Homeless Women's Experiences of Service Provider Encounters

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Abstract:

Service providers are gatekeepers to health-sustaining services and resources, although little is known about service encounters from the perspective of homeless women. We conducted in-depth semistructured interviews with 15 homeless women to better understand their experiences of service encounters. Using a phenomenological method, 160 significant statements were extracted from participant transcripts; more positive than negative interactions were reported. 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. Implications for nursing practice and research are offered.

Keywords: Homelessness | Healthcare | Service providers

Article:

Homelessness in the United States, defined by the US 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, 2011, p. 75995) remained stable from 2011 and 2012; notwithstanding, more than 633,782 persons were homeless on a single night in 2012 (National Alliance to End Homelessness [NAEH], 2013). In 2012, homelessness among families, primarily female headed, was estimated at 77,157; a 1.4% increase from 2011 (NAEH, 2013). Homelessness is associated with poor health (Hwang, 2002) and homeless women are particularly vulnerable. Homeless women report more health problems than homeless men (Wojtuski & White, 1998) and demonstrate 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. However, little is known about homeless

women's service provider encounters. Understanding service encounters as experienced by 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. Thus, the purpose of this study was to understand homeless women's experience of service encounters.

REVIEW OF THE LITERATURE

Although an underresearched area, several studies of homeless persons' perceptions of service providers and encounters can be found in the literature. A few studies have examined homeless youth and homeless young adults' perceptions of services and service providers. For instance, 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 nonreciprocal. In assessing support needs and services that included both homeless youth ages 15 to 25 and service providers, Stewart, Reutter, Letourneau, Makwarimba, and Hungler (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 aforementioned studies iterated the important roles that service providers play in their lives and desired service providers who were respectful, trustworthy, and who had had similar backgrounds including experiences with homelessness and/or drug abuse.

Other studies have offered perceptions of services and/or service providers from the perspective of homeless adults. For example, 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 members in negative terms with the theme “infantilization and objectification” (Hoffman & Coffey, 2008, p. 212) dominating. Martins (2008) assessed homeless adults' experiences in the health care system; negative interactions with service providers comprised the major barriers in securing needed health care. Lee and Peterson (2009) found the service encounters that occur in harm reduction drug recovery programs increased self-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, Hudak, and Hwang (2007) interviewed homeless persons to better understand participants' experiences in encounters with health care providers. Interactions reflective of human mutuality were perceived as welcoming and experienced by participants as empowering and humanizing whereas non-welcoming encounters

reflected a person-to-object communication style and were experienced as disempowering and dehumanizing. In all of these studies, participants reported that negative encounters with service providers (or the conditions of service) were cause for some to consider or actually opt out of further service. Two of these studies (Hoffman & Coffey, 2008; Martins, 2008) reported primarily negative encounters. The two remaining studies (Lee & Peterson, 2009; Wen et al., 2007) reported both negative and positive encounters that were expressed as a humanizing/dehumanizing dichotomy. In the one study found that was women-specific, Sznajder-Murray and Slesnick (2011)assessed homeless drug addicted mothers' perceptions of service providers. Overall, the mothers indicated that service providers were not supportive, 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.

In sum, previous studies with homeless persons regarding their perceptions of services and service providers reported mostly negative findings. However, two that found a balance of both negative and positive service provider encounters reported the experiences within a dehumanizing/humanizing dichotomy. Also, only one study focused specifically on women's experiences of service encounters. This study was exclusive to drug-addicted mothers and reported primarily negative findings (Sznajder-Murray & Slesnick, 2011). Considering the growing number of homeless women and their increased vulnerability, we developed this study to better understand the experience of interacting with service providers from the perspective of homeless women through their stories of both positive and negative interactions with service providers. The research questions that guided the study were:

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?

3. What behaviors or actions of service providers do homeless women consider unsupportive?

METHOD

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.

Participants

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), widowed (2), or divorced (2) with only two participants identifying a current intimate partnership or marriage (one participant did not report relationship status). More than half (8) of the participants had a child or children under 18 years of age, but only 2 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 1 month to 5 years with 12 participants reporting current time homeless of 6 months or less.

Data Collection

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 (HUD, 2011), 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 3 nonparticipating 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 min ($M = 41$; $SD = 19$). 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, e-mail 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 and included informal interactions at the study sites 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 3-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 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 hr 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. Statements that described 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 8 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. 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.

TABLE 1 Emergence of Themes by Participant

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

Unmet expectations									▲	▲	▲	▲	▲	▲	▲
Minimized	▲	▲													▲

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 1 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.

Next, significant statements were also arranged by theme and then condensed into analytic poems in the process developed and described by the second author, 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 (Biederman, Nichols, & Durham, 2010). Richardson (2000) suggested that 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 2 study participants and minor changes were made as a result.

RESULTS

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. 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 (2); and thrift store staff (1).

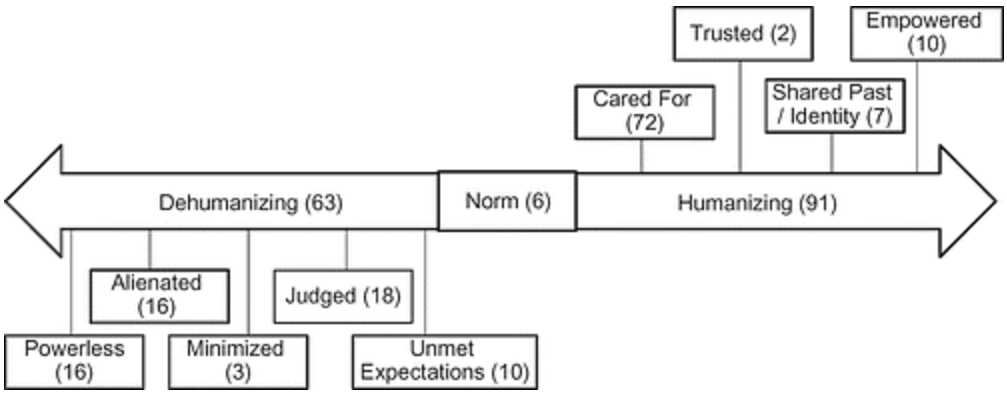

FIGURE 1 Themes With Number of Significant Statements on Humanizing–Dehumanizing Continuum.

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: (a) act in a professional manner, (b) assist in securing the service sought, and (c) 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 community-based 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 that participants reported with service providers. The key 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

In the least dehumanizing interaction experiences, 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, and intra-agency inconsistency. 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,” and “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, had 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, given a shared identity, and/or empowered. In all the positive themes, participants expressed trust in the service provider. 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 over three-quarters 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,” and “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 5 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 city administrators 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 a positive experience, being cared for was not the expectation for most participants. Some women described feeling cared for as “surprising,” some were “overwhelmed” at times.

Trusted

Many women mentioned that 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 that 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 experienced homelessness or substance abuse. In some instances, participants stated that 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 how a parish nurse encouraged her while she was looking for a job, “She's done more than any of them have really. … I've actually talked to her about goin' back to school to get my CNA license back.” Another 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 this study, homeless women indicated that encounters with service providers are experienced as dehumanizing, neutral, or humanizing. Most women described a range of both dehumanizing and humanizing experiences. Neutral encounters had neither a humanizing nor a dehumanizing quality, but rather were instances where expectations of the encounter and service provider were met.

Humanization frameworks have been proposed to guide nursing practice and health care research. The humanistic nursing communication theory, based on Buber's (1923/1996) dialogical thesis *I and Thou*, 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) held 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 these examples and this study demonstrate, experiences of dehumanization and humanization may be better represented as a continuum rather than as a dichotomy.

In contrast to much of the literature on homeless persons' encounters with service providers, overall, the women in our study reported more positive than negative interactions. In this study, *cared for* was the largest theme, accounting for 72 of the 160 significant statements. The subthemes of *cared for* are consistent with the subtypes of received social support measured by the Inventory of Socially Supportive Behaviors (ISSB) as described by Barrera and Ainlay (1983;Biederman, Nichols, & Lindsey, 2013). This finding suggests that researchers should broaden their conceptualizations of providers of social support and also that the ISSB may prove

instrumental in guiding educational programs specific to service providers who routinely interact with homeless women (Biederman et al., 2013).

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 separate from service provider self-disclosure. In their study with persons experiencing 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 that they trust their clients might be an important consideration for community health nurses and others who provide services to homeless women.

In the theme representing the least dehumanizing encounter, *unmet expectations*, participants articulated that they did not feel important, worthwhile, or deserving of service providers' time and energy. One participant who had been homeless for more than 5 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. 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, the women in our study described being judged and stereotyped as a frequent experience. Of interest, some of the women in our study described the need to conceal positive aspects of their past and past successes for fear of harsher judgment and worse treatment. This finding suggests that achievements such as being college educated or having a professional identity are concealable stigmas in the face of homelessness. Living with a concealable stigma is associated with both psychological distress and negative health outcomes (Quinn & Chaudior, 2009). 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.

LIMITATIONS

This 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, nonsheltered 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.

In spite of these limitations, our study makes a valuable contribution to the literature. As frontline staff, community health nurses are in a unique position to influence humanizing or dehumanizing experiences for all their clients, including 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.

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