

In Their Own Words: Exploring Family Pathways to Housing Instability

by

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Dedication

This dissertation is dedicated to the amazing, generous women who shared their stories with me in the hopes of helping other women facing similar housing struggles.

I could not have completed this journey without the support and love from Kayhan, Sinan, Leyla, and my mom and dad. I love you!

“We’re made of star-stuff” Carl Sagan

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TABLE OF CONTENTS

DEDICATION	ii
ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vi
LIST OF FIGURES	vii
LIST OF APPENDICES	viii
CHAPTER	
I. Background and Specific Aims	1
Introduction	1
Prior Relevant Research	8
Cumulative Effects of Housing Instability, Poverty, and Diminished Well-Being	10
Specific Aims	16
II. Literature Review	19
Introduction	19
A Review of Current Literature	24
Overall Findings and Resulting Questions	40
Connecting Findings to a Theoretical Framework	44
Summary	53

III. Research Methods	54
A Qualitative Choice	54
Study Design	63
Study Procedures	71
Data Analysis	76
IV. Results	84
Participant Characteristics	84
Narrative Findings	91
V. Discussion and Conclusions	131
Overview	131
What Does the Data Tell Us?	132
Theoretical Connections and Implications	146
The Good, The Bad, and The Outliers	151
Implications for Nursing Professionals	157
Conclusions and Future Research Questions	161
APPENDICES	165
BIBLIOGRAPHY	265

LIST OF TABLES

Table 1: Demographic Characteristics	88
Table 2: Brief PHQ data	91
Table 3: Primary Causes of Housing Instability	92
Table 4: Pathway Themes	115
Table 5: What Could Have Helped	127
Table 6: Table of Evidence	166

LIST OF FIGURES

Figure 1: Wakefield and Baxter’s Model of Compounded Disadvantage (2010)	48
Figure 2: Wakefield and Baxter’s Model of Compounded Disadvantage (2010) *indicates adaptations to apply a feminist, trauma-informed lens	52
Figure 3: Wakefield and Baxter’s Model of Compounded Disadvantage (2010) depicting participant L1’s narrative	150

LIST OF APPENDICES

Appendix A	Table 6: Table of Evidence	166
Appendix B	Interview Guide 1	174
Appendix C	Framework for Interview 2	178
Appendix D	Data Analysis Template	179
Appendix E	Participant Stories	182

Chapter I: Background and Specific Aims

Introduction

Safe, stable shelter is a basic human need, yet it has become an increasingly unobtainable goal for thousands of American families. Discussions of housing difficulties often focus on the most visible forms of housing instability; that is, individuals experiencing literal homelessness and living in shelters or on the street. Adults and children constituting families, however, are often much less visible; yet represent 37% of all persons experiencing homelessness in the United States (US) today (National Alliance to End Homelessness [NAEH], 2013).

Indeed, according to the US Department of Housing and Urban Development ([HUD], 2012), family homelessness is a growing phenomenon across the nation, impacting the health and well-being of over 530,000 people annually. Between 2007 and 2011, the number of *families* facing homelessness rose 13.5% in the US, even as rates of *individuals* experiencing homelessness declined (HUD, 2012). Perhaps more startling is that for every family experiencing overt homelessness, there are an estimated five families living in unstable housing and on the brink of homelessness (NAEH, 2007). In fact, recent data from NAEH (2014) reveals that even though there have been some small declines in the numbers of families and individuals experiencing homelessness, the number of persons at risk for homelessness has failed to decline in spite of national reductions in unemployment. Families at risk for homelessness often stay

temporarily with friends or family members or live in hotels or motels, making them essentially invisible to the public, social service agencies, policy makers, and researchers (NAEH, 2007). It is not until these families are literally homeless that they are counted or even noticed.

Defining Homelessness and Housing Instability in the US

Before proceeding, it is critical to clarify the definitions of, and the distinction between the terms “homelessness” and “housing instability” used in this study, especially as they have evolved over time. Although homelessness has been a reality in American culture since the 18th Century (Kusmer, 2002), most efforts to relieve homelessness have emerged from the community, grass-roots level (HUD, n.d.). Aid societies emerged from local religious and philanthropic entities, without structure, oversight, or assistance from state or federal government (Kusmer). Not until 1987, with the passage of the Stewart B. McKinney Homeless Assistance Act (later renamed the McKinney-Vento Homeless Assistance Act), did the federal government enact legislation specifically intended to define and reduce the incidence of homelessness in the United States (HUD, n.d.). The original 1987 legislation defined “homeless” to include an individual:

(1) who lacks a fixed nighttime residence; and (2) whose primary nighttime residence is a supervised temporary shelter, institution, or a place not ordinarily used for sleeping.

Excludes prisoners from such definition. Limits homeless assistance under this Act to persons who comply with the appropriate income eligibility requirements (H.R. 558 Summary, 1987).

While this definition remained as HUD’s functional definition of homelessness until 2011, other federal agencies slowly recognized that many individuals and families were living along a continuum of housing instability and homelessness, and began including broader

definitions of homelessness in their guidelines for service provision (NAEH, 2009). Between 1987 and 2009 there were significant changes made to expand the scope of the McKinney-Vento Act, although HUD did not expand its definition of homelessness. In particular, provisions were added to protect the most vulnerable persons impacted by homelessness: children and older adults. The need for these legislative changes was in response to an ever-increasing population of families seeking housing assistance, and growing concern over educational delays and interruptions for homeless children. These provisions were intended to maintain children in their original school even when their family was being sheltered in a distant location, increase access to quality childcare not otherwise affordable for homeless families, and maintain seniors in their homes or provide alternate safe housing when they were no longer able to independently maintain their housing (National Coalition for the Homeless [NCH], 2006). While these programs provided guidance for social service agencies and schools trying to meet the needs of families in shelters and transitional housing, HUD's narrow definition of homelessness left many families living on the edge of homelessness without a safety net. With the economic downturn of 2007, these gaps in unmet social and health needs became too big to ignore.

To address these gaps, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, originally introduced in Congress in 2007, was passed as part of the reauthorization of and amendment to the McKinney-Vento act in 2009 (NAEH, 2009). A significant piece of the HEARTH act was its expansion of homeless services to include Emergency Services Grants (ESGs) to HUD-funded agencies in order to *prevent* homelessness. These ESGs targeted families facing housing eviction or the shut-off of major utilities that would make living in their homes impossible. While this new legislation expanded the scope of services, it took another two years to revise the federal definition of homelessness. The

HEARTH act then included four distinct circumstances under which a person or family would be labeled homeless and thus eligible for emergency housing: if they were (1) Literally Homeless, (2) at Imminent Risk for Homeless, (3) Homeless Under Other Federal Statutes, (4) or Fleeing/Attempting to Flee Domestic Violence.

Although the new definition critically expands available support and prevention services, it confounds the distinction between families experiencing literal homelessness and those facing impending homelessness. While they may indeed be very similar, emerging research suggests that there are some important distinctions between these populations, affecting their future housing stability and well-being (Shinn, Greer, Bainbridge, Kwon & Zuiderveen, 2013). It is critical to further explore potential differences between the two populations in order to better understand the unique needs of families facing housing instability compared to families who are literally homeless.

Toward that aim, this study uses the traditional definition of “homeless” provided by HUD (n.d.) throughout. Thus, *homelessness* is defined as a circumstance wherein a family is without a fixed address and is sleeping either in a place unintended for human habitation (i.e., car, abandoned building, on the street), or in an emergency shelter. *Housing instability* refers to a situation where the family is at imminent risk for homelessness as defined by HUD’s ESG guidelines. These families may be staying temporarily with family or friends (often referred to as “doubling-up”), are facing an impending eviction notice, and/or are dealing with having their major utilities disconnected. Although they still have a roof over their heads, their housing is anything but stable. While this simplifies HUD’s definitions, the dichotomization of homelessness and housing instability intends to provide differentiation of categories of families served by HUD as presented in this dissertation.

America's Experience with Individual and Family Homelessness

The individual experiencing homelessness is an all-too-familiar image for most Americans. Many have seen persons sleeping in doorways, on grates, under bridges, or perhaps pan-handling for spare change in tattered, dirty clothing. Media representations utilize these public perceptions of homelessness to reinforce the stereotypical homeless experience, often conjuring feelings of fear, apprehension, or disdain. These images are not new, but are rooted in the historical experiences of transient poor within this country (Kusmer, 2002).

Homelessness has existed in the US from the very origins of the country, but significant changes in political, social, economic, and labor conditions have notably altered who has experienced poverty, and how society responded to and viewed those experiencing poverty and homelessness. Throughout all of these changes, family homelessness has remained hidden from view, as individual homelessness caught the collective attention of American society.

The traditional image of the “hobo” or “tramp” emerged from a post-war, industrialized society that no longer required highly skilled apprenticed or artisanal craft (Kusmer, 2002). Unskilled laborers were expendable and replaceable; thus, as competition for employment increased, so did the need to travel or relocate in search of work (Kusmer, 2002). Urbanization and industrialization resulted not only in a large number of individuals facing housing and employment instability, but also in large numbers of immigrant families living in hastily-built, overcrowded tenement houses, relegated to unwanted corners of their cities where they could go unnoticed by the general populous (Kusmer, 2002).

Less mobile than individuals, families remained in poverty-stricken neighborhoods, even if they lacked a fixed address. Although charitable organizations and religious societies offered some relief to those in need via soup kitchens and informal assistance programs (Kusmer, 2002),

families experiencing housing instability remained primarily outside of the public conscience until a sudden surge in family homelessness occurred in the 1980s (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). While poverty, transience, and un- or underemployment have long been associated with homelessness, the emerging population of families experiencing homelessness in the 1980s was marked by an upsurge in domestic violence (DV) not previously noted among homeless populations (Grant, et. al, 2013). The upsurge in family homelessness was therefore due, in part, to increased social awareness regarding DV that resulted in the opening of numerous DV emergency shelters, providing women and children with the opportunity to escape abuse (Grant, et al., 2013). Thus, a new image of family homelessness emerged and has continued to evolve over the past several decades.

Individual versus Family Characteristics

Individuals experiencing homelessness are quite diverse in their characteristics, yet there are several demographic features that trend through the general homeless population. Like the “hobos” and “tramps” of the 19th and 20th centuries, individuals experiencing homelessness today are most often male (72%). Consistent with post-World War II characteristics, individuals are most often between the ages of 31 and 61 (70%), a member of a racial or ethnic minority (55%), with 42.6% of individuals in shelters having a diagnosed disability (HUD, 2012). Military veterans are disproportionately represented among homeless individuals. While the rate of homelessness is 29 out of every 10,000 veterans, only 20 out of every 10,000 members of the general public will experience homelessness (NAEH, 2013).

Families facing homelessness tend to be much more invisible to communities and media and are characteristically different from other homeless populations. Although homeless individuals can often be seen sleeping on park benches, under bridges, and in doorways in many

metropolitan areas, vulnerable families exhaust all resources to remain off the street, and thus remain hidden from the public view (NAEH, 2007). Further, because shelter rules often require heads of households to be employed or actively seeking employment and children attending school or in daycare, homeless families blend into communities unnoticed (NAEH, 2009). These families are most often (80%) headed by a single female usually under the age of 30 (~50%), who identifies as a member of a racial or ethnic minority (71.9%), with one to two children under the age of 6. Approximately 16% of female-headed homeless families also include a household member with a diagnosed physical or psychological disability (HUD, 2012). While these disability rates are approximately twice the rate of disability when compared with housed families in the US, they are significantly lower than rates of disability among *individuals* experiencing homelessness (HUD, 2012). Further, it has been reported that approximately 92% of mothers within families that are experiencing homelessness have a history of significant physical and/or sexual abuse (Bassuk, Weinreb, Buckner, et.al, 1996).

Homelessness has been studied as a social and health-related phenomenon for decades (Gelberg & Linn, 1992; Lamb & Talbott, 1986; Rosenheck & Koegel, 1993). However, most research has focused on individual homelessness and how homelessness relates to specific mental illnesses such as a substance abuse disorder or schizophrenia (e.g., Edens, Kaspro, Tsai, & Rosenheck, 2011; Foster, Gable, & Buckley, 2012). Perhaps because of their limited visibility within communities, combined with the marginalization of poor single women with children in general, families experiencing homelessness have rarely been the focus of research or intervention. Thus, what we know about families (particularly women and children) facing homelessness pales in comparison to the rich data associated with individual (predominately male) homelessness.

Understanding the differing characteristics between families and individuals experiencing homelessness thus sets the stage for assessing and understanding the unique needs and experiences of these two distinct populations. This also highlights the reality that research on individuals experiencing homelessness cannot and should not be directly translated to families experiencing homelessness. In sum, family homelessness is characterized by high rates of single female heads of household, associated high rates of trauma exposures and victimization, and an overall dearth of research related to families experiencing homelessness. Accordingly, this document and my related research focus on *maternal* experiences of family homelessness and housing instability.

Prior Relevant Research

My interest in the topic of family homelessness began while pursuing my Master's education as a family nurse practitioner student. Under the guidance of Dr. Barbara Brush, I participated in a community-academic partnership to develop research addressing the needs, experiences, and outcomes of families experiencing homelessness in Ypsilanti and Detroit, Michigan. One of the products of this partnership was the submission and subsequent funding of a small grant to conduct focus groups with mothers experiencing homelessness in Detroit. As a research assistant on the project, I conducted literature searches, maintained field notes and assisted in facilitating focus groups, participated in data analysis, and acted as first author in writing up our findings. The focus groups were an eye-opening experience, where women revealed the multitude of hardships, social isolation, and traumatic exposures they encountered before, during, and in recovery from their homeless episodes (Gultekin, Brush, Baiardi, Kirk, & VanMaldeghem, in press).

The 12 mothers in our study voiced uncertainty about the impact of homelessness on their children, and shared accounts of victimization and abuse throughout their lives, fueling my own interest in the aftermath of trauma. They shared stories of multigenerational housing instability exacerbated by chronic poverty and under-employment that created overcrowded households with aunts, uncles and cousins who faced similar housing crises. Perhaps more startling, women often found they had to return to a relationship, whether with an intimate partner or a family member, where they had experienced prior abuse in order to avoid entry into an emergency shelter. These stories often included accounts of similar housing instability throughout childhood, with frequent moves and doubling up utilized as a means of survival across generations. Family histories of substance abuse and violence were commonplace and tolerated as normal aspects of growing up. Resounding evidence of cyclical and generational patterns of violence, poverty, and housing instability ushered in new questions about how and why these patterns occurred and continued.

This past year, our team interviewed Chief Executive Officers (CEOs) and Executive Directors (EDs) of several Detroit-area homeless service providers to better understand how state and federal policies guiding funding for homeless services impacts the provision of services to homeless families (Grim, Brush, & Gultekin, under review). CEOs and EDs expressed concern about the policy-making process, feeling that politicians often failed to understand the needs of their clients. While they saw some improvements in access to and funding for programs such as permanent supportive housing, they experienced reductions in funding for social work and case management services (Grim, et al.). They reported increases in service demands, but due to budget restrictions, had to reduce the number of service providers within their offices. In short, they were being asked to do more work with fewer people and smaller budgets, and felt that their

concerns were unheard by those individuals who were shaping and enacting housing policy (Grim, et al.) One can imagine that if CEOs and EDs of agencies providing services to unstably housed families are frustrated with and feel powerless in the policy making process, their clients feel the same.

The Cumulative Effects of Housing Instability, Poverty, and Diminished Well-Being

The study of homelessness and housing instability is not simply about housing. It requires an exploration of the personal, social, and institutional conditions contributing to multifaceted disparity. Nursing has a long tradition of holistic, integrative approaches to wellness. Although much of nursing research has shifted its focus to hospital and disease related outcomes over the past few decades, modern professional nursing is rooted in connecting health with home. This is no clearer than in Florence Nightingale's 1860 classic text *Notes on Nursing*, with a full chapter dedicated to the impact of home on general health. Lillian Wald later broadened this perspective, promoting self-care and formal health care services within a larger social and cultural context (Buhler-Wilkerson, 1993). Wald's radical approach to public health nursing integrated home care, social services, arts, education, and even play space for children, into a broader concept of health and well-being (Buhler-Wilkerson, 1993). Nursing professionals recognize the impact of social inequity and diminished personal and community resources in impacting health, acknowledging that wellness is not simply related to physical attributes, but is heavily influenced by social and institutional forces.

Today we conceptualize these personal, social, and institutional attributes that impact health as *social determinants*. As defined by the Centers for Disease Control and Prevention (CDC), social determinants of health are, "the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness," (2013). Research on

social determinants of health consistently reveals that numerous health outcomes directly correlate with socioeconomic indicators (Doubeni, Schootman, Major, et. al, 2012; Haas, Krueger, & Rohlfen, 2012; Pickett, K. E. & Pearl, M., 2001; Reiss, 2013).

As a nurse practitioner student, facing a future practicing in a health care system rife with disparities, I was forced to ponder the future health and well-being of some of the most vulnerable members of our society. Clearly trauma and violence impact the health of individuals and families, but the larger connection between housing, health, and well-being became too obvious to ignore. This is especially true as the national dialog becomes more and more focused on eliminating health disparities in a targeted, cost-effective manner. The US Department of Health and Human Services (USDHHS; 2010), via Healthy People 2020, and the Centers for Disease Control (CDC; 2009) have made redress of health disparities a top priority among public health initiatives. Only by digging into the context of disparities can we begin to understand how to correct them.

Housing and Health

Homelessness and housing instability present a tremendous threat to the health and well-being of millions of Americans. Families experiencing housing instability suffer disproportionately from a multitude of acute and chronic physical illnesses (American Academy of Pediatrics [AAP], 2005; Caton, et. al, 2012; Coker, 2009; Davey, 1998; Grant, et. al, 2007; Harpaz & Rotem, 2006; Kerker, et. al, 2011; Morris & Strong, 2004; Shanzer, Dominguez, Shrout, & Caton, 2007; Teruya, et. al, 2010; Zlotnick & Zerger, 2008), as well as mental illnesses and substance abuse disorders (Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk, et. al, 1996; Karim, Tischler, Gregory, & Vostanis, 2006; San Agustin, et. al, 1999; Zima, et. al, 1999). Homelessness is also associated with increased mortality rates (Metraux, Eng,

Bainbridge, & Culhane, 2011; Morrison, 2009; O'Connell, et. al, 2005), and extremely high utilization of emergency rooms services (D'Amore, Hung, Chiang, & Goldfrank, 2001; Kushel, Perry, Bangsberg, Clark, & Moss, 2002; Oates, Tadros, & Davis, 2009), increasing the human and economic cost of homelessness.

Although long-term consequences of family homelessness remain poorly studied, it is known that homelessness is associated with worse short-term behavioral and educational outcomes among children (Nabors, et. al, 2004; San Agustin, et. al, 1999; Zima, et. al, 1999). Diminished short-term behavioral and educational outcomes may translate to poor long-term educational attainment, reducing employment opportunities, life-long income potential, and overall quality of life (Biggar, 2001). Left unchecked, the challenges of family homelessness and housing instability have the potential to create a self-perpetuating cycle of intergenerational poverty and reduced well-being, increasing health disparities and increasing illness across multiple generations.

More recently, researchers have turned their attention to the health impacts of marginal housing. Although they remain largely invisible to the American public and policy makers, families teetering on the brink of homelessness in chronically unstable housing are being recognized as a population in need of study and intervention. Strong associations are being identified between survivors of interpersonal violence (IPV), their housing instability, and poor physical and mental health outcomes (Rollins, Glass, Perrin, et. al, 2012). Multiple studies have demonstrated that housing instability is associated with poor mental health outcomes, poorer self-rated health, and increased hospital and emergency room utilization, even after controlling for factors such as IPV and economic hardship (Burgard, Seefeldt, & Zelner, 2012; Pollack, Griffin, & Lynch, 2010; Rollins, Glass, Perrin, et. al; Suglia, Duarte, & Sandel, 2011).

Low-income housing carries its own set of health challenges. Historically, public housing developments in the US have been situated on land that is considered unusable or undesirable by the general public, often because of poor soil quality or environmental toxins from industrial processes, or close proximity to toxic or pollution-producing industrial plants (United Church of Christ Commission for Racial Justice, 2007). Poor, minority communities continue to be disproportionately exposed to environmental toxins through lead paint exposures in substandard housing, or being situated in close proximity to toxic dump sites and coal-burning factories (United Church of Christ Commission for Racial Justice). Further, disproportionate rates of violent crime in low income neighborhoods (Hsieh & Pugh, 1993) not only threaten individual well-being, but may limit an individual's or family's ability to engage in outdoor physical activity. Thus, housing instability and its context, not just homelessness, deserve attention as risk factors for poor health outcomes.

Poverty

Homelessness can be the result of a multitude of life circumstances and decisions, but rarely is it considered independent of poverty. Poverty, characterized by an extreme lack on income, is a primary indicator of socioeconomic status. Recent data from the US Census Bureau identifies 15% of the total US population, and 21.8% of all US children currently live below the poverty threshold (DeNavas-Walt, Proctor, & Smith, 2013). In terms of dollar value, an individual under the age of 65 earning less than \$12,119 annually, a single parent with one child earning less than \$16,057 annually, or a two-parent family with two children earning less than \$23,624 annually are considered to be below the poverty threshold (US Census Bureau, 2013).

Poverty itself is associated with numerous poor outcomes in populations across the globe. It has been associated with an increased incidence of preterm births (Auger, Park, Gamache,

Pampalon & Daniel, 2012; Olson, Diekema, Elliot, & Renier, 2010), low and very low birth weights (Kirby, Liu, Lawson, et. al, 2011; Olson, et. al, 2010), and infant mortality (Johnson, Malnory, Nowak, & Kelber, 2011; Olson, et. al, 2010). Among children, poverty is associated with a higher incidence of acute and chronic health problems including traumatic injury (Chen, Matthews, & Boyce, 2002), moderate to severe asthma (Chen, Matthews, Boyce, 2002), hypertension, malnutrition, anemia (Newacheck, 1994), ear infections, and vision problems (Larson & Halfon, 2010; Newacheck, 1994). Not only do children in poor families suffer disproportionately from many acute and chronic illnesses, they are also less likely to have health insurance (Newacheck, 1994), are less likely to have a primary care provider for health maintenance purposes (Newacheck), and are less likely to be appropriately immunized when compared with children in families living above the poverty line (Newachek).

Poverty is also associated with emotional, developmental, and behavioral problems including attention deficit hyperactivity disorder, diminished verbal comprehension (Kaminski, Perou, Visser, et. al, 2013; Najman, Aird, Bor, et. al, 2004), and speech delays and anomalies (Newacheck, 1994). These mental health, developmental, and behavioral challenges contribute to poorer educational attainment and increased educational disruptions (Kaminski, et. al, 2013), limit social mobility, and propagate intergenerational transmission of poverty and diminished well-being (Najman, Aird, Bor, et. al, 2004; Reiss, 2013).

Among adult populations, poverty is associated with higher rates of diabetes, hypertension, hyperlipidemia (Seligman, Laraia, & Kushel, 2011), and early mortality (Sabanayagam & Shankar, 2012). Poverty-associated health disparities are most pronounced in US states where the most wealth inequity exists (Olson, et. al, 2010), and epidemiologic data suggests that these risks are associated not just with poverty-stricken individuals, but are

endemic to entire communities lacking financial resources (Kirby, et al., 2011; Olson, et al., 2010).

Allostatic Load, Weathering, and Diminished Well-being

Although the associations between poverty and health disparities have been studied in depth, less is understood about the causal mechanisms of these disparities. Lack of health insurance and limited access to primary care providers certainly play a role in an individual's or family's ability to prevent disease. However, the association between poverty and health disparities has proven to be much more complex than limited access to appropriate health care. Health and social scientists have developed a significant body of evidence that point to stress as a primary contributing factor to disparate health and well-being outcomes (Beckie, 2012; Keller, Litzelman, & Lisk, et al., 2012; Raposa, Hammen, Brennan, OCallaghan, & Najman, 2013; Theall, Drury, & Shirtcliff, 2012).

Within impoverished communities, stress is a result not only of limited financial resources, but also of degraded environments, increased exposures to violent crime, chronic marginalization, and often, racial and gender discrimination. These multifocal, chronic sources of stress can result in dysregulation of the human stress response, increasing an individual's allostatic load. Defined as the cumulative physiologic response and adaptations to repeated exposures to stress (Beckie, 2012; Wakefield & Baxter, 2010), allostatic load is often assessed through a composite of measured blood pressure, heart rate, cortisol, norepinephrine, and epinephrine levels, waist-hip ratio, lipid levels, and inflammatory markers such as C-reactive protein or interleukin-6 (Beckie, 2012).

Increased measures of allostatic load are associated with numerous poor health outcomes, including hyperlipidemia, hypertension, type 2 diabetes mellitus, obesity, heart disease, and early

mortality (Beckie, 2012; Bird, Seeman, Escarce, et. al, 2010; Geronimus, Bound, & Colen, 2011). When chronically or repeatedly exposed to stressful life events, the physical wear and tear of allostatic load compounds, resulting in a *weathering* process. Weathering is the accumulation of physical deteriorations caused by stress and increased allostatic load (Wakefield & Baxter, 2010). Individuals and communities experiencing the chronic stressors of poverty, degraded environments, exposures to violence and trauma, and discrimination consistently display higher allostatic loads, resulting in disparate health outcomes and diminished well-being (Beckie, 2012; Bird, et. al, 2010; Geronimus, Bound, & Colen, 2011; Theall, Drury, & Shirtcliff, 2012; Walsemann, Gee, & Geronimus, 2009). Explorations of allostatic load and weathering do not fully reveal causal relationships between social determinants of health and health disparities, but they do reveal the complex nature of biological and social interactions that contribute to the health and well-being of individuals and families.

Specific Aims

Recent national efforts at reducing homelessness, such as HUD's Homelessness Prevention and Rapid Re-housing Program (2009), focus primarily on addressing the emergent financial needs of families, and helping them through the rehousing process. The *preventive* component of this program provides financial intervention only when a family faces an imminent threat of homelessness, such as the loss of major utilities or an eviction notice (HUD, 2009). While maintaining housing and rehousing are critical first steps in reducing homelessness, focusing on financial hardship alone misses the broader social and interpersonal factors that contribute to housing instability and homelessness. *Primary prevention* of homelessness depends on identifying families at risk for housing instability further up-stream, and offering targeted interventions at critical junctions to allay crisis. In order to develop such interventions, however,

a better understanding of family pathways to housing instability is needed so that those critical junctions can be ascertained. The best way to do this is to ask families in these situations to share their experiences and perspectives about what is needed to maintain housing stability and when these points may be.

My current research elicited first-hand accounts of the life experiences of women with children facing imminent threat of homelessness. The objectives of doing so were to understand the “how” and “why” of their trajectory into housing instability and what constellation of factors contributed to that trajectory. Through qualitative one-on-one interviews and demographic data collection with 16 women who were seeking emergency services, the study aims were to:

1. Examine individual (age, education, race/ethnicity, relationship status, trauma history, mental and physical health), social (social supports, family history, current family situation, SES), and structural (labor and living conditions, social services) *characteristics* of mothers at risk for homelessness.
2. Explore the individual, social, and structural *experiences* of mothers at risk for homelessness.
3. Explore at-risk mothers’ *perspectives* regarding the chain of events they narrate as an explanation of the trajectory leading them to housing instability.

Although research studying the lives of families experiencing homelessness is not altogether novel, this research is unique in the opportunity it provides for women to share their personal accounts and perspectives regarding housing instability and their life experiences. Through an analysis of their transcribed narratives, this research offers an opportunity for emic understanding of the life experiences of women facing housing instability. This insider insight is critical to developing interventions that prevent housing instability, and ultimately, homelessness

in this growing at-risk cohort. In addition, information of this type allows the development of interventions further up-stream in the process before families experience a decline in their health and well-being.

Chapter II: Literature Review

Introduction

This chapter explains the process used to review, evaluate, and integrate current literatures and theory on homelessness, domestic violence and their combined consequences on the health and well-being of women and their families. This expanded perspective on the intersection of homelessness and domestic violence is particularly pertinent to and underpins the trauma-informed approach that propelled this research from conceptualization to reality. It is important to clarify that although the term domestic violence (DV) is often used to describe intimate partner violence, I am utilizing the term in a much broader sense to explain any experience of violence that occurs within a home and/or family-type relationship, including acts of violence and abuse between partners, and between adults and children in a household. As mentioned in Chapter 1, Dr. Brush, Dr. Baiardi, community partners, and I have spent the past several years examining the experiences of family homelessness from both the family and service provider perspective. The women who participated in our earlier focus groups displayed varying degrees of success in overcoming their housing struggles. Although none of the women in our focus groups were in a domestic violence shelter, many shared stories of victimization and abuse from either intimate partners or in their families of origin. They shared common

experiences of broken family relationships and social networks, and were worried but hopeful about the health and safety of their children.

In listening to the stories shared by our focus group participants, I was struck by the frequency and intensity of the trauma and violence these women encountered. Violent relationships and traumatic life exposures not only preceded their episodes of homelessness, but emerged as recurrent and predominant throughout their entire lives. Several women shared experiences of being neglected or abandoned at a young age (often due to parental substance abuse) and left to fend for themselves and younger siblings. They reported being robbed and manipulated by friends and physically assaulted by intimate partners and family members, creating fear of future relationships that might reap similar outcomes. Their stories marked them as survivors of life-long domestic violence, but they seemed reluctant to accept that label. Although domestic violence is a well-studied phenomenon, the women we spoke to represent a population of DV survivors that were not seeking support or assistance from traditional DV shelters and services, and I began to wonder how common their experiences were within the homeless community.

The linkages between domestic violence (DV) and housing instability have been recognized for decades. Indeed, an upsurge in DV awareness and the need for a viable response spearheaded the opening of DV shelters in communities across the United States (US) in the late 1970s and early 1980s (Se' ver, 2002). Still, legislation to protect survivors of DV lagged behind. While the federal government identified a need for support services, resulting in passage of the Family Violence Prevention Services Act in 1984, vital protections for survivors' rights were not initially included in the legislation. It was not until passage of the Violence Against Women Act (VAWA) in 1994 that victims of DV, sexual assault, and stalking were granted federally

guaranteed protections, access to federally funded support services, and civil recourse against their abusers or attackers (Department of Justice Office of Violence Against Women [DOJ OVW], n.d.). Even with these apparent safeguards in place, however, women continue to face significant difficulty in stabilizing multiple aspects of their lives in the aftermath of DV and trauma. In fact, women struggling with the long-term ramifications of DV face significant challenges to their long-term health and well-being (Centers for Disease Control & Prevention [CDC], 2008; Chuang, Cattoi, McCall-Hosenfeld, et al., 2012).

Our focus group findings also revealed high numbers of incidents of DV among non-DV identified mothers experiencing homelessness that were consistent with a small body of literature on the precipitators of family homelessness. Bassuk, Weinreb, and Buckner et al. (1996) found that 92% of mothers experiencing family homelessness have a significant history of physical or sexual abuse within their lifetime. The work of Anderson (1996), Anderson and Imle (2001), and Anderson and Rayens (2004) reveal women's pathways into homelessness as fraught with trauma and interpersonal violence. Yet family homelessness and rehousing services are typically managed and provided outside of the realm of domestic violence services.

Indeed, research focused on family homelessness often lacks discussion of the relationship of domestic violence to women's unstable housing situations, and conversely, research on domestic violence has traditionally failed to address housing instability as an associated feature or long-term outcome. Recent national policies, such as HUD's Rapid Rehousing program, have shifted critical financial resources away from counseling and case management services for homeless families and focused them almost exclusively on direct housing expenses (Grim, Brush, & Gultekin, under review). Such policies reduce opportunities for both disclosure and treatment of prior DV within families seeking general rehousing

assistance (Grim, et al.). Although DV shelters are intended to meet the immediate housing needs of DV survivors, services are often time limited, resulting in gaps in meeting long-term or recurrent DV-associated housing needs.

During pilot testing of my interview guide for this study, I discovered just how difficult it could be for survivor women to access DV services. “Z” was a 28 year-old mother of 2 young children. She was experiencing homelessness for the second time in her adult life, receiving assistance from a local non-profit housing agency, and agreed to be interviewed to assist me in testing my interview guide. Z’s story was complex, and full of accounts of trauma, domestic violence, and housing instability. Z had a complex childhood household. Her parents had a conflict-filled relationship but managed to stay together until Z was 14. It was then that her father lost his job because of his substance abuse disorder, creating a cascade of events that define her life today. After losing his job, Z’s father disappeared and Z’s relationship with her mother turned from close to confrontational. During this time, Z’s maternal grandmother remained her primary source of emotional support, although she lived out of state, and could only offer loving support from a distance. At the age of 16, Z moved in with friends while her mother moved out of state. She finished high school and was admitted to an out-of-state university on a basketball scholarship. Shortly after arriving at college, however, she was injured playing basketball, lost her scholarship, and her grandmother became gravely ill.

As a result of her grandmother’s condition, Z and her mother reconciled and Z moved in with her mother to help care for her grandmother, working in a fast-food restaurant to help with finances. While living with her mother outside of Michigan, Z, now 20, was raped by 2 acquaintances on 2 separate occasions. She did not report the first assault, but when she went to the hospital and reported the 2nd assault to the police, her mother called her a “whore” and kicked

her out of the house. Having nowhere else to go and no one else to turn to for social or emotional support, Z moved in with a former high school boyfriend who had moved out of Michigan to be closer to her. She continued working full time, and returned to college part time. Within the year, Z became pregnant with her daughter. Shortly after her daughter was born, Z's boyfriend began verbally and physically abusing her. She then discovered that he had a substance abuse disorder, and moved back to Michigan to escape him. When she failed to find work in Michigan, found herself ineligible for public assistance, and ended up homeless in an emergency shelter, Z returned to her mother's home out of state and tried to rebuild her life. Back in the same town as her ex-boyfriend, her mother convinced them to seek couples counseling to arrange for visitation and share custody of their daughter.

Couples counseling reunited Z and her ex-boyfriend, and soon after, they were again living together, and she was pregnant with their second child. This time, life seemed to be on the right path. Z returned to college and finished her BA in English. However, not long after her son was born, Z's boyfriend once again became physically violent. Z and her children again fled to Michigan where they began "couch surfing," staying temporarily with multiple different friends over the course of several months. When she exhausted her informal resources, Z called a homeless hotline number, and was referred to an urban DV shelter for emergency housing and counseling services. After staying only one night, she was informed that because the DV she experienced happened more than 3 months earlier, she was ineligible for DV services. That day, while she was offsite at a job interview, her personal possessions were removed from the shelter by staff, and she had to sleep on the street with her 3 year and 4 month old children until she secured a spot in a non-DV emergency shelter. Personal accounts such as these raise serious and troubling questions about the lack of attention to the connections between family homelessness

and domestic violence, prompting further investigation of these processes, as well as our formal programmatic responses to family homelessness.

A Review of Current Literature

To better understand what is already known about the linkages between DV and homelessness, I conducted a thorough review of the literature. The term *domestic violence* is often used interchangeably with intimate partner violence (IPV), focusing exclusively on trauma and victimization occurring between partnered adults. This narrow definition, however, does not capture the full extent of the term. Indeed, DV often extends beyond the intimate partner relationship to impact children as both victims and witnesses. Thus, this literature search used the term “domestic violence” rather than the narrower term “intimate partner violence” to capture a wider range of victimization experiences. The literature search utilized the search terms “domestic violence” and “homelessness” and employed multiple databases including CINAHL Plus, Family and Social Studies Worldwide, Family Studies Abstracts, Gender Studies database, Global Health, Psych Articles, PsychInfo, Violence and Abuse Abstracts, and Women’s Studies International. The search was limited to research based articles published in peer-reviewed journals between 2000 and 2014 from the United States and Canada. Initially, I considered limiting the timeframe by a decade, looking only at articles from 2004 to present. An initial review of findings from that period proved quite limited, thus I expanded the start date to 2000, and was able to capture a more substantial collection of articles. A total of 49 articles met search criteria, and after review of abstracts, only 16 articles were relevant to the topic. Most of the rejected articles focused on specific diseases, such as HIV or STDs, with only a cursory mention of housing stability or homelessness. Relevant articles were then subdivided based on their target

population (women vs. children), and further reviewed for content and findings (See Table of Evidence, Table 6, Appendix A).

Women, Domestic Violence, and Homelessness

Thirteen articles, spanning from 2002 to 2014, specifically addressed the relationship between DV or intimate partner violence [IPV], and its relationship to some form of housing instability up to and including homelessness. Overall, the articles reveal a clear and persistent connection between the experiences of fleeing an abusive relationship and housing instability, however, that connection is most often addressed in the acute phase of escaping or addressing DV. In fact, 10 of the 13 studies focused on women who were actively seeking and receiving DV survivor services. The remaining 3 studies focused on larger populations of low-income women who were receiving some form of public assistance, with subsets of the participant populations identified as DV or trauma survivors. Because of the potential for significant differences between populations of DV survivors versus low-income women who are evaluated for their exposures to trauma and violence, I will first consider the findings separately before explaining the connections between these seemingly different populations.

Domestic Violence Survivors

Although all thirteen studies included populations of women seeking DV survivor services, their methods of identifying participants differed significantly. The lone literature review (Sev'er, 2002) targeted studies of women with dependent children who were fleeing DV. However, findings from studies identified by the literature review may not be representative of the range of DV survivor experiences. As with most of the remaining articles, only details of women who report DV and seek services are included, thus failing to capture accounts of women survivors who do not access survivor services.

Two articles reported findings from studies that utilized DV telephone hotlines (Anderson, Gillig, Sitaker, et al., 2003; Iyengar & Sabik, 2009). Both studies included large samples of DV hotline callers who, although help-seeking, were not necessarily in a position to leave an abusive partner. Thus, they reflect a population that remains generally unstudied and voiceless within DV research. Hotline callers also represented a wide range of survivor experiences, including women who are at the beginning stages of recognizing a partner's abusive behavior and women who have already fled their abuser and are looking for survivor resources. While these contrasting samples have the potential to be truly representative of survivor experiences, only Anderson, et al., (2003) assessed patterns and severity of abuse, as well as the reasons women reported remaining with an abusive partner.

Anderson et al. (2003) found that 87% of 485 women calling a DV hotline reported physical abuse, and 89.6% reported verbal abuse and controlling behavior. The primary reason women chose to remain with abusing partners were his promises to change behaviors (70.5%) (Anderson, et al., 2003). It is important to note that nearly half (45.9%) of all women calling the DV hotline stayed with their partner because they lacked the financial means to leave, while 34% stayed to ensure their child(ren) would be dually parented; 28.5% had nowhere else to go; 24% feared losing custody of their child(ren); and 18.2% knew the alternative was homelessness (Anderson, et al., 2003). In a secondary analysis, Iyengar and Sabik (2009) utilized a national DV hotline database to assess the unmet needs of 48,350 DV survivors. They discovered that nearly 10% of all requests for services (including emergency shelter and counseling services) go unmet because of a lack of available resources (Iyengar & Sabik, 2009). Qualitative interviews with DV survivors reported by Moe (2007) further reinforce that women unsuccessfully seek assistance from multiple sources prior to entering a DV shelter, resulting in housing instability

prior to entry into an emergency shelter. These articles confirm that women hesitate to leave an abusive situation for fear of having no safe place to go. However, when they do actually seek assistance, they encounter an often over-taxed informal network of family and friends, or formal shelter or advocacy systems that offer little or no assistance.

The remaining studies of DV and homelessness targeted and recruited from populations of DV survivors. Only one study recruited exclusively from DV emergency shelters (reported in both Moe, 2007 and Moe & Bell, 2004). In order to capture a more representative sample of DV survivors in various stages of recovery, most studies recruited from DV service agencies and advocacy centers that included women in emergency shelters, transitional housing, and community dwelling DV survivors living in their own homes (Baker, Cook, & Norris, 2003; Gorde, Helfrich, & Finlayson, 2004; Ponc, Varcoe, & Davies et al., 2011; Rollins, Glass, & Perrin, et al., 2011; Tutty, Ogden, Giurgiu, & Weaver-Dunlop, 2014). The participants in all of these studies were actively seeking and receiving some form of DV support services. Thus, all participants had disclosed their abuse and requested and received some form of support. While requesting services is not equivalent to receiving all needed or wanted services, the simple fact that they were identified as DV survivors gives them an identified support system to negotiate.

Although DV research has occurred for decades, researchers, policy makers, and DV service providers continue to struggle to define and understand the basic “who” and “what” of domestic violence. Thus, most DV research are descriptive studies of the experiences of DV survivors, revealing high levels of violence, including acts of sexual and physical abuse up to and including attempted murder (Moe, 2007; Moe & Bell, 2004; Rollins, Glass, Perrin, et al., 2011; Tutty, et al., 2014). Survivors report financial abuse and control, often preventing them

from realizing independent personal financial stability (Anderson, et al., 2003; Baker, Cook, & Norris, 2003; Moe, 2007; Moe & Bell, 2004).

Financial abuse and controlling behaviors contribute to financial insecurity after fleeing an abusive partner as well, as women generally leave their abuser without financial resources and often accompanied by a dependent child or children (Anderson, et al., 2003; Baker, Cook, & Norris, 2003; Moe, 2007; Moe & Bell, 2004). Women who leave their partners are at greater risk for housing instability than those women whose partners are arrested or forced out of a shared living space (Baker, Cook, & Norris, 2003). Abusive partners continue to threaten their partners even after separation, physically preventing women from being with their children (Tutty, et al., 2014), threatening to take custody of children (Tutty, et al.), stalking ex-partners, and continuing and even escalating threats and acts of violence and abuse against them (Baker, Cook, & Norris, 2003; Moe, 2007; Moe & Bell, 2004; Ponic, et al., 2011; Rollins, et al., 2011).

Women who leave their abusers also face significant difficulty in accessing both formal and informal resources. Those who turn to friends and family (i.e. informal resources) for support report receiving emotional support rather than tangible financial or housing assistance when it is most needed (Baker, Cook, & Norris, 2003; Moe, 2007; Moe & Bell, 2004). Some women are more successful in receiving housing assistance from friends and family (Ponic, Varcoe, Davies, et al., 2011), however that assistance is often unreliable, resulting in frequent moves, and increasing a survivor's housing instability rather than minimizing it (Baker, Cook, & Norris, 2003; Ponic, et al., 2011). Increased housing instability, moreover, contributes to increased financial instability that lasts significantly longer than for women who were successful in rapidly reestablishing stable housing (Baker, Cook, & Norris, 2003; Ponic, et al., 2001).

Women also report numerous challenges in accessing formal resources such as emergency shelter space, government housing assistance, and legal and counseling services. In many communities, there simply are not enough formal services available to meet the needs of the number of women and children fleeing domestic violence (Iyengar & Sabik, 2009). Women who are initially successful in activating formal services too often report a failure within those services. Women who seek legal assistance in fleeing an abuser often find that police are slow or unresponsive in enforcing temporary protection orders (TPOs) or intervening at the scene during an active DV altercation (Baker, Cooke, & Norris, 2003). In fact, poor police response and fear of limited protection was cited as a key reason women remain with their abuser (Anderson, et al., 2003).

Many women experience a full range of posttraumatic stress symptoms in the aftermath of intense trauma and violence (Gorde, Helfrich, & Finlayson, 2004; Moe & Bell, 2004; Rollins, et al., 2011), which may include anxious arousal, intrusive thoughts and experiences, and dissociation (Gorde, et al., 2004). In addition, many women also contend with ongoing physical pain and disability from abuse, concerns of being located by an ex-abuser, expensive or unreliable childcare, and on-going housing instability, which result in frequent relocations that contribute to difficulty finding and maintaining stable employment (Moe & Bell, 2004; Ponic, et al., 2011). Thus, financial and housing stability become precariously balanced, contributing to cyclical unemployment, housing instability, and poverty in traumatized women (Rollins et al., 2011). Rates of housing instability among DV survivors correlate to more severe posttraumatic stress and depression symptoms, increased utilization of hospital and emergency medical services, and reduction in overall quality of life (Rollins, et al., 2011).

Unfortunately, for many survivors of domestic violence, the act of leaving an abusive partner is not her first episode of housing instability or homelessness. Many participants reported that the months immediately preceding flight from a DV relationship were marked by housing instability (Moe, 2007), while others reported more housing instability in the 6 months immediately after leaving an abusive partner (Ponic, et al., 2011). Tutty, et al. (2014) found that a majority of women fleeing DV relationships had histories of homelessness, with 36.2% of survivor women experiencing homelessness two to three times, and 31.9% reporting homelessness more than three times. In addition to the marked association between DV and rates of homelessness, Tutty et al. also found that approximately 25% of their study population had been homeless at least once prior to the age of 18, suggesting long-standing housing instability occurring outside of an intimate partner relationship.

Homeless and Low-income Women who experience DV

In 1996, Bassuk et al. reported that many homeless women with dependent children who were accessing traditional housing services were survivors of childhood and adult domestic violence. Unfortunately, the body of evidence supporting these findings remains remarkably small. The articles reviewed in this section provide descriptive data on both populations of homeless women and women living in low-income neighborhoods who qualify for housing and other government subsidies. These studies examined populations of low-income women in urban counties in California (Lown, Schmidt, & Wiley, 2006; Wenzel, Tucker, Elliott, et al, 2004) and Michigan (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012) in order to capture a diverse cross-section of women in high-poverty communities.

When compared to women residing in low-income housing communities, women in one study of non-DV homeless shelters reported higher rates of childhood physical, sexual, and

psychological abuse (Wenzel, et al., 2004). In fact, among women residing in shelters, 46% reported a childhood history of physical abuse, 41.3% reported childhood sexual abuse, and 56% reported childhood psychological abuse (Wenzel, et al., 2004). These findings were significant when compared to low-income women residing in their own homes, with 19.8%, 21%, and 30% of low-income housed women reporting childhood physical abuse, sexual abuse, and psychological abuse respectively (Wenzel, et al., 2004). High rates of victimization among sheltered women continue into adulthood; 35% of participant women living in non-DV shelters reported physical or sexual violence over the prior year compared to 13% of their peers in low-income housing over the same time period (Wenzel et al., 2004). Similarly high rates of victimization also emerged in a study of women applying for either Temporary Assistance for Needy Families (TANF [welfare for households with dependent children]) or General Assistance (GA [welfare for households without dependent children]), with rates slightly higher among GA applicants over TANF applicants (Lown, Schmidt, & Wiley, 2006). In that study, 28.7% of all participants had been victimized in the prior year, with 33% of GA applicants and 24% of TANF applicants reporting physical assault by a partner (Lown, Schmidt, & Wiley). A third study of women receiving TANF, reported by Adams, Tolman, Bybee, Sullivan, and Kennedy (2012), found that 37.9% of participants followed over 5 years experienced intimate partner violence at some point within that 5-year period. Many of the participant women also experienced material hardships such as food insecurity and housing instability and/or homelessness during the study period (Adams, et al., 2012).

The association between higher rates of victimization and increased housing instability was also significant in non-DV sheltered women when compared to their housed peers. Sheltered women were homeless on average 13.35 months within their lifetimes compared to 1.78 months

by low-income housed women (Wenzel et al., 2004). Further, non-DV sheltered women reported significantly higher rates of mental illness such as mania and psychotic symptoms (Wenzel, et al., 2004). They also experienced significantly higher co-occurrence rates for (i) victimization, (ii) substance misuse or abuse, and (iii) high risk sexual behaviors than did their low-income housed peers (Wenzel, et al., 2004). However, both sheltered *and* low-income housed women were at higher risk for victimization and poor health outcomes than the general population. Notably, the co-occurrence rates of victimization, substance misuse and abuse, and high-risk sexual behaviors were found to be higher among low-income housed women than within national reports of the general population (Wenzel et al., 2004). These patterns of co-occurrence contributed to more disease burden and diminished well-being within the study population of low income housed and homeless women than in the general population.

Both TANF- and GA-seeking women reported high rates of victimization by a partner (>25%), and 51% of participant women seeking welfare benefits reported an episode of homelessness in the prior year (Lown, et al., 2006). Rates of violent victimization, substance misuse and abuse, and poverty, high in both groups, were significantly higher among women seeking GA compared to women in the TANF sample (Lown, et al.). Researchers also identified several participant characteristics that were associated with high risk of severe victimization, including being divorced, separated, or never married, having a child in foster care, misusing or abusing drugs or alcohol, and reporting an history of homelessness over the past year. (Lown, et al., 2006).

Women receiving TANF in a study by Adams, et al. (2012) also reported high rates of DV, specifically intimate partner violence (IPV). Unique in its longitudinal approach, this study also compared long-term outcomes of DV on women's job stability and financial security, and

found a significant correlation between experiences of DV and financial stability (Adams, et al., 2012). The financial impact of DV proved to have a lasting impact; it took many women up to three years after leaving an abusive relationship to stabilize their jobs and establish financial security (Adams, et al., 2012).

Together, these studies present a grim picture of the experience of poverty and victimization for women in the US. Although not causally linked, the co-occurrence of housing instability and domestic violence are significant within low-income communities of women. Women who experience homelessness in the aftermath of DV are even more likely than their housed peers to be revictimized, and to become trapped in a cycle of victimization and housing instability. Awareness of the co-occurrence of victimization of varying kinds and housing instability is on the rise, but interventions and solutions have lagged behind, leading to prolonged negative personal and financial outcomes for women facing housing instability and domestic violence.

Findings Across Studies of Women

Although each reviewed study approached the subject from a different angle, all demonstrated a clear connection between domestic violence and housing instability, financial instability, and overall diminished well-being. Most researchers worked with populations of known DV survivors to better understand their characteristics and situations, and the challenges they faced in stabilizing their lives after fleeing violent relationships. Others took a much different approach, uncovering hidden domestic violence in populations of vulnerable women in order to better understand the complex intersection of violence and housing, financial, and job stability.

Whether women are experiencing homelessness for the first or the 50th time in their attempt to flee abusive partners, they need a combination of formal and informal support to stabilize their lives (Anderson, et al., 2003; Baker, Cook, & Norris, 2003; Gorde, Helfrich, & Finlayson, 2004). These supports must be comprehensive and broad reaching. For example, the financial insecurity that often accompanies flight from an abusive relationship not only fosters housing insecurity (Iyengar & Sabik, 2009; Moe & Bell, 2004), but, in and of itself, places women at risk for revictimization (Adams, et al., 2012; Lown, Schmidt, & Wiley, 2006). Thus, women experiencing housing instability and/or homelessness—whether clearly identified as DV survivors or not—must be assessed for victimization, as an unfortunate majority have experienced or will experience some form of DV (Wenzel, et al., 2004). Far too few survivor women are identified as needing services through traditional DV programs, which are often stretched beyond their capacity (Iyengar & Sabik, 2009), resulting in an absence of crucial services. Housing instability associated with DV does not resolve quickly, and thus can lend itself to a dangerous cycle of unstable employment, poverty, and limited resources. These findings suggest that multidisciplinary, trauma-informed services, as well as trauma-informed public policies for rehousing and public assistance are needed in order to break the cycle of poverty and housing instability associated with disclosed and undisclosed domestic violence.

Other Supportive Evidence

This literature review was intentionally limited in scope in order to capture the intersection of DV and housing instability. Given the limited scope of this review, there were articles not captured in the literature search that nonetheless offer supporting evidence of the relationship between DV and housing. For example, Alexander (2011) examined the cumulative effects of childhood abuse and DV on employment stability and found that specific forms of

childhood abuse, namely physical abuse and sexual abuse, were partial predictors of later DV and work interference by a partner (i.e., actions taken to prevent a partner from arriving at work on time or on a regular basis). Further, 92.5% of women who reported partner work interference also reported physical abuse from that partner that thwarted job stability and financial security leading to homelessness (Alexander, 2011).

As previously mentioned, the experience of DV as an adult is often a continuation of life-long trauma and victimization. A large cohort study of health insurance clients revealed that individuals who grew up in a household with domestic violence (both as witnesses and victims of physical and sexual abuse) experienced a two-fold increase in their risk of experiencing DV as an adult (Whitfield, Anda, Dube, & Felitti, 2003). While this study did not explicitly link DV and housing instability, the connection between childhood exposure to DV with future risk of victimization provides support for examining women's life course when treating adult DV.

DV and childhood maltreatment are overtly associated with future housing instability in research conducted by Bassuk, Dawson, and Perloff (2001) and Anderson and Rayens (2004). Bassuk, et al. (2001) found that mothers experiencing recurrent homelessness had significantly higher incidences of intimate partner violence, childhood sexual abuse, foster care placements, and histories of running away as adolescents than peers with only one episode of homelessness. Anderson and Rayens (2004) also reported that childhood abuse negatively correlated with social support and social connectedness in adulthood, which was associated with an increased incidence of homelessness. Thus, the co-occurrence of childhood maltreatment and adult experiences of domestic violence relate strongly to future housing instability.

Children, Domestic Violence, and Homelessness

As mentioned earlier, women experiencing DV and/or homelessness report extremely high rates of victimization during their childhoods. Thus, it is important to consider how DV affects children, their trajectory of housing stability, and their overall well-being. The literature search revealed 3 studies that focused specifically on the impact of homelessness and domestic violence on children. The first, a 5-year longitudinal cohort study reported by Park, Metraux, Brodbar, and Culhane (2004) followed 8251 children under the age of 16 entering the New York City (NYC) shelter system in 1996 to determine frequency of and risk factors for child welfare services involvement (CWI). The second study analyzed survey data from homeless and low-income families to identify associations between maternal experiences of victimization, family financial insecurity, and child behavioral outcomes (Anooshian, 2005). The final study reports the qualitative descriptive findings from young adults of their personal histories and pathways into homelessness (Tyler & Schmitz, 2013).

Park, et al. (2004) found that, of the 8251 children entering the NYC shelter system in 1996, only 6% had a history of CWI *before* entering the shelter, while 18% had CWI within 5 years *after* shelter entry. It is important to note that CWI included both foster care placement and family support services to maintain a child with his parent or guardian, so CWI is not synonymous with children being removed from the custody of their parent(s). However, 16% of all participant children had an out-of-home placement either at some point before, during, or after shelter entry (Park, et al., 2004). Surprisingly, although families entering homeless shelters often worry about scrutiny from child welfare services while in the shelter, data from this cohort found that families were most likely to have child welfare involvement after or between, rather than during shelter stays (Park, et al.). Children who encountered CWI after shelter entry were more likely than children without CWI to experience reentry into the shelter system, and to have

a significantly longer average annual shelter stays (Park, et al., 2004). Further, children from DV households, school-aged children, and teenagers were more likely to encounter CWI after shelter admission than were preschool-aged children and children from non-DV households (Park et al., 2004). While these findings support an association between housing instability and CWI, the exact nature of the relationship is unclear. Still, findings support an increased vulnerability to CWI and on-going housing instability following the rehousing process, suggesting a concomitant increased risk in victimization worthy of further investigation.

The findings presented by Anooshian (2005) represent a relatively small cross-section of families—specifically women with dependent children—across a continuum of housing instability ranging from homelessness to residence in low-income subsidized housing. Similar to women in Bassuk, et al.'s study (1996), Anooshian's adult female respondents reported extremely high rates of victimization, with 88% identifying as a victim of violence, and 71% reporting victimization as a child (Anooshian, 2005). Maternal reports of victimization, particularly those occurring in adulthood, as well as ongoing familial economic distress, were also associated with aggressive behaviors in children (Anooshian, 2005). In particular, children whose mothers were victimized as adults experienced more social isolation and socially avoidant behaviors than their peers. Thus, housing and economic instability were associated not only with victimization of women, but also negative social behaviors and social isolation in children (Anooshian, 2005).

Finally, Tyler and Schmitz (2013) present findings from a qualitative study intended to uncover pathways to homelessness for young adults. Study participants ranged in age from 19 to 21, and included 24 females and 16 males. Most had a family history of a parent or guardian with a substance abuse disorder (93%), and nearly all had experienced childhood maltreatment (95%).

Many also reported witnessing domestic violence within their childhood homes (Tyler & Schmitz, 2013). These experiences of childhood victimization and violence resulted in participants leaving their homes at a young age, often running away from their homes for the first time between the ages of 12 and 15 (Tyler & Schmitz, 2013). What followed was often a long-term pattern of housing instability, where young people exhausted personal and social resources by staying with friends and family members, spending time in detention centers, shelters, and foster homes, occasionally returning to the family home for brief stays until conflict again forced them to leave (Tyler & Schmitz, 2013).

Together, these three articles depict the cyclical nature of DV and housing instability. When victimization and violence co-occur with economic instability, women and their children face increased risk of future victimization, and children often struggle with resulting aggression and negative social behaviors (Anooshian, 2005), potentially contributing to interpersonal conflict with family and peers. Victimization and housing instability increase a child's risk for CWI, resulting in continued housing instability (Park et al., 2004) and increased risk for revictimization (Park et al., 2004). In addition, by the early teenage years, on-going exposures to violence, housing instability, and family conflict contribute to the risk of running away from one's family home at a young age, further perpetuating housing instability and risk for victimization (Tyler & Schmitz, 2013) in a difficult-to-break cycle.

Other Supportive Evidence

Again, given the focused scope of the literature review, several studies that contribute to the body of evidence connecting DV with housing instability in youth were not included. For example, Oliveira and Burke, in their 2009 ethnographic exploration of homeless street youth in Boston, found that youth living on the street often felt safer and more connected to their "street

family” than to their families of origin. They identified issues of parental substance abuse, conflict, and rejection as key reasons for youth runaways to homelessness (Oliveira & Burke, 2009). Whitbeck, Hoyt, Johnson, and Chen (2007) found that 35.5% of homeless youth in their longitudinal study met diagnostic criteria for posttraumatic stress disorder (PTSD) within their lifetime, although only 16% had active symptoms of PTSD. High rates of PTSD were often associated with histories of physical or sexual abuse from an adult caretaker (Whitbeck, et al., 2007).

A retrospective study examining adverse childhood experiences (ACEs) uncovered strong associations between ACEs, residential mobility, and health risks (Dong, Anda, Felitti, et al., 2005). As defined in this study, ACEs includes physical, sexual, or psychological abuse, neglect, household domestic violence, parental marital discord, substance abuse, mental illness, and/or the incarceration of a household member occurring before the age of 18 (Dong, et al., 2005). ACEs were associated with multiple diminished health outcomes, including depression, suicidal ideation, and substance abuse disorders, which together increased morbidity and early mortality (Dong, et al., 2005). This study also revealed a strong association between ACEs and residential mobility (Dong, et al., 2005). While residential mobility was not specifically defined as housing instability and/or homelessness, frequent moves and displacements (as often happen when a family experiences housing instability) result in broken social supports, disruptions in education, and the repeated stress of adapting to a new environment (Dong, et al., 2005). These findings support a strong association between childhood experiences of trauma and violence, housing difficulties, and poor health outcomes.

Hall’s (1996) research into childhood sexual abuse, while not directly linked to housing, describes household, neighborhood, and community attitudes and conditions conducive to

childhood sexual abuse (CSA). All study participants were adult females who self-identified as lesbian, and were in recovery from alcohol abuse (Hall, 1996). Half of the women involved in the study were unstably housed (doubled-up with friends, living in garages, or with pending eviction notices), and the mean participant income was \$14,800 annually, which was 42% of the average annual income for the region (Hall, 1996). Although participants were adults, this study focused on their childhood environments and experiences. Using the qualitative descriptive information shared by study participants, Hall was able to identify 20 characteristics of childhood home, school, and community environments that supported the occurrence of CSA, including: sexual chaos (overt, sexually explicit comments and images used in front of or directed at children), battering/physical violence, scapegoating (inappropriate blame and hostility targeting one individual), unchallenged verbal abuse, instability of place (frequent moves and relocations), economic instability, absence of nurturing, and developmentally inappropriate task expectations (Hall, 1996). Although these findings predate other literature review findings, they are worth consideration, because many of these characteristics and experiences continue to emerge from findings of more recent studies.

Overall Findings and Resulting Questions

The body of evidence uncovered in this literature review confirms that domestic violence survivors often struggle to regain and maintain housing stability after fleeing an abusive relationship, and that women experiencing homelessness are often survivors of some form of domestic violence whether in their childhood or adult years. Abuse and trauma occurring in the childhood home contribute to unstable housing in childhood, and place children at risk for recurrent victimization as children and as adults. As adults, episodes of domestic violence disrupt job and financial stability, and contribute to prolonged housing instability and family disruptions.

This vicious cycle repeats as victimization contributes to job, financial, and housing instability, which in turn, is associated with increased risk for revictimization.

Trauma-Informed Care

Findings from the literature were confirmed and enhanced in our early focus group findings (Gultekin, et al., in press), as well as in data collected from individual women experiencing homelessness. In fact, the relationship between trauma and homelessness is so apparent, that governmental (e.g. Substance Abuse and Mental Health Services Administration [SAMHSA], U.S. Department of Health & Human Services [USDHHS]) and private national organizations (e.g. National Center on Family Homelessness [NCFH]), have issued guidelines on the delivery of trauma-informed care for persons and families experiencing homelessness (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009; Hopper, Bassuk, & Olivet, 2010).

Trauma-informed care (TIC) is an approach to providing services that recognizes the potential that care-recipients have likely experienced traumatic life events (Hopper et al., 2010). TIC requires time and attention from all members of an organization to ensure that the basic principles of TIC carry through all aspects of service delivery (Hopper, et al., 2010). These include that providers: 1) demonstrate trauma awareness and maintain an emphasis on safety, 2) provide opportunities for women to rebuild control in their lives, and 3) focus on women's strengths and abilities rather than their weaknesses and failures (Hopper et al., 2010). *Trauma awareness* is the recognition that people who have experienced trauma are impacted by that trauma in all aspects of their lives (Hopper, et al., 2010). Agencies that practice trauma-informed care demonstrate trauma awareness by implementing trauma sensitive protocols at all levels of service, including screening for trauma in clients, training staff about behavioral manifestations of trauma, and monitoring staff for signs of "vicarious trauma" when working with a heavily-

traumatized population (Hopper, et al., 2010). An *emphasis on safety* includes not only maintaining the physical safety of clients and employees (through maintaining a safe physical environment), but also creating an emotionally safe space where rules and boundaries are clear and equitably enforced in a predictable manner, and where privacy, confidentiality, and mutual respect regardless of personal differences are the standard of practice (Hopper, et al., 2010). Power and control are often central issues within abusive relationships and traumatic events, thus providing survivor clients with an *opportunity to rebuild control* allows clients to emerge from the powerlessness of an abusive relationship (Hopper, et al., 2010). Trauma-informed service providers can offer opportunities to rebuild control by allowing client input in rule-making and the provision of services whenever possible, promoting self-efficacy and personal control (Hopper, et al., 2010). Finally, a *strength-based approach* to care prompts clients to recognize their personal agency and work toward recovery, rather than focus on deficits (Hopper, et al., 2010).

The Absence of Trauma-Informed Care

In spite of the recent progress developing TIC guidelines for homeless service providers, there are numerous accounts of homeless service providers, police, and healthcare workers providing care that is insensitive to the experience of trauma. These services fail to meet clients' basic safety needs and do not promote a trauma survivor's sense of control over her circumstances (Anderson et al., 2003; Baker et al., 2003). Further, the unavailability of DV survivor services in many communities (Iyengar & Sabik, 2009), and the lack of integration between provision of DV and family homelessness services, contributes to missed opportunities to identify and address the needs of trauma survivors. As a result, the cycle of victimization and housing instability remains unbroken in many families.

Inconsistencies in the delivery of TIC services from emergency shelters in Detroit became apparent while conducting focus groups with mothers experiencing homelessness (Gultekin, et al., in press). In order to provide a clean, safe housing environment for numerous families and individuals, shelters create and enforce rigid rules. Women shared that these rules were sometimes harshly and inequitably enforced, resulting in an inability to feed children on their usual schedule, physical separation of teenage boys from their families, and the abandonment of employment opportunities on off-shifts (i.e., night or evening shifts) in order to meet shelter curfews. In some instances, focus group participants reported encountering shelter staff who were insensitive or extremely abrasive in their interactions. One woman recounted that on the night she arrived at an emergency shelter after fleeing an assault by her fiancé, she received further degradation at the hands of a shelter staff member. Pregnant with her second child, with a 2-year-old son in tow, she had only one diaper and \$10 cash when she arrived at the shelter crying and scared. The first staff member she encountered remarked, “What are you crying for? It’s just a shelter. What, is this your first time here or something?” (Gultekin, et al., in press). These types of interactions left women feeling degraded, humiliated, unsupported, and powerless.

Emerging Questions

Several important questions emerge from the presented findings that could help to bridge this gap between the services and care homeless families receive *now*, and the services and care they *should* be receiving. We know that women are seeking housing services outside the purview of DV services in spite of histories of DV. However, we do not know if they perceive their history of DV as relevant to their current housing status. In fact, because women experiencing housing instability are largely marginalized within the US, we know very little about what they

perceive to be their pathway into housing instability, how they connect the events of their past to their current situation, and what services they value within the process of rehousing. The present research attempts to shed light on these questions in order to better meet the needs of families facing housing instability and to consider future interventions toward family homelessness prevention.

Connecting Findings to a Theoretical Framework

As presented in Chapter 1, one's housing and financial status are critical social determinants of health, and exposures to life stressors such as trauma and domestic violence result in increased allostatic load and weathering. Although the nursing profession recognizes social determinants of health as central to a multitude of health disparities, nurses lack theoretical models for explaining these complex connections beyond grand theory. More specifically, although nursing has recognized the connection between personal health and the physical environment for decades, there is a distinct lack of theoretical explanation for the relationships that exist between individuals or families, their housing, and their health. Complex personal, social, and structural forces exist that propel families into particular communities, where they live, work, and grow, and where health resources may be abundant or absent.

The research presented in this dissertation utilizes primary frameworks ideologically consistent with these issues, but from outside the field of nursing. The primary frameworks are Life Course Theory and the Model of Compounded Disadvantage. Together, these theoretical models provide a framework that, when viewed through feminist, trauma-informed lenses, allow for a broad understanding of the context of family housing instability in the US, and more specifically, Detroit, Michigan.

Life Course Theory

Life course theory (LCT) is a relatively new approach to consider issues of health disparities. LCT has been utilized to explore birth outcomes in minority communities (Lu & Halfon, 2003; Lu, Kotelchuck, Hogan, et. al, 2010), substance abuse vulnerability and relapse among homeless populations (Benda, 2004), and chronic illness prevalence and trajectories (Ben-Shlomo & Kuh, 2002). It is a versatile approach to understanding illness, wellness, and human development within individual and family contexts across time. Rooted in social equity and social determinants of health, LCT can be utilized to better understand how health disparities occur within vulnerable populations across the lifespan.

The US Department of Health and Human Services Maternal Child Health Bureau (MCHB) recently embraced a life course perspective in the evaluation and management of disparate maternal and child health outcomes (MCHB, 2010). Their conceptualization of the life course model specifically outlines the core concepts critical to life course theory. The first of these concepts is that of the *timeline*. The chronicity of life events determines disease risk based on experiences and exposures over time (Brown, Smith & Beasley, 2013; MCHB, 2010). These exposures can occur across generations, as the prenatal and intranatal health and well-being of a mother or family can impact future health risks of their off-spring resulting in specific vulnerabilities to future health outcomes (Brown, Smith & Beasley; MCHB, 2010).

The second core concept in LCT is that of *timing*. Although life pathways and future health can be influenced at any stage of development, it is understood that there are critical developmental periods where a person or family is particularly sensitive to exposures (MCHB, 2010). Allostatic load and resulting weathering processes accumulate across time, so although a single negative stress event may not alter the long-term health of an individual, repeated

exposures to stressful life events is likely to negatively impact one's health and well-being (MCHB, 2010).

Environment, in the broadest sense, represents the third core concept. The personal, physical, and social context of a person's or family's existence impacts exposures to both risk and protective factors that can influence a life trajectory. Ultimately, though, *equity* emerges as central to health disparities, as the availability and distribution of resources impacts many aspects of a person's timeline and environment. Equity, the final core concept of the LCT, reflects the reality that, beyond biological processes and personal choice, the unavailability of critical health resources (such as healthy foods, affordable housing, clean water, and pollution-free neighborhoods) negatively impacts vulnerable individuals and families (Brown, Smith & Beasley, 2013; MCHB, 2010).

Findings from the literature review in this chapter demonstrate why Life Course Theory is essential to studying and understanding the needs and experiences of women and children experiencing housing instability. LCT provides a broad framework for approaching research with families experiencing housing instability, helping to explain the cyclical nature of family homelessness and how life events contribute to intergenerational transmissions of beliefs, behaviors, genetics, and resources. But LCT alone may not explain the complex interactions previously discussed. It is also important to consider the specific existing mechanisms that produce inequity related to housing, health, and well-being. For a more structured model of the context of housing instability, I utilize Wakefield and Baxter's Model of Compounded Disadvantage.

The Model of Compounded Disadvantage

The Model of Compounded Disadvantage emerges from the field of geography and addresses intersecting concerns of environmental and social justice (Wakefield & Baxter, 2010). Defining *compounded disadvantage* as "the cumulative hardship experienced by marginalized populations as a result of multiple and overlapping challenges to well-being and autonomy," (p.99), Wakefield & Baxter (2010) consider the multiplicative effects of risk related to individual, social, and structural factors on a person's wellbeing. Their model assumes a complex interplay between individual characteristics (including age, social class, racial or ethnic identity, and gender), and social and institutional characteristics (such as racism, poverty, community ability to mobilize, and public/legal policy), contributing to disparate health outcomes, compromised wellbeing, and degraded physical and social environments. It also assumes that allostatic processes and weathering are both influenced by social and institutional characteristics, and also contribute to poor health, diminished wellbeing, and degraded environments (Wakefield & Baxter, 2010).

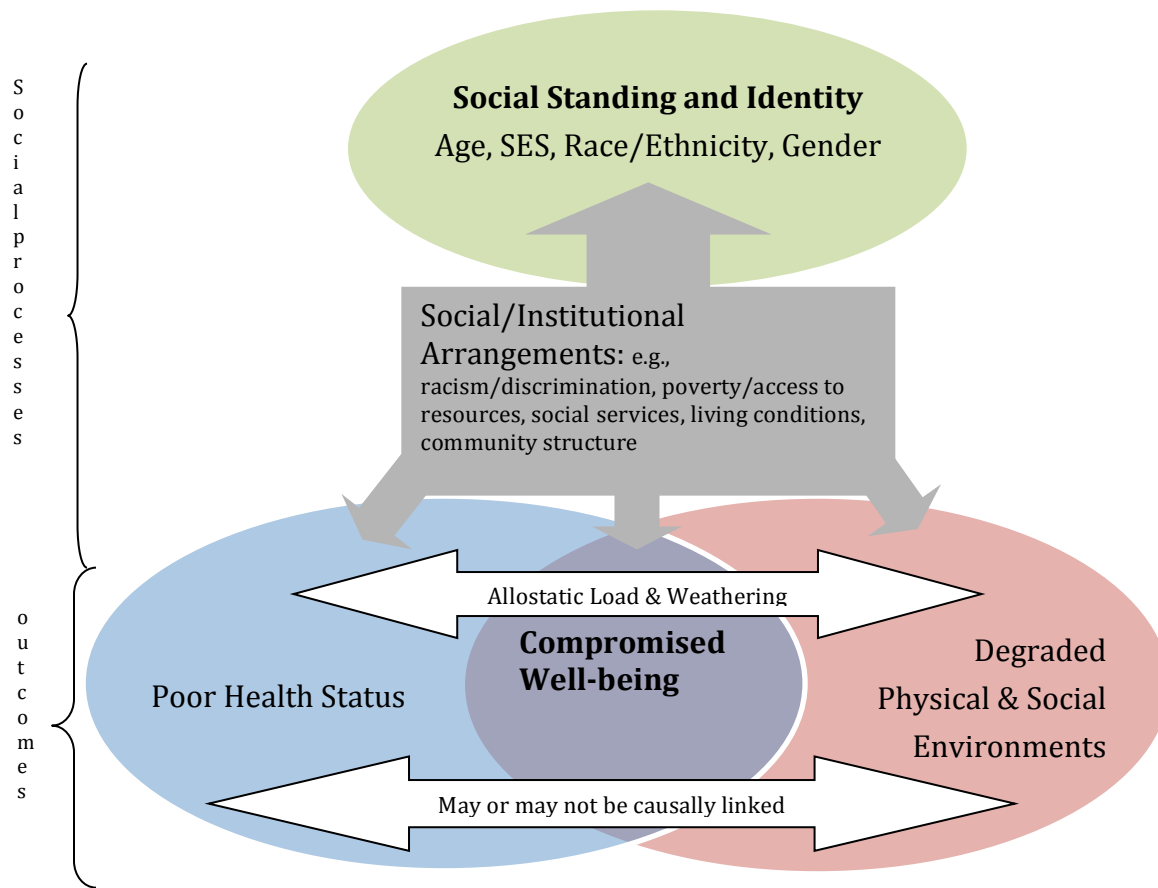


Figure 1: Wakefield and Baxter's Model of Compounded Disadvantage (2010)

Wakefield and Baxter do not assume a causal connection between poor health status and degraded physical environments. Rather, they assume that poor health status and degraded physical and social environments frequently intersect, resulting in compromised wellbeing. This framework represents a call to action that acknowledges the complexities of assigning causal connections. Further, this framework contends that actions to redress social and environmental injustices will likely result in reduced health disparities.

Seen in Figure 1, there are several key constructs within the model of Compounded Disadvantage supporting the authors' assumptions of intersectionality or co-occurrence. *Social standing and identity*, for example, which includes personal attributes such as age, race/ethnicity, sex, gender, and social status, are both naturally occurring (as in the case of age, race/ethnicity, and sex) and a product of social and cultural influences (as with social status). Social standing and identity shape and are shaped by other model constructs, such as those cultural attributes defined as part of one's institutional arrangements. These are attributes that shape individual and community power dynamics, access to resources, public laws, and social policy, and can include social and institutional policies that are overtly or covertly racist or discriminatory, such as educational and work place standards that support or disadvantage any group of individuals over another. These social and institutional arrangements directly influence processes of *allostatic load and weathering*, as defined earlier. The final constructs within this model are *health and environment*. Wakefield and Baxter conceptualize *health* as a holistic state of physical, mental and social wellbeing, rather than the absence of disease. *Environment* refers to the homes, land, air, neighborhood, and larger community in which a person or persons are situated. Wakefield and Baxter use the phrase "degraded physical and social environments" as a proxy for the concept of environmental injustice, where "marginalized communities" (most often, those that

are low-income, resource depleted, and frequently communities of color) are denied basic access to safe water to drink, clean air to breathe, and uncontaminated land upon which to live.

As demonstrated in the literature review findings, family homelessness represents the co-occurrence of degraded physical environments and poor health status in the presence of allostatic load and weathering processes resulting in diminished well-being. Unstable housing, whether in the form of a homeless shelter, a home where violence is occurring, or a house where utilities have been or will be shut off, provides an environment that is degraded, unpredictable, and potentially unsafe. The co-occurrence of job instability or poor financial health, especially in the aftermath of DV, and a history of recurrent or unresolved trauma throughout the life course, results in significantly diminished well-being.

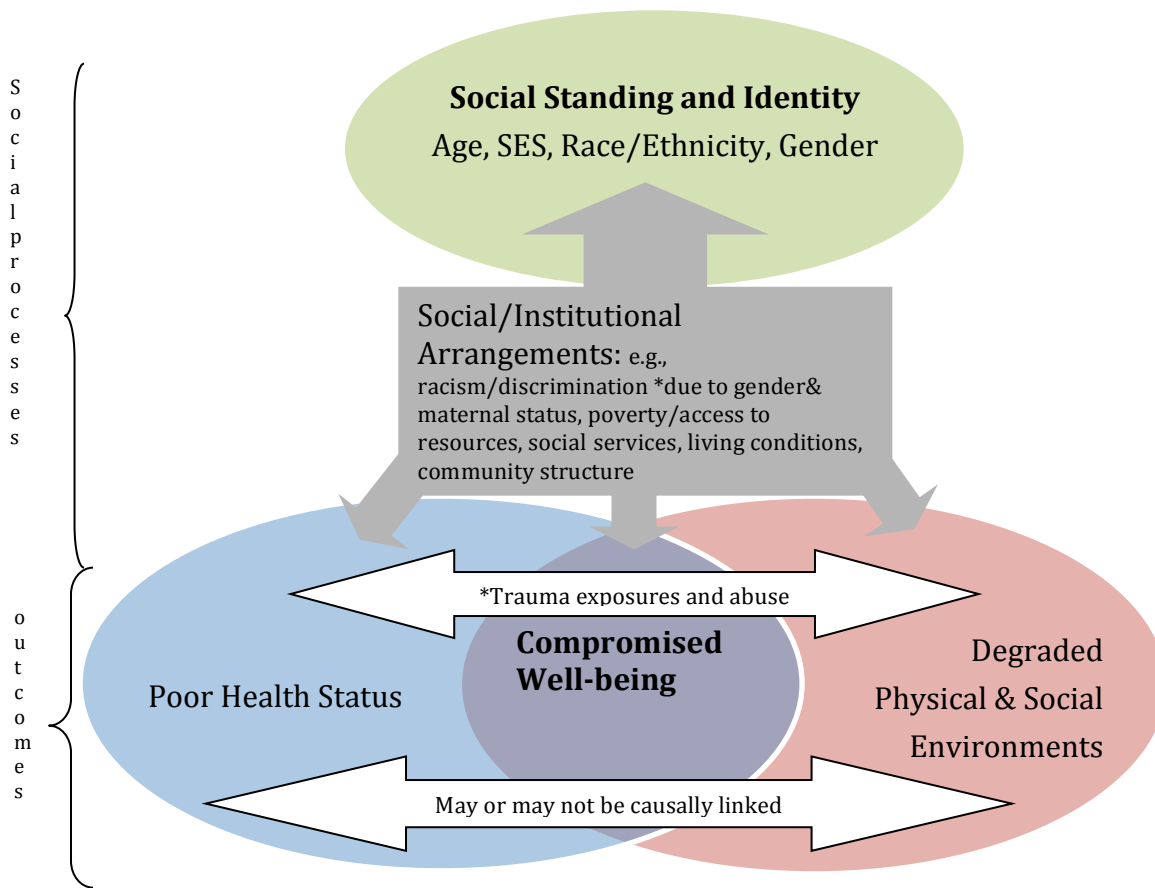
Applying a Feminist and Trauma-informed Lens

Given that most homeless families in the U.S. today are female-headed, this project employs a feminist participatory action research approach (FPAR) to conceptualize the use of Wakefield and Baxter's Model of Compounded Disadvantage (2010) as an organizing framework. The application of a FPAR approach and its trauma-informed focus is particularly important given that Wakefield and Baxter, although making an effort to be comprehensive in their approach, overlook the potential influence of intergenerational trauma in the lives of disadvantaged families. I will discuss FPAR and the importance of a feminist approach to this research in detail in chapter 3.

Wakefield and Baxter thus provide a compelling yet arguably incomplete vision of their Model of Compounded Disadvantage when used to examine this particular population. Missing from their model are discussions of how gender and gender dynamics add to compounded disadvantage. A feminist lens is critical to examining the experience of family homelessness, not

simply because many families experiencing housing instability are headed by women, but because feminism demands critical attention to issues of social justice and power imbalance (Baker, Butter, Reed, & Sutton, 1992). Wakefield and Baxter clearly imply matters of social justice within their theoretical model, however, no specific attention is given to the roles of gender and parenting. It is critical to understand how social arrangements and cultural expectations influence women's perceptions of and ability to obtain and maintain employment, access government services, access survivor services, establish and maintain housing, and raise children without a male partner. Thus, as seen in Figure 2, I embellished the model to specifically address the role of gender in shaping social and institutional arrangements.

As discussed throughout this chapter, DV, trauma, and victimization too often act as formative processes within the lives of families experiencing homelessness. The prominence of trauma and victimization in the lives of women experiencing homelessness demand the use of a trauma-informed approach to research. Trauma-informed approaches require understanding not only of the existence of trauma, but its ability to impact future aspects of life, with or without a person's awareness (SAMHSA, 2014). While Wakefield and Baxter include allostatic and weathering processes that imply traumatic life events, the model requires an overt acknowledgement of the ability of trauma and victimization to act as a force in producing diminished well-being. The modified model is included below (Figure 2).



*Figure 2: Wakefield and Baxter's Model of Compounded Disadvantage (2010) *indicates adaptations to apply a feminist, trauma-informed lens*

Summary

Family homelessness and housing instability frequently co-occur with diminished health. The resulting negative effects on well-being are compounded by DV and traumatic life events. Families experiencing these co-occurrences are vulnerable to financial insecurity, educational interruptions, broken social networks, and are at high risk for revictimization throughout their lives. While research demonstrates these associations, there remain gaps in our understanding of personal experiences and perceptions of these associations. There is a dearth of information on the life trajectories of families on the edge of homelessness, their rates of victimization, their perceived needs in stabilizing their housing, and what they believe could have prevented their housing instability. This research is a starting point for understanding the hows and whys of housing instability from mothers' perspectives, an effort to identify downstream opportunities for intervention to prevent an on-going cycle of trauma, victimization, and housing instability, and an opportunity to honor the survivor stories and recognize personal stories of strength and resilience.

Chapter III: Research Methods

In this chapter, I present the methodological approach utilized for this research and the rationale for its use. I will also detail the research strategy used to collect and analyze data.

A Qualitative Choice

“In Their Own Words” employs a qualitative narrative approach, guided by Story Theory, to elicit personal accounts and perceptions of the events within women’s lives that led to their housing instability. The decision to use a qualitative methodology for this research was driven both by the aims and input from the target population. Several years ago, Drs. Brush and Baiardi conducted a research project with homeless populations in Detroit. Information from a focus group needs-assessment for an agency providing services to homeless families revealed that service providers and recipient families differed in their views on immediate service needs. A focus group participant made a statement along the lines of, “It’s all well and good that you care enough to ask us about our lives...but you don’t have your ear to the street.” Essentially, our research team was told that we could never fully appreciate women’s experiences or needs because we were not privy to their lives and experiences and because we had not ourselves lived similar experiences.

This prompted our follow-up focus group research, “Voices From the Street: Exploring the Lives of Homeless Women in Detroit.” “Voices” revealed elements of the larger context contributing to homelessness among women with children. Homelessness was not an isolated

event within the lives of the focus group women, but was a manifestation of on-going trauma, victimization, isolation, and marginalization. While their caseworkers were focused on finding them safe, stable housing and employment, women were focused on the powerlessness they experienced prior to and upon entry into the shelter, and the lack of social support available to them. Women were focused on immediate, physical needs for survival, such as a bed to sleep on and food for their children, while caseworkers wanted them to focus on “big-picture” goals and future planning. Differing needs and goals contributed to frustration among both caseworkers and women, and revealed a disconnect between perceived needs of the women and available services mandated by policy and funding bodies. This led to literature reviews that revealed limited information regarding pathways into family homelessness, characteristics of homeless families, and the process of overcoming family homelessness.

While demographic data is collected routinely on families entering homeless shelters and is reported annually through several mechanisms (HUD, 2013; NAEH, 2013; US Conference of Mayors [USCM], 2013), they do not portray the scope of the issue, or the context and reality of living on the street or in a shelter. Missing from demographic and epidemiological reports are the personal stories and perceptions of the pathways into homelessness, the personal struggles one encounters when negotiating the shelter system, and accounts of successful and unsuccessful rehousing. The disconnect between the patterns and distribution of family homelessness and the actual needs and experiences of families experiencing housing instability becomes apparent in assessing the impact of national efforts to reduce family homelessness. In spite of broad efforts to reduce homelessness across the US, homelessness among families continues to increase (HUD, 2013). The families most impacted by these systematic failures are missing from discussions of why programs are missing the mark, and how they can be improved. This is

largely because homeless families have never been asked to share their life stories or perspectives on living with unstable housing. This study filled that gap, asking homeless mothers with children to give voice to the pathways, needs, and experiences surrounding their housing instability.

Qualitative approaches allow for an exploration of rich detail of personal experiences and meaning that are missed with closed-ended approaches like survey research. Questions of “how” and “why” often exceed the abilities of Likert scales, requiring instead an individualized response that demonstrates introspection and reflection. Qualitative inquiry allows this process in a less-constrained manner than traditional quantitative research, and elicits contextual details not captured through survey research.

Feminism and Community Voice

Research relating to vulnerable, underserved populations, moreover, often misses the voice of the very people it is trying to influence. This can result in findings that fail to translate to real life settings and circumstances, and interventions that cannot be sustained within their target communities. Over the past decade, interest in community-engaged research to reduce health disparities among underserved populations sparked a movement promoting community-based participatory research (Minkler & Wallerstein, 2008).

Community-based participatory research, or CBPR—while only one approach—requires researchers to connect with the communities they intend to study. The entire research process then becomes a shared experience. It recognizes communities for the strengths they already have, and supports them to build upon their strengths to resolve emerging or existing challenges. The 6 central principles and characteristics of CBPR include that it is *(i)* “participatory,” *(ii)* “cooperative, engaging community members and researchers in a joint process in which both

contribute equally,” (iii) “a co-learning process,” (iv) “involves systems development and local community capacity building,” (v) “an empowering process through which participants can increase control over their lives,” and (vi) “achieves balance between research and action,” (Minkler and Wallerstein, 2008, p. 9). Although “In Their Own Words” does not align wholly with the aforementioned principles of CBPR, it strives to engage with the community and recognize the importance of shared learning so that data collected can ultimately promote community capacity building and personal empowerment.

In addition to the focus on community-engaged research (CE-research), this research utilizes a feminist orientation to address issues of power imbalance between researcher and research participants. This blend of feminist perspective and CE-research ultimately results in a feminist participatory action research (FPAR) approach. FPAR, which integrates feminist theories and community participatory action research methods, is concerned with the dominant societal ideologies about gender and how they translate into protective processes (e.g. power, resource, and health differentials) (Armstrong, 2006; Frisby, Maguire, & Reid, 2009; Ponic, Reid, & Frisby, 2010). FPAR assumes the existence of power imbalances and injustice, but also celebrates individual and community strengths and agency in addressing and overcoming complex issues such as family homelessness (Wallerstein & Duran, 2008). A FPAR approach acknowledges women as the experts of their lives and narratives, and empowers them to give voice to their experiences. This is particularly important given that most of what we know about and use to inform practice and policy about homelessness is based on the experiences of single males.

Certainly, anyone in the vulnerable position of housing instability is likely to experience moments of powerlessness. Those moments of powerlessness are magnified when the head of

household identifies as a member of a racial, ethnic, or gender category that has been systematically marginalized and oppressed. Homeless, minority women with children lack a voice in shaping the policies that directly impact the services they receive. Although many homeless shelters offer a “resident’s council” to provide sheltered homeless persons with a forum to discuss concerns and shape rules within a shelter, those rules can be overruled by government mandates and policies that are often out of touch with the true experience of homelessness and housing instability.

It can be argued that “In Their Own Words” lacks the component of action required for FPAR research. That is, this research study does not offer an intervention or direct action to be taken by the community or service providers. However, this study represents a starting point for a developing body of FPAR. It is critical that this research drives further lines of inquiry and interventions that continue to engage the community, recognize the personal agency of community members, and promote sustainable change within the community.

Why Narrative?

While numerous qualitative methodologies capture individual personal details and perceptions, this research specifically utilizes *narrative* as the qualitative approach. Narrative research uses individual narrative, or story, as a central unit of analysis (Duffy, 2007; László, 2008; Sarbin, 1986). Built on the foundations of both literary and social sciences, it values elements of character, plot, chronology, and context in the creation and organization of a life story and the meaning it derives (Duffy, 2007; László, 2008; Liehr & Smith, 2008; Pennebaker & Seagal, 1999; Sarbin, 1986). Data collected through the narrative process can then be shared so that others can read or hear and understand. Narrative processes are central to many therapeutic processes, and have been utilized across many professions and settings (Duffy, 2007;

Pennebaker & Seagal, 1999; Sarbin, 1986; Squires, Andrews, & Tamboukou, 2008; Webster & Mertova, 2007).

The Roots of Narrative

Narrative methodologies developed within multiple field of social science following World War I, as sociologists and psychologists began to question strictly empirical methods of data collection (Squire, Andrews, & Tamboukou, 2008). In the 1920s, Polish sociologists Znaniecki and Chalasinski began collecting life stories of workers, noting the transformative and informational power of narrative in exploring differing social classes (as cited in Squire et al., 2008). American sociologists were slower to accept narrative methods that focused on life story, hindering the development and uptake of narrative approaches in American social sciences until later in the 20th century (Webster & Mertova, 2007).

Although the field of psychology has long been associated with narrative as a therapeutic approach, it was not until the 1970s and 1980s that narrative was routinely recognized as a unit of analysis in research (László, 2008). In fact, it was not until 1986 that Theodore Sarbin, a pioneer of narrative psychology, organized and edited *Narrative Psychology: The Storied Nature of Human Conduct*, which provided structure for a previously undefined field. Disillusioned with positivist approaches that focused on a singular, knowable, scientific truth, Sarbin instead encouraged a humanistic approach that links contextualism to narrative (Sarbin, 1986). His approach to utilize narrative as the “root metaphor” for psychology, proposed that human actions, thoughts, perceptions, beliefs, and moralities are based and conveyed in narrative structures. Further, he viewed narrative as a universal means of making sense of and organizing the world (Sarbin, 1986). Narrative is both universal and central to the human experience, thus making narrative an available unit of study that is adaptable for all cultures.

James Pennebaker has also significantly influenced the evolution of narrative research. Rather than focusing on content and context, Pennebaker examined the narrative process itself, and how, in his study of personal narratives in individuals experiencing the effects of trauma, narrative allows individuals to process and understand their experiences as a step toward resolution (Pennebaker & Seagal, 1999). His focus on process, however, did not preclude him from performing detailed analyses of narrative content. Pennebaker notes that word choice, especially the use of positive and negative emotion words, impacts not only how an individual re-experiences or recovers from trauma, but also how their health is impacted in the aftermath of a traumatic event (Pennebaker & Seagal, 1999).

Although Pennebaker focuses on the process of *writing* narrative rather than *oral* traditions of storytelling, his research highlights the health benefits of organizing and sharing that is central to narrative processes. His research demonstrates that engaging in the cognitive process of narrative, particularly utilizing language that demonstrates insight and causation, improves measures of physical and mental health (Pennebaker, Mayne, & Francis, 1997). Specifically, Pennebaker demonstrated that when research participants engage in structured narrative processes, they experience an improvement in mood, make fewer health center visits, and improve immune function as measured by serological markers (Suedfeld & Pennebaker, 1997). These findings support the use of narrative within a population of women with diminished health and well-being related to unstable housing status.

Story Theory

Although Pennebaker contributed a considerable body of work to narrative research, the majority of his findings emerge from populations of generally healthy, highly literate college students. Thus, in searching for a narrative methodology appropriate for lower-literacy women

experiencing homelessness, it was important to consider methods that had been developed for and tested within populations with diminished health and lower educational attainment. Story Theory, designed by nurse researchers Smith and Liehr, was developed specifically for populations experiencing illness, and utilizes nurses as active participants in the disclosure and introspection process (Liehr & Smith, 2008).

Liehr and Smith (2008) developed Story Theory as a way to approach narrative research in nursing while embracing the unitary, neomodernist perspectives of nursing grand theorists such as Parse and Rogers. Central to both Rosemarie Parse's Theory of Humanbecoming and Martha Roger's Theory of Unitary Beings is the idea that humans cannot be reduced to a sum of their parts—rather, they must be respected as whole beings, who can define their own concepts of health and well-being (Hemphill & Quillin, 2005; Parse, 2012). The underlying philosophy of Story Theory identifies humans as dynamic, transformative beings with the potential for growth, health, and healing (Liehr & Smith, 2008). In this regard, storytelling is recognized as a therapeutic process which calls on the highly valued listening skills of nurses to apply this process. Story Theory is flexible in its application, but has a structured theoretical framework supporting it.

Story Theory relies on the application of three primary concepts: intentional dialog, connection with self-in-relation, and creating ease (Liehr & Smith, 2008). Intentional dialog involves “purposeful engagement,” (Liehr & Smith, 2008, p. 209) where a nurse interacts with a participant for the specific purpose of uncovering the story of a “health challenge.” The unitary neomodernist perspective allows for a broader interpretation of “health,” including any event that the nurse or participant storyteller deems as influential to the holistic range of health (i.e., not restricted to physical health, but inclusive of emotional and spiritual health and general well-

being). Intentional dialog includes an attentive presence to the storyteller by the nurse and “querying emergence” (p. 210) where the nurse clarifies vague directions or intentions shared by the teller.

Connecting with self-in-relation involves a process of the teller acknowledging or seeking out elements of narrative that identify where they have been, where they are now, and where they are or hope to be going (Liehr & Smith, 2008). The process allows for reflection while narrating, and permits revisiting the story as new connections or associations are recognized.

The final key concept in storytelling is creating ease. This is a process where the teller moves toward resolution. Giving order to a narrative can help in the process of identifying how seemingly chaotic or disjointed events are connected, allowing a teller to see (maybe for the first time), the entirety of their experience. The process allows a teller to view the “hows” and “whys” of his or her life, which can lead to healing and growth (Liehr & Smith, 2008). Their methodology provides a roadmap for the narrative process, but allows for the freedom to apply Story Theory to numerous health challenges across diverse populations.

Liehr and Smith (2008) propose a narrative analysis method using five key steps. Consistent with other proposed methods of narrative inquiry and analysis, they support maintaining the integrity of the narrative as a whole for the analysis process, and allowing the teller to contribute to the data analysis process. Liehr and Smith advise collecting stories in a structured manner that aids in organizing the story for the teller. They then suggest identification of those items that “matter most” to the teller, including the key persons, emotions, and events that comprise the story. Once these elements are identified, the researcher can then turn attention to the evolving plot to identify “critical moments,” such as high points, low points, and turning

points within the narrative. These critical moments can then be used in the analysis process to identify steps toward resolution. Finally, Liehr and Smith suggest moving beyond a singular story to synthesize findings within and across stories to address the research question. This process is consistent with other narrative inquiry and analysis methods, respecting the value of the individual story, and allowing it to be considered within a larger social context.

Study Design

Design

Utilizing an exploratory descriptive design, I initially proposed to interview 24 women with children experiencing housing instability, who had applied for Emergency Solutions Grant funding to prevent homelessness. The sample size of 24 was determined based on the likelihood of reaching data saturation. Within qualitative research, data saturation is an indicator to researchers that they have adequately sampled the target population. Data saturation is determined in one of two ways (Morse, 2005). Saturation has been reached if either new narratives from new participants fail to reveal new themes, or if multiple narratives from different participants explain slightly varied pathways to a common outcome (Morse, 2005). Ultimately, I reached saturation well before 24 participants, and was able to conclude data collection with only 16 participants.

In keeping with the tenets of narrative methodology, I intended to meet and interview each woman on two separate occasions in order to elicit her life story related to housing instability, what she perceived as the “cause” of her most recent episode of housing instability, and her perceptions of potential points of intervention. The interviews employed a narrative methodology, drawing on Liehr and Smith’s (2008) Story Theory to shape the interview process. The first interview was semi-structured, and used concepts and characteristics from Story Theory

(Liehr & Smith, 2008), Hall's (1996) *Geography of Childhood Sexual Abuse*, and Wakefield and Baxter's Model of Compounded Disadvantage to inform the primary and probe questions. Consistent with Story Theory methodology, a second interview was conducted to provide participants with an opportunity to verify their stories, make corrections and add details, review and verify themes identified by the PI as well as add additional themes to their stories.

Basic demographic and health data was also collected via the Homeless Management Information System (HMIS) intake form they completed with their caseworker at Community and Home Supports, Incorporated (CHS), and the Brief PHQ in order to better understand common demographic and health characteristics of the sample population. These tools and the data collection process are described in detail below. Each participant story was analyzed as an individual narrative, and then themes were compared across stories to assess for recurrent themes and life events. Because of the two-interview process, participants were able to verify their own stories and themes, enhancing the validity of PI findings.

Upon consent and enrollment in the study, participants were provided with an identification number, and informed that this number would be used on their paperwork and interview data in order to help protect their identity. Participant names, addresses, social security numbers, and all other potentially identifying information were removed from HMIS data before the data left CHS's office. The decision to use a single capital letter followed by the number "1" was made for several reasons. This allowed for simple alphabetization of participants, promoting organization and allowing the PI to quickly identify the order in which interviews were collected, who was in need of a second interview, and whose data collection was complete. Although I was able to reach data saturation after only 16 interviews, I had anticipated needing more study participants, including the possibility that I may have to exceed the original plan for 24

participants, and thus included a numeric character to aid in participant identification in the event data collection exceeded 26 participants. I had considered using assigned false names, rather than letters and numbers, for identification purposes, but was concerned that women may struggle to connect or identify themselves in a story if it had another person's name attached to it.

Recruitment Strategy

In 2009, President Obama signed the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH), authorizing new programs aimed at preventing homelessness (HUD Office of Community Planning and Development [OneCPD], 2013a). Beginning in 2011, HEARTH earmarked funding for preventive services through the Emergency Solutions Grant (ESG), offering financial assistance to families facing homelessness in order to prevent them from entering emergency shelters (HUD OneCPD, 2013b). Preventive financial assistance became available for payment of rent or rental arrears, security deposits, unpaid utilities, moving costs, landlord-tenant mediation, and tenant legal services (HUD OneCPD, 2013b). This new legislation and newly available support service offered an opportunity to study a previously unknown population—families on the edge of homelessness who have not yet entered a homeless shelter. Thus, I coordinated with a local social service agency—Community and Home Supports, Incorporated or CHS—providing HUD-funded ESG housing assistance to families in Detroit, in order to better understand the life and housing trajectories of families facing housing instability.

Setting

Community and Home Supports, Incorporated is a nonprofit social services agency located in Detroit, MI that provides rehousing and supportive services to individuals and families facing homelessness and housing instability. In 2011, CHS received funding to provide

homelessness prevention services to families through an Emergency Solutions Grant. At the time I was preparing to collect data at CHS, they were providing ESG-funded services to approximately 10 to 12 families per month and following each family over a period of three months. Families aided by CHS were enrolled through a central intake process, assigned to a case manager, and offered the agency's comprehensive supports and services, including housing search and relocation assistance should they become homeless, job development, budgeting, substance abuse referral and counseling, and life skills training.

The agency's central Detroit location allowed easy access by public transportation and was an ideal site for recruiting and following study participants. CHS provided private office space to conduct interviews, and once consent was signed, permitted the PI to access participant HMIS intake paperwork in order to access demographic data without duplicating their intake process, reducing participant burden. CHS was a committed member of our community-academic research collaborative for over three years prior to this data collection, thus we had an established working relationship, had a shared vision for impacting family homelessness, and established a proven record of trustworthiness before initiating this study.

Recruitment

I met with CHS management, caseworkers and support staff in the four months prior to beginning data collection and while awaiting Institutional Review Board approval, in order to share my plan of research and to develop an appropriate, standardized recruitment strategy. Case workers were provided with drafts of recruitment flyers and recruitment scripts, which were drafted with input from our community-academic collaborative, and asked for their feedback and input to ensure that they were comfortable with the recruitment process and that it would engage the target population. Caseworkers provided feedback and edits to the recruitment process, and a

final recruitment flyer and script were developed and approved by CHS management and caseworkers. I then met with CHS caseworkers to review inclusion and exclusion criteria, review the recruitment script, discuss how to contact me with participant information, and answer further questions.

I was initially advised by the agency CEO that as many as twelve potential study-eligible individuals met with caseworkers in group intake sessions to initiate their applications for services, and that I would be able to attempt recruitment directly from these sessions. After receiving full University of Michigan Institutional Review Board for Health Sciences and Behavioral Sciences (IRB HSHB) approval for all aspects of the study and a certificate of Confidentiality from the National Institutes of Health (NIH), I attended a group intake session to attempt direct recruitment. Unfortunately, many of the individuals who attended the group intake sessions did not have key documents required for their applications, so it was impossible to know if they were eligible for Emergency Solutions Grants (thus eligible for study participation), and I had to wait for caseworkers to determine eligibility days or weeks later. This led to confusion among potential participants who thought they were study-eligible, and who contacted me directly only to be frustrated by having to wait for approval from a caseworker. I therefore decided to stop efforts at direct recruitment and instead relied on referrals from caseworkers as a recruitment strategy.

Once study enrollment began, caseworkers were asked to read the recruitment script to all new CHS clients who met inclusion criteria. Participants who expressed interest in the study were given the option of contacting me directly via a dedicated study phone number, or sharing contact information with their caseworker so that I could contact them. When appropriate,

caseworkers then contacted me by phone with potential participant information so that I could answer questions and arrange for a first meeting.

Inclusion and Exclusion Criteria

Participants recruited for *In Their Own Words* were female heads-of-household who qualified for ESG services from CHS. Participants had to be at least 18 years of age, speak and understand English, be the parent or guardian of at least one dependent child, qualify for ESG funding based on the initial intake assessment performed by CHS, be newly enrolled for ESG services at (within the first month), and consent to participate in the study. Although there has been a recent rise in the number of single male-headed families facing homelessness, men were excluded from this study because it is believed that the experience of mothers experiencing homelessness is unique from that of other homeless populations.

Prior to the start of data collection, and throughout the recruitment process, I periodically checked in with Dr. Brush to clarify questions regarding participants who were on the periphery of inclusion criteria. We anticipated, before data collection began, that families often have to temporarily separate when facing housing instability. Our prior research informed us that sometimes parents send children to live with other family or friends when homelessness seems imminent. In some cases, child protective services becomes involved in a family resulting in an out-of-home placement, especially when domestic violence is the trigger for housing instability. We decided a priori that women who self-identified as mothers, whether or not their child was currently in their direct care, would be included in the study.

Another issue of eligibility emerged when a participant who had initially qualified for ESG assistance and enrolled in the study was later determined to be ineligible for the program. The first interview had been completed before the participant was deemed ineligible for ESG,

and based on the feedback I received from CHS, her change in status was due to incomplete paperwork. Thus, I included her data in the study and completed a second interview with her. ESG funding involves a complicated process of initial approval, applications to other government agencies for access to appropriate support services, housing inspections, and efforts at establishing and maintaining monthly income that satisfies preset HUD standards. As a consequence, there are multiple possible rejection points and it is possible that other participants may have had a change in eligibility status after the initial data collection point. After discussion with Dr. Brush, I thus determined that if a participant met initial ESG requirements, she would be eligible for study participation regardless of long-term ESG eligibility.

Attending to Power in the Data Collection Process

Employing a feminist approach to the study design required special awareness and attention to the power differentials at play between caseworkers, study participants, and myself. As a white, graduate school educated female who has never experienced homelessness, I knew that I was coming from a place of potential power, offering financial reward to women who made themselves vulnerable on my behalf. Thus, I worked very closely with the University of Michigan IRB to reduce participant vulnerability to coercion prior to beginning any recruitment or data collection. Not only did I develop a phone script to prevent accidentally revealing research participation to friends and family members of participants, but I also used a phone protocol that involved limiting the number of times a person would be contacted via phone in order to prevent potential participants from feeling harassed or coerced into participating. Caseworkers were provided with a script and I reinforced the need to assure participants that participation was voluntary and did not impact the services available to them from CHS.

The plan to interview participants at CHS was intended to provide a neutral but familiar territory for the data collection process. However, when it became clear that not all participants were able to come to CHS for interviews, the decision to ask participants where they preferred to meet—their home, or CHS—shifted some control back to participants. They were able to decide where they would be most comfortable, and how much of themselves they wanted to reveal to me. Inviting a stranger into one’s home may have increased vulnerability for some participants, but it also promoted their right to choose the “safest place” for our interview. During the interviews themselves, women were given my undivided attention. I focused on being present physically and mentally in the interview process, honoring their time with attention and empathy. I informed them that I would be taking notes during the interview process, but kept writing to a minimum and reserved some note taking for immediately after the interview had concluded so that I could convey attention to each participant’s narrative.

Maintaining privacy and confidentiality during the data collection process was another way of minimizing the power imbalance between participants and myself. Although the consent form included permission to tape record interviews, I asked all participants for permission to record their interviews, informed them of when the recorder was turned on, turned off, or paused so they could answer a phone call or talk to their children. I was careful to be very transparent with participants in how I would access their information from CHS, and reminded them of their rights and ability to stop the interview process at any point, without fear of repercussion from CHS or myself. When sensitive subjects arose, such as the death of a family member or a past rape or victimization event, I asked permission to discuss the topic before proceeding, never assuming participants were ready to explore painful events simply because they had been mentioned in passing. I was also attentive to the process of assigning a study identification

number to participants, explaining my rationale, and asking for their permission to refer to them as their participant number within their stories, prior to meeting with them for their second interview. I worked hard to acknowledge and address issues of power imbalance within the data collection process.

Study Procedures

Prior to recruitment or data collection, I obtained full board approval from the University of Michigan Institutional Review Board for Health Sciences and Behavioral Sciences (IRB HSHB), and a Certificate of Confidentiality issued by the National Institutes of Health (NIH). Caseworkers at CHS were then asked to read the recruitment script to all eligible women, and interested potential participants provided contact information to be shared with the primary investigator (PI). I then contacted participants by phone following a script to standardize the introduction process and prevent accidental disclosure of research participation to family members in the event someone other than the potential participant answered the phone.

At the outset of the study, I intended to interview all participants in a private office at CHS. However, caseworkers quickly informed me that they often had to meet clients at their homes because of clients' numerous transportation and childcare challenges. After several potential participants missed scheduled meetings at CHS, I began offering to meet participants at their homes. This proved a reasonable solution, although I continued to offer meetings at CHS to participants as well.

Upon meeting participants face-to-face for the first time, I reviewed the consent form, explained the research plan, risks, benefits, voluntary nature of the study, and answered any questions. I shared with participants that I would obtain their de-identified HMIS intake data from CHS, and they were asked to complete the Brief PHQ prior to beginning the first interview.

They were also provided with contact information for low-cost or free mental health services in the area in the event they experienced emotional distress and wanted to further discuss traumatic life events with a counselor, as well as instructions for contacting myself or their CHS caseworker (all caseworkers are licensed social workers) in the event they needed assistance accessing mental health services. Participants were assigned an identifying letter and number (A1-P1), and all research documents—including story drafts, HMIS forms, and Brief PHQ—were labeled with the participant’s unique identifier. The interview process and data collection tools are described in detail below.

Instruments

Aim 1

The data gathered via HMIS intake forms and the Brief PHQ is used specifically to address Aim 1 of this study:

Aim 1: Examine individual (age, education, race/ethnicity, relationship and motherhood status, lifetime exposures to abuse, mental and physical health); social (social supports, family history, current family situation, SES); and structural (labor and living conditions, social services) characteristics of mothers at risk for homelessness.

HMIS Service Point Entry Forms

HMIS is the HUD-mandated system for tracking demographic details and resource utilization of individuals and families seeking housing assistance. The information collected includes household characteristics (number of persons living in the home, age, general health status), household employment and income, disability status, current and prior living arrangements (including prior episodes of homelessness), and status as a survivor of DV. At CHS, this information is documented first on paper, then entered into the county HMIS. I was

able to access the original paper forms, and thus able to copy and blackout participant identifiers before the paperwork left CHS's office.

Brief PHQ

The Brief PHQ is a two-page questionnaire used in primary health care settings to assess for depression, anxiety, life stressors, and women's health concerns (Spitzer, Kroenke, & Williams, 1999). The depression screener is a 9-item tool using Likert scale responses ranging from "not at all" to "almost every day" for questions targeting mood, energy, anhedonia, sleep, eating, and suicidal ideation. This is followed by a brief anxiety screener, a question about depression and anxiety symptoms severity, and a series of questions about life stressors. There is a single-item question about physical or sexual abuse over the past year, a qualitative question about the primary cause of stress, as well as a single-item question about current medication for anxiety or depression. Finally, there is a section for female respondents addressing issues of women's health, including changes in menstrual patterns, emotional changes related to menstruation, recent birth, and difficulties conceiving or with miscarriage.

This instrument was selected because it assesses not only mental health along multiple dimensions, but also because it specifically asks about recent victimization and targets women's health issues. It is also available within the public domain, with detailed instructions and scoring, requiring no additional training to administer or interpret. The Brief PHQ and its parent instrument, the PRIME MD, have demonstrated reliability and validity across a variety of populations, including low-income pregnant women (Yonkers, Smith, & Lin, et al., 2009), patients with chronic illness (Hahn, Reuters, & Härter, 2006), and young women in primary care settings (Henkel, Mergl, & Kohren, et al, 2003). Although in retrospect, a measure of posttraumatic stress would have been appropriate given the findings, I did not have a priori

knowledge of the level of trauma I would encounter within this study population, thus this measure of depression and anxiety symptoms was appropriate to the aims of this study.

Aim 2 and 3

The narratives generated by the interview process were developed to elicit information to address Specific Aims 2 and 3 of this study.

Aim 2: Explore the individual, social, and structural experiences of mothers at risk for homelessness.

Aim 3: Explore at-risk mothers' perspectives regarding the sequence of events they narrate as an explanation of the trajectory leading them to housing instability.

The Initial Interview

The first interview followed a semi-structured interview guide (see Appendix B), and lasted anywhere from 30 minutes to 2 hours. The interview guide was designed with guidance from Drs. Brush and Seng. As a student in Dr. Seng's N841 qualitative research methods course, it was pilot tested with my graduate student peers and a mother experiencing homelessness. The interview guide consists of four primary questions with 50 potential probe questions intended to "dig deeper" into participant responses and reveal details of their lives. The four primary questions were based on Story Theory methodology, while the probes were developed based on a combination of Story Theory methodology (Liehr & Smith, 2008), concepts central to the Theory of Compounded Disadvantage (Wakefield & Baxter, 2010), and contextual elements of childhood abuse revealed in Hall's *Geography of Childhood Sexual Abuse* (1996). While Story Theory provided the overall structure of the interview, the Theory of Compounded Disadvantage offered direction in revealing identity, institutional supports and barriers, health, and environmental conditions. Questions developed based on Hall's work (1996) provided a trauma-

informed approach to uncovering past relationships and environments that promoted or enabled trauma and abuse.

The interview opened with participants identifying the top issue or issues that most recently led to their housing instability. In accordance with Story Theory methodology, the interview proceeded from the present day to the past, with a focus on current housing struggles, living situation, and key relationships. Participants were then asked to share details of their childhood, including household structure, key relationships, household expectations and responsibilities, difficulties at home and school, and any abuse or maltreatment they encountered at home or in their community. Finally, participants were asked to consider the future, and share what they wanted for themselves and their families.

With participant permission, interviews were digitally voice recorded for transcription to ensure accuracy in the data analysis process. I also took notes during the interview, and spent time following the interview adding details to the field notes. One participant declined the recording of her interview, thus I took detailed notes of her story, and immediately upon leaving the interview made a digital recording of myself sharing as much detail as possible in order to preserve her story. Once a woman shared the primary details of her narrative, I provided a brief recap of her story to verify that I understood the general sequence of events and key characters in the story. After verifying her story, each participant was asked if she could identify any points within her life where she thought an intervention or support could have prevented her trajectory of housing instability. Finally, participants were thanked and remunerated for their time, and a second interview was scheduled.

Second Interview

The second interview followed a pre-planned structure, but was individualized based on details from the first interview. Prior to conducting this interview, I provided each participant with a copy of her story based on the narrative from the first interview. I offered to read the story along with each participant out loud, or have her read it herself. The participant was asked to point out any errors in her story and make corrections, or add details that were missing. I then asked the participant to review the themes, identify those that she did not believe to be true about her story, and add any additional themes she felt that I had missed. The participant was asked to revisit the top issue(s) leading to housing instability identified in the first interview, to determine if she still felt those issues were central to her housing instability, or if something else had emerged. She was also asked to again consider potential points of intervention that might have changed her housing trajectory. Most second interviews were voice recorded, however four participants declined recording the second interview due to the presence of other adults or children in the home, thus I took detailed notes during the interview, correcting and adding to the story from the initial interview as needed. As the interview concluded, participants were offered a copy of their story to keep as their own, remuneration for their time, and were asked to contact me if they had any additional details or changes to their stories.

Data Analysis

Demographic Data

All demographic data collected was entered into a Microsoft Excel spreadsheet. Initially, I intended to use SPSS to analyze demographic data, however the small sample of the study required to reach saturation made this unnecessary. Instead, I calculated means, medians, and modes using a standard calculator, and had a second researcher calculate means, medians and modes independently to verify my computations.

Brief PHQ Data

Depression

Using the Brief PHQ scoring guide by Spitzer, Williams, and Kroenke (n.d.), I assessed the presence and severity of depressive symptoms in the study population. The brief PHQ can be used to make a provisional diagnosis of depression or major depressive disorder; however, clinical expertise is required to make a definitive depression diagnosis. Thus the Brief PHQ was basically utilized to glean a severity score to identify the need for mental-health follow-up. It should be noted that regardless of symptom severity score, all women were provided with mental health contact information and advised to consider seeking counseling services.

The first nine questions in the Brief PHQ identify the presence and severity of depression using Diagnostic and Statistics Manual of Mental Disorders (DSM-IV) standards. The questions assess the presence of negative feelings or symptoms, and responses range from “not at all” (0 points), “several days” (1 point), “more than half the days” (2 points), to “nearly every day” (3 points), resulting in a final severity score ranging from 0 to 27. Spitzer, et al. (2000) suggest the following depression severity cut points: *(i)* less than 5 denotes none to minimal, *(ii)* 5 to 9 is mild, *(iii)* 10 to 14 is moderate, *(iv)* 15 to 19 is moderately severe, and *(v)* 20 or higher is severe. Participants were assigned a severity score based on their answers. These severity scores were added to the spreadsheet with participant demographic information to allow for comparison of scores across the sample.

Anxiety

The anxiety screening tool in the Brief PHQ only assesses for the presence or absence of anxiety symptoms, without assessing symptom severity. Therefore, participants were identified as positive for anxiety symptoms or negative for anxiety symptoms without further

interpretation. As with the depression screening tool, the anxiety screener is not intended for diagnosis, but to identify the presence of symptoms that may warrant further investigation.

Stressors, Victimization, and Women's Health Items

These items are not intended for scoring, but contribute to an overall picture of well-being. There is a 10-item stressor assessment that asks respondents, over the past 4 weeks, how bothered they have been by concerns over health, weight and appearance, diminished sexual desire, difficulties with an intimate partner, stress of caring for loved ones, stress at work or school, financial problems, having no one to turn to when facing a problem, a recent bad event, or memories of a traumatic life event in the past. Response values vary from “not bothered” to “bothered a little” to “bothered a lot.” There is also an open-ended question about the “most stressful thing in your life right now,” which, although not diagnostic, can be used to reinforce individual narrative findings. For example, if a woman responded on the Brief PHQ that her greatest stressor was her financial status, it reinforced her statements within her narrative about money contributing to her housing instability. The stress, victimization, and women's health portions of the Brief PHQ were reviewed while developing the participant's first draft of her story in order to identify elements of her life story that needed clarification during the second interview.

Narrative Analysis

The initial step in analyzing data from the first interview, which occurred prior to the second interview, was a basic review of each participants' narrative, ensuring that the information that was shared comprised a cohesive story. Initially, I hoped that participants would provide enough structure to their own stories that I would be able to utilize direct quotes, literally using their own words to tell their stories. However, for most women, this was the first time they

were sharing their story in this manner, thus, they had not yet practiced or structured how they wanted to share it. This resulted in fragmented stories with multiple divergent and peripheral storylines. For example, participant G1 shared details about her sister's involvement in a shooting that left her cousin and a friend dead while G1's sister survived. G1's sister subsequently developed a substance abuse disorder, was diagnosed as HIV positive, and died after a prolonged HIV-related illness. While this story was important in providing context for the neighborhood and traumas experienced by G1 and her family, G1 spent 20 minutes of our interview memorializing her sister. Although an interesting and important story, and one G1 felt she needed to share, the details of her sister's life did not adequately shed light on G1's own life situation and housing instability. Additionally, during the interview process there were non-verbal responses, tone, and body language that participants used in order to relay meaning. For example, raised eyebrows at a question about the quality of relationships in home and school, or a nod of the head, could be interpreted as a response, even when nothing verbal was shared. In those instances, I clarified body language with participants whenever possible, using prompts such as, "So that was a bad experience?" or "do you mean..." resulting in *my words*, rather than participant words, being used to describe an event or experience. Thus, I chose to construct narratives using my interpretation of the stories that women shared rather than using direct quotes to formulate a story.

Using detailed field notes and the original voice recording of the interview, I organized each participant's life events into a story structure with an identifiable beginning, middle, and ending. Liehr and Smith (2008) identify this as a critical first step in narrative analysis. I not only focused on chronology, but also examined issues of character (including characters who were absent from personal stories, such as parents), tone, flow, plot, and resolution (i.e. how women

thought their circumstances would resolve, or the hopes they had for the future, and their strategies to reach their stated goals). This process resulted in a two- to five-page story that captured significant narrative detail, yet was concise enough to be manageably reviewed and revised with each participant within a reasonable amount of time. I utilized a third-person perspective in writing the stories, and minimized the use of direct quotes within individual narratives. Although this process potentially distanced participants from their stories, I was concerned that using a first person perspective would make participants feel as though I was co-opting their stories.

As described earlier, each story was then reviewed with the participant, and she verified or corrected its content. This process kept participants close to the research and encouraged them to be involved in the production, verification, and interpretation of the narrative data. Asking participants to provide insights and interpretations of their own stories also increased the trustworthiness and credibility of the data (Duffy, 2007; Liehr & Smith, 2008). Analyzing and co-constructing narratives with participants honored each individual's story as its own unit of analysis, resulting in 16 meaningful stories.

Thematic Analysis

The identification and verification of themes within and across individual stories was a complex, multi-stepped process, involving participants, two research assistants, research advisors, and myself. Initially, I intended for participants to independently identify themes during our second interview. This proved a difficult task, and as I concluded my second interview with participant B1, I realized I had to modify my approach. Participants were still formulating their stories and did not yet have the distance to identify the themes that were buried in their narratives. Thus, in addition to writing up each individual story, I added a section of

themes that I felt had emerged from each story. I was then able to review these themes with participants and have participants validate or reject them, or add additional themes they felt I had missed. Because I had not used this approach to validate themes with participants A1 and B1, I shared their de-identified final stories with Drs. Brush and Baiardi. Both have expertise in qualitative research with women experiencing housing instability and independently identified interview themes. We discussed our thematic findings, and came to consensus on themes emerging from both participants' stories. Themes presented to participants were not coded based on the specific aims or a theoretical model. Instead, I presented them as "...the things I heard in your story that seemed to shape who you are and what has happened to you." Participants seemed to find this an approachable method to discussing themes.

While the process of engaging participants directly in order to verify and validate themes was central to this research process, I was concerned that because participants relied so heavily on my identification of themes, there may be additional themes that I was missing. Therefore, I worked with two undergraduate research assistants to create a secondary method of verifying and validating themes. The first research assistant had worked with our research team previously and thus had experience in theme identification from focus group data. She also transcribed the interviews I conducted with participants and was thus very familiar with the raw data. The second research assistant was less familiar with qualitative analysis, but had spent time speaking with women experiencing housing instability in Detroit in order to better understand the context of participant narratives. Her perspective as an informed outsider served as an important balance point and lent greater objectivity to the data analysis.

Narrative analysis can be a daunting and poorly defined process. Indeed, beyond offering suggestions to analyze individual stories with the participant narrators, Story Theory offers little

guidance on approaching narrative analysis (Liehr & Smith, 2008). Therefore, I utilized content analysis methodology described by Graneheim and Lundman (2004) to develop a template for data analysis that guided the coding process for the research assistants and myself. As directed by Graneheim and Lundman (2004), the research assistants and I independently reviewed the data using the structured template to focus our attention on details of each story. The structured data analysis template (see Appendix D) included space to summarize the participant story, identify key life events leading to housing instability as defined by the participant, and then tease out words and descriptors used by participants to define several central concepts.

The central concepts providing direction for the coding process were defined within Wakefield and Baxter's Model of Compounded Disadvantage and included *identity, family relationships, social interactions, societal interactions, environmental characteristics, and health and well-being* of participants and their children. The research assistants were also asked to pay particular attention to elements of trauma and violence within each of these coding categories. They then reviewed their findings to determine recurrent or dominant life events that emerged as themes within a women's life trajectory. I met individually with each research assistant to review her findings and compare them to the themes I had identified with participants. We discussed how identified themes related to each other, and how new ones might "collapse" into other identified themes, becoming subthemes. Ultimately, very few new themes emerged from this process, demonstrating high inter-rater reliability in the narrative analysis process.

Once individual stories were thematically evaluated, I met with the research assistants to determine what themes were common across all of the stories. Guided by the codes used to tease out details from individual stories, we were able to cluster themes into larger categories. This shifted the individual *themes* into *subthemes* that clustered common elements. For example, the

theme of “parental absence” emerged as a family theme and was demonstrated in a variety of ways through individual stories, leading to subthemes such as “parent with substance abuse disorder,” “incarcerated parent,” and “death of parent.” Each theme from individual stories was evaluated in order to determine how it related to larger themes emerging across stories. This process of identifying meaningful phrases or *meaning units*, teasing out subthemes and connecting subthemes into larger categories of themes was guided by the process described by Graneheim and Lundman (2004). The research assistants and I reached agreement on all themes, which are explicated in Chapter 4.

Chapter IV: Results

Participant Characteristics

The women who participated in this research study were recruited from CHS in Detroit. All participants had met initial eligibility criteria for ESG funding, and were referred to me (with their consent) by their CHS caseworker.

Eligible Non-participants

Undoubtedly, there were potential participants who were informed of the opportunity to participate in “In Their Own Words” but declined the study prior to speaking with me. However, I did not ask the caseworkers to monitor refusal rates or reasons, thus I do not know how many total potential participants were contacted or their reasons for refusal. I did contact all potential participants who expressed interest in the study, although I was not successful in recruiting all of them. Of the 26 women who met initial study eligibility and expressed interest in the study, I successfully recruited sixteen.

The 10 women who did not participate in this study ultimately declined for a variety of reasons. Four of the women I contacted no longer had a working phone number, thus I could not schedule a first meeting with them. One woman, who initially agreed to participate, failed to arrive for our first scheduled meeting at CHS due to a school disciplinary issue with her son that took precedence. We attempted a second meeting, but she reported that her transportation was

unreliable and could not keep the meeting. When I attempted to reschedule a third time, her phone was disconnected. Another woman expressed interest in the study to her caseworker, but when I attempted to reach her by phone, a woman who identified herself as the potential participant's sister answered the phone and informed me that I had just missed her, asking that I try again later. I attempted several more times, each time "just missing" her. Her caseworker later asked me if I had been successful in reaching her, and when I stated that I kept missing the connection, instead speaking to a woman who identified herself as the client's sister, the caseworker informed me that the woman had no sister. I was never able reach the potential participant directly and discontinued further attempts. Several women who agreed to meet with me at CHS were "no-shows" for our appointments, and were not reachable by phone to reschedule. In these circumstances, I communicated with case workers to ensure I had the proper phone number and to determine whether or not there was a secondary phone number, however in most cases, there was no additional contact information available.

Study Participants

HMIS Data

Descriptive data for all 16 study participants is presented in Table 1. However, because the population and their responses were complex, I am also including a detailed narrative description of the findings. The 16 women in the study completed all aspects of the study. They ranged in age from 23 to 54 (mean age =34.1) and had from 1 to 7 children, with a median of 2 children and a mode of 1 child. One woman did not have custody of her child because of her on-going struggles with a substance abuse disorder, but all others had at least one of their children living with them. As was expected from the demographics of the region served by CHS, 15 participants self-identified as African American, and 1 self-identified as Caucasian. At the time

of their interviews, three women were married and living with their spouses, 1 was partnered (in a heterosexual relationship), one was divorced, and 11 were single, although all of the latter reported having at least one significant partnered relationship within their adult lives.

The official household size (numeric described in HMIS data) occasionally varied from the *actual* household size where women and their children were living. Official household size ranged from 1 to 7 people, with a mean of 3.7, median of 3.5, and mode of 2, while the *actual* household size ranged from 1 to 6, with a mean of 3.8, median of 4, and mode of 5. One reason for this discrepancy was that the actual household size often included extended family, such as grandparents or other relatives or friends, who were temporarily sharing space. Another cause of reported household size discrepancy occurred when mothers sent a child or children to live with family or friends until they could reestablish housing stability.

The women in this study faced numerous challenges and interruptions to their educational goals, yet most were able to graduate from high school or successfully complete their general educational development test (GED). The majority of women in this study were also able to continue on to some formal educational or vocational training after high school. Seven participants had completed medical assistant training or vocational nurses training.

Because a central feature of ESG funding is its intent to be a stop-gap measure to prevent homelessness rather than a long-term housing support program, individuals who apply for assistance are only eligible for a one-time payment to cover rental or utility arrears. Thus, in order for women to qualify for ESG funding (rather than traditional HUD funding), they needed to demonstrate a basic level of financial stability to ensure that they could make subsequent payments beyond the emergent funding period. For most of the women enrolled in this study, the reported income that formed the basis for 'financial stability' came from unemployment or

disability benefits. Two women were enrolled in educational support programs funded through the state, and 2 were employed in either full-time or part-time positions. Most participants (13) were also receiving supplemental nutrition assistance program (SNAP) funding. Participant household incomes ranged from \$275 to \$1680/month, with a mean of \$979.91/month and a median income of \$990.17/month. Based on actual household size, participant income ranged from \$137.50 to \$710/person per month, with a mean income of \$289/person per month and a median income of \$245.87/person per month

For most women in this study, this was not their first incidence of housing instability. Nine participants reported at least 1 prior incidence of entry into a homeless shelter, and, although 7 participants denied prior homelessness, all shared episodes of housing instability at some point within their lifetimes. I intended to interview women who were unstably housed but not yet homeless, however I discovered that housing status is often nuanced rather than clearly delineated. For example, women who had moved in with family members, who would be literally homeless if not for the support of a family member, could qualify for ESG funds if they met minimum income requirements. Also, it was not uncommon for a family to qualify for ESG funding after receiving an eviction notice, but to then be evicted before receiving funding, or to be forced to find a new home because their current home did not pass a basic inspection. Thus, the women in this study were living on the edge of homelessness, but occasionally progressed to homelessness within the course of the study.

Victimization proved difficult to measure within the confines of the demographic database. HMIS addresses this information through a single-item question: “Domestic Violence Survivor?” with the response options of “yes”, “no”, “don’t know,” and “refused.” Only 3 participants self-identified as survivors of DV on their HMIS forms, and 1 of the 3 participants

received temporary housing from a DV shelter. It is also notable that the participant who utilized DV shelter services did not have an HMIS form, as women entering a DV shelter do not complete HMIS intake in order to protect their identities. Thus, I had to complete the HMIS form (without any identifiers) with that participant during our interview process.

Table 1

Demographic Characteristics

Variable	Range	Mean	Median	Mode
Age	23-54	34.06	31.5	23, 27, 32
# of children	1-7	2.6	2	1
Child age	6mo-35y	10.2	8.5	1, 2, 5, 7, 13,15
Income/mo	\$275-1680	\$979.91	\$990.17	\$710
Household size (HMIS)	1-7	3.7	3.5	2
Household size (Actual)	1-6	3.8	4	2, 5
Variable		n	Percent	
Marital status	Single	11	68.8%	
	Married/partnered	4	25%	
	Divorced	1	6.2%	
Race	African American	15	93.8%	
	Caucasian	1	6.2%	
Education	Some HS	2	12.5%	
	HS diploma/GED	2	12.5%	

	Post-HS education	12	75%
Employment	Unemployed	7	43.8%
	Disability	5	31.2%
	Employed	2	12.5%
	Student	2	12.5%
Hx of DV	No	13	81.2%
	Yes	3	18.8%
Prior homelessness	No	7	43.8%
	Yes	9	56.6%

Brief PHQ findings

All participants completed the depression screening section of the Brief PHQ. Their depression severity scores were then tabulated. Using the cut points defined by Spitzer et al., (2000)—(i) less than 5: no to minimal depression; (ii) 5 to 9: mild depression; (iii) 10 to 14: moderate depression; (iv) 15 to 19: moderately severe, and (v) 20 or higher: severe depression—5 women had no or minimal depression symptoms; 5 women reported mild depression symptoms, 4 women had moderate symptoms, and 2 were in the moderately severe symptom range. The mean score was 8.5, with a median of 9, and the data was bimodal at 2 and 9.

The “anxiety” portion of the Brief PHQ begins with a dichotomous question asking, “In the past 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?” Respondents who indicate “no” are advised to move on to the next section of the questionnaire. Nine women indicated that they had no anxiety symptoms. Four women indicated that they had an anxiety

attack in the past 4 weeks and affirmed other related anxiety symptoms. The remaining 3 women indicated that they had *not* had an anxiety attack within the past 4 weeks, but then, rather than moving on to the next section of the questionnaire, affirmed that they had experienced other related anxiety symptoms. Thus, nearly half of the study sample reported anxiety symptoms, although not all had recently experienced an anxiety “attack”.

When asked how bothered they were by different aspects of their lives, women identified finances and having no one to turn to when they had a problem as their top two concerns. The least bothersome life events included a diminished sex drive, memories of past traumatic life events, and work or job related stress. These findings were reinforced in the open-ended question where women were asked what thing was most stressful to them. Almost every woman cited financial woes and housing instability as their primary stressor; finding employment and difficult familial relationships were close second and third concerns.

The Brief-PHQ also contains a single question about experiences of physical or sexual violence within the past year, as well as a question about taking medications for anxiety, depression, or stress. Two women affirmed that they experienced physical or sexual violence within the past year, and 2 (different) women affirmed that they were taking medication for depression, anxiety or stress. There is also a section specifically for women asking about recent changes in menstruation, difficulty getting pregnant, and mood swings associated with their menstrual cycles. In this section, 7 participants reported that their periods had become irregular (although 1 of the 7 was aged 54, thus this may have been a normal physiologic change), and 1 of those women stated that she was having difficulty conceiving (this woman, age 34, also had significant health problems including Type 2 Diabetes Mellitus and history of a stroke). Again,

because of the small number of participants in this study, these findings are not being further analyzed, as it would be impossible to demonstrate any reliable, statistically significant findings.

Table 2

Brief PHQ Data

Variable	Range	Mean	Median	Mode
Depression severity	2-18	8.5	9	2, 9

Variable		n	Percent
Anxiety	Yes	4	25%
	No	12	75%

Stressor	Not bothered	Bothered little	Bothered lot	No Response
Health	6	5	5	0
Wt/Appearance	6	6	4	0
Sex drive	9	5	1	1
Partner	8	4	3	0
Caring stress	7	6	3	0
Stress work/sch	9	3	4	0
Finances	1	6	9	0
No support	1	5	10	0
Recent trauma	8	2	6	0
Past trauma	9	3	4	0

Narrative Findings

Primary Causes of Housing Instability

At the beginning of the first interview, I asked each woman to name the top three or four things that led to her housing instability. The responses were used as an entry point to discuss the events in her current life and trace the history of each event. Most women were only able to identify one or two specific events that “caused” their housing instability, although the stories behind those events often revealed complex histories of conflict and struggle. I organized the responses into subthemes and themes, presented in Table 3. “Meaning Units” are the phrases or words provided by participants from which subthemes were derived. Once all subthemes were identified, subthemes were clustered based on similarities into broader themes.

In this process of data gathering and analysis, four major themes emerged—(i) Financial Problems; (ii) Past Mistakes; (iii) Failing Health; and, (iv) On her Own. These themes show a variety of insights and ability to connect current circumstances with past events. While some of these themes re-emerge in later data analysis, others are subsumed by broader themes. For example, although “Financial Problems” were central to immediate housing instability, once interviews progressed, “Financial Problems” were revealed to be symptoms of larger life instabilities such as an interrupted education. While not all participants are quoted directly in Table 3, the themes and subthemes represent the range of responses that emerged from this opening question.

Table 3

Primary Causes of Housing Instability

Theme	Subtheme	Meaning Unit
Financial Problems	<i>Underemployed</i>	“I was working for a temp service, and they would work me for 2 days, send me home ½ a day, call

		me back maybe Monday...I was trying to stretch maybe \$230 between four people..." (D1)
	<i>Job Loss</i>	"I went through a temp agency...I was working there for almost a year...next thing you know...I get a call saying, 'do you want us to send everything that's in your office to your house because your assignment has ended.'" (E1)
	<i>No Maternity Leave</i>	"I'm a teacher's assistant at a school—I've been there for 13 years...I was pregnant, off work from October to January...I was getting \$439/month [state assistance]...my rent was \$530/month...that's how it fell apart." (I1)
	<i>No Margin for Error</i>	"I was on a payment plan with the gas company...you can't miss one penny, or the computer will kick you out. I was \$0.95 off...It went into shutoff status. The money I had for rent had to go to get the service turned back on." (H1)
Past Mistakes	<i>Making Amends</i>	Gives daughter money she can't afford to give because of guilt over her past substance abuse disorder (F1—no direct quote available)
	<i>Legal Trouble</i>	"I actually had a felony...prescription fraud...they [apartment complex] asked me to leave." (C1)
	<i>Trusted an Untrustworthy</i>	"I think I made a lot of bad choices in

	<i>Person</i>	men...thinking that there were going to be there to help provide.” (G1)
	<i>Chose the Wrong Path</i>	“I chose to take the wrong route, hanging out with the wrong crowd...Now I see that the road I took was not the right road.” (D1)
Failing Health	<i>Health as a stumbling block</i>	“The war on diabetes is what triggered everything...it was the first time I felt like I couldn’t fix something.” (A1)
	<i>Disabled</i>	“I resigned from my job due to a back problem. I filed for disability, and it didn’t go through, and then I ended up having a stroke.” (N1)
On her Own	<i>Gives but Doesn’t Receive</i>	“Other people make their problems mine.” (B1)
	<i>Never Had Stability</i>	“I’ve been going through it my whole life—no stability...” (J1) “It’s been a rollercoaster...I had a horrible childhood.” (M1)

Individual Narratives

Each participant’s narrative, presented in full in Appendix B, was typed into a 2 to 5 page story structure and presented to the participant during the second interview. To demonstrate the range of narratives that were shared, however, I present the narrative summaries of three individual stories below.

Participant A1

A1 was a 34-year-old African American married woman with 2 children, ages 15 and 10. At the time of her interview, A1 and her family were doubled up with A1's extended family after suffering a house fire that finally forced the family from their already unstable living situation. She told a story full of hardship that began at an early age. Born to a teenage mother and a father who was regularly in and out of jail, she was raised by multiple transient caregivers throughout her childhood. As she told it,

I was the first grandchild born...and my mom was 17 when she had me. So my grandmother pretty much was my parent. But my grandmother left and moved to [another state] when I was about 5 or 6 years old, with my uncle and my 2 aunts. I remember them going off to [job training program]. And they were going to join her [A1's grandmother] when they graduated or whatever. My one aunt wound up coming back here, which was a blessing for me, because that was my favorite aunt. And whenever things would go haywire, I could call on her (Participant A1, interview, 2013).

By the age of 6, A1 felt like her family had found some stability. Her mother married the father of A1's younger sibling, and they enjoyed what she remembers as a short period of tranquility before A1's mother lapsed into a substance abuse disorder.

You know. Um, my mom was always like—she kept us clothed, she kept us fed. But you know, we had an issue where at one point in time she was on drugs. You know, like hard drugs, like crack cocaine, that kind of thing. My father has always been in and out of prison my whole life. So, I had a wonderful stepdad, which is my brother and sister's father (A1, 2013).

A1 spoke of a childhood riddled with instability and uncertainty along with constant changes in caregivers and living situations:

Growing up, I assumed a lot of responsibility for my brother and my sister ... And um, I haven't always lived in Michigan—I remember my uncle and grandmother taking me to [another state] with them so my momma would get on her feet. And my brother's dad took him because they were separated for a minute... I missed my mom like crazy when I moved to [another state], and her and my brother actually wound up out there with me. And then we came back. My life with my dad was never good. Whenever I would go visit him, it would always be something that goes wrong. Him & his family are the dark family. They come from drugs, incest, rape, fighting each other—you know, that kind of thing. I never fit in with them because that kind of life wasn't for me (A1, 2013).

But even as she viewed her mother's family as preferable to the “dark” side of her father's family, A1 witnessed and suffered acts of abuse and violence within her family and in her neighborhood.

My (relative) used to rape me when I was younger. And he used to tell me stuff like, ‘Oh, your mom—she'll go to jail [if you tell her],’ because he know my mom's temper, and he used that against me to keep me quiet... I was 7 years old and I saw a man murdered right in front of my eyes... My father went to go borrow some sugar because I wanted cinnamon toast for breakfast... he went to go borrow a cup of sugar from the neighbor. She flung the door open and said, “Move!” and my dad stood up against the wall, she flings out a shot gun... [and says] ‘I'm tired of you beating on me’ ... he [neighbor's partner] comes running

out the door—he ran—BOOM—she shot and misses—she hits the car. She shoots again, second time, over the car—bullet went right in the arm. He dropped, laid there, eyes rolled back, tongue came out the mouth, and he died right in front of us... And my favorite uncle on my dad's side was killed in 1985. He got shot 14 times. (A1, 2013).

In spite of these traumas and hardships, A1 recalled her childhood with fondness.

You know what, people would say, “you had a bad childhood.” I don't think I did. I think I went through those experiences so that the Lord would make me stronger, to handle right now, what I'm going through today, without breaking... Even though my mom took me through a bit of a rough patch, it was only 5 years it was like that. Five or six years out of my life. But she's never been out of my reach... Like, if she disappeared overnight she was probably at a drug house 2 or 3 streets over... it was never like we were abandoned or anything... And the dark times outweigh the good times, but then, thank God we did have those good times, because it helped me make it through with the dark times (A1, 2013).

Throughout her childhood and into her teenage years, A1 recalled experiencing the loss of numerous uncles and cousins to premature illness and violence, with each loss taking a major toll on her family support system. She struggled to manage responsibilities at home and school. As a teenager, she turned to alcohol to numb the pain of her childhood: “I had started, like, drinking at 16. Coming home just drunk—numb—so I don't feel nothing,” (A1, 2013). A1 eventually dropped out of high school and by the age of 19, became a mother for the first time.

Two years later, she met her current husband. After a couple of years of dating and cohabitating, A1 gave birth to her daughter. She felt that was a pivotal moment for her.

When I had my daughter, it had made me feel like, “You gotta go back to school.” You know, finish... Show them... the right thing to do. I went back to school and on my way to school... I ran into one of my mom’s friends at the gas station to get change for the bus, and he said, “Well, where are you going?” I said, “To school.” He said, “Well I’ll take you.” I said, “Ok, no problem.” So we got in the car and no sooner than we pulled out from the gas station we were hit. And left me disabled. I had to learn how to walk again... I was on a cane for several years. I didn’t complete my therapy, and, you know everything from the car accident until 2007. (A1, 2013).

A1 eventually married her partner and returned to school, earning her GED, and continuing on for certified nursing assistant (CNA) training. She was employed as a nursing assistant and had returned to school for a nursing degree, when she suffered another significant set-back.

I had a, been real thirsty, like that whole weekend. I was drinking water, juice, pop, soda, tea—nothing could quench my thirst... Everything on me ached. I didn’t know what was wrong with me... We waited on the ambulance for about 40 minutes... the doctor came ... he said, “Your blood sugar level is 750.”

After her diabetes diagnosis, A1 attempted to remain in school. However, her husband became jealous of the time she was spending with classmates, and felt emotionally distant from her. At the same time, A1 discovered that the person she believed to be the property manager of her rental home was not turning her rent money over to the landlord. A1 faced eviction, and

decided to move to a property managed by a family member. Her husband was against the move, and A1 soon discovered that he was having an extra-marital affair. They separated as she moved into her aunt's rental property, but soon reconciled. Attempting to rebuild her relationship, manage her diabetes, work as a nursing assistant, and complete course work for her nursing degree, A1 found herself overwhelmed, dropped out of school, and lost her job. Compounding those problems, A1's family faced yet another disruption when A1 discovered that there was a tax lien on her aunt's property.

My aunt and uncle got into financial trouble with those properties and lost the properties. Asked us did we want our house and it had needed a lot of work and we told them no. Unbeknownst to me, my aunt had went to the City of Detroit and did some pretty fraudulent things and quick claimed it to me—a house I had never signed for...So we wound up stuck there...I couldn't give the house away, because there was no equity. I couldn't sell the house because it needed so much work...the house had already been quick claim deeded in my name for about 2 months before I had even knew about it... when we were renting, I had tried to get the lights and gas turned on legally, because I found out they were on illegally. And she was telling us while we were there renting, that it was included.

(A1, 2013).

A1 and her husband worked hard to pull their lives back together. A1 took a job as a telemarketer, and the family worked to repay the City on back taxes and renovate their home. Her husband found work in restaurants as a short order cook, until a hand injury temporarily disabled him. Then, in the spring of 2012, A1 suffered a mild stroke, leaving her temporarily aphasic and costing her her telemarketing job. The family's home was burglarized, and, in a final

blow, was destroyed in an act of arson. At the time of our interview, A1 and her family were staying temporarily with her extended family, looking for a permanent housing solution.

Although A1 attributed her health problems, particularly her diabetes, as the primary *cause* of her family's housing instability, she expressed a different view point when asked what could have helped *prevent* her housing troubles, she responded, "If I could have got somebody at the City of Detroit to hear my side, and not been stuck with the house, I feel like I wouldn't be going through what I'm going through right now," (A1, 2013).

Participant D1

D1 is a 32-year-old African American single female with 3 children, ages 13, 12, and 6 years old. At the time of her interview, D1 was living in an apartment but had recently received an eviction notice for non-payment of rent.

Participant D1 grew up in North Carolina, in a close-knit southern town in a family structure much like her own current configuration.

My father wasn't around. It was just me, my mother, and my sister... we moved closer to my grandmother's so she could watch us while my mother was working...my childhood, it was a typical, normal childhood. Me and my sister had cousins, we went on vacations to like the beach and different things like that. I mean nothing extravagant, but I had a pretty good childhood. (D1, interview, 2013).

Although D1 denied exposure to childhood trauma or violence, she admitted that as a teenager, she gradually shifted the focus of her attention from education to friendships.

I chose to take the wrong route hanging out with the wrong crowd. I did graduate high school, but I did not go to college and I feel that if I had went to college, of

course I would have had a better paying job – actually, I would've had a career instead of a job. So it's basically my choices in my life. I, I screwed up and the older I got, the wiser I got and now I see that the road that I took was not the right road. I was given the same opportunities as everyone else... And I chose not to. I chose to hang with my friends, chase up the boys, and do things that normal kids do. (D1, 2013).

After high school, D1 worked as a nurse's aide in a nursing home. Not long after starting the job, however, she met a man and moved with him from her family home to Michigan. At 19, D1 gave birth to their first child. The following year, she had a second child with the same partner. During the pregnancies and her children's early years, she worked intermittently in minimum wage jobs with little or no opportunity for advancement. At the age of 26, D1 gave birth to the couple's 3rd child, but a couple of years thereafter suffered the devastating loss of her mother. Her mother's death perhaps serving as a catalyst, D1 was able to establish a relationship with her father for the first time in her life, though the relationship remains fragile.

...Ever since my mother passed, me and my father have gotten a little closer... Well basically, my dad... trying to get me, basically be a little kid all over again... just "do this, do that, do that, you can't do this, you can't do that, well you should do this." Say for example my kids, we go down there in the summer time sometimes, like, if I tell them no, he says yes. (D1, 2013).

Conflict with her father prevented D1 from turning to her surviving family members for support when she most needed it, upon the demise of her 10-year relationship with her partner in 2010. She indicated that the circumstances leading to their break-up involved his infidelity, but also mentioned that there were incidents of physical violence between them.

We had our good times, we had our bad times...we separated because his cheating ways... But, other than that I mean we had a pretty good relationship, like every other relationship we argued...It has got physical before, but it wasn't an everyday thing, every month thing, it happened maybe in those ten years I'd say we had three, maybe, yeah maybe three physical altercations. (D1, 2013)

Although D1 viewed the instances of physical violence as peripheral to the "real" cause of her separation with her partner, she indicated on her HMIS forms that she and her children were survivors of domestic violence. D1 returned to work at a temporary services agency, but struggled to make ends meet in an unpredictable work environment.

I was working for the temp service. And they would work me for two days, in this home half of a day, call me back maybe Monday, by Wednesday the same thing, so basically the job situation. And having three kids, trying to stretch two hundred and maybe thirty dollars between five¹ people...Bus fare, if I ran out of food, and then pay the lights, gas, utilities and rent...It just won't work that way. (D1, 2013)

D1 believed that the path to stability included returning to school for an education so that she could develop a *career* rather than work minimum wage jobs. She was adamant that education could change not only her life, but the lives of her children.

I'm trying to teach my kids, my daughters, especially my son, black male, I do not want him to be a statistic...That is the last thing that I want...is for him to be a statistic. So I'm trying to tell him and teach him that you have the choice...mommy does not have the money for college right now. I may hit the lottery, I may get a good enough job to save up by the time you go, but if I don't

¹ Participant stated 5 people were in her apartment, although she later stated that she had only 4 people in the house.

that's when you need to buckle down and say right now 'this is what I want...and this is what I have to do to get it.' So I'm trying to let him learn, learn from my mistakes so he don't have to learn on his own. (D1, 2013).

D1 is hopeful for the future and feels like she and her children hold their destinies in their own hands. Although she cannot rely on her birth family for support right now, she is able to turn to a close friend and her former partner's sister.

I have my best friend, she's here. She helps me as much as possible...like if I need someone to pick up the kids...so I do have some type of support here. Like I was saying, my children's father's family is here...So their auntie, she actually stays down the street in the next apartment building, so she helps me and we look out for each other as much as possible...she's a single mother as well, so we try to do we gotta do to survive and make it happen.

Participant M1

M1 is a 23-year-old single African American female with a 1-year-old son with special needs. At the time of her interview, M1 had lost her job and was facing eviction for missed rent payments until CHS assisted her through ESG funding. M1 pulled no punches when she stated, "I had a horrible childhood" (M1, interview, 2013). She reported that her childhood began somewhat normally in a home with her mother, father, and half-sister, who is 5 years her senior and fathered by another man. When M1 was 5 years old, however, her parents divorced. Soon after, her mom began dating a man who M1 described as 'extremely violent.' "Lots of things was going on in my childhood, my childhood was not good. He was an abusive boyfriend to my mom and to us, in all senses of that word" (M1, 2013). By the time M1 turned 11, her mother

attempted to leave the relationship, separating from her abuser and then obtaining a restraining order against him after he started stalking her at home and at work.

She [M1's mom] tried to leave, and like, emotionally, it was just a lot of abuse... he was stalking us, she was trying to get away... my uncle was there—they were putting up bars [on the windows and doors] for the house so he [the abusive boyfriend] wouldn't break in... he killed her, then my uncle, then killed himself. (M1, 2013).

While M1 and her sister were at school, M1's mother and uncle were shot and killed by M1's mother's ex-boyfriend as they attempted to fortify the family home from this violent, abusive man. Even at the age of 11, M1 was pushed into an adult role, having to inform the rest of her family of her mother's death. Although proud of being labeled as the backbone of the family, she was aware that the title was also a burden. Police arrived at M1's school and she was called to the office.

...Then they came to the school, they told me "oh your mom is gone." I had to go tell everybody, like I'm 11—I had to go tell my older sister, my dad, my aunts. It was crazy... Why did you pick me? My sister is older than me. They knew, they knew me. Like, I'm strong, I'm a tough cookie, like that's just who I am, I hold everything down, I hold it in. I'm like the rock. So, they're like, okay we know if we tell her sister, her sister's going to have a heart attack or flip out so we can't tell her first, which is exactly what happened. (M1, 2013).

After her mother's death, M1 went to live with her biological father and his girlfriend while her sister moved in with a maternal aunt. Not only did M1 find it difficult to be separated from her sister, but her aunt and father began an acrimonious custody battle over her. Ultimately,

M1 chose to stay with her father, who married his girlfriend. Her new stepmother attempted unsuccessfully to step into the role of mother for M1 at a time when her father faced a serious health challenge.

My dad had cancer, we almost lost him; when I was fourteen he had stage three colorectal cancer...he almost died. He had to have like seven surgeries, chemo, radiation, and then he relapsed and had to have it again. It was just a lot. And then, on top of all that me and my stepmom clashed a lot...so then I left—I got kicked out.

After leaving her father's house, M1 bounced from one friend's house to the next, eventually moving in with her older sister who lived across town from M1's high school. Yet, M1 managed to flourish in school. She felt connected to several of her teachers who recognized her intellect, knew the struggles she faced, and supported and encouraged her academically. She was involved in multiple sports, and took extra coursework in her sophomore and junior years, so that by the second semester of her senior year she had only one course to take.

...My school was all the way out there. I caught three buses every day...in the rain, snow, sleet, hail...I had to walk ... a mile every day, no matter what, and I graduated...It took me three hours to get to school. And I had to do one hour at school...and three hours back. I'm like; it takes me more time to get to school than it does for me to be there all day. (M1, 2013).

M1 graduated with a 3.1 grade point average and enrolled in a local university to pursue a Bachelor of Science degree in nursing (BSN). At the same time, tensions were escalating between M1 and her stepmother. Her father's health had improved, but the relationship between M1 and her stepmother deteriorated.

She has no kids of her own, so she doesn't know how to raise a child, like, she doesn't know how to be a mom... She's crazy. She's mean...and she's of a different race so we had lots of issues with, she would say things that would make me upset and then like, we got into a lot of fights. She spit in my face once, we fought about it... We've been to court, I took her to jail... I had a restraining order against her... they couldn't come up there [to the university], I couldn't go to their house... Like we had no contact with her for like a whole year, it was just crazy. (M1, 2013).

During her freshman year of college, another tragedy occurred that altered the course of M1's life.

I stayed in... the dorms... after about a year one of my best friends died ... he had come and spent the weekend with me... he left that Sunday and that Monday I found out that he was killed... So it was like, "Oh no, I gotta go 'cause he had, he was just like, he was just in my room, he was just there. I can't be here, I just..." so I left... It was just too much.

M1 dropped out of the university and at the age of 18, completed her medical assistant certification and started "couch-surfing," staying temporarily with friends and family until conflict forced her to find a new temporary home. Over the following 4 years, M1 relocated from place to place. As a young adult, M1 bounced from job to job, working as a medical assistant, a receptionist, and a factory worker. By the age of 21, she found herself in a serious relationship, pregnant with her first child. Unfortunately, it was a very difficult pregnancy with an unsupportive partner who had little interest in the prospect of parenting.

Umm, I came back home to my sister. And then I...got my Medical Assistant Certification. Then, where did I go from there? Back home to my dad's. Me and my stepmom just can't get along. I left there, went to a friend's house, me and her got into it – I left there. Went to my sister's house, left there. Went with my son's father, went with his parents, lived in our own house together. And when me and him split up, I left and went to my dad's and then I went back to my sister's. And now I'm here.

Within all of those transitions and changes of address, M1 became a mother. M1's son entered the world at only 29 weeks gestation, beginning another emotional rollercoaster ride for M1.

He came out breathing on his own at two pounds. They were like, "He can breathe..."the whole neonatal team was there. They were like, "Oh my God he's breathing on his own." I was like, "Yes!"...They didn't even think he was going to be able to... He has, he's partially blind in one eye. He has a bilateral coloboma which is holes in his optic nerves...He has branchio-oculo-facial syndrome. He has offset ears and things like that. He has severe asthma. But other than that he's a fighter. Small guy. We just got out of the hospital – he had pneumonia. (M1, 2013).

M1 does her best to support her son and maintain a positive outlook on life, but continues to face uncertainty and loss.

...my sister got into a car accident and my cousin was killed...I had numerous friends die, like my one friend just died four days ago in a car accident...and another friend overdosed two days after that. So in the last week I've lost two of

my friends from high school, so it's just like, I don't know, a lot of pain. A lot of misery. Being by myself...But I make it work...I feel like my son is all I have, so...I gotta do what I gotta do to make sure his life is nothing like my life. I want him to be nothing but happy, nothing but fun and I don't want him to feel like I felt when I was a kid. (M1, 2013).

At the time of her interview, M1 was planning to return to nursing school to pursue her BSN. She maintained a supportive relationship with a cousin and her older sister, but otherwise felt isolated from her family. Her goal was to finish her degree and move away from Michigan in order to start a life away from her painful past.

Themes Across Narratives

The themes, subthemes, and meaning units are presented in Table 4 on page 115. Overall, I, along with the support of research assistants, identified 11 major themes with 35 subthemes. The meaning units represent a small sampling of the statements that shaped these categorizations. Many of the themes and subthemes contain some measure of overlap with each other, as each hardship or choice in the women's lives shaped future options and outcomes. The overlap and interrelationship of themes reflects the reality of compound disadvantage, as each problem influences and shapes the next one, even without a direct causal connection. Each of the eleven themes is described more fully below, in no particular order of relevance.

Theme 1: Broken Family Relationships

Twelve of the sixteen participants described family situations that were strained and full of conflict. Parental substance abuse disorders, absent parents due to incarceration, separation, or divorce, and teen parenting led to grandparents stepping in as primary caregivers. Women described tenuous relationships with abusive parents or parents who were uninterested in raising

them or inadequately prepared to do so. Several participants shared that their mothers chose boyfriends over children, kicking their daughters out of the house when conflict arose. These negative historical family events resulted in altered social support networks and relations that had an ongoing impact on family relationships. As a consequence, participants could not rely on family when they faced housing instability. Those who eventually turned to family for childcare or housing as a last result did so knowing that even the smallest misstep might mean life on the street.

Theme 2: Misplaced Trust in Close Relationships

Many women shared stories of betrayal by partners and friends over the course of their lifetimes. Five participants cited relationships with significant others that were marred by infidelity and mistrust as their pathway to housing instability. “Friends” who initially posed as sources of support took advantage of the participant women’s generosity and trust, contributing to difficulties with landlords and legal struggles. Young women who had been abandoned by their family were especially vulnerable to manipulation by older friends and partners who offered friendship or companionship in return for criminal actions such as retail fraud and theft of pharmaceuticals.

Theme 3: All Alone

Largely because of broken family relationships and unhealthy social networks, women reported feeling alone and unable to trust anyone in their family or community to assist them when they needed it most. When asked who they could turn to for tangible or emotional support, nine women were unable to name a single person. Twelve women were parenting alone, with little or no financial assistance from the father(s) of their children. Although several women turned to friends or family for temporary shelter when they faced homelessness, they voiced that

every offer of assistance came with strings attached, and eventually resulted in yet another broken relationship.

Theme 4: Increased Exposure to Lifetime Trauma and Violence

As expected, there were numerous stories of trauma and violence, with 11 participant women sharing stories of trauma and violence that shaped their lives and pathways to housing instability. Six women experienced the traumatic loss of a parent or guardian, sometimes to violent circumstances. For many women, this marked a major transition point where they had to enter a new living arrangement or reenter an unstable living situation. Women also reported witnessing and experiencing violence within their childhood homes. The witnessed violence was often extreme, and at times occurred not only within the nuclear family, but infiltrated the entire extended family. Fueled by substance abuse, jealousy, power, and rage, women witnessed bones being broken and even homicide within their family circle. Several women recounted histories of rape and molestation, usually by family members who were staying with them in an overcrowded house. These acts remained shrouded in secrecy, becoming a source of shame for the survivors.

Trauma and violence were powerful forces not only in the childhood home, but also within women's communities and adult relationships. Although some women remembered their childhood communities as safe places to grow and play, a few shared stories of rampant drug use and gang violence resulting in shoot-outs and homicides. Five women reported fleeing violent intimate partner relationships after enduring death threats and assaults leading to broken bones and, in one case, a miscarriage. One woman shared a story of stranger abduction and her escape, leading to a fall from a third-story window that resulted in her permanent disability. Another shared a story of long-term manipulation and abuse as her partner cheated on her and then would

threaten to harm himself if she left. The abusing partner eventually made true his threat, committing suicide in front of the study participant and leaving her forever scarred by abuse, guilt, and loss.

Theme 5: Premature Responsibilities

Several women shared details of their early parentification. Whether raising younger siblings or cousins because of a parent's substance abuse disorder, or being expected to serve as the "strong one" in the family in times of crisis, women felt that they had missed out on their childhood and instead became surrogate mothers out of necessity and circumstance. Of the 4 women who took on parenting responsibilities for siblings and cousins, only 2 became teen parents themselves. However, a total of 8 women in the study became teenage mothers. Most of these women moved out of their family homes to care for their own children before the age of 20. Several other women shared that they had sisters who became teenage parents, thus they assisted in caring for nieces and nephews at a young age as well.

Them 6: Putting the Needs of Others First

Several women felt obligated to help family and friends even when they knew they could not afford to do so. Women stretched small budgets to the breaking point and went without clothing and food to make sure those around them were cared for. They saw other peoples' circumstances as more dire than their own, even if helping a friend or family member meant they would not have enough money for rent or utility bills. They also prided themselves on being the "rock" in the family, although they lamented the fact that they did not receive support in return.

Theme 7: Compromised Health

Although the mean age of the study population was only 34 years of age, five of the sixteen study participants were receiving permanent disability support, and a 6th was in the

process of application. Women shared stories of health problems common within a much older population. One participant (age 54) had been experiencing disabling heart disease for over 15 years, and 2 others—ages 34 and 39—had experienced transient ischemic attacks (TIAs) and minor strokes uncommon within their gender and age cohort. Two participants recounted struggles with substance abuse and addiction and 3 shared their struggles with disability from other mental illnesses. Women attributed their poor physical and mental health and predilection to addictive behaviors to on-going stress and early exposures to unsafe environments and physical violence.

Theme 8: Chronic Instability

Although a primary goal of this study was to uncover pathways to housing instability *before* the occurrence of homelessness, 7 women shared that they had experienced at least one previous episode of literal homelessness within their lifetimes. Thus, for many, housing instability was not a new experience. In fact, even those women who denied prior homelessness shared stories of frequent moves from house to house, both in their childhood and continuing into adulthood. Women did not necessarily view “couch-surfing” or “doubling-up” with friends or family as unstable housing circumstances, but considered these actions as normal parts of their lives.

Transience was also expressed in their employment patterns. Sometimes, this was because of difficulty negotiating the needs of their children as a single parent and the needs of an employer. Other times, it was simply a matter of a challenged local economy with only minimum wage or temporary employment opportunities.

Theme 9: Personal Choices

Most of the participants attributed past mistakes and errors in judgment to their current housing instability. Whether deciding to delay their education or choosing the “wrong” friends, most felt that poor personal choices and decisions made at critical points in their lives shaped or influenced future negative outcomes. One participant was especially critical of her past decisions, stating that she alone was responsible for her housing struggles. To the extent that she assumed full responsibility for the course of her life, she minimized her experiences of domestic violence and shifted attention away from her former partner’s behavior to her own decision-making process. Women shared that some of their bad decisions were made without the knowledge of possible consequences or foresight. For example, several women expressed dismay over having made poor financial choices (e.g. prioritizing bills), but did so because they did not understand the actions a bank, landlord, or utility company could take against them. Only 2 of the 16 participants related their detrimental personal choices to the lack of positive role modeling they experienced growing up.

Theme 10: Structural & Systemic Failures

Study participants faced challenges in completing school and accessing institutional resources. Four study participants dropped out of school due to competing responsibilities at home and the lack of a parent to advocate for them within the school system. Six women who successfully completed high school did so without guidance or support from parents. This contributed to difficulty in negotiating pathways to continuing education, resulting in reduced educational and employment opportunities.

Other women shared that formal resource programs, such as utility company payment plans, were difficult to navigate and unforgiving of the slightest mistake. Paperwork processing errors contributed to financial and housing instability, with no option for redress. For example,

one woman's disability status was inadvertently changed through a computer entry error, resulting in a missed monthly disability check. As a result, she could not pay her utility bill, which was already being managed through a utility bill payment program. When she came up 95¢ short on her monthly payment, the utility bill assistance program automatically went into shut-off status for "non-payment." Rather than pay the shortfall, she was forced to pay the full \$1000 balance and thus was unable to pay her rent that month.

Theme 11: Protective Characteristics

Although most of the participants' stories were replete of struggle, there were also many features of women's lives that protected them, regardless of how difficult their lives were, from more frequent episodes of housing instability or homelessness. These protective threads abounded as women shared their motivations to build a better life and seek homelessness prevention services.

For example, education emerged as a key protective life experience. Women felt that completing their high school education and seeking continuing education offered opportunities for advancement and stability. Two women shared middle school and high school experiences of mentoring and connections to teachers that protected them from the otherwise harsh circumstances of their lives. Every participant viewed education as critical not just for herself, but for her children, and women were willing to sacrifice personal resources to ensure that their children had access to a quality education.

The support of family and friends offered mixed results. The few women who felt that they could rely on family or friends for support stated that having that support prevented their entry into an emergency shelter. However, one woman had to rely on a father who had physically and verbally abused her to provide daycare for her son, and two other women had to rely on the

sister and mother of their abusive ex-partner to provide childcare. Thus, family support did not come without an emotional price and concerns regarding potential threats to personal safety.

Several women turned to their faith for support and guidance through their period of housing instability. Churches served as sources of spiritual and tangible support, offering food banks, clothing, and furniture to several of the women. Several women expressed the belief that their struggles were intended by God to strengthen their resolve and fortitude. They were able to see a purpose behind their suffering, and believed that God would not offer obstacles that they could not bear.

Motherhood was also a significant source of strength. Women voiced pride in their parenting successes, and hoped that their struggles would provide guidance and insight to their children. Children were identified as a reason to get up in the morning, and a reason to continue working for a better life.

Table 4

Pathway Themes

Themes	Subthemes	Meaning Units
Broken Family Relationships	<i>Parent/guardian with substance abuse disorder</i>	<p>“...we was adopted by my aunt ...we did get to stay in the family...My mom was on drugs...”</p> <p>(B1)</p> <p>“...my mom had like a real severe bad drug addiction...crack cocaine was new...everybody was trying it. But they didn’t know it was going to be so addictive...” (C1)</p>
	<i>Teen parenting</i>	<p>“My mother, she had me like when she was like</p>

thirteen or fourteen so she didn't really know about being a mother." (G1)

*Abusive
parent/guardian*

"He was an abusive boyfriend to my mom and to us, in all senses of that word." (M1)

"...when I was little, like fourteen my mom kicked me out too over a guy... He, like, tried to touch me, I told my family, you know, after the second time...my mom smacked me in my face and kicked me out." (J1)

Absent father

"My father has always been in and out of prison my whole life." (A1)

"...my father is on drugs ...I don't know him, you know...I talked with him on the phone, and he told me he was trying to get over to Mexico to escape the cops." (E1)

*Rejected by
Mother*

"...my mother...She was mentally gone, she was drinking when I was younger... she admits that she was unhappy raising kids..." (E1)

"...my mom is like a church lady and stuff, but when she got with men she would like put her kids...to the side." (J1)

*Used as pawn by
family*

"...my father was killed...He was in the Army, so I get a social security check for him...Literally, if I

		don't have any money to pay them, they will not do anything for me." (O1)
	<i>Betrayed by family</i>	"...I'm...taking care of my grandmother as a young person and these kids that really needs a mother and that's all I'm trying to be to them— why is everybody so angry with me?" (P1)
Misplaced Trust in Close Relationships	<i>Husband/Partner cheated</i>	"...it was all because he was out cheating... the women that he was involved with made him angry, umm, he'd come and take it out on me." (G1) "...then one day, I caught him cheating on me. I was just hurt, because I don't cheat." (O1)
	<i>Friend's actions led to eviction</i>	"I let one of my friends from middle school come stay with me... When I would leave for work, she would have a whole bunch of guys in and out of my house...Drinking—liquor bottles everywhere. I got evicted because of them." (O1)
	<i>Legal trouble because of friends</i>	"I went to jail last year... for something I did when I was a teenager... for retail fraud... I was living with an older lady... And bad influences led to what I did." (N1)
All Alone	<i>No one available to help</i>	"So, basically, I'm just trying to maintain without any help..." (B1) "I don't have help with them (her children) so the

only person I can rely on is myself.” (K1)

No father for her children

“If I call to get stuff from them (children’s fathers) it’s a hem and haw situation. So, I just applied for child support because, you know, it takes two to make a child.” (K1)

“...I do have, um, I call him my “donor”. The guy that fathered my child. He doesn’t want to have anything—he’s like...He’s not helping me out... he told me he hopes my baby dies in my arms.”

(O1)

Trauma and Violence

Death/loss of parent/guardian

“I don’t remember my father. He was a drinker—didn’t come around. He died when I was 12.”

(approximate quote, F1)

“I wasn’t raised by my mom or my dad. I was raised by my grandmother, and when she passed, she gave guardianship to my uncle...I was 8.”

(H1)

Physical violence in childhood home

“...my daddy used to fight with my mom all the time... he was beating on my momma, so he was going to beat on me... Instead of whooping me, disciplining me the right way, he fought me with his fists.” (L1)

“...my dad and my mom used to fight a lot.

Because my dad caught my mom with another guy in the house, so he ended up beating her up, and breaking her wrist.” (N1)

*Sexual violence
in childhood
home*

“...my (relative) used to rape me when I was younger. And he used to tell me stuff like, “Oh, your mom—she’ll go to jail.” Because they know my mom’s temper and he used that against me to keep me quiet about it.” (A1)

*Violence in
Community*

“...back it up to where it all started... it was this big shoot out, and my sister was one of the ones that was in the car. She escaped. Her best friend, her fiancée, her other best friend, was killed.” (G1)

“Everybody kind of shared because there were a lot of us, born in the 80s and our parents were addicted to that stuff (crack cocaine).” (C1)

*Experienced
DV/IPV*

“...my first husband... He was a very good provider, but he was an abuser...this man would come home and beat the crap out of me. And, I used to say well what, is this love? Is this love? And the only thing that finally got me to realize that it wasn’t love, I mean he was...I’m getting broken noses, cracked jaws... I was pregnant, and

he had kicked me in the stomach and I miscarried.” (G1)

“I was in a domestic violence relationship, so that’s why I took a break. I got tired of going to school with black eyes and busted lips...he pulled a gun out on me, said if I was leaving he was going to kill me. I still left.” (O1)

Trauma/violence leading to disability

“I was abducted, and I was trying to escape...I went to the front of the building...I thought there was a ledge...I fell, like 3 stories, and I broke every bone in my body...next thing I know I was in the hospital...I had to learn to walk, to use my arms...every bone was broke—my arms, my pelvic bone...” (H1)

Death of a partner

“...we was supposed to get married. He committed... suicide...which he did that right in front of me.” (G1)

Premature Responsibilities

Parenting siblings/cousins because of parent’s substance abuse

“...my mom was addicted...I’d like, step up and be the head of the household. When she wasn’t, yeah, when she wasn’t around I took over. I was like the one washing clothes and feeding everyone and just taking her place...until she came back home.” (C1)

“...when I was like 10, 11, and 12 years old...my grandmother, her daughter... was on crack, and had all these children and left them basically on my grandmother...I just stepped up and took care of the kids.” (P1)

Teen Pregnancy “I had my son at sixteen so she [her grandmother] watched him while I finished school.” (I1)

“...I got pregnant with my daughter at 15, and I went to live with my mom three months before I turned 16.” (L1)

Moving out at a young age “...when I was little, like fourteen my mom kicked me out too over a guy.” (J1)

“When I was 17 years old I got my first apartment.” (O1)

Putting the Needs of Others First

Supports others when can't support self

“I bought eighty dollars' worth of food for my little sister ... I did that because when someone says they're hungry and I have some food stamps, I will go do it even though I couldn't afford to do that. I still made my food stretch just because she said she was hungry.” (E1)

The rock “I'm the fixer. When my uncle committed suicide, I held the family together. When my mother's brothers died, I held the family together. When my

		grandfather moved up here from Florida, I took care of him. I held the family together.” (A1)
		“I’m the rock. I keep everybody, everything together. I hold everything in. But I make it work.” (M1)
Compromised Health	<i>Not caring for self</i>	“...I think my health failed mostly because of me doing, not taking care of myself properly...my main focus was that I wanted to take care of my family.” (G1)
	<i>Premature morbidity</i>	“...I started getting health problems... Stable angina... then they diagnosed me with congestive heart failure... that set that stage for the diabetes... then with comes diabetes comes along all these other health risks... it’s been now about fifteen years.” (G1)
		“I have a back problem... I went and filed for disability, and it didn’t go through, and then, I ended up having a stroke.” (N1)
	<i>Addiction & Substance abuse disorder</i>	In her 30s, F1 struggled with addiction to crack cocaine (No quote available)
		“...Once I stopped drinking, I went to gambling real bad...it’s like that compulsive behavior—I kept picking up one behavior to the next.” (P1)

**Chronic
Instability**

*Unstable
housing*

“...my mom smacked me in my face and kicked me out... then I went to stay with my sister...and I missed my old neighborhood...so I had moved in with my friend and her mother. I had been living with them like throughout, umm, I think high school...So I guess you could like say I’ve been going through it like my whole life without stability.” (J1)

*Unstable
employment*

“I worked probably like two or three jobs. Temp services and waitress... and then the cashier job. I guess with the Detroit downsizing around the time, everybody just went out of business.” (C1)

**Personal
Choices**

*Choices made
without
understanding
consequences*

“...it was my fault because I was granted the same opportunities that everyone else was, but I chose to take the wrong route hanging out with the wrong crowd... I screwed up and the older I got, the wiser I got and now I see that the road that I took was not the right road.” (D1)

“...part of my taxes got garnished because of a judgment that I had from a credit card years ago... I kind of went about things the wrong way... just one mistake got me in the hole...”(E1)

**Systemic
failures**

*Falling through
the cracks at
school*

“I was treated differently because I didn’t have

that parent that is coming to speak up for me...
whether I was right or wrong I was automatically
in trouble because I didn't have that voice for me."

(C1)

"I was always kicked out of school. I started
getting kicked out of school in kindergarten--
fighting, talking back—even when I did want to be
good, the teacher would tell the other teachers and
they would be expecting me to be bad and be mean
to me so..." (L1)

Utilities

"I was on a payment plan...you can't miss not one
penny...I was off by 95¢, and it went into shut-off
status." (H1).

**Protective
Characteristics**

Education

"...finishing school was definitely my only
option...Like if I have nothing else going for me,
I'm at least going to have my education... My
teachers were good. I loved my teachers... my
sixth grade teacher...took me in under her wing,"
(M1)

*Family &
Friends*

"...between my mom and my best friend, they
watched my four year old while I went to work... I
had a good support team." (I1)

"My mom... she comes over when I do have to go

	to work. And she comes over, she spends the night and babysits for weeks on at a time.” (K1)
<i>Faith</i>	“...it’s my faith that brought me through and my belief in him because there’s some things that, you know, that I was going through and that I was experiencing and at the time where I just said, “Okay, I’m through. I can’t take no more.”” (G1) “...thank God He blessed me with enough forgiveness to let a lot of that stuff go.” (A1)
<i>Mothering</i>	“I need to focus on my children... my children are my world.” (P1)

What Could Have Helped?

Toward the end of each first interview, and again at the conclusion of the second interview, I asked women if they could identify a point of time in their lives when some form of intervention or assistance could have changed the trajectory of their housing instability. In other words, what help did they wish they had along the way? The women shared a variety of responses, presented in Table 5.

Participant responses fell into three primary thematic categories. The most common responses involved a desire for **guidance or mentoring**. Women wished for someone who had offered encouragement to stay in school, and to support them through making better life choices as teenagers and young adults. They wanted life coaching and peer mentoring from women who understood their circumstances and had been successful in spite of similar challenges. One

participant stated that she wished she had someone to ask her to share her story and talk about her problems years ago, believing that may have helped her recognize the path she was on before she progressed to housing instability. This theme was partially consistent with the identified causes of housing instability, specifically with “Past Mistakes.” Women wished they had someone to offer guidance that would have prevented some of the life choices they made as teenagers. Interestingly, however, they did not specifically wish to have made different relationship or reproductive choices. Only one woman (participant E1) suggested that delaying parenthood might have allowed her to become financially stable.

The second theme reflected a need for **practical, problem-focused advice**. Women wanted assistance negotiating support services, believing that if they had a better understanding of how to access available services, they could have prevented housing instability. Three women cited a need to learn how to better manage finances. They felt they had lacked good role-models for money management in their youth, and never learned how to prioritize bills, apply for financial aid for college, or save and invest money. One woman felt all of her housing troubles could have been avoided if she had paid maternity leave or better healthcare benefits from her employer.

The final theme was the belief that there was **nothing** that could have prevented their housing instability. This was frequently the first response from women. At the conclusion of the first interview when I posed the final question, many women initially responded that they didn’t feel there was anything that could have been done to prevent or alter their pathway to housing instability. After allowing women time to contemplate their stories, however, many women were able to identify either a mentoring need or a practical need. Ultimately, only two women felt that their housing issues were unavoidable or could not have been prevented by any intervention.

These women felt they had opportunities to receive assistance at earlier points in their lives, but either the services failed them, or they were unable to utilize the assistance offered.

Table 5

What Could Have Helped

Theme	Subtheme	Meaning Unit
Guidance or Mentoring	<i>Peer mentoring from resilient, successful women</i>	<p>“...if I’d have maybe come in contact with...the right people who say, “ok, this path you’re taking is going to lead to this or lead to that” or “I experienced it,” and knew right off hand, then I’d have taken a look at it and said, “you’re right. Let me go another direction.” (G1)</p> <p>“...if I had a life coach, somebody to tell me how to react to certain things, and how to stay in control with my stuff...” (L1)</p>
	<i>Guidance to make better decisions as a teenager</i>	<p>“I didn’t have a mom to tell me what I should be doing as a female, like programs for girls; somebody to go talk to, things like that. Guidance. I didn’t have much of it. I had to figure out a lot on my own.” (M1)</p>
	<i>Guidance and encouragement to stay in school</i>	<p>“I think if I had just like one person to say, “go to school, that’s kind of important. You need to go to school,” That would have changed my outcome over a lot of situations. “ (C1)</p>

**Practical,
Problem-
focused Advice**

*Assistance
negotiating
resources*

“If I could have got somebody at the City of Detroit to hear my side, and not been stuck with the house, I feel like I wouldn’t be going through what I’m going through right now.” (A1)

“...it’s difficult ... I know that right now my biggest barrier is the money and if I had someone to help me when I failed... I just wish the Department of Human Services would have said, “Oh, you got unemployment so therefore we can’t help you.” (E1)

*Help learning
to manage
finances*

“Another thing that would probably play a part in my stability would probably be me not really knowing how to pay bills. I pay them, but I wasn’t really sat down and taught how to pay them and I wasn’t taught how to prioritize my bills. And I would love if somebody could teach me.” (O1)

*Maternity
Leave/Benefits*

“...with these companies that you work for, they never have anything for you when you go on any type of leave. They don’t have any kind of help...if they came out with maybe something that would help people when they go on like maternity leaves or medical leaves.” (K1)

**Nothing Could
Have Helped**

I failed myself

“I can’t really sit here and blame, and oh say I had a bad life and all because it was not like that...I chose

to make the wrong choices and that's why I ended up at the situation that I was at." (D1)

Nothing helps "I could be doing better. I could be doing more... There's nothing really holding me back too much. ...I think my brother, I don't know, I just feel like maybe he's just angry and all that because he really wanted our mother around... we've been to counseling... It's just the anger issues he has." (B1)

Additional Incidental Findings

In planning this research study, I hoped that participants would find the interview process helpful and even mildly therapeutic. Narrative methodologies have been widely used within psychotherapy (Pennebaker & Seagal, 1999; Sarbin, 1986), and there was no reason to doubt the therapeutic power of narrative within this population. Indeed, women in this study expressed positive feelings regarding the narrative interview process. As women reviewed their written stories, they volunteered their thoughts on the value of the narrative process. Women often expressed that they interview made them feel heard for the first time.

One participant shared, "I guess this is therapeutic to me in some way, because I've been screaming real loud for a long time." (Participant A1, 2013). Participant C1 shared that she wished she had had the opportunity to share her story in the past, as she found the process therapeutic. Women did not hesitate to correct errors in details of their stories, but seemed overwhelmed with seeing and hearing their life histories organized into a story structure. In fact,

although they offered corrections and additions, several women seemed unready to accept their stories as their own.

Participant H1 had a strong response to reading her story, and proceeded to open up to me about the trauma she had experienced within her life. “Why don’t you write a book? You could write a book, you know that?” (Participant H1, 2013).

Another participant shared that the process made her feel heard for the first time.

You nailed it. Right on the dot. Like it was like I was reading me on paper, but it seems just, like, yeah...it seems like a lot on paper, but I guess...I guess when I lived it, it wasn’t as, I don’t know, it’s just seems like, “Oh my God. Who is this?” Like, what?...I’ve never seen anyone that could put it so verbatim of how I actually said it...like I’ve told my story a lot of times, but you was like, you understood it and you wrote it just exactly how it went like from day one and that’s crazy. It’s like that’s crazy. I don’t know how you did it, but you did. (Participant M1, 2013).

Women expressed interest in meeting again, although I was unable to contact them again after data collection due to the need to protect participant privacy. They also shared that they were interested in helping other women, and hoped that their stories would accomplish that.

Chapter V: Discussion and Conclusions

Overview

In this chapter, I will discuss the ways in which the study findings support what is currently known about homeless and insecurely housed families, how they achieved or failed to achieve the study aims, and how the findings reflect the study's theoretical underpinnings. I will also discuss the study's strengths and limitations and explicate new questions for future research.

As a reminder, the study aims were to:

1. Examine individual, social, and structural *characteristics* of mothers at risk for homelessness;
2. Explore the individual, social, and structural *experiences* of mothers at risk for homelessness; and,
3. Explore at-risk mothers' *personal perspectives* regarding the chain of events they narrate as an explanation of the trajectory leading them to housing instability.

Overall, the study findings met the aims of this research. As expected, the findings supported both the Model of Compounded Disadvantage and Life Course Theory in relation to the characteristics and experiences of mothers at risk for homelessness. Women also shared their own personal perspectives concerning who they were, what they have been through, and on some

level, how their life events contributed to their housing instability. In addition, several women voiced an opinion on the selected research methodology, and what they felt could have altered their housing pathways and outcomes. Importantly, the narrative data from this study raises important questions about how we currently understand and address the needs of women and children who are vulnerable to trauma, violence, and housing instability.

What Does the Data Tell Us?

Addressing Aim 1

The first study aim, to examine the characteristics of families facing homelessness, was met primarily through the collection of demographic data and personal descriptors collected via the HMIS intake form and the brief PHQ, with details added throughout the interview process. Findings from families seeking ESG funding in this study are slightly different from national (HUD) statistics of families experiencing homelessness, although they do share many similar characteristics.

Interpretation of HMIS findings

Characteristics emerge from the data that defined who the women were as individuals, how their friends and family viewed them, and how they interacted with larger social structures and institutions. As individuals, the participants in this study were mostly African American women, in their 20s and 30s, with extremely limited financial resources. Most of the women had finished high school and continued on for some post-secondary education. Half of those who had dropped out of high school had subsequently obtained their GED, and had or were continuing their education. The women who did not complete their high school education were unable to do so primarily because of overwhelming family caregiver responsibilities.

Unemployed participants in the study were all looking for work, but were competing against large pools of applicants in a city hit hard by job loss and underemployment. During the interview process, many women reported long histories of unstable employment, made more difficult because of unreliable childcare which forced them to miss work and risk termination. Several women were disabled and, between their parental responsibilities and physical or mental challenges, were unable to seek employment. Most prided themselves on their roles as mothers; even the participant without custody of her daughter was working hard to maintain involvement in her daughter's life. Participants also took pride in their personal strength, such that they often resisted identification as domestic violence victims or survivors even after the most violent of relationships.

With regard to their familial and household situations, with the exception of 4 women, 12 women parented alone with little or no support from their children's fathers. Even with intermittent support from friends or family members, they reported feeling alone in their struggles to maintain households and care for their children's daily needs. The combined circumstance of single parenthood and limited support created a situation that left them fewer employment opportunities within a competitive job market than their male or single female counterparts who were not mothers. They often stretched their incomes as far as possible and sometimes past their limits, and regularly worried about their ability to pay bills. If and when they turned to family and friends for assistance to avoid entering homeless shelters, this often led to household overcrowding and fractured family and social relationships. Several women in this study also opened their own homes to friends and family, providing support and assistance even when they themselves were struggling to make ends meet.

Most of the study participants also faced significant challenges in their interactions and relationships with structural institutions. For example, the women who dropped out of high school did so because most were assuming responsibilities beyond their young ages. These women reported that they had no advocates and felt unwelcomed in their public school settings. Most of the women also had prior experiences with public assistance programs and many had been previously sheltered for homelessness or needed services to maintain housing. While appreciative of the assistance they received, the support was fragile at best; in many cases, it took only one minor computer error to lose critical benefits such as a disability check or utility payment assistance.

Comparing Study Findings to National Data

HUD data shows that homeless families typically consist of a female head-of-household (78%) under the age of 30 (57%), with 2 children younger than 6 years of age (52.1%) (HUD, 2013). The sample in this study was slightly older than 30 (mean age 34.06), with slightly older children (mean age 10.2 years). The mean reported household size of the study population was slightly larger than the average homeless family, and the mean *actual* household size was even larger at 3.8 people. However, many families move into overcrowded households with friends or family members to delay entry into a shelter. Given this, it is likely that the actual household sizes within this study population reflect a typical household size for families immediately before they enter an emergency shelter.

HMIS intake forms include information on all sources of household income, from employment, disability, and government assistance. In this study, the reported household income is the total reported amount of monthly income from all sources except food assistance. The median household monthly income was \$990.17 or \$11,882.04 annually. Based on the *HUD*

2014 Income Limits Summary for Detroit—which reflects Federal standards that define individuals’ qualifications for housing assistance and related subsidies—the median annual income for Detroit is \$64,600. HUD defines *extremely low income*—an income that is 30% of the area median income and is the eligibility criteria for ESG funding—as \$15,550 annually for a 2-person household; \$17,500 annually for a 3-person household; and \$19,400 annually for a 4-person household (HUD, 2014). Thus, the families in this study had average annual incomes that were even lower than the ESG criteria. Still, most of the study participants were resourceful enough to prevent entry into a homeless shelter.

Given the high rates of prior homelessness in this study population, it is possible that families who seek ESG do so, in part, because of their prior experiences with homelessness, and their desire to prevent a repeat episode of homelessness. This study population may simply represent the continuum of housing instability over time, showing that families who experience homelessness in their pasts improve their ability to access homelessness prevention services, but remain unstably housed for an extended period of time. Of course, the sample size is too small to consider these findings representative of demographic characteristics of all women seeking ESG.

Interpretation of Brief PHQ findings

Validation studies of the Brief PHQ used a cross section of the general population recruited from primary health care providers. This work indicated that 61.6% of the population demonstrated no to minimal depression symptoms, 21% demonstrated mild symptoms, 8.3% had moderate symptoms, 6% had moderately severe symptoms, and 3% had severe symptoms of depression (Kroenke, Spitzer, & Williams, 2001). Among the women in this study, 31.3% scored no to minimal depressive symptoms, and the remaining 68.7% of participants scored at least mild

depressive symptoms. Thus, although not statistically compared for significance, participants in *In Their Own Words* had more depression symptoms than are seen within the general population. This is an expected finding, given the stress and instability faced by families in this study.

The presence of depressive symptoms among women experiencing housing instability is not necessarily indicative of clinical illness. Diagnosing depression requires clinical assessment and judgment not possible by a screening tool alone. The Brief PHQ developers included caveats to interpreting their tool's findings, in particular they ask, "Have current symptoms been triggered by a psychosocial stressor?" (Spitzer, Williams, Kroenke, n.d. p. 4). Thus, the Brief PHQ is not sensitive enough to differentiate between situational depressive symptoms and those associated with a major depressive disorder.

Given the stress and uncertainty associated with housing instability and the narratives women shared, it is somewhat surprising that women did not score higher on the depression screener. Given the chronic poverty and exposures to stress and violence that occurs within homeless and unstably housed families, this tool may not be appropriately sensitive for use in this population. Women who have been living in a chronic state of stress related to housing and financial instability may have normalized their feelings of depression or anhedonia, and may not perceive their feelings as out of the ordinary.

Similarly, questions on the Brief PHQ about anxiety and worry may fail to appropriately identify women with actual anxiety disorder symptoms. It may also be the case that the women who were positively identified as having symptoms of anxiety were actually demonstrating a normal protective response to their impending housing instability. An uncertain housing outcome *should* evoke some level of anxiety, however only 4 (25%) of the participants confirmed anxiety symptoms on the questionnaire. Again, it is possible that issues of chronic or recurrent housing

instability have normalized the experience of housing instability such that it no longer evokes worry or anxiety within the population of study participants. It is also possible that having access to the services provided by CHS has resulted in reduced anxiety symptoms.

Another possibility for what appears to be skewed responses on the Brief PHQ is that the questionnaire was presented to women so early in the interview process that they were still uncertain of whether or not I was a trustworthy individual. Questions regarding mental health are extremely personal and invasive, and some participants may have answered questions conservatively to minimize their personal vulnerability to me. Women were understandably cautious in providing details about their mental and physical health. In fact, participant H1 was so guarded with me throughout our entire first interview that she did not reveal any of the past traumas she had experienced, including her abduction and resulting injury and disability, until we met a second time. Although terse during our first interview, providing simple one-word answers to many of my open-ended questions, H1 greeted me warmly when we met for our second interview and called her son into the room to share his recent high school graduation pictures. It is very likely that because she completed the Brief PHQ during our first visit before we had established any rapport or trust, her responses did not fully reflect her depression or anxiety symptoms.

My clinical expertise lies outside of psychiatric nursing, although as a Family Nurse Practitioner I have been trained to assess basic mental well-being and determine when a patient is in need of follow-up with a mental health professional. However, based on my interactions with participants, I believe that a measure of posttraumatic stress may have been more useful than a depression screener within this population. Measuring posttraumatic stress within this population would likely provide better insight into long-term mental health and coping with life

traumas than the Brief PHQ, which queries symptoms over a recent period of time. Alas, this study was not intended to diagnose illness, but to capture women's perceptions regarding their housing instability. To that end, the Brief PHQ revealed women's perceptions of their own mental health. What remains unanswered is why the Brief PHQ findings and the stories and emotions women expressed during the interviews were so incongruent.

Addressing Aim 2

The process of exploring the individual, social and structural experiences of women facing homelessness occurred through the interview process. Each constructed narrative supplied information about all aspects of a participant's experiences in these realms. The narrative process revealed who the women were and how they fit into their family structures. Their childhood experiences shaped how they viewed themselves, their families, their communities, and large social institutions.

However, the narrative process did not go as smoothly as originally hoped. Women were unpracticed in sharing their stories, and thus the stories were frequently disjointed. The second interview provided an opportunity to fill in gaps in women's stories. For example, Participant I1 shared during her first interview that her grandmother had raised her, but it was not until the second interview that she revealed that her biological mother had *never* been a presence in her life. A character's absence thus became central to her story, but she did not share this detail until prompted. In some cases, the resolution participants offered to their story were disconnected from the reality of their situations. For example, Participant B1 was interested in returning to school to complete her education, but felt that her real path to housing stability involved the purchase of her own home. While this was an appropriate plan for the future, she believed that although she could not pay her rent and utilities, she could probably qualify for a home loan. Her

plan involved saving money over the next several months, which did not match with her current financial reality. Thus, the narratives failed, in some ways, to hold together as complete stories. Thus, I focused primarily on thematic analysis of the data.

The themes that emerged from the data, and which were presented in Table 4, illustrate the span of experiences that shaped women's lives. Absent or broken family relationships, untrustworthy friends and partners, social isolation, repeated episodes of extreme trauma and violence, assumption of responsibilities beyond their age and developmental abilities, making important life decisions without guidance or understanding of their long-term consequences, inability to access needed resources, and experiences of chronic instability all impacted women's pathways to housing instability. Their experiences influenced how, when, and if they asked for help from family and friends, who they viewed as trustworthy, and how they coped with daily challenges.

For example, in her childhood home, L1 was deluged with violent interactions. Her father physically abused her mother until their divorce when L1 was 8 years old. L1's father also pitted his children against each other, offering the winner of physical confrontations praise and respect. She felt that the adults in her family encouraged violence and fighting, irreparably dividing L1 from her siblings. As a result of this early and ongoing indoctrination, L1 came to recognize violence as a means of survival and acceptance. These experiences shaped how she has continued to view and define herself throughout her life, and how she interacts with her family. Further, learned violent interactions at home influenced how she behaved and was perceived throughout her childhood and into her adult years. L1 shared that she was labeled a "bad kid" in kindergarten after fighting and talking back to her teacher. This label stuck with her throughout her education such that "even when I did want to be good, the teacher would tell the other

teachers and they would be expecting me to be bad and be mean to me” (L1, interview, 2013).

As a young adult, L1 struggled to manage her temper. Failing this, she often engaged in physical altercations with people around her. In one such incident, she was attacked by a neighbor after she (L1) spanked the neighbor’s child for hurting her son. During this violent brawl, L1 stabbed 3 women and was arrested for and served several years of prison time for aggravated assault. L1’s criminal record has served as a major roadblock in completing her education and finding employment. She had enrolled in a nursing program, but was unable to complete clinical coursework because of her criminal record. The experiences she and the other participants shared allowed me to understand what they had been through and how it shaped their identity, family relationships, and interactions with their communities and society at large.

Addressing Aim 3

Aim 3 focused on exploring women’s perspectives of events leading them to the edge of homelessness. This aim was met through an examination of the narratives participants shared, in particular, the comparison of themes presented in Tables 3 and 4.

Themes in Table 3 represent what women perceived as the primary causes of their housing instability. Most of the participants were very focused on events in the immediate past that acted as tipping points. Thus, financial problems, including unemployment or underemployment, emerged as the most frequently cited cause of housing instability. Other women associated their housing difficulties with past errors in judgment that led them down “wrong paths” with dire consequences, such as school incompleteness or ongoing associations with untrustworthy individuals. For example, participant D1 felt strongly that she should have made better choices as a teenager and that those early bad choices ultimately prevented her from going to college and pursuing a career rather than bouncing from one minimum wage job to another.

While there may be some truth in D1's connection of poor youthful choices to her current housing instability, she did not immediately ascribe any causation to her 10-year-long relationship with a man who was physically violent toward her. Participants who cited health challenges as the central cause of their housing instability also associated their declining health with lost income potential. In contrast to Table 3, the themes described in Table 4 reveal the complexities of the life stories of women experiencing housing instability. Their experiences were traumatic and recurrent, building upon each other and resulting in intersections of poverty, violence, limited educational opportunities, and fragile social support systems. Thus, it is evident that many participants could only partially connect the experiences in their lives with their current housing outcomes.

Three of the 16 women, however, offered a level of insight regarding the underlying causes of their problem that was not obvious in the other thirteen. For example, J1 stated, "I guess, like, you could say I've been going through it, like, my whole life—without stability..." (J1, interview, 2013). M1 was also able to see that her problems were rooted in experiences from a young age: "I had a horrible childhood. My mom was murdered when I was 11," (M1, interview, 2013). Participant P1 also attributed her troubled childhood to her path to housing instability: "I never had a real good support system," (P1, interview, 2013).

The potential points for intervention offered by participants also revealed how women perceived their own abilities to change their life trajectories. The desire to have mentoring and guidance revealed the realization that those needs had not been met earlier within a woman's life, and demonstrated that some of the women understood on some level that they may have benefitted from positive role modeling, counseling, or guidance as teenagers or young adults. Still, several women focused on very outcome-specific learning needs, such as learning to

manage personal finances that they believed would have prevented their current unstable living situations. These women struggled to connect the events in their childhood to their present circumstances. In the few instances where the need for both mentoring and outcome-specific tasks was mentioned by an individual, it demonstrated that that woman was aware of both her long-term, future planning need for well-being as well as financial self-sufficiency. It was concerning that two women felt there was nothing that could have been done to prevent their life and housing trajectory. It is possible that women were so focused on their day-to-day struggles, they had no time to reflect on their past, thus they had no opportunity to connect past events with current circumstances. Perhaps a third interview would have provided the time and space for reflection, although its possible that the process of developing these connections would take significantly more time, and would thus be more appropriate to a therapeutic intervention.

It is important to consider the reasons why women may not have fully connected their past experiences with their current struggles. The recruitment process involved a stage of priming participants for their interviews. Caseworkers were scripted to inform potential participants that they would be asked about past experiences in their lives related to their housing instability. My first conversation with potential participants to schedule a meeting included discussion about the variety of stories I anticipated hearing, running the gamut from very simple explanations like “I lost my job,” to very complex stories involving abusive childhoods and violent partners. Yet, for many women the first interview was their first real attempt at organizing their personal narrative into a coherent structure. This was obvious in the lack of chronology and coherence in the first telling of many women’s stories. For many participants, this was their first attempt at disclosure and they were not sure how to proceed.

Additionally, my efforts to acknowledge and minimize the power differentials between study participants, caseworkers, and myself were helpful but in spite of my best efforts, there was a power imbalance that remained present during the interview process. This impacted participant feedback and possibly influenced how participants connected to their stories. I worry that women may have been uncomfortable correcting details within their own stories. For example, while reviewing the first draft of her story, Participant M1 became very silent for a moment. I asked if something was wrong, and she very tentatively asked if it was “ok” for her to point out a spelling mistake. At that point, I encouraged her to point out every mistake, including spelling, content, and grammar, and she responded by laughing and showing me my error. By the end of the interview with M1, I felt certain that she was comfortable enough with me to share any and all mistakes present in her story. However in reflecting on other interviews, I wonder how many participants had that same question or concern, and left it unspoken.

Disclosure

Acknowledging that a traumatic event has happened, and then organizing one’s thoughts and experiences surrounding that traumatic event into a structured story allows the trauma survivor to process and make sense of what has happened and begin to recover (Foa & Rothbaum, 1996; Pennebaker, 1995). The process of *disclosing*, or sharing, a traumatic experience with another individual, particularly someone such as a health care provider who is in a position to offer help and healing, is a critical step in recovering from trauma (Pennebaker, 1995). Disclosure is not only an opportunity to put an experience into words, but is an opportunity to have another person challenge the details and reasoning a survivor has constructed to process their experience. It is an intensely personal process, and can only occur when there is some level of trust established between the sharer and the listener. In the case of this study, I

believe that I was able to establish trust because of my role as a nurse and because trusted caseworkers served as my source of introduction to participants. I was also offering them an opportunity to have a voice in their housing recovery process, and certainly empowerment of any individual who has experienced traumatic victimization is an important step in the healing process (Herman, 1997).

Whatever the rationale participants used to establish my trustworthiness, many participants began the process of disclosure with me. For most women, the initial sharing of their stories was highly disorganized. Timelines were jumbled; as episodes of trauma and instability were so frequent that they blended together, leaving participants unable to recall the exact order of life events. Women struggled to remember just how often and under what circumstances they had to move or seek assistance. While I had hoped that women would be able to independently establish the chronology of their stories, I had to assist them by repeating their stories back to them, asking for clarifications on when and how different life events occurred. Thus, I feel that some women were too “early” into their recovery process, having only just started disclosing, to have had the opportunity to reflect and make sense of their own stories.

Although it was not immediately obvious during the first interviews, second interviews provided me reassurance that the disclosure process provided some benefit to participants. Participants expressed excitement when they were handed their stories and had an opportunity to review them. They expressed gratitude at having been heard, and several asked if we could meet for another interview. They were happy to be acknowledged for their strengths and ability to survive hardship, even if they were not in the financial, emotional, or physical place they wanted to be in. At the same time, some of the women really struggled to see themselves within their own stories.

Disconnected from their Stories

Given the level of trauma that most of these women experienced throughout their lifetimes, it is not surprising that they struggled to “connect-the-dots” between their past traumas and their current housing struggles. In fact, it is actually quite surprising that participants J1, M1, and P1 were able to demonstrate the level of insight they provided. Trauma and violence produce a multitude of psychological responses, including *dissociation*, where an individual becomes unaware of their own self within the traumatic experience and is therefore unable to form a coherent memory of the event, and *constriction*, where a person disconnects from themselves during a traumatic event and experiences it almost as an outside observer (Herman, 1997). Both are methods of self-preservation that protect a person who is being victimized from experiencing the full intensity of an extremely emotionally or physically painful moment.

In this study, women did not experience true dissociative or constricted states during their interview process. However, several women seemed to struggle with connecting to their stories. They were able to review the stories and confirm the details, but were surprised at the level of violence and trauma within their own narratives. There was a sense of disbelief that the story in front of them was really their own. For example, Participant E1 stated, “It’s weird seeing it on paper. It’s like my life is all jacked up,” (E1, interview, 2013). E1 recognized that she had a difficult upbringing, with a drug-addicted absentee father, and a disinterested mother, but had felt that her struggles were related to her financial difficulties, not her upbringing. Reading her own story seemed to challenge her beliefs and force her to reconsider what she had defined as the source of her difficulties. Participant N1 responded to hearing her own story by saying, “Wow, you’ve got me in tears,” (N1, interview, 2013). Her emotional response to hearing her own story read revealed that she had not previously organized her experiences into an ordered, coherent

narrative, and she was surprised by how it made her feel. Several other women stated, upon reading the first draft of their story, that they thought their story could be turned into a book or novel. Their statements were made in surprised tones, as though they had never considered their own stories to be interesting or impactful. Their responses left me wishing I had planned for a third interview in order to allow participants time to process their stories before confirming causes, themes, and potential points for intervention. I did ask women to contact me if they developed new thoughts or insights about their stories, but no one contacted me after the second interview. For future interventions and studies, it is critical to utilize a structured approach that purposely engages participants for a set number of meetings, allowing time for reflection and introspection between meetings.

Theoretical Connections and Implications

The Model of Compounded Disadvantage and Life Course Theory guided this research. Life Course Theory, or LCT, addresses the impact of various exposures over time, and how inequity in resource allocation combines with exposures to produce disparate health outcomes. The core concepts of LCT include *timeline*, *timing*, *environment*, and *equity*, as explained in chapter 2 (MCHB, 2010). The Model of Compounded Disadvantage focuses less on chronicity and more on the intersection of individually, socially, and structurally defined characteristics. Further, MCD examines how those characteristics interact within the intersection of degraded physical environments and poor health status in the presence of trauma and violence, acting as allostatic load and weathering processes, and which result in diminished well-being.

Women's narratives fully supported the concepts central to LCT. The concept of timeline, in which exposures to detrimental forces begin in utero and continue across the life span and even across generations, was demonstrated in many of the women's stories. For

example, B1 shared that her mother had a substance abuse disorder that continued throughout her pregnancy with her, such that B1 was discharged from the hospital directly into her grandmother's care. Her younger brother was likewise exposed to drugs in utero, and never spent time in the custody of their mother. *Timing* was another critical element to their story, as B1 and her brother never experienced normal maternal bonding, and also suffered the loss of their grandmother at a young age.

Although both B1 and her brother were well cared for by their grandmother, and subsequently in their uncle's home, B1's brother harbored immense hurt and resentment toward his mother. Because of his resulting emotional and behavioral problems, B1 stepped in to support her brother and his children, fearing that he would respond violently if she did not. The burden of caring for her brother, her own children, and his children was taking a physical and emotional toll on B1, contributing to further reductions in her well-being. B1's brother's presence clearly negatively impacted her *environment*, which was already physically degraded due to limited financial resources. The two bedroom home she was renting was overcrowded with 2 adults (her brother was sleeping on the couch), and as many as 4 children when her niece and nephew were present. During a visit to her home for her second interview, it was apparent that they lacked furniture other than the couch and one chair, using a lawn chair and a mattress on the floor in each bedroom to meet their basic needs. The home was dirty with chipped paint, broken floor tiles and torn linoleum, evidence of insect infestation, and the house siding in significant disrepair. Neighboring houses were in similar states of disrepair, with several houses clearly unoccupied with boarded up windows and doors and heavily graffitied. This was a physically unhealthy environment.

Equity displayed itself in numerous ways in B1's story. For example, as children, B1 and her brother had access to some counseling services and state assistance programs, but those supports were primarily aimed at diagnosing and managing B1's brother's behavioral and emotional disorders until he reached the age of 18. More broadly, there was an obvious lack of public services, including public transportation and regular sanitation services, within the neighborhood. This lifetime of exposures to hardship, B1's degraded physical and emotional environment, and an inequitable distribution of resources and services within the community were contributing to B1's poor health outcomes, chronic disability, and unemployment.

Wakefield and Baxter's Model of Compounded Disadvantage is also supported by the details shared by study participants. Interactions between participants, their families, and their communities defined not only how participants self-identified, but how their families and communities identified and treated them. This was very evident within the narrative shared by Participant L1. As previously described, L1 was exposed to incredible violence in her childhood home, learned to respond to confrontation with violence, and ultimately earned her a "bad child" label. L1 did not complete high school but later returned for her GED and is currently enrolled in a trade school. Her family's behavior toward her and her resulting self-perception as an angry, short-tempered woman who had to literally fight for everything in her life, isolated her from potential friends and opportunities. Thus, when a neighborhood child injured her son, she responded with violence, prompting a larger neighborhood confrontation in which she stabbed and wounded 3 other women.

Her new "felon" label reinforces her self-concept as an angry, violent woman. She now recognizes her violent behavior as a learned response to a violent childhood with thinking and behavior that is in need of remediation. This point was driven home to her when she lost custody

of her son after a teacher told her, “what he really needs is a good whooping, “ and L1 responded by beating her son, resulting in child protective services intervening in the family home. She has been working closely with counselors to manage her anger and to learn to parent without physical violence, but she recognizes that her mental health, particularly her anger management issues and her feelings about her violent childhood, have contributed to her inability to find meaningful employment. She and her family are in a degraded neighborhood, living in a home with some disrepair, although she attempts as best as possible to maintain the house. Their current financial struggles and the potential for eviction could force them into an even more degraded neighborhood and home, further threatening the health and well-being of the entire family. Figure 3 depicts how L1’s story fits into the Model of Compounded Disadvantage and how the trauma and violence she encountered has further degraded her mental and physical health, as well as contributed to her inability to establish stable housing. While L1’s story is specifically depicted here, nearly all of the participants’ stories could easily be characterized by this model.

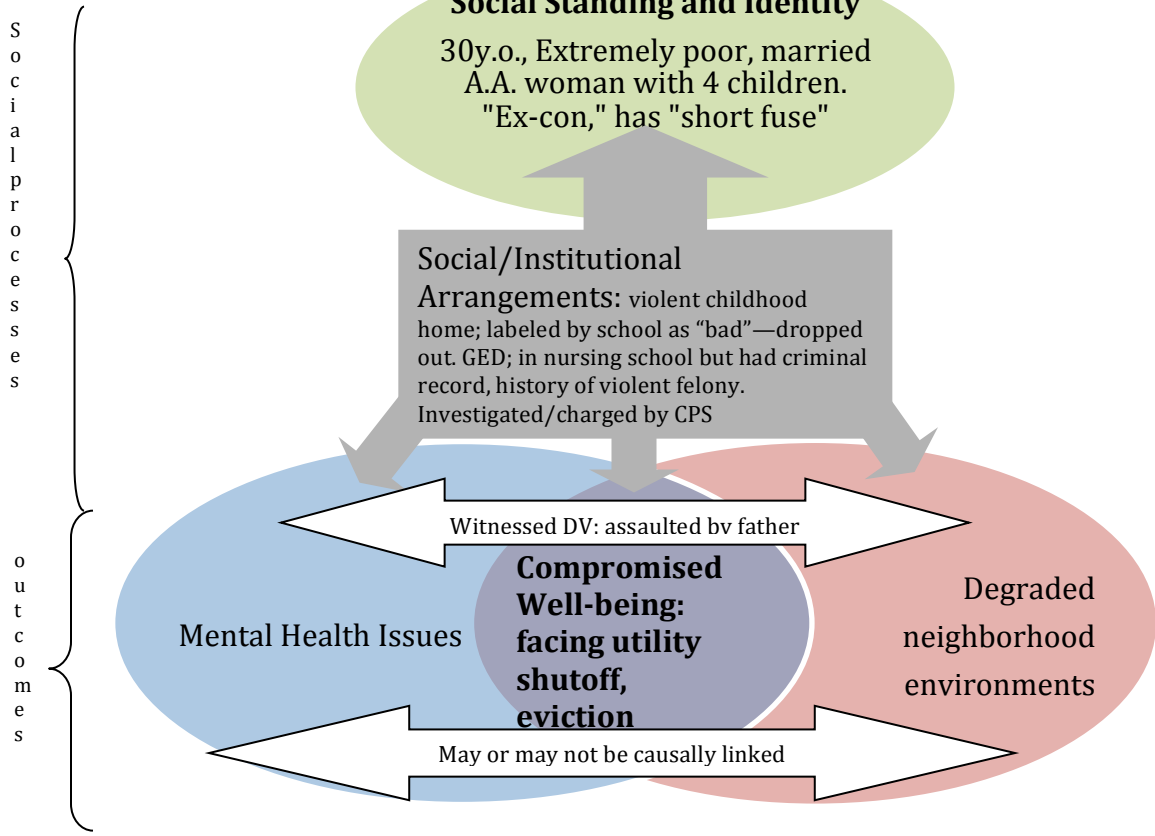


Figure 3: Wakefield and Baxter's Model of Compounded Disadvantage (2010) depicting participant L1's narrative

The Good, the Bad, and the Outliers

In considering what these findings really mean, it is important to evaluate how the stories fit together, and why some stories vary or digress completely from the primary themes. It is also important to reflect on both the strengths and limitations of this research, and to consider what critical next steps are needed.

Outliers

Saturation is the data collection goal in qualitative research. It is achieved when no new stories or data emerge from your sample (Morse, 2005). I reached saturation by my thirteenth interview, but continued to sample to ensure that no new data emerged. However, within my sample there are two narratives that really fell outside of the standard structure and themes expressed by most of my participants.

Participants I1 and K1 offered rosy, positive perspectives on their lives, believing that their current housing struggles were nothing more than a minor financial hiccup. While I am certain that there are families who have no major history of trauma or violence and who suddenly encounter catastrophic financial circumstances, I am not certain that I1 and K1 conveyed an accurate picture of their lives. Instead, I suspect that they were not ready to disclose their own struggles, possibly because they had not yet come to terms with their own experiences.

My suspicions are grounded in the significant inconsistencies within the stories they shared, and how the stories failed to come together as a coherent narrative on their own. For example, K1 stated that her housing instability was connected to a reduction of hours at her place of employment. Working as a certified nursing assistant (CNA) in a

nursing home, she was susceptible to decreased hours when residents died or moved out, reducing the need for a full cadre of staff until they received more admissions. K1 felt that this reduction in hours, as well as a recent unpaid maternity leave, left her in a financially vulnerable situation. Yet, K1 later shared that this was not her first time applying for housing assistance from CHS, implying that this was not a completely isolated incident.

When asked about her childhood, K1 referred to it as “peaches and cream.” She described a loving 2-parent family who, despite caring for her, her brother, and each other, chose to live in separate homes during her early childhood. During that time, K1 lived in her grandparents’ home.

We [K1, her brother, and her mom] didn’t live with him [K1’s dad] because my grandmother and my mom was so close. My mom didn’t want to move away from her so it was just like the small Brady bunch family-- just all of us—my uncles in the same house. (K1, interview, 2013).

Although she reported that she had a close and loving family, and that she was able to ask her mom to watch her two young children while she went to work, K1 also shared that, “I don’t have help with them so the only person I can rely on is myself to take care of them,” (K1, 2013). This contradiction raises questions about the reliability of K1’s entire story.

The story I1 shared was more consistent than K1’s narrative, but still raised questions. Like K1, I1 felt that her current housing instability was directly related to her employment. Indeed, when she took an unpaid maternity leave from her long-term position as a teacher’s assistant, she fell behind on rent and utilities. Being out of work

for the summer also understandably impacted her income. I1 shared that she had a loving childhood home and was raised by her parents (who were separated but on good terms) and her maternal grandparents who cared for her while her mom was at work. She became pregnant with her first child at the age of 16 and, with the support of her grandparents and parents, was able to remain in school to graduate and even enrolled in college to study nursing (although she later switched major to education, and dropped out of college). While I1 was open and talkative about her childhood and educational experiences, she quickly reverted to one-word answers when asked about the father(s) of her 4 children, ages 15 years to 7 months old. I was left to wonder about whether violence, abuse, or manipulation were present within her intimate partner relationships.

The narratives shared by I1 and K1 raised questions for me about why women may not be ready or willing to disclose the details of their lives. Upon introspection, I was reminded that I was being afforded access to many participants' lives that I should not have expected. In reality, I should have anticipated more participants being unwilling or unable to disclose their pasts to a "stranger." Vulnerable populations, such as minority women with very low income, are historically mistrustful of participation in research (Rogers & Lange, 2013). Additionally, participants may feel that narrative research conducted by an "outsider" (i.e., a white female graduate student who did not grow up in Detroit) could yield data that is taken out of context. The power imbalance between participant and researcher may further contribute to mistrust, as the participant may be concerned that personal information could be inappropriately shared or inadequately de-identified. Yet, the majority of participants were willing to share intimate details of their lives with me. It is likely that if I had not utilized the assistance of caseworkers for the

recruitment process, I would not have been able to establish any trust or rapport with participants.

Strengths and Limitations

In general, this study was well received by community partners and participants. Although I struggled with my initial recruitment strategy, the community partners proved invaluable to supporting recruitment efforts, and once participants completed the first interview, they were eager to complete the second interview. There were participants who were hesitant to trust me or open up to me, but most of that mistrust began to fade once the interview started.

Study participants wanted a voice in their housing stabilization process, and were interested in giving back to their community by sharing their struggles. However, contacting participants to arrange and confirm appointments proved challenging at best. Future projects with similar methodologies should include consideration of the transient phone connectivity that many women facing homelessness experience. Although the initial recruitment script for caseworkers asked caseworkers to obtain more than one phone contact number in order to reach participants, I did not reinforce the need for this information, thus caseworkers were reluctant to request additional contact numbers. I also suspect that women were reluctant to provide additional contact numbers because they did not necessarily want to reveal their participation in a research study with friends or family.

There were some initial difficulties in obtaining private office space at CHS for interviews, and confusion among CHS staff about where interviews were to be conducted. On one occasion, a caseworker contacted me to coordinate a visit to a

potential participant's home who had expressed interest in participating in the study to her caseworker, but who was unreachable by phone. When the caseworker contacted me, I assumed she was scheduling a meeting at the CHS office, but while on my way to meet her, discovered that she intended for me to drive along with her to the client's home. Ultimately, meeting participants in their home, once they confirmed that their home was a safe location for them to speak freely about their past, provided additional information about the neighborhoods and housing conditions families were facing. It also eliminated the transportation difficulties many participants faced in trying to reach CHS, and provided women with a choice in where to meet. In retrospect, I would have preferred to conduct at least one interview with all participants in their home in order to better understand the environments they faced every day. I was truly surprised by the level of disrepair, firebombing, and abandonment in some of the neighborhoods I entered, and wonder how impactful those degraded environments are on a family's psyche and physical well-being.

The interview process itself was productive, and the level of violence many women had encountered overwhelmed me. I had expected stories of trauma and violence intermingled with personal accounts of isolation and broken social networks, but was truly taken aback by some of the stories women shared. In fact, these stories were more violent than the stories shared by mothers experiencing homelessness in our focus groups. I do not know whether focus group participants' accounts of their entry into homelessness were less violent because women in focus groups had less time and attention to share such intimate details, or if their stories were just less violent. The opportunity to co-construct stories with participants was vital to the integrity of the data.

Participants were truly able to confirm their stories and validate the themes that emerged. However, the findings would have been strengthened if I had planned a third interview to allow women more time to reflect upon and connect with their narratives. An additional visit would have also provided me with more time to build rapport and establish trust with participants, and may have resulted in fuller disclosure of past traumas within some women's interviews.

Another detail that could have been added to the interview process was some form of visual representation of participant stories. Whether using a timeline to map out a person's life events or a calendar to write out when specific life events occurred, a visual representation of chronology would have added an element of organization to individual stories that was lacking. In most cases, I inserted my understanding of a participant's chronology of life events, and asked them to correct me, but it would likely be more meaningful to participants to organize the stories themselves.

Data collection and analysis were very time consuming processes. Each interview lasted anywhere from 30 minutes to 2 hours, and transcription and management of that volume of data was no small task. The process of condensing the participant interviews into a coherent, manageable story was helpful in filtering out extraneous details and focusing me in on the pathway itself. However, not all participants valued that pathway as much as the opportunity to speak with limited restrictions about themselves and their experiences. This study was useful in building my interviewing skills, and in the future, those enhanced skills will undoubtedly assist me in focusing research participants on the intended discussion topic in a more concise manner, limiting the amount of extraneous data collected, and thus streamlining the data collection and management processes.

Finally, this research study could not have been completed without the support and assistance of my community partners at CHS. The management and caseworkers were absolutely dedicated to assisting me in recruiting study participants. However, it was naïve of me to not consider the time restrictions on ESG funding that threatened to halt data collection before saturation was reached. As I began data collection in April of 2013, the CEO of CHS informed me that their ESG funding would expire September 1, 2013 and would not be renewed. Thus, the target population would totally disappear from the agency. Caseworkers put forth considerable effort in recruiting potential participants, and I was able to complete data collection prior to the loss of ESG funding, but I learned a valuable lesson about communicating timelines early and often with community partners. This entire study could have turned into an unfortunate missed opportunity.

Implications for Nursing Professionals

Nurses are in the unique position to have multiple points of contact with families at risk for housing instability and homelessness. In fact in our focus groups in Detroit, women discussed coming in contact with nurses while receiving prenatal care, in emergency rooms, and during primary care visits for themselves and their children. One woman revealed that she had been pregnant, living in her car, and had hidden her living situation from her employer, friends and family. She first disclosed her homelessness to the nurse in her obstetrician's office, and following her disclosure, her nurse assisted her in accessing shelter and housing support services.

Similarly, many participants of "In Their Own Words" shared that they or their family members had medical challenges that resulted in visits to emergency rooms, hospital stays, or multiple doctors' appointments where they interacted with nursing

professionals. “In Their Own Words” revealed that women facing housing instability are often unpracticed in sharing the stories of their struggles, and that those stories often involve elements of trauma, violence, and victimization. Asking patients about their current housing situation can provide the starting point for disclosure of the negative life events contributing to housing instability.

Just as nurses and other health care professionals have become aware of the need to assess patients for domestic violence, assessing *housing stability* must become a standard practice for nurses. Nursing assessments at the time of a hospital or emergency room admission, as well as during intake in a primary care provider’s office, inform nursing care plans and discharge planning. Understanding a patient’s living conditions and housing stress is crucial to planning short and long-term disease and illness management. Consider the following scenario. A patient is seen in her primary care provider’s office for management of her poorly controlled diabetes. The patient reports that she has been eating less, even skipping meals, but her blood sugar remains out of control. The patient’s primary care provider orders a sliding scale insulin regimen, and refers the patient to a diabetic nurse educator for teaching. This patient recently lost her fulltime job, and after three weeks of unemployment, had to take on a nightshift position resulting in drastic changes to her sleep and eating schedules. The apartment she lives in no longer has a working refrigerator, and she is afraid to call the landlord to report the problem, because she is five days late paying the rent. In addition, the patient is worried that she will not have enough money to pay utilities at the end of the month because of her recent unemployment, and so she has been skipping meals or taking her children to a local soup kitchen, where she has little choice in what she eats. She fears eviction and has

been unable to sleep even on her days off from work because she is so worried that she and her family will become homeless within the month.

A housing assessment, including questions about where the participant is currently living, conditions of the home, and worries about maintaining housing, might reveal this patient's rapidly progressing housing instability, allowing for not only a diabetic management plan that accounts for food instability and lack of refrigeration, but also one that links the patient with critical social services to prevent homelessness. Missing this critical assessment would likely result in continued poor diabetic control, with a plan that fails to consider the role of stress and environmental factors in contributing to a diminished ability to manage diabetes. Further, initiating a housing assessment is likely to open the door to a discussion about the life events leading to housing instability. This may reveal complex social challenges and prior traumas that require mental health care interventions.

A basic housing assessment may also reveal health, behavioral, and educational challenges faced by patients and their family members that nurses can identify and refer to the appropriate level of care. For example, in the scenario of the patient with poorly controlled diabetes, suppose the patient's nurse empathetically inquires about the events leading to the patient's job loss. Perhaps the patient lost her job because an abusive, controlling partner was physically preventing her from arriving at work on time in order to remind his partner that he was the "boss" of her. Maybe his abuse turned physical when she challenged his authority and threatened to leave him. It is possible that her children witnessed this violence, and now struggle to sleep at night because of nightmares of the witnessed abuse, contributing to missed days of school and inattentive behavior in

the classroom. A conversation that started as a housing assessment now reveals issues of untreated domestic violence both for a woman and her children, housing instability, and educational interruptions for the patient's children. If the nurse successfully provides the patient with a safe space to initiate this conversation, even if the nurse is unable to address the multitude of challenges faced by the patient and her family within the limits of a single office visit, she can begin to offer referrals and points of contact for formal support services for the patient and her children. Assessing and addressing housing instability and the complex life events leading to housing instability not only will aid nurses in co-creating targeted, tailored approaches to managing chronic diseases such as diabetes. In addition, this approach can also identify on-going threats to health and well-being for the entire family, creating the potential for *true preventive services*. Through collaborative practice with physicians, social workers, and mental health care providers, nurses can advocate for and refer their patients facing housing instability to a network of service providers.

Housing assessments provide the opportunity to offer proactive access to housing support services in order to reduce future housing instability. Nurses conducting well-baby home visits to new mothers, home healthcare nurses, and nurses involved in discharge planning and case management services are clearly positioned to engage in housing assessments. Further, nurses practicing in other settings—for example, acute care nurses completing admission assessments, maternity care nurses who are supporting mothers through the first days of parenthood, and nurse practitioners completing new patient intake databases, are also positioned to complete housing assessments. Nurses at all levels of practice, in all healthcare settings, have both opportunity and rationale to

assess housing instability, and its impact on health and well-being among all patient populations.

Conclusions and Future Research Questions

When I first conceptualized this research study, there was limited available data about family homelessness or families facing housing instability. Fortunately, over the past few years, national awareness of family homelessness has grown, as has associated research and policy initiatives. National efforts to reduce family homelessness are beginning to gain traction, and slowly, reductions in national rates of family homelessness are occurring (HUD, 2013). However, there remains work to be done. The National Alliance to End Homelessness (NAEH) recently released a report stating that although individual and family homelessness and unemployment are on the decline, the number of persons *at risk* for homelessness remains steady (NAEH, 2014).

There have also been significant gains in the development of trauma-informed care protocols for numerous populations, including female veterans (US Department of Labor, 2011), behavioral health clients (Substance Abuse and Mental Health Service Administration [SAMHSA], 2014), and homeless populations (NCFH, 2010). Given these recent shifts in climate regarding both trauma-informed care and family homelessness, it is appropriate to wonder what unique results are contributed by the present findings, and how they influence future directions for research and interventions.

This research is important to the study of family homelessness because it offers an emic perspective into pathways to housing instability. All too often, policies intended to assist women experiencing housing instability and homelessness are written without input or feedback from those very women. In addition, the experiences of violence and trauma

that influence their pathways into housing instability contribute to a reduced sense of power and self-efficacy. The resulting powerlessness can only be addressed by inviting women into the discussion and using their words and experiences to shape policies and interventions that better identify and target their needs. Thus, this research offered 16 women in Detroit a voice in shaping future research and interventions. Specifically, women wanted mentoring and guidance for themselves, and viewed interventions that taught them real life skills such as financial management as valuable in preventing homelessness. They also identified a need for support services for teenage girls living in unstable life situations (such as homes with substance abuse or DV), that offered guidance and advocacy within schools and homes in order to prevent future housing instability.

“In Their Own Words” also raises questions about cyclical or recurrent homeless and homelessness prevention services. Over half of the women in this study had a history of homelessness, and most had encountered recurrent housing instability. Current HMIS data collection methods do not allow homeless service providers to monitor or review housing service recipients outside of their immediate community, making it impossible to track housing patterns of families who have experiencing homelessness or near homelessness once they leave a service area. Therefore, very little data is available about chronic or recurrent housing instability. I suspect that the women in this study are reasonably representative of family homelessness patterns in other large urban areas, in that women who experience homelessness often face continued housing instability throughout the coming months and years. It is likely that once they have become familiar with the shelter system because of a homeless event, and how to access support services,

they will become more likely to access prevention services rather than wait to progress to homelessness again. Long-term prospective cohort studies would be useful in determining whether or not this is truly the case.

The data gathered through this study is important for understanding personal experiences of housing instability, but more importantly, helped to identify a useful process for disclosure. It also revealed some initial findings about who may benefit from a narrative intervention. Disclosure is known to be a key step in healing from a traumatic event (Foa & Rothbaum, 1996; Pennebaker, 1995). Many of the participants voiced positive responses to the narrative process, and seemed to benefit, at least during the interviews, from the act of disclosure. Other women revealed that they were not ready to disclose their prior struggles, and instead offered narratives that presented only positive life stories, incommensurate with their current level of housing instability. Even when women were not ready to disclose, they were able to craft their own narrative in a manner that did not harm their current belief system. Although challenging one's beliefs and inconsistencies is an important part of utilizing narrative as a therapeutic intervention (Pennebaker, 1995), individuals must feel safe and establish some degree of trust with the person to whom they are disclosing before healing can begin (Herman, 1997). Thus, offering women an opportunity to share their story as they want to tell it could be a useful intervention for *all* women experiencing housing instability, as the narrative process allows time and sharing to create that safe space for later disclosure. Future narrative interventions need to be mindful of the need to practice telling one's story, potentially offering multiple sessions to review life details before asking a woman to attempt to

organize those details into a formal story structure. This process would give women a real opportunity to share their stories “in their own words.”

In addition, this research demonstrates a need for trauma-informed care and the assessment of trauma and posttraumatic stress among families experiencing homelessness. The women who shared their stories with me revealed extremely traumatic pasts that, in most cases, had not been previously disclosed to a service provider. Thus, future research and interventions with unstably housed families should include a plan for training all research staff in trauma-informed care, readily available mental health services for all participants, and a plan for long-term follow-up with participants to ensure their well-being following the disclosure process.

My hope is that this research serves as a starting point for future interventions. Women wanted mentoring and life coaching, as well as practical guidance in skills like money management. Ideally, this research will serve as the basis for the development of a mentoring program that includes an opportunity to disclose life experiences in a safe, trustworthy environment. It is also my hope that the findings from this study will help local homeless service providers, healthcare providers, and schools develop insight into the need for trauma-informed care in all aspects of service delivery.

APPENDICES

Appendix A: Table 6 Table of Evidence

Identified Domestic Violence Survivors						
Year	Author	Design	Participants	Instruments	Findings	Limitations
2002	Sev'er, A	Literature review	Articles focused on women w/ dependent children fleeing DV	None	Children witness violent attacks (up to 45% of children in homes w/ abuse) or aftermath of abuse (injuries, blood, damage to home); DV pervasive & rooted in culture—shelters are a recent invention, and critically underfunded; victims judged for not leaving rather than abusers judged for abuse; leaving abusive partner may trigger a cycle of homelessness no less traumatizing than abusive relationship	Poorly explained methodology—cannot repeat literature search based on article explanation. Anecdotal evidence interspersed with lit review findings.
2003	Anderson, M. A., Gillig, P. M., Sitaker, M., McCloskey, K., Malloy, K., & Grigsby, N.	Retrospective descriptive study	485 women (from June 1998-May 1999) calling a DV intervention Hotline.	Intake surveys from DV shelter (qualitative & quantitative questions) assessing patterns of abuse, potential lethal factors, and reasons for remaining with abuse	87% reported physical abuse, 89.6% reported verbal abuse, and frequent reports of controlling behaviors. Stayed with abusers because of: External Factors-- homelessness (18.2%), & lack of support from police (13.5%), courts (6.8%) and medical personnel (2.3%); Internal factors— abuser promised to change (70.5%), apologized for abuse (60%), lack of money (45.9%), nowhere to go (28.5%).	None identified in article
2003	Baker, C. K., Cook, S. L., & Norris, F. H.	Quantitative descriptive study	110 women in Atlanta receiving services from the criminal justice, welfare, or shelter	Housing Problems Index (HPI—assessed housing stability), Revised	Women had high rates of housing instability and risk for homelessness. Women who left home (rather than partner	Findings need confirmation via longitudinal research. Sampling issues:

			system who had separated from a violent partner or at least 2 weeks within the past 3 years	Conflict Tactics Scale (type/severity of DV), Received social support scale, & Formal System Response Inventory (how police, courts, shelters, & welfare responded to DV)	leaving) were more likely to have future homelessness or instability. Women were more likely to leave if partner wasn't arrested, threatened violence, or had a substance abuse disorder. Received mostly emotional, not tangible, support from friends/family. Contacted at least 2 formal support systems; concerns: slow police response times, poor TPO enforcement, disrespectful/insensitive case workers, limited support groups	recruited from one site via phone— disconnected phone lines may have caused sampling bias. Rates of homelessness inflated by sampling of shelter population. Interviews conducted in public areas, including restaurants and waiting rooms.
2004	Gorde, M. W., Helfrich, C. A., & Finlayson, M. L.	Quantitative descriptive study of women's trauma symptoms & life-skills needs assessment	Convenience sample of 84 women receiving services DV services from 1 of 3 sites: Emergency shelter, transitional housing, & a community group.	Demographic information form, Trauma Symptom Inventory & Occupational Self-Assessment. Focus groups of shelter/trans. housing staff were also conducted to assess staff perceptions of women's needs	Trauma-related symptoms endorsed most often included defensive avoidance, intrusive experiences, tension reduction behaviors, dysfunctional sexual behaviors, dissociation, and depression. Women wanted to learn to manage finances & work on goals, as well as find safe place to live. Workers identified need for employment, parenting skills, day care, housing access, and increase self-esteem; not enough time to manage mental health needs of clients. Overall: housing is important, but mental health needs must also be addressed	Difficult to compare urgent needs of women in emergency shelter to transitional or community-dwelling women. Unexplained: high rates of PTSD symptoms w/ low depression scores; emerging differences between groups of women may represent differing needs, but was not fully assessed.
2004	Moe, A. M. & Bell, M. P.	Qualitative Narrative (part of	19 women in a DV shelter	Semi-structured interviews	Survivors of abuse face significant difficulty	Selection bias— women seeking help

		a larger study of women's experiences with violence and help seeking)			maintaining employment & financial security during abuse (due to physical consequences of abuse & financial exploitation), while fleeing abuse (leaving assets behind or distance from employer or fear of partner locating them), and after reestablishing self (childcare, physical & mental sequelae of abuse). Financial consequences of abuse are long-lasting	via shelter. Had already identified abusive behavior
2007	Moe, A. M.	Qualitative Narrative	19 women in a DV shelter (16 mothers)	Semi-structured interviews	Women sought assistance from multiple sources without success before entering DV shelter; Housing often unstable prior to entry into shelter	Selection bias—women were seeking help via shelter. Had already identified abusive behavior
2009	Iyengar, R., & Sabik, L.	Secondary analysis of national databank	Data collected over a 24 hr period, reviewing use of Nat'l Census of DV services—48,350 people utilized services from 2,016 DV service providers	Domestic Violence Survey Instrument	48,350 people accessed services in a single day. 65% needed shelter—only ¼ of programs offer shelter beyond emergency shelter. 5000 (10%) of requests for services went unmet because of lack of resources. Significant lack of long-term housing, counseling resources, and advocacy services.	Limited information about levels of violence; informal pathways to DV support not assessed. DV programs vary significantly in scope, practice, and resources.
2011	Ponic, P., Varcoe, C., Davies, L., Ford-Gilboe, M., Wuest, J., & Hammerton, J.	Longitudinal multi-methods study	304 Canadian women (community convenience sample) who had separated from an abusive partner	Life history calendar focused on housing stability, economic circumstances, & # of dependent children. Also used Index of Spousal	More housing instability in 6 months after leaving abusive partner vs. the 6 months before, more likely to live w/ family/friends vs. private market housing, increased financial distress after leaving partner. More housing	Convenience sample; pre-leaving abusive partner collected retrospectively. Life History calendar covers 1-mo blocks, so moves of <1 mo. not captured. Unable to

				Abuse (IPV severity)	instability correlates with less financial stability, more unemployment, lower income, more severe abuse.	differentiate % of income used toward housing from financial strain.
2011	Rollins, C., Glass, N. E., Perrin, N. A., Billhardt, K. A., Clough, A., Barnes, J., Hanson, G. C., & Bloom, T. L.	Longitudinal quantitative cohort study—this report represents baseline findings	278 female IPV survivors with housing instability, recruited from 4 DV & housing service providers in Portland, as well as self-referral via community flyers.	Demographics, Perceived general health, Danger assessment scale, Housing Instability Index, PTSD Checklist-Civilian version, Center for Epidemiologic Studies Depression Scale, Quality of Life scale, CAGE scale (alcohol & Drug abuse assessment), work/school absence measure, & Hospital & emergency medical utilization measure.	Greater housing instability was related to more severe PTSD, worse depression, and poorer quality of life. Greater level of danger in relationship associated with PTSD symptoms and higher depression scores. Increased risk for housing instability increased odds of work or school absence for any reason (28%) and due to IPV (32%). Increased housing instability risk also increased odds of use of hospital/emergency medical services. For each increase in risk factor for relationship danger, odds of work/school absence increased 6% (any reason & IPV), as did odds of use of hospital/emergency medical services. Increased age associated with increased odds of hospital/emergency medical service use. Higher perceived general health correlated with lower odds of hospital/emergency medical service use for both all reasons (decreased 36%), and IPV-related issues (decreased 27%)	Cross-sectional analysis of longitudinal study. Population was of help-seeking IPV survivors. Single factor assessment of general health. Housing Instability Index created for this study, so not previously tested.
2014	Tutty, L. M., Ogden, C.,	Qualitative descriptive study	62 Canadian women with a hx of partner	Demographic data and semi-structured	All women described significant IPV. 18 described	Multiple interviewers—some

	Giurgiu, B., & Weaver-Dunlop, G.		abuse and homelessness; women recruited from emergency shelters, transitional housing, group homes, and community environments. 55 of the respondents had children	interview	being kicked out of house & kept away from kids; 17 reported sexual abuse; 44 reported significant physical abuse; 20 had partners who threatened or tried to kill them. Of women reporting housing issues, 1/3 were homeless once; 1/3 homeless 2-3 x; 1/3 homeless more than 3x. Pathways to homelessness included partner abuse, addiction, discharge from institutions (prisons, hospitals). ¼ of women had episodes of homelessness before age 18.	interviewers more skilled than others. Only captured women seeking assistance— did not capture stories of “hidden homeless”
Homeless and Low Income Women who Experience DV						
Year	Author	Design	Participants	Instruments	Findings	Limitations
2004	Wenzel, S. L., Tucker, J. S., Elliott, M. N., Hambarsoomians, K., Perlman, J., Becker, K., Kollross, C., & Golinelli, D.	Quantitative descriptive retrospective study w/ a stratified random sample, to determine co-occurrence of violence, substance use disorder, and HIV risk behavior among low-income and homeless women.	898 women from LA county: 460 from housing shelters, 438 from low-income housing neighborhood (HUD-subsidized apartment neighborhood)	Revised Conflict Tactics scale (experiences of physical & sexual violence over past 12 months); UMich Composite International Diagnostic Interview (substance use disorder); HIV risk behavior questionnaire; Demographic data	Sheltered vs. housed women: sheltered were older, with less education, and more likely to be previously married (now separated, divorced, or widowed) than housed women. Sheltered women had more lifetime homelessness than housed women, and higher rates of childhood physical, sexual, & psychological abuse. Sheltered women had higher rates of violence, sub use disorders, & HIV risk behavior than housed peers. Sheltered women had significantly higher rates of co-occurring violence, sub use disorder, &	Women in shelters may be at higher risk for experiencing violence because of being in the shelter— housing may not necessarily be a protective factor, but may appear that way because of where shelters are located (in high-crime neighborhoods). Co-occurrence may be bi-directional (substance users may enter more dangerous neighborhoods to

					HIV risk than housed peers. Rates of co-occurrence among housed women were higher than national averages. Suggests need for comprehensive services for homeless women, and assessments for low-income women.	obtain substance of choice & increase risk of assault).
2006	Lown, E. A., Schmidt, L. A., & Wiley, J.	Descriptive survey of frequency and types of violence encountered by women seeking welfare	1235 women seeking welfare (TANF [for women w/ dependent children] or General Assistance [GA—for women w/o dependent children]) in CA between June & Nov. 2001. (all women in geographic region applying for assistance were approached [N=1786], w/ 85% response rate).	Demographic characteristics, questions about housing, drug/alcohol use, family/social support, physical violence over past year, and sexual violence over past year.	Rates of victimization were very high among both women seeking TANF & those seeking GA, but highest among single women seeking GA. Violence, esp. among GA-seeking women, often co-occurs with other sub abuse disorders and social disruptions (divorce/separation, & homelessness). Past failures to measure violence outside of DV has limited our understanding of high rates of trauma in welfare seeking women.	Assessments of violence did not capture exclusive non-partner perpetrated violence.
2012	Adams, A. E., Tolman, R. M., Bybee, D., Sullivan, C. M., & Kennedy, A. C.	Longitudinal path analysis of IPV, job stability, and hardship	753 women receiving TANF in an urban county in MI initially interviewed; 536 completed all five waves of data collection over a 7 year period	Job stability, Objective Material Hardship (7-item index), anticipated material hardship, job benefits sum, Conflict tactics scale (IPV), demographic data.	Path analysis showed: IPV reduces job stability for up to 3 years after abuse has ended. IPV has immediate negative effects on finances (housing, income, job benefits, etc...) that last up to 3 years after abuse ends. Welfare-to-work programs may be inadequate for DV survivors due to difficulty w/ job stability post	While correlations are revealed with study, may not all be causally linked. Did not ask about chronic/on-going DV; did not account for less-severe IPV that may interfere with job stability; does not differentiate job loss from promotion/

Children and Families, DV and homelessness						abuse	advancement.
Year	Author	Design	Participants	Instruments	Findings	Limitations	
2004	Park, J. M., Metraux, S., Brodbar, G., & Culhane, D. P.	Prospective cohort study following children in NYC homeless shelters to monitor their subsequent child welfare involvement	8251 children under the age of 16 who entered the NYC shelter system for the first time in 1996, followed for 5 years. 467 had child welfare involvement before entering shelter and were not included in bivariate & multivariate analyses. (N=7784)	Child welfare involvement (out-of-home foster care placement or preventive services from NYC Children's Services); demographic, length of shelter stay, and family characteristics; reason for shelter admission (eviction, DV, or any other reason [disaster, crime, etc...])	24% (of 8251 total) children had some record of child welfare involvement (CWI); 18% (of 8251) had CWI in 5 years after shelter entry & 6% had CWI before shelter entry. 94% of households were female-headed. Children who had CWI after shelter entry were more likely to have recurrent shelter entry (40% versus 24%) compared to those without CWI, and those with CWI had an average annual shelter stay of 143 days versus 66 days w/o CWI. School-aged & teenaged children & children from DV households were more like to have CWI than preschool aged and non-DV children.	Although clear association between housing instability and CWI demonstrated, uncertainty remains about the specifics of the pathways between shelter use & CWI.	
2005	Anooshian, L. J.	Quantitative descriptive study with regression analyses to predict childhood behavior outcomes	93 families (77 currently homeless; 16 low-income receiving support services to maintain housing). Interviews of mother, child (6-12 yrs old), and a sibling (5-17 yrs old). Not all families included siblings, thus sibling data not included in analysis.	<u>Mother</u> : Maternal Reports of Violence; Economic distress; Child Behavior Checklist (measures problem behaviors). <u>Child</u> : Self-rated aggression; Friendship quality questionnaire; Victimization	88% of mothers reported being victims of violence; 63% reported being victim of no less than 20 acts of violence; 71% of women reported being victims of violence as children. When mothers experienced violence as adults, their children were more likely to experience problem behaviors. Both the experience of family violence and economic distress contribute	Distrust, shame, and fear of child protection involvement limits willingness of families to participate in research, thus the sample may represent a subset of homeless families rather than a representative sample. Self-report on sensitive issues may yield biased results.	

				measure; Preference for peer avoidance; Peer beliefs Inventory (attitudes toward peers); & Children's Depression Inventory	independently to aggressive behavior in children, contributing to social isolation Mother's exposure to violence in adulthood negatively correlated with children's ability to resolve conflict with friends, and positively correlated with child's own victimization.	
2013	Tyler, K. A., & Schmitz, R. M.	Qualitative descriptive study. Part of a larger, longitudinal study following homeless youth over a 3 year period	40 homeless young adults age 19-21 in 4 Midwestern states.	Semi-structured interview: open-ended questions to uncover young adult's family background, experiences on the street, mental health, and prior living situations.	<u>Early family history</u> : family substance misuse, child maltreatment, and witnessing family violence. <u>Transitions from home</u> : 95% left family home because of violence in the home; majority first ran away between age 12-15; most ran to home of friend or family member. <u>Pathways into homelessness</u> : housing instability w freq. moves in & out of family/friends houses; foster care with multiple housing transitions; detention facility or group home; drug rehabilitation—all had frequent moves.	Given retrospective nature of interviews, number/frequency of transitions, and amount of trauma encountered, may not have received a fully accurate account of events in young adults' lives. No "other side of the story" provided to challenge details or events. Study not intended to be representative of experiences of all homeless young adults.

Appendix B: Interview Guide 1

Interview guide:

Thank you for coming in today to speak with me. I'm Laura, a nurse and student at the University of Michigan. I've spent the last two years partnering with Community and Home Supports, helping to identify research opportunities, and conducting focus groups in order to better understand the needs of mothers experiencing housing difficulties, including homelessness.

I'm here today to listen to your life story, and it is my hope that the story you share with me today will help me better understand the things that have happened in your life that contributed to your unstable housing.

After you share your story with me, I will type it up, and bring it back to you.

When we meet for the second time, you will have the opportunity to read the story, and make additions or changes.

What I would like to do today is hear the story of your housing instability. Some of the women I have spoken with in the past have told me that there were specific events, such as loss of a job, or a fight with a family member, or other things that happened that triggered their housing insecurity. But when they shared some of the detail of these events, it turned out that they felt like there was a longer story to the actual event. For instance, one woman told me that she lost her job, but as she expanded her story, it turned out that she didn't have the job she wanted in the first place, because she had never had a chance to finish high school because of all the trouble she faced growing up.

I've found that it's useful to start with you telling me the "short" version of your story, and identifying the top three or four things you felt contributed to your housing difficulties, or instability, and we can then go back and discuss the history of each of the main things you think were important. Because I want to respect your privacy and the privacy of your friends and family members, please do not use real names or full names of the people in your story,—you can make up names, or use initials. Or, you could just say, "There was a man/woman/person in my life that..."

Before we begin, I want to make sure that you are comfortable with me recording our session. If there's any topic we discuss that becomes uncomfortable or upsetting, please let me know, and we can take a break, change the topic, or stop the interview.

Source	<i>Opening statement—these phrases are intended to encourage the participant to share her story and self-identify key events.</i>	<i>Probes—for participants who are having difficulty finding a direction for their story, probes will be used to elicit information that may prove relevant to their story, or to help a participant understand the information I am attempting to gather.</i>
	1. Let's start by having you share the top three or four things that have happened in your life that you believe led you to housing instability. You can just list	

	them now, and then as you're sharing your story, you can explain how these things are related to each other and to your housing.	
Story Theory (ST)	2. Now, tell me a little bit about where you are today. What is your life like right now? What is your housing situation, and what do you think led to your situation?	
Theory of Compounded Disadvantage (TCD)		Who are you? (You were identified for this study as a mother who is experiencing housing difficulties, but that doesn't tell me much about who you are as a person). Where are you staying?
ST		Who is staying with you? Who is important in your life right now?
Geography of Child Sexual Abuse (GCSA)		Are you close with your family? Any brothers or sisters? Do you rely on them for help?
ST, TCD		How is your health?
		How is your child/ren's health?
ST		What are the positive things, or high points, happening in your life right now?
ST		What are the challenges, or low points, happening in your life right now?
ST		Were there any recent life-changing events for you or your family?
ST	3. I'd like to hear about your childhood and the journey to where you are now. Tell me about your life growing up.	
TCD, GCSA		Where did you live? Who did you live with?
ST		Who were the most important people in your life?
GCSA		Did you move frequently or stay with family or friends for long periods of time?
TCD, GCSA		What was school like? Did you like it? Did you get along with your teachers?
GCSA, TCD		Were you treated like your peers? Did you have many friends?
GCSA, TCD		What was your neighborhood like? Were the other families like your family?
GCSA		Were there friends and neighbors you could go to if you needed anything?

TCD, GCSA		Did you feel safe in your neighborhood?
GCSA		Would you consider your childhood happy? Did you feel like your family loved you and took care of you?
GCSA, TCD		Did your family have a lot of traditions or cultural practices?
GCSA		Were there times when your parent/s or guardians asked you to be responsible for things that most kids at your age aren't yet responsible for? Were you ever treated like the parent in the house?
GCSA		Did you get blamed for things that weren't your fault?
GCSA, TCD		Were there times when your family couldn't financially make ends meet? Did you have to "go without" compared to friends and neighbors?
GCSA, TCD		Were you punished (at home and/or school) more often or more harshly than your siblings or friends?
GCSA		Were there a lot of secrets in your family growing up? Did things happen without an explanation (like a parent or family member suddenly leaving and not coming back)?
GCSA		Did anyone in your household abuse drugs or alcohol?
GCSA		Were there ever physical fights (other than kids rough-housing) in your house growing up? Between whom?
GCSA		Were you hit, smacked, punched, or kicked by someone in your house or family? Were you yelled at, or talked down to, or treated more harshly than your siblings? Was there any inappropriate touching or unwanted sexual contact within your house or family while you were growing up?
ST		What were the low points, or worst memories, of growing up?
ST		What were the high points, or best memories, of growing up?
ST	4. Tell me about your future. What do you think will happen?	
ST		What things do you <i>want</i> for your life? For your children?
ST		What things are <i>possible</i> for your life? For your children?
TCD		What barriers might you face?

ST		How might you overcome them?
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Thank you very much for sharing your story with me. I will type up what you have shared with me, and when we meet again in a couple of weeks, you'll be able to reread the story, and make changes or corrections. We will also talk about how you think the pieces of your story fit together, and what that means to you. If anything we talked about today is causing you to become very upset, or you think you want to talk about things that have happened to you with a counselor, please call me or your CHS case worker, and we can help you find and refer you to a counseling service that meets your needs.

Framework for Interview 2:

Thank you for meeting with me for a second time. I would like to spend a few minutes first revisiting your story, and making sure I captured the details you wanted to include. This is what I heard in your first interview. (Provide a brief overview of the participant story). Is this an accurate account of what you said? Is there anything you feel I misheard?

(Spend about 5-10 minutes reviewing and confirming or correcting the main points of the participant's story from interview 1.)

Now, we've reviewed your story, and you've had some time since first sharing it with me to think about it. In the time since we last talked, have you thought about other events that might have influenced the story you first shared with me? For example, other women, when they've first shared their stories, have said that they lost their job, and that was the main cause of their housing instability. But then after thinking about it, they felt like they never had the job they wanted or needed because they had to drop out of high school to take care of a younger sibling. So they realized their housing instability was really rather complicated. This is your opportunity to share any of the complicated details of your story that you might have missed in the first telling.

(Spend up to 40 minutes having participant define or redefine detail)

Finally, you started the first interview by sharing these top two/three/four (depending on what was shared in first interview) events that you felt were the main events leading to your housing difficulties. *(read top events back to participant from transcript of interview 1)*. Do you still feel like those are the main events that led to your housing difficulties? If not, what would you change?

(Spend 10-15 minutes summarizing the main events as defined by participant).

Thank you very much for participating in this study.

Appendix D: Data Analysis Template

Interview Data Analysis Template

Participant # _____

Brief summary of Narrative:

	Interview 1	Interview 2
Key life events leading to housing instability		
Identity (words/phrases to describe self)		
Family (words/phrases defining family relationships or events)		
	Interview 1	Interview 2
Social (words/phrases defining friendships or social interactions)		
Societal		

(words/phrases defining interactions with institutional resources or entities—may include schools, police, gov't)		
Environmental (words/phrases defining housing or community, or interactions with physical community)		
Health & Well-being (words/phrases to describe own or families health)		

Themes	Subthemes	Participant Statements supporting themes

Themes	Subthemes	Participant Statements supporting themes

Appendix E: Participant Stories

Participant A1: Final draft

Primary causes:

“The war against diabetes is what triggered everything.”

Follow-up: The diabetes was the trigger because, “I was neglecting me—the diabetes forced me to focus on myself.” “It was the first time I felt like I couldn’t fix something.”

A1’s Story:

A1 has faced struggles from the beginning of her life, with her father in jail, and her mother a teenager at the time of her birth. Her grandmother often filled in as the primary caregiver, and A1’s father periodically reentering her life, only to be re-incarcerated.

A1’s childhood was marked by exposures to extreme violence, including witnessing the violent homicide of a neighbor.

At the age of six, A1’s life found some stability when her mother married the father of her second child, although that stability was somewhat short lived, as A1’s mother developed a substance abuse disorder. Again, A1’s grandmother stepped in to provide care, as did another male relative. A1 often faced responsibilities beyond her young age, caring for her younger sibling. A1’s mother found sobriety seven years later as she welcomed her third child into the world. By this point A1’s grandmother had moved out of the state, and although her mother had found sobriety, A1 took on much of the care giving role for her younger siblings. Throughout this time, A1 felt alienated from her step father’s family, recalling insults and derogatory treatment she received from them because of her mother’s substance abuse disorder.

In spite of these hardships, A1 recalls her childhood with some fondness, remembering family trips across country and to local amusement parks. She feels that her mother did the best she could in spite of her struggles. A1 notes that even when her mother was lost

to her addiction, she was never physically far from her, and A1 never felt abandoned. A1 relied on her spiritual upbringing to carry her through the dark times, and continues to rely on her faith for guidance and promises of a brighter future.

At the age of 16, A1 turned to alcohol to numb some of the pain of her childhood. She dropped out of high school, and was pregnant with her first child by the age of 19. A1 felt that her pregnancy helped her make better choices for her own life, and she took motherhood very seriously. By 2002, she had decided that she needed to return to school and finish her GED. As she was on the way to her first day of school, A1 was in a major car accident that resulted in a broken bones and injuries requiring 6 months of aggressive physical therapy. This accident put her plans for school on hold, but brought her closer to her then boyfriend, who later became her husband, and the father of her daughter. After recovering from her injuries, A1 returned to school and completed her GED with honors. While working as a patient care technician, she applied to college, and was accepted to a local program.

A1 was working full time hours as a patient care tech, and attending classes. She noticed she was feeling tired, rundown, and constantly thirsty. As she was walking home from visiting a classmate's house, she collapsed and was unable to make it to her home. A neighbor eventually called for an ambulance, and A1 was admitted to the hospital with a blood glucose of 750. A1 was later discharged from the hospital with a diagnosis of diabetes, and was forced to start taking control of her health. She lost over 60 pounds, managing her diabetes with a combination of diet, medications, and activity. A1 identifies this event as having triggered her slope into housing instability.

While A1 was in school, she notes that her relationship with her husband became strained. She was more distant with him, and he felt isolated from her, resulting in him turning to another woman for comfort. Although it took time, A1 and her husband reconciled, and worked on rebuilding their relationship. During this time, A1 also found out that her landlord was not receiving the rent money she was paying to an intermediate rent collector. In 2009, she and her family faced eviction in spite of having paid money monthly to a person they thought was turning the money over to the landlord. At the same time, A1's aunt, who owned several properties in Detroit, faced financial struggles. A1 moved her family into one of her aunt's properties in order to provide financial support to her aunt, provide housing to her family, and to act as property manager on behalf of her aunt. Unbeknownst to A1, the house was under a tax lien.

As the City of Detroit moved to seize the property from A1's aunt, her aunt forged documents and quick-claim deeded the property over to A1. A1 was unaware of this until the City of Detroit approached her to claim the thousands of dollars her aunt had owed in back taxes. A1 and her husband worked with the City to create a payment plan, but struggled in sub-standard housing, unable to legally obtain utilities to the house because of her aunt's prior bad faith actions. Just as A1 and her husband started regaining their footing—repaying the back taxes, and fixing up their home, A1 suffered a stroke, resulting in aphasia. Having exhausted her FMLA taking care of her son after he broke his arm, A1 was released from her job, as her aphasia rendered her unable to perform her job conducting phone calls for a fund raising company. A1 eventually was able to recover her speech through hard work and prayer. Within months of her stroke, her husband smashed his hand in a heavy piece of equipment at work, and was unable to work. This

series of events led to a wearing down of resources. The final event contributing to their housing instability was a house fire. Although grateful for the health of her family in the event, the fire has made their house unlivable, leading them to seek emergency assistance from CHS. She and her family are currently doubled up with a family member until they can establish stable housing.

A1 felt this could have prevented her housing instability:

A1 believes that if individuals working for the City of Detroit had listened to her and reviewed the case more closely when she first tried to dispute the quick-claim deed, she would not have been in the financial hole she was in when they lost the house to fire.

A1 Themes:

- Broken family relationships
 - Mom with a substance abuse disorder
 - Dad in and out of prison
 - Grandmother moved out of state
 - Aunt betrayed her—left her with a house with significant tax debt
 - Husband cheated on her
- Trauma and loss
 - Loss of primary caregiver—grandmother—when she moved out of state. Died not long after.
 - Literal—car accident and loss of her health
 - Witnessed lots of violence in her childhood growing up—neighbor murdered husband after years of physical abuse; losses of cousins, aunts, and uncles to sudden illness and violence.
- Responsibilities beyond her years
 - Had to care for siblings while mom was lost in her addiction
- Caring for everyone but herself
- Illness aging her beyond her years

- Diabetes
- Stroke

Participant B1: Final draft

Primary factor contributing to housing instability:

“Other people making their problems mine.”—no one else contributing to the household.

Added: I guess I made some mistakes. I could be back in school right now instead of waiting for next Fall.

Follow-up: Brother is the biggest problem.

B1’s Story:

B1 is the oldest of several siblings, but is really only close to her brother. When B1 was about 3 years old, and her brother was just 6 months old, they were removed from their mother’s custody because of her long-standing substance abuse disorder. B1 reports that she and her brother were fortunate to have been taken in by a family member who loved and cared for them, raising them in a religious household, instead of a “street” lifestyle like that of her mother. B1 felt she was well cared for, and although she noticed that she was given more household responsibility than those of her younger cousins and adopted siblings, she felt that the responsibilities, like cleaning the house, were not inappropriate for her age or ability.

B1 felt protected in her childhood home, going to church, and not being exposed to drugs, alcohol, violence, or even swearing. Her relative was loving, and took in other children whose parents were not able to properly care for them. B1 graduated from high school, and even spent some time in college, but did not complete her degree in either mortuary science or medical assistant as she intended. She moved out of her relative’s home, and began making a life for herself and her then significant other. Her income was primarily from Social Security, providing disability benefits for her sickle cell disease.

Throughout her young adult years, her brother would “drop into” her life, moving in and relying on her to support him physically and financially. B1 has concerns that her brother suffers from having been abandoned by her mother, and therefore struggles to care for himself, looking to her for mothering and support. While she is close to her brother, and speaks kindly of her adoptive parent, she does not maintain a close relationship with any family member other than her brother. She ran into her mother almost 10 years ago at a local store, and B1 became aware of at least 2 other siblings , however, these children are no longer in her mother’s custody, and B1 does not communicate with them regularly.

In August of 2012, B1 moved to her current residence. This is the first time she has supported herself and her children without her partner, but financially, she was initially making ends meet. However, her brother once again moved in with her, bringing his young daughter and newborn son along with him. B1 is now supporting her own children, her niece, nephew, and brother on her disability check. She feels that if her brother would contribute financially to the household, she could stabilize her housing. However, she feels that confronting him and asking him to move out or carry some of the financial burden would result in an angry outburst, and may destroy the only family relationship she has.

B1 has big plans for the future. She intends to re-enroll in college in the fall to complete her education. She hopes that her brother will take on responsibility for his children, and move out on his own. B1 feels that if her brother were to move out, she could begin saving money, and purchase her own home. She hopes that her children continue to do well in school, and wants to build a brighter future for them and for herself.

Could anything have prevented your housing Instability?: There's nothing B1 can identify—states that she and her brother had counseling during childhood, but it didn't help him.

B1 themes:

- Giving without receiving
 - Supports brother & friends without receiving any support in return
 - Takes in nieces and nephews without receiving support from their mothers or father (her brother)
- Abandoned by parents
 - Mother with substance abuse disorder—removed from mom's care at age 3.
 - Met mother later in life, but mother wouldn't acknowledge her
- Impacted by illness
 - On disability for sickle cell disease
- Education will offer new opportunity

Participant C1: final draft

Primary causes:

lost prior housing because of history of drug conviction
currently overcrowded—multiple family members in the house

C1's Story:

C1 is one of 5 children. She was born and raised in Detroit. As a child, she remembers enjoying school, being a good student, and being well liked—popular even. However, by the time she reached middle school her home life had become very complex. Her mother was addicted to crack cocaine, and although she was physically present, she was unable to provide many basic needs for her children. C1 felt close to her mother growing up, in spite of her mom's substance abuse, and close to her older sister.

The instability created by her mom's substance abuse led to C1 moving frequently and experiencing housing insecurity growing up, and although she remained in Detroit, she was unable to complete high school. C1 felt that not attending high school was a low point for her—she wanted the social interaction and normalcy she associated with school. However, school attendance didn't feel like an option for C1, in part because she was helping to care for younger brothers and sisters—leaving home for the day meant uncertainty about their wellbeing. C1 and her sisters had to maintain the household to prevent the separation of the family. She has heard that there was once a CPS case opened against her mother, but she and her siblings were never removed from the home. In spite of her mother's absence, C1 felt that her grandmothers stepped up and became very influential in her childhood. C1's grandmothers often took care of the financial needs of her childhood household, paying bills when C1's mother failed to in order to

keep the children in a home with their basic needs met. C1 felt very close to and protected by her grandmothers, but her paternal grandmother passed away when she was 13, again leading to feelings of deep loss.

Although C1 longed to attend school with her peers, she also felt uncomfortable in school as her mother's addiction deepened, and she no longer had proper clothing, shoes, or supplies for school. And while C1 knew many families in her community were impacted by crack addiction, she remembers feeling that her mother could not act as an advocate on her behalf within the school system. This made C1 feel that she was different from other classmates whose parents provided both praise and discipline, and who partnered with teachers to support their children in school. C1's mother's crack addiction also created conflict between the siblings and their mother, resulting in frequent arguments and disagreements at home. C1's oldest sister became a mom at the age of 17, which also forced C1 to step up in to a co-parenting role with her sister. C1 remembers her nieces and nephews as a blessing in her life, and recalls moving in with her sister to escape her mother's difficulties once her sister was able to establish her own home.

C1 was identified as disabled in childhood, due to a significant hearing impairment. She first moved out on her own as a 19 year old with a young son, relying on her disability check to pay the rent. Eventually, her disability status was revoked, and she was forced to move in with her grandmother and mother, resulting in a very crowded living situation. Rather than attempt to move out on her own again, she spent several years moving between the homes of family and friends. She sought work as a temporary employee but ultimately found that her hearing impairment made it impossible to answer phones, and complete other tasks required by the jobs. C1 also worked as a cashier, but

Detroit's economic downturn impacted her employer, and the business closed. She again applied for, and was granted, disability status for both her hearing impairment and a mood disorder, and currently relies on her disability check as her primary income.

C1 currently faces a lot of stress. In the past year, she gave birth to twin girls. The girls are healthy with the exception of intermittent asthma symptoms, which led to a recent trip to the emergency room, requiring follow-up with their pediatrician. With all the attention the girls have been requiring, C1 has noticed that her 13 year old son has been acting out, getting in trouble at school and home. She feels this is at least in part due to the fact that the twins' father is involved in their lives, while her son's father is not involved in his life. She has worked with a therapist for her son in the past, and is hoping to get him reconnected with mental health services. Adding to that stress, C1 was living in her own apartment with her children until a change in management at her apartment complex resulted in her being asked to leave because of a prior drug conviction. C1 stated that she informed the rental office when she initially signed the lease that she had been arrested and convicted of illegally obtaining a controlled substance. The prior legal issues came about when a man she perceived as a potential suitor asked her to drop off, and later pick up, a prescription for her. She states that she was unaware that the prescription was illegally obtained, and when she entered the drug store to pick it up, she was arrested and charged. When the management changed in the rental office, the new landlord performed a background check, and discovered the prior conviction, which violated the leasing agreement. This led to C1 moving into the same home as her mother, and although they get along, the combination of households had led to some butting of heads between the women. The final insult was a recent small kitchen fire, leaving C1 has concerns about

the safety of the house. C1 recalls the support that her mother had from C1's grandmothers, and feels like that support is lacking in her own life. There is no one she can turn to for financial assistance, and in fact, is often called upon by family members to offer assistance that she cannot really afford to give.

When C1 considers the future, she is hopeful for herself and her children. Although she has attempted to return to school for her GED, she found that her hearing impairment, and her lack of trust of strangers makes crowded classroom situations both uncomfortable and unproductive. However, C1 believes she will be able to purchase her own home in Detroit. She recognizes that her financial situation is a tremendous challenge to home ownership, and she is still developing her plan to make this dream a reality. She hopes that her son will be successful in working through his frustrations and stress, eventually graduating from high school to become a productive member of society. She believes that his barriers to success include his exposure to violence on the internet and in videogames, and his desire to keep up with his peers in terms of material goods. She continues to talk to him about what he needs in order to be successful

C1 felt this could have prevented her housing instability:

As a child: One person acting to encourage her to stay in school and finish her education.

As an adult: not sure. She has difficulty trusting people, and feels this would limit the usefulness of preventive interventions.

Did say that the interview process was helpful for her, and even felt it was therapeutic.

Thinks if someone had given her the chance to talk about this/think about her life before she ran into housing problems, she might not have had such severe housing problems

C1's Themes

- Absent parents—Mom struggled with substance abuse disorder, dad not physically present
 - Although C1’s mom has found sobriety, C1 faced many challenges during her childhood.
 - --Son has absentee father; acting out because of jealousy over relationship between sisters and their father.
 - Grandmothers stepped in to meet the family needs, but without formal oversight—no CPS involvement
- Community problems with substance abuse
 - Lots of friends with parents with substance abuse disorders—very common
- Responsibilities beyond her age
- Unable to finish high school
- Broken social networks—misled by a male friend, causing legal trouble; few friends to turn to for support/assistance
 - Offered more support to friends/family than she received in return
- Change in rules/rule enforcement—led to loss of prior housing
- Overcrowded living situation—physically overcrowded; conflicts between heads-of-households
- Recurrent/ongoing housing instability—has lived with friends/family multiple times

Participant D1: final draft

Primary causes:

“I was working for a temp service, and they would work me for 2 days, send me home half of a day, call me back maybe Monday; by Wednesday the same thing—so basically, the job situation, and having three kids, trying to stretch maybe \$230 between four people—bus fare, if I ran out of food, and then pay the lights, gas, utilities, and rent—it just wouldn’t work.”

“I was granted the same opportunities that everyone else was, but I chose to take the wrong route, hanging out with the wrong crowd. I did graduate high school, but I did not go to college. And I feel that if I had when to college, of course I would have had a better paying job, actually, I would have had a career.”

“Now I see that the road that I took was not the right road.”

D1’s Story:

D1 was born in North Carolina, and grew up living with her mom and sister. Her father was not present in her childhood, but D1’s mother worked hard to support her and her sister, providing all they needed in a loving household. D1’s mother moved them close to their maternal grandmother, also living in North Carolina, who provided childcare to D1 and her sister while mom was at work. D1 completed her high school education, and has very positive memories of growing up with her family. She fondly recalls spending time with her cousins, mom, sister, and grandmother, going on trips to enjoy local attractions like the beach. However, D1 notes that she didn’t apply herself in high school, and didn’t participate in sports or other extracurricular activities, mostly because she was busy living the day-to-day without thinking about the future, but also because she knew college wasn’t financially feasible for her family. Looking back, D1 feels that her choice not to apply herself in school or extracurricular activities prevented her from qualifying for scholarships.

After graduating from high school, D1 worked with her mother in a nursing home until she met the father of her children. D1 feels that she, like many young adults, spent a lot of time hanging out with friends and partying. However, she feels that she was slower than her peers to realize that she had to spend less time having fun, and more time focusing on parenting and caring for her family. She moved with her partner to Detroit to be closer to his family. D1 had a bit of a rocky relationship with her partner. While she reports that things were mostly good, there was occasionally physical violence in their relationship. D1 stated that over the course of her 10 year relationship with the father of her 3 children, she had 3 physical altercations with her partner, which were generally related to his drinking alcohol. The breaking point was his infidelity, leaving D1 to raise her children alone. The father of her children visits somewhat regularly, and contributes “what he can,” in particular by spending time with his children, but is not in a position to contribute financially to the household. D1 found herself in financial difficulty in spite of holding down a job. She was working for a temp service, and she was keeping things together until the local economy took a downturn. D1’s hours were cut back and sporadic, resulting in very little income to spread between the four people in her household.

D1 feels emotionally close to her family—she talks to her sister on the phone daily, and has even established a relationship with her father since the death of her mother in 2009. However, her family lives in North Carolina, making it difficult for her to receive direct support or assistance from them. At the same time, she knows that if she were to live closer to her family, she would have to “answer” to them, constantly explaining her choices and actions to them, and being treated like a child again,

especially by her father. Her father also tends to undermine her parental authority—if she tells her children “no”, her father will come back at them with a “yes.” The distance provides her with the ability to “stand on her own two feet.” D1 also has a close friend she can rely on to help her with picking up the kids from school, or being a shoulder to cry on when needed. She also has maintained a relationship with her children’s paternal aunt, who lives in the same neighborhood, and offers support whenever she can.

D1 is currently struggling to provide basic, daily needs to her family. However, there are some bright spots amidst her struggles. She turns to her faith for strength. D1 uses her story as a motivating tool for her children and their friends. She has spoken to her older daughter’s classmates about decision making, and the importance of education. She encourages her children to study and look to the future. Although she knows that affording college will be difficult for her children, she is encouraging her son to join the military after high school in order to learn to be a productive man, to “see the world,” and to get an education. Her daughter dreams of going to law school, and D1 is keeping her focused on school to make that dream a reality. D1 has plans to complete her own education, and is working with her FIA worker to apply to school to be a dental assistant. She is realistic with the challenges she faces, insightful about how her decisions influenced her life, and knows that if she is successful in starting her own career, she will set a solid example for her children, providing them with a future that is peaceful and less stressful.

D1 felt this could have prevented her housing instability:

Making better decisions as a teenager and young adult—staying focused on her education, and starting a career as a young adult.

D1's Themes:

- Personal choices—didn't understand long term impact of decisions made as teenager
- Personal Responsibility—"I had a good upbringing...these choices were mine alone"
- Children are strength
- Future think/planning for self and children
- "You have the choice"—didn't understand long term impact of decisions made as teenager, but wants to make sure that her kids understand how their choices will shape their future.
- A solid foundation—a good education will set the stage for a solid career that prevents housing instability.

Participant E1: final draft**Primary causes:**

Job loss

No savings

Credit card debt from years ago—tax refund garnished

E1's Story:

E1 was born and raised in Detroit. She is the oldest of 4 children, raised in a Christian home, but her mother was never engaged in the child-rearing process. E1's mother was a single parent, as E1's father had a substance abuse disorder, and E1's mother now admits to never having enjoyed being a parent, turning to alcohol to escape her responsibilities. E1 noted that she and her siblings were each fathered by different men, but that didn't keep her from feeling close to her sisters and brother. She feels that her childhood was different than that of many people she knew—her mother didn't work or own a car, so travel was impossible, limiting E1's culturally and educationally enriching experiences. E1's family of origin had to rely on the kindness of their church congregation and community for food and support growing up. E1 felt that she was mostly responsible for raising herself, and notes that she has worked hard to be different than her mother.

E1 was a good student who enjoyed learning, but felt teased by peers for wearing old, ill-fitting clothing. She participated in an acting program in high school, and connected with a mentor who supported her and exposed her to new and different cultural experiences. E1 felt blessed by this opportunity, and felt that it broadened her world view. E1 also participated in cheerleading and track, spending much of her time involved in extra-curricular activities or working with her mentor. Her mother never attended track meets or cheer events in support of her daughter, and although she now apologizes to her

daughter for not supporting her, E1 feels the sting of her mother's rejection. E1 graduated from high school, and although she wanted to attend a traditional brick-and-mortar university, she opted for a more affordable on-line university that allowed her to work while pursuing her education.

After graduating with a degree in business management, E1 sought employment. She befriended her job developer, and they eventually started a relationship. E1 was able to assist him in recognizing his former partner was lying about the paternity of his "children" from that prior relationship, which was later confirmed via a paternity test. Their relationship blossomed, and they now share three sons, ages 7, 5, and 3 years old. Although they are not married, they have been working hard to remain as a family unit in spite of their financial and employment struggles.

In 2010, E1 and her partner moved their family to Texas after her partner lost his job. They hoped for a change of scenery and fresh job opportunities. However, a dragging economy, non-existent public transit system, and limited job and entrepreneurial prospects forced the family to return to Michigan after only a year and a half. Upon returning to Detroit, the family doubled up with family members until they could locate affordable housing and gainful employment. E1 took a position through a temp agency working for a large, national bank, and secured housing in a newly built rental community. E1 received praise and accolades for her hard work, however as a temp employee, she was not granted time off or health benefits. She faced some minor health challenges, resulting in tremendous out of pocket expenses. Further, as a temp employee, she was quickly reminded that she was replaceable, and missed work would not be tolerated, regardless of the reason. E1 received a phone call one Friday night letting her

know that her position had been terminated. She is currently supporting her family on unemployment benefits while she and her husband focus on starting their own business. E1 was balancing a fine financial line, working to pay essential bills while delaying those that seemed less essential. This method worked for a couple of months until DTE issued a shut-off notice, and demanded full payment of all back expenses. With no savings to turn to, and having lost an expected tax return to past credit card mistakes, E1 and her family had insufficient funds to pay rent, resulting in an eviction notice.

E1 notes that she is the only one of her siblings who has been successful in life. Her siblings struggle to maintain jobs and relationships, often turning to her to ask for money, a ride, or a favor. E1 loves her siblings, but does not feel she can rely on them for support or assistance in return. The same can be said for her relationship with her mother—E1 knows she can talk to her, but conversations are now rather superficial, and she does not feel the closeness with her mother that she once enjoyed.

E1 is hopeful for the future. She is hopeful that her partner will find employment soon, and she intends to focus on launching her new business while she remains on unemployment benefits. Ideally, the business will be able to sustain the family once it is up and running. E1 has plans to build up her savings for both the family and the business. She would like to be able to purchase a second vehicle in order to allow for two working parents, and transportation for her children to a local charter school. Long term, she would like to build a home, and invest in the redevelopment of Detroit. She recognizes that she faces significant financial barriers, but believes that with hard work and financial planning, she can realize all of her dreams.

E1 felt this could have prevented her housing instability:

If she could have had assistance with her tax difficulties, she believes she would have had the funds to prevent this housing instability. She also is frustrated with a system (DHS) that waits until crisis to provide assistance, and provides more support to people who do not help themselves than to those who are working hard and are still struggling.

E1's Themes:

- Credit and tax troubles—uninformed decisions as a young woman came back to haunt her financially
- Women need to be strong—has watched the women around her suffer in bad relationships with men who did not support or respect them
- People are willing to take but can't give in return—family and friends turn to her constantly for support, but offer none in return.
- Frustrated by people who don't help themselves—sees people around her that don't work and don't want to work living without the same financial stress that she and her family are facing, and finds it unfair.
- Women need to take their time in relationships—don't jump in and start a family until you have stability in your life. E1 wishes she had waited to start a family, although she loves her children very much.

Participant F1 Story: Final Draft

Primary contributors to housing instability:

--“A daughter issue”: F1 identified that she gives her daughter more financial support than she can really afford to give, because she feels guilty about her history of not being able to care for her, and providing for her financially represents her efforts to repair their relationship.

--“A man issue”: has a man in her life who relies on her but doesn't provide her with any support in return.

--“Bills”: Utility bills are unaffordable, and prior attempt to work out a payment plan with DTE were unsuccessful.

F1's Story:

F1 is one of 4 children. The oldest of her two sisters and one brother, they grew up with their mother in Detroit. Her mom has always been a source of stability, support, and love; however her father was an alcoholic who bounced in and out of her life. F1 reports that although she never had a real relationship with him, she was close to his brother and mother, developing a loving relationship with her paternal grandmother. The rest of her father's family, however, was known to her and the neighborhood for their drinking and gambling. At the age of 12, F1 lost her father to violent crime, as he was stabbed to death in a local housing project while drinking and gambling with men from the neighborhood. Even without witnessing this violence, F1 notes this as a very difficult event in her life.

F1 felt that her mother provided her with everything she needed growing up. However, she also expressed that starting around age 15, she began making poor

decisions that would ultimately influence her future. At age 15, F1 discovered she was pregnant and had an abortion. By age 16, she was beginning to use alcohol and smoke weed, and hang out with “the wrong crowd.” In spite of this, F1 was able to graduate from high school and continue forward in her education, completing her training to be a medical assistant. However, at the age of 19 when she sought employment in her field, she was met by employers who only wanted to hire a person with prior experience working as a medical assistant. This frustrated her, and she gave up on her job hunt. In hind sight, she acknowledges that she should not have given up on the job hunt so easily, but as a 19 year old, it was hard for her to see the benefit of continuing the job search. From that point on, F1 struggled to find gainful employment. She bounced from job to job, continuing to use alcohol and weed intermittently. By her late 20s, she was introduced to a new drug of choice: crack cocaine.

F1 entered her 30s with a full-blown substance abuse disorder. At the age of 33, she became pregnant with her daughter, but continued to use throughout the pregnancy. Shortly after her daughter was born, she entered recovery, and remained drug-free for about a year. After another period of struggling with her substance abuse disorder, F1 entered rehab again, but her recovery was short-lived. By the time her daughter was 3 years old, F1’s mother realized F1 could no longer care for her daughter because of her illness, and F1’s mother took custody of her granddaughter behind a threat of child protective services involvement. Although losing custody of her daughter was painful, F1 feels that it was the right thing to do for her daughter, and believes that her mother has provided F1’s daughter with a loving, safe home. CPS did eventually get involved to

formalize the custody arrangement, but F1 has been able to maintain contact with her daughter over the years.

In spite of knowing that this custody arrangement was for the best, F1 has struggled to maintain a positive relationship with her mother. F1 feels that she has done her best to rebuild her life, maintaining her sobriety over the last 3 years and providing her mother and daughter with financial support whenever possible. Yet F1 believes that her mother dwells on her mistakes, refusing to let go of past mistakes. Now that her daughter is 16 years old and involved in sports and extra-curricular activities at school, F1 is receiving frequent phone calls from her mother complaining about all of the driving and activity she has to do to support F1's daughter. F1 feels terrible that she can't contribute more to her daughter's life, but with her current unemployment and lack of a vehicle, she feels she has little more to give. F1's daughter has now also begun calling her mother to ask for money for activities with like shopping or having her hair done. F1 admits that she usually breaks down and gives her daughter whatever money she has, even if it means she won't be able to pay rent or utility bills. F1 recognizes that this is largely due to her jealousy over the relationship between her mother and her daughter, and is hurt whenever her daughter is disrespectful toward her because of past mistakes. F1 feels that her daughter treats her more like a peer than a parent, and has noticed her daughter calling F1's mother "mom" as an act of defiance against F1. In spite of her struggles, F1 is working to heal her relationship with her daughter. She sends daily texts to her daughter to remind her of her love and support. F1 admits that her mother has done a good job of raising her daughter and keeping her focused on school and church. F1 and her mother encourage F1's daughter to plan for college.

Adding to her current burden, F1 identifies a significant other as a financial and emotional drain without contributing to her well-being. As a young adult, F1 did not settle into a long-term relationship with a significant other, instead passing through a series of relationships. She recognizes that her current relationship is, “not good.” She speaks negatively about her appearance, and feels that if she ends her current relationship, she may end up alone.

When asked what she sees for the future, F1 first focuses on her daughter. She is certain her daughter will be successful in college, and notes that her daughter will be spending a week visiting a college campus over the summer to get a feel for the college experience. She is very encouraged at the thought of her daughter having a better life than she gave herself. She believes that most of the challenges she faced were brought on by her own decisions. She is also hopeful that she will be able to move into a better apartment by the time her daughter graduates, so that she can have a place that her daughter would be happy to visit. As it is, her daughter does not like to visit F1 in her apartment. F1 also hopes for a better relationship with a significant other who actually cares for her. She is currently receiving disability benefits, and doesn't anticipate returning to the job hunt in the foreseeable future, but is hopeful that budgeting classes provided by a CHS affiliate will help her get financially back on track.

Any interventions that could have prevented housing instability?

F1 feels that many of the poor choices that she made led to her current circumstances, and cannot think of any potential interventions that might have prevented her housing instability.

Themes:

--Trauma and violence: even without directly witnessing the murder of her father, she was affected by his loss.

--Bad choices: F1 believes that her own bad choices led her where she is today. She knows she can't change the past, but recognizes that each poor life choice led to the next.

--Substance abuse disorders: not only has F1 struggled with crack addiction, but she watched as her father and much of his family chose alcohol & gambling at the risk of their health and well-being.

--Guilt over broken relationships: wants to "make up" for past mistakes with daughter, even at the risk of putting herself in deeper debt

--Jealousy & betrayal: feels hurt & jealous about daughter's relationship with her mother—it's the relationship she wishes she had with her daughter

--giving more than she has: F1 financially and emotionally supports her significant other and her daughter even though she gets little support, respect, or affection from them in return. This has put F1 in a deeper financial hole.

--unforgiven: F1 feels that her family can't forgive her past mistakes, holds them over her head, and brings them back up at regular intervals. She feels like even when she succeeds in some aspect of her life, her family can't see it because they keep reliving her failures.

Participant G1: Final draft

Primary factor contributing to housing instability:

- Failing health—has had unstable angina for past 15 years, back pain, and diabetes-- can no longer work.
- Failing health is because she didn't take care of herself the way she feels she should have—too busy working and caring for her family, sometimes working in unhealthy work environments just to bring home a paycheck

G1's Story:

G1 is the oldest of 6 children, born to a mother who was 13 years old at the time of her birth. She was raised primarily by her grandparents, without having a relationship with her father. As she grew, she found she naturally filled the role of “mother hen” with her siblings, looking after them and often acting as a surrogate mother, while interacting with her mother as a sister rather than a daughter. G1 identifies her family home as a loving place, but remembers having been molested as a child. Overall G1 feels she had a good childhood, surrounded by cousins, siblings, and loving family.

G1 finished high school and immediately started a family of her own. She married at the age of 18, and became pregnant with her first child. While he was a “good provider” for the family, he was constantly cheating on G1 with other women and manifested his shame in physical violence against G1—G1's husband beat her on a routine basis. She explained away the injuries to her friends, including broken noses and jaw fractures, by claiming she was victim to her own clumsiness. When friends became suspicious, he learned to hide his violence, striking her on the torso rather than the face or arms so her clothing could hide the bruises. The abuse was severe: G1's husband once kicked her so hard in the stomach she miscarried a pregnancy. G1 tolerated the abuse for three years, recognizing now that she was unsure what it meant to be loved by a man at

that young age. The final straw came when her then-3-year-old daughter walked in on a physical attack, grabbed a broom, and started beating her father to stop him from beating G1. G1 struck her husband hard enough to send him to the hospital, and he never returned to her home.

G1 attempted to rebuild her life after her first failed marriage. She worked as a contracted medical assistant for several automotive companies in the Detroit area, often working 2 and 3 jobs at a time. She was in and out of relationships with other “knuckleheads”—often, the men in her life looked to her for financial and emotional support. G1 returned to school to be a medical assistant, and eventually found herself in another long term relationship, engaged to the father of her 3rd child. Their relationship was rocky, with the fiancé often cheating on G1, leading to arguments, typically ending in the fiancé threatening to kill himself if G1 left him. In fact, G1’s fiancé once attempted suicide by taking a bottle full of pills after an argument with G1, and another time he sat on the freeway wall, threatening to throw himself into traffic. G1 felt that she had to stay with her fiancé to protect him, and because he was good to her children.

About a month after the birth of her 3rd child and a week before they were planning to get married, G1 experienced a very traumatic event—her fiancé shot himself in front of her. She believes his fatal shot was an accident--G1 said he was holding a gun on his lap removing bullets, and he squeezed the trigger, fatally shooting himself in the abdomen. At the funeral, G1 was confronted by several women who identified themselves as her fiancé’s girlfriend, inflicting fresh pain. G1 was traumatized, unable to sleep or eat for 6 months, blamed by her fiancé’s family for his death. G1 finally sought counseling in order to move forward with her life. Counseling helped her not only come

to terms with her fiancé's death, but also aided her in recognizing the trauma of her past molestation and violent first marriage.

G1 reports having always felt like an outsider. A tomboy growing up, she preferred climbing trees and digging for worms with her male cousins to playing dolls with the girls. This sense of being different continued into her adulthood, and G1 found herself without close friends. G1 preferred going to work and trying to move out of the housing projects to hanging out and partying with friends, which alienated her from her peers and led to name-calling and vandalism against her. She continues to stay close to her family, but does not have additional social support from friends. She finds herself carrying the emotional and financial burden in intimate relationships, ultimately reinforcing her distrust of others and choice to keep to herself. In spite of feeling like an outsider, G1 is quick to offer assistance to anyone in need. She has always opened her door to the friends of her children, offering a meal or a safe place for them to gather. She has always felt like the provider in her family, and is really struggling to accept how her health status has impacted this ability.

As an adult raising her own five children (ages 35, 28, 24, 21, and 16), G1 continued to serve as a surrogate parent to her siblings. This made the loss of her sister a few years ago particularly painful. G1's sister contracted HIV from a high school boyfriend, and unaware of her status, lived a care-free teenage life. As a young adult, G1's sister was in a car that fell victim to a violent gun battle, killing several of her closest friends while she escaped without injury. This turned G1's sister's life upside down, and she spiraled out of control, numbing her pain with drugs and prostituting to support her drug habit. G1's sister eventually learned of her ex-boyfriend's HIV status

and discovered her own HIV status. G1 stepped in to support her sister, feeding her and taking her to doctor's appointments. In spite of her best efforts, G1's sister passed away not long after they discovered her illness, again up-ending G1's world. This time however, G1 was able to find some blessing in the loss, recognizing God's promise of peace for her sister.

Approximately 15 years ago, at the age of 39, the stress of G1's hard-working, hard-caring lifestyle finally caught up with her and she began experiencing episodes of unstable angina. Not long after the initial diagnosis, G1 developed congestive heart failure and further testing revealed a congenital heart anomaly that was likely contributing to her illness, as well as COPD (in spite of not having been a smoker). She attempted to return to work, but after 3 separate episodes of angina on the job, her employer felt they could no longer risk allowing her in the work place. Depressed and physically exhausted, G1 found herself turning to comfort food and a sedentary life style. She gained weight, was diagnosed with type 2 diabetes, and developed knee and back pain. G1 decided to increase her physical activity by walking around the neighborhood, but after she collapsed in the street and was left by passers-by for hours, her daughter decided that her mom was no longer safe living without supervision. G1 gave up her home and moved herself and her 16 year old son into a home beside her 35 year old daughter and grandchildren. While G1 appreciates the loving support shown by her children, she feels that she is now treated as a child by her own children.

When asked what the future holds for her, G1 is positive that she has much more to offer to her family and her community. In the past, G1 was able to aid her older neighbors in preparing their taxes as an act of kindness. She aided so many people that

the IRS has informed her that she needs a tax preparers ID in order to continue performing this task. G1 is currently seeking coursework to round out her skill set as a tax preparer, and hopes to continue to offer her services free or at minimal cost to older residents in assisted living and retirement homes. G1 is viewed by her children and their friends as the neighborhood mom, providing structure, rules, and love to all who enter her home. She wants her kids to continue to work toward better lives for themselves and their families.

G1 felt this could have prevented her housing instability:

When asked, G1 has difficulty identifying a single event or circumstance that could have altered her future. She did note that if she had heard from another woman who was struggling with her relationships and housing, she believes she might have heeded that cautionary tale and not made those same mistakes in her own life. At the same time, she recognizes that her trust was broken so early that she probably would not have taken a stranger at her word.

During the 2nd interview, G1 stated that she felt that the people offering her life advise didn't have stability in their own lives, so she always felt she could do at least as well as they had whether or not she took their advise. She believes that if she had role models or successful people offering her advise, she may have made different decisions.

G1's Themes

- Trauma and Violence
 - Childhood molestation—broke her trust and sense of safety at an early age

- Domestic violence—shaped her early relationships with men, and broke her ability to trust in an intimate partner relationship. Skewed her view of love, and set her up for more heartache.
- Suicide—was devastated by personal loss, guilt, and pain after her fiancé ended his life in front of her
- Homicide—watched her sister’s life implode after her friends were killed in a senseless act of violence
- Family is everything—G1 has spent her adult life sacrificing for her family in order to give them the things that they needed. She has filled the role of caretaker from a young age, and finds it difficult to be viewed as a car-recipient now.
- Work, work, work—G1 worked herself almost to death, developing respiratory and cardiac disease after working in an area where she knows she was exposed to industrial waste. She worked because her family needed her to work, but didn’t consider the toll it was taking on her body.
- On her Own—given G1’s past, she opening admits she struggles with trusting others, and is unlikely to turn to another person for support. Even in her current relationship with her significant other, she views him only as a companion, not a source of strength or support. She feels different than others around her, viewing herself as more driven and ambitious than any of her peers.
- God is her strength—G1 finds comfort and strength in her faith.
- Personal choice—G1 felt she is responsible for her own choices. She knows she made some poor choices in her past, and feels responsible for those mistakes.

Participant H1: Final draft

Primary Factors contributing to of housing instability:

--Loss of income

-self & daughter both lost income, putting them behind on bills, and they couldn't catch up

--Struggles with utilities

-DTE eliminated her payment plan when she was short \$0.95 on a bill, forcing her to pay \$2000 in order to have electricity restored.

-H1 was unaware of a broken toilet in the basement that ran continuously, increasing the water bill significantly. The landlord usually paid the water bill, so H1 had no concept of the cost of a water bill, and the big, unexpected expense made an already fragile financial situation impossible to stabilize.

H1's story:

H1 was taken into the care of her paternal grandmother at birth. She did not have a relationship with her biological mother (until she turned 17), but did occasionally see her father. At the age of 8, her grandmother passed away, and she and her adopted brother were taken into her uncle's home, where she was the youngest of 4 girls and 4 boys. She defines her uncle's home as loving, educated, and happy. Growing up in Detroit, the children in the neighborhood got along and played well together, making for a safe neighborhood. In spite of this, H1 felt like an outsider in her home. She knew she

wasn't a biological child of her "parents" and couldn't wait to grow up and start a family of her own.

H1 felt that she had opportunity to achieve and succeed within her childhood home. Although being the youngest was challenging as she watched her older siblings go out and gain independence, she reports that she was treated fairly, and given responsibilities appropriate to her age. H1 was able to graduate from high school and continue her education, pursuing a degree in cosmetology. She completed the program and began working in the field. H1 was involved in a long term relationship with the father of her children for approximately 10 years before it ended. She reports that there was no violence within the relationship, and it produced two children, a son (age 19) and a daughter (age 23).

While still involved in her long-term relationship, nearly 20 years ago, H1 was on her way to a nearby store, and was grabbed by an unknown assailant. She was taken hostage and held against her will in a building. She felt her life was in danger, and in trying to escape her captor, climbed out of a 3rd story window onto what she thought was a large ledge. The ledge was much more narrow than she expected, and she fell to the pavement, breaking her pelvis, arms, and legs, and receiving a significant closed head injury. She awoke in a local hospital days later and spent a full month recovering in the hospital before being transferred to a nursing home for months of rehabilitation. She continues to have hip and back pain, as well as severe headaches, and has unresolved mental health problems resulting from her closed head injury and the trauma of her

experience. She attempted to return to work but found it difficult to stand for long periods of time, her hands would cramp and ache when trying to cut or style hair, and she could no longer see clearly enough to provide the attention to detail her clients demanded.

Because of these injuries, H1 is no longer working or seeking employment within cosmetology. Rather, she is receiving permanent disability and is focused on managing challenges to her health. H1 reports that much of her current financial troubles are due to a mistake in paperwork, resulting in a delay of income. She otherwise feels that her financial challenges are manageable. H1's children and her grandchildren (her daughter's 2 young daughters) live with H1. H1 is the matriarch—she continues to provide for and protect her children. In fact, she feels that her daughter is unaware of how serious the current eviction notice is, because H1 has been shielding her daughter from their current housing instability. H1 doesn't like to reach out to her siblings or extended family for assistance. Although she feels emotionally close to them, she feels her circumstances would burden her family, and she feels that she has already burdened her family with the events in her life.

When asked about the positives in her life, H1 finds joy in spending time with her children and grandchildren, seeing the birth of her granddaughters, and going to church. She swelled with pride when she talked about her son's recent high school graduation, and his enlisting in the Navy. She is relieved that he is not going to have a life on the streets. She said, "Around here, it's the military, or the penitentiary." She prided herself on having raised two children who were not hustling or living life on the street. Her

greatest struggles are facing her current housing challenges and dealing with an eviction notice. Right now she is focused on surviving each day and keeping her family in housing. H1 hopes that in the future she will be able to move herself and her family to California to be closer to friends. She does not yet have a plan to make the move a reality.

H1 felt this could have prevented her housing instability:

“I didn’t really expect to get to this point—I thought I could work it out with the landlord...I just pray that I get back on track...I just want to get things smooth again.”

H1 established a payment plan with DTE , but after missing a paycheck, she was behind on a payment by only \$0.95. In order to have utilities turned back on, she had to pay not the \$0.95 from the payment plan, but the entire \$2000 in late payments she owed. H1 feels that the utility company was unreasonable, and set her back financially.

H1’s Themes:

- Family disruptions—although H1 was ultimately in a loving household, she was separated from her birth parents, and later faced the trauma of losing her grandmother
- I never thought this could happen to me—H1 was unprepared for the financial challenges she encountered.
- There’s no one else I can rely on—even with a large family for emotional support, H1 can’t ask for her siblings for the financial assistance she needs to turn her situation around without creating a burden for them.

- This is a short-term set-back—H1 believes that if she can get caught up on her rent, she can get back on track with her life.
- Trauma, chronic pain and disability—H1 was on track to build a good life for herself and her family before her abduction and injury. However, her trauma left permanent physical and emotional scars, leaving her on permanent disability, impeding her ability to progress financially/economically or within her chosen profession.

Participant I1: final draft

Primary Factors contributing to of housing instability:

- Was pregnant with 4th child—was working, but no paid maternity leave, so had only small amount of state assistance \$ coming in, so could not pay the bills. She's been at the same job for 13 years as a teacher's assistant—can't get unemployment over the summer because she always has off in the summer, and job is planning to cut back hours in the Fall because they can't afford to pay her full-time benefits

I1's story:

I1 grew up in a loving family home. She was the only child of her parents, and although her parents did not live together they were both involved in her life, and she spent most weekends with her father. I1's mother worked midnights, so while her mom was at work, I1 stayed with her grandparents. Not only did her grandparents provide safe, loving child care for her, but they also looked after I1's cousin, allowing I1 to develop a close relationship with her cousin. I1 remembers her childhood neighborhood as safe and friendly—a good place for her to play with neighbors who looked out for one and other. She denies violence in her childhood home, and feels she had a wonderful childhood. I1 enjoyed being an only child, and thus the center of her parents' world. At the same time, she regrets that her mother's work schedule meant they did not always get the quality time together she feels she would have wanted.

At the age of 16, I1 gave birth to her son. In order to ensure that parenthood didn't impede her education, I1's family stepped in to provide support and childcare. I1's mom made sure I1 continued to keep up with school work while she was at home with her newborn baby. Six weeks after the birth of her baby, I1 returned to the classroom

while her grandmother provided childcare to I1's young son. She also took on a job at a local store, working to provide for her son while she finished her education. This family effort aided I1 in graduating from high school on time, and continuing for further education. I1 pursued a degree in education, but switched to nursing, then back to education, and ultimately left school without a completed degree in order to enter the workforce. I1's family has continued to offer significant support, with her grandmother providing child care to both her son and her second-born child (a daughter), until I1's grandmother passed away 9 years ago. I1 was then able to rely on a good friend and her mother to care for her 3rd and 4th child while she worked.

Thirteen years ago, I1 started working as a teacher's assistant for a local school district. Although she worked hard, she was only permitted by her employer to work 35.5 hours per week in order to keep her below eligibility for full-time benefits. Summers have always been lean, with no paycheck and no unemployment benefits offered while school is not in session, but I1 has found temporary employment or tightened the family budget in order to make ends meet in the past. This year has been especially challenging, as I1 was out of work on unpaid maternity leave from October until January, forcing her to apply for state aid to try to make ends meet. State aid proved insufficient to cover the costs of rent and utilities, and I1 faces housing instability, while continuing to hunt for new employment. Although she would like to return to her old job again in the Fall, she is aware that new requirements for employer provision of healthcare benefits will result in her hours being cut back to no more than 29 hours a week, and she's not sure her family can absorb that financial blow. She is working with CHS's job developer to find stable employment.

I1 is the mother of four children, ages 7 months old, 4 years old, 11 years old, and 15 years old. She has a good relationship with their father, but he does not live in their household. I1 works hard to make sure the needs of her children are met. Her oldest children are attending summer school to keep busy, spend time with friends, and get out of the house while I1's mother helps watch the younger children. Although she worries about the safety of the neighborhood where the family lives, I1 makes sure her kids spend time outside in their backyard as often as possible.

I1 is working hard to stabilize her family's future. She is enrolling in school to study criminal justice, and hopes to work as a probation officer one day. She hopes that her son will continue studying hard and playing football, encouraging him to follow his dreams to play football into college and professional arenas. She wants success for her younger children as well, but does not yet know what dreams they will chase. She is realistic about the barriers she faces, recognizing that her finances are an ongoing challenge.

I1 felt this could have prevented her housing instability

Can't identify any intervention that would have changed her current situation. Is paid up a month ahead in her rent—even if she can't pay utilities right now, she knows she can keep a roof over her head.

At 2nd interview: Identified staying in school (college) as the thing that could have positively impacted her future.

I1's Themes:

- Family support—I1's family has been a constant source of support in her life, allowing her to graduate from high school on time and work to provide for her family.
- Hard work isn't always enough, but it's critical
 - Even working for the same school for 13 years hasn't ensured a stable paycheck.
 - However, I1 doesn't give up on her plan to invest in her future by going back to school.
- Sometimes you can't get ahead
 - I1 has been paying ahead on rent, and trying to pay down utility bills, but maternity leave and summer break have reduced her income so substantially that she has to seek assistance to get caught up in spite of her best efforts.
- Education
 - I1 sees education as key to building a better future
 - If she had completed her college education, she thinks she would have a career rather than live paycheck to paycheck.

Participant J1: first draft

Primary Factors contributing to of housing instability:

- Childhood home fell into disrepair—older sister stepped up and provided a home to J1’s mom & J1
 - J1’s mom had to work to maintain her new home, but had never worked in her life. Became a struggle to maintain housing.
- Broken relationship with mom
 - Mom allowed much younger boyfriend to move in with her—mom chose relationship with boyfriend over relationship with J1—J1 was kicked out
- “I’ve been going through it my whole life—no stability...”

J1’s story:

J1 was born the youngest of 5 children, living in a multigenerational family home with her mom, grandmother, great uncle, and two of her older siblings. Her two oldest siblings were 17 and 18 years older than J1, and had already moved out of the family home when she was born. Although he was not in the home, J1 would spend time with her father, and developed a relationship with him from a young age. J1’s grandmother and uncle worked hard to maintain the home, but eventually, J1’s grandmother became sick, and J1’s mother had to step into the role of caretaker for her mother and the family home. This proved a difficult task, and the house slowly fell into disrepair. J1’s grandmother passed away, and one by one, her older siblings and uncle left the house to follow their own life plans. The state of the house continued to decline, and as rain began leaking through the now failing roof, thieves stripped the house of essential plumbing and wiring. Lacking insurance because the house had been owned outright for many years, J1’s mother was unable to afford the needed repairs, and the house was condemned.

J1’s mother found herself at the mercy of her family, and was fortunate to be aided by one of her older children in securing a new place to live. However, J1’s mom also found that for the first time in her life, she had to work to pay the rent and bills—prior to this, her mother (J1’s grandmother), had paid the bills for her only surviving child. J1’s mother turned to boyfriends for stability, however that stability didn’t extend to the rest of the family. At the age of 14, J1’s mother invited her boyfriend to live with

them. Not long after, her mother's boyfriend attempted to molest J1. When she confronted her mother and told her of the boyfriend's behavior, J1's mother kicked her out of the home. J1 moved in with her older sister, but missed her neighborhood friends, and soon moved in with a friend and her friend's mother. J1 moved in and out of friend's home, trying to move in with her father but quickly fleeing after being physically assaulted by her father. Her father would periodically get drunk and beat up J1, usually begging forgiveness in the form of a large sum of cash, or the offer to buy her a car. J1 would move back in with him only to be assaulted again, and return to her friend's house. Her friend's mother had a substance abuse disorder, popping pills and providing minimal supervision of J1 and her friend. They went to school only when they wanted to, and J1 soon fell behind in school work, requiring her to repeat a year of school. Her friend became pregnant and was transferred to a school for pregnant teenagers. Wanting to remain with her friend, J1 received special permission to enroll with her friend, and graduated a year later than originally anticipated, along with her friend.. Eventually, her friend's mom began stealing from J1 to support her substance abuse disorder, and J1 had to move back in with her mother.

This pattern of unstable housing, moving from house to house, continued for several years, even into adulthood. J1 moving home until a new boyfriend would enter the scene and cause a disruption, ending in J1 again being kicked out of the family home. When J1 was pregnant with her son, five years ago. J1 was living with her mom, and her mom again invited a boyfriend to move in. This boyfriend was significantly younger than her mom, and J1 was suspicious of him early on in the relationship. Items began to disappear from around the house, but if J1 mentioned it, her mother would get upset. Shortly after J1 gave birth to her son, she returned from a doctor's appointment to discover that several baby gifts, including a new camera with pictures of J1's newborn's first days of life, and money she had received from friends and family for her baby, had been stolen from her room. J1 confronted her mom, but her mom chose to stay with her boyfriend. J1 was told in no uncertain terms that she was going to have to move out.

J1 remained in her mother's home as long as she could, but eventually developed a new relationship, and decided to move in with her boyfriend. However, J1's boyfriend had a short temper and was violent toward her. J1 soon found herself bouncing back and

forth between her mother's home and her boyfriend's home. Her boyfriend was always contrite after hitting her, and his family was loving and supportive of her, acting as the family J1 had always wanted, causing her to return for reconciliation. The final straw came when J1 was fleeing her boyfriend's home, only to get into a fight with her mother. Thinking an emergency shelter was better than returning to either house, she sought assistance at a local shelter. Unfortunately, she quickly discovered that the shelter was not the right place for her and her son--a bedbug infestation made sleeping a miserable experience, and J1 again returned to her mother's home. J1 spent months bouncing from house to house—sleeping on her mother's couch, at her sister's house, and at a friend's house. J1 recalls that her father would also jump in to lend a hand—purchasing a bed for her son, or helping J1 purchase a car—however, their relationship is full of ups and downs. The gifts her father provides are often in response to a prior bad act. For example, when J1 discovered that her recently purchased car was a lemon, her father offered to help confront the car dealer. Her father returned to tell her that the car dealer would have to be taken to court to get her money back. J1 later confronted the car dealer herself only to discover that he had indeed already refunded her money to J1's father. J1's father also housed J1 & her son for a short period of time, but was constantly confrontational with J1, and would constantly challenge her parenting decisions.

As J1 was dealing with on-going housing instability, she faced another major trauma. Approximately a year ago, the father of her son died suddenly in a motor vehicle crash. Although they were no longer in an intimate relationship, J1 had remained close to her son's dad, and turned to him for advice and emotional support. Not long afterwards, she received notice that she had qualified for section 8 housing. J1 saw this as a blessing, coming at a time when she was feeling alone and uncertain about the future.

In spite of all of the hardship she faced, J1 works hard to provide for herself and her son. J1 recalls working through high school to pay for the things she needed and to make her own way. She graduated from high school, and initially pursued an associate's degree to become a surgical tech. However, she was a few credits shy and work became the priority, forcing her to leave school temporarily. She has, and continues to, work numerous part time jobs to pay the bills, even as she is now attending school to become a dental assistant. J1 has big plans for her future. She is excelling in her coursework, and is

scheduled to graduate from school in a couple of weeks. She plans to find full time employment and once she has developed some stability in her life and housing, she wants to return to school to become a dental hygienist, and eventually, attend dental school to become a dentist. She is aware that she faces significant financial struggles, and worries about how she's going to make ends meet in the coming weeks and months. She recently lost her job, her father (who serves as her son's babysitter) is hospitalized with serious complications from diabetes, and the final weeks of her dental assistant program are looming. Although she is worried about what lies ahead, she is hopeful that school has opened doors for her.

J1 felt this could have prevented her housing instability

J1 had moved in with a very supportive friend while trying to locate safe Section 8 housing, however, J1 and her son had to move out when her power was turned off, and J1 had to move in with her father. J1 feels that this support person has been key in getting her back on her feet, keeping her in school, and inspiring her as a mother. In fact, J1 feels that this person is currently a part of her safety net, and knows that her friend would take her and her son back in if she lost her housing.

J1 feels like school has opened doors for her—people have offered her assistance because they saw her working hard, and she believes that others need to know the same can happen for them.

J1's Themes:

- Tenuous parental relationships—although J1 can now turn to her mom for assistance when she really needs it, and turns to her father when he's in better health, J1 has not been able to rely on her parents for continuous support or assistance.
 - Mother repeatedly chose boyfriends over daughter
 - Father undermines J1's authority with her son and has diverted money away from J1

- Never had a parent to push her to finish school, hold her responsible for reaching goals
- Trauma and abuse
 - J1 has experienced violence within her family home (primarily from mom's boyfriends) and within her intimate relationship, with her son witnessing her past violent relationship.
 - The loss of her son's father has added trauma onto an already challenging chapter in J1's life.
- No parental support/encouragement
 - Graduated a year behind and went to a school for pregnant girls because that's where her friend was.
- Hard work leads to reward
 - J1 has invested in herself, pursuing an education even when she didn't know how she was going to pay the bills. She found that her hard work has been recognized and rewarded by others around her, providing shelter and support when she needed it most.
- Living in uncertainty
 - J1 has been living in uncertainty for years—unstable housing has been a part of her life for over a decade. J1 has learned to be resourceful, seeking assistance from informal networks of family & friends, but also realizes those resources have a way of disappearing.
 - J1's father and primary babysitter for her son is currently hospitalized, facing tremendous health challenges. This forces J1 to consider his mortality, and the challenges that arise if she no longer has child care for her son.

Participant K1: final draft

Primary causes of housing instability:

- Was working full time as a CNA, but hours were cut back to part-time—could no longer afford rent/utilities.
- Applied for cash assistance when her hours were cut back, but took a full month to get a decision—fell behind in bills while waiting for cash assistance.

K1's Story:

K1 grew up in a loving family, with her mother, father, older brother, and grandparents. Although her parents were not living together, K1 notes that her father's house was right around the corner from her grandparents' & mother's home. She reports that her parents were, "the most fun parents in the world," and that her childhood was very happy. She grew up in Detroit, and remembers her relationship with her grandparents fondly, recalling that they spoiled her and her brother during her early childhood. The house was always full of aunts and uncles, with space and resources for the whole family.

K1's family structure changed after her grandmother was diagnosed with Alzheimer's disease. Her grandmother's progressive dementia was difficult for the family, and was a catalyst for K1 to pursue a job as a CNA providing care for adults with dementia. K1's mother had been so close to her mother, that she had chosen not to move out of her parent's home even after she had started a family with K1's father. It was not until K1's grandmother was unable to interact with her daughter in a meaningful way that K1, her mom, and her brother moved in with her father. However, that transition is remembered as, "peaches and cream" in K1's life.

K1 graduated from high school and immediately pursued training for her CNA. She found employment immediately after her certification, working for a friend of her mother's who ran a homecare company. Unfortunately, the home care company folded, and K1 had to seek new employment. Almost 5 years ago, she began working in an assisted living facility. K1 was working full time in her job, but when the facility lost almost half of its residents, K1's hours were reduced to part time, cutting her monthly income from \$1400-1600/month to \$400-500/month.

K1 is a single mother with two young children, receiving no significant support from the father of her babies. She has filed for child support, but that has not yet come through. She knows she is the primary provider for her kids, and works hard to give them the things they need. Fortunately, she is able to turn to her mother for child care, allowing K1 to work midnight shifts and know that her children are being cared for by a loving individual. K1 is close to her mother, and relies on her for childcare, and does receive occasional financial assistance from her parents.

This is not K1's first episode of housing instability. When she was on maternity leave with her first child, a little over 2 years ago, she had to take unpaid leave resulting in a need to seek emergency assistance to maintain housing. Once K1 had her son and returned to work, she felt she was establishing some stability but that stability disappeared when K1's hours were reduced to part-time and her application for cash assistance took over a month for a response. K1's finances were stretched to their limits, and she was unable to pay all of her monthly bills, forcing her to again seek emergency assistance to maintain her housing. K1 stated that Community & Home Supports was an outstanding resource, providing genuine care and assistance when she needed it most.

K1 is now in the process of getting back on her feet. The census at the assisted living facility where she works has increased, and her full time hours have been restored. K1 is hopeful that she will continue to increase her own housing stability by returning to school to complete a nursing degree, either as an LPN or an RN. She is currently looking at area nursing programs, and available financial resources to return to school. She is also hopeful that she will be able to buy a home and move out of her current apartment where she often hears arguing and fighting—this is not the environment where K1 wants to raise her children.

K1 feels this may have prevented her housing instability:

- Benefits for maternity or medical leave—employer provided no assistance when she was out on leave, and it set her back significantly.

K1's themes:

- Doing it all alone—although K1 gets support from her parents, she gets no support from the father of her kids, and feels that she is “it” when it comes to providing for her children
- Family ties—K1 feels close to her parents, and is able to turn to them for support and assistance.
- Education is the way up—K1 wants to further her education so that she can seek a more stable job with better income and benefits, in order to secure a brighter future for herself and her children.

Participant L1: final draft

Primary Factors contributing to housing instability:

- Employment: Having a history of interactions with the legal system has made it difficult for L1 to obtain and maintain employment. Had to withdraw from a nursing program because of history. Husband also recently lost his job.

L1's story:

L1 was born into a family household of six, the youngest of her parents' four children, although not the youngest of her father's eleven kids. Her household was marked by conflict, with her father hitting her mother, and L1's older siblings beating up on her. L1 learned to act out in physical ways from a young age, fighting with classmates and getting kicked out of school as early as Kindergarten. This pattern of behavior continued throughout L1's childhood and adolescence, leading to conflict with teachers, and being treated as a "bad kid" at school even when she was trying her best to be good.

When L1 was 8 years old, her parents divorced. L1 continued living with her mom while two of her older siblings moved in with dad, but her older sister continued to beat up L1 without any intervention from L1's mother. So, when L1 turned 12, she chose to move in with her father, his new wife, and her stepsister. However, L1's father's home proved not to be a safe-haven. When L1 would fight at school, her father would respond by fighting her at home rather than using other methods of discipline. This continued thorough much of L1's adolescent years, until she became pregnant at the age of 15. Pregnant and a few months shy of 16 years old, L1 moved back in with her mother. However, L1's mother was still bitter that her daughter had chosen to live with her abusive father, and would not speak to L1 until she was in the delivery room giving birth.

Between suspensions and expulsions for fighting and the challenges of motherhood, L1 struggled to complete high school. However, she was persistent, and in 2007, with two young children to raise, she earned her high school diploma. Just as L1 was starting to get her life on track, she encountered a massive set back. A 10 year old neighbor threw a basketball at L1's son one day hitting him in the head, and knocking him off of a porch, resulting in a bloody head injury for her then 2 year-old boy. Angered by the 10 year olds actions and lack of supervision, L1 spanked the child then called the child's grandmother to tell her what had happened. The grandmother called the child's mother, who gathered several of her friends to retaliate against L1. L1 and her sister were attacked by an angry mob, and L1 defended herself by stabbing 3 of her 15 attackers. L1 was arrested and charged with bodily harm, less than attempted murder. Although she did not have to go to jail, the charges made it very difficult to find employment. L1 learned from the experience, realizing that she had to get her temper in check, and find new ways to manage her anger.

In her efforts to rebuild her life L1 met a new man. The two are now married, and they share two children: a 2 year old daughter, and a 5 month old daughter. He is also involved in raising L1's 14 year old daughter and 8 year old son. Although this new relationship has added stability to L1's household, her 8 year old son has struggled to accept his new place in the family. Since the birth of L1's 2 year old, her son has started acting out at school and home, fighting with other kids, stealing things, and even trying to burn the house down. After a recent incident at school, a teacher told L1, "he [her 8 year old son] just needs a good whooping." L1 agreed, and spanked her son hard enough to leave a mark on him. He returned to school the next day and showed his classmates and

teachers the mark, prompting a CPS investigation. L1's son was removed from the home, and L1 attended parenting classes. Her son has since been returned to her home, and she feels like she has some new, productive ways of addressing his defiant, violent behavior. She also acknowledges that her son is acting much the same way she did at his age, and would like to change his behavior before it costs him his education.

Amid all of the challenges and changes in her life, L1 decided to return to school. Several months ago, she began a nursing program. Unfortunately, she was forced to withdraw from school when her criminal record was revealed prior to beginning the clinical portion of her program. In the meantime, her husband, who was the primary earner for the family, lost his job, resulting in an inability to pay the bills. L1 is hopeful that her family is back on track—her husband has regained fulltime employment, and she is now enrolled as a fulltime student studying to be an auto mechanic. L1 would like to find employment as a mechanic, and eventually develop the skills to be a mechanic working on trains. She knows the road ahead is full of challenges, but hopes that she is setting a good example for her children, and wants them to focus on completing their education.

L1 felt this could have prevented her housing instability:

- L1 wishes she had the guidance of a life coach or some other mentor to help her with anger management and decision making in her younger years.
- L1 wishes she would have received more support from her family of origin, rather than the hands-off approach they took to raising her.

L1's Themes:

- Violence and trauma:

- In her family of origin—was exposed to DV between her parents, beat up by older siblings, and eventually beaten up by her father. Violence was the standard interaction in her household
- Learned to respond with physical violence when threatened or frustrated—fights at school; physical altercation with neighbors, causing her to be arrested; CPS case when she physically punished her son
- Son is demonstrating same violent behaviors mom once expressed. L1 is trying to break the cycle for him
- Education is the key
 - Persisted at completing high school diploma
 - Trying to finish auto mechanic program
 - Wants to make sure her kids finish their educations
- Growing up on her own/missing stability
 - L1 had to fend for herself. Her parents, although they tried to provide for her, had a lot of other complications in their lives (violence, other children), leaving L1 moving back and forth between houses.
 - Teachers labeled her from an early age as a trouble maker, so L1 didn't get support at school. Instead, school became another battleground. L1 succeeded in graduating with her GED in spite of it, not because of it.

Participant M1: final draft

Primary causes of housing instability:

- Lost her job & was unable to pay the rent.
- Unable to complete BSN because of multiple experiences of trauma in her life—final event was the loss of a friend who had just visited her at college, and memories of having shared his last days in her dorm room were too painful.
- Other life tragedies—loss of friends (recently) adding to pain (cousin died in a car accident while sister was driving; in past week, 2 friends died suddenly –one in a car accident, one in a suicide).

M1's Story:

M1 started life in a household with both parents, the youngest of two daughters. The stability of home was short-lived for her, however, and at the age of 5, M1's parents divorced. M1 remained in a home with her mother and sister, and kept in contact with her father. M1's mother soon developed a relationship with a man who brought violence into their home. M1's mother's boyfriend was abusive "in every sense of the word" to M1, her sister, and her mother. M1 recalls that teachers and friends at school suspected things were not "ok" at home, and reached out to her, offering support and caring to M1 that they did not offer to other students. When M1's mother was able to end the relationship, the boyfriend began stalking & threatening M1's mother. M1's mother feared he would harm the family, and asked her brother to assist her in installing bars over their home's windows. The day her uncle came over to assist in securing their home, M1's mother's ex-boyfriend attacked, murdering M1's mother, her uncle, and then ending his own life. M1 was 11 at the time, and although she had a 16 year old sister, she was the first family

member contacted and informed of her mother's death. She was then given the burden of sharing the devastating news with the rest of her family.

After the loss of her mother, M1 moved in with her father and his fiancé. This living arrangement separated M1 from her sister, who had a different father, and had moved in with her maternal aunts. M1's aunts also wanted custody of M1, and a long and bitter custody battle began, resulting in M1 being estranged from most of her mother's family. M1's father eventually married his fiancé, and although life in her father's house was alright at first, an extreme personality conflict soon developed between M1 and her new step mom.

As a teenager, M1 did well in school, receiving good grades, working above grade-level, and excelling in swimming, softball, gymnastics, dance, and cheerleading. But life at home was anything but easy. M1's step mother had no biological children, and was uncomfortable and grossly unprepared for a teenager who had been through a violent, traumatic childhood, insisting she be called "mom," and picking fights with M1 at every opportunity. Complicating matters, her father was diagnosed with stage III colon cancer when M1 was 14. After some close calls where M1's father almost died, he went into remission although he later relapsed and again had to struggle to survive. During this time, M1 continued to clash with her step mom, resulting in her being kicked out of her father's house at the age of 16.

M1's sister took her into her home, providing a safe place to live although it was far from all of M1's friends, resources, and school. M1 had worked hard in pre-nursing courses, earning college credits before graduating from high school. In fact, M1 had progressed academically so far ahead of her peers that she had only an English class to

complete her senior year. Having relocated across town, M1 had to travel via city bus, taking three transfers and walking a full mile to reach her high school each day, only to attend for an hour-long class and make the return 3 hour trip to her sister's home.

After high school, M1 was accepted into a BSN program at a local university. She worked hard at her studies, hoping to become a nurse anesthetist. However, she felt she had to withdraw from school at the end of her freshman year after learning that her best friend, who had just come to visit and stayed in her dorm room for the weekend, had died suddenly. The memories she had of sharing his last days in her dorm room were too painful, and she needed physical distance from that space. Although she exited her BSN program, she continued to seek education and employment in the medical field, completing her medical assistant certification and working as a medical assistant.

M1 has faced housing instability throughout her teenage years. After leaving university, M1 moved in with her father but the relationship with her stepmom made that living situation unbearable. M1 moved in with a close friend until the two had a falling out, and she had to seek shelter from her sister. She shuffled between her sister's house and the homes of other friends, unable to return to her father's house because of a restraining order she had to seek against her step mother for harassing behavior. Eventually, M1 partnered up with a man, moved in with him, and became pregnant. She and her boyfriend ended up moving in with his family, and eventually were able to find their own home. However, the couple broke up, and M1 had to again seek housing from her father and his wife. That housing situation was short-lived, and M1 again moved in with her sister until she was able to save up enough money for an apartment for herself

and her son. M1's younger cousin also stays with her, and is one of the few family members M1 considers to be close.

M1's pregnancy was difficult, resulting in M1 being admitted to the hospital for 32 days to try to prevent a premature birth. Unfortunately, M1's best efforts did not prevent his early entry into the world, and she gave birth to a 2 pound baby boy at only 29 weeks gestation. Although he emerged crying and breathing on his own, M1's son faced a multitude of health challenges resulting in a 51 day hospital stay, a significant vision impairment, and severe asthma. Like his mother, he was--and continues to be--a fighter, now cruising around the house and interacting like a typical one-year old. M1 admits that in the process of celebrating her son's first birthday, she spent more money than she could truly afford—she was so excited that her son had survived his trying first year, she made a choice to celebrate in grand style. Unfortunately, M1 lost her job within weeks of her son's party, leaving her with no financial cushion to pay the bills or rent.

M1 self-identifies as a “daddy's girl”, and continues to turn to him for support in times of need. She also acknowledges that she has a good relationship with her grandmother and her sister., and feels like she has several good, close friends. In the past, she has turned to those friends for housing, but currently feels that there is no one she could turn to for shelter if she had an urgent need. She does get some support from her son's father, who spends time with M1's son every weekend. However, he does not currently contribute financially to his son's life.

In spite of a traumatic childhood, M1 is certain she has a bright future ahead. She plans to return to a local university in the winter of 2013 to continue her BSN and pursue a degree as a nurse anesthetist. She knows that she will again be eligible for federal

student loans after November, and although she worries about her finances and issues surrounding childcare, M1 knows she can continue to follow her dreams if she plans well. She also hopes that she can leave some of her painful past behind by relocating out of Michigan. She is confident, and acknowledges that she is not where she wants to be in life right now, but is hopeful that she has a solid plan for the future.

M1 feels this may have prevented her housing instability:

- M1 wishes she had solid mentorship as a teenager—someone to walk her through the process of applying to college, applying for financial aid, and give her guidance and support when she needed it most. M1 admits that she might not have been fully receptive to someone mentoring her, but thinks that if she had more stability, more direction for a teenage girl, she would have been able to create stability for her own life.
- Financial education—if there had been someone to help her with budgeting, paying bills, managing a checkbook, etc..., she would have been able to prevent her recent housing instability.

M1's themes:

- Violence, Trauma, & Loss—M1 has experienced more than her share of violence, trauma, & loss, losing her mother and uncle to domestic violence, being rejected by family members at odds with each other, and losing a best friend suddenly.
- Education—M1 values education and recognizes it as a means to a brighter future. She worked hard to complete high school, her freshman year of college, her CMA training, and has her eyes set on a career as an advanced practice nurse once she is able to return to school.

- Strength & Survivorship—M1 recognizes her own strength and value as a single mother and a woman. She has overcome devastating life events to move her life forward and create a future for herself and her son. She has always been viewed as the family pillar, putting on a brave face when confronted with adversity.
- All Alone—Although she has the intermittent support of her father, and can turn to some of her friends, her sister, and her cousin for help in a crisis, M1 carries the burden of raising her son and seeking resources on her own.
- Responsibility beyond her age—M1 was asked to be the strong one in the family even though she was the youngest child. She had to grow up quickly and make her own way from a young age.
- Motherhood—needs to provide for her son and he needs her stability.

Participant N1: final draft

Primary Factors contributing to housing instability:

- Health problems caused her to resign from her job—employer was relocating and could no longer accommodate her back problems in new facility. Tried to work in another job, but had several TIAs, and was not safe to work in factory job. Filed for disability, but not yet approved.
- Routine traffic stop led to arrest N1's arrest for a 20 year old warrant for consumer fraud. Husband had to use rent/utility money to bail her out.

N1's story

N1 was the oldest of four children, born to two parents struggling with alcoholism. N1's father was about 12 years older than her mother, and the house was anything but peaceful growing up. Her mom worked in a bar, and was thus alcohol was always available to her. N1 recalls that her mother was a mean drunk, often picking fights with her dad., and being verbally abusive to her children. Her dad, in turn, would respond with violence toward N1's mom and often acted as the protector of the children.

N1 had to grow up fast and face responsibilities far beyond her young age. By the time N1 was 9 years old, she was the primary caregiver for her 4 year-old, 15 month old, and newborn brothers. N1's grandmother would care for them while N1 was at school, but grandma left when N1 came home, turning over responsibility for the household to a 9 year old child. At 16, N1 was working to support her brothers and herself. In spite of this, N1 graduated from high school on time, and entered the workforce in earnest, working in a local factory. While working in a factory, she met her partner of 20 years (married for 9 years thus far). He encouraged her to return to school and seek a degree in

computer science. When she and her then-boyfriend discovered that her parents had abandoned her younger brothers, she and her husband took in the two youngest boys (the older boy was already living on his own), and raised them to adulthood. N1's parents remained together throughout her childhood, but ultimately divorced in 1992. N1 did not accept her parents' separation, leading to a reconciliation between her parents six months later. They remain together to this day, although N1 now wishes they had remained apart. She feels that her father could have built a happy life for himself if he had moved on from his relationship.

N1 has always functioned as the backbone of her family. She is used to being the provider and is struggling to seek and accept assistance from her friends and family. N1 has held down a variety of jobs, from factory work to paralegal, to administrative assistant, to management at an optical store. She blames herself for much of her family's current financial woes. A little over two years ago, N1's chronic lower back pain from degenerative lumbar disease led to the loss of her job—her employer had accommodated her disability by allowing her to sit in a chair intermittently while on the job. However, the company she worked for was relocated, and taken over by new management. The new management felt that they could no longer accommodate N1's disability, and she was released from employment. She has since struggled with an anxiety disorder, carpal tunnel, and recurrent TIAs, resulting in the need to take multiple medications including ones that impair her ability to operate equipment of any kind. N1 has attempted to work since losing her job, but suffers from dizzy spells and anxiety attacks at work, resulting in several trips to the emergency room, and employers uninterested in taking her on board as an employee. She has applied for disability income, but was denied.

Recently while N1 was driving to a potential new job, she was pulled over on a routine traffic stop in a neighboring County. When the police ran her license, they discovered a 20 year-old arrest warrant for retail fraud. N1 admits that she made a bad decision when she was 18, and followed the misdirection of an older woman. Although the warrant was from another county, and the other county wasn't interested in pursuing the warrant, N1 was arrested in the neighboring County, and her husband had to use all of their savings to bail her out of jail. This led to an eviction, and N1 began hunting for a new place to live and resources to pay the bills. She connected with CHS and had found a rental house. However, CHS could not assist her with rent at the time, because the rental home was in significant disrepair, and the landlord refused to make needed repairs. As N1 was searching for an acceptable rental home, the run-down rental property was burned down in an apparent arson.

N1 again found herself at the mercy of friends. She, her husband, and her 13 year old son were living from house to house, searching for stability. She now hopes that they have found a long-term housing solution. A woman offered to rent her family a home at a reasonable rate. While N1 is waiting for rental assistance, the landlady is allowing N1 and her family to sleep there rent-free. N1's son is also able to stay with an aunt and cousins now that school is out for the summer and he doesn't have to be at school each morning.

Although she lacks a close relationship with her mother, N1 feels like she's close to her father. She feels he was responsible for any good thing that happened in her childhood. Like her parents' relationship, N1 found a partner who is 10 years her senior. She acknowledges that she was looking for a relationship to mirror the relationship with

her father, even if her parents' marriage was extremely flawed. N1 sees that her parents' relationship has had a negative impact on herself and her siblings. She voiced that her brothers struggle with alcoholism, and admitted that her brother has been violent toward his girlfriend. She feels that this is a direct result of the abuse and neglect she and her siblings suffered at the hands of her parents, particularly her mother. N1 feels like she is still responsible for her brothers' care, even though they are technically adults. Her younger brother lived with her in the past year, and still looks to her for support when he's got nowhere else to go.

When N1 thinks about the future, she wishes for the opportunity to return to work, but fears that will never happen. She focuses on her son, and hopes that he will want for nothing. In fact, while N1 has pawned most of her own possessions including her own wedding ring in order to pay the bills, she refuses to consider selling any of his possessions. She has worked hard to provide him with a solid education, enrolling him in charter schools until two years ago when he had to enter the local public school because they could no longer afford to transport him across town to his school. N1 is waiting to hear a final decision regarding disability for herself and her husband (who needs a total knee replacement). She feels that her biggest roadblock is a lack of income, but is hopeful that disability will fill that income gap and get her family back on financial track.

N1 felt this could have prevented her housing instability

- Guidance as a teenager—if she hadn't been arrested as a teen, she feel like none of this would have happened—she became a distraction and a drain on her entire family.

- More stability in her family of origin—less responsibility at a young age and less abuse at home would have kept her from seeking guidance from the wrong kind of people.

N1's themes:

- Substance abuse
 - Both of N1's parents struggled with an alcohol abuse disorder, leading to N1 having to take responsibility for her siblings and the household at a very young age.
 - N1's brothers struggle with alcohol abuse as well
- Violent/abusive interpersonal relationships
 - N1's parents were physically violent with each other
 - N1's mother was very verbally abusive with N1 and her siblings, and continues to be verbally abusive to N1.
- High stress and hard work take a physical toll
 - N1 has worked hard providing for her family from a young age, resulting in chronic pain disorders and degenerative musculoskeletal disorders.
 - N1 struggles with an anxiety disorder that worsens physical symptoms making it impossible to complete any significant physical work.
- Responsibilities beyond her young age

- N1 had to take on the role of caretaker for her siblings and her household from a very young age. She feels she had to, “grow up too fast.”

Participant O1: final draft

Primary Factors contributing to housing instability:

- Apartment was flooded, so had to move. Found a new apartment, then lost job and couldn't afford to pay rent and move her furniture.
- Lost job—fell asleep at work after coming in on a day off for an extra shift (pregnant and overworked)
- No family to turn to for support or assistance.

O1's story

O1 is the oldest of seven siblings, born to a mother with a severe, long-term substance abuse disorder, and a father who was serving in the US military. Her maternal grandmother stepped in assumed care for O1. O1's parents had a second child together, also taken in by O1's grandmother. O1's grandmother struggled with an alcohol abuse disorder, often leaving O1 and her younger sibling with her 12 year old daughter (O1's aunt) while she went out to drink with her friends. One evening in the midst of making fried chicken, O1's grandmother had her daughter watch the children and finish making the fried chicken while she joined her friends across the street for a drink. O1's aunt, rather than finish the cooking, went outside to play with her friends. O1 & her sister were sleeping inside the house. While O1's aunt was playing with her friends, and O1's grandmother was out drinking, O1's father pulled up to the house to discover it was on fire. He rescued his daughters from the burning house, then went to confront O1's grandmother. The grandmother called her nephew to aid in defending her—he brought an AK-47, and shot O1's father to death. While O1 does not remember the incident, she knows that she witnessed the death of her father. Because of her father's prior military

service, O1 and her sister received survivor benefits, making them a source of income for the family.

O1 does not remember her childhood as an especially happy time—in fact, childhood taught O1 to function in survival mode. She remained in her grandmother's care until she was 14, but remembers her grandmother as violent toward her grandchildren, pitting O1 against her siblings, encouraging confrontation and fighting between the siblings. O1 also recalls a lack of stability in her housing as a child. Her grandmother received section 8 housing, and O1 recalls frequent moves from house to house, never staying in the same home or neighborhood for more than a couple of years at a time. At the age of 14, she moved in with her paternal aunt. While her aunt provided a safer environment than her grandmother, O1 was constantly reminded that she was little more than a source of income to her aunt.

O1 also contributed to the household by finding employment. Although her grandmother never worked or held down a job, O1 was expected to find and maintain employment from an early age. From the age of eleven, she began working odd jobs in order to contribute to the cost of her survival. During this period, she was sexually abused by a friend of the family, but did not feel that she could report the abuse to anyone in the family. By the age of 17, O1 moved out on her own and was working 2 jobs to support herself. In spite of all of this, O1 was able to graduate from high school on time, and was accepted in to a local college for a degree in business administration. O1 continued to work a series of jobs to support herself through and following her college coursework. While O1 was able to see the value in education and employment, she feels that she is at a distinct disadvantage from many of her peers, as she had so few role models in her life

who could demonstrate how to hold onto a job or housing long-term; transience was the norm in all aspects of her life.

As a young adult out on her own, O1 developed a relationship with a man she thought would make a good partner. She feels like he befriended her at a time when she felt especially vulnerable, as she was estranged from her family, and just beginning to deal with the sexual abuse she had encountered. She became pregnant with his child when she was 17, but her boyfriend soon revealed his true personality, and began hitting and beating on O1. She had to withdraw from school, as she grew tired of trying to explain her recurrent bruises and busted lips to classmates and co-workers at her work-study job. O1 remained in the relationship for 4 years. In 2006, when her ex-boyfriend pulled a gun on her, she fled to Atlanta, moving in with an uncle and his girlfriend. She initially had to leave her son in Detroit with her friend who is the godmother of her child, but returned for him in a month and brought him to Atlanta with her. None of her family was willing to take in her son while she fled from her boyfriend. While in Atlanta, O1 was able to get a job, start school, and purchase a car but her uncle's girlfriend considered her a drain on the household, and kicked her out two months later. O1 returned to Detroit, but remained away from the father of her son; he does not provide financially, emotionally, or physically for his child. O1 does remain in contact with her ex-boyfriend's mother, however, and she is currently caring for O1's 9 year old son out of state so that O1 can focus on finishing her education. This childcare arrangement, although very difficult for O1, has been the only financially feasible childcare option for O1, as her family insists on being paid for childcare, even when O1 doesn't have enough

income to cover rent and utilities—there’s no such thing as a free act of kindness or support in her family.

After returning to Detroit, O1 worked a series of minimum wage jobs in fast food and retail. In 2008, she felt called to pursue a career in nursing. She connected with the Michigan Works program and was able to receive her CNA training and certification free of charge, and gathered information on available LPN courses in her area. After working as a CNA for a couple of years, O1 decided to return to school to complete LPR training. She has encountered multiple roadblocks en route to completing her LPN training, and has had to take academic leave multiple times.

Housing instability has been an on-going significant roadblock to O1’s success in school and life. Her childhood was marked by transience, moving from house to house with her grandmother for a multitude of reasons, including a house fire. As a young adult, she faced her first eviction not long after her abusive ex-boyfriend went to jail, and she took in a friend who was facing housing instability. The friend took advantage of O1, partying and bringing unruly guests to the apartment while O1 was at work, resulting in an order of eviction. From there, O1 moved in with her boyfriend’s mother, but when he came out of jail, he returned to his mother’s home and continued to be violent toward O1.

O1 spent long periods of time bouncing from house to house until she was able to secure her own apartment. When she returned to Detroit from Atlanta, she moved in temporarily with her aunt until she could secure an apartment. She finally found an affordable place to live with a roommate who happened to be a friend of her aunt. O1 and her aunt’s friend each paid their own half of the rent directly to the landlord. While this arrangement worked for almost two years, her aunt’s friend eventually stopped paying

rent and O1 again faced eviction. She moved in with a friend until she could again locate an affordable apartment.

O1 moved into her new apartment and felt like she had finally found stability—she was there for almost two years, had paid her rent on time each month, and was caught up on utilities. Unfortunately, her landlord allowed the property to go into foreclosure, owing over \$17,000 in unpaid taxes, and O1 again lost her housing. At the time, O1 moved in with a boyfriend she had a relationship with for the prior two years. She thought he had his life together—he had been working in the auto industry, living in the same apartment for as long as she had known him. O1 moved into his apartment but soon found out that things were not as stable as he pretended. O1 took over payment of the household bills, and soon discovered that her boyfriend had been bought out of his job, and had spent all of the buy-out money. In return for paying the bills, O1's boyfriend would watch her son while she was at work. This arrangement worked out for about 18 months, until O1 walked into the apartment and discovered her boyfriend with another woman. Upset and angry, O1 was kicked out of the apartment by her boyfriend and she had to seek emergency housing at a shelter. The shelter proved a short-term solution, as although O1 was working, she had no physical proof of her employment, and was evicted from the shelter, forced to live in her car for a week with her young son.

In 2011, O1 found an apartment and with support from a local assistance program, established housing while she was enrolling in her nursing program. She stayed in that apartment for a year, but became concerned about her safety there when her apartment was burglarized. She found a new apartment in a safer location, but could not afford both the apartment and childcare while attending school and working, prompting

her to make the difficult decision to send her son to live with his paternal grandmother out of state until she could finish school. In February, O1 discovered that she was pregnant with her second child. She also realized that her current relationship was not healthy, and that her boyfriend would not be a good influence on her new baby, thus she decided to end their relationship. This prompted an angry response from her boyfriend, who is now denying his paternity, and tells her things like, “I hope that baby dies in your arms.” She knows he will not have a role in the life of her second child.

In March, the apartment where O1 lived flooded with water reaching a depth of over a foot. Although the water receded, the apartment was uninhabitable, as mold and mildew took over the living space. At nearly the same time, O1 informed her employer that she was pregnant, and provided a doctor’s note requesting that she be placed on “light-duty” and not lift patients over 25 lbs. Her employer responded by removed her from the schedule for 2 weeks. O1 scrambled to find both a new apartment and a new doctor who would provide her with permission to return to regular duty so her hours could be reinstated. She obtained both a new doctor’s note and a new apartment in short order. However, O1 now faced the expense of moving and missing 2 weeks of pay. In order to catch up on her bills, O1 started picking up extra shifts while moving into her new home. Exhausted by the physical demands of her job, moving, and her pregnancy, O1 fell asleep while at work one evening, and was fired. Once again facing tremendous financial strain, she sought assistance from DHS and CHS, and took a leave of absence from school. Although both DHS and CHS came through with financial assistance, and O1 was able to pick up a part-time job as a nursing assistant, her landlord informed her

that he was not willing to accept her late payment, and she would have to again find new housing. This has forced O1 to move back into an emergency shelter.

O1 is currently looking for subsidized housing, planning for the return of her older son and the birth of a new son this fall. She anticipates returning to school in February of 2014, with a goal of graduating in May of 2014. She longs for a time when she earns enough from a single job that she won't have to take on 2-3 jobs at a time, and can spend time at home with her boys. She believes that completing her education will make stability a reality for her and her children, and longs for daily dinners together with her boys, providing the loving home environment that she never received. She is also hopeful that she can leave Detroit and build a life for her children away from her family of origin. She realizes that childcare will likely remain a challenge for her, but is hopeful that a stable job will provide a brighter future.

O1 felt this could have prevented her housing instability

- O1 feels like the adults in her family split O1 from her siblings, encouraging division and competition, and encouraging fighting. She feels that led to her siblings being distant and unsupportive of each other. She wants to be family oriented, but doesn't feel it's possible with her family of origin.
- O1 wishes that she had someone to teach her about managing her bills—she knows she struggles with prioritizing her expenses, and needs to know how to navigate life's expenses.

O1's themes

- All Alone—

- no support from her family of origin (unless she pays them) or the fathers of her children
- couldn't talk about the sexual abuse she had encountered, and felt estranged from her family and vulnerable.
- Education is essential—O1 knows that if she can complete her education, she can find more stable employment and build a better life for herself and her family
- Nothing more than a paycheck to them—O1 feels like she is viewed as a source of income by her family and they don't value her as a person
- Trauma & Violence—
 - has had to deal with physical abuse from people who were supposed to love and protect her, including her grandmother and the father of her oldest child.
 - Her family also encouraged violence between O1 and her siblings growing up, which led to fractured familial relationships.
 - Witnessed the death of her father, and although she doesn't remember the event, she knows he died because he was protecting her. Thus, she not only lost her father in a very violent manner, but also lost the one person who was offering her protection.
- Transience and instability—there has been very little stability offered to O1 in any aspect of her life.
 - She moved frequently as a child, with new siblings periodically being introduced into her life.

- Family took her in but shuffled her between households when she became a “burden” to them.
- O1 worked hard to create her own life, but intimate relationships proved hard to maintain, as the men in her life brought violence.
- Jobs have been low paying with little room for advancement, so O1 has had to change employers rather than progress within a company.

Participant P1: final draft

Primary Factors contributing to housing instability:

- P1 feels that she has never had a reliable support system in her life—she has only ever been able to rely on her grandmother, and has been asked to give (physically and financially) to her family since childhood with no support in return.
- P1 had to take on responsibilities far beyond her age as a child, including the care and upbringing of 6 of her young cousins.

P1's story:

P1 had a very challenging start to life—her mother died during childbirth, and P1 and her older brother were taken in by their maternal grandmother. P1's father was not a part of her life, and in fact, she did not meet him face-to-face until she was 13. Their grandmother was loving and provided the best she could for the children growing up. She taught P1 to take care of friends and family, always putting the needs of others before herself. P1 put these lessons into practice early in life, helping to manage the household from a young age. Unfortunately, P1's family was no stranger to violence and trauma. P1's grandmother, aunt, and uncle not only had to deal with the loss of P1's mother at a young age, but P1's aunt's oldest daughter died very suddenly in a shooting at the age of 13, starting a downward spiral of pain and grief in P1's aunt's life. P1's uncle was also (and remains) incarcerated for a violent crime the family is certain he did not commit.

By age 8, P1 was routinely providing care to her cousins. P1's aunt developed a significant substance abuse disorder, prompting her to leave her six children in the care of P1's grandmother. P1's grandmother, grieving over the loss of her daughter and overwhelmed with responsibilities to her grandchildren, began using alcohol to escape

her pain. As the oldest female child in the house, P1 was then called upon to step up and provide care to her cousins while her aunt would disappear for days at a time. By the age of 12, P1's aunt had completely abandoned her children, leaving P1 and her grandmother as their primary caregivers. Finding housing for a family of 9 was no easy task, and P1 had to enter the work force as a young teenager in order to help pay the rent for houses large enough to accommodate the large family. P1 also witnessed routine violence toward her grandmother, often at the hands of other family members with substance abuse disorders (in particular, to crack cocaine) who were angry that her grandmother would not share P1's & her brother's SSI funds with them. At the age of 13, P1 was told she needed to go see her father—he was dying of liver cirrhosis at the age of 45, and wanted to spend time with his children. P1 recalls that the first time she met him, he demanded that she cook for him. She felt no particular fondness or love toward him, but did learn that he had wanted to be a part of her life although her mother's family did not her father to be involved in P1's life.

When asked about her childhood, P1 speaks positively about her grandmother and some childhood friends, but recalls growing up in some rough neighborhoods. As a young girl, she remembers walking to a local fast food restaurant with her cousins and a neighbor. On their way home, the girls were assaulted by some young men from the neighborhood. The young men beat the two oldest girls on the bare bottom with a two by four until their skin was raw and bleeding, making P1 and another young neighbor watch. P1 remembers being upset by the event, but recalls it as just one of many episodes of violence in her neighborhood.

Given adult responsibilities beyond her age, P1 began making choices beyond her age. At the age of 15, P1 gave birth to her first child. Although she was now directly responsible for the care of 7 children, P1 remained in high school. However when P1 was called upon to contribute financially to her family, P1 found she had to drop out of school. At the age of 18, P1 went out with friends to celebrate her birthday at an after-hours club in Detroit. While there, a fight from the previous day between the club owner and a customer re-ignited, ending in a violent shoot out that cost several people their lives, and resulted in P1 taking a bullet to the jaw. P1 remembers the bloody aftermath of the shootout—walking through the area of dead and injured to get out of the club to safety.

P1 recovered from the shooting, and continued to move forward with her life. By the age of 20, P1 gave birth to her second child. Unfortunately, P1's son had a traumatic birth requiring resuscitation in the delivery room, resulting in a brain injury. This meant that at the age of 20, P1 had 8 children to care for, six of whom were dealing with abandonment of their mother and the death of their oldest sister, three of which had special needs.

In spite of this, P1 was able to find employers who understood her family responsibilities. She took on a job at a pawn shop, and was able to maintain fulltime employment for 6 years at that location. She was also able to take on a job at a childcare facility and maintain employment for 3 years. However, by the age of 25, P1 had developed addictions to alcohol and gambling. When she was able to emerge from her alcohol addiction, she would find herself compulsively gambling or shopping. She

realizes that these behaviors have impacted her older daughter significantly, and she feels that her daughter has become “hardened” toward her.

As P1’s cousins grew older, they began to take out their frustrations and feelings of abandonment on P1. P1 feels that they wanted her to serve as their surrogate mother, and would become violent with her to act out their anger toward their birth mother. P1 recalls being beaten repeatedly by her male cousins, her half brother, and eventually her older brother. The beatings were often so violent that they resulted in broken teeth and busted lips for P1. She also experienced a traumatic sexual assault. P1 got to know her half brother’s mother, and learned that her birth father was a violent man, often beating, abusing, and abandoning the women and children in his life.

In spite of the violence enacted upon her, P1 continued to serve as the family caregiver. She gave birth to two more children (now ages 9 and 7) before settling into a relationship with a man she thought would serve as a source of love and stability to her and her children. Her boyfriend was initially very charming and affectionate, and P1 had known him since her childhood. Early in their relationship, he would encourage P1 to dress up and wear her hair in a particular style. However, these “affectionate” requests soon shifted to controlling demands, and P1’s boyfriend became an abusive partner. P1 gave birth to 3 children (ages 4, 2, and 1), fathered by this man. P1’s grandmother continued to share a house with the family, and offered what emotional support she could to P1. However, her health was in decline, and she could do little to help P1. P1 also began to realize that her oldest daughter was beginning to demonstrate some of the same behaviors she had enacted as a young woman, and realized she needed to set a new

example for her children. P1 began to focus on her sobriety, and has been working on controlling her drinking, gambling, and shopping ever since.

Approximately 3 months ago, P1 faced the final straw in her relationship. Her partner packed P1 and her youngest children into his car, drove them across town, and abandoned them in a dark alley at 11 o'clock at night. With nowhere to turn, P1 entered a domestic violence shelter. She was unable to bring her 15 year old son into the shelter, and had to work out an arrangement with his paternal grandmother to keep him while she attempted to straighten out her housing situation. P1's grandmother was also unable to enter the shelter with P1 and instead had to move in with her substance-abusing daughter. Unable to meet her mother's medical needs, P1's aunt admitted P1's grandmother to a county nursing home, where she has since fallen several times, injuring herself. P1 has been unable to communicate with her grandmother since the most recent hospital admission, and fears for the health and well-being of the one family member who showed her love. She is heartbroken at not being able to see the person she considers to be her mother.

P1 has recently moved into a new home with her 5 youngest children. While she was grateful to receive a voucher for a stove and refrigerator from a local charity, she has no furniture and fears she will not be able to make her house a comfortable home for her children for a long time. Her family will provide no assistance, and P1 spent her last few dollars having the stove and fridge moved to her house. In the process of moving her appliances, P1's phone was stolen during a fight between the movers and some friends of theirs. She worries about how the family will eat, how she will get her stove connected to

gas, how she will find her grandmother, and how she will meet the basic needs of her family.

P1 has plans to return to school and get her GED, then continue on to complete her CNA training. P1 has attempted to enroll in classes in the past, but has hit multiple roadblocks. The female cousins she helped to raise have offered to provide childcare in order to enable P1 to return to school but are unreliable, often canceling on P1 at the last minute. P1 also feels that she gives to her relatives without expectation of a returned favor. However when she is in a bind and has to ask a family member for assistance, she is left repeatedly being called upon to return the favor in excess of the favor provided to her. She believes that her family mistakes her kindness for weakness, and tries to take advantage of her at every opportunity. These repeated disappointments and continued lack of support have prompted P1 to cut all ties with her relative (with the exception of her grandmother). She feels that her family is unwilling to offer even the most basic gesture of support, and now realizes that she cannot include them in her future life plans.

P1 is very insightful about her past relationships. She feel that she received an extraordinary amount of love from her grandmother, but many of the relationships she has tried to form have been with people who chronically lack love in their life. She sees abuses enacted toward her as expressions of self-loathing by her abusers. She is now working to keep those toxic individuals out of her life, and has turned to her religion and church family to try to begin new, healthier relationships.

As she looks to the future, P1 is focused on her children and herself. She is determined to complete her education and create stability for her family. She is hopeful that she will be able to work as a CNA, and eventually return to school in order to open

an adult foster care (AFC) home. She feels that she is not where she needs to be in her life right now, but is very proud of her ability to survive and persevere. She wants to give her children a real childhood, where they are not burdened with responsibilities beyond their ages. She is focused on the happiness she finds in her life, especially from her children.

P1 felt this could have prevented her housing instability

- Felt she was sabotaging herself, forming relationships with people who were violent and hurtful toward her. If she would have had counseling/understanding of how to say “no” to people who were bringing her down, she may have prevented her housing instability
- Mentoring or guidance from other women who could have told her how to keep violent men out of her life.

P1’s themes

- Trauma and loss
 - Loss of her mother
 - Loss of her cousin to gun violence/aunt developing substance abuse disorder
 - Uncle sent to prison
 - Separated from her grandmother and no one will tell her where she is
- Violence
 - Abuse from cousins, brothers
 - Sexual assault
 - Relationship with violent, controlling man

- Witnessed violence toward her grandmother by family members with substance abuse disorders
- Responsibility beyond her years/no childhood
 - Had to care for cousins from a young age
- Giving more than she receives
 - Like her grandmother, P1 gives to family and friends even when she can't afford to give (financially, emotionally, or physically)
 - Is expected to be the family support person, but receives no support in return
 - Has trouble saying no to family/friends in need
 - Is always the last priority in her family—had to give up her own education in order to raise her cousins and her child.
- Education as a way forward
 - Plans to return to school to complete her education
 - Values education for herself and her children
- Children are everything
 - Mother chose P1's life over her own—P1 honors that by putting her children first in her life
 - Looks to kids as a source of happiness
 - Puts care of her kids over employment, other obligations.

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