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Homeless women have few sources of social support but often interact with service providers to obtain or maintain health enhancing and health sustaining services and resources. Little is known about the quality of service encounters from the perspective of homeless women or if homeless women consider service providers as a source of social support.

In-depth semistructured interviews were conducted with 15 homeless women to gain a better understanding of the experience of interacting with service providers from their perspective. Using a phenomenological method, 160 significant statements were extracted from participant transcripts; more positive than negative interactions were reported. Significant statements were then condensed into analytic poems in the process of crystallization to afford a deeper understanding of the phenomenon of the service encounter. Significant statements and their formulated meanings were compared within and between transcripts.

The 10 themes that emerged fall along a dehumanizing / humanizing continuum primarily separated by the power participants experienced in the interaction and the trust they felt in the service provider. The largest theme "cared for" was then analyzed separately and the experiences of care were found to be commensurate with widely recognized sub-categories of received social support.

Ways to optimize homeless women's experience of humanization within the service encounter are suggested. Also, implications for the consideration of social support within the realm of service provision for both researchers and service providers are offered.

UNDERSTANDING THE EXPERIENCE OF INTERACTING WITH SERVICE

PROVIDERS FROM THE PERSPECTIVE OF HOMELESS WOMEN:

A PHENOMENOLOGICAL STUDY

by

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INTRODUCTION AND LITERATURE REVIEW

Overview

Nationally, the prevalence of homelessness is increasing. Over the past 3 years there has been a substantial increase in the number of families experiencing homelessness; the majority of these families are single women with a child or children (United States Department of Housing and Urban Development [HUD], 2011). In North Carolina, both the numbers of persons experiencing homelessness and families experiencing homelessness is increasing as well (North Carolina Coalition to End Homelessness [NCCEH], 2011). Women represent an increasing percentage and are among the fastest growing sub-population of homeless persons (HUD, 2011), warranting research consideration.

Service providers are gate keepers to health enhancing and health sustaining services and resources for homeless persons. However, negative interactions with service providers have left some service recipients feeling dejected (Weiss, 1973) and have resulted in some homeless persons rejecting services in efforts to maintain self-respect (Hoffman & Coffey, 2008). Understanding interactions between service providers and homeless women may enhance services and facilitate service uptake. Connection to

appropriate and necessary services may, for some women, be the path to homelessness resolution.

In an effort to enhance services to homeless women, I studied interactions between service providers and homeless women. I conducted a qualitative study of service provider / client interactions, from the perspective of homeless women, to answer the question "What are homeless women's experiences of interactions with service providers?" with the goal of identifying supportive interactions enacted by service providers in their interactions with homeless women. It is recognized that homelessness is sometimes cyclical (i.e., people move in and out of homelessness) and there are varying descriptions of homelessness (e.g., "doubling up", "couch surfing"). The study included women who were experiencing homelessness as defined by the U.S. Department of Housing and Urban Development (HUD):

> An individual who lacks a fixed, regular, and adequate nighttime residence; and an individual who has a primary nighttime residence that is –
> A. a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
> B. an institution that provides a temporary residence for individuals intended to be institutionalized; or
> C. a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Literature Review

Interactions with service providers can be conceptualized as social support. In an early study examining service provider relationships, Weiss (1973) remarked, "It is widely recognized that many of those who call on physicians for help are troubled by

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socially generated distress more than by physical ailments, and in need of support and guidance as much as they are in need of physical therapies" (p. 325). Cobb (1976) iterated this sentiment in describing social support in medicine as the "deferential manner of the intern" or "the tender care of nurses" rather than the mending of a broken leg (p. 301). Since that time, social support has been defined and differentiated into multiple constructs. Many elements of service provider / client interactions may be construed as social support within the constructs described by Barrera (1986) (Barrera's work is described in more detail in the following section). However, this conceptualization of service providers as providers of support may be dependent upon the nature of the service provided, the nature of the interaction, or the service recipient. In the context of homelessness, "service providers" may include persons and provisions not otherwise considered within the service provision realm. Also, a service provider interaction may be perceived as negative from the perspective of the recipient, even in cases where the services being sought were secured. Thus, although service provider interactions may be construed within the constructs of social support, it remains unclear if homeless women share this perception and if this perception is mutable based on the overall perception of the interaction as positive or negative.

The literature on social support and homeless women is replete with descriptions of sources of social support and intervention studies with social support as an independent variable and a health outcome as a dependent variable, however there is a dearth of studies that examine social support in the context of the homeless woman client/service provider interactions. To better understand the concept of social support

and how it will inform the proposed study, a brief literature review of classifications of

social support, received support (a sub-type of social support) and health, and homeless

persons and service provider relationships is provided. This section also includes a

concise description of the development of my interest in and previous work with

homeless persons relevant to social support and service providers and related findings

from a related pilot study.

Classifications of Social Support

In his classical work on relationships, Weiss (1974) posited that different types of

social relationships provided varied *provisions*, meaning different relationship types (e.g.,

spouse, friend, professional) meet different individual needs. In his analysis, Weiss

(1974) proposed a framework for understanding the benefits of relationships comprised

of six distinct categories or "relational provisions" that included "the obtaining of

guidance…in stressful situations" suggesting this provision would most likely be met by

an "authoritative figure who can furnish them [stressed individuals] with emotional

support and assist them in formulating and sustaining a line of action" (p. 24). Weiss'

work, and the contributions of other researchers at the time (see for instance Cassel

(1976) and Cobb (1976)) gave rise to the constructs of social support and illustrated how

social support influences health.

As social support research expanded, it became necessary to establish common

definitions and measurement techniques. Through reviewing the social support literature,

including his own work, Barrera (1986) defined three distinct types of social support:

social embeddedness (i.e., social integration within a social network), *perceived social*

support (i.e., perception of availability of resources in case of need), and *enacted support* (i.e., received support based on supportive behavioral actions of others) and demonstrated with previous correlation studies, that the three were independent constructs.

Enacted support (also known as and here forward referred to as "received support") refers to observable supportive behaviors and has been further categorized by both House (1981) and Barrera and Ainlay (1983). Each used different terminology in describing four sub-types of received support; both are widely referenced in the literature. House (1981) described received support utilizing the subtypes of: *emotional*, *appraisal, informational,* and *instrumental* (see Table 1). Barrera and Ainlay (1983) developed a scale to measure received support, the Inventory of Socially Supportive Behaviors (ISSB), with four sub-types of: *directive guidance*, *non-directive support*, *positive social interaction*, and *tangible assistance* (see Table 2). Although the sub-types vary by name, the behaviors associated with received social support are captured in both groupings.

Barrera (1986) noted that received support is most likely evident in times of hardship and is, "…suitable for gauging the responsiveness of others in rendering assistance when subjects are confronted with stress" (p. 471). Issues related to the measurement of received support have been noted as this construct is typically assessed with retrospective self-reports of having received support thus could be considered "perceived-received" support (Barrera, 1986, p. 417). Barrera noted observations may enhance the validity of interview or survey self-report received social support measures.

Received Support, Homeless Persons, and Health

Researchers have utilized all three categories of social support in studies examining homeless persons and health outcomes; however studies examining social networks appear in the literature more frequently. Few studies have focused on perceived and/or received support with homeless persons and those that did were quantitative utilizing non-validated measures. For instance, Nyamathi, Bennett, Leake, and Chen (1995) used a scale initially developed to measure social support in men with AIDS to examine received social support in homeless women. The original scale developers, Zich and Temoshok (1987), reported Alpha coefficients of .64 to .89; in their modified version of the scale, Nyamathi et al., (1995) did not report an Alpha coefficient, nor did they relate individual scale items back to widely recognized sub-scale categories. However, their findings included sources of received support and indicated that professionals were more important than family members for obtaining advice, explanations, and in facilitating change. In a study examining both perceived and received support, Hwang, et al., (2009) found homeless individuals to have high levels of perceived support, which was related to higher levels of both mental and physical health and lower victimization, but received support was uncommon and unrelated to health. However, perceived support was assessed by answers to three questions that included tangible support often not available to homeless people (e.g., a loan of $100, transportation to an appointment) and enacted support was measured by a yes/no response of whether family or friends typically accompanied the participant to health care appointments. Interestingly, Hwang et al. (2009) excluded service providers as a source of social support based on the

obligation service providers have to provide elements of support as a function of their job; they suggested social support from service providers is less meaningful to homeless persons than support derived from informal social network members. Currently, there appear to be no studies that examine elements of received social support in interactions between service providers and homeless women in the literature.

Homeless Persons and Service Provider Relationships

Interactions or relationships between homeless persons and service providers are underrepresented in the literature as well; however several studies with relevant findings are noted. Weiss (1973) conducted a longitudinal qualitative study with impoverished (but not homeless) mothers (n=13) examining their relationship with helping professionals including physicians, social workers, and priests. He found that participants sought two different types of help from professionals, *provision of service* (i.e., "the performance of some activity or the delivery of some good which the specialist controlled") and *support and guidance* (i.e., "help in imposing structure on a confusing situation, in choosing some line of action, and in maintaining the confidence to act") (Weiss, 1973, p. 320). In all cases, participants expected professionals to be competent in their field and the two different types of help sought were not necessarily based on the professional identity of the specialist. However, participants reported a "social invisibility" and "injury to their self-esteem" in attempting to access professional within institutional settings.

Lindsey (1998) surveyed service providers (n=89) on their perceptions of which factors (individual or systemic) are beneficial or detrimental to homeless families in their

attempts to secure housing. Social support ranked low on the list while service provider respondents indicated "attitude / motivation" as the primary influence in homeless families' (most often headed by a single female) ability to obtain and keep housing. Lindsey (1998) surmised this finding could influence service providers' willingness to offer assistance to homeless mothers perceived as "having a 'bad attitude'" or lacking motivation (p. 169).

Hoffman and Coffey (2008) conducted a qualitative analysis on the Sisters of the Road (SotR) database focused specifically on the themes regarding positive and negative conditions of services and positive and negative staff issues (The SotR database is a public accessible database of transcribed coded qualitative interviews of more than 600 persons who were homeless in Portland, OR between 2001 and 2004). Overall, participants described their interactions with homeless service agency staff in negative terms with the theme of "Infantilization and Objectification" (p. 212) dominating. Hoffman and Coffey (2008) acknowledged the difficulties of providing services to vulnerable people with limited resources in institutional settings however they concluded the need for service providers to consistently treat clients with "dignity" and "respect" (p. 219), they also commented on the need for qualitative research to provide experiential data to the abundant quantitative data on service agency outcomes and numbers of persons served.

Personal Interest

My previous experiences with homeless persons occurred both in my professional nursing and academic careers. My nursing experience spans 19 years, 9 of which I

provided direct patient care in an Emergency Department (ED) setting. EDs are frequented by homeless persons (Kushel, Perry, Bangsberg, Clark, & Moss, 2002). My encounters with homeless persons in the ED setting were numerous but also brief and routine. Career advancement into ED management both created the necessity and afforded the opportunity to further my education. While an ED manager in Olympia, Washington I completed both my bachelor's (BSN) and master's (MN) degrees. As a student I participated in annual homeless counts in the Puget Sound area twice, which enabled me to meet and interview homeless persons.

Interviews with homeless persons gave rise to personal reflection of my professional nursing practice (Biederman, 2005a) and also marked a period of social activism (Biederman, 2005b). Upon leaving the ED setting, I worked as a case manager for homeless persons in a federally funded community clinic in Tucson, Arizona. While there, I took notice of the relationships our clinic staff (myself included) developed with our clients. Many interactions with clients were not necessarily directly related to physical health but appeared more for purposes of social support and validation. Some clients made appointments to discuss personal or family issues. Many wanted to share their stories and plans for the future. With institutional permission and participant consent, I developed a presentation of the stories of our clients. My alma mater took note of this work and invited me to present it in April, 2007 ("Class Notes", 2007). My formal clinical work with homeless persons ended when I left the community clinic in February, 2007. More recent interactions with homeless persons include a brief assignment on a research team preparing for a Photovoice study of women experiencing homeless in

Greensboro, NC; a recent pilot study in which I interviewed five homeless women; and, assisting the Homeless Services Center's (HSC) "Street Team" in analyzing and interpreting survey data.

Previous experience as a service provider to homeless women provided me with unique insights into the service provider / homeless woman client relationship which certainly influenced interview direction and field observations. In attempts to limit bias in interpreting participant expression and actions I engaged in active recall, rather than attempted suppression, of personal memories with homeless persons before all field interactions (more information on the active recall process of "feelings audit" is presented in the Methods section).

Pilot Study

The overarching purpose of the pilot study was to gain understanding of the experiences of homeless women in Greensboro, North Carolina. The initial recruitment strategy, to approach potentially homeless women on the street, the library, or public places frequented by homeless persons was more complex than anticipated as it was difficult to assess homelessness based on location and / or appearance. Of three potential participants approached outside of an agency (two panhandling at busy intersections and one at the city library), only one of the women consented to be in the study. It quickly became apparent that a homeless service agency would be beneficial for participant recruitment, thus the Executive Director of the Homeless Services Center (HSC; pseudonym) was contacted and agreed to be a study site. A total of five women (one on the street and four at the HSC) participated in the pilot study.

The five participants ranged in age from 19 to approximately 50 years old. All had recently arrived in North Carolina from a different state and four of the five had been homeless since arrival. Two participants had a child under 18 years old that was not in their custody. Four of the five were living in a shelter and at least one had experienced homelessness more than once in her lifetime. Precipitating events for their current experience of homeless varied between participants and included arrest of significant other and a fight with a family member.

The interviews ranged from 17 to 42 minutes in length. One interview took place in a restaurant that was preparing to open for the day (the participant knew the owners), three in the nurse's office at the HSC, and one in my car in the HSC parking lot. Participants were compensated $10 for their time at the completion of the interview. All interviews were audio recorded and transcribed verbatim. Brief notes were also taken during most interviews; field notes were written following interviews.

All of the participants talked about interpersonal support and relationships. The one participant who was recruited from the street did not use services for homeless persons but did speak of supportive interactions of her "patrons" (i.e., people who she saw and received money from daily) and of persons in a local eatery. The other four women spoke of various interactions with service providers at shelters, clinics, or at the HSC. Participants described both positive and negative interactions with service providers and how those interactions affected their self-esteem. Two participants stated that at the time of the interview service providers were their only source of social support.

Tables

Table 1

Subtypes of Received Support (House, 1981)

Support type	Definition	Behavioral example
Emotional	Providing empathy, caring, love, and trust	Active listening
Appraisal	Providing information relevant to self-evaluation	Offering feedback on performance
Informational	Providing information that a person can use in coping with personal and environmental problems	Providing resource list
Instrumental	Instrumental behaviors that directly help a person in need	Giving money or tangible assistance or aid

Table 2

Subtypes of Received Support (Barrera & Ainlay, 1983)

Support type	Definition	Behavioral example
Directive Guidance	Support of a practical nature, aimed at aiding the recipient in improving his or her performance through increased understanding and skill.	Assist in setting goals
Nondirective Support	Expressions of intimacy, unconditional availability, esteem, and trust.	Active listening
Positive Social Interaction	Joking and kidding, talking about interests and engaging in diversionary activities.	Talked about client's personal interests
Tangible Assistance	Providing shelter, money or physical objects of value.	Gave money or tangible assistance or aid

CHAPTER II

METHODOLOGY

Research Goals

I was interested in understanding homeless women's perceptions of client/service provider interactions and relationships. I felt this knowledge may increase service provider awareness of supportive interactions and change the way in which service providers interact with homeless women. This could ultimately result in homeless women's increased satisfaction with service providers and increased service utilization which, for some, may be the path to homelessness resolution.

Research Questions

The research questions for the study included: 1) What are homeless women's perceptions of interactions with service providers? 2) What behaviors or actions of service providers do homeless women consider supportive? and 3) What behaviors or actions of service providers do homeless women consider unsupportive?

Research Sites

The Homeless Services Center (HSC; pseudonym), a day center for homeless people, was the initial study site. The HSC is housed in a newly renovated building close to the downtown area of the city. The HSC has men's and women's locker/shower rooms, a barber room, a laundry facility, and a computer center and offers multiple services to

homeless persons including individual case management, housing assistance, and job training and placement. Most days the HSC is staffed with two nurses, one for mental health / substance abuse issues and the other to address physical health concerns. There is additional office space for homeless-serving agencies on an as needed basis. As a homeless drop-in day center, the HSC has a large common room for recreational activities (e.g., board and card games, arts and crafts) that also serves as a waiting room for multiple service providers/agencies. Support groups such as Narcotics Anonymous and Al-Anon routinely meet at the center. Snacks and a bag lunch are provided to clients. All services at the HSC are free of charge. The HSC has a "street team" that assesses homeless persons' knowledge of homeless services available in the city and to make referrals and also assesses downtown business owners/workers perception of and willingness to intervene in issues related to homelessness; I assisted the team with survey data analysis.

The HSC serves homeless men, women, and families. I chose the HSC as a research site because the multiple services offered results in a varied population accessing the center providing the opportunity to observe interactions between homeless women and different types of service providers in one location. Also, the Executive Director of the HSC is very interested in facilitating research with homeless persons to better understand their needs and perceptions and has offered a private space to me for interviews. Additionally, I had completed a pilot study at the HSC and have established rapport with several staff members.

As the study evolved, it became apparent that I would need another research site to increase study participation and participant diversity. An emergency shelter was chosen as a second site.

Study Timeline

The entire study spanned a 12 month period commencing in November, 2011 and finishing in October, 2012 with a successful dissertation defense.

Qualitative Method and Phenomenological Approach

Qualitative research was the chosen for the study as it includes contextual aspects of lived experiences and allows participants to give meaning to their experience enhancing understanding of those experiences (Guba & Lincoln, 1994). The study was conducted with a phenomenological approach. Phenomenology is intended to elicit the collective experience or "essence" of a phenomenon (Colaizzi, 1978; Creswell, 2007; Moustakas, 1994) rather than to provide individual descriptions or perceptions. While participant variation is important in arriving at the essence of an experience, the culmination of the study is a broad, inclusive, non-varying, descriptive profile of the experience, not the participants (Creswell, 2007; Moustakas, 1994). Colaizzi's (1978) phenomenological data analysis technique was used for the study and is discussed in more detail in the following section.

Participant Number and Recruitment Strategy

Qualitative study participant numbers estimation is frequently based on the concept of "saturation" however saturation, or the numbers necessary for its attainment, is rarely described in detail (Guest, Bunce, & Johnson, 2006; Morse, 1995). The depth

and richness of the study data contribute more to saturation than data repetitiveness driven by participant numbers (Morse, 1995; Sandelowski, 1995). Other factors for consideration in estimating participant numbers include: *scope of the study*, *quality of data*, *study design*, and *the use of shadowed data* (participants discussing other's experiences) (Morse, 2000). Morse (2000) estimated that, depending on amount of data per participant, a phenomenological study may need six to ten participants. Guest, Bunce, and Johnson (2006) found data saturation (i.e., no new codes generated) of 92% at 12 interviews noting that most codes that occurred later were not new in substance only variability. Based on these recommendations and findings, I estimated the need to recruit 6 – 12 homeless women participants.

Data Collection

Interview Data. Before data collection began, a "feelings audit" (Bednall, 2006) was conducted. The audit was a personal review of my experiences of working and interacting with homeless persons. I created a list of those experiences that were germane to the study as a whole and to the research questions and reviewed the list prior to soliciting prospective participants or engaging in interviews in efforts to acknowledge and reduce introduction of my personal bias during data collection.

I used purposive criterion participant selection (Creswell, 2007) and the snowball method as the primary recruitment strategy for the study. Prospective participants were approached at the HSC, at the emergency shelter, or on the street, informed of the study, asked if they would like to participate and, if so, be assessed for inclusion criteria (see Appendix A for recruitment script). If the prospective participant met the study inclusion

criteria and the participant had time available, informed consent was secured and the interview commenced. If the prospective participant was interested but did not have time available, an interview was scheduled for a later date. Study inclusion criteria were: participants must be at least 18 years of age, female, English speaking, currently experiencing homelessness using the HUD definition, and have utilized services of a provider or agency that provides services to homeless people. Males, women who do not speak English fluently, females under 18 years of age, women who do not meet the HUD definition of homeless, and women who have never utilized the services of a provider or homeless service agency were excluded from participation in the study.

After explaining the study and purpose of the interview, answering all questions a prospective participant had and securing informed consent, interviews commenced (see Appendix B for consent form). Participant interviews lasted 23 – 103 minutes and were audio recorded; participants were compensated $10 for their time in completing the interview. The interviews had both a conversational and structured component. The conversational component was intended to elicit stories describing interactions with service providers and evolved differently for each participant. The interviews had "Grand Tour" questions (Spradley, 2003) with follow up questions and probes intended to increase both the breadth and depth of participant responses (see Appendix C for interview guide). Grand tour questions are broad questions whose answers provide the interviewer with an overview of the place, event, or experience being investigated often allowing the interviewer a sense of cultural immersion and an introduction to or confirmation of the cultural lingo (Spradley, 2003). Interview audio files were transferred

to a password protected laptop computer within 24 hours of the interview and erased from the recording device and were transcribed, verbatim, within three days. Data saturation was reached with participant 11 however four additional women were recruited and participated in the study to ensure both thematic and theme variation saturation.

Observational Data. Unstructured observations were captured in field notes upon all encounters with homeless women participants and homeless service providers in the field. The use of "unstructured" field observations was not meant to imply that observations were not planned or happened haphazardly but rather that a priori notions of the range of possible observations and behaviors were put aside allowing for consideration of nuanced or more subtle behaviors and interactions (Mulhall, 2003). Field notes included a description of the day, time of day, setting, participant, and general perceptions of the overall scene and memories and / or emotions evoked and were written, or dictated, on the same day as the encounter. Field notes were transcribed if dictated or typed if hand written and stored on a password protected laptop computer.

Data Analysis

Interview data. Data collection and analysis occurred concurrently. All interviews were transcribed verbatim. For participants who utilize services for homeless persons, I followed the seven step phenomenological process as initially outlined by Colaizzi (1978) and restated by Fletcher (2004):

1. *Increasing familiarity with the data* - Each participant transcript will be read in its entirety to increase familiarity with the data.

2. *Extracting significant statements* – phrases and / or statement that pertain directly to homeless women's interactions with service providers will be extracted from each transcript.

3. *Formulating meanings* – each phrase or statement will have a meaning formulated within the context of homelessness provided by the transcript and from observational data contained in field notes.

4. *Validation* - Each transcript will undergo steps 1 – 3; the formulated meanings will then be clustered into themes. The themes will then be compared to the original transcripts for validation (i.e., "Is there anything in the transcripts not accounted for in the themes?" And "Is there anything in the themes not present in the transcripts?") If non-agreement between themes and transcripts is present then steps 1 – 3 will be reviewed or redone.

5. *Exhaustive Description* – A detailed description of each theme that includes participant's feelings and ideas of the theme will be constructed.

6. *Descriptive Identification* - The results of analysis will be amalgamated into a universal description of the phenomenon of client / provider interactions from the perspective of homeless women.

7. *Member checking* – The findings will be shared with as many participants as possible to ensure the description captures their experience. Any new data or insights gleaned in this step will be incorporated into the descriptive identification.

In addition to the method outlined by Colaizzi (1978), a member check was added after formulated meanings were derived to ensure accurate data interpretation and increase study validity. Thus, two member checks were performed. Also, a step was added in analysis whereas participant significant statements were condensed into analytic poems as described by Biederman, Nichols, & Durham, 2010. (see Appendix D for a example of analytic poems).

Observational data. Field notes were reviewed routinely to maintain a connection with the participants and field; memoing was used to make connections between field note entries to gain more insight and deeper understanding of the social processes underlying observations captured in the field notes. A journal was kept of other study related meetings, process and procedures such as interactions with faculty mentors and issues related to data analysis and report writing. Field notes, memos, and journal entries were used to assist in enhancing the study context through descriptions of participants and settings. Observational data assumed a larger role as the study design evolved through field and participant encounters. Observations were more numerous, lengthy, and variable than initially anticipated.

Validity

Based on an extensive synthesis of qualitative literature, Creswell (2007) outlined eight validation strategies for qualitative studies recommending researchers employ and integrate a minimum of two. In light of this, several recommended strategies were built into the study and others, with modification, were included as follows. First, the feelings audit, as described in the data collection section, was intended to clarify existent

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researcher bias. Second, field notes were kept and analyzed against emergent themes in the process of crystallization. This was not so much for validating participant disclosures in attempts to solidify a truth but rather to recognize the complexity and depth of the phenomenon (Tracy, 2010). Third, after the descriptive identification of interactions between service providers and homeless women was completed, I validated findings with member checking. Lastly, faculty mentors overseeing the study, whose wealth of research experience includes qualitative inquiry, women's health, and homelessness, served as reviewers of the research process and interrogated study findings.

Ethical Issues

There were several potential ethical issues that were anticipated and could have arisen during the study. First, the study aimed to understand the experience of interactions between clients and service providers from the perspective of homeless women; men were excluded. Thus, women who were accompanied by men may have been reluctant to participate or have been discouraged from participation by a male companion. Also, men may have felt left out or as if their perceptions and experiences are less valid than women's. Had either of these issue presented I would have worked to reassure anyone expressing concern that men's issues and perceptions are important but much more research has been conducted with homeless men than women. Next, persons experiencing homelessness are considered a vulnerable population and some may have felt uncomfortable discussing issues related to homelessness. Participants were informed during the consenting process that they may terminate the interview at any time with no penalty. Also, the HSC had a mental health nurse present frequently for consultation if

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the need arose. Additionally, there was the potential that a prospective participant could have been mentally ill or otherwise cognitively impaired or intoxicated. As a registered nurse with extensive experience in physical and mental health assessment I assessed each participant for cognitive impairment and was prepared to reschedule the interview of any participant who appeared to have limited cognitive capacity due to mental illness or intoxication to the level that they could not complete the interview. If, in a future encounter, the prospective participant continued to exhibit signs of cognitive impairment at a level that would prevent them from participating in the study, I was prepared to exclude them from study participation. Lastly, during the course of the study, I could have discovered that a participant engages in illegal activity. I planned no reporting of any illegal activity unless it is required by law such as in the case of blatant child or elder abuse. Although I planned for these potential ethical dilemmas, none actually occurred.

Summary

In summary, I conducted a qualitative study with homeless women to better understand their experience of interactions with service providers with an emphasis on supportive behaviors enacted by service providers and directed to homeless women. This is an important issue because the numbers of women experiencing homelessness is increasing, homelessness is a public health concern, homeless has shown to be bad for women's health, service providers are gate keepers to health enhancing services, there is a dearth of information regarding supportive interactions by service providers to homeless women clients, and both literature and a recent pilot study suggests these interactions are important. Information gleaned from this study may be used to enhance

service provider interactions with homeless women with the ultimate goal of reducing

negative interactions so that homeless women do not suffer denigration from people who

propose to help.

CHAPTER III

**UNDERSTANDING THE EXPERIENCE OF INTERACTING WITH SERVICE
PROVIDERS FROM THE PERSPECTIVE OF HOMELESS WOMEN:
A PHENOMENOLOGICAL STUDY**

Abstract

Homeless women often interact with service providers to obtain or maintain health
enhancing and health sustaining services and resources although little is known about
service provider encounters from the perspective of homeless women. We conducted in-
depth semistructured interviews with 15 homeless women to better understand their
experiences of interacting with service providers. Using a phenomenological method, we
extracted 160 significant statements from participant transcripts; more positive than
negative interactions were reported. Significant statements were condensed into analytic
poems in the process of crystallization to afford a deeper understanding of the
phenomenon of the service encounter. The 10 themes that emerged fall along a
dehumanizing / humanizing continuum primarily separated by the power participants
experienced in the interaction and the trust they felt in the service provider. Ways to
optimize homeless women's experience of humanization within the service encounter and
suggestions for future research are offered.

Keywords: homelessness; marginalized populations; phenomenology; power /
empowerment; qualitative analysis; stigma; vulnerable populations

Homelessness, defined by the U.S. Department of Housing and Urban Development (HUD) as the lack of an "adequate nighttime residence" that includes nonresidential institutions and places not intended for human habitation (HUD, 2011a, p. 75995) decreased in the United States between 2010 and 2011 (HUD, 2011b). Notwithstanding, more than 636,000 persons were homeless on a single night in 2011, which included 79,446 mostly female headed families (HUD, 2011b). Homelessness is associated with poor health (Hwang, 2002). Homeless women are particularly vulnerable reporting more health problems than homeless men (Wojtuski & White, 1998) and demonstrating increased mortality as compared to their non-homeless counterparts (Cheung &Hwang, 2004).

Service providers are gate-keepers to health enhancing and health sustaining services and resources for impoverished and homeless persons and can serve as an important source of support as well. In a longitudinal qualitative study with impoverished single mothers Weiss (1973) found the majority of participants interacted with service providers and, regardless of service provider type, sought "support and guidance" (p. 320) on a frequent basis. Stewart, Reutter, Letourneau, Makwarimba, and Hungler (2010) found that because of estrangement or geographic separation from family and friends, homeless youth depended on interactions with service providers for information, affirmation, and emotional and tangible support. However, negative interactions with service providers have resulted in feelings of dejection (Weiss, 1973) and some homeless persons have rejected services in efforts to maintain self-respect (Hoffman & Coffey, 2008). Understanding interactions between service providers and homeless women could

enhance services and facilitate service uptake. Connection to appropriate and necessary services can be, for some women, the path to homelessness resolution. As a result, the purpose of this study was to examine the phenomenon of interacting with service providers from the perspective of homeless women.

Literature Review

Although an under-researched area, studies of homeless persons' perceptions of service providers and service provider interactions are found in the literature. Several of these studies focused on participants' perceptions of the services offered and/or the characteristics of the providers offering these services whereas other studies examined the experience of the service encounter. Some studies included homeless persons' perceptions of services and service provider characteristics as well as their perspectives on desired services and provider qualities.

Perceptions of Services and Service Providers

Several studies offered the perception of homeless services and service providers from the perspective of youth and young adults. Thompson, McManus, Lantry, Windsor, and Flynn (2006) found 16 to 23 year old homeless youths' main concern was locating and using specific services (e.g., food, shelter, transportation) and participants preferred caring, encouraging, and pet friendly service providers. In assessing homeless young adults perspectives on health care providers, Hudson, Nyamathi, and Sweat (2008) found their 18 to 25 year old participants held negative perceptions that focused mainly on service provider communication styles that were deemed authoritative, disrespectful, and /or unidirectional. In assessing support needs and services that included both homeless

youth ages 15 to 25 and service providers, Stewart et al. (2010) found youths' main support needs stemmed from social isolation, alienation, low self-esteem, and substance abuse; both youth and service providers reported an overall lack of services. Youth and young adult participants across all the above studies iterated the important roles service providers play in their lives and desired service providers who were respectful, trustworthy, and who had had similar life experiences including homelessness and/or drug abuse.

Two studies offered perceptions of services and/or service providers from primarily adult informants. Hoffman and Coffey (2008) conducted an analysis on the Sisters of the Road (SotR) database and focused specifically on the themes regarding positive and negative conditions of services and positive and negative staff issues. (The SotR database is a public accessible database of transcribed coded qualitative interviews of more than 600 persons who were homeless in Portland, OR between 2001 and 2004). By and large, participants described their interactions with homeless service agency staff in negative terms with the theme "infantilization and objectification" (p. 212) dominating. Sznajder-Murray and Slesnick (2011) assessed homeless drug addicted mothers' perceptions of service providers. Overall, the mothers indicated service providers were unsupportive, did not understand their unique situation, and feared service providers would report their drug use to child services. Similar to the studies with youth and young adults, the mothers desired supportive and trustworthy service providers and felt they would be better understood by service providers who had had similar life experiences.

Although these studies highlight the importance of services and services providers for homeless persons, most describe service providers in mainly negative terms. A limitation to the literature as a whole is the over-reliance on focus groups as a methodology. Of the above five studies, only two (Hoffman & Coffey, 2008; Stewart et al., 2010) included one-on-one interviews with participants (Stewart et al., 2010 used both interviews and focus groups for data collection). Of those two, one was a database analysis that did not allow for participant follow up or member checking (Hoffman & Coffey, 2008). The reliance on focus groups as a methodology might bias the findings towards negative perceptions (Sznajder-Murray & Slesnick, 2011; Thompson et al., 2006); less vociferous participants' perceptions might not be represented.

Service Encounter Perceptions

Reports of service encounters move beyond perceptions of actual or desirable service and/or provider characteristics and more effectively demonstrate the experience of the encounter and potential encounter outcomes. In their study on a harm reduction approach with homeless participants who were active drug users, Lee and Peterson (2009) argued against the dehumanizing perspective of traditional abstinence-based treatment programs that, by design, render participants powerless. In their theoretical model, supported by client statements, the service encounters that occur in harm reduction programs increase agency by allowing participants to self-manage their addictions. Self-agency was experienced as an empowering process that resulted in "demarginalization" for some participants. Wen, Hadak, and Hwang (2007) interviewed homeless persons regarding experiences with health care providers to better understand

how "welcome" or "unwelcome" participants felt in the encounters. Buber's (1923/1996) dialogical thesis *I and Thou* served as the framework for their interview content analysis. Interactions reflective of human mutuality ("I – You") were perceived as welcoming and experienced by participants as empowering and humanizing whereas non-welcoming ("I – It") encounters reflected a person-to-object communication style and were experienced as disempowering and dehumanizing. Unwelcoming encounters sometimes precipitated an emotional response from participants; some participants opted out of services as a result.

These two studies suggest that encounters perceived as empowering are experienced as humanizing and those perceived as disempowering are experienced as dehumanizing. Both humanizing and dehumanizing service provider encounters might affect outcomes for homeless persons.

Humanization Frameworks

Humanization frameworks have been proposed to guide both health care research and practice. The humanistic nursing communication theory (HCNT), based on Buber's work referenced in the previous section, demonstrates a relationship between dehumanizing and humanizing attitudes, interaction patterns, and message content (Duldt & Giffin, 1985). Communing, "the heart of humanistic communication" (Duldt, 1991, p. 8), at the core of the model, is based on trust, self-disclosure, and feedback. Duldt (1991) holds that the communication recipient determines the humanizing quality of the interaction based on the consequences of the communication. Todres, Galvin, and Holloway (2009) proposed a framework for qualitative research comprised of "eight

philosophically informed dimensions of humanization" (p. 69) with humanization defined as a "view or value on what it means to be human and . . . ways to act on this concern" (p. 69). The framework is intended to guide qualitative research and, in turn, qualitative research to influence the framework; both the research and framework offer guidance and direction to increase humanization in health care (Todres et al., 2009). As indicated in their model descriptions, both the dehumanizing and humanizing attitudes proposed by Duldt and Giffin (1985; e.g., monological / dialogue) and the dimensions of humanization proposed by Todres et al (2009; e.g., uniqueness / homogenization) represent a spectrum or continuum of possibilities anchored by opposites rather than a dichotomy.

In sum, previous studies with homeless persons on the perception of services and service providers reported mostly negative findings, did not effectively capture the service encounter experience, and were limited by an overreliance on focus group methodology. Studies that focused on the perception of the service encounter suggest that humanization / dehumanization is related to encounters that are perceived as empowering / disempowering, however there are few studies in this area. Also, no phenomenological studies reporting on service provider encounters from the perspective of a diverse sample of homeless women were found. As a result, we focused this study to understand the experience of interacting with service providers from the perspective of homeless women.

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<center>**Methods**</center>

Sample

A purposive sample of 15 women who were experiencing homelessness participated in the study. Participants self-identified as Black (7), White (7), and American Indian (1). Average age was 43 years (SD = 10.9). The majority were single, either never married (6), separated (1), or divorced (1) with only two participants identifying a current intimate partnership or marriage. More than half (8) of the participants had a child or children under 18 years of age but only two participants had a child in their custody. Seven participants were experiencing their first episode of homelessness. The length of homelessness for the current episode ranged from one month to five years with 12 participants reporting current time homeless of six months or less.

Research Design

A phenomenological approach was selected to elicit the collective experience or "essence" (Creswell, 2007, p. 58) of interacting with service providers from the perspective of homeless women. As a former service provider and nurse case manager for homeless persons, it was necessary for the first author to acknowledge her past interactions with homeless women. Thus, an initial "feelings audit" (Bednall, 2006) was conducted to identify past experiences germane to the research questions and to bring those memories to the surface in the process of bracketing in efforts to limit researcher induced bias. Throughout the study she regularly debriefed with a close peer and a mentor. In some instances, it was particularly difficult to hear stories from the women; she felt impotent to intervene. During these times, intensive memoing was done and more

frequent peer and mentor debriefing. However it was not possible, nor desirable, to negate her professional service provider history. Some women in the study regarded her as a service provider; two participants compared the interview with previous service provider encounters.

Procedure

A homeless drop-in day center and winter emergency shelter served as the study sites; the study was approved by the university's Institutional Review Board (IRB). Study inclusion criteria were: participants must be at least 18 years of age, female, English speaking, currently experiencing homelessness using the current HUD definition, and have utilized services of a provider or agency that provides services to homeless people. The first author conducted all interviews and on arrival at the site but before a potential participant encounter, reviewed the feelings audit to bracket prior experiences.

Participant recruitment occurred through introduction by a staff member at a study site (1), snowball method (6) or direct approach (8). On introduction, participants were informed of the study and, if interested, assessed for inclusion criteria. Women who were interested and met inclusion criteria were invited to participate. A total of 18 women were approached, 15 met inclusion criteria and participated in the study. The three non-participating women had living arrangements that did not meet the HUD definition of homelessness. Interviews were conducted between December, 2011 and March, 2012; all interviews were conducted in private rooms at one of the two study sites and audio recorded.

After obtaining verbal consent, women were asked about their lives, previous episodes of homelessness, current homeless situation, service providers who they have encountered during experiences of homelessness, and stories of service provider encounters. Demographic information was also obtained during the interview process. Interviews lasted between 23 and 103 minutes (M=41; SD=19). The first author conducted and transcribed all interviews verbatim. Participants were paid $10 cash for their time in participating and also given a copy of the consent form with researcher and IRB contact information. All participants were asked to provide contact information for follow-up and gave at least one contact method (e.g., cell phone number, email address); over half (8) participated in member checking.

All field encounters included unstructured observations captured in field notes. "Unstructured" does not imply that observations were ill planned or happened haphazardly but rather that a priori notions of the range of possible observations and behaviors were put aside which allowed for consideration of nuanced or more subtle behaviors and interactions (Mulhall, 2003). Field time expanded beyond the expected interview setting. Time with participants included informal interactions at the drop-in day center, eating together and socializing at the winter emergency shelter, and a dinner outing to a local restaurant. During some of these events, volunteers at the service locations were not necessarily aware that the first author was not a homeless woman herself. Also, during the study one participant was hospitalized. The first author, along with one or two winter emergency shelter residents, visited her in the hospital on four occasions over a three week period. The first author also acted as her advocate at a

hospital discharge planning meeting and visited her again in the hospital during

subsequent hospital admissions. Engaging with homeless women in these multiple

service-oriented locales and acting as a patient advocate during hospital discharge

planning provided rich observational data that complemented data obtained through

interviews.

Data Analysis

Colaizzi's (1978) method of phenomenological analysis was used for the study.

Field notes were written and interviews transcribed within 24 hours of the encounter to

maximize data accuracy and increase knowledge of and intimacy with the data. From

complete transcripts, interviewer questions and comments were removed and then

transcript sections containing participant recollections of encounters with service

providers were extracted as relevant statements. Relevant statements were coded into one

of four categories: agency statement, general statement, service provider encounter, and

other person's service provider encounter. Service provider encounters and other person's

service provider encounters (i.e., "shadowed data", Morse, 2000, p. 4) were considered

"significant statements" (Colaizzi, 1978, p. 59). The meanings of these statements were

formulated and a member check performed with eight of the 15 participants to increase

study validity by ensuring accuracy at this step. The formulated meanings were

categorized as neutral, negative, or positive and then further differentiated into themes

using open coding. Next the themes were arranged into clusters first within then between

transcripts. On completion of this step, each participant had a packet that included the

complete transcript, the transcript with the interviewer's voice removed, relevant

statements, significant statements, formulated meaning table, cluster of themes, field

notes, and member check notes when applicable. All themes were then compared across

all transcripts to ensure themes were representative of all the women's service provider

encounter experiences and that all such experiences were captured in the themes.

To determine saturation, each participant packet was read in its entirety to ensure

complete and accurate extraction of significant statements and uniform clustering of

themes. A comparison of between participant clusters of themes was done. Table 3

illustrates the emergence of themes by participant. Commensurate with literature on data

saturation (Guest, Bunce, & Johnson, 2006; Morse, 2000) no new themes emerged after

participant 11. A pilot study (n=5) had been performed earlier in the year to test

recruitment strategies and the study interview guide. Significant statements identified in

the pilot study data were consistent with the emergent themes. Field notes were also

reviewed; study themes were reflected in the observed interactions between participants

and service providers.

Table 3

Emergence of Themes by Participant

Theme	Participant Number														
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Cared for	X	X	X	X	X	X	X	X		X	X	X	X	X	X
Shared past / identity	X				X			X	X				X		X
Powerless	X		X					X			X	X	X	X	
Alienated	X		X	X	X			X	X						X
Judged	X	X	X	X	X			X	X	X	X	X		X	
Empowered	X			X	X					X				X	
Trusted		X				X									
Norm				X	X		X						X		X

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Unmet expectations	X	X	X	X	X	X	X
Minimized			X				X

Next, significant statements were also arranged by theme and then condensed into analytic poems in the process developed and described by Nichols (Biederman, Nichols, & Durham, 2010) which includes extracting the exact words of the participant and keeping words and phrases in the order in which they were originally spoken and transcribed. Richardson (2000) suggests poetry might "better represent the speaker" (p.12) rather than the traditional quotes often used and "is a practical and powerful method for analyzing social worlds" (p. 12). In our study, poetry was used in the process of crystallization. This was not so much for validating participant disclosures in attempts to solidify a truth but rather to recognize the complexity of the phenomenon (Richardson, 2000; Tracy, 2010). The distillation of the significant statements into poems facilitated a deeper understanding of the phenomenon of service provider interactions from the perspective of homeless women and provided a richer exhaustive description of themes and descriptive identification of the interaction phenomenon. On analysis completion, a second member check was performed with two study participants and minor changes were made as a result.

Results

The interactions between service providers and homeless women were dyadic events. The women's experience was a response to the action (or inaction) of the service provider whether the service provider and/or interaction was anticipated or remembered.

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The 15 interviews elicited 160 significant statements that were clustered among 10 themes. The themes were characterized as neutral (1), dehumanizing (5), or humanizing (4) and fall along a continuum; Figure 1 illustrates the theme position on the continuum. Table 4 details the themes by number of significant statements and number of participants with the experience. Service provider type and the number of women who mentioned them were: shelter workers including staff, managers, and volunteers (15), medical, nursing, and mental health staff (12), therapists, counselors, caseworkers (6), police (6), governmental human service agencies (6), church staff (1), and thrift store staff (1).
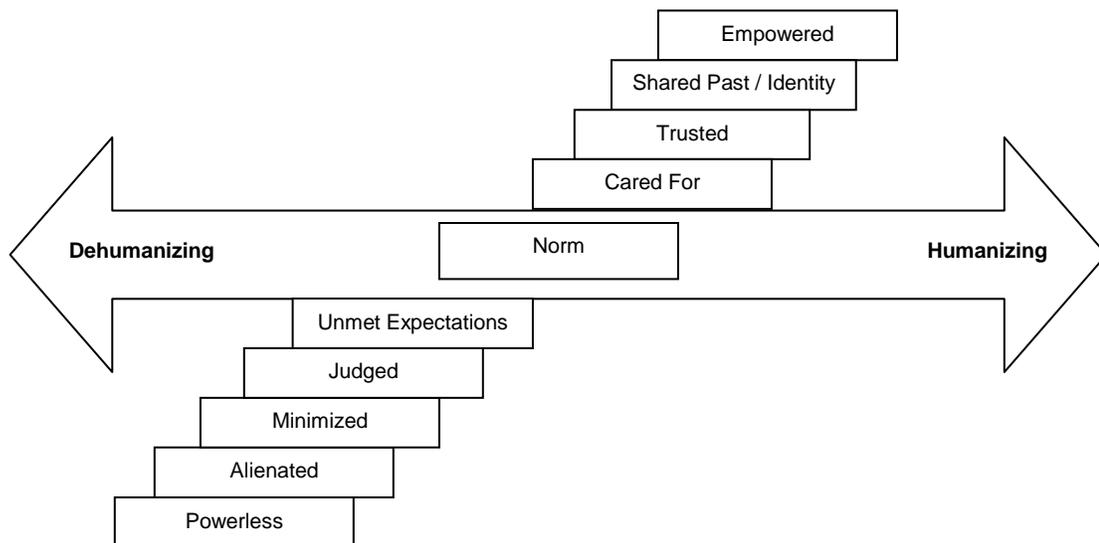

Figure 1. Dehumanizing / humanizing continuum

Table 4

Themes by Number of Significant Statements and Participants with the Experience

Theme	Number of Significant Statements		Number of Participants with Experience	
Neutral		6		5
Norm	6		5	
Negative		63		13
Unmet Expectation	10		6	
Minimized	3		2	
Judged	18		11	
Alienated	16		7	
Powerless	16		7	
Positive		91		15
Cared for	72		14	
Trusted	2		2	
Shared Past / Identity	7		6	
Empowered	10		5	

Neutral Theme

The theme of "norm" is at the midpoint of the humanizing-dehumanizing continuum. Participant/service provider interactions described within this theme were characterized as neither positive nor negative. Instead interactions were described, and later verified, matter-of-factly. These interactions were what one would expect from any given agency, service provider and/or situation and therefore represent participants' expectations of service providers. Participants expected service providers to: 1) act in a professional manner, 2) assist in securing the service sought, and 3) be competent in their field.

One participant described her interaction with a nurse who works at a homeless day center:

I had had some questions 'cause I had to start havin' pains in my breast . . . she set it up about a mammogram and all that, this, that, and the other. And she checked me out to make sure it wasn't nothin' serious.

Another participant described her interaction with a mental health nurse:

Nurse [name], she arranged for me to see a psychiatrist for med- you know, for medication because I have trouble sleepin' and stuff like that which, I have, just got finished. As a matter of fact, I got my medication yesterday.

In each case, the nurse assessed the participant and made an appropriate referral. From the participant's perspective, these actions are within the normal scope of nursing practice and thus were considered neutral encounters.

Dehumanizing Themes

Five themes emerged that captured the dehumanizing interactions participants reported with service providers. As illustrated in Figure 1, the themes fall along a continuum of how dehumanizing the experience was for participants. The primary issues that separate the themes along the continuum include the power participants experienced in the interaction and the trust they felt in the service provider, with the lowest stage representing interactions where participants felt powerless. Moving down the continuum of dehumanizing interactions, we also found individual identity succumbed to negative group association as participants described being stereotyped as "homeless", with all associated negative connotations, and treated accordingly.

Unmet expectations. This theme represents the least dehumanizing interaction experiences. In this theme, women described times when their expectations of service providers or agencies went unmet. These unmet expectations included perceiving a

mismatch between what they were told would happen and what actually happened, double standards where rules were not uniformly enforced, interagency discordance where service providers from different agencies gave conflicting reports, and intra-agency inconsistency based on past experience. Some women described interactions where their needs and time seemed irrelevant such as one woman who was living in an abandoned trailer and trying to secure a shelter bed:

> . . . they told me if I came back on Friday night then they go ahead and accept me in. We come back down there at 7 o'clock, like I was told, brought my stuff, and they said, "You know, we don't do an intake Friday evenings."

Another participant described her experience of receiving differential treatment, from the same physician, for her chronic hip pain that was exacerbated by sleeping outside:

> . . . I said, "Why can't I get what I been gettin'?"…Okay. They give me a shot, and it was not worth a shit. It did not do a bit of good. And, [normally I get] the muscle relaxer plus the thing for anti-inflammatory.

Overall, unmet expectations were experienced as differential or unfair treatment.

Judged. This theme captures the homeless women's overriding experience of being judged and specifically as being stereotyped as homeless and treated accordingly. One participant commented that being judged is so common it is an expectation. Another participant compared being judged as homeless to being judged based on race, ". . . they'll label us, 'You kind'. Kinda like, almost like racial slurs but, 'You kind, you people.' Like, what do you mean? [slight laugh] You people? You kind?"

Overall, participants described feeling pigeonholed into the negative stereotype of homeless or their past, not considered an individual, and denied the opportunity to change. This was portrayed in a variety of ways. One participant recalled a poignant encounter with police when they were called because she was sleeping on the sidewalk outside of a laundromat:

> They were just like, "You can't be sleepin' out here like that. Do you - you need to go somewhere." And I was like, "Well, I have nowhere to go. Do you know of a shelter?" And he was just like astonished because I asked if they knew where a shelter was, that I would want that.

Another participant recalled an instance where, based on not looking homeless, she was initially denied tangible assistance from a local group that provided food and clothing to homeless persons in a public park:

> . . . do I need to be the stereotype . . . dirt on my face and clothes with holes in 'em? . . . People walk around with this stereotyped version of a homeless person. Oh, they have to be dirty, they have to be stinkin', their teeth have to be bad. They have to be really illiterate and just, you know, slow and not that smart - they didn't finish school.

The judgment that accompanies homelessness is sometimes based on a stereotypical association with criminal activity or untrustworthiness. One participant described how she felt under constant surveillance at a shelter:

> . . . they watch us constantly . . . I, you know, laugh it off. I joke, it's like, "You know, I wanna be here, I'm not gonna run away." [laughing] And even though they can watch us from the door, they physically come out with us [when we smoke] . . . things like that make you feel a little stifled and and insulted at times.

Some participants concealed past successes for fear they would be judged harsher if service providers knew that aspect of their identity. A homeless woman described a negative interaction in an Emergency Department where she felt staff were not appropriately managing her blood pressure but was afraid to reveal that she too was a nurse. Another described attending a class very similar to one she had taught before but felt the need to conceal her identity as a college graduate. Conversely, past challenges and perceived failures were highlighted. One participant, a former addict, described an interaction with a shelter worker who angrily confronted her for taking pain medication, as prescribed, for the serious pain she was having.

Minimized. Participants described minimized as feeling service providers held them solely responsible for their homelessness while ignoring the larger social context in which homelessness arises. Feeling or being minimized was considered worse than being judged because, as described by one participant, "it is personal." When working with a housing specialist, one participant was told, "You just need to sell everything and start all over." Another woman who was staying at a shelter described her experience of being minimized when she requested a bus pass to attend a job fair:

> . . . [He] wanted to know why I needed the bus pass . . . he wanted me to come back and get it and I said, "No, if you don't mind, I'll just stand here." Cause it was just the way he was talkin . . . "You look like you could get any job you want!"

Although overt sexual harassment is evident in this participant's recollection of the encounter, during a member check she described the neglect of context, the supposed

ease of getting a job based on appearance, as the prime negative experience of the interaction.

Both participants stated that they now avoided these particular service providers. Although avoidance is an exercise of autonomy, it served to narrow these women's options for success and left both feeling frustrated and deflated. Overall, being minimized was experienced as being called out for individual shortcomings and feeling blamed for being homeless.

Alienated. Moving down the continuum, participants described feeling alienated in interactions where they felt disregarded, unwelcome, or like they were a nuisance or bother to the service provider. The experience was described as 'disheartening", "awful", "brutal", "horrible". One woman recalled the incongruence between an agency's mission and her experience with staff, "I did not expect to be treated so rudely and and coldly. Especially at a place like that, you know, it says, 'We offer hope!' I did my paper work, and got out." Another woman remembered an incident at a shelter where volunteers were serving food:

> I went to walk around the other, other side of the table to pick up the plate you know. I thought that's the way you did it - you just went around like buffet style. . . . and she says, "You don't belong here" . . . "You don't belong on this side of the counter. We only stay on this side of the counter." Okay. So, I went back on the other side [slight laugh] and I sat, I sat in the back.

A third woman described feeling alienated when staff jeopardized her safety to smooth over an issue that occurred at a shelter:

> . . . I was at the [shelter] . . . this guy, completely off the street, came to me and started kissin' on me and I'm like, "Nn nnn. I'm married, leave me alone." . . . I told the place I was stayin' at and they're like, "Don't tell your husband." . . . Because he's a person, with easily fused, blow up, and they know that. . . . So I was like, I wouldn't tell him but I did, and I just told him I couldn't stay here anymore . . .

Powerless. The theme of powerless describes the most dehumanizing interactions experienced by the participants. In this theme women felt they had no voice, no privacy, were infantilized, or felt exploited. In many instances, women felt the inability to advocate for themselves within a situation or lack of action when they attempted self advocacy. One woman who had left a violent relationship recalled an encounter at a job skills class where she and two other women were trying to discuss job leads. The instructor silenced them and then went on to talk about a football game. "I wrote it down on a sack, 'Really, he can talk about football and we're in a job class and we can't talk about job leads?'" She went on to describe how the two women who did self advocate were expelled from the class for 45 days, losing a significant monthly stipend for class attendance.

Lack of privacy and the inability to intervene effectively left women feeling as if they had no space to call their own as one woman described, ". . . he'll come walk around the beds and talk to people and I've already said, you know, 'No! That is my bed!' and he has no business [slight pause] anywhere near my bed."

Another woman described overt exploitation of women that she personally has

not experienced but knows of other women who have:

> I've heard a lot of stories - I've never had to endure that . . . men bein' over pushy because of different positions they're in. . . . A person in this position and he's lookin' at females while you're talkin' to them, he's not lookin' at them in the eye, you know. He's touchin' them in inappropriate ways, and some people may say, "Oh, these people are homeless so they're not gonna say nuttin'. They can't tell nobody. Ain't nobody gonna believe 'em."

Women also felt exploited when groups of people came to the shelter to volunteer

or serve food. One woman remarked, ". . . it's more like we're a science project type

thing to them." Another woman described the experience in animalistic terms:

> . . . Sometimes it's overwhelming . . . , I feel like that we're on display for them . . . Honestly, I'm lookin' for a job, I'm taking care of business, so by the time I get here [shelter], I just wanna chill. Yesterday for instance, there had to be 25 people in here lookin' at us . . . No! I said, looking! - I meant it. Looking! . . . I call it "to watch the monkeys".

In later discussion, this participant further described exploitation as feeling that homeless

women's purpose is to serve others' need for service.

Humanizing Themes

In contrast to the dehumanizing themes, several themes emerged to include

homeless women's humanizing interactions with service providers. Service providers

demonstrated their recognition of participants' humanity through caring, trusting,

disclosing, and empowering and, as illustrated on the continuum, through these

interactions, participants experienced being cared for, trusted, a shared identity, and/or

empowered. In all the positive themes participants expressed trust in the service provider.

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Themes were identified as more humanizing when participants expressed a greater feeling of equity, an equalizing of the power differential, in the encounter.

Cared for. Being cared for was the prevailing positive experience for homeless women accounting for a full one third of positive significant statements. These interactions encompassed a multitude of actions on behalf of service providers (e.g., remembering, acknowledging, listening, talking, giving advice, being available, creating a safe and/or welcoming environment, showing concern, joking, giving tangible aid, reaching out) and resulted in participants feeling worthy of care; recognized as a valid individual. Caring service providers were described as "wonderful", "very, very nice", "one out of a million", "an angel".

Through being cared for, women developed a sense of trust with service providers. Some described the relief of being able to talk freely, of letting their guard down and expressing vulnerability. The catharsis associated with having someone to talk to is evident in the interaction one woman described:

> At first I was nnn- nervous. And when I got there she start tellin' me, "Go ahead, let everything go." So, I did. I talked to her, and talked to her about my family, my situation, bein' stayin' here and there, runnin', this and that . . . I could talk to her! I could really. I got somebody I can talk to, I can break down to and cry and let things go and you know and I ain't got nobody to tell you, "Oh well, it gonna be alright." No, she listen and try to give advice and said everything gonna be okay. "Just breathe".

Some participants described receiving special treatment, where their expectations were greatly exceeded. This typically occurred when a service provider did something out of scope of their normal work or even broke established agency norms or rules. One

participant commented, "They watched my daughter for five hours! These people didn't know me from Adam . . . they called everybody to try and find us a place . . . " as she described her interaction with service agency staff as they worked with her to obtain a restraining order against her abusive husband and secure safe housing for her and her daughter. Another woman described an instance where she was allowed to shower and rest before doing requisite paperwork for shelter admission. One woman told of police allowing her to camp on city property as long as the city did not complain. Another described when a nurse gave her a ride so she would not have to carry a heavy suitcase. Two other women spoke of shelter staff doing their laundry. Although positive, being cared for did not seem the expectation for most participants. Some women described feeling cared for as "surprising", some were "overwhelmed" at times.

Trusted. Many women mentioned they trusted service providers but only two women described being trusted by service providers. In both instances, being trusted implied that these women had moved beyond the stereotypical untrustworthy homeless person and were seen as an individual capable of reason and responsible for their own choices and actions. One woman's experience of being trusted was when a day center staff member invited her over on Christmas. The trust this participant experienced was not explicit in her significant statements. During a member check, she explained this was an experience of being trusted because few homeless women are invited to service providers' homes and the participant felt trust is a prerequisite for such an invitation.

Shared past / identity. Participants reported experiencing a shared past / identity with some service providers, particularly if they knew the service provider had previously

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experienced homelessness or substance abuse. In some instances participants stated the

commonality made them feel more comfortable or increased the credibility of the service

provider. The hope associated with having a shared past / identity with a service provider

is evident in one woman's account:

> Just to hear somebody else's story and they were there in your shoes it's like,
> wow! And lookin' at 'em now and they succeeded and it's good. It gives me a
> positive outlook that I'll be there one day. Because there's days that I'm like, no
> I'm gonna just give up, quit, say I'm done but then I think you know, I can't, I've
> got two kids to live for. I need to get goin'.

Not all service providers who had previously experienced homelessness or

addiction were perceived as caring or thoughtful people. Nonetheless, the experience of

having a shared past / identity increased the women's knowledge of another person's

personal success and resulted in a renewed determination to succeed. Also, a service

provider need not have experienced homelessness or addiction to make a shared identity

connection as one participant described, ". . . you know, everybody's been through

something in their life . . . I mean I think they could just get a little more personal."

Empowered. Several participants reported experiencing empowerment through

their interactions with service providers. These experiences included interactions that

resulted in increased independence for the participant through increased self-sufficiency,

self-understanding, or self-esteem.

One woman described feelings of empowerment as her potential as both an artist

and entrepreneur were acknowledged:

She's talking to us [slight pause] th-the homeless people who go to the [agency], the people that IS in the art - to actually take these position[s] and play these roles and take it serious and make a web site and become entrepreneurs in this art. She's teaching us to bring our self up. So, nobody over us - us bring ourselves up to get credit for somethin' not somebody get credit for bringing these homeless people up out of this. You know what I mean? It's us, bringing [pats table] ourselves out.

Another woman, who secured housing the day of our interview, described how being called out and held accountable for her poor attitude was a transcendental experience:

I learned a lot from him and I'm taking it with me to my classes. You know, different way - an attitude change. He just said "Smile". I said "No". And then I smiled [laughing]. So, it was one of those kind of [slight pause] things. So, 'cause he was telling the truth. He said, "How are you gonna get a job if when you walk in to the room, your face looks like that? Who's gonna wanna talk to you even?" And it was so true. . . . [I have a positive attitude] with my instructors, with my class- fellow classmates and everything I do. I think that's what helped me get this apartment.

Discussion

In our study, homeless women indicated encounters with service providers are experienced as dehumanizing, neutral, or humanizing. Dehumanizing experiences resulted from encounters that included having unmet expectations or that provoked feelings of being judged, minimized, alienated, and/or powerless. Humanizing experiences resulted from encounters that included feeling cared for, trusted, a shared past / identity with the service provider, and empowered. Most women described a range of both dehumanizing and humanizing experiences. Neutral encounters did not have either a humanizing or dehumanizing quality but rather were instances where expectations of the encounter and service provider were met.

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In contrast to much of the literature on homeless person and service provider encounters, overall the women in our study reported more positive than negative interactions. This might be related to the use of in-depth interviews rather than focus groups for data collection. Consistent with the humanization frameworks previously described (Duldt & Giffin, 1985; Todres et al., 2009) the range of service provider encounters detailed by the women in our study suggests that experiences of dehumanization and humanization are better represented as a continuum rather than as a dichotomy depicted in other studies (Lee & Peterson, 2009; Wen et al., 2007).

Similar to previous studies (Lee & Peterson, 2009; Wen et al., 2007), homeless women's humanizing experiences of service provider encounters were related to the power and the individual identity they experienced in the interaction, and the trust they felt in the service provider; the level of humanization experienced increased as these relational dimensions increased in the encounter. Relational Cultural Theory (RCT; Jordan, 2010), a theory that grew out of therapeutic interactions and positions mutual empathy and connection as essential to healthy growth, might provide a useful framework for understanding the role of humanization in interactions between homeless women and service providers. RCT extends beyond individual relationships and examines cultural issues of power and social structures that marginalize certain groups while privileging others. Experiences of marginalization in both society and individual relationships inhibit growth and produces feelings of isolation and hopelessness (Jordan, 2010). Women in our study described how their experience of the marginalization of homelessness was either exacerbated or diminished in service provider encounters.

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Through these encounters service providers are in the unique position to either reinforce or refute the negative associations and frequent victim blaming of homeless persons represented in society at large. Future studies should examine how humanizing and dehumanizing encounters between homeless women and service providers affect homeless women's self-identity and personal growth over time as well as how the marginalization associated with homelessness and the power differential between homeless women and service providers affect these encounters.

In the theme representing the least dehumanizing encounter, "unmet expectations", participants articulated they did not feel important, worthwhile, or deserving of service providers' time and energy. One participant who had been homeless for more than five years described a complete lack of positive expectations because of chronic disappointment from unmet expectations over time. Thus dehumanizing experiences, even those low on the continuum, might have a cumulative effect with consequences manifesting over time. In the more dehumanizing interactions captured in the theme "alienated" women in our study appeared to internalize the negative messages they had received and responded with subservient behavior. These subservient behaviors might be precursors to completely opting out of services as described in other studies (Hoffman & Coffey, 2008; Wen et al., 2007). A longitudinal study could explore the cumulative effects of dehumanizing and/or humanizing experiences resulting from service provider encounters.

Consistent with previous research with homeless persons (Lee & Peterson, 2009; Wen et al., 2007), the women in our study described being judged and stereotyped as a

frequent experience. Homelessness is a stigmatizing situation (Phelan, Link, Moore, & Stueve, 1997) and living with a concealable stigma (which homelessness is in some settings) is associated with both psychological distress and negative health outcomes (Quinn & Chaudior, 2009). Of interest, some of the women in our study described the need to conceal positive aspects of their past and past successes. This suggests that achievements such as being college educated or having a professional identity are concealable stigmas in the face of homelessness. The need to conceal achievements that, in other circumstances one might be quite proud of, could conceivably have detrimental effects on one's self-concept and self-esteem. Also, suppressing positive aspects of one's past might work to increase the appearance of group homogeneity and inadvertently reinforce negative stereotypes associated with homelessness. Future research could explore these types of concealed stigmas and might result in the societal conceptualization of homeless persons as a more heterogeneous group. Also, homeless persons who have concealed stigmas that, outside the context of homelessness, are considered positive attributes might be more readily housed or reintroduced to the work force.

Although trustworthiness was an important and desirable service provider characteristic that manifest across many of the studies that comprise the literature on homeless persons and service providers, our findings suggest the experience of being trusted, a reciprocal trust in the encounter, is humanizing. The trust described by the women in our study, that constitutes the theme "trusted", was associated with actions other than service provider self-disclosure. In their study with persons experiencing

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chronic illness, Thorne and Robinson (1988) found reciprocal trust from health care professionals fostered patient confidence and enhanced patient self-esteem. Thus, exploring ways to demonstrate they trust their clients might be an important consideration for providers of services to homeless persons.

Limitations

The current study has several limitations. First, the study began during the winter months when winter emergency shelters were open. Both sympathy and tangible donations for homeless persons are seasonal (Bunis, Yancik, & Snow, 1996). Had the study been conducted during summer months participants might have had less favorable experiences of service provider encounters or, because of the lack of emergency shelters, fewer encounters altogether. Second, non-English speakers were excluded from the study. The literature on non-English speaking homeless persons in the United States is virtually nonexistent. However, in a study assessing low income ethnic and racial minority parents perceptions of pediatric care for their children, non-English speakers reported worse care than their English speaking counterparts (Weech-Maldonado, Morales, Spritzer, Elliott, & Hays, 2001). Thus, non-English speaking homeless persons might have very different perceptions of their service provider interactions than English speakers. Third, all participants were residing in a homeless shelter when interviewed, although three became unsheltered within days of the interview. Nonetheless, non-sheltered homeless women might encounter service providers not included in this study or might have had negative service provider experiences resulting in their opting out of service. Also, the study was cross-sectional rather than longitudinal although observation

and member checks did span a four month period. Had the study been longitudinal the cumulative effects of humanizing or dehumanizing encounters or strengthening or erosion of the service provider relationship over time could have been assessed.

In spite of these limitations, our study makes a valuable contribution to the literature. As front line staff, service providers are in a unique position to influence humanizing or dehumanizing experiences for homeless women which might ultimately impact homelessness resolution. Our study offers service providers the opportunity to reflect on their own practice, gauge the humanizing qualities they exhibit in their encounters with homeless women, and move their practice to optimize homeless women's experience of humanization within the service encounter.

CHAPTER IV

"WHEN GOD MADE YOU, HE MADE AN ANGEL": HOMELESS WOMEN'S EXPERIENCES OF SOCIAL SUPPORT FROM SERVICE PROVIDERS

Abstract

Homeless women have few sources of social support. Service providers are sometimes excluded as potential sources of social support in research with vulnerable populations including homeless persons. We conducted in-depth semistructured interviews with 15 homeless women to gain a better understanding of the experience of interacting with service providers from their perspective. Phenomenological analysis revealed being "cared for" was experienced within service provider encounters and is commensurate with widely recognized sub-categories of received social support. Implications for the consideration of social support within the realm of service provision for both researchers and clinicians are offered.

Keywords: social support, homeless, women, phenomenology, qualitative research

The very first night that I was there . . . I'll never forget it. . . . She said . . . "Let's just put the paperwork aside and get you comfortable first." . . . I really couldn't believe it . . . I remember my, my bed actually wasn't that comfortable and [she] would not stop until . . . she found enough blankets to put on my cot …, 'cause it sunk down a little bit . . . I was so relieved.

In the quote above, a homeless woman recalls her encounter with a worker at a women's emergency shelter. The quote demonstrates the power of seemingly small and insignificant actions on the part of service providers when viewed through the eyes of homeless women.

How homeless women perceive their interactions with service providers, and the degree to which they perceive these actions as supportive, has been understudied. In fact, there is disagreement in the literature concerning whether service providers should even be considered as a source of social support. In an early study examining impoverished women and service provider encounters, Weiss (1973) remarked, "It is widely recognized that many of those who call on physicians for help are troubled by socially generated distress more than by physical ailments, and in need of support and guidance as much as they are in need of physical therapies" (p. 325). As Weiss refined his conceptualization of social support he posited that different types of social relationships provided varied *provisions*, meaning different relationship types (e.g., spouse, friend, professional) meet different individual needs. He proposed a framework for understanding the benefits of relationships comprised of six distinct categories or "relational provisions" that included "the obtaining of guidance . . . in stressful situations" suggesting this provision would most likely be met by an "authoritative figure who can furnish them [stressed individuals] with emotional support and assist them in formulating and sustaining a line of action"

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(Weiss, 1974, p. 24). In his seminal address, Cobb (1976) included "members of the helping professions" (p. 302) in his assessment of potential sources of social support across the life span.

More recently, some researchers in the field have questioned whether social support is within the realm of service provider encounters. Hupcey and Morse (1997) asserted that due to multiple facets of professional service encounters including payment for service, unidirectional flow, and the ethical obligation of support to clients, support provided by professional service providers should be deemed "professional support" (p. 275). In their study with homeless persons, Hwang et al. (2009) excluded service providers as a source of received social support based on the obligation service providers have to provide elements of support as a function of their job; they suggested social support from service providers is less meaningful to homeless persons than support derived from informal social network members. In defining terms for their review of social support concepts and measures, Gottlieb and Bergen (2010) defined social support as, "The social resources that persons perceive to be available or that are actually provided to them by *nonprofessionals* [emphasis added] in the context of both formal support groups and informal helping relationships" (p. 512). The distinction between professional support and social support may explain the paucity of studies examining social support between various service provider and recipient populations.

While there are valid arguments on both sides of this debate, it is imperative to understand how support from service providers is experienced by the recipient, or consumer, of that support. In this article, we use findings from a phenomenological study

of homeless women's experiences with support from service providers to examine the degree to and the manner in which that support is experienced as social support. We begin by reviewing the classifications of social support with a focus on enacted or received support then present several representative studies that examined received social support with homeless persons. Next we present our research methods and findings and then position these findings in the context of both established definitions of received social support as well as demonstrate how homeless women's realities can improve our understanding of support derived from service providers.

Literature Review

Classifications of Social Support

Following the work in establishing social support as an important construct related to health (see for instance Cassel, 1976; Cobb, 1976; Weiss, 1974), research in the field expanded and necessitated the establishment of common definitions and measurement techniques. Through reviewing the social support literature, including his own work, Barrera (1986) defined three distinct types of social support: *social embeddedness* (i.e., social integration within a social network), *perceived social support* (i.e., perception of availability of resources in case of need), and *enacted support* (i.e., received support based on supportive behavioral actions of others) and demonstrated with previous correlation studies that the three were independent constructs. Although Barrera did not distinguish between professional and non-professional support, his description of enacted support would include the actions of service providers. Therefore, we examined homeless women's experiences of enacted support with service providers.

Enacted support (also known as and here forward referred to as "received support") refers to observable supportive behaviors and has been further subcategorized. House (1981) described received support utilizing the subtypes of: *emotional*, *appraisal*, *informational*, and *instrumental*. Barrera, Sandler, and Ramsay (1981) developed a scale to measure received support, the Inventory of Socially Supportive Behaviors (ISSB). Subsequent factor analysis revealed four sub-types of received support: *directive guidance* (e.g., providing guidance, feedback, or instruction), *nondirective support* (e.g., measures of affection, esteem, availability, and understanding) *positive social interaction* (e.g., laughing, joking, discussing shared interests) and *tangible assistance* (e.g., giving tangible aid) (Barrera & Ainlay, 1983). Barrera (1986) noted that received support is most likely evident in times of hardship and is, ". . . suitable for gauging the responsiveness of others in rendering assistance when subjects are confronted with stress" (p. 471). Although the sub-types described by House (1981) and Barrera and Ainlay (1983) vary by name, the behaviors associated with received social support are captured in both groupings and both are widely referenced in the literature.

Received Support, Homeless Persons, and Health

Researchers have utilized all three types of social support in studies examining homeless persons and health outcomes; studies examining social networks are more prevalent. Although an under-researched area, studies that have focused on received support with homeless persons can be found in the literature. For instance, Nyamathi, Bennett, Leake, and Chen (1995) examined received social support in a sample of homeless women. Their findings indicated that "other professionals" (i.e., non-medical /

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non-nursing) were more important than family members for obtaining advice, explanations, and in facilitating change. In a study comparing low-income housed and homeless mothers, Letiecq, Anderson, and Koblinsky (1996) found both groups reported receiving more help from their child's Head Start program in raising their families than other support sources such as family members and friends. In their study with homeless persons, Hwang, et al., (2009) found received support was uncommon and unrelated to health. As previously stated, the above study did not include service providers for consideration of received support. All three studies were quantitative and used different measures to assess received social support.

In their qualitative study, Stewart, Reutter, Letourneau, Makwarimba, and Hungler (2010) used House's sub-types of received support to assess the support needs of homeless youth and young adults. They found all four types of received support to be lacking and that, due to their transiency, their participants identified friends or agency staff as providers of social support rather than family.

The conceptualization of service providers as providers of social support might be dependent on the nature of the service provided, the nature of the interaction, or the service recipient. Persons experiencing homelessness may have different perceptions of what constitutes a service provider, or service provision, than what is commonly held by practitioners in the field. Thus, we examined service provider encounters from the perspective of homeless women to ascertain whether, based on their experiences, service provider actions are commensurate with widely recognized categories of received support.

The current study is part of a larger phenomenological study that examined the experience of interacting with service providers from the perspective of homeless women. Thematic results for the entire study, which identified interactions on a dehumanizing / humanizing continuum, are reported elsewhere (Biederman & Nichols, under review). "Cared for" was the largest theme to emerge from the full phenomenological analysis. It accounts for almost half of the total participant/service provider interactions, over three quarters of all humanizing interactions, and was the only theme experienced by all participants. In this study, we examine how homeless women's experiences of feeling "cared for" aligns with Barrera and Ainlay's (1983) definition of received support. Through exploring homeless women's experience of 'cared for', we aim to answer the following research questions: 1) How do homeless women's experiences of being cared for by service providers align with Barrera and Ainlay's (1983) typology of received support? 2) Under what conditions do homeless women perceive interactions with service providers as received support?

Methods

Sample

A purposive sample of 15 women who were experiencing homelessness participated in the study. Participants self-identified as Black (7), White (7), and American Indian (1). Average age was 43 years (SD = 10.9). The majority were single, either never married (6), separated (1), or divorced (1) with only two participants identifying a current intimate partnership or marriage. More than half (8) of the participants had a child or children under 18 years of age but only two participants had a

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child in their custody. Seven participants were experiencing their first episode of

homelessness. The length of homelessness for the current episode ranged from one month

to five years with 12 participants reporting current time homeless of six months or less.

Procedure

A homeless drop-in day center and winter emergency shelter served as the study

sites; the study was approved by the university's Institutional Review Board (IRB). Study

inclusion criteria were: participants must be at least 18 years of age, female, English

speaking, currently experiencing homelessness using the HUD definition at the time, and

have utilized services of a provider or agency that provides services to homeless people.

The first author conducted all interviews. As a former service provider and nurse case

manager for homeless persons, it was necessary for the first author to acknowledge her

past interactions with homeless women. Thus, an initial "feelings audit" (Bednall, 2006)

was conducted to identify past experiences germane to the research questions and to

bring those memories to the surface in the process of bracketing. On arrival at the study

site but before a potential participant encounter, the feelings audit was reviewed to

bracket prior experiences in efforts to limit researcher induced bias.

Participant recruitment occurred through introduction by a staff member at a

study site (1), snowball method (6) or direct approach (8). On introduction, participants

were informed of the study and, if interested, assessed for inclusion criteria. Women who

were interested and met inclusion criteria were invited to participate. A total of 18

women were approached, 15 met inclusion criteria and participated in the study. The

three non-participating women had living arrangements that did not meet the HUD

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definition of homelessness. Interviews were conducted between December, 2011 and March, 2012; all interviews were conducted in private rooms at one of the two study sites and audio recorded. Interviews continued until theoretical saturation was reached. Commensurate with the literature on data saturation (Guest, Bunce, & Johnson, 2006; Morse, 2000) no new themes emerged after participant 11.

After obtaining verbal consent, women were asked about their lives, previous episodes of homelessness, current homeless situation, service providers who they have encountered during experiences of homelessness, and stories of service provider encounters. When participants gave generalizations such as, "She really cares about me" or "He's wonderful" they were asked to describe specifically what a service provider does to exhibit care or to be considered wonderful. Demographic information was also obtained during the interview process. Interviews lasted between 23 and 103 minutes (M=41; SD=19). The first author conducted and transcribed all interviews verbatim. Participants were paid $10 cash for their time in participating and also given a copy of the consent form with researcher and IRB contact information. All participants were asked to provide contact information for follow-up and gave at least one contact method (e.g., cell phone number, email address); over half (8) participated in member checking.

All field encounters included unstructured observations captured in field notes. "Unstructured" does not imply that observations were ill planned or happened haphazardly but rather that a priori notions of the range of possible observations and behaviors were put aside which allowed for consideration of nuanced or more subtle behaviors and interactions (Mulhall, 2003). Field time expanded beyond the interview

setting. Time with participants included informal interactions at the drop-in day center, eating together and socializing at the winter emergency shelter, and a dinner outing to a local restaurant. During some of these events, volunteers at the service location were not necessarily aware that the first author was not a homeless woman herself. Also, during the study one participant was hospitalized. The first author, together with one or two winter emergency shelter residents, visited her in the hospital on four occasions over a three-week period. The first author also acted as her advocate at a hospital discharge planning meeting and visited her again in the hospital during subsequent hospital admissions. Engaging with homeless women in these multiple service-oriented locales and acting as a patient advocate during hospital discharge planning provided rich observational data that complimented data obtained through interviews.

Data Analysis

Colaizzi's (1978) method of phenomenological analysis was used. Field notes were written and interviews transcribed within 24 hours of the encounter to maximize data accuracy and increase knowledge of and intimacy with the data. From complete transcripts, interviewer questions and comments were removed and then transcript sections containing participant recollections of encounters with service providers were extracted as relevant statements. Relevant statements were coded into one of four categories: agency statement, general statement, service provider encounter and other person's service provider encounter. Service provider encounters and other person's service provider encounters (i.e., "shadowed data", Morse, 2000, p. 4) were considered "significant statements" (Colaizzi, 1978, p. 59). The meanings of these statements were

formulated and a member check performed with eight of the 15 participants to increase

study validity by ensuring accuracy at this step. The formulated meanings were

categorized as neutral, negative, or positive and then further differentiated into themes

using open coding. Next the themes were arranged into clusters first within then between

transcripts. On completion of this step, each participant had a packet that included the

complete transcript, the transcript with the interviewer's voice removed, relevant

statements, significant statements, formulated meaning table, cluster of themes, field

notes, and member check notes when applicable. All themes were then compared across

all transcripts to ensure themes were representative of all the women's service provider

encounter experiences and that all such experiences were captured in the themes.

As themes emerged, it was noted that the experience of care was reflective of the

subtypes of social support described by Barrera and Ainlay (1983). All experiences of

"Cared for" across all participants were cross-referenced to the factor analysis tables of

the ISSB (Barrera & Ainlay, 1983) to ensure compatibility with the ISSB items for the

"Cared for" theme and theme variant validation.

Results

The theme "cared for" emerged from participants' descriptions of interactions

with service providers where the primary experience was that of feeling cared for by the

service provider. Caring for another person typically involves being attentive and

responsive to the person's needs. Interactions reported by participants encompassed a

multitude of actions on behalf of service providers but the defining characteristic of the

theme was that these actions resulted in participants feeling worthy of care and

recognized as a valid individual. The theme was represented by 71 significant statements that can be categorized within the four sub-types of received social support (*directive guidance*, *nondirective support*, *positive social interaction*, and *tangible assistance*) described by Barrera and Ainlay (1983).

All 15 participants described the experience of being "cared for"; participant descriptions included a number of different types of service providers within a wide variety of venues. Service providers were categorized based on individual participant description of the provider and encounter. Service provider type and number of significant statements of "cared for" by service provider included: employees and volunteers at homeless specific agencies such as shelters, day centers, and food sites (34), nurses / nurse practitioners (10), therapists, counselors, caseworkers (7), governmental human service agency workers (7), church staff including pastors, staff, volunteers (6), police (4), and physicians (3).

Directive Guidance

Directive guidance included experiences of feeling cared for as a result of receiving feedback, instruction, or guidance, sometimes in efforts to secure further services from a service provider. Some participants were not aware of the availability of certain services either because of being new to the area or because it was their first experience of homelessness. Some participants described instances, considered to be the typical experience, where they were given a resource list of the services they were seeking from a homeless service agency. However, several participants described encounters where the service provider who was making the referral guided them through

the process of securing the needed serviced. One young woman, who had been homeless

for five years and had a diagnosed mental illness, recalled an encounter with a hospital

case worker who assisted her in calling local shelters and coached her on how to interact

with intake staff. This was quite different from her typical experience of being

"discharged to the street" following a stay in a psychiatric unit or shelter. Another

woman, who became homeless after the death of her common law husband, described

how a shelter worker helped to secure much needed grief counseling. The few women

who reported this type of encounter described it in terms of feeling cared for stating "they

helped me with a lot" and "she completely goes out of her way". One participant

described her therapist as "wonderful" and went on to describe how he supports her

through guiding her away from negative influences and towards positive ones.

Nondirective Support

Nondirective support is the largest subcategory of the "cared for" theme,

accounting for more than half of the service provider encounters experienced as care and

included when service providers actively listened to participants, remembered details of

the participant's lives, verbalized unconditional availability, demonstrated

trustworthiness, and / or demonstrated concern for participants physical, mental, and

emotional comfort, safety, and/or overall wellbeing. Much of the nondirective support the

women in our study experienced was having someone to confide in. Some participants

described an unwillingness to express vulnerability in the company of their homeless

peers so that they would not be perceived as needy or weak. These women counted on the

support of trusted service providers who listened to their issues and encouraged them to

talk about intimate details of their lives. One woman described such an encounter with a

mental health nurse:

> She just sat and talked to me and let me cry and and try to get it out cause it,
> that's, I didn't have anybody to really talk to to to get it, 'cause I was holdin' it all
> in and so she let me. She's, we went in her office and we set there and she said,
> "Just, don't be afraid, t-t-to cry. Don't be afraid, just, let's just talk." And, I did and
> I felt a lot better.

Another woman who was engaged in ministry study and was being harassed by

other women in the shelter described her encounter with a shelter worker. In this case, the

shelter worker not only provided active listening but also affirmed her decision:

> . . . I needed a good cry. I needed to get away. . . . She assured me I was doin' the
> right thing and that I just have to toughen up you know. So, I could (deep breath)
> run with the dogs and get fleas or I could be tough, so.

Active listening was also manifest as service providers having a greater

understanding of the women's lives within the context of homelessness and

acknowledging their particular situation. One woman commented on her ability to speak

honestly and openly with her physician and his understanding of her lack of desire to quit

smoking while she was homeless. Another woman who had not seen her children in over

two years described how a service provider acknowledged her spiritual needs by giving

her a Bible, praying for her, and encouraging her to go to church. Two women

commented on service providers who allowed them needed space and control in a

relationship. One young woman described how she avoided her counselor but routinely

talked to another paraprofessional woman in the agency:

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I would never go upstairs to my counselor, I would sit downstairs and talk to her [victim advocate].'Cause it was just different. She didn't pressure me or nothin'. She let me get on the computer and do what I wanted to do and talk.

The importance of not being pressured to communicate and, instead, to have autonomy in setting relationship parameters are also demonstrated in this woman's description of her experiences interacting with a shelter worker:

. . . she don't pressure me . . . she's givin' me the freedom to um, not um, mingle or communicate. It's it's like - if that's what you wanna do, if that's what you're comfortable with, we're here for you. . . . VERY supportive . . .

Nondirectional support was also described in instances where service providers showed concern for the women's overall wellbeing. For some women, this expression of care was manifest when a service provider inquired about how they were doing or how their day went. Service providers who inquired about participants' daily experiences were described as "wonderful" and "genuinely interested". The experience of talking about their day was described as "awesome" and "quality time".

Participants also described feeling cared for when service providers "reached out" and spontaneously offered assistance or intervention. One woman described an encounter with a nurse who gave her a ride from one shelter to another when she saw her struggling with a heavy suitcase. During the ride the nurse gave the participant a brief guided tour of the downtown area describing homeless friendly resources. One woman who had just begun seeing a counselor recalled her interaction with a receptionist who had called with an appointment reminder:

. . . She said, "Miss [name], is you okay?" and I said, "Yeah". I said, "Um, no, I'm not." She said, "I know, I could tell in your voice." . . . And she's like, "Miss [name] it's gonna be okay, you know. You can call up, just hit redial, you can call back up . . . and talk to anybody about depression."

The caring associated with "reached out", can have a dramatic impact and outcome on homeless women. One woman recalled how a service provider's willingness to reach out literally saved her life:

I mean they noticed it. All I was doin' was sittin' and starin' and cryin' you know and I was just at the point where I couldn't help myself. . . . That little girl came and got me yeah . . . I had already planned to take myself out and how I was gonna do it and if they hadn't a intervened I'd a probably ended up layin' across the railroad track. I was just really a (deep breath) to d - to me the only really way out was to die. I just couldn't take it. . .

Other participants' experiences of being cared within the sub-category of nondirective support included interactions where service providers followed up with them, reassured participants of their continued availability, or expressed concern for participants' physical comfort and safety. These experiences were not the norm or a typical service provider encounter. Women were surprised by how far service providers extended themselves to ensure their physical, mental, and spiritual comfort and wellbeing. Many expressed a relief from having such a positive encounter as evidenced in this quote from a woman who described her first night at the shelter in terms of feeling welcome:

I mean they welcomed me with open arms and I really slept good that night because at my daughter's house I had a lot of broken sleep but I went in there that night and I slept like a baby.

Positive Social Interaction

While women desired intimate encounters and trusting relationships where they could express vulnerability, they also appreciated service providers who joked with them, talked about shared interests, or provided other diversionary activities to lighten the stress associated with homelessness. One woman described her initial encounter with two men who work at a homeless day center: "They came in, I said, 'I'm a new person.' 'Hmmm. You ain't new. You somebody- you just like the rest of 'em!' They make me laugh." Another woman described attributes of a homeless agency nurse:

> . . . She makes you laugh she's- she's a very outgoing person and funny (laughs) . . . she's gonna try her best to make you laugh. Even if she, even if it means being silly and she's gonna go out of her way to make sure that you're takin' care of.

Another woman, who was separated from her two young children, described how staff went out of their way to engage in a shared activity. This was particularly important due to the holiday:

> The two that smoke will come out with us on our smoke breaks and you know we joke around. On Christmas day [staff member] went out and got some basketballs and we were out playing horse and, and she kicked my butt (laugh).

Some participants described encounters with various service agency personal who joked around or teased them on a regular basis. The women who described this joking and teasing as an experience of care expressed that it was meaningful, that it helped them feel like "normal" people, and "makes people feel more comfortable".

Tangible Assistance

Participants reported feeling cared for in service provider interactions where they received unexpected services, money, other physical objects of value, or some other sort of tangible assistance. Some participant encounters resulting in tangible assistance were within agency norms of providing clothes, food, and/or toiletries; still many women were surprised by the quality, quantity, or variety of items offered. Other tangible assistance women reported included receiving a needed service that, at the moment, was beyond their reach. One participant who was fleeing a violent relationship described how service agency staff provided child care "for FIVE HOURS" while she secured a restraining order. Two other participants described instances where shelter staff did their laundry. One woman commented, ". . . if I needed money here and there which I know that she wasn't supposed to do that but she did. Sh-sh-sh, you know, she helped out that way." Thus, sometimes service providers crossed the boundaries of professional service relationships, or even broke established agency rules, to provide tangible assistance to homeless women.

Two participants' described receiving tangible support from service providers without asking. One recalled her first service provider encounter upon arriving in a new city:

> When I first came up here, I didn't have nothin'. I left with a backpack, that's it. We didn't have no clothes, nothin'. I walked in there – the minute – one of the guys there Mr. [name], he gave me cash out of his pocket (slight pause) to go get somethin' to eat.

The other participant described an interaction with an agency director that she had gotten

to know. The interaction occurred as the participant was preparing to depart the city:

> … just before I left, it was raining really hard one day and I got caught out in it
> without an umbrella . . . [Agency director] gave me, um, a fresh set of clothes to
> put on. She didn't have jeans quite in my size, the jeans she gave me were too big.
> She took her own belt up off and gave it to me…She's, she's just like that.

Discussion

Cobb (1976) conceptualized social support as consisting of three independent

informational "classes" that included: "Information leading the subject to believe that he

is cared for and loved" (p. 300). In our study, homeless women described the experience

of being "cared for" within the subtypes of received social support proposed by Barrera

and Ainlay (1983). Women described directive guidance in terms of receiving instruction

or assistance in securing further services or being steered away from negative influences

and toward positive ones. Nondirective support displayed by service providers included:

respecting client confidentiality, active listening, allowing the participant some control in

the service provider relationship, welcoming and remembering participants, assuring

continued availability, and demonstrating that participant safety and comfort was a

priority. Positive social interaction included joking, teasing, and engaging in shared

activities that were experienced as meaningful. Tangible assistance was given, sometimes

as an agency norm but also in instances where service providers stretched the boundaries

of their professional role or broke established agency rules to help meet a tangible need.

Social relationships are important to homeless women however maintaining

relationships in the context of homeless presents challenges (Butler, 1993). In her study

comparing social support sources and satisfaction with social support between single

men, single women, and women with children, Zugazaga (2008) found a universal lack of

social support with all three groups having more nonfamilial than family support sources

and single women reporting lower support satisfaction. The women in our study indicated

few sources of social support and a reluctance to express vulnerability to their peers.

Thus, traditional sources of social support, such as family and friends, may be few and far

between or completely non-accessible for some homeless women making received

support, the experience of being cared for, from service providers even more important.

For the women in our study, "service providers" represented a wide range of

professionals, paraprofessionals, and volunteers from multiple agencies and service

venues. This finding challenges the notion of what characterizes a "professional" in

agencies that primarily serve homeless people. Lindsey (1998) noted that many people

who work directly with homeless persons (in that case, shelter workers) may not have a

formal education and, of those who do, few have a terminal degree. Thus, professional

support might not be easily distinguished from social support in the context of

homelessness.

The debate bifurcating professional support and social support partially stems

from researchers who surmise service providers provide social support as a job function.

The women in our study clearly indicated that service providers are a source of social

support. Our participants made a clear distinction between when a provider was doing

their job (professional support) and the added dimension of providing social support (e.g.,

providing services in a manner that was experienced as feeling cared for). The experience

of care has been articulated in other studies with homeless persons. Thompson, McManus, Lantry, Windsor, and Flynn (2006) found homeless youth and young adults (ages 16 – 24 years) valued their relationships with service providers. These youth and young adults expressed their ability to perceive if service providers truly cared for them or not and this perception went beyond the mechanics of the service provider performing their job functions. Similarly, Stewart, Reutter, Letourneau, Makwarimba, and Hungler (2010) found youth and young adults (ages 15 – 24 years), valued the experience of being cared for by service providers. For these youth, being cared for was considered emotional support and young women in the group felt this was a priority concern. Also, Hoffman and Coffey (2008) found homeless adults valued feeling cared for by service providers. In this case, care included being made to feel welcome, respected, and service providers being flexible with agency rules and norms.

"Reached out", interactions where the service provider sought out the participant or noticed an issue the participant was dealing with and spontaneously intervened, also emerged as an important variation of the experience of care that cut across several sub-categories of received social support. In their study with 17 formerly homeless persons, MacKnee and Mervyn (2002) reported "reached out" as a critical incident that facilitated the transition from homelessness; participants in their study reported feeling "cared for" and "trusted" when people reached out to them (p. 298). In the current study "reached out" also had dramatic effects including one participant who articulated that a service provider who reached out to her literally saved her life.

Implications

Cobb (1976) suggested health professionals are in a unique position to "teach all our patients, both well and sick, how to give and receive social support" (p. 312). However, in order to teach social support, health professionals must understand the variations of social support and how social support may manifest in the populations with which they work. The women in our study experienced being cared for by service provider actions that fall within the established categories and associated examples of received support included in the ISSB (Barrera & Ainlay, 1983). The ISSB could serve as a guide for creating education programs for persons who work with homeless people including: professional service providers, students likely to become service providers, paraprofessionals, nonprofessionals, and volunteers.

From a research perspective, studies with homeless persons that exclude service providers as a potential source of social support for homeless women may not be capturing the full range of participant encounters, relationships, networks, and experiences. Thus researchers should offer participants the ability to indicate who within their network provides what elements of social support rather than restricting the full range of possibilities.

Limitations

The current study has several limitations. First, the study was limited to adult, English-speaking women. Homeless youth, non-English speakers, and homeless men (who represent the largest segment of the homeless population) may perceive support from service providers differently or may seek services from providers not represented in

this study. Second, all the women in this study were sheltered; non-sheltered homeless women may not share the same perceptions of service providers as women in the current study, or may have a different conceptualization of service providers altogether. Also, the study was conducted in the winter months when emergency shelters were operational. Both compassion and tangible support for homeless persons is higher during the winter months (Bunis, Yancik, & Snow, 1996). Had the study been conducted at another time of year, participants may not have had the full range of experiences of received report or had interaction with the same types of service providers as reported in the current study.

Notwithstanding, our study makes a valuable contribution to the literature. Homeless women have been afforded the opportunity to weigh in on the debate regarding whether social support is within the realm of service provision. The women in our study differentiated between professional support (service providers meeting professional service standards and obligations) and social support (service providers extending themselves in ways that was experienced as being "cared for") and indicated that within the context of homelessness both are experienced in service encounters.

CHAPTER V

EPILOGUE

Summary of Study Goals and Findings

The goal of this dissertation was to gain understanding of homeless women's perceptions of client/service provider interactions and relationships. The constructs and sub-categories of social support were initially identified as a potential organizing framework. A qualitative study was developed that included a semi-structured interview guide aimed at eliciting experiences of both positive and negative service provider encounters. A total of 18 women were approached to participate in the study, 15 participated in an initial interview, and 8 participated in a follow up "member check" to ensure accuracy of the transcript data.

The findings from the study suggest that homeless women have a range of encounters with service providers that can be depicted on a dehumanizing / humanizing continuum anchored by "powerless" and "empowered" with powerless representing the most dehumanizing experiences and empowered the most humanizing. Points along the continuum are separated by the power participants experienced in the interaction and the trust they felt in the service provider. The finding that feeling powerless is dehumanizing and feeling empowered is humanizing is consistent with previous studies with homeless persons. However, previous studies suggested a dichotomy rather than continuum. As

compared with previous studies regarding homeless persons' service provider encounters, our participants articulated more positive than negative experiences.

Within the positive encounters, women described being 'cared for'. These experiences of care mapped on to the existing subcategories of received social support described by Barrera and Ainlay (1983). This finding is not consistent with some previous literature that suggests social support is not within the realm of service provision because service providers provide social support as a function of their job. Participants defined "service providers" as persons they interacted with to receive a service and did not distinguish between professionals, paraprofessionals, and non-professionals. Also, participants clearly identified the difference between a service provider doing their job (professional support) and instances in where the service provider went above and beyond or reached out to the participant in a manner that made the participant feel 'cared for' (social "received" support).

Based on these findings, the following conclusions can be made from the study:

1. Homeless women have a range of experiences in service encounters that are best expressed along a continuum.

2. Homeless women may describe "service providers" differently than non-homeless persons.

3. Homeless women do differentiate between when someone is performing their job functions and when someone extends themselves beyond the functions of their job in a caring manner.

4. Both professional and social support are within the realm of homeless women and service provider encounters.

Implications for the Field and Future Directions

The results from this study have both research and practice implications. From a research perspective, conducting individual interviews rather than group interviews or focus groups may result in a broader and more inclusive range of experiences. Second, homeless women and persons in other marginalized groups and situations should be given the opportunity to define "service provider" rather than be limited to pre-defined categories; otherwise important encounters, relationships, networks, and experiences may be excluded. Lastly, service providers should be considered a source of social support for homeless women. From a practice perspective, the women in our study articulated many ways that service providers' actions equate to dehumanizing or humanizing experiences. Service providers are encouraged to reflect on their own practice and make changes as necessary to optimize the humanizing experience in service encounters for homeless women.

Personal Reflection

I began the doctoral program with the assumption that I would do a dissertation that was focused on homeless persons for a couple of reasons. First, I have experience working with homeless people. Second, I felt there were many gaps in the literature on homeless people; although I have to admit, I did have a hard time honing in on one. I did

not necessarily expect to focus on homeless women but my mentor, Dr. Tracy Nichols, suggested it would be a good way to combine our populations of interest, mine being homeless persons and hers being marginalized women.

The research process was more difficult than expected. Not the interviewing, transcribing, or even writing (although those tasks were difficult at times) but rather hearing stories of women who had been through so much, had overcome so much, but still seemed to have an uphill battle ahead. There were times, more than once, when I didn't think I could face another participant; some were so desperate. There was a point during the study where I felt I was exploiting my participants and felt cheap offering them $10 for their story. I began to doubt the research process, the value of research, the usefulness of research. Considering the lives of my participants research really didn't seem to matter. It was during these times that mentors (Dr. Tracy Nichols and Dr. Betsy Lindsey) and friends (primarily Holly Sienkiewicz) proved invaluable and provided a safe place to vent, curse, debrief, cry – whatever was needed at the moment; their support was (and is) greatly appreciated.

Perhaps one of my biggest doubts through the entire process was that I would be able to contribute anything of significance to the literature. As a novice qualitative researcher I had no idea what I was going to do with all that data. But through the phenomenological method I followed, with much guidance from friend and mentor Dr. Tracy Nichols, I do believe that the study is sound and adds to the literature on homeless women and also the humanization, social support, and stigma bodies of literature.

I've enjoyed my time at UNCG but am happy to be completing the doctoral program and advancing in my career trajectory. I appreciate all the lessons I've learned over the past 4.5 years and will put them to good use in my academic career.

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APPENDIX A

RECRUITMENT SCRIPT

The student researcher will only approach females that appear to be at least 18 years of age. The student researcher will assess the participant's ability to communicate in English and if there is a language barrier the student researcher will explain that she only speaks English and will terminate the conversation.

All interactions with potential study participants will begin with an introduction as follows:

Student Researcher: "Hello, my name is Donna Biederman, I am a student researcher from UNCG and am hoping to learn more about interactions with service providers from a woman's point of view. I am conducting a study and would like to speak with women currently experiencing homelessness. Would you like to hear more about the study?"

The following are scripts that will be used for different scenarios.

Scenario 1:
Prospective Participant 1: "No." [Or participant may say nothing and just walk away or give another type of response that indicates they do not wish to participate].
Student Researcher: "Okay. Thank you for your time."

Scenario 2:
Prospective Participant 2: "Yes." [Or participant says something affirmative indicating she would like to hear more about the study].
Student Researcher: "I am hoping to talk with women who are 18 years old or older, who are currently experiencing homelessness, and have or have had interactions with homeless service providers. Are you 18 or older? Do you currently sleep in a homeless shelter, a welfare hotel, an outdoor camp, or on the street or in a car? Do you have any interactions with homeless service providers (or have you in the past)?
Prospective Participant 2: "No." [Prospective participant may not be 18 years old or older, does not meet our definition of homeless, or has had no interactions with service provider].
Student Researcher: "Our criteria to participate in the study include that you must be female, 18 years old or older, sleep at a homeless shelter, a welfare hotel, an outdoor camp, or on the street or in a car, and have had an interaction with a service provider. It appears that you do not meet our criteria because [reason for exclusion] and I thank you for your time and interest. Do you know anyone who meets that criteria and may be interested in hearing about the study?"

Scenario 3:

Prospective Participant 3: "Yes." [Or participant says something affirmative indicating she would like to hear more about the study].

Student Researcher: "I am hoping to talk with women who are 18 years old or older, who are currently experiencing homelessness, and have or have had interactions with homeless service providers. Are you 18 or older? Do you currently sleep in a homeless shelter, a welfare hotel, an outdoor camp, or on the street or in a car? Do you have any interactions with homeless service providers (or have you in the past)?

Prospective Participant 3: "Yes."

Student Researcher: "The interview will take about 45 minutes to one hour. You will be compensated $10 cash for your time. I have a consent that contains a lot of information about the study. Does this sound agreeable to you? If so, I would like to read the consent form to you and answer any questions you may have. Is now a good time?"

Prospective Participant 3: "Yes."

Student researcher will then read the consent form to the prospective participant and answer any questions the prospective participant may have before asking the prospective participant to sign the consent form. Student researcher will give participant a copy of the consent form and a business card with the student researcher's business contact information on it.

Prospective Participant 3: "No."

Student Researcher: "When would be a better time? Student researcher will offer participant a business card with study name and student researcher's name and office phone number to allow potential participant to contact student researcher at a more convenient date / time.

[Note - The student researcher will ensure she is not interrupting any activities of the prospective participant during this process. For instance, if the prospective participant is in line for food, the student researcher will wait until the prospective participant has had the opportunity to secure food and eat before beginning the recruitment process].

CONSENT FORM

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

Project Title: Understanding the Experience of Interacting with Service Providers from the
                   Perspective of Homeless Women

Project Director: Tracy Nichols, PhD; Donna Biederman, RN, Student Researcher

What is the study about?
This is a research project. We would like to know more about interactions between homeless
women and service providers.

Why are you asking me?
We are asking you to participate because you are a woman who is 18 years old or older, are
currently experiencing homelessness, and interact with homeless service providers. We value the
information you have regarding homelessness and service provider interactions. We do not want
you to feel coerced to participate in our study in any way.

What will you ask me to do if I agree to be in the study?
If you agree to be in the study, I will ask you questions about your experience of interacting with
service providers. These are people who work at shelters, soup kitchens, and other places that
offer services to homeless persons. The interview will take about 45 minutes to one hour. If it is
okay with you, I may come back and ask you more questions at a later date. Sometimes talking
about experiences of homelessness is difficult and may be stressful. You do not have to answer
any question or talk about anything that makes you feel uncomfortable. You can stop the
interview at any time if you wish. If you have any questions regarding this study, you may
contact me (Donna Biederman) by phone at (336) 334-4738 or Tracy Nichols at (336) 256-8504.

Is there any audio/video recording?
I would like to audio record our conversation. Because your voice will be potentially identifiable
by anyone who hears the recording, your confidentiality for things you say on the recording
cannot be guaranteed although we will try to limit access to the recording by having it on only
one computer and erasing it from the recorder as soon as it is downloaded onto the computer.

What are the dangers to me?
The Institutional Review Board at the University of North Carolina at Greensboro has determined
that participation in this study poses minimal risk to participants. The risks associated with this
study include potential uncomfortable feelings associated with participating in dialogue related to
the experiences with service providers while being homelessness. If you have any concerns about

your rights, how you are being treated or if you have questions, want more information or have suggestions, please contact Eric Allen in the Office of Research Compliance at UNCG toll-free at (855)-251-2351. Questions, concerns or complaints about this project or benefits or risks associated with being in this study can be answered by Tracy Nichols who may be contacted at (336) 256-8504.

Are there any benefits to me for taking part in this research study?
There are no direct benefits to participants in this study.

Are there any benefits to society as a result of me taking part in this research?
Understanding interactions between service providers and homeless women may enhance services and facilitate service uptake. Connection to appropriate and necessary services may, for some women, be the path to homelessness resolution.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you for participating in this study. Upon completion of the interview, you will be given $10 compensation for your time.

How will you keep my information confidential?
All information that is on paper will be kept in a locked file cabinet in Donna Biederman's office at UNCG. All audio files will be transferred to a computer that has a password that is in a locked office. All information obtained in this study is strictly confidential unless disclosure is required by law.
Information from the interviews will potentially be used for future presentations and / or publications. Your identity will be protected through the use of pseudonyms (a female name other than yours).

What if I want to leave the study?
You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state.

What about new information/changes in the study?
If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:
 You agree that you read this consent form, or it has been read to you, and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. You are agreeing that you are 18 years of age or older and are agreeing to participate in this study described to you by Donna Biederman.

INTERVIEW GUIDE

Purpose: The reason I would like to talk with you today is to better understand homeless women's experience of interacting with service providers. As a woman currently experiencing homelessness in Greensboro, your perceptions of interactions with service providers will help us to understand your experience and may serve to enhance service delivery and client satisfaction.

Conversational Interview Questions

Interview Opening:

- There are no right or wrong answers, I just want to know what your experiences are.
- I will be tape-recording this discussion and only project staff will hear these tapes, you will not be identified by name on the tape.
- Please be honest. You won't upset me or hurt my feelings.

Q1. Tell me about the people who provide services for homeless women?

- Who are they? Where do they work? What do they do for homeless people?

Q2. Tell me about your experiences with some of these service providers.

- Which ones do you see frequently? What do you see them for? What is that like?

Q3. Can you describe a recent experience with a service provider from start to finish?
- What happened first? What happened next? What was it like? How did it end?

Q4. Can you tell me about a time when you had a bad experience with a service provider?

- What did the service provider do? What did you want the service provider to do?
- What did you do? Have you had any more interactions with that provider?

Q5. Can you tell me about a time when you had a good experience with a service provider?

- What did the service provider do? What did you think the service provider would do?
- What did you do? What were the good parts?

Q6. If I just became homeless what advice would you give me about service providers?

Q7. What other experiences with service providers have you had that you can tell me about?

-What else can you tell me about being a homeless woman and interacting with service providers?

Structured Interview Questions

Q1. How old are you?

Q2. What is the highest level of education you have completed?

If college, what type of degree?

Q3. How would you rate your current health status among the following choices?

Very Good   Good   Fair   Poor   Very Poor

Q4. What is your marital status: Married   Divorced   Widowed

Separated   Never been married   A member of an unmarried couple   Other: _____

Q5. How many times have you been homeless in your lifetime?

Q6. How many times have you been homeless in the past year?

Q7. How long have you been homeless (this episode)?

Q8. Where was your last residence?

Q9. What event precipitated this episode of homelessness?

Q10. Where do you currently sleep at night?

Q11. How many children do you have? _____

Q11a. Are any under 18 years old? _____

Q11b. Who are your children living with? _____

I'd like to thank you for all of your help today. I appreciate your openness and willingness to talk about your experiences. Would it be ok to contact you again, in case I have additional questions and to make sure I've understood everything you said today?

If no, "Once again, thank you." – Turn off tape recorder.

If yes, "Thank you." – Turn off tape recorder. Then ask the following

What is your first and last name?

What is the best way to contact you?

Phone number: _____

Email and snail mail address: _____

APPENDIX D

SAMPLE OF ANALYTIC POEMS

<u>Positive Theme Poems</u>

She gave me the blanket,
she gave me the pilla,
she said
"You won't get in no trouble"
she gave me clothes,
she gave me and [boyfriend] a bus pass
 I said, "When God made you,
he made an angel."
You feel like you're alone
but you're not,
you're not really
(Experience of "Cared For")

Just to hear somebody else's story
they were there in your shoes
Wow!
 and they succeeded
I'll be there one day
(Experience of "Shared Past / Identity)

<u>Negative Theme Poem</u>

I've heard a lot of stories
 I've never had to endure that…
I've heard a lot of um,
a person in this position
he's lookin' at females
while you're talkin' to them,
he's not lookin' at them
in the eye you know
he's touchin' them
in inappropriate ways
"Oh, these people are homeless
so they're not gonna say nuttin'.
They can't tell nobody.
Ain't nobody gonna believe 'em."
(Experience of "Powerlessness and example of "shadowed data")

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