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Making a Positive Change: A Qualitative Study of Homeless Women's Perceptions and Experiences of Shelter Living

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MAKING A POSITIVE CHANGE: A QUALITATIVE STUDY OF HOMELESS WOMEN'S PERCEPTIONS AND EXPERIENCES OF SHELTER LIVING

By

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The primary objective of this dissertation was to address factors that influenced homeless women's health behaviors based on the theory of gender and power (TGP). A total of 18 participants described their experiences of being homeless, living in a shelter and its impact on their HIV risk behaviors. The interviews were framed by the constructs of the TGP, which included economic, physical, and social risk factors**.** The TGP describes the multiple social and structural factors that impact homeless women and their health risks. The TGP was chosen because of its adaptation by Wingood and DiClemente (2000), who exclusively tailored it to women, identifying poverty, homelessness and a history of abuse as health risk factors for women (Wingood & DiClemente, 2000). According to the theory, three major structures characterize the gendered relationships between men and women: (a) the sexual division of labor, which examines the economic inequities favoring males; (b) the sexual division of power, which examines inequities and abuses of authority and control in relationships and institutions favoring males; and (c) cathexis, which examines social norms and affective attachments.

Women residing in an all-women's shelter in Miami-Dade County were recruited for individual in-depth interviews. Participants were eligible if they were 18 years or

older, currently living in a designated homeless shelter, spoke and understood English, and self-reported a negative HIV status. Content analysis and constant comparison techniques (Miles, Huberman, & Saldana, 2014) were used to analyze the data. The data were broken down into discrete incidents and then were coded into categories. Each category was compared to previously coded categories to establish relationships and elicit overall themes.

The results of the study illustrated the themes of "making a positive change" and "breaking the chains." "Making a positive change" was described as both a reason for coming to the shelter and a result of living in the shelter. The women of the shelter stated that it provided an opportunity for independence, safety and growth. Since living in the shelter, women stated their lives improved with regard to their basic needs, their emotional and mental states, and their sexual health. Women also indicated the hardest part of being homeless revolved around their roles as mothers. The main theme regarding motherhood was "breaking the chains," women wanting to change their lifestyles for the sake of their children. All of the women discussed their struggles with motherhood and histories of violence in their lifetimes, including child abuse, partner abuse and sexual abuse, as factors that impeded their abilities to provide for their children. The women's current struggles and histories of violence victimization hindered their abilities to raise their children in a positive environment.

The findings of this dissertation suggest that homeless women are trying to make positive changes in their lives. For many of the women, they aspired for independence, safety and personal growth, which extended to their desire for a better life for their children. This study also showed the significant role sheltered living played in the growth

of the women. The findings have implications for practice, research and policy concerning homeless women and victims of abuse. The high prevalence of violence among homeless women indicates an ongoing need for awareness and more importantly, prevention of violence and abuse toward women and children. Future work is needed in order to address and understand the complexity of violence victimization and its long-term impact on homeless women, specifically homeless mothers.

Dedication

This work is dedicated to all homeless women and children; may they persevere through the difficult times, know they are worthy of love and be given the opportunity to make a positive change in their lives.

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CHAPTER 1

Introduction

Problem

Homelessness is an escalating public health crisis and women are disproportionally affected. Approximately 3.5 million people experience homelessness in a given year (National Law Center on Homelessness and Poverty, 2007). Although, the homeless population has declined by 9 percent since 2007, its character has changed dramatically. Most studies previously reported that a majority of the homeless were men--although men still account for the majority of single homeless adults, a growing number of families without a home are headed by women (U.S. Conference of Mayors, 2007). The United States has the highest number of homeless women among industrialized nations (The National Center on Family Homelessness, 2011). Fifty years ago, women accounted for only 3% of the homeless (Bogue, 1963), but women now account for 20-30% of the homeless population (National Coalition for the Homeless, 2009a).

Housing is associated on multiples levels with increasing risk for HIV infection. The conditions of homelessness itself and not the traits of a homeless individual put them at risk for HIV (Aidala, Cross, Stall, Harre, & Sumartojo, 2005). The co-occurrence of HIV and homelessness has been recognized and documented extensively. The prevalence of HIV is three to nine times higher among homeless or unstably housed people compared to those with adequate and stable housing (Aidala et al., 2005). Lack of stable housing is associated with high rates of drug use and risky behaviors (Aidala et al., 2005; Sethi et al., 2004). Stable housing is a significant component of a woman's overall well-being and security. Practices that deny a woman's access to housing are related to HIV,

and HIV/AIDS has been reported as a leading cause of death in homeless women (Cheung & Hwang, 2004). Lack of secure and stable housing increases the risk for HIV and without a secure residence, women cannot access medical care or take care of themselves. Therefore, the purpose of this study was to address and understand factors that influence homeless women's sexual health behaviors related to HIV, based on the theory of gender and power (TGP), which is a social structural theory based on sexual inequality, gender and power imbalance.

Background of the Problem

Population

Homeless women face special circumstances; both homeless men and women face barriers to obtaining health care (Burt, 1999), but women encounter the additional challenge of obtaining sexual and reproductive health care. Men do not face the same challenges as women for multiple reasons; women are more likely to have mental health issues, partake in high risk sexual behaviors as a means of survival, and be victims of violence (Frencher et al., 2010; Nyamathi, Leake, & Gelberg, 2000; Sacks, McKendrick, & Banks, 2008). Furthermore, women become homeless as a result of multiple interconnected social risk factors, including substance abuse, victimization, and mental illness, leading to risky sexual behaviors (Bassuk et al., 1996; Wenzel, Tucker, Elliott, & Hambarsoomians, 2007; Wenzel et al., 2004). These risk behaviors are not only causes of their homelessness, but effects of it, making an exodus from homelessness extremely difficult.

The relationship between homelessness and HIV risk behaviors is complex. For a majority of homeless women, the root causes of their housing instability are also effects

of it. It is a complicated cycle that unfortunately keeps women in their unstably housed positions. For instance, substance abuse can be seen as both a cause and a result of homelessness. Dependency on alcohol or drugs debilitates people and hinders their abilities to carry out their daily responsibilities, consequently leading to job loss and ultimately homelessness. It is estimated that 38% of homeless people are dependent on alcohol and 26% abuse other drugs ("Homelessness- Provision of mental health and substance abuse services," 2003). In a 2008 survey, substance abuse was reported as the single largest cause of homelessness for all individuals in 68% of the 25 major U.S. cities surveyed; 12% of these cities also reported it as one of the top causes of homelessness for families, which are often headed by women (U.S. Conference of Mayors, 2008). In many cases, however, substance abuse is a result of homelessness, often used to cope with the situation and a way to seek temporary relief from their problems. Unfortunately, the use of alcohol and drugs only worsens the problem and limits their abilities to find employment and change their housing situations (Didenko & Pankratz, 2007).

Homeless individuals have also reported drug and alcohol use as necessary in order to fit in the street life. Shying from the norms of the homeless community may potentially put a person at risk for violence or victimization. Moreover, anyone who suffers from addiction has a very difficult time breaking the addiction and for those who are homeless, this becomes even more challenging. Survival is the top priority for the homeless population; finding food and a safe place to sleep is more important than receiving drug counseling. It also is more trying for the homeless because many of them are alone and have no support to encourage them to get clean. Even if a person wants to break the addiction, living on the street sober is very difficult due to easy drug

accessibility (Fisher & Roget, 2009; Percac-Lima et al., 2009). Finally, seeking medical or drug therapy is extremely challenging for the homeless population due to the high prevalence of individuals being both drug dependent and mentally ill; many programs will only accept individuals who have one condition or the other.

Homeless women also face violence victimization, which much like substance abuse is often a cause and a result of homelessness. For women specifically, abuse or violence is a principal cause of becoming homeless. Reports have indicated that between 22%-57% of homeless women point to abuse as the immediate cause for their homelessness (National Law Center on Homelessness and Poverty, 2010). Rates of intimate partner violence tend to be higher among women with low incomes and a high school education or less, both of which are common characteristics of homeless women (Thompson et al., 2006). There are also specific traits of being homeless that put women at an increased risk for victimization. Those who have had a longer period of being homeless, those who have been turned away from a shelter, and those who have committed a crime since being homeless, all have a significantly higher chance of being a victim of violence (Garland, 2010).

The impact of domestic violence not only affects women physically, but also mentally, often causing fear, depression and fear of victimization (Tutty, 2006). Violence toward homeless women has the potential to prolong homelessness due to the considerable long-term effects it has on a woman's mental stability. Mental health issues in homeless women can be very concerning, as they can lead to negative social circumstances in which they become more withdrawn and have more difficulty with daily functioning, such as keeping a job (Lilly & Graham-Bermann, 2009). Although a

majority of homeless women with mental illness have a history of violence in their lifetime, mental illness alone is seen as a key cause and effect of homelessness. Approximately 50% of homeless women have experienced a major depressive episode since becoming homeless (Weinreb, Buckner, Williams, & Nicholson, 2006). Homeless women are also three times more likely to suffer from post-traumatic stress disorder (PTSD) compared to those who are stably housed. One study suggests that individuals in impoverished communities are more likely to experience heightened depression and anxiety due to their living conditions (Hill, Ross, & Angel, 2005). Homelessness causes women to experience distress as they struggle to meet the daily needs of food and shelter, which ultimately affects their abilities to transition out of homelessness (Bogard, McConnell, Gerstel, & Schwartz, 1999). For many homeless individuals, mental health issues co-occur with substance abuse. Those with both substance abuse and mental illness experience additional challenges to recovery, such as recurrent stints between the streets, jails, and emergency rooms (Fisher & Roget, 2009).

As a result of these interrelated social risk factors, homeless women engage in risky sexual behaviors for a multitude of reasons. Homeless women may become involved in relationships or sex work to meet their basic survival needs (Brown et al., 2006; Harding & Hamilton, 2009). Researchers have termed this *survival sex*, which can be extremely risky and put women in danger of violence, exploitation and HIV (Brown et al., 2006; Harding & Hamilton, 2009). Protection against HIV infection can be more difficult due to living conditions and limited access to health care (Nyamathi, Leake, et al., 2000). Homeless women often partake in unprotected sex because condoms are not available to them and even when condoms are freely available, many homeless shelters

only allow for two condoms to be taken at a time (Gelberg, Browner, Lejano, & Arangua, 2004). For women who are using sex as a way of survival, this limitation of resources forces women to use condoms inconsistently, thus leading to an increased risk for HIV. Homeless women are also more likely to have multiple sexual partners at the same time and be sexually active with high risk individuals.

It is undeniable that suitable housing provides protection from a number of individual and public health threats, including HIV, violence, and abuse. For example, a study of indigent women looked at a range of health risks, including violence, drug use, sex exchange and HIV, comparing homeless women in public shelters with a group of very low-income housed women. The study found that homeless women were at much greater risk for all health problems examined, including HIV infection. The homeless are at greater risk of HIV infection than the unstably housed, and both groups are at greater risk than the stably housed (Wenzel et al., 2004).

Understanding the complex web of social factors that interact with HIV risk behaviors is essential. A key theme found in the HIV literature is the link between social disadvantage and HIV vulnerability (Klein, Easton, & Parker, 2002). The condition of being homeless itself influences risk behaviors. It is a common misconception that the traits of homeless people are what put them at risk for HIV, when it is their unstable housing. Homelessness is implicated in multiple causal levels of risk for HIV (Aidala et al., 2005). It is critical to evaluate social and economic divisions that create health vulnerability because it is what creates the separation of power and ultimately leads to women's shortage of opportunities. A paradigm shift in HIV prevention frames risky behaviors in the context of socially structured vulnerability (Klein et al., 2002). Since

women who are homeless, and not just those who are disadvantaged, are more likely to participate in HIV risk behaviors, an exploration of the association of homeless women and HIV risk behaviors is warranted. Thus, the goal of this study was to understand the risk factors related to HIV among homeless sheltered women.

Theoretical Framework

Behavioral and social science theory provide a foundation for understanding the health risk behaviors of individuals and help distinguish the multifaceted internal and external factors that influence their behaviors. Social theory also provides insight into diverse psychosocial factors that contribute to and maintain health risk behaviors (Glanz, Rimer, & Viswanath, 2008). This study will be grounded in the theory of gender and power (TGP), because the TGP considers the multiple social and structural factors that impact women and risk for HIV. Additionally, Wingood's (2000) adaptation of the TGP is the only HIV framework exclusively tailored to women, and it also identifies poverty, homelessness and history of abuse as risk factors for HIV among women, all of which are of interest in this study. The theory is a social structural theory based on philosophical writings of sexual inequality, gender, and power imbalance (Connell, 1987). Connell's theory of gender and power was adapted by Wingood and DiClemente (2000), who applied the TGP to HIV risk (Wingood & DiClemente, 2000). Wingood and DiClemente incorporated outside factors that are essential to understanding HIV risk behaviors among women, particularly vulnerable women. The adaptation proposes that the sexual division of labor, the sexual division of power, and the cathexis or social norms and attachments have a strong influence on risk for HIV among women.

The theory of gender and power (TGP), developed by Robert Connell (1987), affirms that power relationships between genders and within genders arise from the global dominance of men over women (Wingood & DiClemente, 2000). The concept of a power imbalance between women and men arose in the early 20th century by Charlotte Perkins Gilman (2009), who wrote "all our scheme of things rests on the same tacit assumption; man being held the human type; woman a sort of accompaniment and subordinate assistant, merely essential to making people" (p. 2). She elaborates on our androcentric culture where man defines woman not in relation to herself but in relation to him. This idea was further explored by Simone de Beavoir in 1949, who stated that men are perceived as "real" and everything else, including women, is perceived as "other." By "otherizing" women, women are defined by their relation to men, and their functional significance to men, rather than their own significance. The theorists during the feminist movement of the 1970s and 1980s continued to elaborate on the concept of sexual inequality. Robert Connell then integrated the existing concepts in his development of the TGP.

The philosophical underpinnings of Connell's work in gender and power are derived from the work of political activist Antonio Gramsci (1891-1937), who developed the concept of "cultural hegemony." His ideas were built upon Marx's notion that "the ruling ideas are the ideas of the ruling class" (Marx, 1970, p. 64). Gramsci's concept of "cultural hegemony" referred to the idea that the ruling class maintains its dominance not primarily through force or coercion, but rather through the willing, "spontaneous" consent of the ruled. In a similar manner, Connell coined the term "hegemonic

masculinity," referring to the pattern of practices that allows men's dominance over women to continue.

The major epistemological assumptions of gender and power are rooted in postmodern feminism. Postmodern feminism acknowledges the importance of grounding narratives in the context and specificities of peoples' lives and cultures (Giroux, 1991). Postmodern feminism challenges the essentialist definitions of femininity that were disseminated during modern feminism. Modern feminism's focus is on the social and cultural construction of women by the system, whereas postmodern feminism looks at women as a category that is complicated by class, ethnicity, sexuality and other facets of identity. Postmodern feminism addresses issues related to gender-based bias and discriminations and has been used extensively when studying public health issues such as rape and prostitution (Maharaj, 1995).

The theory of gender and power was developed in attempt to resolve some of the difficulties raised by the controversies surrounding feminism at the time. Connell proposed a systematic social theory of gender where the definition of gender went beyond the assumption of being biological or natural and defined it in its social context. Connell's theory proposed that the oppression of women is a matter of human agency, not nature (Connell, 1987).

According to the theory, three major structures characterize the gendered relationship between men and women: (a) the sexual division of labor, which examines the economic inequities favoring males; (b) the sexual division of power, which examines inequities and abuses of authority and control in relationships and institutions favoring males; and (c) cathexis, which examines social norms and affective attachments. The

three structures are overlapping but distinct, and serve to explain the gender roles that men and women assume (DiClemente, Crosby, & Kegler, 2009). The theory of gender and power has been used multiple times in studying how the three sexual divisions of power influence women's risk of HIV.

The three structures occur at two different levels: societal and institutional (DiClemente, Crosby, & Kegler, 2009). The higher level in which the three social structures are embedded is the societal level. The structures are rooted in society through historical and sociopolitical forces that segregate power and assign social norms based on gender-determined roles. Although society evolves, these structures remain intact at the societal level. The institutional level is the lower level, which includes schools, work, families and relationships. The three structures within institutions are maintained through social mechanisms such as unequal pay for comparable work, discriminatory practices at school or work, and in the stereotypical or degrading images of women in the media (DiClemente, Crosby, & Kegler, 2009). The presence of these social mechanisms hinders women's daily lives and practices by producing gender-based inequities in women's economic potential, women's control of resources, and gender-based expectations of women's role in society.

The structures are more clearly delineated when they are fully developed at the societal and institutional levels. The division of labor at the societal level adversely affects women economically. Women are often assigned different and unequal positions relative to men and are also delegated the responsibility of "women's work;" due to the extra time and organization that is necessary to carry out women's work, their potential for economic growth and higher career paths are often limited. At the institutional level,

the sexual division of labor is sustained by social mechanisms such as the segregation of unpaid nurturing work for women such as child care, care for the elderly and housework (DiClemente, Crosby, & Kegler, 2009). Since this work is uncompensated, women often have to rely on men financially. Other aspects of the sexual division of labor that favor men are attainment of education and the segregation of income-generating work for women; therefore, men are destined to be the main source of income in a household (DiClemente, Crosby, & Kegler, 2009).

The mechanisms of the division of labor play a key role in the root causes of both homelessness and HIV for homeless sheltered women. Homeless women face dire economic hardship and most can attribute these difficulties to lack of education, unemployment, living in poverty and lack of affordable housing (National Coalition for the Homeless, 2009b) . These circumstances contribute to discriminatory gender roles and housing instability. As inferred by the TGP, without equal opportunity to progress in the labor force, women are at a greater disadvantage compared to men and as a result can become homeless and engage in HIV risk behaviors as a way of survival. Additionally, homeless women face the economic challenge of finding affordable and adequate housing not only for themselves, but for their families. A majority of homeless women are the head of a household, whereas a majority of homeless men are living on their own.

The sexual division of power is the second fundamental structure. At the societal level, the difference in power between men and women sets the stage for the sexual division of power. Power has been defined various ways and by various disciplines. The psychological literature defines power as having the capacity to influence the actions of others, conceptualizing power in terms of power over others (Antonovsky, 1988). At the

institutional level, sexual division of power is most commonly seen in relationships. For instance, women who depend solely on men for all financial assets give men greater control in the relationship, and the power in the relationship is unbalanced. Also, at the institutional level, the sexual division of power is maintained by social mechanisms such as the media, where women are often sexually degraded and are disempowered (DiClemente, Crosby, & Kegler, 2009).

The mechanisms of the division of power play one of the most critical roles in the experiences of homeless women and their risk for HIV. Power and control in present or past relationships of homeless women are often the purview of their male partners. If in an unhealthy relationship, where men exploit their control and power over their partners, women often become victims of violence, substance abuse and mental illness, which are overrepresented in homeless women. A history of violence and abuse is a principal cause of homelessness, specifically for women. As a result of violent experiences, homeless women also suffer from mental illness which impacts their ability to meet the tasks of daily living, as well as forming healthy relationships in the future (Lilly & Graham-Bermann, 2009). Mental instability often coexists with substance abuse and leads to women's powerlessness in their economic and social circumstances. Women are at a higher risk for violence victimization compared to their male counterparts and therefore their risk for homelessness and HIV risk behaviors are increased. One study found that victims of interpersonal violence are twice as likely as non-victims to report unmet needs for mental health treatment (Lipsky & Caetano, 2007).

The final structure is the structure of cathexis, also referred to as affective attachments and social norms. Cathexis at the societal level establishes "appropriate"

sexual behavior for women. The structure is specifically described as the emotional and sexual attachments that women have with men. This structure also characterizes how women's sexuality is attached to other social concerns such as impurity and immortality. At the institutional level, the structure of cathexis influences many cultural norms that are formed through biases toward women and sexuality. For example, some cultures believe women should only have sex for procreation. Many cultures also look at the sexuality of women as taboo, including having premarital sex, multiple sex partners and masturbating, but consider these behaviors as appropriate for men (DiClemente, Crosby, & Kegler, 2009).

The mechanisms of the final division of cathexis expose women to social risk factors that put them at risk for HIV. Homeless women often face a lack of social support, lack of access to healthcare and distrust the medical system. Homeless women often are on the streets because they left a violent situation and feel they have nowhere to turn for help. Additionally, many homeless women are socially isolated, which contributes to their negative health outcomes and increased risk for HIV (Khandor, 2007). Homeless women live very stressful lives and with a lack of support to appease those stressors, they are faced with various mental and physical health issues (Kawachi & Berkman, 2001). Furthermore, because of their lack of support and financial resources, a majority of homeless women are uninsured and report an inability to access healthcare resources (Kushel, Vittinghoff, & Haas, 2001; Lim, Andersen, Leake, Cunningham, & Gelberg, 2002). The theory of gender and power provided a framework to understand the factors that may affect HIV risk behaviors of homeless women. In this study, the principal investigator explored the domains of economic exposure in relation to the

sexual division of labor, physical exposure in relation to the sexual division of power, and social exposure in relation to the structure of cathexis or social norms (see Table 1). The TGP offered a basis for better comprehension of the complex and interrelated social risk factors that affect homeless women economically, physically and socially, leading to HIV risk factors.

Table 1: Domains Framed by the Constructs of the Theory of Gender and Power

TGP Constructs/ Societal Level	Institutional Level	Social Level	Domains
Sexual Division of Labor	Work, school, family	Manifested as unequal pay	**Economic examples:** • Lack of education • Unemployment • Lack of affordable housing • Criminal activity
Sexual Division of Power	Relationships, medical system, media	Manifested as imbalance of control	**Physical examples:** • Mental illness • Violence • Substance abuse
Cathexis: Social norms and affective attachment	Relationships, family, church	Manifested as constraints in expectations	**Social examples:** • No social support • Mistrust in medical system • HIV risk behaviors

Approach

To explore the domains framed by the constructs of TGP, the principal investigator used an interpretive approach and qualitative data collection methods using in-depth interviews. Qualitative research is useful in collecting culturally-specific information about the values, opinions, behaviors, and social contexts of particular populations. Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem (Creswell, 2009); it builds a holistic picture and reports detailed views of the informants in their natural settings.

This study enrolled participants that represented the homeless population, based on a sample of homeless sheltered women in Miami-Dade County. To be eligible to participate, women had to reside in a designated homeless shelter, be 18 years or older, speak and read English, and self-report a negative HIV status. Participants were recruited through community-based interactions with the principal investigator at the shelter. A total of 18 women were interviewed. Interviews took place until saturation was reached. Saturation is the point when, during qualitative data collection and analysis, there are no new data emerging (Given, 2008).

Data were collected through semi-structured, in-depth interviews. In-depth qualitative interviews were the most appropriate approach for this population because they allowed participants to provide detailed and rich insights of their experiences of being homeless. It also allowed the questions to be revised based on responses given during the data collection process. The study protocol was approved by the Institutional Review Board (IRB) of the University of Miami, ensuring that the rights and welfare of all human subjects involved in the study were protected. Data were analyzed through the constant comparative method, in which the researcher took information from the interviews and compared it to emerging categories. The audiotaped interviews were transcribed verbatim and were then reviewed by the principal investigator using a line by line technique to identify common themes. A preliminary codebook was developed after the first five interviews were completed.

Purpose Statement and Aims

The primary purpose of this dissertation was to address factors that influenced homeless women's health behaviors based on the theory of gender and power. The

participants were asked to reflect on their experiences of being homeless and its impact on their HIV risk behaviors and future needs. The domains of the interview were framed by the constructs of the TGP. The domains included economic exposures and risk factors, physical exposures and risk factors, and social exposures and risk factors. By exploring the experiences and perceptions of homeless women, the findings of this study will contribute to future intervention development. The purpose was accomplished through three aims:

Aim 1

Identify economical, physical and social risk factors for homelessness and HIV as described by homeless women in Miami-Dade County.

Aim 2

Describe the intersection of homelessness and HIV as presented by a sample of homeless women in Miami-Dade County

Aim 3

Describe the impact homelessness has on women's HIV risk behaviors and needs.

Significance of the Study

Homeless women are vulnerable individuals and are at a higher risk for HIV infection compared to their housed counterparts. The National Housing and HIV/AIDS Research Summit reported that unstable housing is more strongly associated with increased HIV risk behaviors than individual characteristics of unstably housed individuals (National AIDS Housing Coalition, 2005). This study provided the opportunity to get insight into the experiences of a diverse group of homeless women. The homeless shelter where recruitment took place housed 208 adult women in 2013. Of

those women, 89.42% had trauma histories, 32.69% survived childhood sexual abuse, 39.9% survived childhood physical abuse, and 48% had substance abuse histories. By exploring the experiences of these women and identifying domains of exposure and risk factors, behaviors can be identified that can benefit from prevention efforts. This will later assist in effectively designing prevention programs delivered to at-risk populations.

Connell's TGP has been elaborated upon and applied to various risk factors for women and HIV (Buelna, Ulloa, & Ulibarri, 2009; Mbonu, Van den Borne, & De Vries, 2010; Salud, Marshak, Natto, & Montgomery, 2014; Weine, Bahromov, Loue, & Owens, 2012). Wingood and DiClemente's work is the most recognized in HIV literature using the TGP. They identified a great need to revise existing theories to better understand HIV risk factors specific to women (Wingood & DiClemente, 2000). Researchers in the HIV prevention field noted that most of the existing theories being used in the field were driven by individual characteristics of the women and failed to take into account the broader context of these women's lives; little attention was given to gender roles and power differentials that may increase women's vulnerability to HIV. Wingood and DiClemente's (2000) adaptation of the theory of gender and power proposes that the three major social structures that characterize the gendered relationships between men and women-- the sexual division of labor, the sexual division of power, and structure of cathexis or social norms-- all have profound influences on HIV risk among women.

Previous work studying HIV and homeless women has been very specific to one risk factor such as violence, substance abuse or mental health. However, no attention has been paid to the interrelationships of economic, physical and social exposures as constructed by the TGP and their roles in HIV risk behaviors among homeless women.

The TGP provided a framework for understanding the factors that influence homeless women's sexual health behaviors. By identifying these factors through the theory of gender and power, this study provides an understanding of how homelessness has affected these women's HIV risk behaviors. The interaction of the constructs of the TGP and the influence of homelessness on a woman's risk for HIV is illustrated in Figure 1.

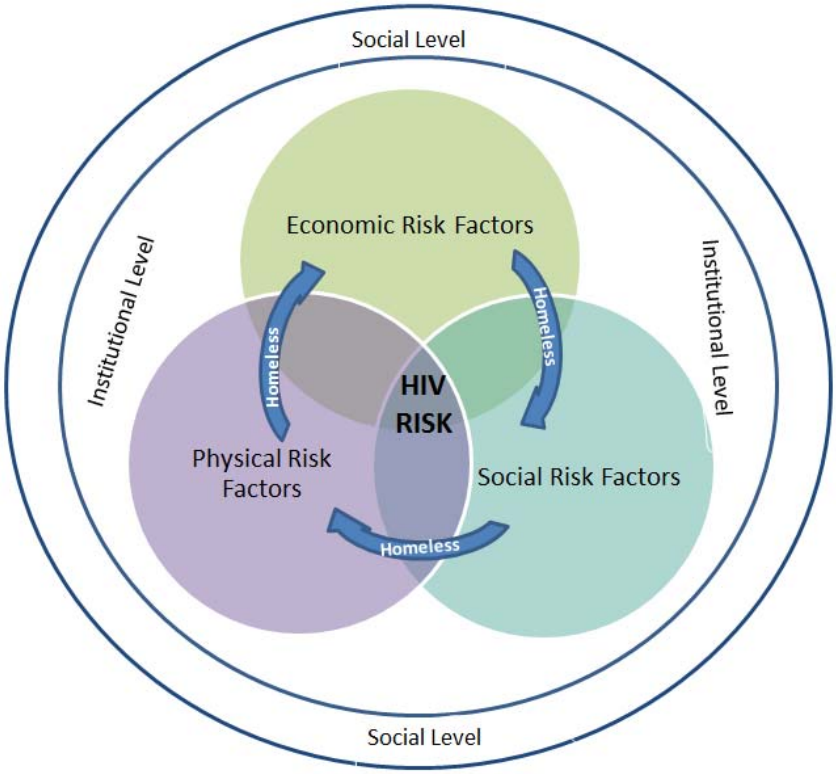

Figure 1. Influence of Homelessness on the Interrelationship of TGP constructs

By heightening the awareness and creating dialogue among this understudied population, this research fills a void in the existing literature and leads to a better understanding of the perceived barriers to HIV risk reduction behaviors of such disadvantaged women.

Limitations

This study maintained certain methodological boundaries in order to achieve the aims of the study. The sample of women was recruited from one women's shelter in the Miami-Dade metropolitan area. The recruitment site was chosen because it is a shelter that accepts women of all backgrounds and experiences. Other specialty shelters were not chosen (e.g., substance abuse, domestic violence, etc.) in an effort to have the sample of women be diverse in experiences. Women at this homeless shelter reported histories of trauma, abuse, and violence.

Summary

The rise of homelessness among women in the United States is a concerning public health issue. Homeless women are vulnerable to many social risk factors including substance abuse, violence victimization, and mental illness. These risk factors are often considered causes and effects of homelessness; however, regardless of the time of occurrence, they often lead to risky sexual behaviors and therefore put homeless women at a greater risk for HIV compared to those who are stably housed. Through qualitative in-depth interviews, a sample of homeless women was asked to describe their experiences of being homeless for the purpose of understanding how homelessness is related to HIV risk factors.

CHAPTER 2

Literature Review

Using Gender and Power Framework to Understand Risk Factors of Homeless Sheltered Women

The Theory of Gender and Power (TGP) has been used extensively in studying HIV risk among women and other vulnerable populations. The TGP was chosen as the framework of this study because of its unique approach in considering the multiple social and structural factors that impact women and risk for HIV. Wingood's (2000) adaptation of the TGP is the only HIV framework exclusively tailored to women, as well as identifying poverty, homelessness and history of abuse as risk factors for HIV among women. Homeless women are at higher risk for a myriad of adverse health outcomes including mental health problems, substance use, high risk sexual behaviors and sexually transmitted infections including HIV (Frencher et al., 2010; Nyamathi, Leake, et al., 2000; Rayburn et al., 2005). Substance abuse and mental health issues have been seen as predictors of HIV risk behaviors independent of homelessness. In addition, there is a high correlation between homeless women and substance and mental illness. (Elifson, Sterk, & Theall, 2007; Tucker et al., 2010). Housing instability is also a key predictor in increased HIV risk (German & Latkin, 2012). Homeless women represent a heterogeneous group, in which very little is known about how the differences in their backgrounds, health status, histories of victimization and sexual behaviors affect their risk for HIV.

The framework of the theory of gender and power that guides this study was presented in Chapter One. In this chapter the literature review establishes the relationship between homelessness and HIV risk factors among homeless women. Next, the chapter continues with an overview of homeless women and the risk factors that cause

homelessness and HIV vulnerability. Then, the implementation of the TGP in HIV literature is discussed. The final section summarizes the main concepts in the study and a literature review of homeless women and HIV.

Implications of Using Gender and Power Framework with Homeless Women at Risk for HIV

The incidence of homelessness in the United States is critically high. It is estimated that 3.5 million Americans are homeless each year (National Law Center on Homelessness and Poverty, 2007). The 2013 Annual Homeless Assessment Report to Congress stated on a given night in 2013, 610,042 people were homeless in the United States. Sixty-five percent of individuals experiencing homelessness are living in emergency shelters or transitional housing programs (U.S. Department of Housing and Urban Development, 2013). Women account for almost 20% of all homeless individuals living in the United States. Major factors that contribute to the recent rise in homelessness are a shortage of affordable housing and an increase in unemployment rates. Homeless women are disproportionately affected by every risk factor specific to their gender, race and ethnicity. Homelessness can have a devastating effect on women and a majority of homeless women are victims of economic, physical and social risk factors, making them more vulnerable to adverse health outcomes when compared to stably housed women.

A primary factor that leads women to homelessness is economic disparity. Homeless women experience multiple economic factors that have caused them to be homeless. Some economic causes of homelessness include lack of education, unemployment, living in poverty, and lack of affordable housing (National Coalition for the Homeless, 2009b). These factors cause their economic inequities and contribute to the

discriminatory gender roles described in the TGP. A fundamental structure of the TGP is the sexual division of labor. The sexual division of labor primarily affects women economically. At the societal level, women and men are allocated to certain positions based on their gender. Women are often assigned unequal positions relative to men. As a result of this social mechanism, economic imbalance occurs due to men being valued for their work either through financial wages or higher status, whereas women are not justly compensated for their extra work and are often not recognized for their nurturing work. Additionally, women are less likely to receive higher education compared to their male counterparts. Education level has been viewed by some as one of the most important tools to reduce poverty (Teal, 2001; Tilak, 2007) . Nieuwenhuis and colleagues (2007) state that education is "an essential social process [which] has potential to shape the future of society" (p. 7). This is supported by the idea that education enhances the earnings potential of the poor when competing for jobs and earnings (Van Der Berg, 2002). Lower skilled and less educated individuals are less likely to find employment and if they are employed, they are usually the first to be dismissed during economic decline; therefore, falling into poverty is more likely for less educated individuals (Schiller, 2008). Based on multiple studies, 35-61% of homeless women have reported having a high school diploma or graduate equivalency diploma (GED), compared to the national average of 75% of women having a high school diploma or GED (Burt, 1999; Caton et al., 2005). A study examining the risk factors of homeless adults with no history of psychotic illness found that level of education (<12 grade or >12 grade) was a significant risk factor for homelessness when comparing homeless individuals to those who have never been homeless (Caton et al., 2000).

As a consequence of having little or no formal education, homeless women are often unemployed. Some women may be employed; however, their wages are usually very low and unequal to their male counterparts. A 2009 survey of 500 homeless individuals stated that over 90% of the homeless surveyed were not formally employed. Those surveyed reported disability and health issues as their main barriers to work. Other common barriers to finding work include lack of work training and education, being homeless, lack of appropriate clothing and appearance, and lack of transportation (Acuna & Erlenbusch, 2009). Women face more extenuating circumstances in finding employment compared to men and are not compensated at the same rate as men. The average full-time working woman made only 77 cents for each dollar earned by a man in 2010 (United States Department of Labor Women's Bureau, 2011). The wage gap is even worse for minority women, many of whom are over-represented in the homeless community. In 2010, the average Black woman working full-time made 63 cents to every dollar of her male counterparts. The total loss in earnings for African-American women and Hispanic women are $19,581 and $24,224, respectively, every year (United States Department of Labor Women's Bureau, 2011). In addition to the unequal wages, if women become unemployed, their unemployment benefits are tied to past wages and therefore they receive less in unemployment benefits than men (National Women's Law Center, 2011). The current job market is designed to support nuclear families with males as the main source of income; consequently poor, uneducated women do not have a place in the labor market and are often forced into jobs that do not pay a livable wage.

Economic inequality for women not only negatively affects them financially, but also adversely affects their mental and physical health. In a qualitative study looking at

gender-related power differences in relation to HIV-infected people, the TGP was utilized as the framework for conceptualization and analysis. The participants reported financial inequity as a key factor in women's vulnerability to HIV. Many women reported that they depended on their husbands for money and many believed that women become infected with HIV because they live in poverty and have no other option but to do as men say (Mbonu et al., 2010). It was also noted that because of the power differential, women are less likely to question their husbands on issues such as infidelity, which also put them at risk for HIV (Mbonu et al., 2010).

Another significant factor causing women to be homeless is living in poverty. As discussed above, women who lack education and are not employed must live in poverty. Over 46 million Americans are currently living in poverty; of those, almost 25 million (55%) are women (Crossroads Rhode Island, 2011). To date, every year, women living in poverty outnumber their male counterparts. The poverty rate in 2011 among women was 16.2%, and increased by almost 4% from 2009, making it the highest poverty rate in the past 17 years (National Women's Law Center, 2011). Over 17 million women lived in poverty in 2010, including more than 7.5 million in extreme poverty, with an income below half of the federal poverty line, defined as $11,139 for an individual (National Women's Law Center, 2011). Living in poverty is the most common cause of homelessness; next is lack of affordable housing.

The lack of affordable housing is a key factor to the current housing crisis and rise in homelessness. Studies reporting on the aggregate levels of homelessness for metropolitan areas have shown that lack of affordable housing is associated with higher rates of homelessness (Lee, Price-Spratlen, & Kanan, 2003; Quigley, Raphael, &

Smolensky, 2001). In 2009, 63% of extremely low-income renters had unreasonable housing cost burdens, paying over 50% of their income in rent (Joint Center for Housing Studies of Harvard University, 2011). The lack of housing is most severe for units affordable to extremely low income renters. The federal minimum wage continues to be $7.25 per hour in 2014. The inflation-adjusted value of the federal minimum wage has fallen by more than a third from its peak and is currently 20% less than it was in 1981, therefore not keeping up with the rising cost of living. It would take approximately 2.6 full-time minimum wage jobs to afford a modest two bedroom unit in the United States (White House Office of Press Secretary, 2014).

Furthermore, the lack of affordable housing has not only caused high rent burdens, but has also contributed to overcrowding and inadequate housing, leading to a rise in homelessness and risk for homelessness. There is a very limited amount of housing assistance for poor families and individuals, the demand greatly exceeds the supply, and low income individuals are forced onto long waiting lists, averaging about 35 months (U.S. Conference of Mayors, 2008). The excessive waiting for public housing has forced many people to live in shelters. The average stay in homeless shelters for families is 5.7 months and 4.7 months for single individuals (U.S. Conference of Mayors, 2007). Compounding the challenges faced by low-income women are rules that govern public housing. Through a “one strike” policy, women may be evicted for violent activity regardless of the cause or circumstances (The National Center on Family Homelessness, 2011). With that, many women who are victims of domestic violence face the risk of losing their homes due to violence acted out upon them.

As a result of violence, many homeless women are in need of medical attention and unfortunately their access to medical care is limited; when care is received, the quality is often low (Teruya et al., 2010). The primary barrier to receiving care is understandably their financial situations; more than half of homeless individuals in the U.S. do not have any form of health insurance (Kushel et al., 2001). Being uninsured causes more hospitalizations, less ambulatory care, and almost three times the likelihood to report inability to obtain necessary medical care among the homeless population (Kushel et al., 2001; Lim et al., 2002). There are also many non-financial factors that create resistance for homeless people to seek medical care, including lack of knowledge of where to seek care, lack of transportation, and lack of child care. More significantly, survival is again noted as their top priority. Homeless people who spend a majority of their time meeting their basic needs are less likely to seek care and are more likely to go without medical care altogether (Henry et al., 2008).

Homeless women have few housing options, a problem magnified when a criminal background is present. Many homeless women have criminal records either as a cause of homelessness or as a result. Most rental subsidies are under federal government regulations which require public housing screenings to exclude people with a criminal background. Although there are specific guidelines as to the types of criminal activity that should be excluded, many individuals are excluded no matter the offense, due to the large demand for housing. It is estimated that 3.5 million Americans are currently ineligible for federal housing because of this rule (Carey, 2004). The strict exclusionary policies are intended to protect individuals from criminals; however, 80% of women entering a U.S. prison are convicted of a non-violent drug or property offense, which is

often the case for homeless women. Arrest rates among a sample of homeless individuals over a 12 month period ranged from 10-20% (O'Toole et al., 2004). Almost 25% of homeless adults have been arrested for a serious offense (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005), and homeless individuals with an incarceration length of at least 6 months are more likely to experience long-term homelessness (McGuire & Rosenheck, 2004).

In addition to the economic risk factors of homelessness, many homeless women are faced with physical factors that put them at risk for homelessness and HIV. The most frequent physical factors reported as causes of homelessness and HIV among women are violence, mental illness, and substance abuse (Frencher et al., 2010; Nyamathi, Leake, et al., 2000; Rayburn et al., 2005). These physical factors are seen in the second fundamental structure of the TGP, the sexual division of power. At the societal level, the difference in control between men and women becomes the basis for the sexual division of power and through this social mechanism, it restricts women's opportunities and produces inequities in their control of resources. At the institutional level, sexual division of power is associated with relationships. In the context of HIV risk, the TGP suggests that gender-based power inequities both in society and in relationships may reduce women's control over their sexual relationships, thus putting them at risk for HIV (Wingood & DiClemente, 2000).

Up to 100% of homeless women have reported abuse, either physical or sexual, at some point in their lives (National Law Center on Homelessness and Poverty, 2010). Homeless women are at an increased risk for both violence and victimization (Fazel, Khosla, Doll, & Geddes, 2008; Kerker et al., 2011). The prevalence of victimization

among the homeless population ranges from 14%-21%, and over 30% have reported witnessing a violent act against another homeless individual (Lee & Schreck, 2005), rates that greatly exceed the average population, of whom only 2% report experiencing a violent crime (Truman, 2011). The TGP has been used as a framework for multiple studies looking at women's power and its relationship to HIV risk behaviors (Buelna et al., 2009; Kershaw et al., 2006; Raj, Silverman, & Amaro, 2004; Wechsberg et al., 2003). One of the studies examined power as a potential mediator of the relationship between violence and sexually transmitted infections (STIs). The study reported that women with lower levels of power had higher rates of violence victimization and STIs. Power was also identified as a partial mediator in the relationship between violence victimization and STIs (Buelna et al., 2009). Another study looking at the relationship between violence victimization and HIV risk behaviors also used the TGP. Abused women were significantly more likely to report male partner control in relationships, fear of partner response to condom negotiation, and partner control over condom use (Raj et al., 2004). The TGP has been used extensively in the HIV literature and has shown a strong relationship between women's lack of power and their risk for HIV. Homeless women face not only economic and physical obstacles that have put them at risk for homelessness, but also are subjected to overwhelming social factors that have caused them to become homeless.

The most commonly reported social factors associated with homelessness in women are lack of social support and distrust in the medical system. Homeless individuals often lack social support and are frequently socially isolated, both of which contribute to negative health outcomes (Khandor, 2007). Research has shown that social

networks can strongly impact one's health through social influence and engagement, and access to medical resources. Social support can also help appease stressful events that would otherwise cause physical and mental harm to one's health, as well as encourage healthy behaviors such as seeking medical care (Kawachi & Berkman, 2001; Noh & Kaspar, 2003).

In the TGP, the structure of cathexis, also referred to as affective attachments and social norms, addresses the social factors that put homeless women at risk for HIV (DiClemente, Crosby, & Kegler, 2009). Cathexis at the societal level establishes "appropriate" sexual behavior for women. The structure of cathexis acknowledges that women's sexual behaviors may occur within a social context that condones passivity and inequality in sexual matters and refers to the differences in norms and affective attachments. Studies have examined the social risk factors for HIV and have suggested addressing emotional distress or disempowerment through peer support (Weine et al., 2012). It has also been noted that women could benefit from education on the importance of medical care and condom use. The acquired risks generated by the structure of cathexis define social inequities that enforce gender roles. Risks in this domain include decreased condom use and condom negotiation.

Compounding their lack of resources, homeless women often have a fear of or distrust in the medical system (Luhrmann, 2008). Research suggests that much of this distrust is rooted in previous negative experiences with health care providers (Martins, 2008; Nickasch & Marnocha, 2009). Homeless individuals have reported feeling unwelcomed and a sense of discrimination by health care providers because of their low social class, therefore decreasing the desire to receive health care in the future (Wen, Hudak, &

Hwang, 2007). Many homeless women also fear seeking care because of the effects it will have on their lives in their community. A study of homeless women with mental illness reported that by seeking care, they may lose their independence and will be stigmatized in a street subculture. Luhrmann (2008) explains that once women accept medical care, they are also accepting a "crazy" label, which puts them at risk for predation. When asked about engaging in medical care, Padgett and colleagues (2006) found that homeless women with a history of mental illness reported betrayal of trust, anxiety about leaving their surroundings, and gender-related stigma as the main reasons for not seeking care.

Sexual Risk Behaviors of Homeless Women

Homeless individuals, specifically homeless women, are more likely to engage in sexual risk behaviors for multiple reasons. Substance abuse and mental illness are strong predictors for sexual risk behaviors and when associated with homeless individuals, the risk is increased further (Elifson et al., 2007; Tucker et al., 2010). The instability of homeless women also contributes to the increased risk for partaking in risky sexual behaviors such as survival sex (German & Latkin, 2012). Survival sex is trading sexual acts for money, drugs, housing, or other needs. This poses great risk for homeless women for several reasons. Women who engage in survival sex are more likely to have multiple sexual partners, who also engage in high risk behaviors; further, the women have unprotected sex with both their risky partners and steady partners (Bobashev, Zule, Osilla, Kline, & Wechsberg, 2009). One study has shown that over 50% of homeless women have reported partaking in survival sex for food, money and shelter, and 48% of these women reported trading sex for drugs (Wechsberg et al., 2003). When compared to

their homeless male counterparts, women are more likely to report using survival sex as a means of surviving on the street (Kidder, Wolitski, Pals, & Campsmith, 2008). Homeless women are at a greater risk for engaging in survival sex because of their history of sexual abuse, which is not only a predictor of survival sex (Hudson et al., 2010), but also a result of it (Henny, Kidder, Stall, & Wolitski, 2007).

Homeless women are more likely to report histories of abuse, have multiple sexual partners, and drug use, including injection drug use, all of which place them at a significantly high risk for adverse health outcomes, including HIV (Hudson et al., 2010; Kidder et al., 2008). Condom use is another critical factor to consider when determining the sexual risk behaviors of homeless women. It is reported that homeless women commonly do not use condoms consistently nor are they likely to use a condom with their steady partners, thus putting them at a high risk for adverse health outcomes such as HIV (Gelberg et al., 2008; Kennedy et al., 2010). It has also been reported that when homeless women are surrounded by others participating in sexual risky behaviors, they are more likely to continue in the same behaviors (Nyamathi, Stein, & Swanson, 2000). Homeless women with history of drug abuse are less likely to use condoms as well as have low condom use self-efficacy (Kidder et al., 2008; Ryan et al., 2009). Homeless women's inconsistent use of condoms may be caused in part by their unstable housing, lack of support or history of drug abuse; regardless of their reasons for not using condoms, these women are at a heightened risk for women's health issues. Wenzel and colleagues (2001) reported that among a group of over 950 homeless women, two-thirds of the women experienced one or more gynecological issues in the previous year and 48% reported a history of STIs or pelvic inflammatory disease.

Homeless Women and HIV

In the United States, the transmission of STIs including HIV infection is one of the most significant public health concerns. The Centers for Disease Control and Prevention (CDC, 2012) estimates that 19 million new cases of STIs are diagnosed every year in the United States and approximately 50,000 new cases of HIV are diagnosed each year (CDC, 2012). Women account for 25% of all individuals living with HIV. In 2010, it was reported that women accounted for an estimated 9,500, or 20%, of the estimated 47,500 new HIV infections in the United States (CDC, 2012). Eighty-four percent of the new infections in women were from heterosexual contact with a person known to have, or to be a high risk for, HIV infection.

HIV is an epidemic that increasingly affects women, with homeless women being among the most vulnerable (Culhane, Gollub, Kuhn, & Shpaner, 2001). Homeless women are more at risk for morbidity and mortality from HIV infection compared to those who are stably housed (Cheung & Hwang, 2004). Research has shown that HIV/AIDS is the leading cause of death in the homeless population and rates are even higher in homeless women. The death rate due to HIV is almost ten times higher for the homeless than the stably housed (Ledergerber et al., 1999; Riley, Bangsberg, Guzman, Perry, & Moss, 2005). Homeless individuals are 3 to 16 times more likely to become HIV infected compared to those who are stably housed (Culhane et al., 2001; Kerker et al., 2011; Robertson et al., 2004) and 3-10% of all homeless individuals are HIV infected, making the homeless population ten times as likely to have HIV compared to the general population (Culhane et al., 2001; Robertson et al., 2004). The living conditions of homeless women increase their likelihood of contracting HIV. Many of the shelters have

limited privacy with communal sleeping and bathing, which not only poses health issues dealing with cleanliness and infection, but also makes it more difficult for residents to develop healthy sexual relationships (University of California San Francisco Center for AIDS Prevention Studies, 2005).

Furthermore, homeless individuals also fail to get tested for HIV infection, a critical health behavior that places them at a heightened risk for HIV infection. Fourteen percent of individuals who are HIV infected are unaware of their status (CDC, 2014). Most underestimate their risk and do not get tested, consequently increasing the risk of infecting others (Knox, 2008). The CDC recommends that all persons aged 13–64 years be screened for HIV in health-care settings irrespective of an individual's risk. If an individual is at increased risk for HIV, it is recommended they be retested at least annually (CDC, 2006). HIV testing and counseling have been reported as cost effective and a critical element in HIV prevention (Weinhardt, Carey, Johnson, & Bickham, 1999; Wolf & Walensky, 2007). Despite the efforts to increase HIV testing, evidence shows many high-risk individuals have never been tested or delay testing (Anderson, Chandra, & Mosher, 2005). The homeless population is more likely to delay testing and treatment due to their pressing survival needs (Kalichman, Hunter, & Kelly, 1992). Homeless individuals fail to test for HIV because of the persistent stigma and perceived discrimination that comes with an HIV diagnosis. Many fail to test for HIV because they are in denial of the HIV risk associated with unprotected sex and the presumed seronegative status of their partners (Simon, Weber, Ford, Cheng, & Kerndt, 1996).

Not only does homelessness increase the likelihood of individuals becoming infected with HIV, but HIV-infected individuals are extremely vulnerable to

homelessness. Many factors contribute to HIV-infected individuals becoming homeless such as stigma, loss of income, and lack of social support. Sixty percent of all persons living with HIV/AIDS have reported a lifetime experience of homelessness or housing instability (Aidala, Lee, Abramson, Messeri, & Siegler, 2007). Homeless individuals with HIV encounter many obstacles to their health, both physically and mentally. Homeless people often suffer from poor hygiene, malnutrition and exposure to extreme weather conditions, factors that place an individual with HIV and a weakened immune system more at risk for becoming ill (National Health Care for the Homeless Council, 2009). Also, living in a shelter can expose HIV-infected people to harmful illnesses such as pneumonia, hepatitis A and tuberculosis. One study reported that sheltered people with HIV are twice as likely to have tuberculosis (National Alliance to End Homelessness, 2006). One study found that housing status is one of the strongest predictors of health outcomes for HIV-infected individuals (Kidder, Wolitski, Campsmith, & Nakamura, 2007). Additionally, psychological factors play a significant role in disease progression among homeless people infected with HIV. Homeless individuals face severe daily stressors including depression and anxiety, which have been shown to increase the severity of the disease (Greeson et al., 2008). Homeless people with HIV also face major barriers to receiving and adhering to antiretroviral treatments (ARTs). ARTs are complex regimens and may be extremely difficult to adhere to when one does not have stable housing, clean water, refrigeration and adequate food (National Alliance to End Homelessness, 2006). Overall, homeless individuals infected with HIV experience worse physical and mental health, have lower CD4 counts and higher viral loads, and are less likely to receive antiretroviral therapy, compared to those who are stably housed.

The association between homelessness and HIV risk has been widely demonstrated, although few have focused exclusively on women and no studies to date have used the TGP as a framework to understand its relationship. For example, Caton and colleagues (2013) studied the prevalence of HIV and STI infections among homeless sheltered women, looking at the association of demographics, homeless history and clinical risk factors. Their findings reported a greater risk for HIV/STI infection among homeless women with a history of childhood sexual abuse, arrest history, current psychotic symptoms and substance use disorder. This study was limited in looking at the characteristic of homelessness or being unstably housed as a risk factor for HIV as well as the economic and social burden that has resulted from homelessness as a risk factor. Additionally, this study had limitations in its participation rate. Findings of lower than average HIV rates may have been due to women not participating because they did not want their status revealed. Another study, however, did look at housing stability as a risk factor for HIV, reporting housing instability as a structural barrier to HIV prevention (Grieb, Davey-Rothwell, & Latkin, 2013). This study's primary focus was the relationship between housing instability and HIV testing, which is a very important preventative measure of HIV; however it does not take into account other critical behaviors that place women at risk for HIV, including multiple sex partners and survival sex. Kidder and colleagues (2008) compared substance abuse and sexual HIV risk behaviors of homeless women to stably housed women with HIV. Results again showed a high prevalence rate in homeless women compared to the stably housed. However, the sample size was skewed with only 4% of the total sample being homeless; additionally the measurements used to determine sexual risk behaviors were weak. Participants were

asked if they had participated in HIV risk behaviors in their lifetime, which all should have responded positively to since they were already HIV infected. Other studies have also explored the relationships between violence and psychiatric disorders and HIV risk among homeless women (Kilbourne, Herndon, Andersen, Wenzel, & Gelberg, 2002; Wechsberg et al., 2003), both studies finding that a history of violence and psychological distress made homeless women more vulnerable to HIV.

Current research lacks insight into the interrelated factors, including economic, social, and physical risk factors, which may play a key role in homeless women's risk for HIV. Using the TGP as a framework, this study addressed these factors and explored a deeper understanding of homeless women and their risk for HIV from a holistic approach, one that has yet to be done. Previous work has examined the role of economic, social and physical risk factors separately, but never together; thus the relationship among the three domains have never been studied. Additionally, this study aimed to understand the roles gender and power play in HIV risk behaviors. Research is warranted in this area because of the complexity of homelessness and the risk factors that have led to their housing situation, as well as resulted from it.

Conclusion

To date, the roles of economic, social and physical risk factors have not been translated into determinants of HIV risk factors for homeless women. As health care scientists, we urgently need to expand our understanding of health and gender inequities among the homeless population. The TGP offers a unique approach in considering the multiple social and structural factors that impact women and risk for HIV. This framework looking at the domains framed as constructs of the TGP, while specific to

homeless women, can be modified to reflect the social determinants of health relevant to other populations and offers a framework for future work.

CHAPTER 3: Methodology

Qualitative Study Design

A qualitative descriptive design was conducted to understand the HIV risk behaviors of homeless sheltered women in Miami-Dade County. Qualitative description is especially amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to exploratory questions. Moreover, the description in qualitative descriptive studies entails the presentation of the facts of the case in everyday language (Sandelowski, 2000). This qualitative study contributes to the awareness of factors that influenced risk behaviors of homeless women, especially those that emerged during homelessness, as well as provided detailed information about the interaction among these factors (Creswell, 2009).

Study Aims

The direction and aims of the study were changed following the first three interviews. By conducting data analysis simultaneously with data collection, it was apparent that HIV risk behaviors were not relevant in the lives of the participants. They were unable, due to the rules of the shelter, to engage in sexual relationships. However, although women were not reporting HIV risk behaviors, they were still reporting critical experiences that had influenced their homelessness. My dissertation chair and I agreed that I should continue the interviews and focus on the events the women described as life changing. All of the women interviewed were still asked about their HIV risk behaviors.

Study Setting and Population

This study took place in an all-woman's homeless shelter in Overtown, in Miami-Dade County. The shelter provides housing for women and their children as well as multi-faceted comprehensive supportive services, including access to medical and mental

health care, parenting education, and counseling. The shelter houses over 110 women and children on a daily basis. Women are permitted to live in the shelter for up to one year. The shelter serves over 275 women and children on an annual basis. Eighteen women residing in the homeless shelter shared their experiences and perceptions of shelter living through in-depth interviews.

The shelter sits in the center of Miami, Overtown. Overtown is one of the poorest neighborhoods in the United States, with the median household income of $13,211.99, 1.7 times below the poverty line as reported by the Census Bureau of 2010. The residents of Overtown face multiple health disparities, including obesity, diabetes, hypertension and HIV/AIDS. The city of Overtown has one of the highest rates of mortality from chronic disease and HIV/AIDS in Miami-Dade County. Census figures show Overtown's death rate from HIV/AIDS was 125.8 per 100,000, compared to the U.S. average of 20.4.

Participants and Recruitment

Participants were recruited primarily through the efforts of the principal investigator. She has undergone extensive training about how to approach potentially eligible individuals and encourage their participation in research studies. Participants were recruited from a women's homeless shelter in Miami-Dade County. Residents of the shelter were approached by the principal investigator in the courtyard of the shelter, where the study was briefly explained and they were asked if they were interested in participating. If interested, the women met with the principal investigator and were screened for eligibility (see Appendix A). In order to be eligible to participate in the study, women had to be 18 years or older, currently live in the designated homeless shelter, speak and understand English, and self-report HIV negative status. HIV status

was a critical element of eligibility because the experiences and perceptions of health and risk behaviors would potentially be very different for women who were HIV-infected compared to those who were not. For those who were eligible, the principal investigator further described the study. The participants were told that the purpose of the interviews were to understand the risks and needs of homeless women. Women were interviewed individually and each interview lasted 45 minutes to 90 minutes. Each interview was audio recorded for data analysis purposes. All information collected was kept confidential and all names and identifiable information were removed from the files and replaced by a study identification number. The participants received a $20 gift certificate as compensation for their time and effort at the end of the interview. The information collected at the eligibility screening for those who were eligible, but not interested in participating, were kept in order to understand the representativeness of the sample. There was only one resident that was eligible and not interested in participating; she reported the audio recording as the reason. Two of the approached women were not interested in screening for eligibility; their reason was lack of time. For those individuals who were eligible and agreed to participate, the interviews took place the same day as the screening process. The screening process and interviews took place in a private room in the main office of the homeless shelter.

Demographic Form and In-Depth Interview

Prior to beginning the demographic form and in-depth interview, the principal investigator explained the study in further detail. The principal investigator answered any questions the participants had and if they still agreed to participate, a signed informed consent form was obtained. After obtaining consent, the demographic survey took place.

The demographic form was very brief and all information was collected through paper and pencil (see Appendix B).

Upon completion of the demographic form, the in-depth interview began. The in-depth interviews were semi-structured and the script was guided by the domains of the TGP: economic, physical and social exposures and risk factors related to homelessness and HIV. The interview guide was designed with probes to ensure that key topics were explored with each of the participants. The interview guide was structured to probe what is already known about the women (e.g., homelessness) and new areas that the researcher aimed to explore further (e.g., risky behaviors, history of illness, history of abuse). The key topics focused on the economic exposures, physical exposures and social exposures of being homeless and how they were related to exposure to HIV (see Appendix C). All interviews were conducted by the principal investigator.

Data Analysis

Data were analyzed through the constant comparative method (Miles et al., 2014). The constant comparative method allowed for relevant categories of meaning and relationships between categories to be derived from the data itself, rather than initiating the process with pre-defined categories. This process of inductive reasoning allowed the researcher to access and analyze the perspectives of the individuals in order to integrate them into the TGP. In using the constant comparative method, the data were broken down into discrete incidents or units and then were coded into categories (Glaser & Stauss, 1967; Lincoln & Guba, 1985). As Taylor and Bogdan (1984) summarize: “In the constant comparative method the researcher simultaneously codes and analyses data in order to develop concepts; by continually comparing specific incidents in the data, the researcher

refines these concepts, identifies their properties, explores their relationships to one another, and integrates them into a coherent explanatory model" (p. 126).

The codings were created using a hybrid approach, meaning the use of pre-set (a priori coding) and emergent codes. The a priori codes were based on the constructs of the TGP and the emergent codes were ideas and concepts that came about during analysis based on the women's interviews. The data were initially coded through first level coding: direct quotations from the participants, paraphrased by the principal investigator. There were a total of 291 first level codes that were then separated into categories. The categories were refined based on the significance of the findings; some categories were collapsed together, while others were expanded upon based on the data. For example, the category, history of violence, had numerous accounts and was expanded into 4 separate sub-categories: partner abuse, sexual abuse, child abuse and abuse from mother/motherly figure. Alternatively, HIV risk factors, which was a pre-set code, ended up having very little data and was collapsed into one category which included sexual practices and HIV testing. These findings indicate how HIV risk was of little importance in the lives of these homeless women and thus changed the focus of this study. A total of 15 categories were derived from the participant's quotations. These categories helped conceptualize the participants' experiences. After further analysis the 15 categories were organized into a total of 3 main themes: making a positive change, as a reason for coming to the shelter and as a result of shelter living; struggles of motherhood; and history of violence victimization. Transcripts were written using Microsoft Word and the coding and categories of the data were organized using QSR NVivo 10; both forms were password protected.

Study Trustworthiness and Validity

The trustworthiness of the study was maintained in several ways. In order to reduce bias and enhance the confirmability of the study, the data were retained and an audit trail detailing the methods (e.g., semi-structured interview guide) and analytic procedures (e.g., data coding) were created such that the data could be reanalyzed (Miles et al., 2014). Furthermore, the dependability of the study was preserved by having the committee chairperson code 20% of the data and meet with the principal investigator regularly to review findings, assess inter-coder congruence and explore issues of divergent findings (Marshall, 2011). Additionally, in an effort to ensure the qualitative design was credible and valid, the constructs used in the conceptual framework were clearly defined and the interview guide was developed to measure the constructs of the TGP (Miles et al., 2014). Lastly, in order to enhance the transferability of the qualitative data, the principal investigator provided rich descriptions in the findings so readers can connect the findings to the conceptual framework (Miles et al., 2014).

Ethical Considerations

The principal investigator was responsible for monitoring the safety and quality of the proposed study. Consent forms had the contact information of the IRB of the University of Miami and the principal investigator for any additional questions that may have emerged. There was no contact with the principal investigator during or after data collection from study participants in this regard. In addition, the consent form explained that the use and storage of the audio-recordings and demographic data would be saved in a password protected file. The principal investigator encouraged participants to discuss any concerns with her and if for any reason during the interview the woman felt

uncomfortable or distressed, they were able to terminate the interview. At no point during the interview process did any of the women feel distressed and want to stop the interview; therefore, no interviews were terminated during the study. All interviews were completely voluntary and all information collected was confidential. A list of counseling and medical services was available to women if they reported distress or extreme feelings of discomfort; none of the participants reported any extreme feelings of discomfort or distress; therefore, none of the participants needed outside services. In order to maintain an environment where the participants felt comfortable, the interviews were conducted in a private room in the main office of the homeless shelter.

Data Management and Protection of Human Subjects

Multiple steps were taken to guarantee confidentiality. All electronic data were stored in password protected files that only the principal investigator could access. There were multiple levels of security once placed on the local network. Participants were assigned an identification number. All participant forms and audio recordings were locked in the principal investigator's car trunk and transported to University of Miami School of Nursing and Health Studies within 24 hours of each interview. All study personnel were approved to conduct human subject research by the University of Miami Institutional Review Board. All data were inspected for quality assurance prior to analysis by listening to the interviews multiple times and comparing them to the transcriptions. Additionally, the dissertation chairperson randomly selected interviews and compared the audio version to the transcript.

Summary

This study aimed to understand the HIV risk behaviors of homeless sheltered women. The theoretical framework of the TGP was illustrated extensively in this proposal as well as how its constructs guided the course of this study. A literature review was conducted to rationalize the significance of studying homeless women and their risk for HIV. The final part of this chapter describes the justification for qualitative research and in-depth interviews as a means of data collection, as well as ethical considerations, data management and data analysis issue.

CHAPTER 4: A Choice for a Better Life: A Qualitative Study of Homeless Women's Perception of Shelter Living

Overview

In 2013, over 610,000 individuals reported being homeless in the United States (U.S. Department of Housing and Urban Development, 2013). Women and children are the fastest growing group of the homeless population, with 34% of the total homeless population composed of families (The National Center of Family Homelessness, 2011), and 84% of those families headed by women. Lack of affordable housing has been reported as one of the leading causes of homelessness among families, with unemployment, foreclosures and rent disproportionate to income as key contributors to home loss (National Coalition for the Homeless, 2009a). Additionally, many women face other risk factors including alcohol and substance abuse, mental illness, experiences with violence and previous criminal activity, putting them at a higher risk for homelessness as well as a more difficult time transitioning out of homelessness (Zlotnick & Zerger, 2009).

Many women with families turn to homeless shelters or transitional housing programs in the hopes of making it back on their feet. Sixty-five percent of the homeless population report living in an emergency shelter or transitional housing program (U.S. Department of Housing and Urban Development, 2013). Since 2007, the number of sheltered individuals has increased slightly by 1%, while the number of sheltered families has increased by 7% (U.S. Department of Housing and Urban Development, 2013). Homeless women are among the most vulnerable populations and as a result, seek safety, basic needs and stability in sheltered living.

The theory of gender and power (TGP) is a lens through which to examine this phenomenon, and was used as the framework for this study. TGP considers the multiple

social and structural factors that impact homeless women and their potential for health risks. Wingood's (2000) adaptation of the TGP is exclusively tailored to women and also identifies poverty, homelessness and history of abuse as health risk factors for women. According to the theory, three major structures characterize the gendered relationship between men and women: (a) the sexual division of labor, which examines the economic inequities favoring males; (b) the sexual division of power, which examines inequities and abuses of authority and control in relationships and institutions favoring males; and (c) cathexis, which examines social norms and affective attachments.

The purpose of this study was to better understand the experiences of homeless women and address factors that influence their health behaviors, based on the theory of gender and power (TGP). The findings described herein are a part of a larger study. All of the interviewed women were asked about their experiences of homelessness. The women described multiple factors that led them to shelter living and how being homeless has changed their lives. No previous studies have looked at the interrelationship of the constructs of the TGP and its influence on homelessness among women. This study adds a new perspective of how the power imbalance between men and women impacts the housing stability of women.

Methods

Design. A qualitative descriptive design was used to better understand the experiences and perceptions of health of homeless women. Qualitative description was the most appropriate design since it is amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to exploratory questions (Sandelowski, 2000). This qualitative study contributes to the

awareness of factors and experiences that influenced the lives of the women and their encounters of homelessness (Creswell, 2009).

Data Collection. Data were collected through semi-structured, in-depth interviews. Demographic information was collected before the interview. In-depth interviews were most appropriate for this population because of the sensitivity of the subject matters discussed. It also allowed the questions to be revised based on responses given during the data collection process. The interview questions were developed based on the constructs of the Theory of Gender and Power (TGP). Every interview began with the open-ended question, "Tell me how you became homeless." Topics covered in the interview reflected the women's economic, physical and social risk factors. The interview guide also contained prompts to encourage elaboration and elicit themes. Each interview ranged from 45- 90 minutes in length. All interviews were audio recorded and transcribed verbatim to maintain integrity of the data. The study was approved by the Institutional Review Board (IRB) of the University of Miami, ensuring that the rights and welfare of all human subjects involved in the study were protected.

Participants. Purposive sampling methods were used to recruit the sample of homeless women. Purposive sampling meant that the principal investigator would select participants because they were part of the homeless population and they were living in a shelter at the time of the interview. Homeless women residing in an all-women's shelter in Miami-Dade County were recruited for individual in-depth interviews. Participants were eligible if they were 18 years or older, currently living in a designated homeless shelter, spoke and understood English, and self-reported a negative HIV status. Potential participants were approached by the principal investigator in the courtyard area of the

homeless shelter. Residents of the shelter were asked if they were interested in participating in a study about their experiences of being homeless; if the woman was interested, the principal investigator would further explain the study and screen for eligibility in a private room in the main office of the homeless shelter. If the woman was eligible and agreed to participate, the terms of the study were described and an informed consent form was read and signed by the participant. All participants received one $20 gift certificate at the completion of the interview.

A total of 18 in-depth interviews were completed. Twenty-three women were approached; 2 women did not meet eligibility criteria and 3 were not interested in participating. Of the women not interested, 2 reported lack of time and one did not want to be audio recorded. Participants ranged from the ages of 23 to 69, with a mean age of 35. Ninety-four percent of the individuals interviewed were from minority groups: 7 African-American, 6 Hispanic and 2 Haitian/Caribbean women. Women reported being homeless from one month to ten years, with an average of two years of homelessness and living in two shelters in their lifetimes. Characteristics of the study sample are presented in Table 2.

Table 2: Demographic Characteristics of Study Sample

Characteristics	Frequency (*N=18)*	Mean
Age		35
20-29	10	
30-39	3	
40-49	1	
50-59	3	
60-69	1	
Race		
Black	9	
White	7	
Other	2	
Ethnicity		
African-American	7	

Caucasian	1	
Hispanic	6	
Haitian/Caribbean	2	
Other	2	
Born in Foreign Country	4	
Highest Education		
Less than 12 years	4	
High School only	4	
More than 12 years	8	
Associates Degree	2	
Unemployed	17	
Monthly Income		
None	10	
1-200	2	
401-600	2	
601-800	0	
801-1000	1	
Refusal	3	
Insured	13	
Medicaid	10	
Medicare	2	
Sexually Active in last 6 months	11	
Number of Years homeless		2.1
<1	7	
1-5	9	
6-10	2	
Number of Shelters Lived		
1	10	
2-5	7	
6-10	0	
>10	1	

Data Analysis. Content analysis and constant comparison techniques (Miles et al., 2014) were used to analyze the data. The constant comparative method allowed for relevant categories of meaning and relationships between categories to be derived from the data itself, rather than initiating the process with pre-defined categories. The data were broken down into discrete incidents and then were coded into categories. Each category was compared to previously coded categories to establish relationships and elicit overall themes. Transcripts were written using Microsoft Word and the coding and categories of the data were organized using QSR NVivo10.

Results

The main theme that emerged from the data was "making a positive change." The women referred to "making a positive change" as both a reason for coming to the shelter and a result of living in the shelter. The dimensions of "making a positive change" is twofold;, the first subtheme, "it was time for a change, so I just came to a homeless shelter," illustrated the women's perceptions before entering the homeless shelter as it being a place to find a better life. The women came to the shelter seeking independence, safety and personal growth. The second subtheme, "It makes you feel secure, it makes you feel safe, and it makes you at peace," described the women's experiences after living in the shelter, and its impact on their lives. As a result of living in a shelter, women described their lives as changing for the better, specifically in meeting their basic needs, their emotional and mental states, and sexual health.

"It was time for a change, so I just came to a homeless shelter."

Provided an opportunity for independence. Independence was an emerging category seen throughout the interviews as a reason why women chose to live in a homeless shelter. Independence was defined as an individual's desire to live on their own and take control of their financial and housing status. Close to half of the interviewed women stated that living in a homeless shelter was a choice they made in order to better the lives of themselves and their families. Multiple women reported living in a homeless shelter as their only opportunity to make it on their own. A few of the participants stated:

> I was tired of staying with people like it was time for a change cause I got kids and I just got tired of staying with people. I was ready to stop staying with people and be on my own.

> I tried to just focus on myself, like I tell everybody I'm not here to make best friends, I'm here to get my life together. I have two children who look up to me, you know so.

> I was staying with um my cousin, so I just left one day and just came to a homeless shelter. I've pretty much like got fed up with like staying with people cause I was going from one person, to this person, to that person, basically and I've said that wasn't stable for my kids, so I was just like it's time for me to step up and be the mother that I know I can be and just like forget it.

Although some women said they could live with family members, they stated that a shelter would provide them with more long-term benefits and help them get back on their feet. They also noted that they would rather receive help from strangers instead of asking for help from family members. Many of the women, however, faced the harsh reality that their families could not help them and worse, would not help them. Some women's experiences with their families included:

> They help you more than what you think. A lot of people would say 'oh they're in a shelter, it's not good, it's not this, it's not this, oh you know.' Don't listen to them, in the shelter will help you, it will help you more than staying with a relative or something because a relative is not gonna help you get a job, a relative is not gonna help you get your own housing, a relative will not even help you with stuff that you need help with but a shelter will supply you with everything you need, you just need, have to apply yourself.

> But I think it's my time to like get on my feet and I go visit them. But I gotta get it together first.- In response to staying with a family member who offered her a place to stay.

> Yes, I prefer to be here than to be with any of my sisters. My brother doesn't live here or my children… I would be guilty for everything. I would be detrimental, they are very judgmental individuals and the judgments would never be positive for me, the judgment is always negative…don't get me wrong there's really, I really have an issue right now with the roommate that I live, but even that's not an issue compared to my family.

Women also added that they were tired of living "pillar to post," living on couches and floors of their friends and families for short periods of time; however, many referred to this phrase as "pillow to post." Some women explained that staying at a friend's place was not a possibility when having kids. Additionally, many of the women felt they needed to make a drastic change in their life, such as living in a homeless

shelter, in order to get out of the negative cycle in which they were living. Women described their experiences of living "pillar to post" as:

> "I left my mom's house. I gone from basically pillow to couch, I sleep at this one's house or I'd sleep in this one's house, but the places I was staying, there was no room for me to stay there like temporarily. You know only for like a day or two or maybe a couple of days that's it."

> Because if I would have been by myself um… I could have crashed here and there and I wouldn't have cared, you know I had a job so it's like okay um… maybe I would've been like at a friend's house like oh I'll help you pay rent or… but because I do have kids I can't crash. You know until I get on my feet because you can't with a little kid sleeping on the sofa for months to months. Even if you are working, even if you are helping with the rent, it gets tiring after awhile, you know, people like to have their own privacy so it's, everybody like to have their own privacy, so it's better to be here than to be on the streets or crashing at somebody's sofa. At least you have your own room, bathroom to take a shower, you know washer and dryer to wash your clothes, they'll help you with anything they can.

Provided safety. Another specific reason women chose to come to the homeless shelter was to feel safe and secure. Safety was a subject that was discussed frequently among the interviewed women. Safety was defined as a woman's desire to feel protected from harm by living in a homeless shelter. Almost all of the interviewed women stated a history of violent relationships and for some women, these were the main reason for coming to the shelter. Some women stated that they feared for their lives in their relationships and coming to a shelter was their only way to make their lives better. When some women were asked, "How did you become homeless?" the responses included:

> I was in an abusive relationship so I left because I didn't want to get mistreated anymore…I guess he started drinking again and then he started hitting me every night and I didn't want my son to see that, so after he broke my tooth, I saw that it got serious. And then after he stabbed me, I was like I can't do this anymore, the next step is he could try to kill me.

> Umm, I was in an abusive umm relationship and umm he pretty much umm would hurt me pretty bad… he would go and um… because he was paying the rent because I couldn't pay it because I didn't have a job. I'm an epileptic so um… so I'm not able to work. So um… that's how I became homeless.

Romantic relationships were not the only conflicts for these women; many women reported abuse from family members, both verbal and physical, which forced them to find safety in a shelter. Younger women specifically reported running away from home in order to find a safe place to live. Some accounts of these experiences are:

> Um… sadly my aunt didn't want me. So I left home…My aunt didn't want me so she sent me to a group home, I ran away from the group home. And I've been homeless ever since.
>
> I was actually living with my uncle and he kicked me out because I didn't have a job, I couldn't find another job and then I started drinking all the time so that's where my money went and now I'm here.
>
> I became homeless um… due to my family um… because I wasn't working and um… they also stole money from me, I was receiving a monthly check and once I found out that they went into my account and took that money um… I did not not ask them to pay me back, I just said you know whatever you have just you know I'm willing to accept even though they was wrong um… but instead my mom just told me get out and you know go to a shelter, you know, get out of her house even though she stole from me and instead of me calling the police and pressing charges I just left the house not knowing where I was going because I knew she was wrong and I shouldn't have left but the fact you know she said if I don't leave she's going to call the police and that freaked me out and I just left.

Provided opportunities for personal growth. Women not only came to the shelter for a sense of independence and safety, but an opportunity to grow as a person. Personal growth was defined as a desire to make a change in their lives either mentally, emotionally, or physically. Many women stated that coming to the shelter was seen as an opportunity to better themselves and grow as a woman and a mother. Women were looking to change their behaviors. A few women stated the following in response to why they came to a shelter:

> I never thought in a million years, I never thought I would be at a homeless shelter. Me being a mother, I never thought I would have to bring my kids to a place like this but like I said me bettering myself and growing, by me wanting to bettering myself as a mother and growing as a mother and stop some of my ways, this was like a good like option, like it was a good, like I don't regret coming here now.

> but I got to the point where I'm like I'm getting older and older, I'm tired, I want better for myself.

"It makes you feel secure, it makes you feel safe, and it makes you at peace."

Provides basic needs. Living in a shelter provided women with a variety of services; however, one of the most important aspects of living in the homeless shelter was receiving the basic needs they were missing such as a roof over their heads, three meals a day, and a warm shower. Several of the women stated that living in the shelter provided them with these needs and for many they were living better in the shelter than when they had their own places to live. Some of the women's responses regarding their changes in basic needs included:

> It's just made me like really feel grateful for what I do have and not so much focus on the things that I don't have because like I said my kids eat every day, they're clean, they bathe, they have a bed to go to everyday, they have a safe place to go to. It's just made me open my eyes that much more, just motivate myself to like get myself together.

> But health wise like we have breakfast, lunch, and dinner and I think well, actually we're better here than at home because we really don't do breakfast, lunch, and dinner um… all at once every day like we do here.

> Physically, the worst thing that's happened to me since I've been here is I've gained weight because we've gone from 3 meals a week to 3 meals a day if you want.

Provided opportunities for personal growth. Personal growth was seen both as a desire for the women and as a result of living in the shelter. Many of the women had taken advantage of the resources given to them at the shelter. For many of the women, a lack of education was an aspect of their life that was holding them back and with the help of the shelter, many were able to get their GEDs. Women were also given job interview training and some were able to find jobs. Some women explain their growth in these examples:

> I can actually say that I'm not happy that I'm here, but that God worked the way he worked because I'm getting my life together, I'm getting my GED. I'm getting back on my feet, I'm doing what I have to do to get where I have to be.
>
> I'm going to go for my GED because they offer the GED classes. I'm going to go for my GED and once I finish my GED, I'm going to go for either my hair license or my business license, I don't want no stops at all, just want to go for it to make it better for me.
>
> A week after I got here, at the shelter, I got a job.

Provided support to improve women's emotional and mental states. All of the women interviewed had a history of mental and emotional turmoil either before or after becoming homeless. Most women struggled with depression and anxiety. Many of the interviewed women stated that the shelter made them feel secure, provided a sense of relief, and has changed their outlooks on life. Women also reported that since arriving at the shelter, they were able to see mental health specialists and were able to receive medication for anxiety, depression and other mental health issues, all of which they were unable to do on their own. Women described improvements in their emotional and mental states since coming to the shelter:

> It has helped me emotionally to get over my over my fears and consider other people's feelings; basically it's helping me to be a better person.
>
> I mean, I feel like I have more support now because like people see that I want to change and they see I'm, that I'm trying to change, so that's the good thing.
>
> They actually helped me get back on my medications for um…anxiety, depression with insomnia, and ADHD,so they helped me get back on meds. I was taking them, but then I stopped taking them cause I had no way to pay for it; I had no medical insurance that year…I had…I had...I had Medicaid but they still didn't pay for it.

Improved their sexual health. Another key theme that emerged as a result of living in a shelter was the change in sexual practices. A majority of the women stated that they had not been sexually active since living in the shelter. Women stated that they were there to make a change in their lives and sex would only complicate the matter. Women

also stated that they were unable to have male guests in the shelter and they were forced to comply with the shelter's curfew, both of which made having sex very difficult for the women. Additionally, all interviewed women stated that they had been HIV tested within the year and are tested on a regular basis. When asked about sexual practices and risk for HIV, women answered:

> I need to get it together. Sex is just like, it will bring you down if you have sex with the wrong person, it will bring you down. …you have to get yourself together before you have sex.
>
> No, I've just been abstinent. I'm not even thinking about sex right now. I'm thinking about getting us out of here.
>
> I actually have, I just did it not even a month ago. I do it every six months. It's every three to six months and the mobile guy comes and he does it.

Women reported since living in the shelter, they have been given the opportunity to see medical professionals on a regular basis, which many of them were unable to do before living in the shelter. Many of the interviewed women stated that because of the shelter, they had a well women's check-up and were able to receive contraceptives. The shelter promoted women's awareness of health and prevention, not only for themselves, but for their children, too. Two women described their change in health care since coming to the shelter as:

> Since I've been in this place, like I been getting the right health treatment. Ms. (woman's name) showed me, she's up on our health, down to the Planned Parenthood down to the eyes to everything. She makes sure we get the proper care, even the kids she makes sure that all of them are up to date on their shots and everything.
>
> She (counselor) had me go into the planned parenthood and I went and I got, first I went and got the pills and I'm like no, I'm not going to deal with the pills because I know me, if I miss a pill I know that, that's not, so I went back and got the shot.

Discussion

The findings indicate that homeless women found solace in sheltered living. Additionally, many women stated that they were living in the shelter because they chose to be there in hopes for a better life. Previous work has described sheltered women as having no other options or choices for living except for a shelter (Eisikowitz, 2013); although this was the case for a few of the women, more women described their situation as a choice they made. Consequently, for the women living in the shelter, whether they chose to be there or not, the shelter had provided them with services that positively impacted their lives. Recurring themes emerged from the data that supported the concept of "making a positive change," and these themes fell in line with the constructs of TGP.

All of the interviewed women had experienced economic, physical and social risk factors as described in the framework of TGP. It is significant to note that with each risk

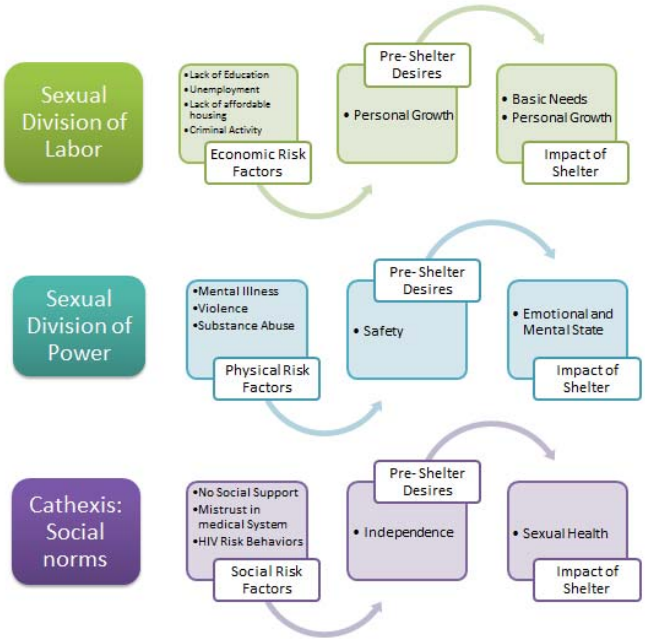

Figure 2: Interrelationship of pre-shelter desires and impact of the shelter based on TGP

factor, women addressed a desire for change before living in the shelter and reported a positive change once they had lived in the shelter in regards to each risk factor. The interrelationship of the risk factors of TGP with the women's pre-shelter desires and the impact of shelter living can be seen in Figure 2.

TGP's construct of sexual division of labor was seen within the themes of the study, specifically the women's desire for personal growth and the shelter's impact on the women's basic needs and personal growth. Women reported their desire to better themselves mentally, physically and emotionally, and as a result of living in the shelter women had their basic needs met and were given opportunities to advance their education and employment status. Some examples of economic risk factors that were impacted by living in a shelter were a lack of education and unemployment. Seventeen of the eighteen women interviewed were unemployed, showing a clear connection with a 2009 survey of 500 homeless individuals who stated that over 90% of the homeless surveyed were not currently working (Acuna & Erlenbusch, 2009). Also, 4 of the 18 women reported completing less than 12 years of education, which is consistent with the findings of Caton and colleagues (2000), stating that level of education (<12 grade or >12 grade) was a significant risk factor for homelessness when comparing homeless individuals to those who have never been homeless. The shelter provided educational training, such as GED certification and job training, which led to employment. A history of criminal activity affected only a few of the interviewed women, but of those women, they were able to change their ways, given that the shelter had rules and curfews they were forced to abide by in order to stay. Finally, the economic risk factor of a lack of affordable housing was

not resolved; however, women were receiving housing by living in the shelter and the shelter was providing help with signing the women up for future housing.

The sexual division of power was very evident in the women's lives both before and during shelter living. Examples of the physical risk factors included a history of mental illness, violence and substance abuse, all risk factors that were prevalent in the women interviewed at the shelter. All of the women had at least one of the physical risk factors, which supported the previous findings that homeless women's most frequent causes of homelessness are violence, mental illness and substance abuse (Frencher et al., 2010; Nyamathi, Leake, et al., 2000; Rayburn et al., 2005). These risk factors fell in line with the women's desire for safety in shelter living. Many of the women moved into the shelter as a result violence and abuse. The shelter provided care and services to help women with each of these risk factors. For example, women who reported a struggle with depression and anxiety both before and while living in a shelter were receiving counseling as well as medication if necessary to help with their mental status, opportunities that they did not have when living on their own. Additionally, with the classes and programs offered through the shelter, women felt a change in their outlooks on life and felt a sense of relief and security as a result of shelter living.

The final construct of cathexis or social norms was seen in the themes of the women's desire for independence and the impact the shelter had on participants' sexual health. Women stated they sought independence by coming to the shelter and as a result of living in the shelter, it was apparent that women had taken control of their sexual lives by abstaining from sex while in the shelter or being tested for HIV infection regularly. The sexual health of the women had improved since living in the shelter. This finding is

significant as it contradicts previous work stating homeless women are less likely to be HIV tested and are more at risk for risky sexual behaviors (Anderson et al., 2005; Kalichman et al., 1992; Simon et al., 1996). The reason for our findings is most likely due to the structure of the shelter and the enforcement of a curfew and no visitors. Although social support was not seen as a main theme, women living in the shelters struggled with finding support; most women stated they had no support in their lives, which was consistent with previous work reporting homeless women were socially isolated and lacked social support (Khandor, 2007). Lastly, when asked about seeing medical professionals, all women reported trust and cooperation with all medical staff, which contradicts the findings of homeless women having a fear or distrust in the medical system (Luhrmann, 2008).

It is critical to discuss the type of shelter from which these women were recruited. The shelter was not just a place where individuals were provided a place to stay at night. It provided comprehensive supportive services, including medical and mental health care, parenting education, counseling and parent/child therapy, life skills and educational advancement, job readiness training, as well as enrichment activities including art, acupuncture, yoga and meditation. The services provided to these women have helped them grow in all aspects of their lives. Many shelters provide a place to stay for the evening and force the residents out during the day, often leading to chronic homelessness. Although it may seem as if they are helping the residents by making them leave during the day, it is quite the opposite. When individuals are forced to leave all day, they are unable to develop a routine of daily habits such as personal grooming and cleanliness of their clothes, which may impede their ability to find employment (Hulchanski, 2009).

Additionally, individuals will find it difficult to attend a job interview if they have been outside in the sun or rain all day. As policy makers are looking toward improvements in care for the homeless, or more importantly, a decrease in the homeless population, it is important to note that with the proper resources, individuals can make changes and improve their lives. For future studies, it would be beneficial to follow up with the sheltered women in 6 months to 1 year to see the progress they have made since living in the shelter. Following the women after they leave the shelter would provide insight as to the success of the shelter and if the training the women received while in the shelter impacted their lives long term.

The main focus of this study was to understand the factors that led the women of the shelter to homelessness. The outcome showed that the women struggled with each construct of the TGP, including economic, physical and social hardship. The women's accounts led to the awareness of the women's choice to live in a shelter as well as the positive influence the shelter has played in the women's lives. With this discovery, future work can be designed to assist women in need, focusing on these specific factors (economic, physical, and social). Previous work has shown consistent implications for homeless women, suggesting that social service providers should assess homeless women's receptiveness to assistance. Some of the suggested therapeutic strategies to help women leave homelessness include development of trust, personalized structure and control, instillation of hope and careful management of mental health problems (Finfgeld-Connett, Bloom, & Johnson, 2012). Additionally, providing services and resources to women at a shelter has shown to help with their overall well-being, which should be taken into account when shelter programs are being designed. Based on the findings and

implications of this study, programs should be designed based on the constructs of the TGP, since women struggled in each of these areas. For example, educational programs can be developed to help with overall self-efficacy and empowerment of homeless women and those at risk for homelessness. As violence was seen as one of the key contributors to the women's housing situation, resources for safe housing should be available to women in convenient locations including doctor's offices, salons, and markets. Additionally, shelters should provide women with resources for how to handle the basic needs of daily living such as bank use, job applications, and education opportunities, to promote independence and self-worth; as women feel they are more capable of controlling their lives and futures, perhaps they will be more willing to make long-term changes in their lives.

CHAPTER 5: Breaking the Chains: Struggles of Motherhood among Homeless Sheltered Women

Homelessness is an escalating public health crisis affecting families across the United States. Currently, families are the fastest growing segment of the homeless population, comprising 36% of the total 1.5 million reported homeless individuals (U.S. Department of Housing and Urban Development, 2013), with an additional 7.5 million families cohabitating with friends and family members due to the loss of their homes (National Alliance to End Homelessness, 2014). In 2013, the U.S. Department of Housing and Urban Development (HUD) reported a 13% increase in the number of homeless families in the past 5 years. Homeless families are more likely to live in a shelter than on the street; currently 86% of homeless families are living in a shelter and 50% of the total sheltered population consists of families (U.S. Department of Housing and Urban Development, 2013). The number of sheltered families has increased by 7% since 2007 (U.S. Department of Housing and Urban Development, 2013). Living in a shelter provides families with basic needs of living such as housing, food, and hygiene; however, there are still many struggles they deal with on a daily basis.

A majority of the homeless families are headed by young (under age 30), single mothers (77.9%) of ethnic minority background (72.3%), having two or more children under the age of 6 (U.S. Department of Housing and Urban Development, 2013). Women are disproportionately affected by homelessness for multiple reasons. For women, abuse or violence is a principal cause of becoming homeless. Reports have indicated that between 22%-57% of homeless women point to abuse as the immediate cause for their homelessness (The National Law Center on Homelessness and Poverty, 2010). Rates of

intimate partner violence tend to be higher among women with low incomes and a high school education or less, both of which are common characteristics of homeless women (Thompson et al., 2006).

Many women struggle with their roles as mothers while living in a shelter. The family structure is compromised as they are in an environment of poverty and instability. As a result, many women's stress levels rise and their coping skills are tested (Meadows-Oliver, 2003). Homeless mothers often feel a sense of incompetency as a parent which can lead to feelings of shame and a lack of worthiness (Haight et al., 2002). Many homeless women also face the struggle of being separated from their children, which not only causes high levels of depression and grief, but also feelings of guilt and anger (Carlson, Matto, Smith, & Eversman, 2006; Schen, 2005).

The purpose of this study was to better understand the experiences of homeless women, specifically the challenges and needs of women living in a shelter. The findings described herein are a part of a larger study, which sought to address the health risk factors of homeless women. The purpose of the parent study was to understand the factors that influence homeless women's sexual health related to HIV, based on the theory of gender and power (TGP). The women spoke candidly about their struggles before and after living in a shelter. This study provides new insight into the lives of homeless mothers and how their past experiences have a strong impact on their futures as caregivers.

Methods

Design. A qualitative descriptive design was conducted to understand homeless women and their struggles with shelter living. Qualitative description was chosen because it entails the presentation of the facts of the case in everyday language and answers

exploratory questions (Sandelowski, 2000). This qualitative study design has provided awareness of the influence past experiences have played in the current state of living for homeless women. The relationship of motherhood and homelessness was also discovered. Qualitative descriptions provided detailed information about the interaction among these factors (Creswell, 2009).

Data Collection. The study was approved by the Institutional Review Board (IRB) of the University of Miami, ensuring that the rights and welfare of all human subjects involved in the study were protected during the study. Data were collected through semi-structured, in-depth interviews. Demographic information was collected before each interview. In-depth interviews were most appropriate for this population because of the sensitivity of the subjects discussed. It also allowed the questions to be revised based on responses given during the data collection process. Every interview began with an open-ended invitation: "Tell me how you became homeless." Topics covered in the interview reflected the women's economic, physical and social risk factors for homelessness and HIV. The women were also asked to discuss the hardest part of being homeless and living in the shelter. The interview guide was used to encourage elaboration and elicit themes. Each interview ranged from 45-90 minutes in length. All interviews were audio recorded and transcribed verbatim to maintain integrity of the data.

Participants. Homeless women residing in an all-women's shelter in Miami-Dade County were recruited using purposive sampling methods for a qualitative study. In order to be eligible for the study, a participant had to be a woman, 18 years or older, currently living in a designated homeless shelter, able to speak and understand English, and self-report a negative HIV status. The shelter provided women with comprehensive

supportive services, including access to medical and mental health care, parenting education, counseling and parent/child therapy, life skills and educational advancement. This shelter was chosen because the residents were from different backgrounds and experiences, whereas other shelters specialize in specific problems such as substance abuse or domestic violence. Additionally, the residents of this shelter reported histories of abuse, trauma, or violence. The women were approached by the principal investigator in the outdoor common area of the homeless shelter. Residents of the shelter were asked if they were interested in participating in a study about their experiences of being homeless; if interested, the principal investigator would further explain the study and screen for eligibility in a private room in the main office of the homeless shelter. If the woman was eligible and agreed to participate, the terms of the study were described and an informed consent form was read and signed by the participant.

Data saturation is the point when, during data collection and analysis, there are no new data emerging (Given, 2008). In this study, data saturation was reached at the 18th interview. Participants ranged from the ages of 23 to 69, with a mean age of 35. Ninety-four percent of the individuals interviewed were of minority background, consisting of 7 African-American, 6 Hispanic and 2 Haitian/Caribbean women. Seventeen of the eighteen women were mothers, with 10 women having 1-2 children and 7 women having 3-5 children. Among the 17 women, there were a total of 41 children ranging from the age of 2 months to 35 years old. Demographic characteristics of the sample can be seen in Table 3.

Table 3: Demographic Characteristics of Sample Population

Characteristics	Frequency (*N=18)*
Age	
20-29	10
30-39	3
40-49	1
50-59	3
60-69	1
Race	
Black	9
White	7
Other	2
Ethnicity	
African-American	7
Caucasian	1
Hispanic	6
Haitian/Caribbean	2
Other	2
Born in Foreign Country	4
Has Children	17
Number of Children	
1	5
2	5
3	3
4	3
5	1
Age of Children	
<1	4
1-5	17
6-10	11
11-15	3
16-20	1
>20	5

Data Analysis. Content analysis and constant comparison techniques (Miles et al., 2014) were used to analyze the data. The constant comparative method allowed for relevant categories of meaning and relationships between categories to be derived from the data itself, rather than initiating the process with pre-defined categories. The data were broken down into discrete incidents and then were coded into categories. Each category was compared to previously coded categories to establish relationships and elicit overall

themes. Transcripts were typed using Microsoft Word and the coding and categories of the data were organized using QSR NVivo10.

Results

After interviewing 18 homeless women, 17 of whom were mothers, many identified the hardest part of being homeless was coping with their roles as mothers. For most of the women, this was the last place they expected to be raising their children. Unfortunately, due to circumstances that were out of their control, women chose to come to the shelter for a new start. Women discussed their experiences of motherhood while being homeless and the events that led them to the shelter. All of the women interviewed had a history of violence in their lifetime including at least one of the following: child abuse, partner abuse and sexual abuse. It was evident that the women's violent pasts had impacted their current roles as mothers. The overarching theme throughout the interviews was "breaking the chains," in which women wanted to change their lifestyles for the sake of their children and for many of these women, the first step was coming to a homeless shelter. Although these women were making positive changes for their children, their pasts were making their journeys more difficult. The themes supporting this overarching theme were struggles of motherhood, history of child abuse, history of partner abuse, and history of sexual abuse. Women described these four themes as the main barriers in overcoming homelessness and being the mothers they aspired to be.

Struggles of Motherhood.

Throughout the interviews, when women were asked about their experiences of being homeless and living in a shelter, the most common theme that emerged was the struggles of motherhood. The theme, struggles of motherhood, is defined as women's challenging experiences in providing for and raising their children before and/or while

living in the shelter. For some women, they explained that being a mother was what brought them to the shelter. Many women stated that they wanted better for their children and the only way to accomplish that was to come to a shelter:

> Well, being homeless, emotionally, like I never thought I'd be in a place like this. I never thought in a million years. I never thought I would be at a homeless shelter. Me being a mother, I never thought I would have to bring my kids to a place like this, but like I said me bettering myself and growing, by me wanting to better myself as a mother and growing as a mother and stop some of my ways, this was like a good like option. Like it was a good, like I don't regret coming here now.
>
> I was going from one person to this person to that person basically and I've said that wasn't stable for my kids so I was just like it's time for me to step up and be the mother that I know I can be and just like forget it.

Another aspect of motherhood that was discussed was the struggle of providing for their children. Many of the women spoke about the regret of having to ask for help and the shame of bringing their children to a homeless shelter. The women were grateful for what the shelter had provided for their children, but felt guilty that they could not provide for them on their own:

> It was really hard, it's my first time ever being in a situation like this, and um… I cried all the way there because at the end of the day I'm a mom and it was more of a thing of a pride, like I don't want my kids to go through anything, any struggles I been through.
>
> Uh…it's incredible, I mean you're very, very emotional um…just maybe when you're alone, when you don't have kids, it's different, but when you have kids you want to be able to support them, give them whatever you want, whatever they want um… their own room, their own bed, not have to share with another mother or share an apartment with three other mothers, you know…

On the other hand, some women struggled with the fact that they could not have their children with them because of their living situations. Many of the women had some or all of their children stay with other family members until they got back on their feet and for some women, they had no choice but to leave their children with others, since the shelter had an age limit of 12 years old: "My mom has all four of my kids so that I could

actually get my life together so when I do get them back I'm stable, I have a place to stay, I have a steady job." Another said:

> My oldest is with her father and my youngest, I gave her up for adoption. I gave her up for adoption because I felt like I couldn't provide for her. So the best thing to do was to give her to someone that could give her what she needed.
>
> Yes, 'cause the other two are too old to be here, so they're with my mom in Virginia. Being away from my kids, that's the hardest part. Being away from my children and not being able to provide for them, it's like him (son), I'm taking care of him here, but it's not really me taking care of him, it's like them taking care of him, it's like I should be able to give them what they need and I can't give them what he wants and I just want my kids back and like a normal life.

For older women with adult children, they struggled to maintain relationships with their children. For many women, they had lost the trust and respect of their children and none of the women were welcome to stay with their grown children. The women also reported that even if they were welcomed, they would not want to be a burden to their children. Many of them were still in contact with their children, but not as often as they would like. One woman spoke of her struggling relationship with her son:

> He just started insulting me, that why was I messing with his, what he does and you know…and I explained it to him. You know, son, I been sober for two months, that's what I told him, I think I been sober for two years, it's about time you realize that mamma is back, you know, whatever, I would not ever…and I see you as this individual that's going ahead in life that's that's getting ahead in his work force.

When asked if she would ever stay with her daughter, the woman responded:

> Oh no! She staying or so she says that she stays at a house that she shares with some other people, so I stayed with her before, remember. It didn't work for me, I mean, they are too different and I wish I could find somewhere, somebody, some angel that could help me and support me and I could talk to.

History of Violence Victimization.

As the women continued to discuss their experiences and struggles as mothers during their time in the shelter, it became apparent that all of these women had other experiences that were also impeding their ability to be the mothers they aspired to be, as

well as their potential to have a home. All of the women struggled with violence at some point in their lives. Women described a lifelong struggle with violence and how it has shaped their lives, particularly the impact it has had on their roles as mothers. The three themes of violence history - child abuse, partner abuse and sexual abuse - combine with the women's struggles of motherhood as the chains holding the women back from making positive changes for the sake of their children.

History of Child Abuse. A history of child abuse was defined as women who experienced verbal abuse, physical abuse or neglect from parents or other family members as children. Many women spoke about their childhoods as being a very rough time in their lives. For many of the women, they were raised in broken homes and witnessed violence on a regular basis. In addition, many were victims of violence from a young age. Women suffered abuse not only from parental figures, but also siblings and cousins. One woman's account of being abused:

> Like, I can recall one time when I got in trouble for something I didn't do and I was crying and when I get upset my nose, nostrils flair and um… so she (aunt) took that as a sign of me wanting to get aggressive with her and she punched me in my chest. So hard, literally knocked the wind out of me. I couldn't have been more than 10 years old, shit like that would happen regularly. If I didn't do what she wanted me to do, I had to go to bed with no food, she would leave me with her daughter and her daughter would beat us. Her daughter beat me so badly one time, I ran from her and busted my head on the dresser and then she made me lie and say I fell off the bed and shit, even my cousin that was the same age as me was allowed to hit me, but if I ever did anything back, I would get my ass beat.

Many of the women described volatile relationships with their mothers. Abuse from mothers emerged as the most common type of child abuse among this sample of women. The abuse from their mothers included physical, verbal and neglect. Some women believed that their mothers resented them and did not care for them at all:

> It was…my life was rough, like I had mostly, I was abused. Like abused by my mama, so that's why I think I am the way I am with my kids, like I don't beat my kids.

> I never had a relationship with my mother, we always argued. Argued and I'm a pretty much laidback person and I don't like conflicts or problems, but every time she would pick anything, just to, you know, argue with me. She don't treat the other kids like that, but out of all her nine kids she had, only me she treats like that and if anything I'm the first one to help her, the first one to do this for her, the first one, but I just always felt like my mom never liked me ever since I was little. I always felt like the black sheep out of everybody, the whole family, I never felt wanted.

> Very bad. My mom was, um…into drugs and she actually died from her liver and she lost me and my brothers to CPS (Child Protective Services) and so she was never really a mom, she was there, but she was never really a mom. I never called her mom, my grandmother raised me and she's the one I see as my mom, but she passed away also.

It was common that the participants were left by their mothers for other family members to raise them. It was also reported that because of their mothers, these participants were homeless. Regrettably, for some of the women, their mothers kicked them out of the house if there was no room, if they could not pay rent or if they had an argument. When asked about their relationships with their mothers, women answered:

> The first time I was homeless it was 2008, I got pregnant with my second child, my mom and dad wasn't having it, they sent me to the shelter, I stayed there for two months, maybe three.

> I became homeless because I lost my job and where I was staying (mom's house), I was no longer able to help like pay bills or anything, so I basically couldn't…I had to stay and say you can't live nowhere for free so I couldn't, I had to leave. At that point, I felt like she was basically, how can I say, like pushing me, kicking me when I'm down, like I had lost my job, I just found out I was pregnant and I had nowhere to go, so I basically resented her for that, so we had stopped talking for a while.

Ironically, many women identified with their mothers and their mothers' struggles. For some of the women, they stated they did not blame their mothers for their abuse or neglect. They believed their mothers did the best they could:

> Yeah, smacking and iron cord whipping and um pretty tough stuff. First of all, she did the best she could and we know this now and my dad, as crazy as he was, did the best they could and I figured that out, but it was pretty tough working with her.

Other women made it clear that they would be nothing like their mothers, as this woman stated:

> I tried to change that around for my children and it takes time and it's not going to work overnight, but one things for sure, I'll never be my mom and it's one thing I told myself. I'll never be my mom's daughter you know, it's that's who she was, that's not who I am.

History of Partner Abuse. Unfortunately for these women, the violent cycle continued into adulthood. Partner violence is defined as verbal or physical abuse from a partner. The women stated that they had witnessed violence for most of their lives and it was present in most of their relationships. A majority of the women interviewed had at least one experience of abuse from a partner in their lifetimes. Many of the women reported that they had moved from one violent relationship to the next several times in their lives.

> I mean, did I see abuse? Yes, I saw abuse: my father, my mother; my sister and her husband; my other sister and her husband. I have been married 4 times, 2 times to the same guy and my first um marriage was at 18 and I had abuse there. My second, that one hit me, the first one hit me and broke my eyebrow. And my second was abusive verbally and third and fourth, that is the same husband, the father of the two youngest children, he abused me also, very much mentally, verbally.

> I've had abusive relationships, I had a stillbirth at seventeen due to domestic violence um…after that I will never put up with a man putting their hands on me, um… verbal abuse I've gone through with my ex, but he's never physically hurt me.

In a few cases, women reported that earning more money than their partners was the root cause of the abuse. Women also stated that they were abused during their most vulnerable state, pregnancy:

> To me he felt powerless against me because I was making the income, I had income, I had the house and I was the provider and he wasn't, that's how that affected me as being a woman and because of that action that's why we got into the arguments and the hitting and everything, because he told me he was jealous of me and it wasn't no reason to be jealous, I was there helping you and you were helping me so.
>
> One day we be good or a couple of weeks or that last week or that next month when it was time for me to get paid, that's when everything went crazy, if I didn't do something for him because my thing was God, my kids, my house, and me last, I didn't give any money, I don't pay nothing for him, I don't. You the man, you suppose to do what you're supposed to do and he got mad because I wouldn't buy him a pair of shoes or a pair of pants and I wasn't going to do it because you the man and you know how to work with your hands; you stop working because you thought I was going to take care of you and actually I was taking care of him but I wouldn't put money in his hands, I wouldn't go buy nothing for him.

Another common theme seen in the partner abuse cases was the need for control by the male. Most of the men in the abusive relationships were extremely possessive, which in some cases manifested as the women being forbidden to work; when the men would leave, the women would be locked in their own homes:

> He didn't want me to work; I had to leave my job. He wanted me to be a housewife so I could be able to raise my son. But in reality, he did that because he didn't want me to meet anybody. You know how those possessive men are, they don't want you to be friends with anyone, they don't want you to meet anybody new.
>
> He had locked me in the house and told me to clean up this 'f-in' house or it's going to be a problem. And I felt like, if I didn't do it, why should I clean it up? That's how I felt and he didn't like that, so he locked me in the house and I unlocked myself out and I ran, trying to get away from him and we had one of them big fights, where he bashed my head up against the wall in front of my kids and my friend's kids and dragged me through the house and beat me up in my room, all the way to the closet, like I was a man.

History of Sexual Abuse. Some women living in the shelter not only experienced child abuse and partner abuse, but were also victims of sexual abuse. A history of sexual abuse is defined as women being sexually assaulted at any point in their lives. For many of the women, the sexual abuse started at a young age, by family members. Many of the

women were touched, assaulted or raped by members of their immediate family including fathers, grandfathers, and brothers:

> The rape was by my brother, he was 7 years older than I was. He was a teenager when it happened because I was 8, he was 15, 16, something like that and he asked me like, he would take me to the top of the roof of the house.

Two women reported that their rapes resulted in children, one being a product of incest. Two women speak about their experiences:

> The first incident happened when I had just turned fifteen, my cousin raped me, the second incident happened when I was seventeen, that was supposed to be my dad's step nephew, I mean, nephew and the last incident happened, well the other incident happened when I was eighteen, my first daughter is actually a rape baby.

> Rapes, and my dad sexually assaulted me. My son is from my dad so me and my son grew up together in the same household and when I got pregnant, I had it in '82, so I was fifteen when I had him.

For some of these women, the hardest part of dealing with the sexual abuse was the backlash they received from others when they reported the abuse. Many women reported that their mothers did not believe them or blamed them for the sexual activity. One woman stated:

> I told my mom and she would hit me and say I was lying, but she knew all the time because when I turned thirteen, fourteen, and fifteen when it happened, my mom like she would walk past the room and one day I saw her just stand there and tears coming down her eyes and she didn't say a word. She watched the whole thing and then she didn't let him know that she was watching. She would say that I was enjoying it. But, I wasn't, I really wasn't.

Other women reported sexual abuse as an adult. Some were sexually assaulted by boyfriends or people they knew, whereas others were attacked by strangers while living on the streets. These experiences were described by some of the women below:

> It was one night where I didn't want to be bothered with him, I didn't want to have sex with him and he forced himself and I was telling him to get off of me. I guess he thought I was playing, I was telling him no, stop, you're hurting me and he just kept going.

> I started staying with my friend and her brother and her dad was raping me so I was going from friend to friend so that's how I got raped so many times and sometimes I just ran away and trusted people. I had no choice.
>
> I was raped. I was an old lady already, I don't know what was going on in his head…Well, it was a guy who was crazy and he drugged me and I tried to get out and I was afraid and he would respond to me in a bad way. But I went down. In fact, the rape itself for me it was an assault, it was an assault but it was not something that I could not overcome.

Discussion

The results of the study show the significant influence motherhood plays in the lives of homeless women. Women stated their roles as mothers and the lives of their children were their highest priorities. The main overarching theme that emerged from the data was "breaking the chains," women's attempt to change their lives for the sake of their children. "Breaking the chains" symbolizes a ball and chain holding the women back from becoming the mothers they aspire to be. Each chain represents struggles of the women's pasts that are ultimately preventing them from moving forward in their lives. As their desire to become better mothers was expressed, the barriers holding them back also emerged, including the struggles of motherhood, history of child abuse, history of partner abuse and history of sexual abuse, all of which prevented the women from changing the lives of their children. These hardships of the women's pasts can be seen as a ball and chain, holding them back from being the mothers they aspired to be. Figure 3 depicts how these negative experiences have impeded their futures.

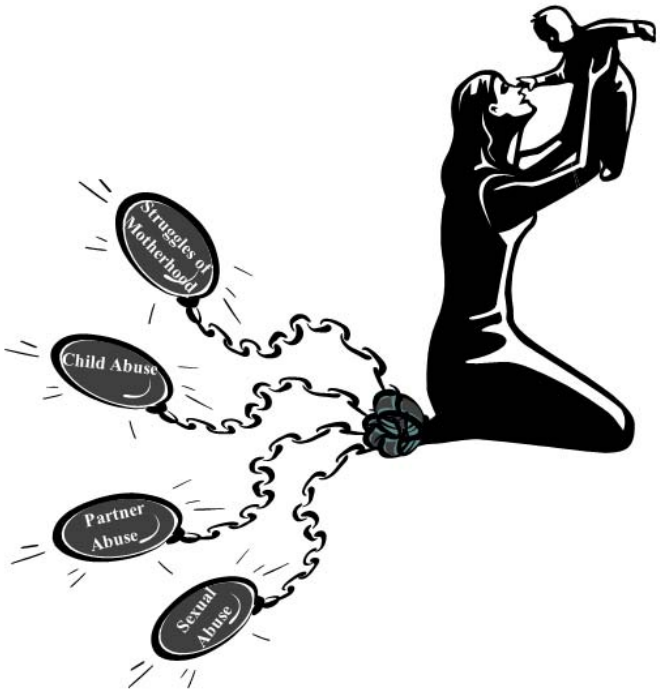

Figure 3: Homeless Women's Attempt to "Break the Chains"

Many of the women discussed the daily struggles of motherhood. Mothers did everything they could in order to keep their families safe and healthy. As women shared their experiences, they expressed the overwhelming feelings of regret and guilt for putting their children through the experience of homelessness, which is consistent with the findings of Haight et al. (2002), who reported homeless women feel a sense of incompetency as parents and feelings of shame. These inept feelings then impact their ability to take care of their children, as well as make changes in their lives. The mental state of the women can lead to a ripple effect, as one may become upset regarding their family's current living situation and become depressed, making it less likely that they will move forward and out of homelessness.

Other homeless women struggled with not having their children physically with them or not having a relationship with their children if they were older. Like the other

struggling mothers, these women expressed guilt and grief, which has been previously reported by Carlson, (2006) and Schen, (2005), as well as feelings of anger and anxiety. Again, these struggles of motherhood can be seen as holding them back from reaching their potential of fully providing for their children, mentally, emotionally and physically. The women must first stabilize their own mental states before they are able to totally care for their children.

All of the struggling mothers were also victims of violence at some point in their lives, which is consistent with the 2010 Report of National Law Center on Homelessness and Poverty stating that up to 100% of homeless women reported abuse at some point in their lives. For many of the women, violence had been present their entire lives. The women's history of child abuse, more specifically abuse from their mothers, has influenced their choices in parenting and lifestyle. There is a strong correlation between one's emotional state as a child and one's overall well-being as an adult (Illouz, 2008). The mother-daughter relationship in particular is considered the most emotionally charged relationship of a parent/child relationship due to its unique sexual identity (O'Reily & Abbey, 2000). A mother for a daughter poses as an identification object for their primary source of love and identity (Gordon, 1998). Therefore, if a mother is mentally incapable of caring for their child or living under harsh conditions, mothering may be marked by feelings of anger, negativity, depression and hostility (Peled, 2011; Richmond & Stocker, 2008). As we saw with the participants, their histories of abuse by their mothers have played a critical role in their abilities to provide for their children. It is paradoxical how their violent pasts, current struggles, and future goals are all centered on

motherhood, thus showing the significance motherhood plays in the overall well-being of the women.

It is also noteworthy to discuss the impact partner abuse plays on the women and their aspirations for better lives for their children. Most women who were victims of partner abuse had partners who had control and power over their daily lives. Women who have lower levels of power have higher rates of violence victimization (Buelna et al., 2009). The women in this study stated that their history of partner abuse was repeated throughout their lives in different relationships; these incidents cannot be considered coincidental. Partner abuse not only affects women physically but mentally as well, causing long-term effects such as fear, depression and fear of victimization (Tutty, 2006), thus leading to repeated abusive relationships. The toll on the women's mental states prevents the women from moving forward with their lives, thereby impeding their abilities to provide for their children.

Abused women are often victims of sexual abuse as well. Victims of abuse are more likely to report male partner control in relationships, fear of partner response to condom negotiation, and partner control over condom use (Raj et al., 2004), which was seen in multiple accounts of women who were sexually assaulted and as a result, conceived a child. Many women who are raped or assaulted feel that it is their fault, or as seen in our interviews were blamed for it. The struggles of sexual abuse again influence the futures of the women and their hopes for new lives for their children, as most victims of sexual abuse have long-term mental effects such as post-traumatic stress disorder (PTSD) (Breiding et al., 2014), again hindering them from being able to provide for their children on their own.

The “chains” of the homeless women - struggles of motherhood, and histories of child abuse, partner abuse and sexual abuse - have all shown to play a key role in the mental states of the women, consequently leading to the women’s inability to change lifestyles for them and their children. The women’s histories of violence have shown long-term effects on the women’s lives and mental states, as most of them have reported feelings of PTSD, depression, and anxiety, both before and after becoming homeless. These long-term effects reveal themselves as difficulties in daily functioning such as child care. For some women, their mental instabilities led to leaving their children for others to raise. These findings are consistent with the data stating that mental health issues in the homeless can lead to negative social circumstances in which they become more withdrawn and have more difficulty with daily functioning (Lilly & Graham-Bermann, 2009). Additionally, violence toward homeless women has the potential to prolong homelessness due to the considerable long-term effects it has on a woman’s mental stability.

The findings of this study have implications for practice, research and policy concerning homeless women and victims of abuse. The high prevalence of violence among homeless women indicates an ongoing need for awareness and more importantly, prevention of violence and abuse toward women and children.

Clinically, the first priority is always the physical health of the victims of abuse, especially when working with the homeless population, who often lack the resources to care for themselves. Once the basic needs have been assessed and injuries have been treated, it is critical to deal with the mental health of the victims. Since the women are both homeless and victims of abuse, they face special circumstances that make them

more vulnerable to repeated abuse. Victims of abuse suffer long-term mental effects which impact their ability to care for themselves and others, while being homeless compounds the problem with a lack of resources and support. Health care professionals need to recognize these risk factors and create realistic goals and treatment for these individuals. When women and children are cared for at hospitals as a result of abuse, long-term counseling and mental health services should be offered to them. Programs should help with self-esteem, empowerment and coping skills. Women should also be referred to programs that provide shelter or transitional housing. Health care providers are also responsible for educating their patients. Women need to be educated about the signs of abuse or molestation. Since acts of abuse and violence tend to repeat themselves, their children are at an increased risk of abuse. Children of homeless families are more likely to witness violence in their lifetimes and are more likely to exhibit frequent aggressive and antisocial behavior, increased fearfulness, higher levels of depression and anxiety, and have a greater acceptance of violence as a means of resolving conflict (Osofsky, 1997). Homeless shelters should offer regular counseling services for all women and children of the shelter, whether or not the women admit to violence in their past. As seen in this study and previous literature (National Law Center on Homelessness and Poverty, 2010), close to 100% of women experiencing homelessness have been in a violent relationship at some point in their lives. Improved mental health services for these women and children could aid in their overall mental states and perhaps help in long-term changes. In addition, women should be educated about non-confrontational resolution strategies when dealing with a power imbalance with their significant other. Many of the women cited making more money than their partner as the root cause of their violent

relationships; thus, by raising awareness of the issue and teaching women that they should never be punished or abused for their accomplishments, perhaps women will be more likely to recognize an abusive partner.

Research is needed in order to address and understand the complexity of violence victimization and its long-term impact on homeless women, specifically homeless mothers. This study sought to understand the health risks of homeless women and the themes of motherhood and violence emerged; with these findings future studies can be designed to focus on the needs of homeless mothers. By focusing on a specific subpopulation in the homeless community, there is better opportunity to design interventions to assist them. Evidenced-based interventions have been shown to improve the lives of individuals experiencing homelessness, more specifically those who experience co-occurring disorders such as mental health issues and substance abuse. For example, motivational enhancement therapy, which includes one or more conversational sessions between consumer and provider where progress is discussed in a non-confrontational manner, has been shown to be beneficial for residents of homeless shelters (Fisk, 2006). For those individuals who have a history of substance abuse, contingency management interventions, which offers rewards for adherence to program rules, have also been shown to be successful in the shelter setting (Schumacher, 2007). By following the framework of these interventions, as suggested, residents of homeless shelters have the potential to make a permanent change in their lives. In addition, it would be beneficial to have homeless mothers describe their needs as victims of abuse and create interventions looking at the differences in mental health of the women based on counseling sessions.

Finally, as policy considerations are developed, it is important to create a responsive health care system. As women are seen in a hospital setting, there should be an established protocol at all hospitals to address such situations, including resources for safe housing. In addition, clinicians and health care providers should receive specialty training on abuse awareness and response. This is consistent with the U.S. Preventative Services Task Force screening recommendations, which state that clinicians should screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (USPSTF, 2013). Awareness and response training for abuse should not be limited to the health field, but should also take place in school systems where teachers and counselors can recognize signs of abuse in children. Furthermore, the social service systems in which homeless shelters fall under, such as the Department of Homeless Services, should design a standard screening protocol for all new residents of a shelter. With such a high prevalence of violence victimization among homeless women and children, it should be standard to address the mental health of these individuals in order to best assist them over a long-term basis. Once the residents have been assessed by the shelter staff, the shelter should offer classes to help with stress and coping skills for both their inception to homelessness and history of abuse/violence. In addition, women should also be offered classes on mothering and childcare. Parent training has been seen to serve a preventative and therapeutic function as the skills learned by the parents improve the parent-child relationship and serve as the cornerstone of the mental health of the children (Kolos, Green, & Crenshaw, 2009). When a family experiences homelessness or any type of crisis in household stability, the main concern is the housing problem. However, it is

equally important to assess the relationship between the parent and children of the household. Homeless parents expend a great amount of their emotional resources in order to meet basic needs of living and as a result the children are left with little attention and do not receive the necessary support they need from their parents. Parenting education classes in a shelter have been shown to be an effective tool to support parents as they struggle to relieve the effects of homelessness on their relationships with their children (Kelly, Buehlman, & Caldwell, 2000). As seen in the participants' statements, abuse and neglect from their mothers were highly prevalent; therefore, many of these women have never had good examples of how mothers should care for their children. Although these women are trying to change their lifestyles and break away from the "chains" of their past, it is difficult to do so without the proper education and training because ultimately they do not know what is right and wrong because of the lack of stability in their childhoods.

CHAPTER 6: Discussion and Conclusions

The purpose of this chapter is to summarize the study that was described in previous chapters. The purpose of this study was to address and understand the factors that influence homeless women's sexual health behaviors related to HIV, based on the theory of gender and power (TGP), a social structural theory based on sexual inequality, gender and power imbalance. The specific aims were to: 1) identify economic, physical and social risk factors for homelessness and HIV as described by homeless women in Miami-Dade County; 2) describe the intersection of homelessness and HIV as presented by a sample of homeless women in Miami-Dade County; and 3) describe the impact homelessness has on women's HIV risk behaviors and needs. The research questions were based on the constructs of TGP, specifically related to the women's economic, physical and social risk factors for homelessness and HIV. Qualitative data were collected and analyzed to address the research questions using semi-structured interviews. The research questions inquired as to how the women became homeless, what the hardest part of being homeless has been, and how being homeless has changed their health. Further questions were asked based on the women's responses. Chapter 1 discussed the background and significance of the problem as well as outlined the purpose and aims of the study. Chapter 2 provided a review of current and relevant literature, while Chapter 3 described the methodology and analysis used in the study. Chapters 4-5 presented the results and themes of the study; this final chapter summarizes the findings and reports how a fuller understanding of the subject was gained through qualitative data collection. Nursing implications are discussed in detail including implications for practice, policy and research. Strengths and limitations of the study are also presented.

Study Summary

The primary purpose of this dissertation was to address factors that influenced homeless women's health behaviors based on the theory of gender and power (TGP). The participants were asked to describe their experiences of being homeless and its impact on their HIV risk behaviors. The interviews were framed by the constructs of the TGP, which included economic risk factors, physical risk factors, and social risk factors

The theoretical framework used in this study was the theory of gender and power (TGP). The TGP describes the multiple social and structural factors that impacted the homeless women and their health risks. The TGP was chosen because of its adaptation by Wingood and DiClemente (2000), which exclusively tailored it to women, identifying poverty, homelessness and a history of abuse as health risk factors for women (Wingood & DiClemente, 2000). According to the theory, three major structures characterize the gendered relationship between men and women: (a) the sexual division of labor, which examines the economic inequities favoring males; (b) the sexual division of power, which examines inequities and abuses of authority and control in relationships and institutions favoring males; and (c) cathexis, which examines social norms and affective attachments. This theory was chosen for the multi-dimensions of the social risk factors and the interactions in which they work together, where previous studies have focused solely on one construct and not the interrelationship of the three. The participants were homeless sheltered women in Miami-Dade County. Participants were recruited from an all-women's shelter. The shelter was chosen as the site of recruitment because of the diversity in the residents of the shelter. Additionally, the shelter had reported their residents to have a history of violence, drug abuse and mental health issues, all risk

factors for HIV among the homeless population. In order to participate in the study, women needed to be residents of the designated homeless shelter, be 18 years or older, speak and read English, and self-report a negative HIV status. Participants were recruited by the principal investigator of the study in the yard of the shelter. A total of 23 women were approached to participate in the study and 78% (18) of those screened were consented and completed the interview. Women stated lack of time and refusal to be audio recorded as reasons for not participating. Two women did not meet eligibility criterion.

Data were collected through semi-structured, in-depth interviews. The interview guide was based on the TGP and was revised during the data collection process based on the responses and themes that emerged. Histories of violence and struggles of motherhood emerged as main themes; resultantly, more questions were asked about their experiences with violence and parenthood. On the other hand, HIV risk behaviors were not common among the sample of women; therefore, only the initial questions were asked. Being that women were not participating in risky sexual behaviors, there was no need to probe further. Interviews were audio recorded and transcribed verbatim for analysis. Data were analyzed through constant comparison method.

Summary of Results

The results of the study were described in Chapters 4 and 5. Chapter 4 outlines the underlying presence of the TGP in the women's perception and experiences of homelessness. The constructs of the TGP - economic, physical and social risk factors - all played a relevant role in the women becoming homeless and their experiences living in

the shelter. Chapter 5 describes the experiences of homeless mothers and how being a mother has impacted their lives both before and after becoming homeless.

In Chapter 4 we see the emerging theme of "making a positive change." "Making a positive change" was described as both a reason for coming to the shelter and a result of living in the shelter. The women of the shelter stated that the shelter provided an opportunity for independence, safety and growth. For most of these women, they chose to live in the shelter for these reasons and the opportunity for a better life. Chapter 4 also described the women's lives in the shelter and the changes that took place. Since living in the shelter, women stated their lives improved with regard to their basic needs, their emotional and mental states, and their sexual health.

Chapter 5 reports on the struggles of homeless women living in a shelter as mothers, which women indicated was the hardest part of being homeless. Women discussed their experiences of motherhood while being homeless and the events that led them to the shelter. The main theme regarding motherhood was "breaking the chains," women wanting to change their lifestyles for the sake of their children. All of the women remarked on the struggles of motherhood and histories of violence in their lifetimes, including child abuse, partner abuse and sexual abuse, as factors that impeded their abilities to provide for their children. The women's current struggles and histories of violence victimization were hindering their abilities to raise their children in a positive environment.

Discussion

The qualitative study design was an appropriate and effective way to address the research questions of this study. The in-depth interviews allowed women to describe their

experiences in full detail, resulting in rich and meaningful data. The semi-structured questionnaire allowed the women to lead the course of the interview. Although there were probes in the interview guide, the women were the creators of the themes that emerged. The meta-themes that emerged from the data were "making a positive change" and "breaking from the chains." The themes are interrelated as they both can be seen in the women's experiences with homelessness and their struggles to become independent, both as women and as mothers.

The theme of "making a positive change" tackled the three constructs of the TGP and revealed how each construct played an integral part in the women's lives both before becoming homeless and after living in a shelter. Many of the women's experiences fell in line with each social risk factor outlined in the TGP. For instance, many of the women had less than a high school education, were victims of violence and suffered from mental illness, all key examples of economical, physical and social risk factors. The three constructs of TGP were seen as the underlying framework for the reason for coming to the shelter as well as the result of shelter living. The examples given by the women illustrate the power differential between men and women and how their roles as women shaped their living situations.

The construct of sexual division of labor addresses the economic inequities women face because of their gender. All participants pointed to their struggles with education and employment as reasons for their housing instability. Most of the women only completed high school or GED certification and all but one were unemployed. A few of the women had criminal backgrounds. As the women discussed their economic hardships, the theme emerged of their choice to come to the shelter for the hope in

"making a positive change." The women were seeking a change in their lives and had a desire for personal growth. As women became residents of the shelter, many of these factors were addressed and for some, resolved. Many of the women completed or were in the process of completing their GED since coming to the shelter. All of the women were also given the resources for employment and job training. These changes seen in the women led to the discovery of the second aspect of the theme, "making a positive change," because of the role the shelter played in the women's lives and more specifically, the impact it had on the women's basic needs and personal growth. Women reported the shelter offered them an opportunity to make changes in their lives that helped them grow as a person, such as education and life skills. Women also reported receiving basic needs such as housing, food and clothing, all of which they felt were not possible on their own or living with family members. There was a clear distinction in the women's choices to come to the shelter, as many of them said it was the only way they could make changes in their lives.

The second construct of the TGP is the sexual division of power, which examines the inequities in authority and control favoring males. The sexual division of power frames the physical risk factors of homeless women. The women all reported a history of mental illness, violence, and some had a history of substance abuse. In terms of their physical risks, women came to the shelter for safety. Many of the women reported coming to the shelter as a result of leaving a violent relationship or environment. Many of the women were victims of rape, partner abuse, and child abuse. The power differential in favor of the male was apparent in these women's experiences as a majority of the violent relationships stemmed from the males demanding control. The shelter was the best option

for the women and their children, as many of them stated they feared for their lives in their previous living situations. As residents of the shelter, women described the improvement in their emotional and mental states due to the support they received while living in the shelter. The shelter provided a sense of stability and relief for the women, feelings the women said they had not had in a long time. Participants also reported the opportunity to see mental health specialists for depression and anxiety, which 100% of the women reported experiencing.

Lastly, the construct of cathexis, which examines the social norms or affective attachments, was seen in the women's desire for independence. Women reported coming to the shelter as a way to gain independence in their life. Many women wanted to live on their own and take control of their financial and living situations; living in a homeless shelter was the only way they could. For most of these women, their living conditions were either uninhabitable or they were living on the couches and floors of friends. Therefore as ironic as it sounds, the homeless shelter was their best option for "making a positive change" in their lives. In regard to the social factors of living in the shelter, there was an evident improvement in the sexual health of the women. Since living in the shelter many of the women claimed to have less or no sex due to the shared quarters, curfews and rules of the shelter. Additionally, since living in the shelter, women were HIV tested regularly, with an average of 2-4 times a year because of the mobile clinic that visited the shelter and the HIV education provided by the shelter.

The second theme reported was "breaking the chains," women's desire to change their lifestyles for the sake of their children. Women reported the most difficult part of living in the shelter was related to motherhood. The four "chains" which the women

described as their main obstacles in providing for their family included struggles of motherhood and past victimization from violence (child abuse, partner abuse and sexual abuse). Each chain has played a key role in the mental states of the women, contributing to the women's inability to change their lifestyles and environments. The women's histories of violence have long-term effects on their lives and mental states. Each "chain" a woman carries from her past adds to her struggle toward independence; therefore, the more "chains" or experiences with violence a woman has had in her past, the more she has to overcome to be the mother she wants to be.

The first "chain," struggles of motherhood, emerged as one of the themes within the overarching theme as being the hardest part of homelessness and living in a shelter for the women. The women stated that they were unable to provide a healthy and safe environment for their children on their own; therefore, their best option was to come to a shelter. By coming to the shelter, women were able to give housing, food and clothing to their children. For many of the women, they stated that for the first time, in a long time, they felt relieved, as their children were safe and well-nourished. Although many of the women were happy and grateful that their children were cared for, at the same time, there was still a feeling of guilt and shame because it was not them who were providing for their children, but the shelter. The women felt a large burden for making their children experience homelessness and even more so because they wanted something better for their children, better than their own childhoods. There was a great sense of regret as the women spoke about coming to the shelter with their children; many of the women reported feelings of depression and anxiety both before and after coming to the shelter due to their concern for their children. Another aspect of the homeless women's

"struggles of motherhood" was the women who were unable to have their children with them while at the shelter. For various reasons, some women did not have their children at the homeless shelter. Some women asked other family members to care for their children until they were able to, some did not have custody, and some were unable to have their children at the shelter because of age limits. Regardless of the reasoning for their absence, the mothers felt guilt and grief for not being able to provide for their children.

In addition to the women's current struggles of motherhood, the women were also dealing with their pasts. All of the women reported experiencing abuse or violence at some point in their lives. For many of the women, they were victims of abuse throughout their lives. The three "chains," child abuse, partner abuse and sexual abuse, are closely related as we saw a frequent occurrence of more than one, if not all, forms of abuse occurring in the women's lives. The women who were abused as children were more likely to be in a relationship where they suffered partner abuse as well as sexual abuse. The experiences of violence not only physically harmed the women at the time of the act, but mentally debilitated the women long-term. Many of the women reported depression, anxiety, and PTSD as a result of the abuse. Women also stated that being abused made them live in fear and not trust others. The women's mental health was greatly impacted by their violent experiences and as a result was hindering their ability to move forward with their lives and provide for their children. As many of these women stated, their experiences with abuse led to their mental health issues, which in turn were also their reasons for unemployment and ultimately homelessness.

Other themes emerged in the interviews, specifically the critical role of social support and lack of trust. Many of the women reported feeling no social support from

friends or family before coming to the shelter, which for many of them was part of their reason for coming to the shelter. Women also reported feeling more support since living in the shelter and as a result they felt better about themselves and their future. The theme of trust also emerged as women said since becoming homeless, they have lost trust in others and often keep to themselves. Some women described always being distant from others as a result of abuse and violence in their past. Although these findings were not seen as main themes of the study, they are important as both have an influence on the women's overall well-being as a result of homelessness.

Implications for Nursing

Implications for Practice. In this study, the findings indicate that homeless women need assistance in many areas. First and foremost, the basic needs and physical health of the women are of the highest priority. Many women reported that before living in the shelter, they were not properly nourished and lived in unsafe environments. Women also expressed not receiving healthcare or a well-women's visit until living in the shelter. Homeless women usually seek care from free clinics or emergency departments. Nurses should assess their patients and speak with them about the last time they received care. One of the best ways to help homeless women is to build a rapport with them and help them feel equal. As we saw in the sample of women interviewed, when asked about their health before living in a shelter, many said it was the last thing on their minds; survival and providing for their children were their top priorities. As nurses work with homeless women in emergency departments and free clinics, it is critical to first make them aware that their health is important and second, to provide resources regarding where they can receive care, such as yearly physicals, well-women visits, mammograms,

and dental visits. It is important that all individuals know that their health is important, no matter their economic status.

In addition to providing care for the physical health of their patients, nurses are also responsible for helping safeguard their lives. One key role of nurses is being the patient's advocate. As an advocate, nurses safeguard the patients' autonomy, act on behalf of the patient, and are the protectors of the patients' rights and self-determination (Baldwin, 2003). As many of the women reported, they were seeking independence and safety. A nurse's duty is to not only advocate for the human rights of the patients we care for in a clinical setting, but also be able to identify a person in need outside the walls of a hospital. One of the most critical roles in nursing is the ability to assess and recognize a woman or child in need. When assessing a person or a situation, it is vital that it occurs before injury or severe risk to health. For instance, we cannot only look for signs of abuse in a clinic or emergency room; very often women arrive to those settings when it has become too late or too severe to handle on their own. As we saw in the stories of the women, the acts of violence had been occurring throughout their lives, and for many of the women it took a serious act of violence, such as a stabbing or broken arm, for them to make a change and move to the shelter. Therefore, it is imperative for nurses to look for clues from women in other places before they are seen in these crisis situations.

As the mothers in our study reported, their main priority was the health of their children; therefore, these women, much like other women in their position, would take their children to the doctor before they themselves would go. It is in settings like these, such as pediatric clinics, that the mothers should be assessed. Nurses should develop a protocol for screening for the well-being of the mothers seen in a pediatric clinic, for if

the mother's health and safety is at risk, so is their children's. A mother's lifestyle predicts the immediate and long-term welfare of their children (McLoyd & Wilson, 1991). Lower levels of parent-reported psychological distress are related to children's lower levels of behavioral problems, and higher adaptive functioning and school achievement. Additionally, in regards to maternal life stress, children had lower levels of behavior problems if their mothers reported higher levels of support (Huntington, Buckner, & Bassuk, 2008). Therefore, the safety and living environment of the family is critical to the health of the children. The living situation of families should always be assessed. The U.S. Preventive Services Task Force recommendations suggest counseling, home visits, including emotional support, education on problem-solving strategies, and parenting support as interventions for abused women (USPSTF, 2013). Nurses should always ask women and children if they feel safe in their homes, because as seen with these participants, there is no common "look" of women who are abused. If a nurse suspects that a woman is in need of a shelter, they should speak with the woman and offer to call a homeless hotline for her. It may be difficult to work through the system for many of these women; therefore, just giving them a phone number may not be enough.

Another practice nurses could implement is the placing of signs or flyers with information about safe places or abuse helplines in common areas for women, such as the bathrooms of parks, supermarkets or salons. Many of the women stated that once they were forced to leave their homes, they had no idea where to go or who could help them. Therefore, if nurses help women find a safe place to go, perhaps more women would seek their help, especially since many of the women are afraid to get law enforcement involved.

Nurses must also care for the emotional and mental states of their patients. Based on the holistic approach of care, nursing focuses on the well-being of the entire person and not just their physical ailments. When working with the homeless community especially, it is critical to assess the mental state of the individual and then help with any mental health issues such as anxiety, depression and PTSD. Many homeless women have reported these disorders as well as low self-esteem and self-worth. With the high rate of victims of abuse among the homeless population, when women and children are cared for as a result of abuse, long-term counseling and mental health services should be offered to them. The optimal strategy would include a multi-faceted care team that could assist with the mental, social and economic needs of the women.

Lastly, it is also important for nurses to care for all individuals equally. Some women described being judged or mistreated in a hospital setting because they were homeless. The women reported being stereotyped as drug addicts. If they went to the hospital complaining of pain or sickness, the nurses and other health care providers assumed they were drug abusers and were there only for prescription drugs. As discussed earlier, one of the best ways a nurse can care for their patients is to build a rapport with them and make them feel worthy of care. Homeless women struggle with their identity in society and self-worth. Many of the women have never felt a sense of belonging, even from their own families and as a result are often mistreated and unfortunately think this is acceptable. Nurses and other healthcare providers should not only treat the women with respect, but also teach them that they are worthy of it from everyone.

Implications for Policy. Results of this study provided an in-depth view of homeless women and the experiences that have impacted their living situation. As

women spoke about their struggles, many women reported lack of education, violence victimization and mental health as the key contributors to their housing instability. Furthermore, women discussed that their biggest struggles since becoming homeless dealt with their pasts and its effect on their future. Policy changes should assist women to make changes in their lifestyles as well as develop violence prevention strategies.

As policymakers make changes in the homeless community, these findings can be useful. Violence victimization and mental illness stood out as the biggest impediments to changing the women's lifestyles; therefore, women who are victims of abuse should be offered mental health counseling, at no cost to the victims. For many of these women, their mental health has never been addressed and as a result the violent acts of their past carry on to affect their futures.

Additionally, as we saw with the women of the study, many of them have been around violence their entire lives and have no idea what a healthy family looks like. The main goal of policy change should be prevention, thereby targeting violence prevention from an early age rather than after an abusive relationship as an adult. Designing an educational program for children to be aware of violence and how to deal with it could help them recognize it as an issue and may ultimately help children of abusive households find support. Programs should also be designed for young men and women, teaching resolution strategies based on respect and non-confrontational tactics. If children are surrounded by violence in their households, as we saw with the women in this study, they do not know how to resolve issues without violence and need to be taught the proper way to communicate with others in a non-confrontational manner.

Another program that can be implemented to help homeless women is a mentor group or homeless navigator system. Assigning homeless women to other women who have been through the same situation could help homeless women with resources, home placement, and could serve as a confidant for the women. These services would benefit the women in multiple ways. For many women, they felt alone and unworthy. If the women were given the chance and provided a person they could trust, perhaps for the first time in their lives they would feel able to make a change in their lives.

Implications for Research. Future research about homeless women is certainly warranted with the dearth of literature regarding the impact of shelter living. The current study focused on women living in an all-women's shelter that provided support beyond the basic needs of the women; further research would be justified in comparing the types of shelters and how they impact the lives of the women. The current shelter provided more than merely a place to sleep; they provided resources for employment and education opportunities, classes on family care and counselors for mental health. Other shelters require their residents to leave the shelter by 6 AM and not return until 5 PM; the only support offered is a place to sleep and a meal to eat. A study comparing the mental health status of the residents of each shelter would decipher if the type of shelter made a difference in the long-term mental health of the women.

This study was cross-sectional, only interviewing the women at one time point in their lives; future studies would benefit from interviewing the women longitudinally to follow their progression through the shelter program and following up with the women once they left the shelter to see the long-term outcomes. The benefit to studying the

women longitudinally is the ability to see where things went wrong in their lives and where intervention would be most advantageous.

Another aspect of research that could be explored is interviewing women who are not homeless, but are at risk for homelessness. The current study provided awareness about the common qualities of women who were homeless; perhaps by interviewing women with these same qualities who are not homeless, it will provide insight to what the differences are in being at risk for homelessness compared to those who are homeless. This type of study would help in the prevention of homelessness.

Lastly, a randomized control trial (RCT) can be designed to see the impact of a "homeless navigator." Studies have shown the positive impact of patient navigators, individuals who are trained and provide personal guidance to patients as they move through the health care system (Campbell, Craig, Eggert, & Bailey-Dorton, 2010; Wilcox & Bruce, 2010). Perhaps if homeless women were given a homeless navigator to guide them through the different services such as housing, healthcare and unemployment, they could make a change in their lives. Using a RCT, we would be able to see if there is a change with a navigator.

As new studies are being designed and interventions are implemented, I would recommend the continued use of the theory of gender and power as the framework of future studies. The TGP provides an approach that allows for multiple factors to attribute to the understanding of a phenomenon.

Limitations

Although this study provided important insights in the understanding of homeless women and their risk factors, there were limitations in study design. The study was

limited in the recruitment of women from a single shelter. The sample of participants from the shelter were diverse in race, ethnicity, age and education level; however, by recruiting from a single shelter, the experiences were limited to this particular shelter, since for many of the women, this was the only shelter in which they had lived. By interviewing women at multiple shelters, it would have provided a better understanding of sheltered living.

In addition, the type of shelter in which the women were recruited was different from the traditional homeless shelter. The women of the shelter received medical care, counseling, assistance with employment and housing, and healthcare for their children. Most shelters do not provide all of these resources, which may have played a role in the women's positive experiences in the homeless shelter. It is important to note the approach of the shelter when discussing the experiences of the women.

Lastly, the original aims of the study were developed around HIV and the preconceived thoughts that homeless women were at an increased risk for HIV. Although other studies found the sexual health of homeless women to be negatively impacted by their housing status, the sample of the women interviewed here did not report an increased risk. For most of the women, they reported safer sex behaviors since living in the shelter. Since living in the shelter, women were being HIV tested on a regular basis which was a fairly new implementation of the shelter's services. The women's experiences changed the direction of the study.

Strengths

The strength in this study lies in the utilization of the qualitative data. The in-depth interviews allowed participants to describe their experiences in their own words

and as a result, they provided rich and detailed information about their experiences of being homeless, living in a shelter, and the daily struggles they encountered. Also, since the interview was semi-structured, it allowed the women of the study to choose the direction, rather than follow a pre-determined guide. The use of the TGP as a conceptual framework is another strength; this allowed the researcher to analyze the roles of multiple risk factors, including economic, physical, and social risk factors, rather than focusing on one specific risk factor.

Another strength of this study was the recognition and change in the aims of the study. As described in the limitations section, the primary aims were based around the women of the shelter being at heightened risk for HIV. Once it was seen that the women were not engaging in risky sexual behaviors and were being HIV tested regularly, the course of the study changed. Questions were still asked of all participants regarding their sexual behaviors; however, once it was seen that HIV risk was not an issue, the aims of the study shifted based on the findings of the interviews. This is one of the biggest strengths of this study and the use of qualitative research. It is critical to note that by using qualitative research, we were able to change the focus of the study based on the accounts of the women; therefore the findings and conclusions of the study were data driven by the participants and not preconceived ideas of the researcher.

Conclusions

Overall the findings of this study suggest that homeless women are trying to make a change in some aspect of their lives. For many of the women, they aspired for independence, safety and personal growth, which extended to their desire for a better life

for their children. This study also showed the significant role sheltered living played in the growth of the women.

As women discussed their experiences, there was a sense of relief and hope expressed throughout the interviews. It is imperative to mention this paradox of shelter living. As many of the women expressed, it was a choice to come to the shelter for a better life and as a result of the shelter, their lives had improved remarkably. Prior to interviewing the women, sheltered living was not thought to be such a great place for living, as described by these women. These findings spoke volumes as to how terrible their lives must have been prior to living in the shelter, for them to feel this way. Most would assume that when you have reached the point of a shelter, you are at the lowest point in your life; however, for these women, the shelter has been their saving grace and place they have come to for resolution.

Women also discussed their family lives and events of their childhood, all of which have played an influential role in their adult life. All of the women had suffered abuse at some point in their lives and as a result many of the women suffer from mental disorders including anxiety and depression. For many of the women who were abused as children, they often were in violent relationships and were abused as adults. The cycle of violence throughout their lives is due to the events never being reconciled. When violent acts are not reconciled, they often reverberate later in life (Cunningham & Baker, 2004).

Additionally, the women reported feeling worthless and a sense of not belonging anywhere. For most of these women, they have felt this way their entire lives. As children they were maltreated and continued to be abused as adults because they lacked self-esteem and self-worth, to the point where they excused violent behaviors toward them.

Many of these women believed they were not worthy of anything and when abused, they believed it was their fault, ultimately because they had never been in a situation where people loved and supported them.

Finally, the women of this study suffered multiple acts of hardship without learning mechanisms of coping. Fundamental coping skills are learned from a functional family. Sigmund Freud posited that humans use coping mechanisms to prevent their ego from feeling inadequate (Freud, 1961). Coping mechanisms allow people to temporarily avoid the effects of stress and maintain their mental equilibrium. When these mechanisms are not used, there can be maladaptive effects leading to a distorted reality and ultimately avoiding personal problems. For many of these women, maladaptation had occurred because of their nontherapeutic coping strategies such as substance abuse, avoidance of conflict and abandonment of social activities.

Since coming to the shelter, the residents have started to address their mental health issues and receive all-around care. Furthermore, women of the shelter are finding an inner strength and sense of empowerment through the shelter program, a feeling very foreign to them. For the first time in many of these women's lives, they feel they are capable of making a positive change and there is a glimmer of hope for their future.

Appendix A: Screener Sheet

Participant ID: ☐ Date: ☐

Age: ☐ ……if <18,

INELIGIBLE

Gender:……..if Male,

INELIGIBLE

☐ Male

☐ Female

Do you Speak and Understand English?.....if NO,

INELIGIBLE

☐ Yes

☐ No

Do you currently live in a Homeless Shelter?..... if NO,

INELIGIBLE

☐ Yes

☐ No

What is your HIV status?.....if Positive,

INELIGIBLE

☐ Positive

☐ Negative

Participant Eligible?

☐ Yes

☐ No

Appendix B: Demographic Form

Participant ID:

Age:

What is your race?

- ☐ White
- ☐ Mixed (interracial)
- ☐ Refusal
- ☐ Black
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Other
- ☐ Hawaiian Native/ Island Pacific
- ☐ Don't Know

What is your Ethnicity?

- ☐ Caucasian
- ☐ Other _____
- ☐ African-American
- ☐ Don't Know
- ☐ Hispanic
- ☐ Refusal
- ☐ Haitian/Caribbean

What country were you born?

How long have you lived here?

What is the Highest Education you have received?

- ☐ No formal schooling
- ☐ Completed high school only
- ☐ Completed less than 4 years
- ☐ More than 12 years of school
- ☐ Completed less than 8 years
- ☐ Finished Associates degree
- ☐ Completed less than 12 years
- ☐ Finished Bachelor's degree
- ☐ Refusal
- ☐ Don't Know

Are you employed?

☐ Yes

☐ No

What is your monthly income?

☐ No monthly income

☐ $1-$200/month

☐ $201-400/month

☐ $401-$600/month

☐ $601-$800/month

☐ $801-$1,000/month

☐ >$1,000/month

☐ Refusal

Do you have health insurance?

☐ Yes

☐ No

If YES, what type?

☐ Private

☐ Medicaid

☐ Medicare

☐ Obamacare

☐ Don't Know

☐ Refused to answer

Do you have children?

☐ Yes

☐ No

If YES, how many and what are the ages

How do you identify yourself?

☐ Heterosexual

☐ Refusal

☐ Lesbian

☐ Bisexual

☐ Transgender

Have you been sexually active in the past 6 months?

☐ Yes

☐ No

How many years have you been homeless?

How many shelters have you lived in, in your lifetime?

Appendix C: Interview Guide:

The following script will guide the in-depth interviews; however all questions will not be asked. Questions will be determined based on participants' responses.

- Homelessness:
    - Can you tell me about how you became homeless?
    - Can you describe to me some life events that you feel put you in this position?
- Economic Risk Factor:
    - Can you describe to me your financial situation before becoming homeless? Did you work? Describe your work? How do you think being a woman affected your opportunities at work?
    - Can you describe your housing situation before you became homeless? Where were you living? What forced you to leave?
    - What do you think was the hardest part in trying to stay in your home? (paying bills, relationships, etc)? Do you think this was an issue because you were a woman? How?
    - Can you tell me about any experiences you have had with the law, with you or others around you? How do you think criminal activity has affected your living situation?
- Physical Risk Factors:
    - Can you talk about some times where you have felt depressed or anxious?
        - Do you think these feelings led to you becoming homeless? Can you tell me about that?

  - Can you talk about some times where you have experienced violence before being homeless? And what about now? Who was involved in these violent acts? How has being a woman affected you in these situations?
  - What have been your experiences with drugs and alcohol before being homeless? How about now? How has alcohol and/or drug use affected your living situation?

- Social Risk Factors:
  - Let's talk about your relationships. Did you feel like you had people that supported you before you were homeless? Who were they and what did they do/not do? Do you feel you have people that support you now? Who are they? What do they do/not do?
  - Can you talk about any experiences you have ever had where you felt alone? How has that affected your living situation?
  - How do you feel about seeing a doctor or going to the hospital? Describe how your experiences have been when going to see a doctor?
  - How do you think it's different for women being homeless to take care of their health?
- Health Behaviors
  - What are some of your major health concerns? Tell me about some health issues you think affect you because you are homeless?
  - Can you tell me about your sexual activity before you were homeless? How about now?

  - Since becoming homeless, tell me about some times where you think you put your health or safety at risk? What led you to these behaviors?
  - What are some things you feel more at risk for, now that you are homeless? How are you dealing with these?

- HIV
  - Can you tell me what you think about HIV?
  - What are your experiences with HIV? (have you known somebody who has it, do people talk about it, etc.)
  - Can you tell me about a time, if any, where you felt pressured into having sex? Having sex without a condom? Having sex for food or money? Do you think being a woman put you in those situations?
  - Have you ever been HIV tested? Do you feel you have support from others around you to get tested?
- Summary:
  - Overall, can you tell me how being homeless has affected you most physically? Emotionally? Socially?
  - Are there any other things you would like to discuss with me?

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