just prior to arriving at the shelter or they came to the *Entré* shelter after a stay at a Domestic Violence (DV) shelter. Two women who had been sexually abused in their lives told me sad, disturbing stories about their partners sexually abusing a female child, either their own daughter or granddaughter. This was particularly upsetting. The effect of the trauma was not always evident or obvious in their lives.

Conceptualization of Homelessness – Women’s voices

Homelessness is socially constructed by a societal view and perception that creates a specific picture and image of who is homeless and what it means to be homeless. The lens through which the women look at homelessness may appear contrary to those of society. The women’s views on their living situation must be appreciated to fully comprehend how they arrived in this situation, what they perceive as their life trajectory, and what they think their future will hold. It is rare for women to be asked whether they consider themselves to be homeless and how their perspective corresponds to that of society. The main themes that emerged from this question were: 1) a rejection of the homeless label since they “had a roof over their head” and were not living on the streets; 2) the notion that home is more than a physical place; 3) a desire to be treated as unique individuals, not as a homogeneous group; and 4) a need for respect. The women also provided their own conceptualization of why they were living in a homeless shelter. Beliefs about the causes for their homelessness ranged from economic

hardship imposed by structural factors like high unemployment, bad economy, etc. to just plain old “bad luck”.

“Do you consider yourself to be homeless?”

I wanted to know whether women staying at the *Entré* shelter consider themselves to be homeless, what their perception was of homelessness, and if their interpretation was in-line with society’s view. Contrary to the title of my research where I claim to be studying “Homeless Women” some of the women I interviewed did not describe themselves as homeless. The notion of being homeless is wrought with negative stereotypes, criticisms, and stigmatization. People who are homeless are generally marginalized, ostracized, and criticized by society at large. Because the population can be invisible, and the women I interviewed at the shelter are invisible since they are not out on the street, they are often forgotten, overlooked, and ignored. The people who are seen on the streets are thus those that are the stereotype of a “homeless person”. They are typically viewed as “dirty”, “drug addicts”, and “crazy”. Many of the women I spoke with are cognizant of this image and were eager for someone to understand the heterogeneity of the group of people who become homeless. Moreover, the women voiced their need for others to respect them and understand their current situation.

When I asked the women if they considered themselves to be homeless, I received mixed responses. Many of the women did not consider themselves homeless because they were not out on the streets and they had a roof over their head. Rachel said, “I think that I didn’t necessarily consider myself homeless. I never let the idea of it sink in until actually you asked me. It is, it’s true. *[Laughter]* I don’t know, it’s kind of stressful.”

Diane, a 26 year-old mother whose daughter was not with her at the shelter, agreed that homelessness was defined by the possession of a physical home. Conversely, the loss of a home

could be defined as homeless to her:

(W024) Well, homeless is when you don't really have a home to call your own. You know what I mean? Like being at home in your own environment. This is a group environment. Homeless, I don't really consider this homeless because you're in a house. You have a bed to sleep in. Homeless is like people that are sleeping outside. I see it quite a lot in the park, sleeping on the benches, sleeping on the gazebo. I seen some guy get—a cop came up to him the other day, yesterday, and told him pretty much he can't be sleeping here. At the end of it, we're not homeless right now, but in 60 days I might be. That's the scary part. I know I'm safe for 60 days, but now it's like what's gonna happen after that? [I: You don't consider yourself homeless now?] No, no. Not until I'm actually living on the streets, that's what I consider homeless. It's not really a home, but—

Carrie, a 21 year-old woman at the shelter with her boyfriend and their 2 year-old daughter, did not consider herself to be homeless, despite being at the shelter. Her concept of homelessness was defined by her relationships and the people she has around her and not by the physical building of a home:

(W007) No, I'm not homeless right now because even though I live in a shelter it's still a place to go. To me homeless is living on the street. That's what homeless is to me....I'm still with people that love me. I'm still with [boyfriend]. I'm still with my daughter. I'm not homeless. That's my theory of being homeless.

Laura was in her twenties and pregnant. She was at the shelter with her one and a half year-old daughter. Her perspective on being homeless revolved around her feelings that she still had her possessions and her daughter's material items, plus her daily routine remained relatively consistent. Feeling that she had not lost possessions or personal freedom made her concept of homelessness seem less applicable to her situation.

(W023) I used to have an image of homeless people. And now I look at it different. My image of homeless people was they're all on drugs. They're all very dirty and convincing people...They're all old. [I: Do you consider yourself homeless?] I don't think about it that way. I am. But it doesn't seem that way. Actually no, I really don't because right now because I'm not because every day I wake up, I'm in the same bed. With my blanket that I have. My daughter's stuff that she has. Eat just like I was in a normal house. Like this feels like I'm just in my own apartment. Rent free. Cause I wake up and go to sleep in the same bed. I wash my clothes with laundry in the laundry room. I clean the

bathroom. And clean up.

Some of the women expressed feeling that society lumps all homeless people into the same categories. They discussed that they would like to be seen as a heterogeneous group. When asked if she considers herself homeless, Marian, a 50 year-old chronically homeless woman, expressed her desire to be treated the same as people who are not homeless, while at the same time wanting to be considered as a unique individual:

(W016) That's a hard question, cuz I don't—yeah, I think of myself as homeless because I don't have the money to get a place, but I think some people, I mean, treat people in the shelter differently. That's one thing that I didn't like about the library. It's like, we're all here for different reasons. I mean, I don't think you can lump all people that are homeless into one—you know what I'm saying?

Like, don't stereotype, cuz I don't feel I'm any better or worse than anyone. I don't. I mean, I've gone through my experiences, and this just happens to be where I'm at right now, but if I end up winning my [disability] case, I'm not gonna start treating people that aren't doing so well as me at that time—I'm not gonna treat them any different, cuz I've been here.

There was general agreement that society looks down on people who are homeless and considers them to all be similar. They were aware of this perception and it was degrading. Most of the women expressed their desire to be respected. They felt that as a person who is homeless they were treated poorly, as second-class citizens. An example of this is the way they felt they are looked at when they walk through town. As Andrea, a 44 year-old woman at the shelter with her husband and son, described,

(W030) Oh, we've had—awful. We've had looks, we've had—you can tell. People can tell when we walk down the street in here, and down—just walking down that main street. You can tell that when people—like people walking their dogs, older people, they can tell. They know that we're [staying at the shelter] Yeah, they know. They can tell instantly that we are. I would like to have said to them, "I do have an apartment next week. I am moving into a new apartment, if you care to know." *[Laughter]* It don't bother me. I mean, at first when just me and my husband were walking down the street and—I think because I felt so ashamed and miserable about what happened, people could see it all over the faces. Now, you know, I got that positive [attitude] and I'm okay with it today. I'm all right with it.

They felt they were not treated with respect by people around them. They were looking to be treated with dignity. Marilyn, a 36 year-old mother of four children, described how frustrated that made her:

(W005) I think society's wrong. They associate homelessness with drunks, drug addicts. They just don't have a real clear picture of homelessness. I remember I was homeless one other time and they brought these people in to do a tour. I said "What the hell is that?" So I pulled the lady aside and I said "Well, you really need to let them come in and talk to us cuz we're not animals in a zoo on display like an exhibit. You need to come in here cuz we're not" – I had a job at the time and I said "You need to let them know why we're homeless." I think I was homeless one time because the building I was living in was getting condemned. And I needed a place to stay 'til I found somewhere else to go and I said "They need to understand that I don't have a drug, substance abuse problem, I don't, you know what I mean? I'm homeless because my building got condemned. I said "You just walk by" and I said "you see us sitting here at this table and what's going through your mind is 'Oh, they've got a drug addiction or they're alcoholics or ya know, they're this that and a third.' And ya know you couldn't be more way off base." Not to say that that's not the case all the time but that's not always the case.

When asked what society thinks of homeless people some women expressed their agreement with what they believe society thinks and they, too, felt looked down upon. Mary, a woman in her mid-fifties, who was at the shelter alone expressed her idea of what society thinks and her own views, which express a sense of self-loathing and shame:

(W013) [Society thinks] [T]hat they're losers. They do; I'm sorry, but—and I can say I have been one of those people. Like I said, in [city where she used to live] on the corner where there's plenty—when jobs were plentiful and they can't get a job. How do I feel about being here? I feel dirty; I feel...dirty's a good way to put it. I just feel filthy. I have very low self-esteem since I've gotten here...I feel almost like I'm in jail here.

Beliefs about Causes of Homelessness

The women's perceptions of why they were in this situation varied. Some placed responsibility on themselves or "the system" while others felt it was fate or that they were "dealt a bad hand" or "down on their luck". These women were more apt to blame themselves and their decisions more than society. Others took a structural approach and felt the economy was to

blame. For example, Margaret was an almost 40 year-old depressed woman whose two sons were not with her at the shelter. She felt she got “mixed up with the wrong person” and her life went downhill. She lost her place and was living in her truck for three weeks “without any food and a coffee to split throughout the day and laying in [her] truck for two days without movin— ’cuz [she] just didn’t have the energy or will or want to move”. She was admitted to the hospital for depression and afterwards she spent some time at a domestic violence shelter. Margaret spoke at length about the painful decision to leave her sons with her ex-husband. She felt personally to blame for her situation.

(W026) Everybody thinks you’re the lowest of the barrel and they look down on you. It’s like we’re just normal people; everyday people that either was dealt a short deck or like me, just made the wrong turn on the wrong path...I’ve always had somebody there so it’s a whole new experience for me. I didn’t get up one morning and say, “All right. I’m 39. I wanna be homeless.” It’s not something that you plan. I mean and it just goes to show that it can happen to anybody...No matter what your situation and that’s the biggest thing that people out there don’t understand. Because they got this nice, cushy job and everything that it can’t—with the economy now, guess what? You’re just as vulnerable as anybody else.

There were other women who took a more structural perspective, not feeling that they were at fault but that the economy and unemployment were responsible. Focusing the blame away from themselves may appear to some to be an evasion of responsibility, regardless, it seemed to help them cope with the reality of the situation. Alice was a 38 year-old woman at the shelter with two of her three children. She was a victim of domestic violence and was trying to get her life back together for her children. In her words:

(W014) [Homelessness is a] stepping stone. Something some people have to go through. I mean I consider everybody is one paycheck away from what we are right now. I mean this economy is terrible. It’s hard to find jobs. Whatever job you do, if you don’t save your money you’re gonna be exactly where we are.

Her views are echoed by Dottie, a woman in her fifties at the shelter with her youngest teenage son, whose husband of almost 20 years decided to leave her with nothing. She felt

similarly that it is the structural factors that have forced her into the shelter.

(W025) Looking at the economy the way it is there is a lot of homeless people that need a lot of help. A lot of them have not asked to be homeless. It's just situations that get out of control. Then there's some that they just don't manage their money right or they're strung out on drugs. You know, there's a lot of situations. A lot of situations but I believe that there's hope. That's what needs to be conveyed to them that it's not the end of be-all. It's not the end of the world. It's not. It's not where you just stop your life.

Causes of homelessness aside, many of the women conveyed their feelings that this was only a temporary or transient state. They felt that they were in the predicament of being in a shelter but it was only a phase. According to Andrea, a 44 year-old woman at the shelter with her husband and their pre-school aged son:

[W030] ...this is only a temporary place. It's a roof over our head, and food in our stomachs, and a warm place. It's temporary. It's what we choose to do with it. I don't choose to stay here for the 60 days that they are allowing us, and to bounce to another family shelter in [another town] that they allow us to go to. I don't choose to do that.

Providers' Views

In an effort to expand my understanding of homeless women and to contextualize their views on homelessness, I sought the views of housing service providers on the homeless experience. I asked 13 providers located throughout Connecticut to tell me about their work, the services they provide, what they think homeless women need, what they believe homeless women need to change their situation, and to discuss their perspectives on homeless women. The providers were a diverse group including direct service providers and administrators. Some took a CMA perspective and focused on shortcomings of the system, stemming from a lack of affordable housing and a system that does not provide adequate social support. Others blamed the women for their situation. Overall, most were empathetic and took their jobs seriously and were eager to do whatever they could for homeless women. Their views provided insight into the conceptualization of homelessness from a broader perspective.

“What do homeless women think about homelessness?”

I asked the 13 providers that I interviewed what they think homeless women think about homelessness. One direct service provider said, “I think they feel more of a failure than guys do. That is what they feel. Often they’ve lost their children and all that. It’s just so much baggage that they have. It’s so painful for them.”

After listening to their interviews multiple times, I created a list of the terms they used to talk about homeless women. The words the providers used to describe their thoughts were very powerful. A list of the terms they used included:

Devastated. Dejected. Discouraged.
Fear. Desperate.
Anxious. Stressed. Depressed.
Shame. Guilt. Embarrassed.
Unloved. Low self-esteem. Alone. Insecure. Isolated. Helpless.
Loss of control. Lack of a support system. Lack of resources.

One provider explained what he thought they experienced:

They feel helpless being homeless. They go to DSS [Department of Social Services] and they are treated like they are bothering them – they go to the utility company and they get treated like dirt. They are not treated like human beings and that doesn’t help. If you want to change the way people perceive themselves and get themselves back on their feet, you’ve got to treat them right.

A housing policy advocate took the CMA perspective stating what she thought homeless women think:

I think that they think the system doesn’t work and has a lot of cracks in it. I think they think there really isn’t a safety net for them. I don’t know that they think the system has failed them but they often think the system can’t work for them. That they’re sort of up against it and that poor people get screwed. And that they’ve been screwed.

Whereas, a direct service provider looked from an individual or personal lens:

You feel like you're a non-person. You feel like people are pegging you or labeling you. Why is a person who is homeless any different from anyone else? They are just going through a rough patch. Probably a function of institutions – even when you use the term “the homeless” what does that mean?

Another very compassionate direct service worker said,

They don't want to be judged. You have to just see them as people, that's all they are, people in a bad spot. However they got to that bad spot doesn't matter to me. To help move them to where they want to be not where I want them to be. Some people will never be comfortable in a spot where I think they should be – not where I want them to be but where they want to be – you can only help get them to be where they want to be – just spend time with them.

Free Lists

To further conceptualize what the women think about homelessness I also conducted Free Listings with some of the women at the shelter, asking them what homelessness means to them (Appendix F). There was some overlap between the women who participated in the in-depth interviews and the women who participated in the Free Listing. These women used words and phrases that could be categorized as: a) their feelings about being homeless; b) their views on what homelessness means; c) how they think other people perceive them; and d) their optimism for the future. Some listed single words and others provided phrases. Some of the terms they used to describe their feelings were:

- 1) Loneliness
- 2) Depression
- 3) Hopelessness
- 4) Lost
- 5) Helplessness
- 6) Angry
- 7) Empty
- 8) Degrading
- 9) Anxiety
- 10) Unstable
- 11) Sorrow

- 12) Regret
- 13) Shame
- 14) Uncertainty
- 15) Fear
- 16) Humbling
- 17) Embarrassed
- 18) Unloved
- 19) Drained

They used words to describe what homelessness means to them, which included:

- 1) No income
- 2) No family or friends to turn to for help
- 3) Child – don't ever want my son to go through this again
- 4) No support system
- 5) Not having anywhere to go
- 6) Uncertainty of the future
- 7) Not having a home
- 8) No control
- 9) Needing direction
- 10) No future

The words they used to express what they thought society thinks about people who are homeless include:

- 1) Not valued as a person
- 2) People staring at you
- 3) Loser
- 4) Seen as "lazy"
- 5) Seen as "deserving of it"
- 6) Seen as a "bad person"
- 7) Uneducated
- 8) Alcoholic/Addict
- 9) Mentally Ill

On the other hand, the women provided terms that expressed their optimism for the future. This was also evident in their interviews. The words they used to express this were:

- 1) Grateful
- 2) New beginning
- 3) Motivated

- 4) Strength
- 5) Hopeful
- 6) Getting on track
- 7) Only way is up

These words and phrases clearly show the range of emotions experienced by homeless women staying at a shelter. Not all of the words they used in the free listing were directly expressed in the one-on-one interviews. For example, the terms “lonely” or “loneliness” were mentioned by 6 of the 21 women who participated in the free listing yet none of the interviews revealed those exact words. They also used words such as Tragedy, Struggles, and Mistakes to describe their situation. Some of the women felt they “took the wrong road” or they “hit speed bumps”. All of these terms express a lack of satisfaction or frustration with their lives.

Summary

My conceptualization of homelessness has been altered since I began this research. I, too, had primarily seen homeless people on the streets who were often disheveled and looking for money; those are the visible homeless. They biased my vision of homelessness and they provide an image for society. People who reside in homeless shelters are also, by definition, homeless, yet their daily lives are more structured and they are able to eat, sleep, stay warm, and safe. Their basic needs at the moment are met, yet they are still lacking in inner resources to get out of their situation. Moreover, their childhoods were plagued with painful, detrimental relationships and situations that created the current chaos in their lives. The providers I interviewed recognized that homeless women are in need of services, they face relentless discrimination and stigma, and they need respect and dignity in their lives. Some providers were more empathetic than others and would be able to provide the understanding and dignity the women needed. Others were part of the “system” that blamed the women and created the

structural violence that they had to endure. The women, themselves, felt they needed supportive services and the providers were in the position of power to meet these needs. They also didn't categorically describe themselves as homeless since they were staying in a shelter and their basic needs were being fulfilled. The women were well aware of how they were perceived by society and they felt some of the staff treated them similarly, as marginalized people.

This chapter frames the setting of the shelter and provides a lens into the lives of homeless women through their own voices. The women's concept of homelessness is thoughtful and contemplative. They recognize the gravity of the situation but they show optimism and realism. Their lives are disorderly and complex.

For most of the women the road to homelessness was similar. They had experienced great losses and instability in their lives, their relationships were problematic, the system had let them down, and they were coping with overwhelming personal issues, including poor physical health, mental illness, substance use, and a history of abuse, that set the path for homelessness. Despite these various hurdles, overall, the providers and the women recognized the crucial need for personal dignity and respect.

Chapter 5: Shelter Experience

I interviewed the women at one point in time once they were staying at a homeless shelter. This is only a snapshot of their lives. Prior to arrival at the shelter many of the women had already struggled with being unstably housed. Some had tried to stay with other people and others were evicted from their current living situation. These were precursors to their homelessness and they are important factors in their homeless experience. Both “doubling-up” and eviction were events that may have occurred more than once in their lives. Being at the shelter the women suffered through feelings of shame and embarrassment, a desire for dignity and respect, and lack of self-esteem. In the shelter environment they dealt with unique, challenging parenting issues, and intense relationships with other shelter residents and staff. These were experiences that were shared by many of the women.

Housing Before the Shelter

Doubling-up

Doubling-up is a term used to describe a common situation among individuals and families trying not to enter a shelter who are unable to remain in their place of residence and they are attempting to keep the family together and to find a place to stay. Since families or single women with children rarely end up living on the street, they are more apt to go to a shelter, and they are often desperate to find a safe, warm place for their children to sleep. Doubling-up with friends or family is not usually a viable option and most of the women I spoke with had doubled-up with someone prior to arriving at the shelter. The problems related to doubling-up or “couch-surfing” are numerous. Often the place where they try to stay is already too crowded or the family member or friend does not want them to stay with them for one reason or another. Another huge issue is that generally the person they stay with is also in subsidized housing and it

is a violation of Section 8 and other subsidies to have someone else stay in the apartment who is not on the lease.

Although it was not their first choice and it was often a humbling experience, the women were sometimes forced to ask a family member or a friend for additional assistance. Mary Beth had asked her sister for help but she was denied.

(W004) I said, “[Sister’s name], we’ll pay your light bill. Can you house me and my family for two weeks? That’s all we need is two weeks. We got money put away; we just gotta wait for another check to come in two weeks so that we have more money to get whatever kind of house that we need to have,” cuz like I said, my husband and I had good jobs, but we got paid every two weeks and we were waiting for our new checks to come.

Jessica expressed how she felt about having to ask someone to double-up with them or to ask for a place to stay:

(W022) I know I’m only doing this [staying at the shelter] so that me and my son can have our own place. So that I don’t have to knock on somebody’s door and “Oh can I stay with you because I have nowhere to go?” Nobody wants to do that.

Not wanting to overstay their welcome with friends or family was sometimes a reason for terminating doubling-up situations. Some women had tenuous relationships with their family and knew that living with them put a strain on the relationship. A few women told me they preferred to come to the shelter rather than stay with family because their relationship was so stressed. They admitted that going to visit for a few hours was the limit of their tolerance for each other such as the experience that Margaret had:

(W026) I had stayed with my sister for a little while a couple years ago and it started puttin’ too much of a strain on our relationship and that’s one thing that I didn’t wanna lose ’cuz she’s the closest thing to me.

Some of the women were able to rely on outside sources for support such as the church or a landlord or a family member who put them up in a hotel or otherwise helped them temporarily. Dottie handled the situation this way:

(W025) They put me in a place for three months. It’s a bigger efficiency apartment.

Within the three months I could not get anything stable jobwise—I mean with jobwise and housing wise. Then our time was up at that place. My son and I was out on the street. Thankfully I knew I had support from the church. Therefore the pastor put us up in a hotel for a couple nights...Then I spoke with DCF and I let them know hey, you know, I'm homeless, I need some help here. They paid for a couple of nights at the hotel. I just kept calling shelters and this one became available and they drove us out here.

Eviction

Another source of concern and risk for the women was the threat of eviction. Many had been evicted from previous housing settings and they knew the consequences. One of the major issues with having an eviction on your record is that you are often not eligible for other housing support, such as Section 8. Pat, a 46 year-old woman who had just arrived at the shelter when her car ran out of gas, explained how she lost her last housing:

(W006) The situation was nonpayment of rent. They say I didn't pay my rent although they didn't give me but less than five minutes to get all my things out, so I was unable to get my receipts and have proof...Eviction. It was eviction. Legal eviction due to nonpayment of rent... It was lack of work, didn't have a whole lot of work so I couldn't—I paid some of the rent. I probably was behind somewhat, so I got evicted.

Doubling-up with friends or family or eviction does not always result in homelessness yet this housing insecurity was often a precursor to homelessness. Understanding the factors that affect the likelihood that someone becomes homeless and another does not are essential to preventing homelessness in the future. According to the literature the variable that plays the greatest role is social support (Rossi, 1989). These relationships are discussed in the following chapters.

The Shelter

Once at the shelter, social networks developed with the shelter staff and with other residents. Most of the relationships were transient but many were established on the fact that they were in the same situation and had many common experiences. As Audrey put it, “They

[all the shelter residents] were all in the same boat”:

(W015) That’s what’s nice about it. There are no pretenses here. There are no, “I’m better than you because I got a car,” or “I’m better than you because.” There’s no pretenses here...We’re all in the same boat.

These relationships varied and some were more negative than positive. The shelter is an emergency shelter with a 60 day stay; this sometimes limited the length of the relationships and many ended abruptly when one person left the shelter and some continued after they left. While some of the relationships appeared intense for the time being, Marian understood the superficial nature of the relationships:

(W016) It’s hard though, sometimes. I mean, I get depressed, and it’s—now that I’ve been here I can talk more to the people here, but I don’t know—but it’s not—I mean, I have one good friend here. I’ve known him over a year, and I’m making—other people, they say they’re my friend, but it’s like, all right, but when I move out of here or they move out of here, I’m probably never gonna see them people again.

At the Shelter - Structural Factors

A CMA perspective encourages us to examine homelessness from a structural view that incorporates macro level factors that affect health. The women were faced with challenges with “the system” that often prevented them from ending their homeless situation. Attaining housing and employment were key. The issue of housing was complex since there were limited options for people with minimal resources. Some of the women worked and others were dependent on entitlements, such as welfare, unemployment insurance, or disability.

Housing – the “Waiting Game”

The women’s need for housing was unanimous although their reasons for being at the shelter varied. Some of the reasons for leaving housing or losing housing included domestic violence, non-payment of rent (eviction), trashing an apartment, end of a relationship or divorce, loss of income/job, or health problems. Frequently when I asked the women what they needed to

get out of their current situation they flippantly replied, “a place to live”. Although this response is obvious, it is notable for the complexity of the solution. If they had a place to live they would not have been at the shelter, even for a temporary stay. The options for finding housing were limited. Because the women had few or no financial resources, most were relying on receiving some form of housing assistance either through a subsidy such as Section 8, Transitional Housing, a housing voucher, or another supportive housing program. A major complaint by the women was the amount of paperwork they needed to complete to get into housing and the length of time they needed to wait on lists. It seemed as though almost everyone was on some type of waiting list for housing, either Section 8 or another subsidy. The system was not sympathetic to their challenges of mailing forms, completing the correct forms, or getting turned down for housing for one reason or another. Marilyn, a 36 year-old woman with four children explained that she ended up at the shelter because she lost her rental assistance program (RAP) certificate. She had previously been in a two-year program for single mothers to help them get back on their feet. She had applied for multiple housing vouchers and was finally able to secure one for a four-bedroom apartment. She explained to me that there is a time limit to the voucher and she needed to use it quickly or they would take it away from her. She had trouble getting Section 8 since she had a pending court case with the agency. She was apparently on four different waiting lists for housing. I repeatedly heard the story that the women were waiting and waiting for something to happen and they were at the mercy of the system. This caused a great deal of frustration for them. Some of the waiting lists for Section 8 were town-specific and some of the lists were several years long. Not only were the lists seemingly endless and not a reasonable waiting time but also because they were sometimes tied to housing in a particular town it required the woman to deal with relocating her family. This was problematic for the women

with school-aged children since it meant the children would have to change schools, which was very disruptive for their already unstable lives. A Section 8 housing recipient has to stay in one place for one year before they can apply for another voucher to transfer to another town. I was told once you qualify for subsidies it is possible to take the Section 8 voucher from town to town or even out of the State. The major barrier is the lack of affordable housing.

Another form of State housing assistance that was available when I was conducting the interviews was Homeless Prevention and Rapid Rehousing (HPRP) funding. In 2010 the State of Connecticut had committed \$15 million (*Entrée* staff member, personal communication) for HPRP. The concept of rapid rehousing is twofold: 1) as prevention: if you provide some assistance to people living in poverty who may need some support then perhaps you can prevent them from becoming homeless and going into the shelter system; and 2) rapid rehousing for those people who lose their housing because they can't pay the rent or can't afford to pay a bill (e.g., electric bill) may benefit from HPRP. The *Entrée* shelter was provided with a certain amount of money to assist people with payment of their first or last month's rent, which was needed to secure an apartment, a security deposit, or payment of their utilities to avoid eviction. The funding was limited but some people benefited from the payments. One resident at the shelter told me that you needed a job or a paystub to receive HPRP assistance, which eliminated many of those in need. Another hindrance to receiving housing assistance or eligibility for low-income housing was having a previous history of an eviction or a conviction. There were many different stories about housing applications, apartments for rent, and their aspirations to have a place of their own. All the women were well aware of the difficulties they had to overcome to secure housing.

Employment

Employment was an integral part of daily life in the shelter. Whether currently employed or seeking employment it was huge source of discussion, frustration, and worry. The women fell into different groups in terms of employment. The first group was the women who were currently employed. This group was small and it included women who were working, or looking for a second job, or a higher paid position, or who were hoping that their partner could find a job so they would be able to pay their bills. Most worked in service industry positions that were low-paying and with few, if any, fringe benefits. Then there were the women who were not working. They fell into at least four categories: 1) the women who had lost “good” jobs prior to coming to the shelter; 2) the women who were looking for a job; 3) the women applying for or on disability; 4) the women receiving some form of unemployment or State assistance. Within this typology are the women with children whose lives were complicated by the need for childcare. Most of the women in this situation were not in a position to contemplate job hunting until their lives were more stable with housing and if possible, childcare. This is particularly true for the single women with pre-school aged children or younger. They discussed the difficulty of looking for a job when they had to also find an apartment and watch their children. At one point during my field work there were five single mothers aged 23 or younger at the shelter with a total of seven children (ranging in age from about 18 months to 7 years).

Joan was a currently working mother of two teenagers who worked at a fast food restaurant. She was trying to save enough money to afford an apartment. She said,

(W009) ...I can't afford to lose my job. I like what I do...I love the people I work with. They're great people. There's not really one person that I do not like there. Well, maybe one...Well, there's always opportunities [to move up] at [name of restaurant], but I'm the prep person—I like what I do. I do all the, make all the salads, the parfaits, then I fill in where I'm needed. I don't run the register, I get too overwhelmed on register, I don't know why. In the window, they put me in window sometimes, handing out the food and stuff, I do not like that at all. *[Laughs]* ...Well, I need to find another job. *[Laughs]*

Either two jobs, or get a better one...I'm actually very comfortable where I am, where I'm afraid that if I get another job and I wasn't comfortable enough, I wouldn't go, I'd quit—stress or something, but I'm very comfortable where I am.

Finding a job is obviously a challenge during tough economic times. Some of the women were job-hunting for themselves and others hoped their partner would be able to find a position. There were multiple barriers to finding a job and because the shelter was in a rural part of the State, finding and keeping a job were even more complicated than in an urban area. Much of the industry had left the area and unemployment was high. The women often did not know where they were going to live and finding a job was dependent on the location of their apartment or vice versa: the location of the apartment was dependent on where they found a job. Adding children into the equation and where they would be attending school made these decisions more complex. Public transportation was limited. Buses ran to many of the nearby towns but only during the day. This made it difficult for the shelter residents to acquire many of the positions that were vacant since they were often third shift positions and they could not get a ride to the job. Some told stories of walking five miles or more to their job. Doing this in the winter was unbearable or nearly impossible. It was even more difficult for women because walking home from a job that ended at night or early in the morning was a safety concern.

Transportation and childcare were the biggest barriers to finding a job, as summed up by Laura:

(W023) My main thing is...I can get a job like that. I just have to have day care for her and my car. If I can't get my car then just find someone that can bring me to a job or something to get me to a job.

The lack of transportation and the need to relocate to find employment put added stress on the women. Sarah and Amy discussed how complicated these factors made their situation:

(W019) Well, I have a job in [town] through Labor Ready and it's a diversified job. My biggest holdup right now is my car is dead. I need to wait until I get monies to get the car

fixed. It's probably just the battery or it could be—the guys downstairs were telling me it could be a voltage regulator or something like that so it shouldn't be too expensive. Nonetheless I'm stuck right now at the moment.

(W020) [I have training at] I believe 2:00, I have to double check. [I: How do you get there with no car?] Walk or...It's an hour walk. Maybe two or three [miles]. I'm havin' trouble with the bus schedule because I don't know what keeps happenin'. I think I've maybe only taken the bus once since I started. Which I've gone there four times now, between orientation. Actually to get hired, to go for the interview.

The loss of a good job and the fears associated with re-entering the workforce were primarily felt by the women in their 40s and 50s. This loss of security and confidence added further challenges to an already daunting task. Mary had relocated from another State where she had a high paying job and she was presently working three 12-hour shifts per week at a warehouse:

(W013) I've always worked all my life. I gotta say when I got here I've never felt more alone in my life. I felt that I was in the wrong place, that I—honestly—I know you're recording this—but I felt like I'm better than these people. I don't belong here.

These women were in the difficult position of either entering the workforce for the first time or re-entering it after a hiatus. They were lacking appropriate and up-to-date skills, or needing re-training. For example, Peggy explained how vulnerable she felt about going into the workforce at her age and the challenges of finding a skill when she didn't have one:

(W017) When I was in high school I was in foods and dietary. I used to be a dietary aide when I graduated. I worked in nursing homes and a hospital before [I became sick]. It was just quite confusing when that occurred. I had no idea what was going on. It was very scary with my parents moving away and then that happening right after I had my first son close to 20 years ago...I wouldn't mind whether it be furthering my education or just trying to get some sort of ability to do something on my own. I do believe I might need some assistance to learn how to do things since I've never done anything by myself like that...I mean I was a dietary aide, but certainly with my memory I'd need to go over everything again in my head, I mean practically learn it all over again. I tried staying in shape and do think I eat well, but when it comes to certain diets and stuff I might need to get a refresher a little bit there if I was gonna do that.

Part of the daily routine at the shelter was to look for employment. This involved going

to an agency called CT Works and getting a form stamped to show that you were trying to find a job. The people who were not actively job-hunting because they were receiving some type of support (e.g., unemployment, disability, State assistance) still had to check in with CT Works. The women who were looking for jobs spoke about the types of jobs they would like to find. Some, like Marilyn, had worked in a specific field or were trained for one type of position and they were hoping to find a job in the same field.

(W005) I've had a job since the age of 14; however, I've been out of work now for about three and a half years. Normally I do waitressing. It's what I do. It's what I know. My family's owned restaurants. I've managed restaurants. I've waitressed. I've cooked. I've done dishes. I've done every aspect in the restaurant industry. It's what I do. It's what I know. It's what I love.

Others had certain training or experience and were willing to take any type of position. Others talked about going to school to acquire additional skills or training that they thought would bolster their chances of finding a position.

At times the woman's mental health stood in the way of her ability to look for or keep a job. Depression and anxiety made certain positions unattainable or unrealistic. Diane, a 26 year-old woman who had temporarily lost custody of her daughter, discussed her thoughts about finding a job but they were random, disjointed ideas that reflected her preoccupied mental state and her inability to focus on her immediate goals, her specific needs, and her future:

(W024) I really don't know what I want to do, to be honest with you. I went to school for CNA [Certified Nursing Assistant], and I had all 80's and 90's. Then I actually had to do the real work, and I didn't know how uncomfortable it would be to wash people in their beds, and then having Alzheimer's or whatever when they start screaming. I couldn't deal with it. I just felt really uncomfortable. I really don't know. Nothing really excites me that much, I mean I like to cook, but at the same time I don't want to do it because then I'm probably not gonna like cooking after that. When you're made to do something, you don't like it after that. Maybe I—I like cleaning. I'm really good at cleaning; I have OCD. Housekeeping, or something, but I want to make decent money... [Food service] it's just the customers. Some of them just get really aggravated and just rude. Then I get nervous in big crowds, so when it's lunchtime or something you've got lines everywhere. Everyone's complaining, and I'm rushing and getting anxiety. I don't need something

slow-paced, I just need something not—I work a lot better without public. Honestly, I'm more of a loner. I like to keep to myself. That's why I like second shift and third shift...not that I don't like people, I just feel uncomfortable in big crowds. That's why it was a little easier coming here because there wasn't so many people. I'll take anything right now. Obviously I'll take anything to start with. I do like cleaning, I don't know if you can go to school for that or something? I'm pretty much a professional. I do like helping people, but I feel it's—I feel bad when I see them hurt or handicapped or Alzheimer's or anything. It just hurts—I felt bad for them. It almost makes me want to cry sometimes when I see them. It's like they were once my age, young, walking around, and now it's like I'm going to be like that when I get older and it's gonna suck.
[Laughter]

At the Shelter - Personal Factors

Shame and Embarrassment

Primarily because of the stigma associated with being homeless the women tried to hide their situation. They spoke about the shame and embarrassment they felt from being at the shelter. The shelter is in a small town and the location of the shelter is well known to the townspeople. Mary had worked in town for many years before coming to the shelter so she knew many people. She had relocated to a State in the Western US and after many years she got divorced, lost most of her source of income, and then returned to the area. She discussed her reluctance to go into her former workplace again or even to walk around the neighborhood for fear of running into someone she knew when she previously lived in the area. Mary was quite concerned that people would know that she was homeless.

This fear also affected the children staying at the shelter and sometimes to hide their homelessness they would walk down the street to get on the school bus. They get off the bus down the street so the other kids on the bus don't see where they were staying. Alice mentioned that her teenage son is very proud and he didn't tell anyone that he was staying at a shelter. She explained the family's ability to hide their situation, "We have a story if his friends ever ask—

which they haven't asked—but if they do ask we have a story. We're staying at a friend's house; we're not here."

Many women hid their location and said that they don't tell people where they are. As Mary put it: "...and no one knows I'm in a homeless shelter. I mean on Facebook I just crack jokes like it's every day." This need to conceal their housing status illustrates their shame and desire to keep their situation a secret. It also provides insight into how their everyday life affects how they conceptualize homelessness. For example, Laura described her views on being considered homeless and who was aware of where she was staying:

(W023) I don't tell people. My friends don't know. Her [daughter's] father doesn't know. Only about three people know. Only cuz if you find out I'm not going to lie. No they don't know but if they know and they find out that doesn't make me a bad person cause I'm homeless...I mean I could tell everybody and if they treated me different then I don't need to talk to you anyway cause if one slight difference change in me then you're not friends with me because of me, you're friends with me because of what I have or what I had...Being homeless doesn't make you a bad person...what you do when you become homeless defines who you are.

Dignity and Respect

Achieving a sense of dignity is related to a need for respect. Respect and dignity were two central themes discussed by the women at the shelter. When asked about being homeless or how they felt they were treated by others several illustrated how they wanted to dispel myths about homeless people as being "dirty" or "addicts". Two examples of this come from Marilyn, whose family was broken up by being in the shelter and by Margaret, who had spent some time living in her truck. Both express their need for respect and dignity.

(W005) There was a fire in an apartment building in [name of town] and my best friend and I went to the donation center so that people could recoup some stuff for free. I had people donate dirty underwear. Just to say they donated stuff. Had I known that prior, had I gone to the bag just as they dropped it off but we just got inundated with stuff. I wouldn't have taken it but it's just like "Are you serious?" Just because they're homeless or just because they went through that doesn't mean that they're just going to take whatever you throw at them. And I think that's some people's perception of the

homeless that they'll take whatever they can get. And that's not true. We like nice things, too. We just live in a different environment.

(W026) Ya know I mean I don't live in my house and let it look like a pigsty. I'm not gonna—even though this isn't my home, for right now it is. Why am I gonna let it get dirty and dingy? I don't live like that. I don't wanna live like that. Never have. Never will. I mean even when I was stayin in my truck everything was all nicely folded. I had spots for everything. I knew where everything was and everything went. People make jokes, "Well, whadda you got? A house there?" If it wasn't for not having a portable sink and one of those little Porta Potty's, I would've had everything in there.

Mary was receiving food stamps and she said she was too embarrassed to use them. She had a lot of pride. She felt her family was degrading her for being at the shelter and she felt she did not belong there. She articulately expressed her feelings of dignity and gave examples of how she saw society, including her own family, treating people who are poor. Here she provides her experience with using health care, in this case a dentist, who took Medicaid. She explained her views on the system:

(W013) My doctor does not take Medicaid, so I have to pay him out of pocket. I'll tell you my experience as to why I will not go over there [to the clinic across the street from the shelter]. One is about a month ago I had to have a tooth extracted. I grind my teeth. Way back here a molar [was] pulled and I was so mad that that had to be pulled because I'm used to Blue Cross Blue Shield, real dentist. I had to go to a dentist who had tattoos all over his arm, who looked like a biker who basically ripped my tooth out, which—I thought for sure I was gonna get dry socket—which has not completely healed yet. That's been a month now. That's my experience with how they treat people on Medicaid. Maybe it's me being paranoid, but that's my experience...Society. That's the way society, I think, looks at people.

Shelter Life and Power Differentials at the Shelter

The institution of the shelter created an environment where the women sometimes felt demeaned. The shelter staff was in a position of power since the women were dependent on them for shelter, food, and resources. Some of the women, such as Carrie, expressed their dissatisfaction with the way she felt she was treated by a staff member:

(W007) But with this [staff member] treating me like shit today because my room wasn't clean. Excuse me my room is as clean as it was going to get and given the fact that my daughter's screaming but she didn't want to hear my bullshit excuses...She wouldn't even let me talk when I was in there. She just snapped at me. I'm a human being and I deserve to be talked to like a human being.

There were many rules at the shelter and some of the women approved of having so many rules and others were frustrated by them. Regardless, the shelter rules were a source of a great deal of discussion. Margaret expressed how she felt about the shelter staff and the rules:

(W026) The staff's cool. The staff's good. If you have a problem you can go to them. Any concerns—the director scared me at first but she's just doin' her job. If everybody picks up and does their chore and does what they're supposed to do, then there's no problem. That's why people get kicked out and they ask why.

Tanya gave her perspective on the need for rules:

(W011) Nothing here is ours, we're here temporarily. Basically we have to live by their rules...It's okay...I wouldn't say it's a lot of rules. I mean you would think if people lived in a building like this I mean you have to have rules, if not everybody would go crazy.

Feelings about the staff varied. Certainly not all the staff was regarded the same way. There were also staff changes during the time I was there. Some negative emotions were expressed as anger and frustration with the job the staff was doing or a belief that the staff was disinterested or overburdened. Marilyn expressed her thoughts like this:

(W005) For the most part they [the staff] do what they can. But again there's only so much they can do. They're more like referees sometimes. (Laughing) But they have to be. I mean some of rules don't make sense. But some of the rules don't always make sense. I think certain unnamed staff are harsh. People skills leave a lot to be desired. But that's just me.

Some of the women acknowledged the challenge of working at the shelter and were very appreciative of the assistance they had received. Audrey went on to explain her feelings about the shelter staff:

(W015) Some of the staff are good, some of them are bad. It's just like anything else. Yeah, some of the staff is really good, some of them were really bad. Some of them go

by the strict book guidelines. Other ones are like lax, and they roll with the flow. No, it's okay.

Margaret had had a rough time and expressed her gratitude for the ability to stay at the shelter. She was critical of the other residents who were less appreciative:

(W026) Ya know they [the other residents] complain about what's for lunch or what's for dinner or the rules or they have to do this or—be thankful that there's something like this here. Ya know, I am. Sleepin' in my truck wasn't exactly peaches and cream. I appreciate everything that these people here are doin'.

Relationships with Other Shelter Residents

Feelings about the other residents at the shelter ranged from distrust, due to frequent reports of possessions being stolen from residents' rooms, to heartfelt love. Several romantic relationships had developed between residents over the course of the years I was there. At least one of the women became involved with a male resident and they were supposed to share an apartment after they left the shelter. One young woman who I interviewed got involved with a much older man at the shelter. She spoke about her concern about the future of their relationship and his ability to maintain a substance-free lifestyle.

Overall, the women spoke kindly about the other shelter residents but they may have not wanted to appear critical to me during our interview. There was frequent gossiping and complaining that occurred among the residents. There were clearly cliques that formed and people formed groups based on age or situation. For example, young mothers sometimes hung out with the other young mothers. But many unexpected bonds seemed to form among residents, such as middle aged men befriending a single mother and helping her with her children. When I asked Kristen what she thought about the people at the shelter she replied,

(W012) They seem pretty cool... Yeah [I made friends]. I opened up a lot more now. I think the first few days I was here I wasn't talking to anybody or anything and now it's just like—I don't know, it seems like a family. It's weird. It's weird. I guess, when everybody shares the same bathroom and things, you just consider everybody family.

Some of the women mentioned that they tried to keep to themselves to avoid conflict.

Marilyn expressed it well:

(W005) For the most part we all get along. There's obviously when you have communal living you're always going to have a problem. No matter how much you try to stay to yourself. Not involve yourself in gossip or not listen to gossip or just whatever. You're always going to have a problem. I think that's anywhere you go whether it's in work, school, wherever you go. Um but for the most part we all pretty much get along. There's a few little tiffs here or there.

As Andrea explained,

(W030) Everything—I think everything has just been amazing. I mean, you have to do what you gotta do with the personalities, you know? Right? That's a pick and choose. You have to learn how to just walk away and humble yourself. If you don't, then if you choose to do the argument and the bickering, then you choose to. Personally me, I don't choose to. I'm not here for that. I'm here to get myself an apartment and get back where I was before. I'm not here to hang out and walk on my slippers, and go sit under that little gazebo every day, that's not for me. We had to do that for the first two days, we didn't have our son. Let me tell you, never again.

She went on to say,

(W030) That's one good thing, I am—staff is wonderful. I don't have no issues whatsoever with the staff, right down to the Director. I don't care what people say. If you're nice, and you're respectful, you're gonna get it back. I don't get involved with all their crap. That's just me, I don't know if it's because I'm older. I don't want to be bothered. If somebody needs help with their children, whatever, I'm there to help them. I'm just, I'm not here to make friends. I'm not here to socialize.

Living under the same roof and seeing the same people each day led to complex relationships. Prior to coming to the shelter most of the other residents were strangers to them. They were forced into living together, not by choice, but by circumstance. Although most residents were respectful of each other there were some situations that were confrontational. Sue gave an example of how she had been treated by other residents:

(W002) When I first got here...and ya know settling in it was not too bad and I had people come and go. Ya know got attached to people and then they'd leave and then we got a group in that was...ya know it started out that they were nice and then they just turned and ya know like accusing me of stealing stuff and even after things were found they wouldn't say "Oh, sorry I accused you." I was accused of stealing a wallet

(indignant) ...and it was like at that point I wouldn't come out of my room. And it turned...the wallet turned up on a bus. She had left it on a bus. But they would spit in front of my door on the floor and I couldn't walk by anybody without cat calls, and the guy...male of the group was in the laundry room one night and he made a point of shoving me...coming in and shoving me going out and I was so paralyzed 'cuz somebody said why didn't you scream? Why didn't you just holler? And it was like... I had no voice I couldn't...[teary]

Summary

Shelter life is challenging. Fortunately the shelter where I did my field work was clean, welcoming, and a safe haven for people whose lives have been disrupted. I have visited several other shelters throughout the State where the rooms are huge with beds lined up in rows, dormitory-style, or the people wait in-line for their medications, or residents arrive drunk or high. Complaints of people stealing from one another are common. Even those shelters that accept families are cluttered and crowded. This was an ideal shelter in comparison. Still there were multiple problems inherent in staying at a shelter, including the rules, loss of privacy, and congregate living.

Chapter 6. Narratives of Homeless Women's Lived Experience: Love and Loss

Taking into consideration the manner in which homelessness is conceptualized by the women and providers I interviewed, I was able to explore how daily encounters frame sheltered women's existence and shape their lived experience. The domains that were most influential in the women's lives were the losses they faced and their relationships. In fact the majority of the women grew up in poverty with complicated family relationships and their lives were molded by the struggles they faced by being poor and having limited resources as well as by the social support and interactions they had with family, friends, shelter staff, and most importantly their children. In childhood the women faced life-altering events, including physical or psychological abuse that scarred them for life. This chapter provides a glimpse into the lived experience of the women from their descriptions of what they have experienced, how they feel, and what worries, risks, and vulnerabilities they believe lay ahead.

Loss

Throughout their lives the women were faced with life changing losses. Loss can be separated into several themes. It can be tangible like loss of a job or loss of material possessions, such as a home and its contents, money or personal effects like clothing or priceless papers. It can also be emotional, such as estrangement from family members or abandonment by parents. It can be intangible like loss of self or dignity. Loss can also include a loss of innocence that may come with trauma (e.g., physical abuse) or with being molested as a child. Other losses mentioned by some of the women were losses they felt by being at the shelter, such as a loss of freedom or privacy.

One common focus of emotional loss described by the women was loss of their children; several had their children taken away from them by the Department of Children and Families

(DCF). Another common result of being in the shelter was that their family was often separated. Many women had some of their children with them at the shelter and other children were staying with different people; usually the woman's family or the child's father. Reasons for this separation were complicated, sometimes because the children were school-aged and the mother wanted them to remain in the same school where they had previously lived so she was willing to have the child stay with one of her family members or the child's father. The women were willing to endure this separation for the good of the child. For instance, Marilyn, a 36 year-old mother of four children who had two children with her at the shelter, explained, "My 14-year-old stays with my mother and my 12-year-old stays with a friend of ours. So it's been really hard. It's kinda like broken up my family." In some circumstances, the children were older than 18 years old and living on their own. Some of the women were estranged from their children and did not have contact with them. Others expressed frustration with limited time or ability to see the children. Commonly they were unable to go see the children not at the shelter with them because they lacked transportation or barriers in their relationships with those taking care of the children stood in the way.

Another type of emotional loss was the death of kin, such as a parent or sibling. This traumatic event often took place during the woman's childhood, when her future and identity was being formulated. Emotional loss also included the loss of childhood, often brought on by a parent's lack of attention due to abandonment or alcoholism or work. These situations unto themselves represent loss of the parent. Rose, a 52 year-old woman whose mother had left the family when they were children, expressed it this way:

(W018) I was never a child. My brother, when my mother left, my youngest brother, was nine months old...That was our doll. I helped take care of him, yes, with my sister.

Rose had dealt with loss, abandonment, and abuse throughout her life. She discussed how her first husband left:

(W018) ...actually, he abandoned me in a motel room. Yes, we had moved to [another state]. He took everything through my marriage. It's not the materialistic stuff that he took, but he took my clothes, come on. I was like I'm not gonna let a man do that to me again. I'm not gonna get married again. It's just plain and simple. I just don't want to be bothered. A friend, you know, companion, go to the movies maybe, to dinner, but that's about as far as it's gonna go. I'm not—it doesn't look like that's gonna be in the cards for me because I was angry at men for a long time, five years...He took my life, basically, and I want it back. That's a promise to myself. I want my life back. I need my life back. I need to be the way I was.

Material Loss

The very nature of leaving a home due to eviction or the end of a relationship constitutes a material and emotional loss. Such privation can have devastating and long-lasting effects on women's lives. Regardless of what possessions the individual or family is able to bring with them, the loss of the home is detrimental. Many women discussed what they missed about being in their own home; often it was comforting things like being able to cook their own food or watch TV when they wanted. Mary Beth, who had arrived in Connecticut because her husband's family was here, explained:

(W004) I sold everything in my house that could possibly be sold except for my memorabilia, things that are important to us. I put all that in a storage unit. I sold everything else in our house in two days, moved everything else out by myself, packed and loaded my car down...I had the middle seat ...for my son and I had a cubbyhole seat right here behind the passenger seat for my [other] son. I packed everything behind me. I packed everything in my front seat. I loaded down my trunk. We were out of there. We left, we just left, came all the way back up to Connecticut...

Loss of material items is also an emotional loss. It can be sentimental and leaving possessions behind is quite painful. Joan, the mother of two teenagers, was at the shelter with her children and her boyfriend. She had been at the shelter on at least three previous occasions. She told me a story about a paper her son had written about homelessness that she thought was

“the most amazing paper [she’d] ever read in [her] life.” When they were evicted and had to leave their apartment very suddenly, they left most of their possessions behind because they did not have the money for storage or for a truck, so they just took their clothes and what meant the most to them and they left everything else behind, including that paper. She expressed how she felt about the loss of her son’s assignment:

(W009) I cried, I was like—I wasn’t thinking about it when I was grabbing stuff and after we left and locked the doors and left the keys behind, that’s when I realized that I left that paper behind. It kind of made me sad... ‘Cause it was a really, really good paper. It was just a picture of a homeless man sitting on a sidewalk with a cup in his hand and you see a sleeping bag and you had to write about what you saw in the picture and it was—it was an incredible paper. I was very, very impressed.

Emotional Loss

Relinquishing parental rights either to a family member, parent, or third party was often voluntary, perceived as the best thing for the child, or it was involuntary, such as when DCF was involved. Having DCF involved in the woman’s life or the concern about the risk of DCF involvement was discussed by several of the women. Tessa, a young, single mother with a pre-schooler asked me if being in a shelter could prompt a DCF investigation. Several women were concerned that having their child in a shelter would be held against them. While I was involved in participant observation at the shelter I heard about DCF coming to the shelter with children for supervised visits with their mothers. The fear and avoidance of DCF in their lives was mentioned frequently. For example, Diane, a woman in her mid-twenties, who had lost custody of her daughter to the daughter’s father explained how she felt about the loss. Her ex-boyfriend had custody of their daughter and he was accusing her of being an alcoholic. She did not confirm or deny her alcohol use to me but seemed to feel she was unjustly denied the right to custody of her child. The entire interview revolved around her painful desire to regain custody of her daughter:

(W024) Yes, [I can see my daughter] through supervised visits until they [DCF] decide that they have no concerns about anything. My—the father of my kid - told them that I was unaffectionate to her and that I drank all the time. They said that I neglected her...I'm going through this whole process right now, and being in a shelter on top of everything, not having any friends or family. ..The father's going for custody now. I don't know what's gonna happen. I know they're not supposed to discriminate [against] you being in a shelter, but I don't know because I've never gone through any of this. I do get to see her, as long as DCF calls me back, which they were supposed to today and never did. They were supposed to yesterday, and never did...They said I was unaffectionate, but that's—how can you say someone's unaffectionate? I mean how affectionate do you have to be? Nobody sits there and smothers their kids constantly. They didn't prove anything. Why do you have the right to take my child away?..Yeah, but I just want to clear my name. Show them that I am a good mother, because I really am. I'm not the most affectionate, like I don't sit there and coddle my kid all day long. I'll play with her. I make sure she has everything she needs. I do hold her. They were only there for not even an hour that day. They really—the whole thing was the alcoholism part, and I wasn't drinking or anything. They didn't prove it. ..I feel like there's got to be something I can do to get her back, or at least see her a few times a week. It's only fair, I'm the mother. I should be having her right now. He didn't give much into it. You know, what did he do? It just—I don't—something doesn't feel right about this whole situation. I really want it to change. That's why I'm trying to find out from everybody what their input is...That's why I want a better life for my kid. That's why this is bothering me. I've always been in control of everything that I do. One thing that is the most important thing in my life is her. Not to be able to have control of her is bothering me.

Other women gave up custody to a family member or foster care. Mary Beth who was at the shelter with her husband, his son, and their baby also had two other children who were not with her. Her story was long and convoluted. She had years of trouble with the father of her daughter. She had given birth as a teenager and then endured physical and psychological abuse from him, beatings, threatening her with a gun, run-ins with law enforcement, stalking her from one State to another, and finally his parents gaining custody of the child. Eventually, he was incarcerated for an unrelated issue, his mother passed away, and there was no one to care for her daughter and she had left the State and was unable to regain custody. She arranged to have her daughter adopted by a woman she knew so she could maintain contact with her.

(W004) I had to adopt my daughter out so that she could have—so that she could live a good life and not worry about the things that the state of [Midwestern state] were doing to her. [*Crying*] Knowing no one could care for her as much as the way I used to...That's

the only good thing. Her foster mom and I are the ones who agreed to this...It's just crazy. I've come to terms with it, but it breaks my heart because my daughter shouldn't have had to have gone through that and I probably would've never ended up here. I know it sounds kind of like terrible to blame all of my whatnots on him [daughter's father], but really, if he woulda never done the things that he had done to me I would really probably still be in [Midwestern state] working at the same place, talking to my same old friends and living my same little old life.

I just get sad about my daughter. That's about it. It's not uncomfortable...It's just sad because I love her very much...Actually, I got to see her last year. I got to see her last year for about an hour...That's why I let her adopt her, because if I wouldn't have I would never have been able to have any type of physical contact with my daughter. [Midwestern state] would've kept her from me forever. They would've just kept her from me.

For children in the foster care system turning 18 years old can be accompanied by significant loss, often resulting in homelessness. When they "age out" of the foster care system, they frequently have nowhere to go since the foster parents no longer receive payment to support them and the system no longer has responsibility to find them a place to live. Robin was a mature 19 year-old woman who was a product of this system. She explained:

(W008) [The place that was her foster home] was transient. I went to three foster homes. The second one I stayed for three years. I was so close to everybody, and without warning, without telling me why, to this day I have no idea why, they let me go. [She was 18]... It hurt a lot.

Several women in their fifties stressed the loss of their former lives. They were at the shelter alone, they were divorced, and their children were grown. They lamented the sudden change in their lives and the inability to return to the life they had had previously. They had left good jobs and financial security and felt trapped, vulnerable, and unsure about their ability to acquire work at their age. Their concerns went beyond financial independence. They were also worried about being able to conduct some daily activities like writing checks or paying bills, if those were tasks they had not performed for themselves. Mary, who, in her fifties, was unexpectedly homeless, described her life with her ex-husband in another state. She expressed a

longing for the life she once knew:

(W013) Our last house was a log house and that was our dream house. We had tons of acres; my horses were there. I had a beautiful barn. It was finally everything I really wanted for me, because my outlet was my horses. When things were miserable, animals are unconditional and that's where I'd go... I don't know what's gonna happen tomorrow, in all honesty. I don't know. This is not the way my world was. My world right now, being Friday night. .. I know exactly what I'd be doing right now. I'd be making dinner. There'd be kids at the house, my son and his friends. The TV would be on. I'd probably be doing a little laundry or vacuuming while I'm making dinner. [My dog], we'd maybe be going for a walk, whatever. I don't know... That was my life. That's all I ever knew. I was taking care of the horses, I was doing the laundry, I was taking care of my family. I was at the grocery store. I was always on the go. I was always moving. I had a schedule. .. Yeah, I miss it.

She elaborately expressed her thoughts about her vulnerability and the risks she was going to have to take in the future which included being able to get a job, working in something she was trained for, and her future:

Those things aren't out there. I can't go back to [previous work] because it's frozen. It's broke... What I know how to do and what I do the best I can't go back to, so all I can do is keep going to school, and I'm 54, but that doesn't really matter. One thing that scares me the most—and I'm gonna tell you—I don't wanna die alone; I don't wanna be alone anymore. I'm tired of being alone.

Many relationships resulted in separation but regardless of the cause of the separation, the result was loss and pain. Marian, a 50 year-old woman, was at the shelter alone. I knew she was an alcoholic because I had seen her at an Alcoholics Anonymous (AA) meeting and she had been at the shelter multiple times. In our interview she mainly spoke about her relationship with her father. At one point she mentioned she had children. When I asked about her daughter she said she was not in touch with her and had not been since prior to when the daughter was in high school.

(W016) It's not good. I mean, I'd love to be in touch with her, but she doesn't want anything to do with me... I don't really wanna get into that a lot, but—I don't know. One day I would like to see her and sit down and talk with her anyway, try to—I wanna see her. I love her, so I miss her a lot.

Estrangement from a child or parent was common. Throughout the interviews the

women mentioned that they had not been in touch with a parent or sibling or child for many years. Most expressed sadness about this; it was a huge loss. Some of the women discussed the impact of the death of a parent, either at a young age or in adulthood. Sue spoke in detail about the death of her “father”. This man was actually her step-father and he had sexually molested her when she was a child.

(W002) [My dad] always saw me for three hours on Sunday when he showed up... He was an alcoholic. And I understand why my mother left him. But ya know at that point I was a daddy’s girl and they took my dad away from me (crying) and wouldn’t let me see him.

Jessica was at the shelter with her 19 month-old son. Her mother died when she was 9 years old and she was raised by a grandmother. Her mother died from drug use and she claimed:

(W022) I didn’t have issues with it [drugs and alcohol] cause I never wanted to be like that. Ever. It made a mess out of me. I was 9 years old....I know now that she’s in a better place because obviously she wasn’t strong enough to stop so obviously she’s better off right now and I don’t want to say much [inaudible] or whatever but I just know my mother and— like right now if that didn’t happen to her she would have died already. You know what I’m saying? I don’t know. I’m not scared of death anymore and I’m not going to stop living my life because if I stop then my son’s not going to have a life. I don’t want him to go through anything that I ever had to go through when I was younger...I’m not doing drugs or alcohol all that.

Loss of Romantic Love

Several of the women spoke about the love they lost when a partner left them. The end of long-term relationships dissolved the little stability that they had had in their lives. It often took them by surprise and the consequences were life changing, affecting their life course indefinitely. Although many women knew they could get back on track, the end of a marriage took a drastic toll on their psyche and made them vulnerable to additional dire consequences in life. The loss left them in a depressed and confused state; they lost their self-esteem, their security, and, generally, their source of income. There were many examples of this life altering

event and the effect it had on the woman and her children. Audrey, a 51 year-old woman, spoke with sadness about the loss of her relationship with her husband:

(W015) You have no idea. I say this. My heart wasn't broken, it was shattered, and it's probably taken me seven years to piece it back together, but we won't ever be the same now. Will I ever trust a man? No, never fully again because I thought I knew this man inside and out... You fight with your feelings every day. Do you know what I mean? You just get up on a normal day and everything's fine, and then wham, it'll hit you. No, you're not married anymore. I've got to roll over and hug him. I spent 25 years with him, you know. I go to roll over and hug him—

Dottie had a similar experience with her husband of almost 20 years:

(W025) I'm 51 and I'm living here with my...son. Reason being is my husband was the sole income in the home. He decided that he was leaving. He left. Therefore we ended up—ended up getting evicted so my son and I became homeless and that's how I got here. I mean 19 years of marriage. I know I'm not gonna get over it in a day or two but I'm going through it...No reasons. Then I get a call a month later telling me that he's seeing somebody. Why would you call me back and tell me that? I'm saying why would you do that? You're already gone and you left me and you hurt me by leaving and now you want to turn it around and hurt me more by telling me that you're seeing someone...I don't know what he thought. I just thought it was heartless...All that I've gone through and all that I'm still going—now I'm going through a separation from 19 years of marriage. I mean I thought I almost was gonna lose it when he left cuz I was an emotional wreck.

Loss of Freedom, Self-respect, and Privacy

One of the women, Peggy, who is described in more detail in the next chapter, is a prime example of a woman who faced unbearable intangible loss of freedom and self-respect. She lost much of her childhood by being physically abused by her brother and her entire adult life at the hands of her husband, who kept her imprisoned in their house in the woods. She lost all sense of worthiness and dignity.

(W017) ...but I do need to find out how to live on my own. My husband never even let me pay a bill by myself. He was very—controlling and abusive when it comes to not showing me any respect whatsoever. He said I was as stupid as Edith on Archie Bunker and wouldn't let me pay any bills, saying that he didn't want to pay anything twice and was continuously reminding me that my father liked my sisters more than me and just a whole lot of stuff.

I'm telling you he was continuously putting me down and just making me feel like I wasn't worth anything so I wouldn't feel like I could be on my own.

He'd given me quite a bit of alcohol and all sorts of drugs, whether it be mescaline and cocaine and THC and a number of things that I thought would be a cure for my emotions, but I actually realized later when all three of my children, that I did have, became older, they noticed that I was too emotional. They said I took everything too personally and wanted me to leave my husband because of the lack of respect that he showed me.

What he was doing was trying to practically hold me captive or keep me prisoner there.

Staying at the shelter created a different kind of loss. After the woman arrived at the shelter and endured material and emotional loss she was often affected by further loss at the shelter. Rachel, a 22 year-old woman with a pre-schooler, mentioned the lack of freedom she felt at the shelter because she couldn't eat what she wanted or when she wanted, she couldn't have a snack when she wanted or take food to her room.

(W029) It's been fine [being at the shelter]...the people are nice, and the staff have been pretty good. I mean, as good as I guess they can be for the rules they have to follow. Certain things have been—we're already in a tough spot being this low and having to be this low in life, that the small things like food and just a snack you're used to having, and stuff like that, [to have it] taken from you. You have certain rules that are so strict here—that's my only thing that I've had a problem with. I guess about being here in particular, is just not being able to have food and stuff in our rooms. That's all.

This same frustration was expressed by women whose freedom was restricted by the seemingly endless shelter rules: they had to wake up before 7 a.m. and leave the shelter to look for work or housing, they had chores to do, they were not able to stay out past 9 o'clock, they could not watch TV late at night, and they could not leave their children with any other resident (even for a few minutes). The rules were abundant and they presented the women with a sense of loss of freedom from their "normal" routine. Mary described her frustration at the shelter:

(W013) I'm just looking to be happy. I'm just looking to get my dog back. I'm just looking to get my life back, have my freedoms back. People take that freedom very—I mean I took it for granted. There's no freedom here. There's people sick here; there's

people who are mentally ill here; there's people that this is the system they use and they abuse it. They go from one to the other two—there's no aspirations in here.

Further, the shelter living situation created a loss of privacy. Meals were eaten in a congregate setting, the living room was shared by all the residents, the single rooms each contained four beds (two sets of bunk beds), and the bathrooms on each floor were shared by everyone staying on that floor. The women also mentioned feeling that there was a lot of “drama” at the shelter, with people involved in each other's lives and gossiping about each other.

The multitude of losses the women experienced was complex and troubling. They seemed to cause them a lot of pain and regret. In most cases, the losses could not be undone; they were permanent reminders of a life they could have had or one they never had. Being at the shelter caused an influx of emotions that reinforced their sense of loss. Some of the emotions caused a further loss of self-esteem and respect.

Loss of Self-esteem

Coping with loss, abusive relationships, and other trauma throughout the women's lives was a consistent source of degradation and humiliation with a devastating effect on their self-esteem. Many of the women spent years being put down by their mother or their partner. This miserable sense of self-worth was very evident in their tone of voice and their descriptions of their relationships with these people. Often it was a partner who broke their confidence, but it often followed a childhood of negativity and insults from their parents; frequently their mother. Once their self-esteem was lost it was very difficult to regain confidence. For instance, Mary explained how her relationship with her husband damaged her self-esteem and Alice felt criticized throughout her life:

(W013) Well, when I got genital crabs at nine months [pregnant]. Hello? Yeah. He broke

my heart. Let's put it that way. The man broke my heart. He literally broke my heart. It's like my mother said it good—he broke my spirit, is what he did. He was the kind of person—he just broke my spirit, he really did. He broke my self-esteem. He did a lot of emotional damage to me that's the baggage still, I think, [that] follows me around.

(W014) I wanna be able to have my kids have a memory, a good memory, of me and not what I'm feeling about my mom. I still loved her. She's my mom, of course, but I didn't like her choices and what she did to me. It doesn't erase anything she did to me in the past, nothing. I'm not saying I blame her for my mistakes now, but I blame her mostly for my emotional state now, because I went through a lot with her...I used to run away all the time. I never was a drinker; I never was a drug user back then. Never did nothing, but I was a very emotional kid and was put down my entire life from her and my stepmom a little bit, and he's [son] started to do it.

Alice's older son was very angry about being at the shelter. He was over 18 years old so he had to sleep in a room with single men, not in the family room with her and her younger son. He also had a medical problem while at the shelter that was infectious and he was forced to leave temporarily. He slept in their car during this time and took out his frustrations on his mother. She had been a victim of domestic violence and was acutely aware of the language men used to speak to her and she was concerned about the way her son was treating her. She had addressed this issue with him because of her concern that he would treat a girlfriend the way she had been treated and she wanted him to respect women and treat them with dignity. Alice also talked about wanting to go into school systems to teach students about bullying and domestic violence. She felt her experience could be useful to them.

Consequences of being put-down can cause feelings of depression or rebellion to overcome the negative impact of this oppression. Margaret's two sons were not with her at the shelter because she had recently been hospitalized for depression, and they were being cared for by their father. She described how her relationship with her partner affected her self-esteem and mental health:

(W026) I let a person [partner] influence me into thinkin' that I was useless and worthless and no good. It just made me depressed and depressed and depressed, even to the point

where I didn't even want to leave the bedroom. I coulda stayed there with the shades drawn all day underneath the blankets and not even be bothered and it wouldn't have phased me a bit.

Narratives about Relationships

Social support from family members, children, partners, and others was a crucial aspect of the women's life histories. Although many of the relationships were detrimental, particularly those in childhood, they were extremely important to the women and they shaped who they were and what they felt about themselves. Their narratives about these relationships provide a telling tale of the psychological trauma the women experienced and how their relationships with the people who they loved, who were the most important people in their lives, caused them unbearable pain. As they sought refuge at the shelter, they looked for relationships that would fill some void, even temporarily, to make them feel whole and safe. At times the shelter provided this comfort but for some it was more power struggles.

Family

Relationships with Fathers

Relationships with fathers were somewhat different than relationships with mothers. Most of the women's fathers were in and out of their lives and, like their mothers, some were alcoholics or preoccupied with their own lives, providing little attention to their children. The women described this dynamic in varied ways. According to Sarah:

(W019) [Things growing up were] awful—very, very tumultuous. My dad was an alcoholic. When I became older he became a recovering alcoholic. He was able to go to AA and accept that he had a problem and that type of thing. My mother was an enabler and in total denial and very volatile—not very loving at all—just not a great mom. It was hard and my brothers were all older so they just took off if my dad had a bad day and had a dry drunk, or whatever, or was drinking. They took off and I was stuck there. I was too young to do anything about it.

Sue was beaten repeatedly by her “father” (he was actually her step-father) but she cared for him until the day he died. Sue was an adult when her father died but his death caused bad relationships with her mother and siblings. Over time, she became more depressed, left her job, and was hospitalized for depression and a suicide attempt. Her stories were convoluted and difficult to follow, illustrating her mental health status, and her complex, disjointed thoughts:

(W002) It was a love-hate relationship? It was a love-hate thing, I don't know...Well, ya know, there's no book for parenting. I figured out at one point that a lot of those beatings were generated from my mother. Who would meet him screaming at the door. And his only way to shut her up and to pacify her was to do what she wanted... Take action...Oh no, we never discussed things in my family. But...ya know when somebody's dying that's when you...that's what I've done all my life: be a care-giver. I worked in nursing homes and my dad was a big man and ya know it would take like four aides to walk down the hall with 'em, ya know. It's like they had it in for him and he's going to be crazy and he's not going to know anybody and it's like NO he's going to stay in the house. So I did [take care of him]. And that's when it all fell apart after he died.

Audrey casually mentioned that her father molested her but she didn't really realize it until she was about 30 years old when her sister told her that she had been molested by their father. She spoke about her father this way:

(W015) My father had us move to [another state] December 3rd. December 6th was their wedding anniversary. December 15th, he died. December 18th, we put him in the ground. I hit the road. I hated her [her mother] then. [I was] Sixteen. I hit the road...We had a normal—well, not a normal life. We got our asses beat with switches and we got told when, where, and how. We were scared to death of our father, but you know, but we respected him. We did respect him, I'll have to give him that, whether he whooped us or not, we respected that man.

Relationships with Mothers

Interactions with their mothers ranged from non-existent to co-dependent. Some relationships were more positive than others and some were quite destructive. Troubled

relationships with their mothers were discussed at length. The women needed support and encouragement from their mothers and many described how this was lacking.

For example, as Sarah described:

(W019) [My relationship with my mother was] at one time it was very close, or so I thought. As I've been told in therapy and that type of thing, that it was just a parallel relationship where we did things together and that was it. It wasn't unconditional. It was always very conditional...Meaning that my mother expected me to mother her instead of the other way around...[She was] very, very needy.

They dealt with rejection and painful criticism from their mothers that endured throughout their lives. Rose described her relationship with her mother this way:

(W018) She [mother] finally divorced him [step-father – who sexually molested her] after so long, and then she ran with another man. It was different. She had—I think she had mental issues, too, very young age...Yes, but she didn't want to get help, she wanted to continue the way she wanted to live, you know, she just—to me, I really—and this is bad to say, but I really think she didn't really care about us kids. Why did she have us? I'd always asked that. She said, "Well, I could have flushed you down the toilet." Yeah, you could have done that...Yeah, oh, yeah [she said that]. This was when she was younger now. She had alcohol issues, yes. She drank a little bit, not much. I mean not like full-blown alcoholic, like my sister and I was. I have five years sobriety under my belt. He [her son] thinks my mom's the greatest, and my mom's not the greatest. Don't get me wrong. I love my mother, and I honor her, but as far as a relationship, my last counselor told me "a mother like that, I wouldn't have a relationship", and that's pretty bad, and she's a very good counselor. She knew. She could tell the emotions on my face, when I just want to go in there and do nothing, just feel my low self-esteem. My self-esteem has always been put down. ..I told her the last time [I went to live with her], remember, I told her I'll try it this one last time, but I can't do it. It's just too much emotional—it's like she—my brother said it's like she's jealous. For what? I'm doing what I'm supposed to be doing. I'm getting counseling and—because I've been all in the turmoil, that's not a reason to be jealous...She just tells me things like you try to tell me—manipulate me in thinking I did this and I didn't do this. This is your fault, and some I'll take blame, but—and I'm not angry with her. I'm just over it. I'm just so tired of keep bumping into the walls, and nobody hearing what I have to say, not that it's—it is important, but to me it is important, and it's nothing about issues or just let's chill. Let's just forget the past. Every time we try to forget the past, we end up fighting.

Several women felt that their lives had mimicked those of their mothers and that they were following in her footsteps. This was not always described as a positive event but they

presented it as if they had no other options; it seemed inevitable. Some felt it was a cycle that they wished to break. For example, Mary Beth explained:

(W004) I'm telling you. I'm really telling you, man, that whole thing, whatever a mother's daughter does is the daughter's doing is what happens to her. It's like seriously, whatever your mother's life was - is what your life's gonna be. I mean you can try to change it all you want, 'cuz I surely did try to change it all I wanted, but I'm following every footstep of my mother, 'cuz I'm her firstborn. ..My mother's path of what she lived and my path of what I've lived are completely identical. Mine's just a little more severe than what hers was.

Not only were the women concerned that they would end-up like their mother based on their history but some had legitimate reasons to fear living a life similar to their mother since they had already experienced homelessness in childhood. This cycle of homelessness was discussed multiple times by the women. One staff member had worked at the shelter for over 20 years and she saw women come to the shelter with their children who had, themselves, been residents of the shelter in childhood. Laura was in a shelter when she was a child. She was currently at the shelter with her young daughter and she was pregnant. She had a good relationship with her mother but explained how she was trying to break the cycle and not follow in her mother's shoes:

(W023) My mom's up here and I'm having another baby. Six months pregnant so I figured I would come up here. I mean I've had jobs in between and I had a job for about three months. My daughter got sick last year. She was just sick for months and we couldn't figure out what was wrong with her. I lost that job. I just started getting back – I had the job, I had her in day care, which I paid all on my own. I didn't get any help from the State because the certain amount that you – it has to go by what you make and I made too much to get help with day care or anything. That alone took my check. Doing it on my own. Her father was in jail so still trying to do all that on my own. My family just...really wasn't there at all. I have to do it for my daughter. I've always had to do it...It's kinda like it's not cool but my mom does the same thing. 'Cept she was younger when she had her first kid. She had me at 17 and had my brother at 19. And she was in a shelter when she was younger. I mean when I first got here I was like really crying because I didn't just get here and then wind up in the shelter. I came out here with money. Okay, I'm going to get a place and have all this. And I have my car. I got a new car when I got my last job. I owned that one. I paid for that one but can't get it out here from [another state]. So that's kinda a "no-go" thing...When I was really young my mom

– I mean she had me and my brother and we went to a women’s shelter with women and children. I have a good memory. It wasn’t that long that I remember. But it was when I was 5 or 6 and then she’s been on Section 8 ever since. And I always said my mom did a good job but I don’t want to follow in her footsteps. So I always wanna do things on my own...Cause I don’t want it to be a cycle. I really want to be the one that kinda stops the cycle and again I did with the going to school and I finished school. My mom’s trying to go back to college now...From not being in school from 16 and now you’re 39 is a big gap. You know going back to school. I help her with her math.

Relationships with Step-parents

Blended families sometimes presented problems and complicated relationships. Amy is a 22 year-old who was at the shelter with her boyfriend. She spoke angrily about her step-mother’s treatment of her:

(W020) I’m 22 years old and I was living with my dad and step-mom. I’m originally from [another state]. My step-mom, not a very nice person, she was my mom’s best friend and she’s also my sister’s boyfriend’s mother and my sister’s—It is [complicated]. My sister and her boyfriend they’ve been together for 13 years and then our parents decided to get married and she found me a threat because my father and I were close. She ended up throwing me out in the middle of the wintertime...I left my dad’s house quite a few times. Every other month when I was there she kept throwing me out... Well she told me I had to [leave]. One night her and my dad boxed me in, literally boxed me into that room so I couldn’t leave. She started going through all my stuff, ripping out, throwing it all over the place and I called the cops on her. Then she told the cops that it wasn’t true. She hurried up and cleaned everything up before they came. Told them that wasn’t true and they were getting all ready to arrest me...Because she lied to them and told them I had stolen property on me...That’s when my dad stepped in and he was like no don’t arrest her. ..I went and I stayed the night at my aunt’s. She would know that I had no vehicle at the time, no way of getting back and she’d know I was at work and I didn’t get out until a certain time and she would wait until she knew that I wouldn’t be out at that time. She would send texts while I was at work, oh if you’re not back by 9:00 the door is locked and you’re not allowed in here.

Relationships with Other Family Members

There was a wide range of other relationships with family members. Jessica was raised by her grandmother; her mother died when she was 9 years old. When I asked who raised her she explained:

(W022) My grandma. I mean we're just now becoming friends. And we complain because when I was growing up I always figured she'd always be picking on me or whatever and then I realized why she did some of the stuff she did. She just could teach me basic stuff like how to clean, like if... Basically how to be a lady. So when I was younger all I wanted to do was go outside and all this other stuff but then now... I'm only 19 and I talk like I'm so old but it's because I ran away when I was 16. I've been through a whole bunch of bull. By now I'm not proud of all of them but [inaudible] but I'm ready to get my life together.

Children

Of the 30 women I interviewed, all but 5 were mothers. Being a mother exemplified the love and loss domains that were omnipresent in my interviews. Regardless of whether their children were with them at the shelter or not, or if they were over the age of 18 and on their own, the women spoke with palpable emotion about their children. Their devotion to their children and desire to be "good mothers" was a consistent theme. This was particularly true when a woman lacked confidence in other areas of her life. Especially for the women who had children taken away by DCF or whose children were living elsewhere for other reasons. Tessa expressed concern that moving around from apartment to apartment and to a shelter would make her vulnerable and at risk for being an "unfit" mother. She was quite fearful of the consequences of this instability and expressed her need to find an apartment and consistency in her son's life. She explained, "I think it's really important that I'm there for my child, as well. It's important that I provide for us, too." She explained how she would do anything for her son and the changes she had made in her life since he was born:

(W003) I want the best for him. I really do. I want to provide a good life for him. I try and make good choices. The best choices as possible. My whole life has changed since I've had my son... Well when I was younger I liked to hang around different crowds and ya know. Kinda do bad things. I was into drinking and stuff like that. Never like heavy drugs or anything. But after I had my son I stopped doing all that. I stopped hanging out and now I could never picture myself ever doing any of that stuff again. I look back and I'm pretty much regretful of my past behaviour.

Their role as a mother was one of the most important roles they played. They described how they cared for their children and some discussed their criticism of the way other mothers parented their children. Mary Beth was staying with her sister-in-law who she felt was not attentive to her own child:

(W004) I'm like "Seriously?" Because I'm like, "How were you raising your kid before we came here?" because this isn't normal, and let me tell you what: children are everything to me. I may be a little harsh in my tone with my children at times, and I may be a little over-disciplined with some things, but I'm there for my kids every step of the way. If they need help with homework, I'm right there. If they need a hug, I'm right there. If they need—I'm right there. This woman is not there for her kids.

This philosophy on parenting and discipline, was echoed by Peggy, mentioned above, who had been kept a prisoner by her husband in her own home for 20 years. This 47 year-old mother of three adult children managed to care for and raise her children despite the unfathomable abuse she had endured in her life.

(W017) Yeah, they are nice children. I love them. I'm thankful that they all come out and tell me I'm one of the best moms and things like that. I've never wanted to be abusive with them. I believe talking to children's more beneficial than hurting them, which is something my husband didn't like. He always said I was trying to make him seem like the bad guy since he'd wanna throw them against the wall or get very abusive with them, and I don't like things like that. I think if you talk to children they're much more apt to listen to you if you hear what they have to say or what their reasons are, but I'm also willing to tell them what my opinion is and why I wouldn't want them to do certain things.

An added challenge of being a parent and being homeless was being a single parent. This situation led to additional complexities and difficulties. The women mentioned the issue of having no one to care for the children when they go to look for a place to live or a job, only having one income, and needing to make arrangements for child care. Furthermore, the single mothers spoke about being tired and understanding the need for more patience than when there are two adult caregivers. Carrie clearly expressed her frustration with the fact that she was solely responsible for parenting, even with a boyfriend in her life:

(W007) It's that I'm a single mom even though I'm with my boyfriend here, I'm a single mom. He works all the time. When he comes back he wants to sleep. He doesn't want anything now when he's working. He doesn't want anything to do with helping me with the baby.

Tanya who was also at the shelter with her partner explained:

(W011) Basically our hardships, [my husband] has been taking care of me and the family for two years now. I've worked on and off but it's really difficult for childcare and just me trying to work a full-time job at the same time trying to take care of the youngest baby...I mean it's just that I'm the type of person where I want to make sure my kids are okay first. Daycare of course is always a big issue and you have to pay for that.

Some had confidence about their role as a mother and others were less secure. A

frequent comment revolved around the desire to be a better mother than their mother was to them. For example Diane, who was alone at the shelter because her ex-boyfriend had custody of their daughter, said:

(W024)...my mom didn't—she didn't really take care of me, and she wasn't in my life. It's like, I want different for my daughter. I want to be able to stay home and see her, at least until she goes into school. Then whatever, I'll work during school. It just didn't work out that way.

Jessica described the role of her son's father and then her role as a mother:

(W022) No. [Son's father is not in the picture at all] Not at all but my ex-girlfriend is his dad because when we were together I was the mother primarily and she gave him his name and he has her last name. And that's who he calls 'Daddy'. Coming here honestly I think it made me into a better person than I was when I was in [another town]. Not a better mother but a better person. I've always been a good mom...since I had him I hadn't really been going out...I hope he's being taken care of. I hate letting people watch my child. Why? Because I don't know what's going on. You hear what I'm saying? I barely let friends...I don't leave him with nobody. Except for his dad, my ex. Other than that...He's my baby. I love him...That's why I ...don't want my son to grow up like I did. Ya know have somebody else take care of you like not your mother or not your parent at all. It was rough. But everybody's like "You're such a good mom. You're an inspiration to the other moms" and I'm like, "How, I'm only 19. I just treat him how I would want to be treated." I talk to him. My son is very smart. Like he has a very good vocabulary. Because anything I tell him if he don't get it I sit there and I'll make sure he understands it. I'll even try to have him repeat it sometimes. He understands so much that's because I make sure he knows.

There were many examples of the women discussing their pride in their children. Their

children's accomplishments seemed to ground them or give them validity as a good mother.

When so many other factors in their lives were in disarray it was important for the women to feel good about their ability to parent. Sarah, who had once been a teacher, talked about her pride in her teenaged sons:

(W019) We are without a home right now but I am not ignorant, nor am I ill educated. I have my master's degree. I graduated magna cum laude with a 3.97 average GPA. I have a very, very rich vocabulary, as do my sons. They are avid readers because I've read to them since they were in utero and had access to hundreds of books. Their favorite—one of their favorite things is going to the library and checking out books. They're wonderful students and wonderful, wonderful young men. They don't swear, drink, smoke—nothing. I am very, very lucky and I'm very, very proud of them.

The chaos in their lives often caused the burden of daily tasks to fall on their children.

Sarah explained her relationship with her two teenaged sons and how they had to care for her.

(W019) I have generalized anxiety disorder so I worry about everything. My sons are my primary goal in my life and I'm their life so we are very, very, very close. I've just started learning how to take care of myself physically, emotionally—spiritually—that type of thing. That's been a great thing for my sons because they don't have to worry about me so much anymore.

Even if the women did not have their children with them they still wanted the best for them. Many discussed the frustration of not having their children with them but still trying to provide for them. Marilyn was facing daily struggles of dealing with car problems and then needing to attend to pressing tasks for a child who was not with her at the shelter:

(W005) ... 'course the brake line just went on my car so I'm not quite sure—I'm supposed to go [see my son] tomorrow, so I'm going to see if someone else that lives here will give me a ride because the school there is telling me if I don't go there and have a paper notarized, with the guy where my son is staying—the family where my son is staying—he won't be able to go to school anymore because he has to show proof of residency.

Life in the Shelter with Children

The decision to go to the shelter in the first place caused some women to face challenging decisions related to their children's well-being. Many expressed concern about the effect being

in a shelter would have on their children. There was a range of emotions associated with raising children at a homeless shelter. Margaret came to the shelter alone, leaving her two children with her ex-husband because she felt it was the best for them:

(W026) I'm here by myself. I do have two children but they're staying with their dad right now to try to keep a comfortable environment for them. I'm here for a mistaken path that I chose to go but I'm makin' the best of it...Psychiatric issues—mostly depression because of the situation. Not bein' with my kids. Not bein' able to support them or myself, but I mean it was the right decision. I know that as much as it hurts them not bein' here with me, I know that it's better for them mentally 'cuz it's hard enough of a change goin' without mom to have too many changes.

Tessa, whose young son was with her at the shelter, expressed her feelings about being at the shelter this way:

(W003) It's good [being in the shelter]. I have a little concern for my child just kind of being around so many different people but I try to take the best care of him as much as possible... [Problems with the shelter] That I don't have my own privacy. That my son is disobedient towards me. That we're here and it's a change, I think. But that's about it. Just not having my own secure home. A place for my family.

Tanya described the effect the shelter had on her child's behavior.

(W011) [My children have been] ...pretty good, my oldest has changed a little bit...In a way like he feels he can say certain stuff and do certain stuff, because you can't discipline your kid here really. You have to put 'em in the corner, put 'em in timeout. Yeah [those are the rules], like you can't discipline them, smack them in the hands or anything like that. You get in trouble for that. [My son is] a little bit talkative, talking back because he's seen [other children do that]. I've saw a couple kids come outta here that I did not believe would do that. If I would say that to my mom, I probably wouldn't have any teeth. I don't know it's just crazy. Kids and their parents and the youngest is five and four. [Kids talking back to their parents] Yeah, and hitting them, punching them in the face, yeah. I couldn't believe it. That made me not want to be here. I didn't want my son to see that because that's not good at all. That is bad...and if he [boy at shelter] treats his mom like that, that's how he's gonna treat women? She's not teaching him.

Children's Relationships with Mother's Ex- or her Boyfriend

The mothers' relationships with their children were often complicated by their involvement with a male partner. Sometimes these men were the only male role model the children had and their relationships with them were challenging. Many of the children were

raised by someone other than their biological father and often the woman's current partner fills this role. I asked Joan (W009) what her children think about her boyfriend and she answered, laughing, "They don't. Not very much. My oldest daughter does not like him at all...It makes it hard on me, and I feel torn and—I don't know. It's hard." Regarding her future, Joan was facing the difficult decision of including her boyfriend in her plans and in her housing decisions. She knew she might have to consider moving forward without him in her plans. She said, "Well, I was hopin' I wouldn't have to consider that, but I gotta do what I gotta do for my kids."

Because some of the women were no longer involved with the father of their children, this often made the children's relationship with their fathers either inconsistent or non-existent. If the women were resentful or angry with these men they were not enthusiastic about having their children involved with them but they recognized that their children's relationship with their father was important. The women feared that the same issues that caused the woman problems, such as abuse or substance use, would affect the fathers' interactions with their children. The women also sometimes expressed the concern that the father was not a good role model for the child since many were involved with substance abuse or had been involved with the criminal justice system.

Relationship with Adult Children

The cohort of women in their 40s or 50s with adult children faced very different challenges with their children than the women with young children. Some relied on their children for moral support but not necessarily for financial support since that was generally not an option. Mary described her relationship with her 20-something son who lived in another state:

(W013) It can be volatile at times. I mean [son] and I are really, really tight. I mean we're really very close. He tells me everything; there's nothing he won't tell me. He was mortified when I was here, when I text him and it was, "OMG, Mom. I can't believe—when did this happen?" I said when it happened and he goes, "I know you,

Mom; you're tough. You'll kick ass. You'll get out of there."

These relations were often strained or inconsistent prior to the women coming to the shelter. Marian had not seen her son in a few years and she had not been in touch with her daughter since high school. When asked about seeing her children she replied:

(W016) My son I do, but I haven't recently. It's hard. I don't drive...On the phone. I mean, we text each other cuz he doesn't have minutes on his phone, but I text him and he texts me back. [Saw him]...maybe a year [ago], probably...We're actually really close. It's just he's busy right now. He's got like two jobs, and like I said, I don't drive, and it's hard on him to find a day free to get out here—but I know he loves me. I love him.

Parenting at the Shelter: Parenting in Public

The everyday challenges of parenting are further exacerbated when staying at a homeless shelter. Donna Haig Friedman (2000) in her book entitled "Parenting in Public" discusses the stress of parenting in a public place under the scrutiny of others: parents and non-parents. People often feel it is their responsibility or their place to provide guidance about parenting other people's children. This self-imposed obligation may be more intense when there are multiple families living in a congregate setting. The advice may be welcomed or unwelcomed. Tanya described her interaction with another mother about parenting her child. She was not pleased with the way the mother was disciplining her child and she was quite upset about the child's behavior. This discussion reveals the bi-directional nature of parenting in public: sometimes the mothers have to take advice and sometimes they give advice.

(W011) I spoke to the mom [another mother at the shelter]. I told her because that's her only child and she's two years older than me but I gave her some advice. My oldest is five, my oldest is a year older than her child. I was telling her you have to let him know who's the boss. She speaks to him like she's his friend. If he throws a fit, kicks the stuff and throws stuff, she'll tell him to stop and two minutes later she'll give him a cup of juice and a piece of candy. I tell her you can't do that...See she didn't understand that and I understood where she was coming from because this is her only child. When my oldest was my only one, I would spoil him. Let him sometimes do what he want, but it would never pass that. He wouldn't put his hands on me, like ever. I mean we were still

good friends or whatever but I just didn't agree with—I just thought it was terrible. I felt so bad for her because you don't have to—you're teaching him the wrong things...because I had never seen anything like that before in my life, ever. He was four, four years old. He would punch her in the face, he would tell her to shut up, he would tell her that she's evil, yeah. He would run from her. I mean it was just—I've never seen that before and I just said you are doing the wrong thing. I'm only 26, I don't have a 13 year old and a 12 year old but I have a son. He's a boy and he'll become a guy and eventually he'll have girlfriends and I don't want him punching them in the face. You know what I mean?

That's basically what he's doing to his mom and his father's not in his life. I mean ever since he was born the girl's son's father he's never been there so I mean I'm trying to help you out.

I asked her how the woman reacted to her conversation. She said,

(W011) I mean we had a little disagreement about it because she's, I don't know, I have nothing against church I mean my family goes to church. I'm a Christian, she's a Christian but I told her it's not about spanking your child all the time. Because believe me it doesn't work but you have to—don't give him a piece of candy when he throws a fit just to make him be quiet. You have to let him know 'stop.' If you have to stand there for 20 minutes until he's quiet, then you do that. If you have to keep picking him up and putting him in the same corner until he stays still, you have to do that...I'm not perfect [in parenting techniques]. My own he talks back sometimes and stuff but I never used time out with him and that's why he's so good with it. If I told him to go to time out he wouldn't even know what it is. If I tell him to stop, before we came here if I said stop he'll stop. I was dead on. I'm talking to you, when I'm talking to someone and you're like mommy, mommy, mommy, in my face that doesn't happen. I'm not perfect, he does things, he's a boy he jumps up and down, he makes his sister cry. He gets me mad. I really try but it is hard...Right, it's not about spanking your child, it's not about taking your hand and beating them to the point. It's not about that. I don't agree with that all but you have to smack 'em in the hand then you smack 'em in the hand...Hopefully when we get out of here I can get him [son] back to the routine that it's supposed to be. I only give him certain stuff if he's good. He knows he's a good boy, you know I'm not gonna say you're not being a good boy. I'll say you need to stop doing that because you're five, you're not one like your sister.

Tanya went on to discuss how her son's feelings about being at the shelter affect his behavior there. The child's sense of loss, including privacy, loss of toys and their own things, loss of freedom, often these frustrations lead to poor behavior and affect the mother's ability to discipline her child, especially in public at the shelter.

(W011) I think at some point he's getting tired of this place too. Because he's not getting

all the attention, he can't do certain stuff like go outside and play or ride his bike. It's not a situation everyone wants to be in but until changes are made I guess something has to happen...He wants to be with his father a lot now because of the fact that he doesn't have his own room. Before we came here he had his PlayStation and he had his bike, he had his own room. He could turn off the light, turn on the light, close the door, open the door, he did what he wanted. Now—He can't go upstairs unless I'm upstairs with him. He can't go to the bathroom unless I'm in the bathroom with him. I don't know these people around here so if he's in the bathroom I want him to lock the door and I'll stand outside the door. If I'm in the room I have him lock the door. He's five but he's not stupid, you know what I mean? I speak to him about it and he wants to be with his father [biological father not the one at the shelter with him] more because he has the freedom that he had at home. Like I say he doesn't have all the attention, which kinda makes me feel bad because me being a parent I'm supposed to have things under control, you know what I mean?

Her son's feelings about being at the shelter seem to be pretty typical. I asked several of the mothers how their children felt about being at the shelter and how they were doing. Joan is a mother with teenagers and she described how they feel about being at the shelter:

(W009) They hate being here. [They hate] being homeless. Because it's not their first time, and it's a struggle, especially because my boyfriend got laid off. He got another job, he got laid off. He got another job shoveling snow, hurt his—ruptured a tendon in his arm so he couldn't do that no more. It's just been a struggle and jobs are not easy to come by. I've been working at [a fast food restaurant] since last May, thank God that I have this job because if I don't, didn't, I don't know where I'd be.

Watching how other mothers parent their children was particularly difficult for a mother, such as Margaret, who was at the shelter without her children. She expressed her opinion about the other mothers' parenting.

(W026) The hardest thing I think is the parents with the children. They tend not to watch their kids a lot. I mean I've seen—since I've been here I've seen one kid fall down the stairs. I've seen one kid fall off the picnic table head first onto the ground and the parents are nowhere to be found. Ya know—they throw food all over the place and the parents pick up what they want and, "Oh. Well, it's somebody else's chore. They'll pick up the rest." Ya know it's just not like that. Kids—they just terrorize everything and the parents just sit there. They throw their garbage on the ground out back. Ya know that patio area with all the picnic benches and everything was donated to the shelter? They just don't respect it and it's getting old. That and recently we've had the peevin' and the poopin' on the floor and people goin' to the bathroom with the door wide open—people goin' in other people's rooms—stealing their stuff. Ya know everybody here is here for just about the same reason.

Her accusations were not substantiated and I did not witness any of the issues she described about the parents and children but this was her perception of the manner that children were cared for by parents at the shelter.

Partners

All of the women had been in some type of relationship with a significant other in their lives. Some were married and others were not but most had had long-term relationships with a partner. Bad relationships were often blamed for their current homeless situation. While at times this involved the painful loss of a partner, it was also sometimes a welcomed separation. Like other aspects of their lives, their relationships with men (although a few had relationships with women, most partners were male) were often complex. Diane put it this way:

(W024) It's like every time I get my life together, it's like, I make one stupid decision. It's usually involving men, definitely involving men... Yes, with the baby's father, it was we both wanted a child, but we—I told him I didn't want to be with him. He wanted a kid, and I wanted a kid, and I said we can each share her and raise her the way whatever. It didn't turn out that way... Just anything to hurt me [he called DCF and was trying to get custody of the child], but in the long run all he's doing is really hurting my daughter the most... we were supposed to get married actually [in] July. Yeah. It just sucks. I thought that I could trust him, even though he left me before. I thought this was different, because it just felt different to me anyways. We were doing so good. We weren't having any problems, and then they [DCF, the child's father, and his mother] took my kid away.

The institution of marriage was not highly regarded. Relationships were transient and unstable, like other aspects of their lives. The women I interviewed stated quite defiantly how they felt about being married. In the interviews they seemed confident about their decisions to leave men or to be on their own. Perhaps this was because they were in a relatively safe environment at the shelter and had had time to reflect on their relationships. In the midst of the relationships, they seemed less empowered. For example, Carrie explained:

(W007) I was living in an apartment... And I um, then I eventually, even though the marriage or the relationship had gone completely downhill, I still married him. Like even though I knew it was over. I still married him because his mom had custody of his other

two children and she threatened that she would call DCF and get the same thing [done] to me if I didn't marry him and just totally brainwashed me to think that I had to marry him so I did. And then 2 months later I realized that I didn't want to be with him. It was just ya know I'm not going to pay for your friends to get drunk every night and to get you high all the time. And pay for my son on the social security I get. It's just not gonna happen.

Sue told several stories about relationships with men:

(W002) I said unless I saw him go to AA. I would be his friend but I'm sorry, that man put me through too much. That's not going to happen. Now [younger son]'s father, I didn't marry. Had the blood test. Was ready to do it. And I was pregnant. And I thought about it and I thought 'What, I'm going to have two children to take care of, I don't need three.' And I said, "You've got to go". He eventually moved to Florida. Then he died.

(W002) So, there is another story. Now, technically I'm married now. I've been married for 27 years, I think. Something like that. 27-28, well uh, yeah 27...I didn't have any children with my husband. I had my tubes tied immediately after having [younger son]. My boys were already born. And I married [husband]. Three years into the marriage he went out for cigarettes and never came back. But because he didn't get along with my older son he got along with [younger son] but he and [older son] were like oil and water. And it was like oh no, love me, love my children and when he left. I was like, ya know what? This is a good thing. I never looked for him, I didn't care. So somebody said "Did you report him missing?" I said, "No. No, he's a big boy. He can find his way home. He chose to leave." And this has made the decision much easier for me.

Qualities the women looked for in a partner and how they defined their relationship with a man were often determined by their past relationships or relationships they had seen with their mother or that they had with their own father. Sometimes their standards were simply defined, like by Mary Beth:

(W004) He [husband] is [a nice guy]. He maybe got problems with drinking, but he is actually probably one of the nicest guys—he doesn't beat on me; he doesn't cheat on me. Those are two great qualities to me [*laughter*]. He's a hard worker.

Multiple Partners

Another factor that affected relationships with partners was having multiple partners, whether for companionship or sex. These were either sequential partners in committed or monogamous relationships or in concurrent relationships. Some were "hook-ups" for sex.

Although not discussed in detail, these relationships occurred and some resulted in unplanned pregnancy.

Carrie was at the shelter with her boyfriend and baby. They had typical issues dealing with jealousy, trust, and fighting but these were made more difficult because they were planning their next move. All current relationships involved their future plans:

(W007) Someone nit-picking at every little thing that I do wrong making me the asshole and all his friends don't like me because he didn't want to introduce me and another girl because that's his friend. He didn't want to introduce us so he came up with the excuse that I was jealous of her. So now I'm a jealous girlfriend. I'm a jealous, nagging girlfriend. You know what I mean?... And I told him. I said I'm a little embarrassed that your friends, because of what you say to your friends, they think I'm a person that I'm not. Yeah, but they're just going to go on what he said because they know him and not me. But I don't understand why he has to be friends with so many girls...Yea, I do. I honestly think he is [seeing other girls]. Yea. I'm trying to catch him. Trying to catch him so I can walk away...I'll live with him. Even if it comes to the point of living with him and kicking his ass out 'cause I can pay for it. I can afford the apartment. But if it comes down to it. Yeah, I want to be with him. I want to make it work but not at the cost of breaking my heart up in little pieces and stepping on them...It's not that I don't trust him I don't trust the people that...he's constantly with.

Infidelity in a relationship causes a lack of trust and insecurity. These losses in the relationships may have contributed to feelings of rejection and a loss of self-esteem that continued throughout their lives, such as Mary's story:

(W013) We were together four years before we got married. We built our first house together before we even were married. When I say build it, we built it ourselves. I mean I have a tool belt. I can do stuff. They taught me all that, plus I grew up with my dad. I mean I used to tune up my own car. It was kind of a man's world, my world was, growing up...I was very self-sufficient in that respect, but anyways, one thing led to another and we got married, but not till four years later. I was 30 when I got married. Anyways, then we had my son. I was 31. Life was good for probably ten years of our marriage. I knew of his infidelities. He cheated on me a lot and I filed for divorce when [my son] was one. I should've just followed through, and I didn't.

Relationships with Friends

Relationships with friends were seldom discussed. Many of the friends the women talked about were people they had met at the shelter. In a few instances they mentioned their desire to

have a friend they could talk to. Some were married or in relationships with men they had previously met at a shelter. This relationship, between Sue and a man at the shelter, developed while at the shelter and he helped her get ready to move out:

(W002) How am I going to get this stuff out and into my storage? Ya know at 8 o'clock you're out. So there was no way I could do it. And then the stress in all of it was just...and that 's when [friend] helped me, too. He went in there and he started packing and he said cuz I couldn't make a decision, I was literally, just doing circles in my room. And he says, "Ya want this or are you going to throw it away?" "Ya want this or you going to throw it away?" And I'm like "No, no don't throw it away". And he was "What are you going to use it for?" "Well that's something [another friend] gave me." "Do you really need this?" "Yes, I do." Ya know he made me [sort things out]. So ya know he really saved my life in that. I think that's when our friendship really started to develop.

Often the friends were people they hung out with in the past but they rarely discussed spending time with friends while at the shelter. Sometimes they had slept on a friend's couch prior to coming to the shelter. Alice explained, "It's all about the people you hang out with, your communities, who you associate with. It's all about that." While Andrea said:

(W030) I don't have no friends or no girlfriends, nobody around here that I used to hang out with. I like people, but I think I'm too trusting. I like everybody. I think everybody is the way that I am. *[Laughter]* I think everyone's honest, and when they say things I think that they're supposed to mean it. I've found that's not true.

Chapter 7. Life after the shelter: Narratives about the Future

Coming to the shelter is a critical juncture in the women's lives. Once they are situated in this circumstance they are forced to make decisions about their future and their lives. They only have 60 days to get organized, even temporarily. Their experience at the shelter can be transitory or it can become a part of their identity. For some of the women it was their first time being at a shelter or being homeless and for others it was a chronic condition and they had been at a shelter multiple times in their lives. Some had experienced homelessness as children. Some described the shelter as a starting point for their future. I found the qualities that they gained from their experience were those that gave them the ability to move forward. Some with addiction issues had worked on their recovery or rehabilitation as an effort to make positive changes in their lives and they discussed these attempts or successes with emotion, sometimes with pride or periodically with regret, or a sense of failure. They had also acquired some personal skills and characteristics that gave them agency. Attributes such as confidence, resilience, and hope were apparent in their narratives and it is these strengths that allowed them to take control over some aspects of their lives and to shape their future.

Confidence

Although their self-esteem was often demeaned by parents or partners, some of the women were empowered by these relationships and they expressed their confidence in themselves and in their outlook for the future. Rachel described her confidence in her plans this way:

(W029) I'm not sure that [I want to get back together with boyfriend] —I do, but I'm hoping for the right reasons. I'm hoping that he wants me enough that he's gonna treat me right. Not just—if he wants—it's kinda if he wants me to come back or not at this point. If he doesn't, then—and he says yes anyway just for him, then it's not gonna work. If it is, then hopefully we have a fresh start, just a clean slate, and try to do what's right for him. I would just wanna make sure that I have a job though, so I can have a plan B. I

need a cushion and security so I could have a savings or something, like in the bank 100, like a \$1000, or \$1500, just in case it doesn't work. Then I don't have to worry about being in this situation again, and I can just get my own apartment or something and go from there.

Women often gained confidence by an achievement or positive change in their life. Two women talked about getting their teeth fixed and how they wanted to do that to gain more confidence and to feel better about themselves. Dental health was something that most of the women were not able to afford. Years of drug use or alcoholism also contributed to poor oral hygiene. One woman stated that she thought she got rejected for a job because she had no teeth. As Marian explained:

(W016) I'm gonna go get my teeth done, too. Yes, I am. My teeth have been bad since I was young...so I made an appointment. I'm gonna go. I want the rest of my teeth out and get dentures while I'm able to. The state will cover the dentures and everything. I only have like eight teeth left...I mean I've had people actually made real rude comments at me, and I just think, "Well, all right, whatever," cuz I figure, well, they don't really know me, so they wanna make fun of my teeth or whatever. I don't care, and I mean I really don't. It doesn't really get to me. It's just—and I mean, I know my teeth are all—they're ugly. I know that. They're all rotten, but I don't let comments like that get to me. It's just fine. That's how you think, but you don't know me as a person or how I am.

It was encouraging to hear the women who had been put down in their lives, who lacked self-esteem, to speak out about wanting to be more confident and to overcome what they had experienced. Jessica explained how she teaches these life lessons to her young son:

(W022) I don't set my son up for failure. And I don't let nobody else set him up for failure. I wouldn't want nobody to feed him a bunch of lies. I'm like "no." And if that's the case you might as well tell him the truth so that he knows now so that he isn't upset about it. I was always one of those who when somebody told me something I'd be so happy and then I'd be let down and I'd be so hurt because I was so looking forward to it. Even now he's only 19 months but this is why he's so smart because I always tell him "Don't let anybody put you down. If somebody gonna tell you to do something wait until they do it first and then you can." I mean always say thank you but don't have your hopes up for something to happen and then you will be disappointed. I experienced this personally.

Resilience

Resilience is the construct that was the most clearly present or absent among the women and it seemed to be derived from their difficult past. This characteristic appeared to be developed by a life of hardship. Furthermore, their ability to face each day and move forward was shaped by this construct; it is part of their lived experience and gave them agency.

Resilience seemed to be what was needed to survive their current circumstance and progress into the future. Inner resources, such as strength, a positive attitude, leadership, independence, self-confidence, coping mechanisms, a sense of humor, etc. created the character of some of the women and assisted them in their daily survival. Others used external resources to get by. These resources included an understanding of the “system” or the support of family and friends. The primary source of strength for the mothers was their children. Most used a combination of both internal and external resources.

Resilience can be developed by overcoming difficult situations. All the women had faced some sort of catastrophe either during childhood or more recently. Some faced extreme, unfathomable tragedy or abuse. As Andrea said:

(W030) You think back, and it's like, I never expected to get married, never expected to have children again, because I had one son at 18 and never got pregnant again until I was 35 years old. I lost my first husband when my son was seven...He got shot. Yeah, his best friend [accidentally] killed him.

Somehow they were able to wake up every day, get out of bed and put one foot in front of the other to face the day. Examples of resilience were found in the statements made by Mary Beth, Marilyn, and Audrey:

(W004) I feel as soon as we get a job we'll be just fine—one of us gets a job, we'll be just fine. We made it through this one other time and he and I can do it. I know we can, because bad things may happen to us but good things do come out of it. They really do. I met him, we had a baby together, we got married. I think that's a positive, good thing after everything I had bad that happened to me this was good.

(W005) But...We'll just go with the flow I guess. Not really much you can do in a situation like this. You just gotta...take it one day at a time, and...access every resource that you can access and...My theory is we're all homeless. Not one person better than the other. You know we're all in crappy situations but you gotta make the best of it. So. You do what you can do.

(W015)...it's my life. You learn to live with it. You learn to deal with it, you handle it...Yeah, right now I am [living day to day]...What kind of future am I gonna have right now? There's no future, there's no outlook. Then again—it's a new beginning, see, so there's a flip side to that coin, okay. Just when I start going down that dark road [being depressed], I say, "Wait a minute, wait a minute, wait a minute."

Mothers felt the most obligations to find inner strength and move forward for their children. They knew they were responsible for someone other than themselves and they were able to prioritize what is most important in their lives. As Tanya, a pregnant mother of two young children at the shelter with her husband said,

(W011) Like I said we have to do this together. If we were here just me and him, then I wouldn't care but we have two kids that we have to keep our heads straight for. I'm trying, I really am. I think we're gonna be okay. I don't need a million dollars but I just need a house, a home, I think we'll be okay. As long as my kids are happy, I'm happy. That's what matters.

Often their positive attitude translated into determination to move forward. A sense of self-sufficiency and self-reliance was expressed by Alice and Tessa:

(W014) I just looked around. I don't take no for an answer from anybody. Believe me, any caseworker I ever met will tell you I'm very determined and very on the ball when it comes to—cuz no one else is gonna do it for me. If you don't do things for yourself no one's gonna do it for you. You have to get up and do it. You can't just lounge around and pity party. You can't do that. I just can't wait to move.

(W003) I want to be more independent. I really wanna find – I really wanna be more independent so I don't have to depend on what I'm doing now on the State. I can't really depend on my parents so ideal would be to be able to stay with my mom and get a college education. You know that would be nice but that's a goal of mine to be more independent. I don't like to rely on the State or just ever becoming homeless again.

Laura described her feelings of empowerment. Although she was only 22 years old she had multiple medical issues that she discussed with indignation. She was proud of what she had

achieved in her life, particularly as a single mother

(W023) There's times where I can't stand up on my own. I try to hold on to the dresser and I'm going to fall down if I let go. They're like "I want to help you" "No, let me try to do it on my own" because if there's no one else there you have to do it on your own. And it's the same thing with being homeless. When you want to find a job you have to get up and do it yourself. You have to do all this yourself. You have to want it for yourself. To not be that anymore -- just like being a drug addict. It takes hard [work]. Some people need support or they think they need support but you don't -- you just have to trigger your mind to say "I don't want to live this way." "I don't want to be like this."

Being realistic and maintaining a focus on reality forced Audrey to look to the future.

She also had a difficult life after being abused, raising four girls, and then having her husband molest one of the girls and she was raising one of her daughter's sons because her daughter had substance abuse issues. Her outlook on being homeless framed her outlook on life. She knew she had responsibilities to take care of:

(W015) You have to maintain reality here, okay. Reality is that I am homeless. That keeps you motivated. It does. To me, it does. For me, it does. I can't speak for anybody else. Motivated in making the phone calls, getting the meetings set up, getting to—like tomorrow, I have a big meeting with Social Services, so that's like getting—I'm bipolar, so that gets me in a new clinic that I don't have to drive my broke-down car. No, it's to meet up with my therapist and all that. Now I'll have it already here, which is really closer.

The challenge of keeping a positive outlook is hindered by mental illness, such as depression or having bi-polar episodes. Mental health problems make every daily task more difficult. Despite their inner emotional state, an outward positive attitude was mentioned by several of the women, such as Diane and Audrey, as essential to cope with their situation:

(W024) My whole family's negative. They're not good for me anyways. I need to be uplifted. Negative's just going to make me more depressed, it's not going to make me be like, "Yes, I'm gonna get out there and go do something with myself." It just makes you think about what you didn't do.

(W015) I want to make a life for my kid and me. Okay, that kid is my motivation. They ask me all—every time I turn around, somebody, you know, in a mental health clinic or whatever, they'll say, "Are you suicidal?" I'm like, "Are you nuts? I've got a 13-year-old." He's suicidal, you know what I mean? He's 13. Everything is crazy, so no. I ain't got time to be suicidal.

For some of the women their history tore down their self-esteem but for others it empowered them and made them more determined to get out of their current homeless situation.

As Rose, who at 50-something had also suffered gravely in her life, stated:

(W018) You kind of sometimes take self-pity on yourself. I don't give myself any pity. I don't want pity no more. I think I'm getting stronger every day. It's hard. I sit and—it's hard, but I don't want no more pity. Pity is not for me... You have to take care—you have to advocate for yourself. That's what I wasn't doing before is advocating. I'm letting everybody else do it. Now let me do it now. This is my turn.

Hope

Beyond resilience, empowerment, and a positive attitude, the women also discussed Hope. This term was used frequently and it appeared to give them strength to move forward. This somewhat nebulous term was used to express their goals and what they wanted in the future. They 'hoped' they would get the apartment they wanted, or the job they applied for, or they 'hoped' they wouldn't get thrown out of the shelter. It's a commonly used term with various implications, such as, "Let's hope for the best" or "I have faith and hope". Although they often worried about their future and knew there were risks to take, they often expressed "hope" that things would go their way, such as Tessa, who had a lot of faith and was quite religious.

(W003) I'm also on a waiting list for an apartment – for a low-income apartment in Massachusetts. I should be getting a call in March about that. You know that's something I'll fall back on. I plan on getting out of homelessness within the next two months. I'm hoping.

Dottie was also hopeful about her future:

(W025) I still worry a lot though. I worry—I just - I'm hoping—even though that it's my third week here I'm just still hoping that I get into one of these subsidized housing before my time is up here. I don't wanna keep going from shelter to shelter.

I spent quite some time with Rose over the course of several months because she left the shelter and then returned. She was dealing with estrangement from her son and his family because her ex-husband had molested her granddaughter. She tried to maintain a positive outlook and hope. She expressed her pain and optimism this way:

(W018) It is painful, but you know, Ruthanne, I cry and cry and cry, and I know one day that my son's gonna talk to me...It's gonna happen. I believe in that good faith, that he will talk to me because I know he's hurting, and I'm giving it space. They say sometimes you love something, let it go, and it will return to you. I have to believe that. There's a longer version of it, but I don't remember too much of it...If you love something set it free, [it will] come back.

Recovery

Being at the shelter was often a turning point in their lives, or a perceived new start. Some had been in rehabilitation programs for drug or alcohol use and were eager to move forward with their lives. Recovery was part of their hope for the future. Past substance abuse was mentioned by many women. Dottie had not been using for many years and boasted about being drug-free:

(W025) I been 15 years clean. No, that's not an outlet for me. No. I mean I remember where it took me and I'm just happy that I'm not there anymore.

Similar to recovery from drug use, recovery from alcoholism was also an accomplishment and it was discussed with pride by women like Sue and Andrea:

(W002) I got my 90 coin from AA and my 90 key chain from NA. I think I'm over that hump that..course it's so controlled here...

(W030) I've been clean since 2004, [date]. I've been clean since—alcohol—was my choice of drug. I've been clean since [date], 2004. Yeah, oh yeah. It's—believe me there was times—[Laughter] There was times, believe me, but I never picked up. I never picked it up again... I did meetings before, but I just stopped. It was like I just—everything was just on hold when I had the children, and stuff. I just totally stopped doing everything for myself. Oh yeah. I never picked up again. Yeah, that was—that definitely wasn't an option.

The struggles of recovery were apparent as explained by Marian, a thin 50 year-old woman who had tried for many years to remain sober. Several weeks after my interview with her I was told by a staff member that she had left the shelter and was staying with another male shelter resident nearby and they both had relapsed. One evening while I was at the shelter, her friend called to speak with a staff member because the woman left without her diabetes medication and was in desperate need of it. She had been drinking and was unable to come to the shelter to get her medication and she needed it quite badly. During my conversation with her she described her battle with addiction:

(W016) I've been in and out of the [name of] Shelter. I think I've been there four times also. I went to [rehab facility], cuz I'm an alcoholic. I went to [rehab facility] and I had like ten months. I relapsed, and I stayed drinking for a while after that. Now I'm trying again. I've been sober now for six months.

She had been attending AA meetings at the local church next to the shelter. Throughout the interview she talked openly about going to AA meetings, how she tried to deal with being an alcoholic and how drinking shaped her personality:

(W016) I go to the meetings—I don't really talk in them. I sit and listen, but—except for on Sundays. We read from a book, and cuz I love to read, I won't pass. I will read...I mean, I was drinking for 30 years, and it's hard. It's hard to stop something and it's not there. I mean, I was used to drinking. I was more talkative around people, and I was working...That's how I always was when I was drinking. It's just I'm still trying to figure out now that I'm not drinking, who am I exactly? Because if I'm close to somebody like my friend here, I mean, I am. I'm a loudmouth, and I'm always picking at him and stuff, but in fun.

Summary

As the women presented their life histories and their trajectory, they described how they dealt with insurmountable losses, relationships with family, children, others in their lives, their agency, and the environment in which they lived. All this resounded in their stories. As they spoke about their relationships with family during their childhood, the bridges that have been

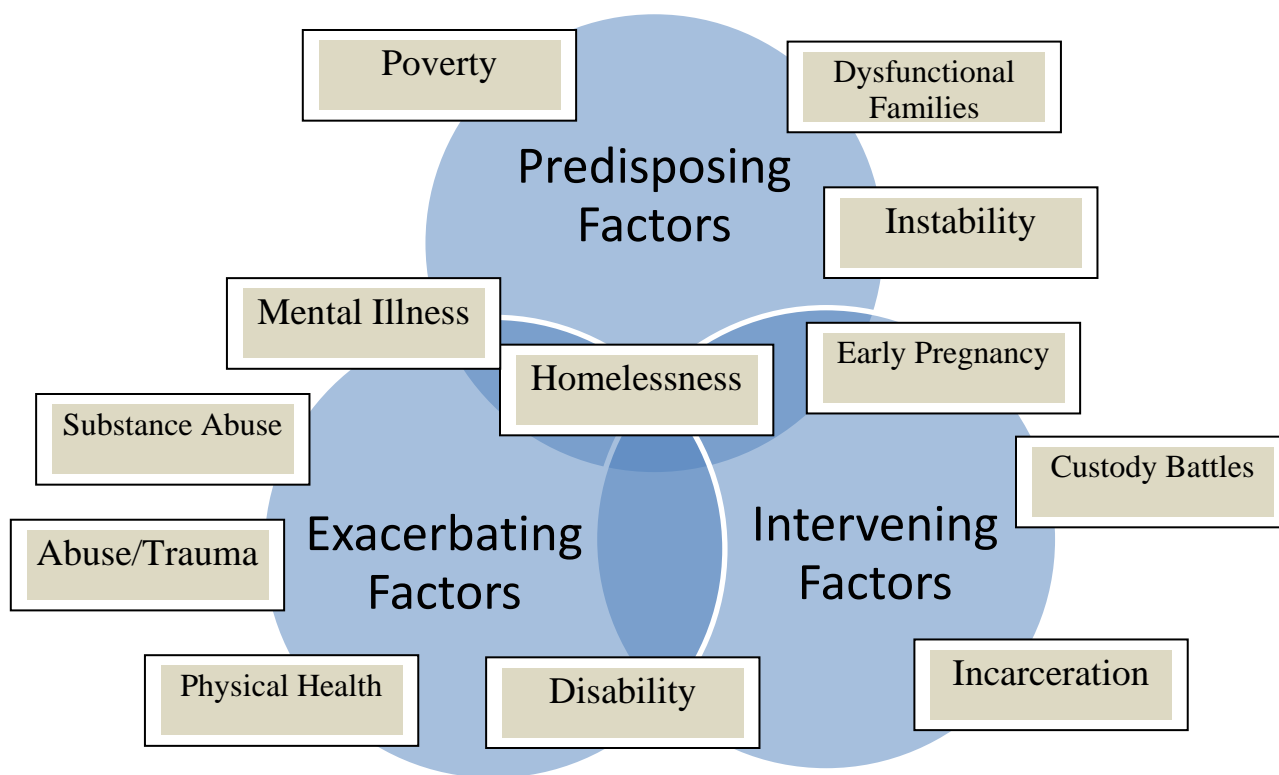
burned, and the losses they experienced, I felt they sincerely wanted to reconstruct their lives and move forward more positively in the future. The women were remarkably optimistic and resilient, full of hope for their own lives and those of their children. They spoke openly about their past failures, short comings, and mistakes. They described childhoods that involved abuse and rejection. These vulnerabilities positioned them for a challenging future and yet they seemed hopeful about moving forward by putting one foot in front of the other each day.

Chapter 8. Analysis of Themes

Examining how homeless women conceptualize homelessness and how they exist on a daily basis, including their struggles living with loss, parenting, and life in the shelter, provides the foundation for understanding homeless women. This is not the entire story. The complexity of the women's lives was impacted by numerous factors. There are elements that predispose women to homelessness, there are factors that exacerbate their situation, and there are intervening issues that affect their developmental trajectory. These influences are interwoven into their lives and they create a thorny, sometimes tortuous, existence. The interrelatedness of poverty, physical health, abuse (psychological, sexual, physical, substance abuse), mental illness, loss, and instability are the central domains I identified in the lives of homeless women (Figure

1).

Figure 1. Interrelated Factors Affecting Homelessness



Predisposing Factors

The primary predisposing factors that led the women into homelessness were influences that began in childhood and impacted their entire lives. These key constructs were evident on a macro and micro level. From the CMA perspective, poverty was the overarching issue that plagued the women's lives. Integral to a life of poverty are social structural factors such as class discrimination and internalization of oppression that affect working class people, regardless of their housing status (Willis, 1977). On a micro level, which included social networks, the women dealt with dysfunctional families. In using the term "dysfunctional" I am not passing judgment on their lifestyle or their family or criticizing a path they have taken, I am referring to factors that were seriously detrimental to their physical and mental health, including enduring abuse and trauma, witnessing violence, having alcoholic or drug addicted parents, suffering institutionalization, and being exposed to the criminal justice system at a young age. Furthermore, household instability created regular exposure to chaos in everyday life that prevented them from achieving their long term goals. A lack of control over events in their lives limited their ability to move forward and face the future.

Poverty

Overall, the women's lives were substantially impacted by the political and economic factors that contribute to their trajectory. The most obvious was poverty. All of the women were living below the federal poverty level; many had no income or savings whatsoever. Some, but not all, had grown up in poverty. Those that had not been poor all their lives faced new and somewhat foreign emotions. For example, Mary, a 54 year-old woman who had worked all her life was an exception. She explained:

(W013) I come from a culture of educated people, family, hard-working. All of us owned homes before we were 30. My first home, I was 26 years old I bought it. I had an excellent childhood; I couldn't have had a better childhood...We had a hobby farm. I'm a person that has always been outdoorsy, always owned horses, animals, those kind of things. I like gardening. I like doing things outside. I like kayaking; I like skiing. That's all I've ever done and I never wanted for anything. I could afford it, and here I am on unemployment, making sure my dog's being fed before I would—you know what I'm saying? Before I put gas in my car.

Most of the women did not discuss coming from impoverished backgrounds or that poverty was a factor that influenced their upbringing. Perhaps they didn't feel it warranted mentioning or it was an assumed aspect of their lives. It is possible that growing up with no money was considered normative for many of the women. Only a few women had come from backgrounds that were middle-class or a life where they lived comfortably financially. Those who had lived financially secure lives may have been dependent on a husband or boyfriend to support them and when the relationship ended they found themselves strapped for money. Regardless of their discussion of the influence of poverty in their lives, many of the women were in situations during adolescence, such as emancipation from their families, institutionalization for drug treatment or mental illness or juvenile detention, or early pregnancy that interrupted their lives, deferred education or careers, limited income and resulted in poverty.

In general, poverty was one of the major underlying problems for all the women. If they had sufficient income they would not be in their current circumstance. Lack of steady income whether from a job or an entitlement program made their daily lives impossible. Their financial status affected their ability to find a place to live and pay their bills. Being poor affected all aspects of their lives. For example, having a car was a luxury. Those who owned their own car were either dealing with car repair bills, broken brake lines, or feeling they were taken advantage of by the other shelter residents who wanted to hitch a ride to a local store. People with cars

were generous about transporting other residents to appointments, shopping, or jobs; all for a price. If someone was going to a store they would bring back snacks, Mountain Dew, and cigarettes for others who paid them.

Vehicle ownership was a status symbol since so few shelter residents had a car. It represented freedom to leave the shelter during the day or in the evening to go see friends or family; to visit children living in another city. Having a vehicle expanded options when looking for housing or employment. Driving your car was an escape. Some of the women mentioned living in their car prior to arriving at the shelter. One of the women, Pat, was at the shelter because she had been brought there by the police when her car ran out of gas on a nearby highway. It was the winter and she had no money for gas and did not know where she was; she had been travelling the U.S. for months with no specific place to call home. She was brought to the shelter to have a warm place to sleep and a hot meal. She only stayed a few days and then was on her way again.

Roll-your-own cigarettes or rollies were also indicative of a lack of disposable income. Almost everyone at the shelter, men and women, smoked cigarettes. They were a common bond and source of discussion: who had cigarettes, who they could borrow one from, what brands were the cheapest, and of course, continual roll-your-own sessions that took place on the picnic table in the yard or in the congregate dining area. Those who rolled their own cigarettes had little contraptions with Zig-Zag rolling paper and tobacco; they would roll 20 or 30 at a time; no filter, no menthol, just pure, cheap tobacco. Many of the women smoked Carltons, an inexpensive brand of cigarette, or cigarillos. They stored stubs in their packs to save them for later. Each evening after dinner the women migrated from the dining room outside to the parking lot behind the shelter for a smoke. The back parking lot was a congregating place where

people stood around or sat on the long cement wall telling stories, gossiping, and entertaining their children before bedtime.

Being in a rural area also had an effect on socioeconomic status and poverty. Poverty rates are higher in rural than urban areas. Some of the women mentioned that the cost of living in the rural area around the shelter was lower than in some other areas of the State. Relocating to this more rural area, they felt, would reduce their rent and expenses. They were aware of the limitations of living in the area including available housing, transportation, and jobs.

The upshot of being poor and having few resources to get out of their lifelong impoverished situation was a constant financial cycle that involved looking for employment or waiting for an unemployment or disability check, the inability to pay bills, possible eviction, doubling-up with family or friends, and unfortunately sometimes homelessness. If their lives were more stable and circumstances were different, they may have been able to make ends meet and remained housed. Nevertheless, they needed more than just housing to keep them economically viable and able to pay bills, care for their children, and live comfortably. Other factors, such as social support or drug or mental illness treatment may also be needed to get them out of homelessness.

Instability/Relocation

The women's chaotic lives were further upended by numerous residential moves during childhood, relocation to different areas, and being carted between various family members. Instability can be defined in multiple ways and it may or may not affect an individual's life. Instability may involve relocation and it can arise from physically moving from place to place or from mental illness or substance abuse that makes it difficult to maintain relationships, jobs or housing. Some of the women I interviewed had volatile childhoods in which they were shuffled

from one family member to another due to divorce, death, abuse, or desertion by family members. Audrey made light of this pattern of mobility during her childhood. When I asked where she grew up, she explained:

(W015) I was born in [city in] Maine. I stayed there for a while. I think we moved here when I was like six to eight, and we lived in [nearby city] for a long time. [nearby city], we lived there for like six years. Now there's five of us children. My oldest sister was born in [city], Maine. My next sister was born in [city in] Maryland. My brother was born in [city in] New York. I was born back in [city in] Maine, and then my little brother was born in [another city in] Maine. I have gypsies for parents.

This pattern continued in their adult life as they moved from town to town and in and out of shelters or other housing to find stability. From a CMA perspective, this movement was fueled by the lack of affordable housing or jobs in many areas and the restrictions on the use of certain housing subsidies. Most HUD vouchers were only applicable in one town and were not transferable from town to town, limiting the woman's options to relocate to an area that was suitable for her and her children.

The women were from throughout Connecticut and some had relocated from elsewhere in New England; few came from much further away. They had often relocated from somewhere else to be closer to family or to get away from family or sometimes they were in the area because it was only shelter that had space; particularly for families. Several of the women were originally from the area and they still had relatives nearby or the woman's partner was from the area, and others arrived to escape a previous living situation. The rural location of the shelter was both a positive and negative factor. The remote location made some structural aspects such as transportation, employment, or housing more difficult. On the other hand, some women expressed their satisfaction with moving to a place where they did not know other people and would not be influenced by previous relationships and where they could start a new life. Some of the women planned to return to where they had previously lived and others were interested in

finding an apartment in the general vicinity of the shelter or a nearby town.

Not knowing where they wanted to relocate resulted in an unsettled feeling. Rachel's situation was pretty typical of the scenarios the women played in their minds when deciding whether or not to stay in the area or to move. They were limited by the rurality of the shelter and hindered by many factors inherent in a rural location.

(W029) [Boyfriend's] father lives in [town nearby] area, so we've been—things have been kind of up in the air between me and him getting back together or not. I've been looking for employment in that area, as well as this area. If I was to get employed in that area, odds are I'd probably try to relocate maybe back to that area, to like the [other towns] area, just because there's not a lot of jobs around here. It's like the few job opportunities that there are, it's kind of like—everyone's looking...

Relocating to this rural part of Connecticut was a bold move for some of the women since it was far from family or friends. Homeless women feel isolated from family and friends and moving to a remote location sometimes worsened that lack of connection and feeling of separation. Others discussed relocating to the area to move away from their previous environment and begin a new life where their past did not follow them. Tanya and her family came from a large city in Connecticut and they were planning to settle in this more rural part of the State:

(W011) I came a long way...to actually be in a different environment, you know what I mean? Because if you're in a certain environment you kind of continue to do the same thing over and over, you just sometimes really don't care. I thought that maybe if we would come out here and maybe we would do better. That's what's happening actually... we plan on moving to [nearby town]. I don't know anything about [nearby town], never been there except for apartment hunting and stuff like that. We're just gonna make the big sacrifice of going.

Often relocating involved uprooting children to transfer to another school. This situation was not ideal for anyone and it sometimes determined where they would reside. Margaret explained, "My oldest is in the same school. My youngest had to go back to the school he was in

in kindergarten. That's my goal is to try to find somewhere—a place over towards that part of town so they can both stay at the same school and not have to be changed again.”

Relationships were affected both positively and negatively by relocating to a new environment. Some women were attempting to move away from their past situation and were hoping to start a new life. Others had to leave their prior location due to abuse, divorce, or eviction and had nowhere to go. Their social networks were disrupted by moving but this was very often a positive change since their past relationships were frequently detrimental, filled with rejection or abuse. The women described their previous locations and social support as contributing to undesirable behavior that caused problems for them. They needed to reestablish social support and begin a more positive lifestyle. For example, Alice's relief about moving to a new area exemplifies this:

(W014) Being up here, I could be anybody and no one has to know my past. It's like a different life up here...It feels real good. Once I get in the apartment I'll feel a whole lot better. I feel like I can breathe again.

Dottie had been in shelters in the past in larger cities and she wanted her teenage son to be comfortable with the decision to relocate. Her husband had recently left her and she expressed the need to start anew. Her family was primarily in another State but she was willing to attempt to stay in the area. I asked her how she felt about returning to a shelter and relocating to the area:

(W025) Honestly I was very thankful because I didn't know what was gonna happen. DCF looked at me to take my child if I didn't find a place to stay. Therefore I pushed myself that much harder to keep [my son] every day, every day, every day. There was nothing available in [different city in Connecticut]... We were just coming to [this town] when they showed us out here I was kinda happy. I mean it was something new. I was looking for a new beginning place. I decided that I'm gonna stay here in [this town]...I've already applied for two subsidized housing places and I'm on the list for one other—I'm on number six for a one bedroom. I'm number 36 for a two bedroom...Well honestly, since he [son] loves it out here. He's able to think clearly. It's not fast. It's not city. It's not, you know, high anxiety that he had over there and going through what we

were going through; his father leaving. He said this is a new beginning for us.

The rural location of the town was another factor that influenced their decision to stay or to leave the area. Some found it desirable while others discussed the limitations of being in a small town. Rose liked the idea of being in a small town.

(W018) I like [this] area. It's kind of rough, but it reminds me of Mayberry, without the roughness. [It's a] very small [town], and that's what I like about it because you can just walk downtown and just browse and—

Andrea summed it up this way:

(W030) We want to relocate out here. It's quiet, we don't know nobody, even though it's a small, tiny little town. There's other towns right over away that we can take the bus if we have to until we get a car. School bus picks our daughter up right in front...Where—where else would we have gone? I didn't want to be separated. I didn't want to be in the [city] shelter, because I went and looked at it. That just wasn't—that was a shelter. That wasn't for us. When they told me this was a house, and that you and your husband and your children can be together. I said, "Well, I don't know where [this town] is. I don't care, but I'm coming." *[Laughter]*

Dysfunctional Childhood Relationships

Complicating a life of poverty and unstable living arrangements were the women's dysfunctional and detrimental natal families. All family relationships are complex but the women I interviewed described amazing stories of complicated emotions of love and hate that were very difficult to fathom. Love, or lack of it, was woven into all of the women's life stories. Their relatives often consisted of parents who were alcoholics, working several jobs to make ends meet, or they were divorced. Their siblings may have had different fathers and the women were raised by various relatives. Many had been hurt or rejected by their family. A few had been emancipated as teenagers because of their tumultuous relationships with their parents, usually their mother. This lack of familial support and nurturing may have contributed to subsequent dysfunctional relationships with boyfriends and husbands that involved early parenthood, substance use, and domestic violence. Mary Beth, a young woman in her twenties

who had come to the shelter from “down South” with her husband, his son, and their baby daughter, exemplifies this complex situation:

(W004) ...but my mom, she disowned me when I was younger, and then my sister was taken from her by her dad. Then she just raised my [other] sister. I was in a foster home until I was of legal age of [state] law statute. They emancipated me at 15. I was basically kicked out on the curb and I was like homeless and then my mom let me come live with her and her husband at the time, but he didn't like me so he threw me out. I think that's kind of why I ran into [father of her first child] and then I got pregnant so young, because I was 17.

Rejection and instability in childhood relationships carried over into adulthood. The women felt as rejected as adults as they did when they were growing up. Tessa, a single mother with a pre-school aged child, talked about not being able to go stay with her family while she was in her current financial situation. She felt they treated her disrespectfully and they did not support some of the decisions she had made:

(W003) My family are not as supportive, compassionate. ..You know how I would ... like [them] to be...Or even my family. My family now. That's how I want my family to be...My child and myself. More compassionate and caring and loving and respectful. Sometimes my family isn't that way. I feel as though I am compassionate and loving. I'm not easily bothered. It seems they get easily bothered...I don't know. I kinda feel lonely but it just...I don't know how to explain it. I just think it would feel less lonely if I had, you know, family that was more caring and stuff. But I still love them. I treat them with respect.

Many had complex family relationships and few were products of nuclear families. Many of the women came from “broken” homes where their parents were divorced or siblings had different fathers. Some moved often from one family member to another throughout their childhood. At least 19 (63%) of the women mentioned that their parents were divorced. Although having divorced parents certainly does not cause one to become homeless, it is possible that the instability and relocation in their lives is a greater factor. For example, as Marilyn described her family structure:

(W005) [Lived with her father and mother during childhood] Off and on, back and forth almost my whole life...I have two sisters from my mother and one sister from my father.

And a brother from my mother. And not with my father. I have one sister with my father from another woman. We all have different “people”.

Their relationships with their fathers revolved around fear and respect. Many of their fathers were alcoholics, abusive, or absent from their lives. Several of the women mentioned being raised by single mothers. Their mothers were controlling and critical. They fought with their mothers and were often kicked out of the house. Sometimes their mother would remarry and their relationships with their step-fathers, who they looked to for love, were also detrimental. Siblings were at one point a good friend and someone they relied on when parental support was not around and at another time they were competition, vying for attention from negligent parents. Parents often would pit one sibling against the other, showing favoritism and hurting the feelings of the rejected child.

Exacerbating Factors

Coping with poverty and dysfunctional families were common issues for almost all of the women. They are factors that contribute to the hard lives the women have had. It's impossible to speculate on whether their experience with predisposing influences of poverty and dysfunctional families would have resulted in homelessness or would they have found strength and resilience for success? Without the additional burden of struggling with personal, exacerbating factors, would they have been spared this current lifestyle? Although these vulnerabilities may define who the women are, they are often the factors that give them confidence and provide the impetus for reflection and fortitude needed for survival and hope for their future. These individual or micro level factors were shared by many of the women and overwhelmed their lives and their discourse. I categorized these exacerbating factors into: 1) Physical health problems; 2) Mental illness; 3) Substance abuse: drugs and alcohol and tobacco; and 4) Abuse/Trauma: sexual, physical, or emotional abuse, by parents, relatives, or partners.

Physical Health Problems

The first factor that influenced and exacerbated the women's existence was dealing with poor physical health. Their health issues included asthma, diabetes, musculoskeletal problems, and heart disease, among other acute and chronic health conditions. Many of these factors were a result of obesity and poor nutrition, complicated by poverty, no or inadequate health insurance, and limited access to health care. Treatment adherence was also interrupted or inadequate as a consequence of high residential mobility, the need to frequently switch health-care providers, as well as noncompliance resulting from staying in shelters where their medications are controlled and competing priorities prevail. Congregate living, lack of sleep, and stress added to their health problems. Habitual substance use increased their likelihood of infection with HIV and hepatitis, as well as sexually transmitted infections due to both high risk sexual behaviors and the mixing of sex and drug use. Several of the women were morbidly obese, a dynamic risk factor for diabetes, osteoarthritis, and heart conditions. Overweight and obesity in poor women are related to the inability to achieve adequate nutrition, limited access to exercise and well-paid jobs, inappropriate health education, and the societal view of poor women's bodies as "a devalued work tool" (Aguirre, 2000). Societal views on obesity caused discrimination against the women in the job market and in obtaining housing. Their weight restricted their mobility, created problems in providing child care, and it was a hindrance to attaining work and housing. In the shelter the women's weight issues were problematic in several ways. Some problems revolved around finding clothing since many of the women were dependent on donations for their clothes. Also the mothers with children at the shelter complained because the rooms for families were on the third floor with steep, narrow steps to climb. The women had to go up and down the stairs multiple times during the course of a day to accomplish simple tasks such as changing their

baby's diapers or washing their children's hands, or bringing laundry to the laundry room on the first floor. This was a particularly arduous task for the women who were overweight or with musculoskeletal problems. The fact that they had to return to the third floor to use the bathroom was additional evidence of the structural power the shelter staff had over the women. There was a bathroom on the first floor and only staff was allowed to use it. I noticed this inequity on warm days when the mothers were playing outside with their children before dinner and then they were called inside when dinner was ready. The children, in particular, had dirty hands and when they went inside for dinner the mothers had to bring the children to the third floor to wash their hands although there was a sink in the staff-only bathroom next to the dining room, most didn't wash their hands.

Another health issue that affected the women's social suffering was poor dental health. Oral health disparities are created by inequities in dental health insurance, unequal access to dental care, lack of education, drug or alcohol use, and poor nutrition. Lack of dental care can begin in childhood if children are unable to attain access to dental care and they develop dental caries, missing teeth, and oral malformations at an early age (Carrion, Castañeda, Martinez-Tyson, & Kline, 2011; Castañeda, Carrion, Kline, & Tyson, 2010; Horton & Barker, 2010). Into adulthood, stigma and discrimination exist due to bad teeth. The way an individual's teeth and mouth look is visible to everyone around them and can cause criticism, rejection, discrimination, and subsequent loss of self-esteem. Limited or absent dental health care due to inequities in dental insurance adversely impact oral health. Mary described her experience with a two-class system in dental health care where people with Medicaid receive inferior treatment:

(W013) I had to go to a dentist who had tattoos all over his arm, who looked like a biker who basically ripped my tooth out, which—I thought for sure I was gonna get dry socket—which has not completely healed yet. That's been a month now. That's my experience with how they treat people on Medicaid. Maybe it's me being paranoid, but

that's my experience...No, I've had a tooth pulled and a fake one put in but I was treated with dignity [when she used private insurance]. This was like this guy came in, rip, and just went on his way to the next one.

Several mentioned that they planned to have their teeth fixed or to get dentures once they had some money from disability insurance or a job. This was one obvious factor that affected their self-esteem and their confidence and led to further social suffering.

Mental Illness

The second factor creating additional hardship in the women's lives was living with mental illness. Dealing with a mental illness affected their relationships and often caused them to face losses including family and friends. Not all the women disclosed their mental illness to me, but those who did were quite open. Of the 30 women interviewed, 22 (73%) mentioned some type of mental health issue. This ranged from stress related to their current living situation to anxiety, depression, or being bi-polar. Although they discussed the stress of the shelter and their situation, it wasn't a focus of their discourse. With few exceptions, the women didn't directly express the stress or anxiety they were feeling. They often mentioned that they only had 60 days at the shelter and that put pressure on them to find a place to live and a source of income. Few recognized this as stress. Some of the women mentioned that their partner was stressed by being at the shelter and in their current situation.

Depression

Depression was the most frequently discussed mental illness. Several women discussed their depressive illness and how it affected their daily lives or the consequences the illness had, such as hospitalization or suicide attempts. The toll the illness had taken on their future was evident but the amount of suffering throughout their lives was not always clear. Some seemed to

have been recently diagnosed but it may be that they discussed a recent incident that had precipitated their homelessness and not how they coped in the past. Sue, a woman in her late fifties with grown children, discussed her recent bout with depression:

(W002) Ya know whatever they said I just, I couldn't think. I couldn't hold a thought, very scattered, very anxious, very depressed. And then I went to an outpatient service – [name of program] at the hospital for it was either 3 or 4 weeks I'm not sure. I found out a lot of stuff just talking that I didn't... realize. And by the time I got out of there my diagnosis was major depression, anxiety disorder. I was oh I'm not going to be able to think of the word now, agoraphobic. Prior to that when I was at home. I couldn't leave, I couldn't, I couldn't even go out on the back porch. I could not leave the house. ...I was really starting to go under but I didn't, I didn't know that.

This severe depression resulted in a suicide attempt:

(W002) Ya know, life just takes different turns that you don't expect...I evidently (pause) started going into a deep depression and took some pills but not enough to do anything other than a long nap. But then circumstances changed (crying) and I (sigh) I just spiraled down very swiftly. And then made a serious attempt but my sons found me before I did anything and I was taken to the hospital and admitted to the hospital to the psychiatric inpatient unit.

Depression was discussed by many women. Some were being treated for the condition, others had lived with the illness for many years, and others were just dealing with it. Those who had struggled for many years were more nonchalant, discussing their mood and feelings in an unemotional way. Diane had a relatively flat affect. She explained:

(W024) I've had depression since I was like 13. It's not a big issue. I've been taking medication. Obviously I'm not gonna be the most ecstatic person, I never have been. Obviously in this situation, I'm not gonna be all happy about it. I mean it couldn't hurt. Whatever I have to do I'm gonna do it for her [daughter].

Her feelings were not unlike those of Margaret, another woman whose family was also split apart. Whether they endured a psychiatric illness for many years or it was newly diagnosed or whether it was a result of the current circumstances did not matter. Their immediate emotions were at the forefront of their minds and their discussions. Margaret told me how depression had affected her life:

(W026) Psychiatric issues—mostly depression because of the situation. Not bein' with my kids. Not bein' able to support them or myself but I mean it was the right decision. I know that as much as it hurts them not bein' here with me, I know that it's better for them mentally 'cuz it's hard enough of a change goin' without mom to have too many changes...It started in May and every time I think I'm strivin' and doin' better and gettin' on the beaten path to get back on my feet, something else happens and I hit a roadblock and I just sink right back into the depression. It just like starts all over again. It's not where I wanted to be—not where I pictured myself bein' at 39... Nobody asks for depression. Nobody asks for most problems or health problems that come into their life. I could see if I was a druggy or something, but I mean I'm just like everybody else. Get up in the morning, go to work, get your kids off to the bus, go to work, come home, make supper, get your kids to bed, do your cleaning and go to bed that night and get up and do it all over the next mornin'.

Anxiety

The second most common mental illness was anxiety. Generalized anxiety is certainly difficult to separate from situational anxiety created by their current homeless condition. The women who spoke about their anxiety discussed it as a life-long factor that they faced. They did not always identify their current feelings as anxiety. When asked what they worried about or what concerned them I often heard that they worried about their children. This cause for anxiety could be differentiated from frequent, constant, recurrent anxiety that they confronted throughout their lives.

Mary Beth dealt with anxiety exhibited as panic attacks:

(W004) I'm medically sound. I can tell you that, because I can tell you what's wrong with me, but I probably should be in therapy but I'm not right now because I have so much else going on, but it is something I'm working on. I do have anxiety, panic attacks. I actually had a really, really high strung panic attack the day that I actually had to come here because I'm in an area that I don't know.

Other Mental Illness

Beyond depression and anxiety several women mentioned other mental illness diagnoses. Most had been in therapy at some point in their lives. These discussions often centered on the services they were or were not able to receive. Shauna, a 25 year-old woman who was at the shelter with her toddler, discussed her experience with the mental health system. She spoke very

fast and her stories were difficult to follow. She discussed how the mental health providers treated her:

(W021) No. I've never been on one set kind [of medication] for so long...No. Every doctor switches it just like my diagnosis has been switched many times. I went from regular childhood depression to schizoaffective to bi-polar, manic-depressive, PTSD and depression. As soon as I go somewhere else it's going to be something different...But pretty much they are all about mood changes. The basic main focus is the mood changes. So if I go into an office and I seem fine like I am now. [talking over child in room talking loudly] Nothing's wrong then "Oh my God we have to change it." But then if I go in there with my hair all crazy and talking all weird then it's something else. You know what I'm saying? That was another problem with the Transitional Housing guy. He said I lied on my application. He said because he saw a happy-go-lucky person when I was in the interview that when I came and I was down and stuff that I had lied to him. I told you I told you up front that I was bi-polar and manic-depressive and so yeah he said "Well, I see two different people". I said "It's not that you see two different people it's just that you see me in a good mood and you see me in a really bad mood." I said yea – he tried to tell me that I was showing him two different people. I don't have a split personality. I'm just sometimes in a really good mood or a really bad mood.

Mental illness in their children was freely discussed. Marilyn described how her 14 year-old daughter, who was not at the shelter, was angry that their family was broken up:

(W005) I know she is [angry]. I know I've made her angry...so I know she's got to be angry, but she just doesn't...or doesn't have the social or coping skills...that adults have. But I take medication, so I probably handle it a little better. She takes medication as well...but...probably...I've had longer...I've had a longer time to deal with [mental illness]...I've been diagnosed with bipolar and post-traumatic stress disorder, and...a slew of other things (laughs), so I've had—I have life experience, and I've had years to learn how to deal with it, and how to back away from a situation, and how to...address a situation. I don't always do it properly, but I know how to do it. Whereas, she hasn't gotten the...experience yet.

Suicide Attempts

The hardships the women had to face sometimes were so unbearable that they contemplated or attempted suicide. Robin was dealing with detrimental family issues and she explained, "things got to the point where they were so stressful that I attempted suicide. I went to the hospital, and when they discharged me to go home, I told my mother that I wasn't going

home. I was going to check myself into a shelter and start making a living for myself.” Another woman lost her mother to suicide. And two others mentioned that they had attempted suicide in their lives. Dottie’s father was killed in New York and she tragically lost her mother, after years of being abused by her:

(W025) I had two parents. My mother was very emotional and physically and mentally abusive to me. I don’t know why, but I was—of the six that she had...She was a manic depressive person. In 2008 was it, she took her life finally. She was always suicidal. For some odd reason it always would be me who would find her cutting her wrists or find her trying to take a bunch of pills...I was always the one around. For some unfortunate reason I was the one always trying to save her life; calling the ambulance and stuff...

Mental Health Services

I asked the women about their ability to get the services they needed while at the shelter, including mental health services and psychiatric medication. Their ability to cope with their mental illness and maintain functioning was affected by their access to care and treatment. The availability of psychiatrists, counselors, and therapists was scarce. Relocating to the town where the shelter was situated complicated their follow-up care. Many who had originally been receiving mental health services had a lapse in their care due to a change in provider, loss of insurance, or the inability to get to an appointment or fill a prescription. Marilyn, who had been discussing her daughter’s mental health issues, described her own medication experience, “Well some days are better than others, some days I handle it very well. Some days my medication seems to even me out. Some days it doesn’t really seem to work.”

Carrie, a young mother with a history of mental illness since she was a teenager, explained,

(W007) I want to get on an antidepressant but everyone I find makes me suicidal. Like Zoloft. And not to the point where I’m going to kill myself but it just puts these crazy thoughts about it. Not even thinking about it. I just get depressed to the point of thinking of like my kids would be better off if I was dead. Ya know that kind of thought. It’s not like actually suicidal suicidal but I don’t want to think that way. Suicidal...I had a

therapist in [program name], this program in [another town]. I don't know if you know what [program] is. It's like a mental health center but it's therapy and psychiatry all in one building.

Substance Abuse

Mental illness and substance use disorders (drug and alcohol use) are closely linked comorbid conditions. Drug or alcohol use by the women themselves or someone in their family was quite prevalent. Either scenario, personal use or by a family member, friend, or partner, heavily influenced the path they took. Use of substances contributed to many losses in their lives: if their parent was an alcoholic or drug user, or if a partner was an addict. Almost half (n=14; 47%) mentioned using substances at some point in their lives either as teenagers or as adults. Some were in recovery. Discussions about drug or alcohol use among the women were quite prevalent but it was sometimes not disclosed. One troubling event that occurred during my data collection involved Joan, a mother at the shelter with her two teenaged children. Her partner was also at the shelter with them. She had been at the shelter at least three times previously with her children and she was well-known and well-liked by the staff. When I interviewed her she talked about her pride in her children, her job, and being eager to move into their own place. Several months after our interview I heard from a staff member that she had died of hypothermia; she was found outside a bar in the cold – she was an alcoholic – something she never disclosed to me. The fact that she had not mentioned anything about her alcoholism was understandable: she did not know me, I was a stranger, and there is obvious stigma surrounding alcoholism. I was told her children would be taken care of by an older sibling; she also had never mentioned that she had an older child. These omissions taught me a great deal about the reality of semi-structured interviews. The interviews reflect the perspective of the interviewee who determines what is revealed and discussed.

Drug and alcohol use was a central theme in many of the women's lives. Some of the

women were involved with drugs or alcohol at an early age, or their partner was involved with drugs or alcohol, or they lived with a parent with these addictions. Some attributed their drug or alcohol use to their childhood exposure to it through their parents. They explained their involvement with a man who used drugs or alcohol being related to their selection of a partner who was similar to their father who was also an alcoholic. For example, Tanya said:

(W011) I got into drugs, got into drinking, I met my son's father, got pregnant, was with him for three years. He was an alcoholic, because my father's an alcoholic and for some reason I seem to mess with the guys that have drinking problems, which is pretty bad.

Recovery from drug use and a positive outlook on the future seemed to be the norm.

Several women discussed how they were currently not using drugs and some of the reasons they had stopped. Often stopping was related to being a parent and the need to be a good role model for their children, as Tanya further discussed:

(W011) I guess just being around the kids, I didn't want to do the same things that I was doing around all those kids and my son. I was a single mom, my sister was helping me out. I was helping her out with the five kids. I just didn't want to do the same thing over and over. Because at some point you're gonna hit that borderline where you're like okay you know what? I have to stop. That's how it was with drugs and the same thing with the cigarettes, I just stopped. I was so tired of just wasting all this money. ... I was just tired. It was a waste of money, it was a waste of my health, it was wasting my time, wasting my life.

Drugs

Alice told her story about being involved with drugs in the past and how she didn't want her children to suffer in their lives the same way she did:

(W014) I'm a recovering addict. I don't even like saying that word, 'cuz even though I am it's been a while, but it just hit me real hard, my mom died, 'cuz I only have bad memories of her and I don't want my kids to have bad memories of me, so I'm never, ever touching drugs again.

Alice's mother had recently died and she explained how that affected her life:

(W014) Right now I have flashbacks of me using and screwing up relationships. This drug thing is—now my mom's gone I just—I'm never gonna do it again...I really think I can [put it behind me], 'cuz if I even think about doing it I'm not going to 'cuz I can't

even imagine myself doing that to my kids. I'm not only hurting myself; I'm hurting my children, and I'm not doing that. I'm gonna cry 'cuz I don't want to do it.

She went on to discuss how her relationships with partners frequently revolved around drug use. She expressed how she didn't want another relationship with someone who used drugs. More than once the woman described being given drugs by her husband or partner. This method of controlling her or demonstrating power over her had a direct impact on the woman's feelings of self-esteem and independence, never mind the effect on her mental and physical health. Rose spoke about her abusive relationship and the toll alcohol and drugs had taken on her life:

(W018) [My husband] was very abusive, you know, alcohol, drugs, the same thing over and over, alcohol and drugs, that's my whole life, alcohol and drugs, that's all I've seen.

She described how this exposure had led her to continued drug use which haunted her most of her life.

(W018) ...like I said, I wasn't much of a drinker. I was after the pills, actually, you know...I've taken a lot. I've taken like barbiturates, and I've taken speed, and I've taken—I've took Percocet, but I don't like those pills no more. If I'm hurting, I would take a Tylenol, you know, just no more. You would just not think I would be wild, but I was. I was just wild. That's all I knew, that's the violence, everything, and never got in trouble and never got caught with the law.

Often the women discussed wanting to separate themselves from the lifestyle of drinking or using drugs that they had known or distancing themselves from any association with drug users. They claimed that they did not want to be like a partner or parent who used drugs or to be labeled as a drug user by association. Shauna explained that the shelter was located in the area of the State where her daughter's father grew up and the challenges of being in close proximity to his friends and family:

(W021) [her father lived around here?] Yes, but right now he's in jail. And I haven't been with him forever...So she was like 3 months. It's been awhile. It's just his neck of the woods and everybody knows who he is and he's a big drug addict...I just didn't feel like dealing with stuff because when I got with him I had to let everybody know that I

wasn't an addict because he was. I wouldn't even touch the drug that he touches. You know what I mean? It's like you know what I'm sayin' I had to fight so hard when I was living down here with my daughter's father to let people know I'm not the same as him just cause I'm with him.

Alcohol

Some of the women had childhoods that were plagued by alcoholic parents. Opening up about their past experience revealed a vulnerability that some were willing to expose. The effect this had on their younger years and their current situation is described by Rose:

(W018) That's a cycle with my past, you know. He [her father] used to give us beer in a Dixie cup. We'd go out and get snow and put snow in it. At first, I didn't like it, and then afterwards, I started liking the beer. I was about six, seven years old. It was a problem. It started very young. It's like everywhere I turn, my family has always had an issue with drinking.

A family history of alcoholism was of concern to the women as mentioned by Laura:

(W023) They have a lot of alcoholics in my family. I mean when I drink – I don't drink all the time – I'm like a compulsive drinker but obviously I don't drink now 'cuz I'm pregnant. When I drink, I drink a lot. But I don't get like vulgar or anything. I also don't drink in public because of I'm scared of whatever will happen even if I'm not the one driving. You never know. So, my uncles, my grandmother was a drunk. And used to beat my mom. My grandfather was a drunk after he was out of the Vietnam War. My uncles are drunks. Really not drugs – just alcohol.

Abuse

Relationships clearly defined who they are and many were negative in their lives; from abusive parents to partners, many women experienced life changing interpersonal violence in their lives including – physical, sexual or emotional abuse. Of the women interviewed, 13 (43%) had been physically abused at some point in their lives, either as a child or as an adult. Most of the women were abused by their father or step-father during childhood or by a partner in adulthood. Eight had been sexually abused in their lives. Their abusers included their father,

step-father, or other relatives. At least one-third of the women had been emotionally abused by someone in their life, including by their mother or father or a partner.

Emotional or psychological abuse occurred when a parent or partner damaged the woman's self-esteem by controlling her, insulting her, or otherwise demoralizing her. This psychological distress was difficult, if not impossible, to overcome. It left the woman unable to care for herself or her children, make her own decisions without the fear of criticism, or function independently. The detrimental effects of this form of abuse left scars on the women as painful as physical abuse.

Sexual abuse occurred by the woman's father or by someone other than her father. Some of the women openly discussed this with me and others found it more difficult. In all situations and conversations I felt that they believed it was an important aspect of their life story and it needed to be mentioned. Sexual abuse in childhood often affected their relationships as adults. At times it made them confused about sex or it made them more sexually indiscriminate, eagerly looking for physical contact from several men. These activities presented further complications in their lives as they got involved in negative, sometimes superficial relationships to fill a void. For example, Audrey's story from childhood continued throughout her life, creating a cycle of molestation with her daughter:

(W015) My father molested me, too. Yeah, he did, when I was six. I didn't [remember it] until I was like 30. I couldn't remember like some of my childhood memories and all that. That was all gone. Then my sister told me about being sodomized by him, and as she said the words—Then I read it online. I looked it up online. I didn't know what she was talking about. I thought he must have done to her what he did to me, but as she was telling me her story, which she needed to tell me really badly, I saw mine.

Later she discussed how this impacted her sex life as an adult:

I got so deeply depressed, I'd have sex with other guys. I'd cheat on him [her husband]. That was all from my childhood. Then I did not understand why I was doing what I was doing, even when I was doing it.

Audrey was one of two women, both of whom had been sexually abused as children, whose husband molested either their daughter or granddaughter. In this case, her husband molested their adopted daughter. As she explained the complicated story:

Until maybe ten years into our marriage, and then he started to try and—he fell in love with our oldest daughter. I finally—and he moved out, took her with him. She didn't believe that that's what he was doing, but that's what he was doing. Now she knows it, you know. I forgave him, let him come home. We moved back up here [to Connecticut]. He started an affair with our 15-year-old, which was mine and his...That lasted a year. I left because he was treating me so badly, not knowing that he was doing that.. ..He's not the dad of any of my kids. He's her adopted father, okay, that's it. That's the only one. Me and him share her, that's it. She doesn't have anything to do with him either anymore. He walked away from all of them because he knew they could put him away for ten years. They wouldn't tell...All the girls... had made a conscious decision as a unit, not to tell on him... Legally, she was underage. It was three weeks before she turned 16, okay, when they started. It was all the way up until she was 17. That's consensual, to me. If you're having sex with somebody at 17, it's because you want to. ..For her, I bet it was [complicated]. I only looked at—really, I look at it through her eyes, and I get disgusted. I always want to throw up.... He did do this to her...I know he did...See, now, my daughters, my biological daughters knew better. I just assumed she would, too. You know what, she was...She was already damaged goods when I got her. Her mother died of a heroin overdose a few years ago, before she turned 18. She didn't get to meet her. ..he manipulated her. She used to catch him watching her in the shower and jerking off at the door. I'm trying to be as honest as I can. She used to feed—he used to feed her drugs, and that's what started her drug habit...He's scum, okay...He should be a registered pedophile right now, and here he is with a new family, starting it all over again, okay.

It's really hard to explain how I feel about it. She's apologized to me...but I don't think she was ready to do it. Do you know what I mean? There's an apology, and there's an apology that's from the heart...She's twenty-five now—twenty-four now. She's not a bad person, she's just screwed up. I know that a lot of it had to do with him. Me, too, I got to—I got to own my part of it, too. You know what I mean? I didn't see it, and that kid got abused because of it, so I own that. I should have never took him back when he tried with the first one. He'd have never got to her.

None of us knew it. When they found out for sure, they were devastated, everybody... Yeah, they were devastated, yeah they were. They hit the floor, all of them, and then they wouldn't tell on him. I turned around and walked away from them all for a year...Walked right out, yep...Everybody was [confused]. What are you supposed to feel when that happens? That's somebody's sickness. I told him—our life turned into Jerry Springer. Who wants to be on Jerry Springer for real?

Into adulthood, intimate partner violence frequently occurred. Several of the women had been involved in relationships with men who physically abused them, others were violated emotionally, or sexually. Alice described her abusive relationship with her husband and how it affected her children, the stability in their lives, her homeless situation, and her use of drugs:

(W014) I've actually been considered homeless since June of 2009. I went to a transitional domestic violence program in [another town nearby] and moved up here. My abuser broke into my apartment and I had to move up here away from that city. He knows [where I am now] but he's moved on. He was just real mad. He is no longer-but he's no longer in my life anymore and I just came [here] for a fresh start, got a job at the school system. My sons were happy...[Younger son is] with his father 'cuz he is—I consider [other son's] father his father, too, 'cuz we were together for so long, but [youngest son's] father was my abuser and it was so much that...I consider him his father, but it's kind of a hard situation and I don't really want to say 'cuz it's a little weird, but he's with his dad. He was my abuser. He treated me like crap, beat the crap out of me for five years and I had to get away. I didn't realize what services were around here for domestic violence, 'cuz I never would have left my son with him.

I had to leave the state 'cuz he wouldn't leave me alone, and I left the state with [younger son's] father. I don't regret having him. I just regret the things that led up—I figured things would be better once I had a baby, that he'd be okay, and it didn't work. It didn't work, and I stuck it out for a year and a half after he was born and I just couldn't do it no more. I was on drugs and—I don't wanna say double pain—but just an excuse to get high.

Marian's life illustrates how some of the women were abused as children and then it continued with the partners they chose in adulthood. In this case, she experienced being abused by her father and also witnessed her mother being abused. Although she and her mother were in the same situation it is not something they discuss. This tragic lifestyle creates a sense of “normalcy” which carries over into adult relationships.

(W016) Yeah, I've had—I mean, I was with one guy for ten years, but he was starting to get abusive, and I ended up leaving him after ten years. I had had enough. I was with somebody else after that for five years, but he was starting to be abusive too, so I don't know. I haven't just found anybody that I really wanna stay with. You know what I mean?...I got two older brothers and two younger sisters, and my dad passed away. He was 57. That's when I was young. I was like—I think I was like 24 or something. He was very abusive. Towards my mom a lot, but he was towards me too...Mostly me [not my siblings], and I didn't—my brother and me and my sister were like, “Well, yeah, but

he treated [me] a lot worse than all of us.” I’m like, “Well, that’s great, but why?” My brother is like, “Well, you think”—he goes, “I think it’s because you were a diabetic at a young age.” Whatever, you know? What kind of reason is that? I mean, why? He was mad because I—I became a diabetic when I was three years old. I’ve been on insulin shots since I was a three-year-old kid. I mean, I don’t understand. I don’t understand that. I mean, I don’t know why he was abusive to begin with, but—I know he hurt my mother a lot...She’s still alive, but it’s like—I don’t know if she’s still in denial or what, because it’s like she just is always like, “Well, he did a lot of good for us.” It’s always the good. I don’t ever even bring it up with her because I can’t talk about it with her...

One of the worst situations involved Peggy, a woman who was abused for most of her childhood and into adulthood. Her husband of 20 years kept her a virtual prisoner in her own home. Here’s her story:

(W017) I’ve had quite an unusual childhood. I’ve been abused most of my younger years to the point where when I gave birth to my first son, when I was just 18, I became epileptic. I’d actually had my husband from the past who I just got divorced from had me living with him out in the woods for over 20 years now trying to keep his best to make sure I wasn’t in contact with too many people...I didn’t realize what he was actually doing to me, trying to take away all my social life from me, and being epileptic I didn’t wanna drive just so I wouldn’t hurt other people besides myself. I’d never gone for any counseling or anything of the sort and my parents didn’t know anything of my abuse...I had been abused both sexually and physically by someone in my family my whole childhood and then my husband emotionally most of my marriage, but my children were very kindhearted and really wanted me to get some help.

Another unfortunate situation, described by Rose, included her life of drug and alcohol use in several family members and then continuous physical and emotional abuse throughout her life.

(W018) My situation is that I’m homeless. I got kicked out of my mom’s house because she has Alzheimer’s and she’s verbally abusive, and I’m the kind of person that’s sweet and try to help. It’s just like every corner I take in my life; I’m bouncing off of walls. No matter [how] much He gives me, I still stand tall. I have to. I have to take care of myself...My past is very, very bad past. It consists of abuse. We had no mother. My mother decided to leave with a man, and she got married, went to [Europe], left us children in the United States, never even bothered to call. My brother was nine months old...Just drama every day, you know, my brother, my sister was drinking at the age of 13, was just out of control. My father had to work. He worked at [name of company] for many years. He retired from there, and it was just out of control. My brothers doing drugs—including myself, you know. We all—no matter what, we loved each other, but it wasn’t the kind of love that I was looking for. This great family, you know, and it was

just not a lovable family. My father beat us. My brother could have played professional basketball, and I felt guilty for years because he had to take care of me, and my youngest brother babysat.

Her mother returned to the US with her husband and this man molested her:

We went one year to school there, but the thing ... was my mom was working in a bar. I was being molested. I was being molested by him (step-father).

This lifelong abuse framed who she was but the situation that finally altered her life was the revelation that her second husband was sexually molesting her granddaughter. This incident put a permanent rift in her relationship with her son and his family. It seems this incident was the most painful.

(W018) Whatever way, you know, at first, I thought no, he couldn't have done that, but then there was red flags because one night, she spent the night... I was making breakfast for my grandson. He's a big eater. My house was a single-family home. It's small. I went down to tell [granddaughter] I had her waffles ready, and the breakfast my grandson was eating.

When I went down there, I saw my ex-husband in the bed, with his face beet red. I looked for [granddaughter] in the bathroom...and about the time I got out in the living room, he comes out hand-in-hand with a robe and telling me I need to bathe her. I bathed her last night. Why are you telling me to bathe her again? That's a red flag. The Department of Social Services stepped in with this. They did the right thing, and they did all this paperwork, and it just really ruined my world. It really did. It just really, really, really—I've cried many nights, many nights because my son don't talk to me right now because I was married to him, and at first, all this stuff was going on.

Physical, sexual, or emotional abuse from family or partners revolves around issues of power. Many of the women felt put-down or belittled by partners or parents. Often the women were involved in power struggles with their mother. Sue's relationship with her mother exemplifies this:

(W002) I was told all the time I was growing up when I would try to explain something that you had done wrong and I would say "I thought" "Don't think, I'll think for you. I'll tell ya." It's like, ya know that gets to you, too.

Power struggles with partners are discussed by Carrie. She had an embattled relationship

with her mother and then she dealt with multiple relationships with men that further broke her spirit. Here she is explaining how she was treated by one boyfriend. She had a son with him at a young age and then her boyfriend used his ultimate power to report her to DCF and he and his mother obtained custody of the boy.

(W007) So about three months after I had my son, me and him were living at his mother's house. We were living at his mom's house and I just decided enough was enough ya know every time I told him something it would go in one ear and out the other. His opinion was always on top of mine. Holier than thou attitude. Wouldn't listen to anything I would have to say. Basically I was just there. I wasn't even...ya know what I mean?... He was in charge of everything. Even if I yelled at him he wouldn't even...ya know got to the point where I would be yelling at him and he still wouldn't be listening. Like yeah whatever. Wouldn't even comment back to anything I said. He made me feel like this big.

Intervening Factors: “Stuff Happens”

Multiple factors interrupted the women's lives and upset their ability to maintain a stable, positive life. The women considered some of these factors beyond their control (e.g., loss of a child through DCF, incarceration of a family member) and others were life decisions or unplanned events that altered their course (e.g., early parenthood). These actions affected future decisions like completing an education, either finishing high school or continuing onto college, or pursuing careers in a field of their choice. They were then limited in their ability to get ahead and to stay on track for the future.

Early Parenthood

Becoming a mother as a teenager has numerous complications since it can abruptly end or delay high school graduation, destroy relationships with parents, and create challenges with employment and careers. Caring for a baby and oneself at that age is difficult financially and emotionally. For the women I interviewed, it was common and it contributed to their life

struggles. Alice, who at 38 years old had a 19 year-old son at the shelter with her, is an example of this situation:

(W014) Yeah, I finished high school. I got married at 17. I finished high school at 17. I had my son. I finished high school at 17—I'm sorry, 19. I graduated June the year he was born and I got married at 17 'cuz I got pregnant and I had a bad miscarriage and went downhill from there. I should never have gotten married. If I could go back I wouldn't change my kid, but I wish I could go back. Oh, my God. I would go to college, and I want better for my kids.

Undoubtedly, most of the fathers of the babies born to these teenage mothers were no longer involved in their lives. Most of the women had several relationships with men after their early pregnancy. Not all of these were positive. When asked if she finished high school Diane explained:

(W024) No, I dropped out. I went and got my GED in [year] when I was pregnant. It's like every time I get my life together, it's like, I make one stupid decision. It's usually involving men, definitely involving men.

Education

In my analysis education was coded broadly as the education the women had attained as well as the education they would like to receive in the future. Often their educational level had been affected or interrupted by the personal factors that had contributed to their homelessness, such as mental illness, substance use, abusive relationships, or early parenthood. Seventy percent of the women had graduated from high school and 6 (20%) had received a GED.

Graduating from high school had challenges for some of the women, like Shauna, who also mentioned her hope that her children would have a better educational experience:

(W021) I did 9th grade in [town name]. Then I went to juvie and stuff for getting kicked out, running away, under age. You know you get in trouble for that. I did do that. Other than that I've never...and it's not what they say that people run away because they want to be able to run the streets or whatever. That's bullshit. Maybe for other people that's what it is. But me -- I just have like bad depression and bi-polar but more on the manic side of bi-polar and stuff like that. I just never felt comfortable in my own skin and that's my issue. And I didn't feel comfortable in my house. It wasn't like anybody was being mean I just didn't feel like I belonged so me and my mom used to get into fights or

whatever and I'd either leave or she'd kick me out and she wasn't expecting me to go but I'd go and it wasn't like I wanted to go party or hang out. I always showed up at school every time the cops came to find me I was at school. That doesn't sound like a person that runs away. They don't go to school. They don't worry. They don't keep getting good grades. But finally...I graduated high school. I did juvie and I went to regular high school. I graduated in 4 years. Technically I skipped junior year, I did. Even though I did juvie for about a year and a half I still went back and do what I had to do. My transcript is awesome. Like I might have two Fs in gym and an F in psychology but that's not because I failed the course. I only took it half semester and I got switched to another school. Nope I graduated in four years.

Some of the women revealed that they had struggled in school either because of behavior problems or academic issues. Audrey explained her situation:

(W015) When I got [GED]—I couldn't read. I had dyslexia or something, I'm not sure what it is. I couldn't read, and it used to drive me insane. Now I read everything I can get my hands on. Isn't that funny? That is funny. My kids have always grown up watching me read. I couldn't read to my kid. It was extremely difficult. It was extremely embarrassing. I wasn't taking that—I wasn't gonna take—that's what motivated me right there, was my first daughter. She'd bring me a book, and no.

She had goals for the grandson she was raising:

(W015) [I want to] work a few years on the road [as a truck driver], get a house of my own, then come maybe work locally, and be with him [grandson] till he graduates... and then I want to put him through college. I'll bust my butt. I'll work two jobs, whatever it takes to get him through college.

Many of their educational plans hinged on a range of other factors, such as where they were going to live, finding an apartment, and arranging childcare. A few of the women had attended school after high school to get professional licenses or certifications as a CNA, hair dresser, or dental assistant. Several of the CNAs had hoped to go on to nursing school. Some attended local community colleges or discussed their plans to attend these programs. Most were limited by not having the funding, a place to live, and/or stability in their lives. College was considered by some of the women but there were too many obstacles or they did not see the value in it at this time in their lives. Amy, a 22 year-old, expressed her views about college:

(W020) It's like I already knew most of the stuff and I was just done with high school

and I didn't feel I was ready for it. I didn't want to go and spend so much money for college knowing that I wasn't ready and just end up droppin' out. I seen it happen with most of my friends. They thought they were completely ready and they weren't. They ended up wastin' it.

Educational goals were sometimes lofty. Tanya had these aspirations:

(W011) I'm interested in law, that's my passion. Going to law school. Being a forensic scientist or just figuring out investigations. I like stuff like that. That [community college] was just a way for me to start off and kinda do better. I thought that's what I wanted to do, but it's really not...I know I started certification but like I said I wouldn't mind doing CNA but the thing is everything costs money, like you have to pay money. Yeah there are [scholarships]. Grants and stuff like that.

Certain issues such as being pregnant as a teenager or inconsistent family support often obstructed their educational plans. Many of the women had completed high school or had received a GED but their education was abruptly interrupted to deal with parenthood, substance use, emancipation, arrest, or truancy. Some of the women had no goals or unrealistic educational goals. At the time of the interview, when they were staying at a homeless shelter, most of the women did not have the resources to pursue further education although many discussed it. Several showed me course catalogs from local community colleges and they spoke at length about continuing their education or initiating it at a local school or technical program. I was interested and encouraged to hear about their plans yet I was, unfortunately, somewhat skeptical. I am sure some will achieve their goals, but I thought perhaps some were telling me about college plans because they knew that the purpose of the interview was for my research toward a post-graduate degree. I also continued to remind myself that I was only getting a snapshot of their lives and their goals probably fluctuate, depending on their current situation and being in a homeless shelter presented pressing needs that may have been more urgent at that time.

DCF and Custody Battles

One of the major risks or worries some of the women had was the fear of losing the custody of their children to the Department of Children and Family Services (DCF). Tessa was concerned that she would be vulnerable to losing her child if DCF found out she had moved around and was at a homeless shelter. Her own mother had suggested this idea to her and the fear of that was upsetting:

(W003) I'm kind of worried now. Would like the State people... would they think that I would be an unfit mother because I've moved around? ...A little bit [concerned]. My mom had told me that. Because of moving...Would they consider that not stable?

She was particularly worried because she had seen that DCF was involved with some of the other mothers at the shelter. If DCF was involved with a woman at the shelter it was common knowledge. The shelter rules about having someone else watch your child were very strict. No one was supposed to watch your child unless a staff member approved it and no one who was involved with DCF could ever watch your child.

Some of the women had lost custody of their children and they were fighting with the court and/or family to regain custody. There were a multitude of reasons that they gave for losing custody of their children. Most felt they had been unjustly accused of doing something (e.g., neglecting their child, using drugs or alcohol) and that was why they had lost custody. The purpose of DCF is to protect the child and it seems that their primary responsibility would be to reunite the children with their family. In many cases, the child's father had custody of the child, regardless of whether this was in the best interest of the child. All of the women who described their involvement with DCF felt that they had a right to regain custody of their child. Based on their accounts, it seemed that the longer they were away from their children the more difficult it became to regain custody or even to get adequate visitation rights.

The stories women told me about DCF involvement were long and complex. The women seemed to want to tell me all the details of the situation; perhaps hoping I had some influence or ability to help them regain custody of their child or perhaps because this was the most important issue on their minds. Diane had lost custody of her child through a case with DCF and her baby's father had custody. She was very distressed by the way he was caring for their child, which made it even more difficult to be separated from the child.

(W024) The whole reason why I started going for child support, and I went for joint custody, where he'd get her every other weekend, is because when I got out of work at midnight, we came to pick her up at her father's brother's house. She was outside on the front step in her car seat, and he was nowhere to be seen, at midnight...He went around the side of the house to go to the bathroom, he said. I said, "The door's right there. All you had to do was bring her in and go to the bathroom. It's not that hard." That was my first reason I was very scared. If he's gonna do that, and I caught him, what is he doing when I'm not around?... That was quite a few concerns...I know he's into smoking pot, and all that. So is his family, that's all they do. He drinks every day, so that's why I don't understand why he's doing this. That on top of all this, and I'm losing my car. ... I never once try to take her away from him. I used to give her to him even a couple days extra a month, just because he wanted to, or I was being nice to him. He used it against me with DCF, and told them that I said I couldn't handle it, that's why I always kept giving her to him, which as a lie. I was trying to be nice and give her to him more because I know every other weekend's gotta be hurting. At the time I said every other weekend because I worked second shift, so I didn't have a lot of time to do things with her, that's why every other weekend. Then when I wasn't working, I let him take her a little bit more here and there. That's when he used it against me. Whatever—like everything I do to be nice for him, he uses against me...Yeah, but I just want to clear my name. Show them that I am a good mother, because I really am. I'm not the most affectionate, like I don't sit there and coddle my kid all day long. I'll play with her. I make sure she has everything she needs. I do hold her. They [DCF] were only there for not even an hour that day. They really—the whole thing was the alcoholism part, and I wasn't drinking or anything. They didn't prove it...well anything's gonna help me get her back, yeah. Definitely, I mean my biggest fear is he's gonna get custody of her. I mean I hope not, but I don't know. They said they can't discriminate about being homeless in a shelter. I'm doing all the steps. I'm going to everything that I'm supposed to be going, plus more. I'm job hunting, because you have to get the paper stamped by CT Works, and I did...Yeah, as soon as DCF calls me back. Which, if I don't hear from her by tomorrow afternoon, I'm gonna call and tell them I want a different worker. This is ridiculous. This is my child that we're talking about. This isn't just like, "Oh, you need a ride to the store?" It's like my life—the only thing that I actually really care about. I'm not going another two and a half months without seeing her.

Carrie, a 21 year-old mother had endured the loss of a son through DCF and she was at the shelter with her infant daughter and her boyfriend (the baby's father). Her story was complex and difficult to follow. From the time she was 15 years old, she had been put in various residential programs. Carrie said,

(W007) And I got arrested and I was in jail for five months. Fifty dollar bond and no one would pay it. No one would pay \$50 bond not even my mom. [That made me feel] like crap. Eventually I had gotten out and I went to [city in Connecticut on opposite side of the state] and I met my son's father... She [her mother] put me in mental health center in [that city] 'cuz like I said she thinks I have all these mental issues. But she put me in that program and...eventually they just stuck me in an apartment and they just left me there. So obviously I went back to what I was doing before with drugs and everything and then eventually I met my son's father. My son is almost two years old now. And me and him [son's father] we lived together. He was living on the street at the time and I don't know what I was thinking at this time but I let him move in. Everything was going fine ya know whatever...During the time that I was at the hospital [for surgery] him and his mom called DCF on me. After I had gotten out of surgery or before I went to surgery I freaked out. I was like "Where's my son? Where's my son? He's supposed to be here right now. He's supposed to come in the morning so I can take him to my mom's house." He never came. Well DCF called my mom's phone 'cuz obviously I was under [anesthesia] and said that they weren't taking him away from me that they were taking me away from him. Which didn't make any sense to me. There was no court order saying I couldn't have my son. Nothing. So I went back to [home town]...Well what they did was illegal. What they did was illegal. No my husband said that I was a heroin addict. First of all they could have done the testing at the hospital 'cause I was there. Which they didn't do. And the DCF worker that took my son from me was the DCF worker that took his other two children from the first mother and she did it illegally, too. She illegally took the first two kids from the first mother. Eight days went by when I was down in [home town] and I didn't have my son, I didn't have anything...I've already tried [to get him back]. They don't want to give me my son back. And I don't know why. She's [her mother] my payee and I'll text her and I'll call her once in awhile when I go see my son I'll stop over there. 'Cause I'd rather visit my son at my mom's house where it's clean. And see her for about three hours. We don't fight in three hours. When we live together. We can't live together.

The primary purpose of DCF is child protection. The women I spoke with certainly did not feel that their children were being protected by removing them from their custody. I am sure there are a range of factors that go into these decisions and I was cognizant of the fact that I was only hearing one side of the story. Nevertheless, the woman who had lost custody of their child

and had a DCF case filed against them all felt they had been unfairly treated. I would hope that the main objective in most DCF situations is to reunite the child with their mother and that they would work with the mother to achieve this goal. In many cases the woman's ex-boyfriend, the father of the child, and his mother had custody of the child. I don't know if this was a bad situation for the child but it was in all cases, a very detrimental situation for the mother. A few of the women mentioned that they had contacted DCF to help them find a place to live when they were going to be evicted or lose their housing. These situations were different and they spoke positively about the assistance they had received from DCF.

Incarceration

Another issue that interfered with acquiring a stable life was involvement in the criminal justice system. None of the women mentioned doing time in jail or prison except as adolescents when they were involved in the juvenile justice system. Several of the women mentioned that a current or former partner was imprisoned. This is to be expected given the fact that so many of the women and their partners were involved in substance abuse, which can result in arrest, either from possession of illegal drugs, theft to support a drug habit, selling drugs, or driving under the influence.

Marilyn dealt with an abusive relationship and then her partner was sent to prison.

(W005) And then my kids' father was very abusive. Broken ribs, cracked jaws, I tried to poison him. [I: Were you married?] Nooooooooooooo. I wouldn't marry him. Nooooo. He's asked me. Twice. But then he went to jail and I pawned the rings. What the hell am I going to do with rings? They don't mean anything to me. No. I don't think I ever wanted to marry him... But I've seen him [in jail] because I want money from him, so I do what I have to do to get what I have to get. [I: How long has he been incarcerated?] Three years now. Three years. Four years. Something like that. Probably not [getting out] for another—he got sentenced 20 years, it's pending after 11. He allegedly sexually assaulted his older daughter from his previous relationship. Don't know if that's true. But I'm not sure that even happened. Part of me that says that oh man I've spent almost 14—I've been with this man almost half of my life, no way he woulda done that. Then part of

me says well, there must've been something. He was sentenced. Then part of me is like well, they put people in jail for 20, 30 years to turn out to be innocent. It happens.

Some of the women were concerned about the effect their children's fathers have on them if they had been imprisoned. Alice's children's father was in jail and she spoke about having him involved in their lives.

(W014) He's around. He's not a very good influence on [son]. He's not a very good influence on him at all. My 14-year-old, his father's incarcerated... Yeah, their father is incarcerated and there's no chance of him getting out for a while... He is just in a jail. [They have a relationship with him] when he's out, yeah, but ya know—he's got six other kids. I mean six others including mine. I mean that's just—that's nuts... When he's out, he's a good father to them, but they know it won't be for long. He'll screw up and go right back to jail.

It was difficult to tell what effect imprisonment had on the women's children since it was not openly discussed. Sarah explained her situation with the father of her children who was in and out of prison.

(W019) I haven't been receiving child support. He owes our sons over \$70,000.00. He's a deadbeat dad. He hasn't seen our sons since—[about 10 years]—something like that. It's been a long time. It is hard on them and I know his phone number and I've asked them if they wanna call him and they certainly have access to calling him and they refuse. They're angry and they have a right to be angry... Something really needs to be done to get these deadbeat dads to pay up. Ya know they have to understand that it's costly to raise children and he's been in and out of jail and everything else. He's still self-employed supposedly and gets paid cash under the table so according to the courts he has no money coming in... He loves it [jail]. He says, "Three cots and a hot. Three cots and a hot meal."

Waiting for a partner in prison puts life on hold for the women and it creates a void in their lives. Many of them were no longer romantically involved with the men who were incarcerated. Some were playing a waiting game for them to be released. Some relationships continued while the man was incarcerated and others ended.

Disability

Poor health and disability affected the women's capacity to look for, attain, and maintain jobs. These factors intervened in their lives and made their future uncertain. The number of women receiving disability benefits (Social Security Insurance – SSI) was striking but is understandable given the preponderance of women with physical health problems, mental illness, and substance use disorders. As discussed above, the women faced innumerable physical health problems including diabetes, arthritis, heart conditions, and dental conditions. Most issues were a consequence of poverty and associated limited access to health care, no or inadequate health insurance, lack of exercise, poor nutrition, and intermittent adherence to their medication regimens. Marilyn, who looked older than her mid-30s and was considerably overweight, discussed the issues that limited her ability to work:

(W005) I haven't worked. I'm applying for Social Security, so that's pending. I have lower lumbar disease...disc degeneration...hypothyroidism...something with my cholesterol, and Vitamin D deficiency...Plus my mental health issues [bipolar, post-traumatic stress disorder, etc].

Audrey also had multiple health problems but she was determined to continue working to care for her child.

(W015) I have a very bad heart. I had a double bypass. I had a stent. I have a pacemaker defibrillator. I have neuropathy in my feet and my hands. I'm bipolar. I have—let me think. They just took out my gall bladder not that long ago. I had surgery on my knee and now my shoulder.

Sometimes the disabilities caused the women's homelessness, but ironically if they applied for disability and were labeled as “disabled” and then received government assistance they had some form of income, which made them eligible for housing or housing subsidies. This was the case for several women including Marian:

(W016) How I ended up here—I'm applying for Disability. It's been pending since 2008 [interview in 2010], and I have a hearing [date]. When I started applying for Disability I stopped working, and I couldn't stay where I was at any longer, and that's pretty much

how I became homeless.

Margaret and Peggy both knew that proof of income from Disability (SSI) aided their ability to find a place to live:

(W026) I'm technically still employed but I'm out on disability right now. I had been gettin' short-term disability but that had ended. Luckily I was able to get in here so at least now I'm getting' meals and well, it's not exactly comfortable, but a lot more comfortable bed than squashed up on the back seat of my truck...Right now knowin' that I got my long-term disability approved, I'm gonna meet with—once I get the paperwork in that's gonna be used as proof of income—I can start callin' and settin' up appointments to go look at apartments and stuff.

(W017) They say that if I do try to go for disability that they would try their best to make sure I could find a home of my own, just because I don't have anywhere to go. Like I said, I'm trying to figure out exactly what to do with my life. I am good with artwork and I love little children and elderly people, too.

I discovered that there is little incentive to find a job when on disability because it limits eligibility for certain entitlement programs. Even working a few hours per week can change eligibility status. Here is the way Andrea explained her situation:

(W030) He [her husband] collects disability but he said—they said that—see we went to Social Security and spoke with them and let them know his change of address. He asked the worker, he said, "The bottom line is, I need to definitely collect social security, I need it for the rent." He said, "What could I do for work that I could keep my disability to pay my rent, and can I work?" The gentleman showed him the paper everything, broke it down. He said, "You can work 20 to 25 hours a week. No more than 25. Do not accept any more than 25." He said, "And you can put over two grand in a bank account, and we cannot touch it." He will still get his benefits.

Pursuing income from disability insurance was common. Many of the women knew the rules for applying and the limitations on employment if they received disability. The reasons for applying were sometimes due to physical or mental health issues. Waiting to receive disability benefits often took years and they had to attend hearings, get letters from doctors, and fill out abundant paperwork. Like applying for housing subsidies, applying for disability involved a waiting game, patience, and perseverance. I am aware of the perception by some employed

people that certain individuals who seek disability income are lazy, “moochers”, or trying to take advantage of “the system”. I am not passing any judgment on the credibility of their disability, I am simply presenting the fact that it was mentioned by the women I interviewed.

The Future

As the preceding analysis shows, these women’s lives were influenced by predisposing, exacerbating, and intervening factors. The interrelationship among these complex issues created an environment that resulted in homelessness. They dealt with the issues in various ways, but the outcome was depressingly similar for all of them. Growing up poor with complex, often dysfunctional, family relationships predisposed the women to homelessness and set the stage for their life course. Once on this trajectory, they were challenged with factors that worsened the outcome; most notably coping with physical and mental illness, substance abuse, and trauma. Other prevailing issues that periodically affected some, but not all, of the women, such as dealing with loss of their children by DCF, incarceration, or disability further tipped the balance towards homelessness.

Multiple risks and vulnerabilities affected these women in their daily lives and surely would dog their futures. Most of the discourse and training at the shelter revolved around the progression of the remainder of their lives, but many of the women could only cope with the short term. They had few long-term plans – dreams, yes, but few concrete plans. A range of issues was mentioned that caused concern in their lives. For example, one of the risks the women faced was a fear that they would get involved with someone who is like their father, who may have been abusive or an alcoholic. Often they spoke of being worried that their relationships with men were similar to their relationships with their father; they didn’t want the cycle to continue. One mother mentioned that her son periodically put her down and insulted her

and she was concerned that he would treat a woman or girlfriend the same way. Tanya, a 26 year-old pregnant woman at the shelter with two children and her husband was preoccupied with this concern. Her husband drank occasionally but she did not want him to drink at all because it reminded her too much of her childhood and problems with her father.

(W011) That was the first time I was here [at the shelter] and I'm like oh my God what am I going to do? My thoughts were just going crazy. I wish I could find a job or just everything was going through my mind. My shoulda, coulda, woulda's my what am I gonna do next and me and [my husband] were bad. We had an argument before I left. I kinda knew what was gonna happen but he has his issues, I mean sometimes like I said I have a thing for guys that have a drinking problem. I don't want to say that he has a drinking problem but he seems—because he doesn't really drink but when he gets to drinking it reminds me of my father kind of. I just don't want him to do it and he thinks that because he's an adult he can do it...He thinks it's gonna fix things. When he drinks he thinks it's gonna fix the situation. It helps him I guess numb what's going on, I don't know what the deal is about that.

Their future is also fraught with risks and concerns. The women often worried about getting involved with the same crowd again, perhaps with people who were bad influences in their lives. They expressed concern about not being able to find employment or a place to live. All of these are risks they have to face. Still they expressed a desire to look forward for a new lease on life and a new beginning with the hope of leaving their old life behind. As Alice said,

(W014) Living up here is gonna be—it's a total change. It's the community; it's all the people you hang out with and I'm involved with the school system now and I mean it's like I have real friends. Not real friends, but normal friends, 'cuz my old friends, they're all users [drug users]. Being up here, I could be anybody and no one has to know my past. It's like a different life up here...It feels real good. I can breathe again.

Summary

This chapter discusses the major themes that constructed the lives of the homeless women I interviewed. The central domains of love and loss were intertwined with themes of sexual abuse, violence, dysfunctional and/or broken natal families, mental health issues, substance use and recovery, DCF, incarceration, disability, and for most a history of living in

poverty and its associated insecurities. These predisposing, exacerbating, and intervening factors created a complex life that often resulted in homelessness. Although for some this homeless experience was a single episode, for others it was a chronic condition. It was difficult, if not impossible, for some of the women to recover from their current situation and for others it was their first and last experience. I am not aware of what transpired in their lives after I met these women but undoubtedly, based on their complex and difficult circumstances, some returned to the shelter (or others) multiple times.

Chapter 9 – Discussion/PHAMILIS Syndemic

Interwoven in the narratives of homeless women's lives are the themes discussed in the previous chapters that have contributed to their risk for homelessness. In particular their often fraught relationships with family and friends and the losses they have experienced define the vulnerability that shaped their lives. Their lives are complicated by physical and mental illnesses brought on by a lifetime of individual and structural factors at the heart of a Critical Medical Anthropological theoretical perspective. Social, political, and economic issues define homelessness, but it is the people who have experienced it directly who can speak most poignantly to the underlying causes of the problem.

Loss is one of the overarching themes I identified in this research. The women describe endless losses from loss of their childhood to loss of possessions when they lost their home to loss of custody of their children. They suffered from emotional loss, material loss, and loss of love, freedom, privacy, and self-esteem; all of these affected their feelings about themselves, their ability to organize their lives and their inner resources to cope with daily living. Instability was prevalent throughout their lives. The women moved frequently as children, their parental relationships often changed as parents divorced or different father figures came into their lives, and they relocated to escape or engage in relationships. These interconnected factors—social conditions and a set of interacting health problems—form a syndemic that defines the lives of homeless women, which they cannot escape without financial, educational, and social resources that, for most, have never been attained in the first place. As one woman noted, most poor people only know other poor people who are barely scraping by themselves and not in a position to offer much assistance. Thus, personal resources and social connections fail them as does the state,

which offers an inadequate, piecemeal system that is not aimed at lifting people out of poverty, but functions to maintain them in it.

Several classic ethnographic accounts of homeless women's lives have been published. I drew from these narratives and utilized their findings as a framework for my exploration. Elliot Liebow's book, "Tell Them Who I Am: The Lives of Homeless Women" (Liebow, 1993) is a wonderful perspective on homeless women in emergency shelters outside of Washington, D.C. He recognizes that "Most homeless women are engaged in an unrelenting struggle to remain human in the face of inhuman conditions," (Liebow, 1993:3) The women I interviewed exemplified this notion as they experienced social suffering in their lives.

I found that not all women staying in a homeless shelter consider themselves to be homeless. Some were comfortable with having a roof over their head, hot meals, and a safe place to sleep. They were also content to have their basic needs met for their children. They felt that since they were not on the streets and thus they were not literally homeless. Many had spent time "doubling up" with family or friends, trying to remain housed. Most of the women were working diligently to get out of their homeless situation. They spent each day looking for jobs, housing, and child care for their children. They expressed the need for dignity in the face of their living situation.

Their relationships in the past, currently, and in the future will most likely affect who they become and shape their success after they leave the shelter. Family relationships were the most tenuous. Some were sources of great joy and others were destructive. According to Liebow, "Shelters and streets are littered with the bits and pieces of broken families. Some of the women are desperately trying to rebuild family relationships, some are just as desperately trying to run away from them, and others are struggling to hold on to what they have. This

complex pattern is further complicated by the fact that a family relationship is not a single strand but a collection of many, and each strand can itself be complex and slippery in its own right.” (Liebow, 1993:82). The women whose lost or fractured relationships were fresh in their minds or who were at the shelter without their children were the most emotional. Very often family ties had been broken and the women were no longer able to return to the home they once knew or to return to their childhood home. They were lacking family support and this rejection caused anger, resentment, frustration, and sadness. The older women who had been homeless for a long time and whose relationships had been broken for many years seemed to be more accepting of being family-less.

My research focused on homeless women who face unique obstacles to dealing with homelessness. Women are affected by personal issues such as physical and mental illness, substance abuse and intimate partner violence, as mentioned above. Personal trauma, identified as sexual, physical or emotional abuse, was a universal factor in most of the women’s lives and it caused profound loss. Many of the women had destructive family relationships filled with trauma and abuse. Because I did not interview men I cannot assume that their lives were void of these issues but based on my review of the literature it would appear that women are disproportionately damaged by abuse and violence in their lives. The trauma that homeless women have experienced needs to be recognized and dealt with. Only after this occurs will the women be able to build secure, trusting relationships.

My interviews were conducted predominantly with White women (n=23; 77%) since that was the majority of the women staying at the *Entré* shelter. This differs from the racial/ethnic distribution of homeless women in more urban areas. This distinction is noteworthy since it is possible that the perspective of the women I interviewed is not representative of all homeless

women or even of homeless women in Connecticut. Relationships between residents that developed at the shelter were sometimes affected by issues of race and social class. In his work with homeless women, Liebow also found that “Friendships turned on many axes. Sometimes two women seemed to pair up because they were both black or white, or of the same age, or were perhaps both better educated or more refined than the others. But for the most part, race, age, and social class appeared to be low-lying boundaries easily crossed rather than deep structural faults that separated the women cleanly from one another.”(Liebow, 1993:162). I witnessed very little outward discrimination by the women toward the residents of different backgrounds but it may have existed. As in society as a whole, “race [can be a] divisive and destructive force in shelter life, although in practice it was usually contained...Public expression of racial animosity was against the rules – the informal rules by which the women governed themselves as well as the formal rules that prevailed in every shelter. The formal and the informal, working together, generated a strong moral force....” (Liebow, 1993:190-191)

Parenting

Motherhood was, by far, one of the most frequently discussed issues. Homeless women's lives are quite chaotic and they need to find stability to raise their children. Attempting to maintain a stable life for their children is of utmost importance. The shelter, although preferable to being on the streets, is not conducive to raising children. Specific issues such as finding child care and keeping their children clothed, fed, and safe are huge challenges for all mothers, but these were complicated by homelessness. Donna Haig Friedman (2000) in her book on parenting in public discusses the complexity and difficulty of dealing with personal problems while living in a shelter since most people would prefer to deal with these in their own home. Shelter policies affect their ability to parent and their confidence in being a parent. The rules and

policies of the shelter require that the women are responsible for round-the-clock supervision of their children and the staff reinforce these rules and monitor how the women carry out these responsibilities, including the way they discipline their children. Speaking for the homeless mothers she interviewed, Haig Friedman asks “Does becoming homeless mean that I am unable to parent? How am I to explain to my child that I have to get staff approval for getting them a baby-sitter? My children see me being treated like a child. They lose respect for me.”

(Friedman, 2000:95)

The Shelter

The shelter, itself, and the staff affect the woman’s well-being and her ability to be a good parent. The “location, size, facilities, amenities, and layout all contribute to the quality of life and personality of any given shelter, but these can easily be overridden by the people who staff the shelter and the philosophy that defines their jobs and shapes their relationship to the homeless clients.” (Friedman, 2000:115). Shelter staff can be a major source of support. In addition to providing them with a safe, warm place to sleep at night, maintaining order, and seeing to it that they have food and other essentials, they also listen to them and provide advice and encouragement (Liebow, 1993). This positive support is tempered by the underlying tension created by the power struggles between the staff and the residents. The staff can provide these amenities but they can also take them away. Liebow noted that the “unequal power relationship tended to put a ceiling on the development of personal relationships, even when the impulse to build them was present. For some staff relationships were inhibited by the desire to maintain a more or less professional relationship with their “clients”. In addition, many of the staff both paid and volunteer were separated from the women by the real or imagined abyss of social class.”(Liebow, 1993:161)

Theoretical Models

I selected two theoretical models to guide my research. These models assisted in identifying and delineating the culture of homeless women. Mary Douglas' (Douglas, 1992; Douglas & Wildavsky, 1982) writings on the social construction of risk was a useful framework for describing the experiences of homeless women. Some of the women took personal blame or responsibility for their homelessness while others felt they were "wronged" or dealt a "bad hand" by society. The women's individual risk factors for homelessness, including substance abuse or mental illness, were influenced by their interactions with the environment around them. Neither can operate in isolation and neither can be completely responsible for homelessness. Risk generally deals with dangers in the future. Risk factors for medical conditions are generally equated with objective clinical risk and with epidemiologic risk. Gifford, in her discussion of "the meaning of lumps" about women's conceptualization about breast cancer says, "Scientific risk is quantitative, objective and relatively unambiguous. Lived risk is qualitative, subjective and highly ambiguous." (Gifford, 1986:220). She goes on to say, "Lay risk will always possess an inherent quality of unmeasured ambiguity and uncertainty as a central characteristic. It emerges from an individual's subjective feelings about the meaning of scientific and clinical risk mediated by their social and cultural background, context, and experiences. Lay risk is not objective, cannot be quantified or measured, and is not static. Rather, it must be understood as a dynamic experience of personal uncertainty about one's future." (Gifford, 1986:231). Risk, when associated with homelessness, can be considered lay risk. It is the lived experience of women who have been vulnerable to their surroundings and the people with whom they associate. It also becomes a factor in their future, which will be further defined by their environment and their social experiences. It is incorrect to say they were "at risk" for homelessness since they were

already staying at a homeless shelter, regardless of how they perceived their living situation. Yet they faced risk daily, primarily due to their vulnerable condition brought on by poverty, unemployment, or a lack of housing. I sought to identify the risk and resilience factors in their situation (Moxley et al., 2012) . Self-efficacy determined their ability to adapt to their situation and move forward. Their resilience helped to reduce their vulnerability. The women were functioning at levels where they could endure their current situation and adapt to their environment while they were at the shelter. They were able to set personal goals and move forward. Their positive outlooks were often surprising but inspirational as they navigated the system, dealt with their losses, and attempted to alter their life path to move forward to recover from homelessness and the many other wrongs in their lives.

From the CMA perspective, homelessness is influenced by social, political and economic factors, including poverty, unemployment, and a lack of affordable housing. The women I interviewed expressed their frustrations with dealing with “the system”, entitlement programs, and often DCF. These macro-level factors affected their health and well-being in numerous ways. For example, the women spoke about anxiety, depression, and physical health problems associated with their lack of housing and unemployment. Several had applied for disability due to physical or mental illness that prevented them from working. Some of the providers I interviewed were part of the system that affected the women’s ability to attain support and housing.

Structural violence (Farmer, 2004; Lyon-Callo, 2001) is evidenced by power differentials in the women's personal lives and within the shelter and social service system. Lyon-Callo (2001) addresses this unequal power distribution that affects homeless women and contributes to structural violence, “Domination through processes of class exploitation, racial injustice, unequal

educational opportunities, and gendered inequality are also all fairly easy to document components of homelessness.” (Lyon-Callo, 2001:295). Relationships can be premised on a power dynamic that leaves one member of the relationship in an inferior or subservient position. These relationships can be detrimental to the individual’s self-esteem when one partner is domineering. A consequence of this risk environment for homeless woman is a need for support and belonging. While at the shelter the women are at the mercy of the shelter staff. They rely on them for food, shelter, and “normalcy”. Too often the shelter staff utilizes their power to create obstacles for the residents to attain their goals. Residents spent a gross amount of time playing a waiting game while they were waiting to hear about jobs, housing, and disability decisions. Susser describes this dynamic clearly, “Poor people are practiced at waiting, operating on institutional time, a requirement that creates unequal power relations between poor people and service providers” (I. Susser, 1996:418). Waiting develops into boredom, frustration, and discouragement with the system, the shelter staff, and the situation. This is one example of the structural violence they endure.

A Syndemic Approach: PHAMILIS

A syndemic approach is a theoretical perspective that helps in understanding the complexities of homelessness and provides a window on its causation. According to Singer, a syndemic is the “...concentration and deleterious interaction of two or more diseases or other health conditions in a population, particularly as a consequence of social inequality and the unjust exercise of power” (Singer, 2009:xv). In a syndemic there is a synergistic interaction of two co-existing diseases that contributes to an excess burden of illness (Singer & Clair, 2003). The clustering of diseases in a population, and hence the conditions that foster the potential for disease interaction, are facilitated by physical and structural violence, including poverty,

discrimination, abuse, and social trauma. Women, in particular, are subject to interacting conditions that are exacerbated by social structural factors affecting their lives (Meyer, Springer, & Altice, 2011). I suggest that the intertwined factors that emerged from my study of homeless women constitute a syndemic, which I call PHAMILIS (read families) -- Physical Health problems, Abuse (physical, sexual, emotional), Mental Illness, Loss, Instability, and Substance use (alcohol, tobacco, and other drugs). Together these domains typify and explain the lived experience and making of homelessness at the individual level. These micro factors are, in turn, promoted by social policies and practices that produced economic downturns and loss or lack of access to jobs, as well as restrictions on housing access, the policing of the poor, and related enactments of power. As defined, syndemics rely on two interrelated interactions: first, at least two health constructs interacting with each other (e.g., HIV and tuberculosis). In my model there are several enmeshed health conditions (i.e., poor physical health, physical and sexual abuse, mental illness, and substance abuse) that co-exist and potentially interact. Second, there is the interaction of these health issues with a set of social conditions. In the PHAMILIS syndemic these are loss and instability, and the overarching condition of poverty which enhance disease burden and contribute to homelessness. Homelessness is both created by social inequalities and disparities that affect the health and well-being of those who experience it and is facilitated by the resulting poor health of those who are forced into homelessness. The women I interviewed expressed feelings of being unjustly treated by society, shelter staff and other residents, and mostly importantly by their families. The women's social suffering (Bourgois, Lettiere, & Quesada, 1997; Kleinman & Kleinman, 1997; Rhodes et al., 2005) as they experience homelessness is synthesized and described by this syndemic.

In this dissertation I described the factors that interact to form the PHAMILIS syndemic. Foremost, poverty is the overarching predisposing construct that affects homeless women from early childhood throughout their lives. Although not all homeless women came from poor natal families, they find themselves in situations where they are unable to utilize their resources and provide for themselves or their family. Poverty creates a risk environment in which people must cope with discrimination and multiple health disparities (Rhodes et al., 2005). Poor women face unequal access to health care, marginalized treatment by health-care providers, class discrimination, gendered inequalities, competing priorities, denial of health problems, and the inability to leverage social capital and economic resources to provide adequate health care for their families. Homeless women rely on support, often from the government, for their health insurance, food, and housing subsidies, among other assistance, but this source is not accessible without admonishment, social hurdles, and changing ground rules. One woman explained, “I do have health insurance. I have Food Stamps but I just have no cash.” Their family’s financial support is generally non-existent or sporadic, and they cannot depend on them economically. This was primarily because their families were also impoverished, living on the edge, sometimes had members who were alcoholics or drug users themselves, or due to the fact that their relationships with their families were strained or had been severed. Most of the women I interviewed, did not discuss being poor or growing up in poverty, yet their current situation being at the shelter illustrated this indisputable fact. Factors such as not having a car or rolling their own cigarettes are concrete examples provided in this dissertation of a lack of financial resources. Although some of the women described a life they once knew that included a well-paying job, owning a home, or material possessions such as video games for their children, most spoke about not being able to pay their rent, not having money to pay for gas or car repairs, or

not being able to afford medications or medical care. Poverty is a well-known cause of health disparities (Marmot, 2005; Plumb, 2000). People who are poor or lack economic and social resources experience poorer health due to lack of access to health care and adequate insurance, poor nutrition, and a host of other factors that affect their physical health.

The first component of the PHAMILIS syndemic is Physical Health. This involves a bidirectional interaction as poor physical health affects homelessness but conversely homelessness can affect physical health. The physical health problems of the homeless people I interviewed include heart disease, diabetes, arthritis, and dental problems. Women, in particular, face unique health issues such as pregnancy, sexual and reproductive health problems, including sexually transmitted infections. The women I spoke with mentioned poor health as restricting or limiting their ability to work or making them disabled and unable to obtain employment. Some participants had worked or were currently working in low paying service positions with few, if any, health benefits, which delayed or restricted their attaining health care. Some of the women mentioned having had working class jobs that created health conditions, such as back problems (e.g., disc degeneration or osteoarthritis) that they attributed to working at jobs that involved bending and lifting, like being a nursing assistant, a job that requires moving and lifting heavy patients. Others had heart problems that could be exacerbated by stress. One woman described in detail being epileptic, which she felt was a result of serious physical abuse in childhood including head trauma. Another felt that as a child she was singled out among her siblings and abused by her father because she had Type I diabetes. Almost all of the men and women smoked cigarettes and thus were at greater risk for lung disease and cancers of the head and neck. Many of the women were in the process of applying for disability benefits. They needed a letter from a medical or mental health provider verifying their disability and they discussed the complexity of

attaining that documentation. Receipt of disability benefits, in general, were adequate to pay for housing and living expenses, so for many it was essential to regaining housing stability.

The women discussed insuring medical care for their children but sometimes neglecting their own health. Some of the women had relocated to the area from another city and they had not, yet, identified a medical provider for themselves, although most had prioritized this for their children. The children had to have a physical examination and requisite immunizations prior to attending school so they sought out a health care provider to assure their child could go to school.

Some of the women's physical health problems resulted in mental health issues, such as depression, stress, and anxiety. For others, being homeless exacerbated their health problems and promoted ill health, especially stress-related diseases (e.g., hypertension, heart disease), diet-related problems (e.g., overweight and obesity, nutritional deficiencies), mental health problems, substance use, and intimate partner violence. The well-known syndemic of depression and diabetes exemplifies the social suffering experienced as a consequence of the interrelatedness of two illnesses that combined with social influences result in a worsened health condition (Mendenhall, 2012). The women interviewed for this research did not specifically mention the dual health conditions of diabetes and depression but given the high rates of mental illness, and depression, in particular, combined with the observed obesity among the women it is certainly likely that this phenomenon existed in this population, creating worsened health conditions.

The next factor that comprises the PHAMILIS syndemic is Abuse. Another health condition, this broad domain includes psychological or emotional abuse, sexual abuse, and physical abuse. These related concepts damage the women for life and contribute substantially to their risk of homelessness. The number of women who had experienced a form of abuse in

their lives was startling. Beginning in childhood, many of the women were traumatized by emotional or physical abuse by their father or mother, people who often struggled with substance use disorders. Witnessing violence in their homes and community was also detrimental to their psyche (Romero-Daza, Weeks, & Singer, 2005). I was disturbed by the amount of sexual abuse by a family member or family “friend” mentioned by the women. This violation of their bodies carried over into their intimate relationships with partners and made them vulnerable to further abuse. They desperately sought attention and belonging that had been lacking in their younger years and too often their adult relationships were fraught with additional abuse. Intimate partner violence was common and some of the women had spent time at domestic violence shelters prior to arriving at the *Entré* shelter. Wide spread personal abuse was part of their lives and it resulted in susceptibility to further violence and abuse commonly resulting in mental health problems (Singer, 2006).

Another health component of the PHAMILIS syndemic is Mental Illness. Mental illness of self, partners, or family members is a key factor in most of the women’s lives. For women themselves, the most common types of mental illness were depression, anxiety disorders, and bipolar disease often exacerbated by substance use in a context of physical and emotional violence. The manner in which homeless women deal with their mental illness and address it as a factor in their lives varies from woman to woman, yet it affects a huge aspect of their daily experience. It challenges their ability to seek and maintain employment, care for their children, organize and manage their finances, and maintain relationships with partners, family, and friends.

Mental illness is closely linked with substance abuse, which includes all mood/mind altering drugs and alcohol and tobacco. The women who discussed substance use in their lives

were often coping with depression, anxiety, personality disorders, and low self-esteem. Personal substance use in early years or by family members negatively impacted their ability to maintain a stable life and to deal with life stressors of jobs, housing, or relationships. Too often people self-treat their mental illness by using substances such as alcohol or illegal drugs that temporarily alleviate some of the pain and suffering (Khantzian, 1985). Involvement in drug use may have social or economic factors. Relationships are sometimes built upon a common reliance on drug activity. Buying and selling drugs or exchanging drugs for sex, food, housing, or other commodities may be a means of survival. One of the issues faced by the homeless women at the *Entré* shelter was an interruption in their mental health care and their medication due to relocation, lack of health insurance, or complex issues related to making or keeping medical appointments.

Physical health, abuse, mental illness, and substance abuse are inextricably interrelated and mutually enhancing health conditions that comprise the PHAMILIS homelessness syndemic. The experiences of trauma and loss exacerbated physical and mental health problems and substance abuse. Substance abuse complicated mental health problems and contributed to a deterioration of physical health. Enduring physical health problems produced stress that enhanced the mental health challenges faced by the women. Social factors that contribute to the risk of homelessness and, in turn, impact the complex of health issues experienced by study participants are: loss and instability. I found that the women faced a range of social and physical losses that impacted their everyday lives and created challenging circumstances. They experienced material loss, such as loss of possessions, a home, or finances, through eviction, relocation, or relationships. Emotional loss occurred when they were robbed of their childhood or their innocence when they had alcoholic parents, dysfunctional families, or experienced sexual

abuse. Many relationships ended abruptly or painfully resulting in loss of romantic love. Lastly, they dealt with the structural violence of loss of freedom or privacy that involved power relations at the shelter or with social service systems or government entities. Shelter staff controlled their daily lives and their future by countless rules and restrictions. Social service agencies demanded numerous applications and forms repeatedly asking personal questions that left the women waiting for responses or put on endless lists or lacking control and privacy. These losses added to the social suffering of homelessness.

The final interwoven social construct affecting the PHAMILIS syndemic is instability. Homelessness is defined by unstable housing yet it goes beyond the loss of a housing structure. “Doubling-up” with family and friends or being thrown out of their homes, being evicted, displaced, or relocating results in loss of a roof over one’s head but it also creates painful emotional loss and health issues that are enmeshed in the homeless experience. Moving to different locations or being shuffled from home to home either due to divorce, being rejected by family members, or poverty creates a chaotic living situation. Some of the women had been foster children and then were left on their own after “aging out” of the system at the age of 18.

Other intervening factors such as early pregnancy or incarceration resulted in an unstable life. If the women were pregnant as teenagers they were not always welcomed to stay in their natal homes, due to stigma and discrimination, rejection, disappointment or the inability to afford another mouth to feed. The women were forced into early adulthood with the responsibility of caring for a baby, often as a single parent, and trying to find a place to live and to make ends meet. They sometimes sought security and stability by entering into relationships that were of equal consequence and sometimes abusive. The men they became involved with at times had criminal histories due to drug charges or other infractions that limited options for housing.

Felonies, sex offenses, or arson convictions severely inhibit the places one can live or the ability to obtain housing subsidies. Moreover, incarceration, in itself, is disruptive to family life.

Several of the women I interviewed were involved with men who were serving prison or jail time. Many of the men were the fathers of their children, adding additional stress, instability, and loss to their lives.

This unsettled life led to multiple physical and mental health problems that create the social suffering of homeless women. Not only did they have personal health issues but they were also impacted by the manner in which society treats people who are poor, homeless, and marginalized. The women were vulnerable to abuse on multiple levels, as a result of power inequalities imposed by their unequal relationship with family, partners, shelter staff, and the institutions of society. They led complex and often unstable lives influenced by social structural factors and related “conjunctures of vulnerability” (Ribera & Hausmann-Muela, 2011). The PHAMILIS syndemic captures the complexity and interaction of the multitude of issues experienced directly but emanating from micro, meso, and macro levels of social complexity that affect homelessness. It is the synthesis of these factors that defines the struggles of homeless women and shapes their experience and understanding of being homeless or living in a homeless shelter. It is only by considering the interaction of these factors that it becomes possible to devise effective preventive measures.

Prevention

While listening to homeless women tell their stories, I identified specific themes that affect their lives. It is not enough to hear what they say, it is important as a medical anthropologist to take action and strive to alleviate this situation. There are several avenues that can be chosen to attempt to prevent and minimize homelessness. As the PHAMILIS syndemic

suggests, homelessness cannot be alleviated by simply providing everyone with a place to live although that is important. Rather homeless women have multiple complex needs that must be addressed to lift them out of poverty in order to end homelessness. Each element of the PHAMILIS syndemic must be addressed to prevent homelessness. This can be done using both micro and macro preventive measures. First, we should focus on preventing homelessness before it happens. Although homelessness stems originally from poverty, not all people who are poor become homeless. We need to identify the specific factors that contribute to or result in homelessness as well as those that protect against it among the poor, an understudied topic.

On the micro, individual level, homeless women have experienced abuse and trauma in their lives. Providing trauma-informed care would help to reduce the effects of abuse and violence experienced by homeless individuals. This would require training of shelter staff and housing providers to be cognizant of the trauma homeless people have experienced and to be more sensitive to their needs. Creating shelters and services that are organizationally informed about trauma would assist in building relationships at the shelter among residents and staff that would foster positive and successful outcomes. Various techniques and programs have been developed to assist in building trusting relationships that would keep women housed and avoid relapse to homelessness.

Too often homeless women are enmeshed in a cycle of abuse; many of the women I spoke with were abused as children and as adults and some of their own children were abused. For example, I interviewed a woman who is epileptic who was physically abused by her brother and she thinks he had been sexually abused by a priest. She mentioned that her daughter was also sexually molested. This same woman was emotionally abused by her husband for at least 20 years. Although this is an extreme situation of generational abuse, it demonstrates that child

victims need timely, adequate psychological care and counseling after abuse in order to learn how to avoid getting into relationships in adulthood that result in similar abuses. Second, homeless women have mental illness and substance abuse issues (including tobacco use) that need to be addressed. Improving drug treatment and mental health services and smoking cessation programs for homeless women is essential both to reducing homelessness and providing women with the resources needed to get out of homelessness and to foster more optimal physical and emotional health.

“Housing First” models that provide supportive services must be considered even for those who are chronically homeless and have mental illness or substance abuse issues. Although there is varied opinion about the use of housing first versus treatment first (Henwood et al., 2011; Montgomery et al., 2008; D. Padgett, Stanhope, Henwood, & Stefancic, 2011; Stefancic & Tsemberis, 2007), these models are effective in maintaining people in stable housing, and this is necessary to help them overcome their addictions. It may also be necessary to realize that not all people can be rehabilitated and may need long-term income and housing subsidies.

There is also a cycle of homelessness that needs to be broken. Some of the women spoke of being in homeless shelters as children or at a previous time in their lives. Many of the women had been in either a “No Freeze” shelter or a domestic violence shelter. Shelter recidivism creates a sense of normalcy that can be perpetuated by the current system because it is only a temporary emergency "cure" for a deeply complicated problem. If we provide counseling, create job opportunities and provide education, health care and a path to income security, we may be able to empower women to be more independent and self-sufficient and enable them to avoid generational homelessness. These resources would also give them the ability to leave an abusive relationship and be on their own if they experience interpersonal violence and abuse.

On a structural level there are numerous programs that can be enacted to prevent homelessness. On May 20, 2009, President Obama signed the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act. The **HEARTH Act** amends and reauthorizes the McKinney-Vento Homeless Assistance Act with substantial changes, including: 1) A consolidation of HUD's competitive grant programs; 2) The creation of a Rural Housing Stability Program; 3) A change in HUD's definition of homelessness and chronic homelessness; 4) An increase in prevention resources; and, 5) An increase in the emphasis on performance. Most families are homeless on a short-term basis, averaging from three to six months, therefore, programs that provide rapid rehousing and subsidies to keep them out of homelessness or to limit shelter stays, are essential. And lastly, decreasing poverty, creating jobs that pay a living wage, supporting child care subsidies and other needs of low-income men and women would also reduce homelessness.

Importantly, prevention must begin with understanding the importance of enhancing the dignity of people who are homeless. We should instill the importance of respect and dignity for all to those who provide the myriad helping services to the poor from housing assistance to health care. The providers and the women expressed the understanding that supportive services are needed but also a feeling that dignity and respect need to be accorded to all no matter their circumstances. This is especially important for homeless women who have experienced multiple injuries to their psyche.

“A New Beginning”

Life at the shelter was a pivotal point in some of the women's lives. I found that the struggles and tragedies they experienced gave them strength, the ability to overcome adversity, and a positive attitude for the future. This empowerment, hopefully, can be utilized to help them

lead more independent lives, be responsible for themselves and their children, and leave their homeless state permanently.

Liebow clearly describes what I also found that the women I talked to were searching for in their lives. Most wanted to move forward positively into the future and acquire some respect and dignity along the way. He explains, “The struggle then moves rapidly to the search for companionship, modest measures of independence, dignity, and self-respect, and some hope and faith in the future. These needs are not particularly sequential or hierarchical. One can just as easily be immobilized by hopelessness and despair as by hunger and cold. Body and soul are equally in need of nurture and the women must grab whatever they can get when they can get it.” (Liebow, 1993:27)

In the free list exercise, the women mentioned “New Beginning” as a term they used to describe their thoughts on homelessness. I hope they can make this happen, but I have no crystal ball to see into their future and my study was a cross-sectional view of their lives, not a prospective study. This ethnography is only a glimpse into their lives past and present, described with the goal of making their own voices heard. Hopefully, a better understanding of their history and personal vulnerabilities will help identify needs, services, and solutions to prevent homelessness among women and provide them with better lives in the future.

Future Research

Additional research is needed to better understand the “culture of homelessness”. This ethnography explores the lives of homeless women in a rural shelter. This was not a comparative study and I have not interviewed urban homeless women but I would like to explore this area of research. It would be important to further understand if there is a difference between homeless women in rural versus urban areas. Based on knowledge from review of the literature,

I found the individual, personal level factors to be similar – mental illness, substance abuse, history of abuse but some of the structural factors may have been different. Specifically, there were fewer options for housing, jobs, access to health care, or transportation in the rural areas. I tend to think that the PHAMILIS syndemic also exists among urban homeless women and to rural and urban homeless men.

I would like to have interviewed men, specifically men alone at the shelter with children. I met several men in this situation during my participant observation and I spent some time talking to them. Many were caring for young children without a partner or mother of the children because the woman had left for any number of reasons. Most of the women had substance use or mental health disorders, according to the men. This would be an interesting area of further research.

Future research would also benefit from an interdisciplinary approach in which researchers from disciplines including nursing, psychology, addiction medicine, public health, and anthropology combine their respective expertise to examine the personal and structural level factors that affect the culture of homelessness.

Limitations

As with all research there are limitations to this ethnography. First, it was conducted in only one shelter in Connecticut thus limiting the range and diversity of homeless women I interviewed. The shelter was in a rural area of the state and it's possible that women in other types of shelters would have different experiences and they may perceive their homelessness differently. It would have been useful to interview women in a variety of shelters in urban and rural areas.

A second limitation is my ability to return to the shelter to conduct follow-up interviews with the women. I think it would have been valuable and interesting to do long-term follow-up of the same women over time. Such a study could provide a unique perspective about their lives and the chronicity of homelessness, if it exists.

Conclusion

The overarching domains I identified dealt with loss and relationships. It is these two constructs that were intertwined with recent or long-term poverty in all aspects of the women's lives as they defined their risks and vulnerabilities throughout their lived experience. They create a homelessness PHAMILIS syndemic, which includes physical health, abuse, mental illness, loss, instability, and substance use. Starting from a Critical Medical Anthropologic perspective and Douglas' model of risk I explored the themes that affect a homeless woman's agency and life trajectory. Often born into poverty or plunged into it by divorce and coping with detrimental family relationships, the women I interviewed faced obstacles throughout their lives that predisposed them to homelessness and influenced their future. They dealt with grave instability and relocated frequently throughout their childhood and adult life, causing uncertain futures and complex living situations. The women faced challenges in their personal lives and relationships that exacerbated their risk for homelessness; this was further impeded by structural, intervening factors such as the impact of DCF and the role of incarceration in their lives.

Risk factors for homelessness can be categorized into those that are structural and those that are individual. They begin in childhood and influence the remainder of their lives. Structural risk factors that affected the women, primarily lower socioeconomic status and extreme poverty, were pervasive. Additional structural factors, such as unemployment, instability or relocation, or the high cost of housing impacted their adult lives and gravely

affected their risk of homelessness. These systemic causes of homelessness were further affected by material losses, including eviction or loss of property.

The individual, personal risk factors such as poor physical health, mental illness, substance abuse, interpersonal violence, or sexual abuse exacerbated the situation and contributed to a multitude of life-long detrimental losses and complex, conflicting relationships. These losses manifest themselves in an abundance of ways throughout their lives including a loss of childhood, loss of freedom, loss of identity, loss of self-esteem, and loss of health. Furthermore, losses can be worsened through damaging relationships in childhood, for example when a parent is an alcoholic, a child is molested, or a woman's troubled relationship with her mother causes her to be emancipated during adolescence. In adulthood, relationships can be further strained or ended through domestic violence, substance abuse or mental illness.

Creating more affordable housing is one factor that would help alleviate homelessness but it is not the sole solution. Homelessness needs to be tackled from diverse angles. Starting with providing stability and support for people living in poverty and with dysfunctional families would be one aspect of the solution. Another would be provision of more treatment for substance abuse and mental illness. A third, important remedy would be improved identification of women who have experienced abuse or trauma and providing them with trauma-informed care to address their complex feelings of loss, shame, embarrassment, and low self-esteem. Until women feel better about themselves and are empowered to get out of their situation, they will be struggling with homelessness. The measures necessary to prevent homelessness become clear when a syndemic approach to the problem is used. This approach leads to a multidimensional conceptualization of homelessness that goes beyond the individual to encompass the social,

economic, and structural factors that result in homelessness. It incorporates the upstream-downstream epidemiological approach to solving health and social issues.

Appendices

Appendix A

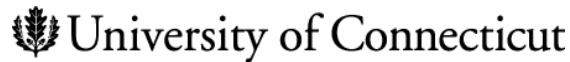
Table of Characteristics of Women Interviewed at Entré Shelter (n=30)

Characteristic	
Age, mean (years)	36 (range 19-58)
	N (%)
Race/Ethnicity	
White	23 (77)
African American	4 (13)
Latina	2 (7)
Mixed	1 (3)
Had children at Shelter	17 (57)
Had children not at the Shelter	8 (27)
No children	5 (17)
At shelter with partner	7 (23)
Previously homeless	11 (37)
Substance abuse	14 (47)
Mental Illness	22 (73)
Experienced any abuse	18 (60)
Physical	13 (43)
Sexual	8 (27)
Emotional	10 (33)
Divorced parents	19 (63)
Involved with DCF*	5 (17)
Disability	10 (33)
High school graduate	21 (70)
Or GED	6 (20)

*Department of Children and Families

Appendix B

Consent Form for Participation in a Research Study - Women



Principal Investigator: Pamela Erickson, DrPH, PhD

Student Researcher: Ruthanne Marcus, MPH

Study Title: Women's Discourse on the Homeless Experience.

Introduction

You are invited to participate in a research study to help us understand more about the lives of homeless women. You are invited to be in this study because you are either staying at the [REDACTED] Emergency Shelter in [REDACTED], CT or you have stayed there in the past.

Why is this study being done?

I am doing this study as part of my PhD program in medical anthropology at the University of Connecticut. The purpose of the study is to help us understand how women who are homeless feel about their situation from their own point of view and how these issues affect their physical and mental health.

What are the study procedures? What will I be asked to do?

If you agree to take part in this study, you will be interviewed by the student researcher, Ruthanne Marcus, about your reasons for being at the Shelter, your own thoughts on your experience as a homeless woman and how these beliefs are affected by your health and how they affect your physical and mental health. The interview will be tape recorded. Your name and other personal information about you will not be written down and they will never be linked to you.

The interview will take place in a private place at the shelter such as in one of the staff offices. The interview should take about 30 minutes to one hour, depending on how long you want to talk.

What are the risks or inconveniences of the study?

We believe there are no known risks from being in this study; however it is possible that someone may find out you have been in this study. The interviewer will not discuss your case with anyone other than you and will keep her notes and transcriptions stored in a locked cabinet. There will be no identifying information with these data, only an ID number. In writing about women's experiences with homelessness, you will not be personally identified, nor will details of your situation that could allow others to identify you be revealed. If you become upset during the interview and want to talk to a professional counselor, we will first have you speak with the case manager at the Shelter and then she will provide you with some names of places to contact.

Appendix B

What are the benefits of the study?

There will be no personal benefit to you for participating but we hope that your participation in the study will help us learn more about homeless women living in rural areas.

Will I receive payment for participation? Are there costs to participate?

There are no costs to you and you will not be paid to be in this study.

How will my personal information be protected?

Your name or other identifying information will not be collected for this study. The interview will be audiotaped. The student researcher will transcribe the tapes. Only the student researcher and the Principal Investigator will listen to the tapes.

The following procedures will be used to protect the confidentiality of your data. The researchers will keep all study records (including notes taken and the audiotapes) locked in a secure location. Research records will be labeled with a code. Any computer with data will also have password protection to prevent access by unauthorized users. Only the members of the research staff will have access to the passwords. At the end of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. If you decide that you do not want to participate this will in no way affect your standing at the shelter or any services you receive. You do not have to answer any question that you do not want to answer and you can stop the interview at any time.

Who do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Pamela Erickson, PhD, at UCONN at 860-486-1736 or the student researcher, Ruthanne Marcus, at the Shelter at 860-774-4977. If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

Appendix B

Documentation of Consent:

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I have received a copy of this consent form.

Participant Signature:

Print Name:

Date:

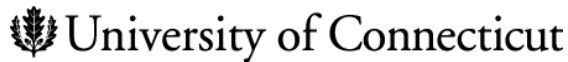
Signature of Person
Obtaining Consent

Print Name:

Date:

Appendix C

Consent Form for Participation in a Research Study - Providers



Principal Investigator: Pamela Erickson, DrPH, PhD

Student Researcher: Ruthanne Marcus, MPH

Study Title: Women's Discourse on the Homeless Experience.

Introduction

You are invited to participate in a research study to help us understand more about homeless women. You are invited to participate in this study because you either work at the [REDACTED] Emergency Shelter in [REDACTED], CT or you provide services for homeless women.

Why is this study being done?

I am doing this study as part of my PhD program in medical anthropology at the University of Connecticut. The purpose of the study is to help us understand the worries, fears, and concerns of homeless women who stay at the Shelter and how these issues affect their physical and mental health.

What are the study procedures? What will I be asked to do?

If you agree to take part in this study, you will be interviewed by the student researcher, Ruthanne Marcus, about your views on homeless women and the services your agency provides. The interview will be tape recorded. Your name and other personal information about you will not be written down and they will never be associated with you.

The research will be conducted in a private office at your convenience. The interview should take about 30 minutes.

What are the risks or inconveniences of the study?

We believe there are no known risks associated with this research study; however, a possible inconvenience may be the time it takes to complete the interview which should be about 30 minutes.

What are the benefits of the study?

There will be no personal benefit to you for participating but we hope that your participation in the study will help us learn more about homeless women living in rural areas.

Will I receive payment for participation? Are there costs to participate?

There are not costs and you will not be paid to be in this study.

Appendix C

How will my personal information be protected?

Your name or other identifying information will not be collected for this study. The interview will be audiotaped. The student researcher will transcribe the tapes. Only the student researcher and the Principal Investigator will listen to the tapes.

The following procedures will be used to protect the confidentiality of your data. The researchers will keep all study records (including notes taken and the audiotapes) locked in a secure location. Research records will be labeled with a code. Any computer with data will also have password protection to prevent access by unauthorized users. Only the members of the research staff will have access to the passwords. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.

You should also know that the UConn Institutional Review Board (IRB) and the Office of Research Compliance may inspect study records as part of its auditing program, but these reviews will only focus on the researchers and not on your responses or involvement. The IRB is a group of people who review research studies to protect the rights and welfare of research participants.

Can I stop being in the study and what are my rights?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are no penalties or consequences of any kind if you decide that you do not want to participate. You do not have to answer any question that you do not want to answer and you can stop the interview at any time.

Who do I contact if I have questions about the study?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the principal investigator, Pamela Erickson, PhD, at UCONN at 860-486-1736 or the student researcher, Ruthanne Marcus, at the Shelter at 860-774-4977. If you have any questions concerning your rights as a research subject, you may contact the University of Connecticut Institutional Review Board (IRB) at 860-486-8802.

Appendix C

Documentation of Consent:

I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible hazards and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time. My signature also indicates that I have received a copy of this consent form.

Participant Signature:

Print Name:

Date:

Signature of Person
Obtaining Consent

Print Name:

Date:

Appendix D

Women's Discourse on the Homeless Experience TOPIC GUIDE

Informal Interviews with Homeless Women Staying at the **ACCESS** Emergency Shelter

Events leading to homelessness:

- 1) Can you tell me what brought you here to the shelter?
- 2) Where did you live before coming here? What happened there?
- 3) Why did you come to this shelter?
- 4) How did you feel about coming to a shelter?
- 5) Society has this concept of homeless persons. Do you think of yourself as a homeless person (why/why not)?
- 6) What does "homeless" mean to you? Do you have any thoughts about that?

Experience of homelessness:

- 1) Can you tell me what it's like here at the shelter?
- 2) What do you like best about being here?
- 3) What do you like least about being here?
- 4) What is your typical day like?

Coping with homelessness:

- 1) What are your immediate goals (eg, housing, job, medical care)?
- 2) Do you plan to stay in this area (why/why not)?
- 3) What are your goals for the future?

Social network and support:

- 1) Can you tell me about your family? Where are they? Are you in touch with them? (if not, since when?)
- 2) Where did you grow up?

Service needs:

- 1) Tell me what you need to get out of your current situation.
- 2) Can you get that here?
- 3) What services have you received since coming here? How has this gone, have the services been what you expected? Have they helped (how so?)

Appendix E

Women's Discourse on the Homeless Experience

TOPIC GUIDE

Semi-formal Interviews with Housing Organization Staff and Homeless Service Providers

Name of Agency _____

Address of Agency _____

Position of Person being Interviewed _____

Description of Services Provided: (check all that apply)

Housing ____ (explain: _____)

Social Service Support ____ (explain: _____)

Mental health services ____ (explain: _____)

Health care: ____ (explain: _____)

- 1) In your experience, what do homeless women think about homelessness?
- 2) What are the primary concerns on the mind's of homeless women?
- 3) How can homeless women change their situation?
 - a. If you had to pick one change they need to make in their lives, what would it be?
- 4) What services help them the most?
- 5) What services are most needed by them?
- 6) What are the barriers they face to getting these services?
- 7) What specific steps can society take to most help homeless women end their homelessness?

Appendix F Free Listing Output

FREELIST - Run 2 - Ruthanne's data FL homelessness 12/13/11 N=21

Sensitivity level: OFF
Max respondents: 50
Max items: 500
Input dataset: C:\AP\HOMEFL.TXT

SORTED BY FREQ

	ITEM	FREQUENCY	RESP PCT	AVG RANK	Smith's S
1	LONELY	4	19	4.250	0.137
2	DEPRESSION	3	14	4.667	0.083
3	HOPELESS	3	14	3.333	0.071
4	LOST	3	14	4.333	0.113
5	GRATEFUL	2	10	6.000	0.039
6	STRENGTH	2	10	8.000	0.040
7	MOTIVATED	2	10	4.000	0.067
8	DEGRADING	2	10	4.500	0.048
9	HELPLESSNESS	2	10	2.000	0.089
10	LONELINESS	2	10	3.500	0.052
11	ANGRY	2	10	14.000	0.008
12	SAD	2	10	3.000	0.076
13	NOT HAVING ANYWHERE TO GO	2	10	2.500	0.056
14	ANXIETY	2	10	6.500	0.047
15	HOPEFUL	2	10	8.500	0.034
16	SCARED	2	10	14.500	0.013
17	EMPTY	2	10	4.500	0.079
18	DON'T EVER WANT MY SON TO GO THROUGH THIS AGAIN	1	5	5.000	0.029
19	LOST IN LIFE	1	5	1.000	0.048
20	LACK OF INCOME	1	5	2.000	0.040
21	SLEEPING AT A FRIENDS	1	5	2.000	0.036
22	INSTABILITY	1	5	2.000	0.044
23	DOING WHAT I NEED TO GET ON MY FEET	1	5	4.000	0.033
24	NO SUPPORT SYSTEM	1	5	2.000	0.043
25	I WANNA PROVIDE A STABLE HOME FOR MY SON	1	5	6.000	0.024
26	NO FAMILY OR FRIENDS TO TURN TO FOR HELP	1	5	3.000	0.032
27	I WANT TO BE INDEPENDENT	1	5	8.000	0.014
28	DENIGRATING AS A PERSON	1	5	4.000	0.037
29	NO HOME	1	5	1.000	0.048
30	UNCERTAINTY OF THE FUTURE	1	5	1.000	0.048
31	WORRISOME FOR MY SONS	1	5	11.000	0.011
32	UNABLE TO BE "OURSELVES"	1	5	12.000	0.007
33	LACK OF FREEDOM	1	5	13.000	0.004
34	NOT HAVING A HOME	1	5	1.000	0.048
35	POOR	1	5	3.000	0.016
36	NEEDS	1	5	1.000	0.048
37	SEEN AS "DESERVING OF IT"	1	5	8.000	0.022
38	UNSTABLE	1	5	1.000	0.048
39	HARD	1	5	10.000	0.015
40	NEEDING DIRECTION	1	5	5.000	0.029
41	UNDERSTANDING GOALS	1	5	6.000	0.024
42	RECEIVING CARE	1	5	7.000	0.019
43	NEW BEGINNINGS	1	5	8.000	0.014
44	UNDERSTANDING WHAT I NEED	1	5	9.000	0.010
45	GUIDANCE	1	5	10.000	0.005
46	ISOLATION	1	5	1.000	0.048
47	GETTING A JOB OR CAREER	1	5	9.000	0.010
48	HELP OF OTHERS	1	5	4.000	0.033
49	ANGER	1	5	4.000	0.037
50	FEAR	1	5	5.000	0.033
51	UNLOVED	1	5	6.000	0.029
52	WOULD	1	5	7.000	0.026
53	COULD	1	5	8.000	0.022
54	SHOULD	1	5	9.000	0.018
55	WHY	1	5	10.000	0.015
56	NO INCOME AT ALL FROM ANY SOURCE	1	5	4.000	0.024
57	STRANDED	1	5	5.000	0.016
58	DRAINED	1	5	13.000	0.004
59	HUNGRY	1	5	1.000	0.048

60		HUMILITY	1	5	3.000	0.043
61		SORROW	1	5	4.000	0.040
62		REGRETS	1	5	5.000	0.038
63		LOWERS SELF-ESTEEM	1	5	5.000	0.033
64		NOT VALUED AS A PERSON	1	5	6.000	0.029
65		SEEN AS "LAZY"	1	5	7.000	0.026
66		NO FUTURE	1	5	10.000	0.026
67		DIFFICULT TO STAY STRONG	1	5	9.000	0.018
68		SPIRIT	1	5	12.000	0.021
69		LIFE	1	5	13.000	0.019
70		NEW BEGINNING	1	5	14.000	0.017
71		LOVE	1	5	15.000	0.014
72		HOPE	1	5	16.000	0.012
73		JOY	1	5	17.000	0.010
74		FAITH	1	5	18.000	0.007
75		GOALS	1	5	2.000	0.043
76		TRAILS	1	5	3.000	0.038
77		SHAME	1	5	1.000	0.048
78		STRESSED	1	5	3.000	0.036
79		TIRED	1	5	4.000	0.030
80		ON THE EDGE	1	5	7.000	0.012
81		UNCERTAINTY	1	5	1.000	0.048
82		DIRTY	1	5	1.000	0.048
83		UNEDUCATED	1	5	2.000	0.041
84		ALCOHOLIC/ADDICT	1	5	3.000	0.034
85		MENTAL ILLNESS	1	5	4.000	0.027
86		GO BACK TO SCHOOL	1	5	10.000	0.005
87		LAZY	1	5	6.000	0.014
88		NO JOB SKILLS	1	5	7.000	0.007
89		EAGER	1	5	2.000	0.041
90	BEING IN THE SHELTER WITH NO OTHER PLACE TO GO		1	5	4.000	0.012
91		GRATITUDE FOR THOSE HELPING	1	5	4.000	0.027
92		HUMBLING	1	5	5.000	0.020
93		STRESSED AT THE UNKNOWN	1	5	6.000	0.014
94	HAPPY THAT I REALIZE OTHERS ARE STRONG		1	5	7.000	0.007
95		STRESSFUL	1	5	2.000	0.040
96		PRESSURE	1	5	3.000	0.032
97		MOTIVATION	1	5	4.000	0.024
98		DILIGENCE	1	5	6.000	0.008
99		NO ONE WANTS YOU	1	5	1.000	0.048
100		NO ONE CARES ABOUT YOU	1	5	2.000	0.040
101		NO MONEY	1	5	3.000	0.032
102		NO JOB	1	5	4.000	0.024
103		NO SUPPORT	1	5	5.000	0.016
104		NO LIFE	1	5	6.000	0.008
105		MAD	1	5	1.000	0.048
106		SICK TO MY STOMACH	1	5	2.000	0.036
107		WANT TO HURT MY STUFF	1	5	3.000	0.024
108		WANT TO GO TO MOM'S HOUSE	1	5	4.000	0.012
109		TRAGEDY	1	5	1.000	0.048
110		STRUGGLES	1	5	2.000	0.044
111		MISTAKES	1	5	3.000	0.041
112		PUNISHMENT	1	5	4.000	0.038
113		NOT ALL ARE LAZY	1	5	5.000	0.035
114		NOT ALL ARE ADDICTS	1	5	6.000	0.032
115		NOT ALL ARE FREELOADERS	1	5	7.000	0.029
116		SOME ARE STRONG	1	5	8.000	0.025
117		SOME ARE SMART	1	5	9.000	0.022
118		SOME ARE KIND	1	5	10.000	0.019
119		SOME ARE OUTGOING	1	5	11.000	0.016
120		HIT SPEEDBUMPS	1	5	12.000	0.013
121		LOW POINTS	1	5	13.000	0.010
122		ONLY WAY IS UP	1	5	14.000	0.006
123		DON'T GIVE UP	1	5	15.000	0.003
124		ABUSED	1	5	5.000	0.020
125		TOOK WRONG ROAD	1	5	2.000	0.043
126		SAD FEELINGS	1	5	3.000	0.039
127		TERRIBLE FEELINGS	1	5	4.000	0.035
128		PEOPLE STARING AT YOU	1	5	5.000	0.030
129	LOOK AT YOU LIKE YOU'RE A BAD PERSON		1	5	6.000	0.026
130		EMBARRASSED	1	5	7.000	0.022

131	SHY	1	5	8.000	0.017
132	NERVOUS	1	5	9.000	0.013
133	FEEL FUNNY	1	5	11.000	0.004
134	NO PLACE TO CALL YOUR OWN	1	5	1.000	0.048
135	HUMBLING EXPERIENCE	1	5	2.000	0.032
136	HELPLESS	1	5	1.000	0.048
137	NO CONTROL	1	5	2.000	0.043
138	GETTING ON TRACK	1	5	3.000	0.038
139	AGGRAVATION	1	5	4.000	0.033
140	SOMETIMES HAPPY	1	5	6.000	0.024
141	DOING EVERYTHING AT ONCE	1	5	7.000	0.019
142	STRESS	1	5	8.000	0.014
143	MAKE FRIENDS	1	5	9.000	0.010
144	MAKE ENEMIES	1	5	10.000	0.005
145	ALONE	1	5	2.000	0.040
146	EMBARRASSING	1	5	3.000	0.032
147	LOW	1	5	4.000	0.024
148	DEPRESSING	1	5	5.000	0.016
149	DEPRESSED	1	5	3.000	0.037
150	LOSER	1	5	4.000	0.032
151	THANKFUL	1	5	6.000	0.021
152	APPRECIATION	1	5	7.000	0.016
153	CONTENT	1	5	8.000	0.011

Total/Average:		175	8.333		

Appendix G

Code System [2294] – updated 12/26/12

Basic Needs

Housing [112] – discussion about past, present, or future housing; looking for a place to live; Section 8 or other housing subsidizes or vouchers or services; discussions about a place they found to live in

(subcode) **Eviction [16]** – mention of eviction; generally in past to explain how they got to shelter

Jobs [117] – past, present or future jobs held; training for certain jobs; looking for a job; types of jobs; need to get a job

Transportation [44] – discussions of using a vehicle, bus, or other method of transportation to get somewhere like a job; issues with cars (eg, in need of repair)

Education [58] – discussions of schools they went to for high school or further education; discussions about plans to return to school; their children's education

Money [30] – vague discussions of money/income or lack of it; income from unemployment, SSI, other entitlements

Health [33] – any discussion of their physical health

(subcode) **Health insurance [25]** – “state” insurance; Husky

(subcode) **Disability [28]** – SSI, usually used in reference to inability to work due to mental or physical disability

Problems/Barriers (Individual level)

Abuse [45] – physical or mental interpersonal violence in their lives by parent, partner, other family member; in childhood or adulthood

(subcode) **Domestic Violence [27]** – abuse that occurs within the family; physical or mental

(subcode) **Sexual abuse [45]** – abuse that discusses sex; in childhood or adulthood

Drug Use [47] – discussion of drug use by the woman or a family member; current or past use

(subcode) **Rehab [7]** – getting treatment for drug use by woman or someone else

Alcohol [49] – any mention of alcohol, alcoholics, alcoholism

(subcode) **AA [14]** – discussion of treatment for alcoholism by the woman or someone else in her life

Mental Illness [50] – any mention of mental illness in themselves or someone else; if specific illness mentioned then a subcode was used; also included mental health (eg, going to counseling, going to United Services – mental health providers in area – being on psych medications)

(subcode) **Suicide [10]** – attempts at suicide; suicide committed by someone else

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- (subcode) **Stress [15]** – mention of stress in life
- (subcode) **Bi-polar [7]** – specific mention of bi-polar disorder
- (subcode) **Anxiety [14]** – specific mention of anxiety
- (subcode) **Depression [38]** – specific mention of depression

- Prison [32]** – any mention of someone in prison or jail
 - (subcode) **Police [4]** – police involvement in their life; run-in with police
 - (subcode) **Crime [9]** – committed by the woman or someone else

Social Support

- Relationships [9]** – mostly used the subcodes to specify person they were referring to
 - (subcode) **Marriage [71]** – discussion of person they were going to marry or were married to; overlaps with Partner; not always clear if they were legally married or separated or never married
 - (subcode) **Friends [15]** – male or female friends
 - (subcode) **Partner [94]** – any reference to a partner or children's father

- Family [53]** – reference to family members; usually used subcodes to specify; used general family code if "other" family member was discussed such as Aunt, Uncle, cousin, grandparent
 - (subcode) **Children [253]** – any mention of their children whether the children were with them, separated from them, taken away from them; young children or grown children; often used this code when parenting was being discussed; DCF involvement also went under this code
 - (subcode) **Siblings [74]** – any mention of their brothers or sisters; not their children's siblings
 - (subcode) **Father [68]** – any mention of their father; not their children's father
 - (subcode) **Mother [116]** – any mention of their mother

Challenges

- Relocate [56]** – leaving where they lived to come to the shelter; moving around to find housing or to be with family or to move away from family

- Loss [86]** – children being taken away by DCF or other family member; loss of family member through death, jail, estrangement; loss of possessions when left abusive relationship, eviction, etc.

Feelings

- Dignity [36]** – not allowing themselves to be put down by others or the system; pride in themselves

- Self esteem [35]** – how they feel about themselves; references to being put down by others (eg, mother, father, boyfriend/husband)
 - (subcode) **Confidence [34]** – confidence in their abilities to do something like get out of the current situation

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(subcode) Insecurity [10] – not feeling good about their abilities

Resilience [45] – positive attitude about life and situation in the face of adverse events earlier in life; discussions about moving forward in their lives and not letting past or current situation get them down [“I don’t need a million dollars but I just need a house, a home, I think we’ll be okay.” W011]

Hope [18] – positive attitude about future; mostly used subcode

(subcode) Future [34] – discussions about plans for the future

Religion [19] – mention of religion or belief, faith in God

Homelessness

Homelessness [77] – discussion prompted by interviewer’s questions about society’s notion of homelessness and how they feel about it; Do they consider themselves homeless? What is their image of homeless people?

Shelter [86] – references to the shelter we were in or another shelter they had been to; feelings about being at the shelter; response to interviewer’s questions about how things were going at the shelter

(subcode) Staff [34] – mention of shelter staff members either spontaneously mentioned or prompted by interviewer’s questions

(subcode) Other residents [66] - mention of other shelter residents either spontaneously mentioned or prompted by interviewer’s questions

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