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Article 68

Socio-Emotional Vulnerabilities in Homeless Women: A Qualitative Study

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Abstract

Research documents varied socio-emotional risks predicting and exacerbating homelessness. Many of these risk factors are shared among homeless subpopulations. However, some risk factors are unique to specific homeless populations and these influence the course and treatment of homeless persons in powerful ways. The current study explored 28 homeless women's childhood memories using a grounded-theory approach. Based on the findings, the authors advocate counselors become versed in trauma-informed care as a means of lessening risk, bolstering resilience, and increasing trauma recovery in homeless populations generally and homeless women specifically.

Keywords: homelessness, homeless women, trauma, trauma-informed care

The National Alliance to End Homelessness (2016) estimates that as of January 2015, over 564,000 Americans were surviving outside, residing in an emergency shelter, or living in a temporary housing program. Research documents powerful and varied socio-emotional risks predicting homelessness and exacerbated by it (see Anderson, 2003; Coates & McKenzie-Mohr, 2010; Guarino & Bassuk, 2010; Hamilton, Poza, & Washington, 2011). Trauma features prominently in these risks given its impact on self-efficacy, safety, coping, and interpersonal functioning (Figley & Kiser, 2012; Hamilton et al., 2011; McNaughton, 2008; Tyler & Schmitz, 2013). For example, homeless persons are likely to have mental disorders, substance dependence, and victimization histories (Erford, 2008; Hamilton et al., 2011; National Alliance to End Homelessness, 2016; Tyler & Schmitz, 2013).

Yet these risks differ among specific populations and homeless women's profiles are unique. For example, homeless women are typically younger than homeless men and somewhat less likely to have been incarcerated or have substance abuse histories (Chambers et al., 2014). They also are more likely than homeless men to report past sexual or physical trauma, such as childhood abuse and neglect, as well as ongoing trauma, including domestic violence and/or other community violence (American College of Obstetricians and Gynecologists, 2013; Chambers et al., 2014). The National Center on Family Homelessness at the American Institutes for Research (2013) found female veterans are 2 to 4 times as likely to be homeless than women who are not veterans. These data also found female veterans are likely to be exposed to trauma both before and during military service, and 23% have children under the age of 18.

Perhaps one of the greatest differences between homeless women and men is the number of homeless women who have children in their custody (American College of Obstetricians and Gynecologists, 2013). Indeed, some argue that women are underestimated among the homeless since families represent 34% of this population, and women lead an overwhelming 84% of these families (American College of Obstetricians and Gynecologists, 2013).

Twenty-eight homeless women living in a homeless shelter participated in the current study. The research examined themes of parental physical and empathic absences through grounded theory analysis. Grounded theory emphasizes data-driven hypotheses and theories versus hypothetical- and theoretical-driven data collection (Kolb, 2012; Strauss & Corbin, 1990). The resulting work highlights the ways parental absences contributed to this group's vulnerabilities and recommends trauma-focused approaches as best practice models for counselors intervening with homeless women.

Method

Participants

Thirty-three women living in one of two homeless shelters in a large, urban, southeastern city volunteered to participate in the study. Twenty-eight women were included in the final data analysis; fourteen from each of the two shelters. Eighteen of the 28 (64.29%) women were from rural southern areas. Six (21.43%) were from northern urban areas and four (14.29%) were from southern urban areas. Participants ranged in age from 20 to 61 years (mean age = 35.5 years). Fourteen (50%) participants identified as African American. Two (7.14%) identified as bi-racial; the remaining 12 (42.86%)

identified as European American. Five of the 33 (15.15%) participants were excluded from the final analysis. Three did not attend the their one-on-one interview. One participant was dropped from the study because of discrepancies in her interview and information provided by the homeless shelter. One participant withdrew her data.

Procedures

The research team consisted of two primary researchers, one of whom co-authored this paper, and three undergraduate research assistants; each member of the team was female. The primary researchers visited homeless shelters where women were living and talked briefly about the study. The women were given written information about the study procedures, a list of interview questions, and the study's informed consent. Women were able to opt to participate in the study at that time or to contact the researchers later.

Each of the one-on-one interviews was held in the shelters where women were living and was led by one of the five research team members. Interviewers used a protocol loosely modeled after *A Family History Questionnaire* (Allee, 1978; see Appendix). This questionnaire has been utilized in several previous studies examining individuals' memories (e.g., Carstensen, Fung, & Charles, 2003; Carstensen et al., 2011). The questionnaire's open-ended prompts were designed to elicit autobiographical information about family, early childhood, neighborhood, and friends.

Interviews were audiotaped and transcribed verbatim by research team members. Participants reviewed their transcripts and endorsed that they accurately reflected their experiences. Only one of the 28 participants requested clarification of one of her responses. Her clarification was audiotaped, transcribed verbatim, and included in the final transcript.

Analysis

Coding procedures followed systematic grounded theory procedures (Kolb, 2012; Strauss & Corbin, 1990). Data collection and analyses were simultaneous. This allowed ongoing comparisons of the women's memories as well as the codes researchers developed to organize them. These procedures also allowed for a shift in the research question and purpose.

In the initial, open coding stage, each of the five research team members independently conducted a line-by-line examination of the transcripts to identify resonant terms and phrases. After the independent coding, researchers began organizing data by connecting and comparing independent observations to create collective codes and concepts. The subsequent axial codes focused on memories of events during childhood and particularly those concerning caregivers' roles in those events.

Thus the original research focus on understanding patterns in the women's memories about childhood relationships and environments was revised to examine why these women were at particular risk for homelessness and, furthermore, continued homelessness. The women's memories about their caregivers and events, emphasizing how these caregivers were—or were not—providing care, featured prominently. Consequently, caregiver absences were selected for study and researchers revisited transcripts for these themes. From this, five codes emerged across two themes. Caregiver physical absences included the codes *father absences in two-parent homes*, *mother*

absences in single-mother homes, and *chronic caregiver absences*. Caregiver empathic absences included codes labeled *negating safety and trust needs* and *lack of supportive connection*.

Finally, throughout the analysis processes, persons not vested in the research or its publication were asked by the research team to review transcripts as well as examine the research team's summaries and examples of the selected themes and codes. These informal auditing processes were invited based on both grounded theory best practices and on the belief they could provide rich opportunities for better understanding the participants' perspectives and experiences.

Results

For the purposes of this study, caregivers were defined as custodial parents and/or guardians from the time of the women's birth until they were 15-years-old. Researchers verified participants' reported caregivers by matching reports with the homeless shelter's intake questionnaire. This was completed for 22 (78.57%) of the women. Six (21.43%) women had incomplete or missing information on their intake forms. In these instances, the women's reports were assumed accurate based on shelter staff recommendations.

Eleven of the 28 (39.29%) participants reported living with both of their parents. Eleven of the 28 (39.29%) women reported living in single-mother homes during childhood. Five (17.86%) women identified their maternal grandmothers as their primary caregivers. One woman was raised in foster care. As noted above, researchers selected to examine five codes categorized into themes of caregivers' physical and empathic absences. Detailed information about these findings follows.

Caregiver Physical Absences

Caregiver physical absences were coded when participants recalled a custodial caregiver absence for at least 3 months, not due to work or planned travel. Researchers did not code this information for non-custodial parents because the amount of information and ability to verify information about these parents varied greatly. Information about each of the caregiver physical absence codes (*father absences in two-parent homes*, *mother absences in single-mother homes*, and *chronic caregiver absences*) is below.

Father absences in two-parent homes. Of the 11 (39.29%) women who lived with both their mothers and fathers during childhood, five (17.86%) reported memories of periodic or permanent paternal physical absences. Interestingly, none of the women living in two-parent homes cited instances of maternal absences. Participants attributed these absences to substance use, incarceration, relationship dissolution, or some combination of these factors. Four of the five women attributed their fathers' absence to substance abuse. Additionally, three of these four participants added their fathers' substance use led to the end of their parents' relationship. Two of the four in this group said substance use led to their fathers' incarcerations. Another of the five said her father was absent due to incarceration, but she did not recall why he was sentenced.

Three of the five women described seeing their fathers on a "consistently inconsistent" basis. One said, "My mom was more of a caretaker and my dad was like carefree; he wasn't home that much." Another reported, "I didn't know when daddy'd be

back or not. It was a good surprise when he was home and not much of one when he wasn't." Two of these five participants completely lost contact with their fathers. One lost contact after her parents' relationship ended. She reported, "I knew Mama just wanted to get away and I knew we wouldn't never go back. That meant we wouldn't see Daddy and I haven't since I was eight." Another lost contact after her father was imprisoned. She noted, "My father? Who knows? Some people say he died. I don't think he die, though. I think he just taking his time to come see me."

Mother absences in single-mother homes. Maternal presence was more common in the women's lives than paternal presence. Twenty-two of the 28 (78.57%) women lived with their mother at some point during childhood, 11 (39.29%) in two-parent homes and 11 (39.29%) with single-mothers. Maternal physical absences arose only in the context of single-mother homes. Of the 11 women living in single-mother homes, four (36.36%) reported maternal absences. During these absences, two lived in foster care and two alternated between their maternal grandmothers' homes and foster care.

Just as contributors to men and women's homelessness differ, so did contributors to maternal versus paternal absences (Chambers et al., 2014). For example, financial hardship due to romantic break-ups figured into two of the four mothers' absences. One participant recalled, "the person my mama was dating left us all by ourselves. My mama was stuck and working all the time and not making nothing. She couldn't take care of me." Another cited financial hardship due to chronic illness as a reason for her mother's periodic absences. She noted, "My mother was sick sometimes and she would have to go to the inclytorum [sic], so I wasn't with her all the time and money was hard." In contrast, only one woman cited substance abuse and incarceration as contributing to her mother's absence. She recalled:

> My mother was a drinker. She did drugs, so at the end of the day we go get high together. In the beginning, when I was younger, we didn't do too much of nothing because she wasn't hardly ever there. Then she spent some time in prison, so we wasn't together all that much then, either.

Finally, one participant attributed time away from her mother to her father's murder. She witnessed this when she was 6-years-old. Her father was picking her up from her mother's home and was murdered at the door. Shortly after, she was placed in foster care. Her mother regained custody 9 months later.

Chronic caregiver absences. Six of the 28 (21.43%) women did not live with either their mothers or fathers during childhood. Four of the six had contact with their mothers; two did not. Two of the six had contact with their fathers; four did not. When mothers and fathers were absent, grandmothers largely filled in as caregivers. Five women identified their maternal grandmothers as their primary caregivers during childhood. One participant was raised in foster care. There were no reported physical absences when grandmothers served as primary caregivers. The quotes below represent sentiments shared by several of the participants raised by grandmothers.

> My mama was my grandmother. She raised me up. She was a strong, brown, Christian woman. She raised so many of us. Almost all her grandchildren she was a mama to. She worked for the government for a while, I think, too. I think she's back up North now. I think she was from there. So strong. Such a fine mama.

> My favorite were my grandparents. They were very good to me. They were very, very, very good to me. I didn't get everything I wanted, but if it was in reason, I got it. I was a spoiled grandchild for sure.

Caregiver Empathic Absences

In addition to caregivers' physical absences, there was ample evidence of the codes in caregivers' empathic absences. Twenty-two of the 28 (78.57%) women cited examples of their caregivers' inattention to their physical or emotional needs. Although both mothers' and fathers' empathic absences were coded, mothers' behaviors featured more prominently here, perhaps due to their overall greater presence in the women's lives. Likewise, there were instances of empathic absences reported by women whose grandmothers served as primary caregivers. This theme and its corresponding codes were powerful reminders that caregiver physical presence did not equate caregiver emotional presence. Findings related to each of the three codes in this theme (*negating safety and trust needs* and *lack of supportive connection*) are below.

Negating safety and trust needs. Twenty of the 22 (90.1%) women who recalled an empathic absence noted times when their caregivers' negated, discounted or violated their needs for safety and trust. This code represented exposure to domestic violence and physical abuse, as well as inattention to the women's physical care as it pertained to health, food, and shelter.

Twelve of the 22 (54.55%) women reported childhood exposure to domestic violence. One woman remembered "at 13 I was sent away from home to be protected from my dad because my dad was abusive. Nobody wanted him to hurt me. I got to come back, though, when he went on." Eight of these 12 (66.67%) reported physical or sexual abuse. One participant recalled her mother's break-up as the start of her experience with physical abuse. The quotes below detail some of the participants' perspectives.

> My mom used to beat me and I didn't understand why she beat me. She used to take a lot of stuff out on me. I look a lot like my mom. I assumed she did it because my dad was mean to her and so she was mean to us – not all of us, just mainly me.

> My daddy did incest to me. My daddy was a sick man because his mama was a sick woman and her daddy. It was an incest thing, you know, something that's passed on through the generation. I believe that's why he used to do that to me.

Ten of the 22 (45.45%) women recalled being sick or hurt and not receiving care for their illnesses or injuries. Similarly, seven of the 22 (31.81%) women cited events where their physical limitations were discounted. See the following example from one participant.

> I don't think he would realize what he was doing in this, but I had bronchial asthma. I was allergic to cats and dogs and birds and feathers and fur and everything. . . . Daddy would bring me a puppy or something when he came to visit and I'd play with it as much as I could, you know. . . . I would be so sick.

Ten of the 22 (45.45%) women noted instances where they did not have enough food and five of the 22 (22.73%) recalled instances of homelessness. The quotes below represent two participants' experiences.

> My mama, she had things for herself, but she didn't share them. I had a selfish mom. I can say that. She's still selfish. We was so hungry when we was little, so hungry. When we would get something, we would have to hide it from mama cause she would say, "how am I gonna protect you if I am weak from hunger?"
>
> I remember when we lived in a nice home, eating out of nice dishes. Mama had a really good job. Then came the real bad times when we had to live in the projects and stuff. Mama lived paycheck to paycheck trying to make ends meet. Sometimes we had food. Sometimes we didn't. One time we all of us lived in a van. It wasn't easy.

Lack of supportive connection. Fifteen of the 22 (68.18%) women described feeling disconnected or unsupported by their caregivers. Supportive connections offer empathy, responsiveness, and empowerment (Hopper, Bassuk, & Olivet, 2010; McKenzie-Mohr, Coates, & McLeod, 2012). Yet these characteristics often seemed absent when their presence was most critical.

For example, 10 of the 15 (66.67%) women remembered when their caregivers did not empathize with their feelings or supportively respond to their most difficult experiences. One of the ten women recalled when her mother blamed her for being raped by her father and subsequently sent her away. Her description of this follows.

> My father raped me when I was 13 and my mom didn't understand it. I told her the next day and a couple of days later she sent me to a girls' school. . . . I had a sister one year older and he been molesting her, too. Only I didn't know about it then. My mom blamed her and she blamed me, too, for the way daddy was.

Nine of the 15 (60%) women described being "unknown" or "disconnected" from their parents during childhood. Often the lack of support and disconnection emerged from scarce communication and love expressions. One woman summed up her relationship with her father, "I mean, I know of my father, but I never had a relationship with my father." The following quotes provide further examples of memories with this code.

> My mama was from a dysfunctional family, pretty much just welfare, dysfunction, broken down families, single parents, ghetto neighborhoods. So I had no choice but to go with the flow. I was a child living under my mama's roof and I was lucky to do that, she said. She didn't say much else.
>
> Well, I can say I love my mom and dad. But coming up it wasn't always love in the home. And, uh, at the age of a – when I was small I remember, uh, mostly we just fend for ourselves cause my parents wasn't home all the time and my mother was trying to work where she was, make sure we had stuff.
>
> My grandmother was strict. She wouldn't let us go outside and play and stuff like that. She didn't let me out very often, but she didn't talk to me or let me sit in the light either. She was mean. I don't guess she liked me.

In other instances, the lack of supportive connection was about the mothers' inappropriate attempts to connect. For example, four of the 15 (26.67%) women providing examples of a lack of supportive connection remembered their mothers'

invitations to use drugs with them as the first time their mothers had ever reached out to them.

Discussion

Caregiver physical and empathic absences contribute to understanding why some women are at particular risk for homelessness, as well as why they are likely to be at continued risk without relevant and targeted care. The trajectory of trauma can be one of devastation to the individual's sense of control, personal safety, emotional self-regulation, relational competence, and coping adequacy. Consequently, trauma and the chronic stressors that contribute to it are pathways to homelessness (McNaughton, 2008). Importantly, the absences reported here provide insight for building and implementing best practices for counselors and those in counseling-related fields serving such populations.

The following discussion examines the limitations to the present study and suggests additional avenues for understanding the experiences contributing to women's homelessness. The section ends with a call for counselors to become versed in trauma-informed approaches and to implement them when working with women finding their way out of homelessness.

Limitations to the Present Study

Only limited attempts at verifying the women's memories were available. Researchers compared written and anecdotal data provided by homeless shelter staff with the women's accounts, but these data were often missing or incomplete. Except for the instance noted in the participants' section, when data were available, the women's memories were consistent that data. Balancing this with the recognition of the inherent challenges of examining the lives of people without homes, the researchers made a purposeful effort to accept the women's memories as truth even when there was no formal documentation of them.

Another study limitation focuses on the assumption that the absences the women experienced were traumatic or stressful. The women were not asked to recall traumatic experiences or their current views of particular experiences. They were simply asked to recall and describe experiences related to childhood and family. Diverse family structures, such as single parenting and parenting provided by caregivers other than biological parents, do not pose risks in and of themselves (Erford, 2008). However, inconsistency within these structures likely does pose risks through stressed attachments. This study's findings certainly reflect those vulnerabilities. The psychobiological consequences of childhood trauma and chronic stress in childhood are well documented (Ehlert, 2013; Grothaus, Lorelle, Anderson, & Knight, 2011; McLaughlin, Conron, Koenen, & Gilman, 2010). Accordingly, the assumptions that lead to labeling the women's experiences as stressful and/or traumatic appear warranted.

Implications for Counselors: Trauma-Informed Care

Based on findings discussed in the literature review concerning the risk factors for homelessness, as well as those documented in the current study, homeless women likely require different types of supports than homeless men to effectively move out of

homelessness. Namely, these supports should emphasize recognizing the specific role of trauma and chronic stress in leading to and sustaining women's homelessness.

Yet services addressing the role and side effects of trauma in homelessness are few and far between (Chambers et al., 2014; Hodgson, Shelton, & van den Bree, 2014). In their place are uniform approaches stressing rehabilitative strategies focused on housing, education, employment, and life skill development (Coates & McKenzie-Mohr, 2010; Guarino & Bassuk, 2010; Hopper et al., 2010; McKenzie-Mohr et al., 2012; Steele & Malchiodi, 2012). These approaches disregard and/or minimize the complexities, causes, residue, and connection needs of homeless persons and families (Webber, Mascari, Dubi, & Gentry, 2006). Furthermore, these services typically fail to adequately contextualize the sociopolitical influences on issues related to homelessness or the communal responsibilities counseling professionals have to these issues. Thus, homelessness, as opposed to trauma, is the central target for therapies and services. The women's narratives in this study highlight the need for effective interventions geared toward alleviating trauma for resolving homelessness. Such interventions must target past and current vulnerabilities leading to and sustaining homelessness.

Trauma-specific services address the estrangement from others and the disconnections described by so many of the women in the study. Counselors who are trauma-informed and who implement trauma-specific interventions offer empathy, responsiveness, empowerment, safety, and bridges to interpersonal mastery, as well as practical and comprehensive community resources (Constantine, Hage, Kindaichi, & Bryant, 2007; Ferguson, 2009; Hopper et al., 2010; McKenzie-Mohr et al., 2012). These elements were consistently absent for the homeless women interviewed in this study.

Two approaches to trauma-informed care. Approaches considered to be trauma-informed are fundamentally those with "a philosophical/cultural stance that integrates awareness and understanding of trauma" (Hopper et al., 2010, p. 81). The foundation of trauma-informed care supports the intentional delivery of trauma-specific services targeted at decreasing trauma symptomology while increasing trauma recovery (Steele & Malchiodi, 2012).

Although many programs serve the homeless population, few intervene with systematic and evidence-based approaches with a core focus on long-term trauma recovery (Grothaus et al., 2011; McKenzie-Mohr et al., 2012). Thus, trauma-informed care is a new and necessary paradigm for homeless services and contains widely accepted principles across definitions. These principles are trauma awareness; emphasis on safety; opportunities to rebuild control; and a strength-based approach (Guarino & Bassuk, 2010; Hopper et al., 2010; McKenzie-Mohr et al., 2012; Steele & Malchiodi, 2012). Psychological First Aid (PFA; The National Child Traumatic Stress Network, 2015) and narrative reconstruction are two trauma-informed care models counselors might utilize.

Psychological First Aid. PFA is essentially a culturally responsive, cognitive-behavioral approach grounded *in trauma-informed* principles (The National Child Traumatic Stress Network, 2015). Used with schools, community faith agencies, Medical Reserve Corps, and those experiencing homelessness, PFA emphasizes the provision of safety and comfort; education about psychological reactions to traumatic experiences; empowerment around resilience-based present and future choices; and the integration of community service linkages. PFA also builds social connections for support and intervention for developmental issues, anger management, sleep difficulty, and co-

occurring mental health and substance abuse complexities. In these ways, PFA provides resources for bridging the isolation, stigmatization, and disconnections apparent in the women's narratives in the currently described study (Brymer et al., 2006).

Narrative reconstruction. Narrative reconstruction provides a second clinical model for trauma-informed care. Although narrative reconstruction approaches pervade contemporary models of grief recovery, they are often unknown to counselors (Flesner, 2013; Ober, Granello, & Wheaton, 2012). This constructivist model is built upon meaning-making wherein the personal narrative evolves within a social context and contains metaphors and themes that give autobiographical coherence and identity to the individual, family, or organizational system (Bragin, 2010; Figley & Kiser, 2012; Neimeyer, 2009; Rubin, Malkinson, & Witzum, 2011; Saul, 2013). Counseling relationships can provide the experiential base from which a resilient narrative thrives and serves as a model of safety, consistency, stability, and empowerment.

Further Research

The current work focused on homeless women's memories of their caregivers. Future work might examine how non-custodial caregivers factor into mediating or contributing to stressors and trauma. For example, *trauma-informed care* advocates a holistic and community approach toward addressing trauma. It may be that for some women, peers, schools, religious organizations, and /or other community sources provide alternative and compensatory supports lessoning the influence of risks associated with homelessness. Unfortunately, in this study, the memories cited about these types of potential supports tended to further highlight disconnecting experiences. However, finding women who have similar childhood experiences to those in the study, yet who are not homeless could highlight ways to optimize these potential resources.

Conclusions

The psychosocial reintegration of the homeless and traumatized person or family necessitates community development efforts that educate the broader society to ways of understanding and valuing these populations into the whole. This means that counselors are called upon to act as change agents who assist traumatized persons in healing as they achieve mutual gains in and with a larger community that holds them in respectful regard. Bragin (2010) eloquently illustrated this concept with combat veterans when she wrote "perhaps not only the veteran, but also the family, community and the body politic can begin to work toward transforming the future" (p. 325). Perhaps counselors and women like those who participated in this study can co-construct a shared narrative that binds the traumatic past with the healing connections of trauma-informed care. Such an approach offers hope to the many individuals, families, and communities sharing the experiences and effects of homelessness.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://www.counseling.org/knowledge-center/vistas

Appendix
Interview Protocol

SECTION A: FAMILY

Tell me about your family.

1. How would you describe your mom and dad? What is/was your relationship with them like?
2. Tell me about your grandparents? Do you remember any stories about them?
3. Do you have brothers and sisters? If so, what is/was your relationship with them like?
4. Do any family celebrations or gatherings stand out in your mind? If so, can you tell me about them?

SECTION B: NEIGHBORHOOD

1. What was your childhood home like?
2. Was your family different from your neighbors in any way? If so, in what ways?
3. Who were your friends as a child? What were they like?
4. What kinds of things did you do with them?

SECTION C: SCHOOL

1. Describe the school(s) you attended.
2. Were your classmates from the same background as you? How were they different?
3. What subjects were your favorites?

SECTION D: INTIMACY

1. Do you date or are you married?
2. Who was your first boyfriend (girlfriend)?
3. What was he/she like?
4. What qualities would you like in a partner or spouse?

SECTION E: CHILDREN

1. Do you have children?
2. How many children do you have and what are their ages?
3. What are your hopes for them?

SECTION F: OTHER

1. When you were a child, what did you daydream about becoming when you grew up?
2. Did you have any favorite stories as a child?
3. What were your happiest times as a child?
4. What were your saddest times?
5. What would you most like people to know about you?