

Examining How the Environment and Trauma Contribute to Mental Illness in Homeless  
Populations

Lindsay Marie Banks Matthews, B.A.

[Lbanks3@mail.csuchico.edu](mailto:Lbanks3@mail.csuchico.edu)

California State University, Chico

### Abstract

This study examined housing insecure individuals' pathways to developing mental health issues. Fifteen semi structured interviews were conducted with residents of a transitional housing facility (n = 4) and unsheltered individuals (n = 11) identified by a community liaison. Participants were screened for having ever experienced mental health issues. This study used two methods of analysis: 1) analytic induction and 2) content coding. Analytic induction builds the framework for theory development (Creswell, 2007), so it was utilized to construct assertions surrounding housing insecure individuals' pathways to mental health issues. Two assertions were composed: 1) participants described their relationships with others as having an effect on their mental health in both beneficial (i.e. from supportive relationships) and harmful ways (i.e. from marginalization, isolation etc.), and 2) participants often described their mental health as being associated with trauma (i.e. being in war, being assaulted, untimely death of a loved one, etc.) and/or abuse (i.e. physical, sexual, emotional, neglect, etc.). Furthermore, in keeping with a strengths-based approach (Rappaport, 1995; Thomas, Grey, & McGinty, 2012), this study used content coding to identify resources and coping mechanisms that housing insecure individuals identified as beneficial. Four strategies emerged: 1) therapy, 2) therapy with medication, 3) meditation, and 4) distraction.

*Keywords:* Homelessness, mental health, distraction, meditation, therapy

Examining How the Environment and Trauma Contribute to Mental Illness in Homeless  
Populations

*“Like an earthquake, the homeless situation is a state of emergency in California”*  
(Anyon, 2018, para. 2).

One only has to look in the newspaper or walk down the streets of any major city in America to know that homelessness is a problem. The link between homelessness and mental illness is a prominent theme within the academic literature (Aubry et al., 2016; Fazel, Khosla, Doll, & Geddes, 2008; Greenberg & Rosenheck, 2010; Pearson, Montgomery, & Locke, 2009; Rosenheck, et al., 2002; Shern et al., 2000; Stefancic & Tsemberis, 2007). It is often presumed that mental health issues precede homelessness; however, recent findings indicate diverse pathways between those who developed mental health issues prior to homelessness and those who developed mental health issues after becoming homeless (Johnson & Chamberlain, 2011; Wong & Piliavin, 2001). This study attempts to highlight homeless individuals’ personal narratives surrounding their development of mental health issues. This study employed a strengths-based narrative approach by collaborating with homeless individuals to define and explore their mental health in relation to housing insecurity and other life course milestones (Rappaport, 1995; Thomas, Grey, & McGinty, 2012). As Rappaport (1995), a prominent community psychologist, notes:

*Much of this work requires privileging the voices of the people studied. This tends to be a methodology that is consistent with the empowerment of people because in addition to the content discovered, the metacommunications that follow from listening to and giving respect to the stories of people’s lives tends in itself to be an experience that changes the role relationship from researcher and subject to coparticipants (p. 801).*

For the purpose of this study, participants reported on what life events contributed to the development of their mental health issues and how both they themselves and their social networks responded to this development. This particular qualitative approach was utilized to

empower participants as they were able to define their own circumstances (Rappaport, 1995). It is critical for prevention researchers to understand the thought processes that homeless individuals engage in surrounding seeking support, in order for preventative resources and efforts can be allocated toward these domains. Thus, it is the objective of this paper to inform future prevention and intervention efforts.

This paper begins by reviewing the existing literature on 1) the demographic trends of homeless individuals, 2) mental illness within the homeless population, 3) prevalent barriers homeless individuals and individuals with mental health issues face when trying to seek help, and 4) prior intervention and prevention strategies; this paper also illuminates areas that need to be further addressed. Next, this paper highlights major qualitative themes through semi-structured interviews with homeless individuals (n = 15). Results highlight pathways to mental health issues and challenges among sheltered and unsheltered homeless individuals. Lastly, implications and future research are discussed.

## **Literature Review**

### **Demographics**

Homeless populations are diverse. There are many different sub-groups of homeless individuals. People experience homelessness differently, and one's unique account should not be marginalized by unwarranted generalizations of an entire population. As Paradis (2000) notes: *"...psychologists have called for research that is explicit in its support for the interests of marginalized individuals and communities...and to ensure that research promotes the interests of marginalized groups"* (pg. 841).

Single adults, unaccompanied youth, and families all experience homelessness (Henry, Watt, Rosenthal, & Shivji, 2016). In 2016, only 68.9% of homeless people were older than 24 years old (Henry, et al., 2016). In regards to race, about half of all homeless people in 2016 were white (48.3 %), with African Americans the second most prevalent group (39.1%), followed by Latinx/Hispanic individuals (22.1%). Notably, African Americans were five times more likely to be homeless than the general population (Fargo et. al., 2012). Research indicates that being African American is one of the most prevalent sociodemographic characteristics linked to homelessness (Greenberg & Rosenheck, 2010). This high prevalence of homelessness within the African American community can be traced back to a long history of intergenerational economic disparity, along with institutional segregation and oppression (Alexander, 2010; Desmond, 2017).

Prior research indicates that both veteran status and LGBTQ+ identification are also significant predictors of homelessness (Corliss et al., 2011; Fargo, et. al, 2012). This prevalence can be expected due to the disproportionate amount of trauma each group experiences (Alessi, 2013; Applewhite, 1997; Corliss et al., 2011; Johnson & Chamberlain, 2011; Read, Perry, Moskowitz, & Connolly, 2001; Russell, 2009). In sum, homeless populations are diverse just like any other group of people. This study is interested in the subcategory of homeless individuals who have mental health challenges.

### **Mental Illness**

Mental illness is defined as a disorder or illness once the symptoms are distressful and disrupt daily function (Colman, 2009). Individuals with mental illness make up about 20-30% of the homeless population (Johnson & Chamberlain, 2011; National Coalition for the Homeless, 2009). It is important to note, however, that the relationship between homelessness and mental

illness is spurious, and further exploration is needed to tease out patterns of causality (Johnson & Chamberlain, 2011).

For instance, Johnson and Chamberlain (2011) conducted a study in Australia, evaluating the stereotype that most homeless people are mentally ill and that mental illness contributes to homelessness. Notably, only about 31% of the homeless population that the research team sampled were mentally ill, with roughly an even split between those that developed mental health issues before becoming homeless and those that develop mental health issues after becoming homeless. For those that were mentally ill *prior* to becoming homeless (i.e. 15%), the largest predictor of them becoming homeless was the withdrawal of familial support (i.e. stopping communication, removing individuals from family home, etc.; Johnson & Chamberlain, 2011). Moreover, based on the qualitative data, Johnson and Chamberlain (2011) concluded that 16% of homeless individuals experienced mental illness *after* becoming homeless. Specifically, these individuals developed mental health challenges as a result of isolation and lack of social support in addition to the uncertainty of housing, income, and overall stability. Alternatively, for others, mental illness developed from engaging in substance abuse, which is a behavior often co-occurring with individuals experiencing housing insecurity (Johnson & Chamberlain, 2011). For instance, Johnson & Chamberlain (2011) found that 78% of the individuals who developed a mental illness after becoming homeless were aged 12 to 24, and 63% had comorbid substance abuse issues. Substance abuse may require different treatment methods for homeless populations in comparison to housed populations as substance abuse may be a coping strategy for homeless individuals to navigate their current environments (i.e. relational bonding, and self-medication; Johnson & Chamberlain, 2011; Martins, 2008). The research on homeless culture and the

prevalence of substance abuse and its effects are limited. While substance abuse can often co-occur with self-medication behaviors (Martins, 2008), it is not the focus of this paper.

### **Barriers**

Both homeless and mentally ill individuals experience discrimination and stigmatization across multiple environments. For example, people diagnosed with a mental illness are less likely to be hired than those without a mental illness or those with the same psychiatric difficulties that have gone undiagnosed (Overton & Medina, 2008). They are also paid less than those without a diagnosis (Overton & Medina, 2008). Furthermore, individuals with a mental illness tend to withdraw from social and occupational settings to avoid judgment, which overtime can result in a decrease in their functioning within those settings (Overton & Medina, 2008). Research highlights the importance of integrating into the workforce and expanding social networks to feel a sense of purpose and decrease loneliness, which can also mitigate the effects of psychiatric symptoms for people with mental health issues (Granerud & Severinsson, 2006; Kloos & Townley, 2010). Therefore, it can be extrapolated that withdrawal from occupational settings can increase feelings of loneliness, as well as decrease an individuals' perceptions of self-worth, which may cumulatively heighten one's psychiatric symptoms.

In regard to treatment, homeless individuals described being treated poorly when they sought medical care (Martins, 2008). Examples of poor treatment include being prematurely discharged, receiving minimal treatment to merely keep individuals alive, being treated with disrespect, receiving experimental treatments, and undergoing long wait times when accessing services (Martins, 2008). For instance, one participant in Martins' (2008) study stated, "*They don't treat you like you're a human being. On the ward I was on, the workers treat you like you're stupid*" (p. 428). In their review of the existing literature, Overton and Medina (2008)

identified the following factors as key contributors to diminished feelings of self-efficacy and self-esteem among individuals with mental health issues: 1) how society discusses mentally ill people, 2) mentally ill people's lack of "loving" relationships (i.e. familial, romantic), and 3) their lack of autonomy. In regard to prevention efforts, lowered self-efficacy and self-esteem may arguably prevent individuals from seeking needed help and resources.

In efforts to end homelessness and its effect on society, governments create laws such as the sit-lie ordinance, which are aimed to "clean up" the homeless problem (Wilking, et al., 2017). The sit-lie ordinance specifically prohibits "individuals to sit or lie in public sidewalks, curbs or streets adjacent to commercial properties" (Wilking, et al., 2017, pg. 3). This law and others place regulations into effect such as banning loitering or the placement of personal property in public spaces or next to commercial properties (Romney, 2010; Rosenberger, 2014; Wilking, et al., 2017; Ybarra, 1996). Notably, the National Law Center on Homelessness and Poverty's report found with the creation of more laws, there is justification for significantly more arrests, which facilitates a revolving door for homeless populations within the criminal justice system (as cited in Wilking, et al., 2017). These laws perpetuate societal messages that homeless individuals are the cause of uncleanly public spaces and are exhibiting criminal behavior, which furthers societal stigma surrounding homeless individuals (Harter, et al., 2005; Wilking, et al., 2017). In sum, the literature indicates that being labeled as "mentally ill" or "homeless" is associated with decreased pay, lower rates of employment, limited treatment, lack of support, and a higher chance of a criminal record.

### **Prior Intervention Efforts**

Next, this paper will outline the current literature on prevention and intervention efforts for homelessness and individuals who are suffering from mental health challenges. First,

literature on housing interventions and homeless prevention will be discussed and then interventions for mental health issues.

Housing First focuses on autonomy and integration of homeless individuals into apartment complexes that are shared with individuals from diverse socioeconomic backgrounds (Stefancic & Tsemberis, 2007). Housing First approaches have the most robust empirical evidence supporting the effectiveness of securing long-term housing (Aubry, et al., 2016; Brown, Vaclavik, Watson, & Wilka, 2017; Stefancic & Tsemberis, 2007). In an analysis of one Housing First program, around 70% of participants still maintained permanent housing after four years (Stefancic & Tsemberis, 2007). One of the trademarks of Housing First is that these programs don't require sobriety (Stefancic & Tsemberis, 2007). Researchers have argued that drug rehabilitation should be part of individuals' treatments rather than a precursor to other interventions (Pearson, et al., 2009; Stefancic & Tsemberis, 2007; Tsemberis, Gulcur, Nakae, 2004). Housing First encompasses programs that intervene in homelessness (i.e. Rapid Re-Housing) as well as programs that assist before an episode of homelessness (i.e. paying off medical bills, etc.) in order to prevent it (i.e. Homeless Prevention) (Brown, et al., 2017). Family housing builds on the Housing First approach; however, because children are involved, sobriety is often required (Fischer, 2000). Findings indicated that family housing is effective in helping women gain employment, housing, and access to government assistance (Bassuk, Huntington, Amey, Lampereur, 2006; Fischer, 2000).

In regard to mental health, common treatments for serious mental health issues include psychotherapy and psychotropic medications (Cadenhead et al., 2010). Interestingly, education of both patient and parent, as well as the being a part of the Caucasian race, increased one's likelihood to have taken psychotropic medications, alluding to the accessibility being limited to

more privileged populations. Fortunately, the Housing First approach has also shown to be effective in treating serious mental illness (Aubry, et al., 2016; Stefancic & Tsemberis, 2007). Participants of Housing First have shown a decrease in psychiatric symptoms and days spent in psychiatric hospitals (Aubry, et al., 2016; Stefanic & Tcemberis, 2007). Interestingly, a Canadian study found that mental health improved more in the control group than the experimental group (i.e. whom received free housing; Aubry, et al., 2016). Aubry and colleagues (2016) postulate this difference in findings from Canada to the United States may be due to Canada's policy of universal medical and mental health care policies compared to America's predominantly private sector system (Aubry, et al., 2016).

In sum, this review highlights the diversity amongst housing insecure individuals as well as the complex relationship between mental health and homelessness. Notably, common treatments for mental health (i.e. psychotherapy and pharmaceuticals) are not always available to underprivileged groups. However, housing interventions (i.e. Housing First) have been shown effective in stabilizing housing as well as addressing mental health issues for individuals who have access to these services.

### **Study Introduction**

This study uses a strengths-based approach, elevating homeless individuals' lived experiences to identify what factors they themselves believed contributed to their mental health issues as well as their reasoning for why they did or did not seek help. Furthermore, the study illuminates the participants' complex histories and highlights prominent shared conditions and experiences that contribute to poor mental health. Researchers interviewed mentally ill homeless individuals who were either unsheltered or residents of a transitional housing shelter. The research objective was to identify the pathways in which homeless individuals developed mental

health issues, as well as how they defined and sought help, especially during the initial onset of their mental health symptoms.

### **Research Questions**

The purpose of this study was to answer: 1) What are the experiences of individuals with mental health issues who are currently experiencing housing insecurity? And 2) What strategies and supports do housing insecure individuals utilize in addressing their mental health issues?

## **Methods**

### **Sample**

Participants were either residents of a transitional housing program in northern California or unsheltered homeless individuals who were identified through a community liaison. All participants self-identified as having experienced mental health issues at some point in their lives. The inclusion of both sheltered and unsheltered homeless individuals broadens the results to encompass narratives of both individuals who have been successful in seeking help in securing housing and those who either selected not to seek housing help or were relatively unsuccessful in obtaining or maintaining access to housing services. Through analyzing both groups' narratives, this study can highlight different thought processes surrounding obtaining housing (i.e. did the unsheltered group experience more barriers to housing, did the sheltered group have more social support, etc.).

Community-based research emphasizes the importance of soliciting personal narratives to further understand a social issue and identify strategies towards social change (Miller & Shinn, 2005; Rappaport, 1995). It is crucial to understand this population's thought process to adequately interpret what they need, what is already helping them, as well as what barriers they

encounter (Miller & Shinn, 2005). Notably, once the needs and barriers of a population are addressed, current services can be evaluated and improved upon. Furthermore, new services can be implemented where a need is currently not being met.

Participants were screened for 1) having ever experienced mental health issues and 2) being presently emotionally and mentally stable enough to handle the interview process. Both populations were sampled from a rural environment with a poverty rate of 21.9%, compared to a national average of 14.7% (Data USA, 2015).

Prior quantitative survey data from both a transitional housing facility and a sample of unsheltered individuals experiencing homelessness were utilized to provide contextual demographic information (see Figure 1). Surveys were collected by trained researchers. The first was a survey of the residents from the transitional housing facility as part of a program evaluation. The second was a random sample of housing insecure individuals in the downtown area (see Table 1). This data was collected, de-identified, and approved by an Institutional Review Board at a Regional Hospital and an Institutional Review Board at California State University, Chico, respectively.

Individuals from the sheltered sample were on average 31.61 years old with a range of 18 to 56. The majority of participants identified as female (71.8%) and almost half (44.7%) of the sample had been diagnosed with a mental illness. Eighty six percent of the sample supplemented their income with government assistance and 23.6% obtained money from earned wages. Comparatively, individuals from the unsheltered sample were predominantly between the ages of 25 to 34 (25.9%) and 45 to 54 (24.7%), and the majority identified as male (61.6%). Only 7.0% identified mental illness as a barrier in obtaining services; however, the 2017 Point in Time survey (PIT) indicated that 78.5% of unsheltered homeless individuals in the state were severely

mentally ill (HUD, 2017). Notably, fewer individuals from the unsheltered sample had income from government assistance (15.2%) or wages (11.3%).

### **Procedure**

There were two settings in which semi-structured interviews were conducted. In the first, participants were recruited from a transitional housing facility in northern California. Interviews were conducted in private rooms. In the second setting, participants were identified by a community liaison around a rural city in northern California. These interviews were conducted outside; however, great effort was made to relocate participants to a more private area. In both settings, either staff or the community liaison assisted in screening for individuals identified (professionally or on their own) as having mental health challenges. To reduce risk of causing any additional stress to the population, shelter staff and the community liaison also assessed who was emotionally and mentally stable enough to handle the interview process. IRB approval was obtained for both samples.

The interview protocol consisted of 13 open ended questions. It solicited participants' narratives of their development of mental health challenges and how they sought support or accessed resources during that time period. For example, "*At what age do you think you started developing mental health challenges?*" and, "*If you are comfortable sharing, describe any obstacles that stood in your way for getting treatment,*" and "*Did you reach out to anyone when you started noticing that you were struggling?*" Audio recording devices were used to gather initial data. Audio recordings were transcribed, de-identified and quality checked.

### **Analysis**

Analytic induction was used to analyze the data (Robinson, 1951). Analytic induction is a

method for analyzing qualitative data that results in developing credible statement(s) regarding phenomenon(s) exhibited within the data (Creswell, 2007; Robinson, 1951). Analytic induction is a process of revising claims or *assertions* about a phenomenon until each assertion is true throughout all cases of the data and can be used to generate an initial theory concerning the phenomenon. The lead researcher first developed an initial set of assertions about the phenomenon being studied. Then, alongside a team (her advisor and a trained research assistant), she checked each qualitative transcript for refuting evidence that disproved the assertion. If negative cases were identified that refuted or challenged the assertion, the assertion was revised until it accurately represented interviewees experiences (Greeson & Campbell, 2011; Robinson, 1951).

To illustrate the process, a researcher may start with the assertion, “*Homeless individuals often experience instances of marginalization from the housed population.*” Then, after reviewing multiple transcripts, the research team may discover that these experiences are only described when participants are living on the streets, not while couch surfing or while living in other settings (i.e. shelters, with friends, etc.). Therefore, the assertion would be revised to state, “*Homeless individuals living on the street often experience instances of marginalization from the housed population.*” This statement would then be checked across interviews and revised until it is reflective of all cases. Qualitative researchers stress that thematic results and narratives emerging across 33% (or more) interviewees fit the criterion for salience (Creswell, 2007).

Notably, there have been several studies analyzing the experiences of both homeless individuals (Bukowski & Buetow, 2010; Martins, 2008; Zugazaga, 2004) and individuals with mental health issues (Granerud & Severinsson, 2006; Kloos & Townley, 2010; Townley, Kloos, & Wright, 2009); however, this study is the first to employ analytic induction. Although analytic

induction does not end in a theory itself, it lays the groundwork for grounded theory, which does generate theory (Creswell, 2007). Studies using other approaches (i.e. photovoice, phenomenological, surveys, etc.) have highlighted themes regarding individuals' experiences or relationships between different phenomenon/variables. This study aims to expand and build off of prior literature by generating assertions that can be used as a conceptual framework in guiding future theoretical building and testing.

Lastly, content coding was used to identify which resources and coping strategies this population finds most useful. Notably, qualitative themes are deemed salient when they have reached 33% saturation as well as when expressing novel ideas in the hopes to inspire further analysis (Creswell, 2007).

### **Integrity of Findings**

Quantitative data is tested for its reliability and validity. These measures have become standards by which to evaluate the quality of data. It is just as important to judge qualitative data by standards of how reliable and valid the data is. However, due to the inherent differences between qualitative and quantitative data, researchers have found it imperative to define and use new measures to evaluate the accuracy or credibility of qualitative data (Creswell, 2007).

Creswell (2007) discusses different terms that qualitative researchers have developed to measure the credibility of their work. For example, the research team used "consensual validation," which is the agreement between "competent others" that the analysis is accurate (Creswell, 2007, p. 204). Consensual validation was achieved by having weekly meetings with a team of two "competent others" to discuss how assertions fit with the data, as well as consulting a senior qualitative researcher as an external auditor. In team meetings, coders would discuss

how the quote fit an assertion or deliberate as to whether the assertion needed to be changed to better reflect the quote.

Additionally, the research team actively sought “construct validation,” which is defined as “recognizing the constructs that exist rather than imposing theories/constructs on informants or the context” (Creswell, 2007, p. 204). Qualitative researchers recognize that one’s positionality is important to articulate when doing research so that one is aware of and reflective of their personal viewpoints or leanings (Langhout, 2015). In qualitative research, this is known as an interpretive orientation, and is used to explore how one’s own biases, culture, and background shapes one’s interpretation of results (Creswell, 2007). Therefore, in the analysis process, our team actively referenced our positionalities and checked one another when our biases influenced our assessment of the data. For example, the lead researcher held a clinical standpoint that therapy was the best method to treat mental health issues. Because of this bias, she repeatedly analyzed the data as in favor of therapy when the quote didn’t explicitly convey those sentiments. The rest of the team, knowing her positionality, would then refute her analysis and have her check her implicit biases to examine where her biases had had an effect on her conclusions. Thus, the research team’s active reassessment of individual team members’ positionalities and of the credibility of their conclusions as a team ensured construct validation (Creswell, 2007).

Creswell (2007) identifies eight additional validation strategies, or techniques, that he recommends qualitative researchers use at least two of per study. The current study used three of the proposed strategies: 1) negative case analysis, 2) member checking, and 3) triangulation.

The first strategy, negative case analysis, is inherent to analytic induction. It posits, “The

researcher refines working hypotheses as the inquiry advances in light of negating or disconfirming evidence” (Creswell, 2007, p. 208). The method of analytic induction already “revises initial hypotheses until all cases fit,” therefore, analytic induction uses negative case analysis intrinsically (Creswell, 2007, p. 208).

The second strategy, member checking, refers to sharing findings back with participants to make sure they accurately encompass the participants’ narratives. Aggregate data was shared back with experts on this population (i.e. community member working with this population, and members of the population) to discuss themes, and to ensure that data was reflective of this population’s experiences. Two member check sessions were conducted. In the first session, the research team gave a presentation to a community organization that works with housing insecure individuals. This organization often advocates for housing insecure individuals and is active in the development of new housing interventions. The presentation consisted of an open conversation about the data (i.e. presenting assertions and illustrative quotes). Presentation slides were printed out as PDF documents and shared with community members. During the second member check session, the research team met with housing insecure individuals at a short-term shelter. Participants were preselected by the shelter staff. Five small group discussions were conducted with participants to assess their thoughts on the results. During both of these reporting sessions, participants were asked to share their thought process concerning how best to use the data gathered to benefit others facing housing insecurity and mental health challenges. This is a participatory approach for qualitative data that empowers participants to be a part of the research process (Guba & Lincoln 1982; Guba & Lincoln 1994; Kornbluh, 2015; Lincoln & Guba 1985). Extensive field notes were taken after each member check session, and were referred back to in the analysis. The corroborating evidence from both of the member check sessions will be shared

in the results section.

The third strategy, triangulation, refers to using “multiple and different sources, methods, investigators, and theories to provide corroborating evidence...to shed light on a theme or perspective (Creswell, 2007, p. 208). Triangulation was utilized in the data collection process: 1) Qualitative interviews, and 2) ethnographic field notes during member check sessions.

### **Theoretical Framework**

This study applied an ecological framework to analyze the qualitative results (Bronfenbrenner, 1977). An ecological lens was used to analyze participants’ narratives in terms of 1) the individuals’ relationships with their “changing immediate environments,” 2) how they are “affected by relations obtain[ed] within and between these immediate settings, and 3) the larger social contexts... in which the settings are embedded” (Bronfenbrenner, 1977, p. 513). The ecological environment has four levels. The first level, the *microsystem*, refers to an individual’s immediate settings (i.e. home, school, etc.) and their relationships with the people involved (i.e. mom, dad, teacher, etc.). The second level, the *mesosystem*, refers to “the interrelations among major settings containing the developing person...” (i.e. interactions between family and school, etc.) (Bronfenbrenner, 1977, p. 515). The next level, the *exosystem*, refers to the social structures that affect the individual’s immediate settings (i.e. laws, rules, mass media, government, etc.). The final level, the *macrosystem*, refers to the culture, ideologies, and customs that contain and create all of the other levels. The qualitative results illustrate how different forms of relationships and interactions relate to mental health. The next section will discuss these relationships in terms of their respective ecological levels.

## Qualitative Results

### Assertions

Through the application of analytic induction, six initial assertions were tested against the data, resulting in two unrefuted assertions. The first assertion states that *participants described their relationships with others as having an effect on their mental health in both beneficial (i.e. from supportive relationships) and harmful ways (i.e. from marginalization, isolation etc.)*. The second assertion states that *participants often described their mental health as being associated with trauma (i.e. being in war, being assaulted, untimely death of a loved one, etc.) and/or abuse (i.e. physical, sexual, emotional, neglect, etc.)*. Both assertions describe relational connections with others and will be discussed using an ecological lens (Bronfenbrenner, 1977; See Figure 2 and 3).

### Assertion 1: Relationships

Participants discussed the connection they felt between supportive relationships and their positive mental health. In contrast, they discussed the connection between experiences of isolation and marginalization in relation to negative mental health symptoms. Narratives across interviewees highlight that relationships could be dyadic, group, or community-based. This assertion was exhibited in 6 out of the 15 interviews.

*Microsystems.* Out of the six, four interviewees described their immediate relationships as having an effect on their mental health. Notably, participants discussed their support networks in positive ways. For example, when Jess<sup>1</sup> was asked if the new relationships she had built at the transitional housing facility has had any effect on her mental health, she responded, “*I believe*

---

<sup>1</sup> Pseudonyms were used to preserve confidentiality.

*that they've improved my mental health.*" Jess had developed one particularly close relationship at the transitional housing facility. In this relationship, Jess and another shelter resident supported each other by spending time in each other's apartments and doing housework together. The significance of intrapersonal relationships at the dyadic level was corroborated by a member check session with individuals residing at a short-term shelter; 100% of the individuals in one of the member check sessions (n = 3) agreed that having friends improves one's mental health (L.M. field note March 29, 2019).

Participants also discussed their relationships in terms of groups and communities. For instance, Quinn discussed how being surrounded by individuals who have had similar life experiences (i.e. motherhood, navigating child protective services, housing insecurity, etc.) within the transitional housing facility improved her mental health:

*I've learned that I'm not alone, that I'm ok, that I'm not the only one, you know, that... That's a, that's big right there... as far as mental health goes [pause] I learned that [pause] it's ok [pause] and I learned and gained skills and the knowledge, and the wisdom [pause] on how to [pause] get better... Get better and that I'm gonna get through it and I, and especially with a support system and community and people here too, that's so important and I feel it's so important even outside of here, you know, um and, but this community, this place has given me that and how to um how to ask for help, how to find help... You know, but um, [pause] mainly to know I'm that, that I'm not alone.*

Quinn discussed how community support helped her cope with her mental health issues in two ways. First, Quinn shared similar life experiences with others within her community (i.e. motherhood, housing insecurity, and navigating child protective services). Meeting individuals who have gone through similar circumstances helped Quinn feel "not alone," which she attributed to an improvement in her mental health. Notably, Wechsler and Pugh (1967) found that when individuals live in neighborhoods that predominantly consist of demographic characteristics that are different than their own, they are more likely to be admitted into inpatient psychiatric care. Secondly, Quinn's housing facility had numerous resources (i.e. life skills

classes, case management, etc.). Through her active involvement in the community, she was able to gain skills not only from the case managers and classes, but also from other members of the community who were further along in the program. Quinn indicated that the overall social support of her community fostered improvement in her mental health. This finding was further corroborated by the member check sessions with individuals residing in a short-term shelter. One participant of the member check described that “[she] could be having a really bad day, and then once [she is] with people [she] trusts, [her] mood improves drastically” (A.M. field note, March 29, 2019). Participants within this member check session discussed how “having a few close people can provide security, comfort and a better sense of mental health” (A.M. field note, March 29, 2019). These field notes illustrate how having close friendships in a community setting can bolster residents’ feelings of security, happiness, and overall positive mental health.

Only one participant, Kami, indicated that community support could have varying effects on an individual based on how resourceful that community is:

*P And then I come here. And we’re not allowed to be crazy and so um you have to be kind of nice, I mean I’m nice but you have to be low key and...And not crazy crazy and so watching other people keep their stuff together helps me keep mine.*

*I So do you think that the community actually plays a role in helping your mental health?*

*P Yeah, cause a community isn’t crazy its kind and loving and helpful... And if you’re in a crazy community you’re crazy and if you’re in a good community you’re good.*

Kami lives in a transitional housing facility that consists of a multitude of life-skills classes and provides two distinct case managers for both her and her children respectively. Kami discussed not being “*allowed to be crazy*” in the transitional housing facility, alluding to the abundance of resources available that encourage healthy relationships as well as knowledge surrounding strategies to help reach professional goals. Whilst enveloped in this resourceful setting, Kami is more likely to behave in socially adaptive ways. Conversely, while residing in a community that lacks recourses, one may be more likely to behave in ways that the community has deemed

adaptive (i.e. engaging in substance abuse as described in Johnson & Chamberlain, 2011), which may or may not be beneficial to one's mental health. Therefore, constructed communities that are designed to promote prosperity offer more supports and resources to aid individuals in selecting effective coping strategies.

Notably, only one individual, Marge, from the unsheltered group discussed social support in relation to improved mental health. She discussed both reading about social support being important for health as well as discovering the significance of social support via her interactions with friends online.

- I     *And do you think that community is helpful for um folks to be healthy and well—*  
P     *I think so...It and from some of the things I've read, we actually need to socialize... because if we don't... we're too lonely then it seems to do something to our psyche. This is something new I've found out on Facebook with my Facebook friends and I said oh my goodness I better go out and get busy (laughs)...*

Marge's experience is different than the individuals in the sheltered group. Individuals who were residing at the transitional housing facility discussed their peers' physical presence in their lives through doing chores together, offering to watch another's child, and spending time in one another's home. Marge, on the other hand, discussed communicating with people online, thus seeking out positive social relationships. Arguably, an online community could be a safer way for discriminated groups to maintain social connections without risk of physical harm. Kloos and colleagues (2012) argue that online communities increase access to social support for individuals that are unable to attend support groups in person due to mobility issues and fear of social stigma. Furthermore, Rice and Barman-Adhikari (2013) found that homeless youth who use e-mail and social media are more likely to look for housing and jobs online than those who did not.

In sum, individuals experiencing housing insecurity and mental health issues indicated that social supports in their immediate settings had a positive effect on their mental health. Social

supports can be in the form of homogeneity within one's residential community (Felton & Shinn, 1992; Wechsler & Pugh, 1967) as well as the resources available within that community (Kloos, et al., 2012).

*Mesosystems.* Just as participants described social supports in their immediate settings as contributing factors to their improved mental health, Amy discussed how both her dad dying and having no friends at school, resulting in a lack of support, negatively impacted her mental health:

- P *I was diagnosed with um emotional disturbed when I was eleven... 'cause apparently I was seeking approval way too much. While I was eleven. I had no friends, my dad just died, and it felt like everybody at that point was shoving me away when I just wanted somebody to give me a hug...I had depression, anxiety, and ADHD since I was about seven. Like five.*
- I *What was happening in your life around this time? Do you think anything contributed?*
- P *We just moved around a lot. I didn't really have any friends...like legitly I had no friends...so I didn't really have friends, which when I was around people gave me social anxiety.*

The above quote illustrates both how a loss of relationship in her home and a lack of relationships in her school collectively contributed to Amy's personal stress and deterioration in mental health. Prior literature has indicated that a lack of loving relationships contributes to lowered self-esteem and self-efficacy (Overton & Medina, 2008). Amy lost her father while not having any peer support, resulting in isolation across two settings. Therefore, just as participants reported social support to have a positive effect on mental health, Amy reported that lack of support, and relationships in general, contributed to a worsened mental health. This finding was corroborated by one of the member checks, in which a participant indicated that when they are isolated, their depression gets worse (A.M. field note, March 29, 2019).

Conversely to Amy, Kami depicted the interrelation of her familial relationships and her social support from the transitional housing facility as a contributing factor to her improved mental health. Kami described how her community support offered her opportunities to develop

coping skills to manage her bipolar disorder and cultivate positive dyadic relationships with her family.

*So I'm bipolar... And manic depressive and um [pause] they help me get through that. Like if I'm having a bad day...They help me find [pauses] results to making it better or um...If my kids are driving me crazy, which they do... Um some of them offer "hey do you want me to hang with her for a minute?" Er my son's name is son, um son can come to my house... Yeah It makes me feel good that I can be like go hang out downstairs... Okay cause you're driving me crazy-y and obviously you need a minute and I need a minute... And then when he comes back we, we regroup we...Have a better conversation er...I can handle it a little bit different if he gives me a minute...And umm for me to be able to go and talk about what I'm going through...And even if I don't they don't have anything to say, um they just listen...*

Kami described how having support from her community allowed her more time and feasibility to be able to work on her interpersonal and coping skills. For instance, her friends in the community offered to watch her children when she needed time to work on managing her emotions as well as when she required individual time with one child to resolve a conflict. This support helped her gain skills in a more controlled setting. Moreover, Kami's friends listened to her when she needed to discuss what she was "going through." Toro and Oko-Riebau (2015) also found social support to buffer the effects of stressful life events in homeless adults in Southern Poland. This finding was further supported by the member check session with the community experts on housing insecure individuals. They reported that when they screen individuals to enter housing programs, about half discuss supportive relationships as beneficial to their mental health (L.M. field note, March 4, 2018).

In sum, participants discussed the interrelation of their immediate relationships as a contributing factor to their mental health in both beneficial and harmful ways. Amy described how feeling isolated in two different immediate settings contributed to her mental health issues. Kami, on the other hand, discussed how community support helped her manage her familial bonds as well as work on her coping and interpersonal skills.

*Macrosystem.* Furthermore, one's setting can be affected by overarching societal beliefs that influence how individuals behave toward one another. One participant, Pat, experienced societal marginalization because of her housing status. U.S. culture values having a permanent residence. Furthermore, citizens often discriminate against those who do not have a permanent residence (Johnstone, Jetten, Dingle, Parsell & Walter, 2015). Pat explains how being marginalized and discriminated against affects her mental health:

*Oh yeah, yeah. If you don't wear a backpack or you don't walk down the street with a bag in your hand, you're ok. You're not homeless, but if you do or you're riding a bike and a backpack, everybody gets harassed, so they, I mean, it's like they're picking people out, you know...I don't know, I think it makes my anxiety ten times worse, like, I've had two heart attacks already. Thank god it hasn't got my heart muscle 'cause I have Acute Anxiety Disorder.*

Pat experienced harassment and prejudice at a local level. Pat described this relationship as a contributing factor to her anxiety. Notably, Khan, Ilcisin and Saxton (2017) found discrimination to be a predictor of mental health issues in minority groups due to a higher exposure to risk factors, stress, and lower access to protective factors. Furthermore, a housing insecure participant of the member check session also discussed her experience with marginalization and harassment. She discussed her experiences of being approached by the police when she walked down the street with a bag in her hand. She further discussed being avoided by other citizens and that the experience of isolation made her feel like she's not a part of society or human (Communication with G.M., April 5, 2019). This finding further corroborates the relationship of macro level prejudice and poor mental health symptoms.

In sum, relationships at multiple levels of one's ecological environment contribute to one's mental health in various ways. At the *micro* level, social support can benefit one's mental health. At the *meso* level, lack of relationships in multiple groups can lead to isolation and diminished feelings of self-esteem and self-efficacy; alternatively, relationships across contexts

can bolster positive support and resources. Lastly, at the *macro* level, being a part of a society that discriminates against one's housing status can contribute to feelings of anxiety.

### **Assertion 2: Trauma and Abuse**

Participants also related their past experiences with trauma and abuse to the onset of their mental health issues. This phenomenon was depicted by 11 of the 15 individuals experiencing housing insecurity (see Table 2 and Table 3). Notably, childhood trauma and abuse have been linked to the later development of psychosis (Isvoranu, et al., 2016; Read, Agar, Argyle & Aderhold, 2003; Read, Perry, Moskowitz, & Connolly, 2001; Read, van Os, Morrison, & Ross, 2005). The pathway from childhood trauma to psychosis is often mediated by other traumas and general psychopathology symptoms such as anxiety and depression (Isvoranu, et al., 2016). Notably, five out of the eleven participants who recounted experiencing childhood trauma/abuse discussed experiencing more than one type of trauma/abuse.

*Microsystem.* Trends across interviewees highlighted that housing insecure individuals most often experienced abuse in childhood (9 out of 15) that was perpetrated by a family member (6 out of 15; See Table 3). For example, Wayne described experiencing multiple types of abuse from his parents throughout most of his childhood:

*“My step-father and my mother decided to take a walk on the wild side of sex...and I was part of it. Sorry... Mentally, physically, sexually abused from about ten all the way up to about 17.”*

Wayne said he first started developing mental health challenges when he was about 11 or 12. He directly related the onset of mental health challenges to his experiences of abuse perpetuated by his step-father and mother. According to his narrative, Wayne didn't start experiencing mental health symptoms until he had been abused repeatedly for one to two years. Results corroborate Isvoranu and colleagues' (2016) finding that trauma doesn't always directly lead to psychosis but

is often mediated by another trauma or psychological distress. Furthermore, in the member check session, a housing insecure individual indicated that mental health could take a negative turn when multiple bad things happen in your life (Communication with A.B., April 4, 2019).

Similarly, James discussed his interpretation of the pathway from sexual abuse in early childhood, to anger, followed by his disordered addictive behavior.

*“My first addiction was sugar. When I was five or six years old...And milk. And then progressed from th-there. I’ve been working myself through addictions, most of my life...Sugar, cereal, crank, coke, not too much heroin, marijuana started to get back in...I was abused when I was like five or six years old. Sexually. And I...I turned it to anger...”*

James initially described himself as having an addictive personality, but he later elaborated that his symptoms started after he was abused as a child. James discussed feeling angry after he was sexually assaulted, and he then tied the anger to his later addictions. Research indicates that sexual abuse is related to mental health issues (Brown, Cohen, Jeffery, & Smailes, 1999; Zeanah & Humphreys, 2018). Moreover, this finding mirrors Isvoranu and colleagues’ (2016) model, in which James’s anger would be the mediator from his sexual abuse to his addictions. James’s narrative highlights the interconnection of childhood abuse, a heightened state of emotional distress (i.e. anger), and coping with substances (i.e. food and drugs).

In sum, at the microlevel, the majority of participants discussed being abused as children by their parents (see Figure 3). Moreover, participants expressed having either multiple instances of abuse or heightened emotional distress that preceded the onset of mental health issues.

*Mesosystem.* Multiple occurrences of trauma and abuse can also happen across different settings. For example, Jess was bullied at school in addition to experiencing abuse at home. Jess responded to the bullying with self-harming behaviors. When the school found out she was self-harming, she was expelled. After she was expelled, her parents homeschooled her, which she depicted as “much worse” due to the abuse she experienced at home.

*I'd say probably by the time I was six or seven I was suffering with depression. By the time I was eight and nine, I was, um, self-harming...I had a very abusive childhood... [my mother] was very abusive, she was very, um, very alcoholic (slight laugh) ... and it just made our home life very disruptive... I was caught with a box-cutter...using the razorblade as a function to self-harm...they expelled me from school...I started doing that because I was being bullied very badly...it was much worse because I was—I was home.*

As a child, one's life revolves around the back and forth from school to home. Jess was being abused in both settings. This made her abuse inescapable. Moreover, after she was expelled, she was confined to stay with one set of abusers (i.e. her parents). In school, there are designated times when students are being supervised by a teacher and engaging in school work where abuse is less likely to occur. These periods of time would be relative breaks from danger. When being homeschooled by abusive parents, there is always the threat that abuse could happen at any given moment. Jess related these experiences of inescapable abuse across multiple settings to the onset of her depression at a young age. Notably, Brown and colleagues (1999) found that children who were maltreated were 3.4 to 4.5 times more likely to have a depressive disorder in adolescence and young adulthood.

While Jess related the onset of her mental health symptoms to abuse across multiple microsystems, Quinn associated the cumulation of loss and abuse to her negative mental health symptoms. Quinn was in an abusive relationship, and during the same time period, watched her mother die in a car accident.

*...everybody needs help at some point in their life, you know, um I had a lot of mental stuff um, lot of trauma, um, 'cause I was in an abusive relationship and I watched my mom die in a car accident.*

Quinn discussed how losing a relationship through the death of her mother, as well as being in an abusive relationship with her partner, contributed to her mental health issues. Furthermore, the death of her mother wasn't just a loss but a trauma that she experienced as well. Therefore, three types of trauma and abuse are at play in this particular situation: 1) Quinn is

experiencing abuse from her partner, 2) Quinn is experiencing bereavement from the loss of her mother, and 3) Quinn being in a car accident with her mother. Quinn related the culmination of these three types of trauma to her mental health issues. Two of the types of trauma Quinn experienced relate to experiences of loneliness (i.e. loss of a loved one, domestic violence). Women who are subjected to intimate partner violence are known to experience alienation and loneliness (Rokach, 2007). In a factor analysis on pathways from bereavement to depression, loneliness was found to be the main symptom leading to depression (Fried et al., 2015). Hence, the interrelation of Quinn's bereavement and exposure to intimate partner violence would contribute to her loneliness and depression (Fried et al., 2015). Additionally, a housing insecure participant from the member check session described a similar culmination of abuse and trauma contributing to her poor mental health. She was abused by her first husband, then her second husband passed away recently. Furthermore, she recently became homeless again, which she described as making her feel retraumatized and depressed. She related these three traumatic events to her depression (Communication with L.K., April 5, 2019).

Pat was also abused across multiple settings. Conversely to Jess and Quinn, Pat depicted abuse in one setting contributing to the onset of her mental health symptoms then, years later, abuse in a different setting exacerbating the issues. Pat described developing mental health symptoms around the same time as being sexually assaulted by her father. Moreover, Pat said that her symptoms got worse after her friends spiked her drink with LSD.

P *I told everybody that and "I don't want any, I don't want any." They slipped [LSD] in my uh big bottle of Southern Comfort... well I flipped out...*

I *...Do you think it was the, the LSD that first onset the mental health issues or was anything else going on in your life that—?*

P *No, I had a good, no... Well, my, okay, okay (chuckle, sign). The only thing that set it off was my dad molesting me when I was five.*

I *...Did you start having any symptoms, any mental health symptoms around that*

I *time?*

- P *Lots of them, lots of them, lots of them...*  
 I *So that's [interviewee is referring to mental health challenges as a question] when they started and then it just got worse with LSD?*  
 P *Oh yeah.*

In both situations, different behaviors and activities were forced upon Pat. As a child, she was forced to partake in sexual activities, and as a teen, using LSD was forced upon her without her knowledge. In Pat's case, the use of LSD was not recreational. Due to how adamant Pat was that she "[didn't] want any" and how that choice was taken away from her, this experience is classified as a trauma. Both situations stripped her of her autonomy. The literature indicates that the "effects of trauma ... can propagate through other types of trauma as well" (Isvoranu et al., 2016, pg 193). Therefore, Pat described her trajectory of abuse in childhood and trauma in adolescence across microsystems (i.e. family and peers) as having a cumulative negative effect on her mental health.

In sum, the culmination of multiple experiences of abuse and trauma can be related to lasting negative mental health symptoms. Moreover, it is difficult to pinpoint the exact incident that led to negative symptoms as, often times, there is no leading cause to mental health issues but rather a culmination of multiple events. Furthermore, the participants of our member checks (i.e. the community organization) indicated that abuse effects individuals' sense of stability and hinders their future living situations (L.M. field note, March 4, 2019).

*Macrosystem.* One participant, Alex, on the other hand, wasn't abused by a person but alternatively experienced trauma from being in the war.

- I *At what age do you think you started developing mental health challenges?*  
 P *Uh, about right after I got out of the Marine Corps. About 25.*  
 I *25? Okay. What was happening in your life around that time?*  
 P *Uh wife, kids, marine corps, you know.*  
 I *... Do you think that they contributed to the mental health challenges?*  
 P *A little bit yeah, especially when they call me back up in 91. Because—*  
 I *Who called you back up?*

- P     *The marines...I had to go out to the gulf so. Kind of trippy.*  
I     *So was like, the war what contributed you think?*  
P     *Yeah.*

Alex related the onset of his mental health symptoms to his time in the war, noting that the war “especially” contributed when he was asked to serve again. War is a product of our culture, and this socially constructed concept elicits a setting (i.e. the battleground) where individuals are constantly at risk of harm, including death and loss of loved ones. Not only do participants of war perpetually experience trauma while in that setting, but Alex was asked to return to the setting after he had already left. The literature supports the notion that one’s veteran status can be tied to trauma and mental health issues (Alessi, 2013; Applewhite, 1997; Corliss et al., 2011; Johnson & Chamberlain, 2011; Read, Perry, Moskowitz, Connolly, 2001; Russell, 2009). Ultimately, experiencing war is facing a collection of traumas, which can culminate to contribute to negative mental health symptoms.

In sum, participants often relate the onset of their mental health symptoms to trauma and abuse. Moreover, some participants discussed their mental health issues as being related to a culmination of multiple events of trauma and abuse. These multiple occurrences of trauma and abuse can happen simultaneously in a period of time across multiple settings (i.e. abuse at home and school) or they could happen at different times (i.e. continuous abuse with one perpetrator or different unrelated events across time).

### **Qualitative Themes: Content Coding**

One of the main goals of this study was to identify helpful strategies for housing insecure individuals to combat mental health issues. Moreover, in keeping with a strength-based approach, this study also asked participants what coping methods and services they thought were most helpful for their mental health issues. About half of the participants (53.34%, n = 8)

identified therapy as the best treatment for their mental health challenges. For example, Amy elaborated on the benefits of play therapy, specifically:

*Um honestly, play therapy...Because you have an activity that you like where your brain is "I'm having fun" ... And even around new people when your brain is saying I'm having fun, you start to open up to new people...That's what I say play therapy I don't care if you're an adult, play therapy works [laughs].*

Amy recommends using play therapy to treat her mental health issues. Play therapy is a therapeutic practice designed predominantly for children (Bratton, Ray, Rhine, & Jones, 2005). In play therapy, play is used to symbolically communicate what the child is not able to express verbally (Bratton, et al., 2005). Amy has had trouble trusting practitioners in the past. Thus, she finds her relationship with her therapist integral to the therapeutic experience. With play therapy, she found it easier to open up because she is distracted and in a positive mood due to the game they are playing. Amy noted that when she is less guarded, there is more opportunity for the relationship to grow and the therapeutic process to transpire.

Wayne also viewed therapy as the best treatment method for his mental health issues; however, he focused on the characteristics of the therapist rather than the therapy methods:

- I *What treatment method do you think would have been the best for treating your particular mental health struggles?*
- P *Uh, some one on one... Ok, coming in and just checking. One thing that my—my therapist said to me, is, is you already know the answers, you're just afraid to face them. So, getting from point B back to point A, is sometimes tough because you have to accept that you're an idiot! And You're stupid!... And you make rash, retarded decisions.*
- I *Did your therapist phrase it like that?*
- P *Oh, I always phrase it like that because it's the truth. Ok. I'm a realist... A practical, get down to the brass tacks of life.*

Wayne commented on his appreciation for blunt honesty in therapy sessions. When his therapist speaks with him in a direct manor, it helps challenge him to take action. His therapist tells him what he needs to hear to reconnect with his circumstances and move forward.

Two of the individuals who described therapy as the most helpful mental health treatment also elaborated on the benefits of medication. For example, Pat commented on her frustration in not receiving both treatments.

*Just for them to get my medicine back and to have somebody to talk to when we need to...Once you get your medicine, they don't give you therapy anymore, it's like...they're done talking to you...that person to go in once a week or once a month to talk to...that you can tell anything and they're not judging you, makes you feel like a whole person...when you don't get that no more, you just go in. I mean the pills are good, okay...but the attention and somebody to listen to...to let you pour it out, so you ain't gotta put all that drama on your family because they worry and care more 'cause they are your family or your friends. And you can go to them and they don't judge you at all.*

Pat described the importance of having a confidante that she can express anything to without worrying about burdening her loved ones or receiving judgement. Furthermore, Pat is an individual who is unsheltered. She described therapy as getting “attention and somebody to listen.” She also described the conversations as making her feel like “a whole person.” Unhoused individuals are often transient, which makes it difficult to build relationships and a social network.

Although the majority of participants identified therapy as the most helpful treatment, two unsheltered participants, who identified as never being physically safe, described novel approaches to coping with their lack of physical security. The first approach was through meditation. For instance, Sky described going within himself to a place where he feels safe through practices he learned in meditative books.

*And they rarely consider really the totality of what makes them safe. You can feel safe in your home with the door locked, but there's still tens of thousands of thermonuclear weapons cocked and loaded ready to wipe all mammalian life off the face of the planet. Every minute of your day, waking or sleeping, so how safe are you? People like to feel safe though, so I've just decided instead of, instead of trying to arrange my world or, or, you know, build a fortress in order to feel safe, I just go within myself to the place where one feels safe.*

Sky discussed how no one can know for sure if they are safe at any given moment. He contributed learning about meditative practices to an improved state of mental health. Sky elaborated that meditative practices are “self-help techniques” and that such practices would have been his preferred treatment method when he first started developing mental health issues. Moreover, because of Sky’s meditative practices, he believes he no longer has mental health issues. This finding corroborates Grabbe, Nguy and Higgins (2012) study, which found that mindfulness meditation interventions for homeless youth facilitated a decline emotional distress (i.e. somatic, depression, and anxiety).

The second participant, Wayne, described using methods of distraction coping. He described feeling closest to a sense of safety when he was engaging in role playing games (RPGs), reading science fiction, or playing a video game. An RPG is a game where players engage in fantasy adventures while taking on the role of an imaginary character. Being immersed in these fictitious worlds helped Wayne to be a part of an alternative space.

P *I’ve never actually felt 100% safe... You’re never safe. So, sorry, I can’t define that one...*

I *Is there a scenario of like a place you’ve been where you felt at your best, though, even if you’re never actually safe? Where you feel maybe the most open?*

P *(laughs) Being in an RPG, yeah. It’s not here...I’m not joking when I say if I could turn my computer on, shut the door, and listen to the tricorder readings, maybe on the starship bridge in the background. I’d be really happy. ‘Cause I’m, you know, I’m, different conversation...*

Wayne is housing insecure, and at the time of the interview, he lived on the streets. He further explained the dangers associated with his environment by describing all of the deaths he had witnessed in his life. Therefore, in Wayne’s circumstance, he never feels physically safe.

Throughout the interview, Wayne often referenced science fiction characters and story lines. He also often related aspects of his life to super hero plots. For example, he related the death of his little brother to “a good super hero story, or a great villain. Depending on what earth you’re on.”

Wayne used these distractions to be able to cope with the instability he feels surrounding his own setting. When the interviewer asked if Wayne uses games as his escape, he responded, “well, not just as an escape but uh, yeah therapy release.” Wayne noted that when he is immersed in these fictitious worlds, he is able to not think about his own circumstances and trauma for a little while. The literature indicates that distraction is associated with a lessened dysphoric mood and heightened positive emotion scores compared to rumination (Broderick, 2005).

### **Discussion**

This study sought to examine how housing insecure individuals develop mental health issues. Participants identified having interpersonal conflicts (i.e. abuse, marginalization, isolation) in their dyadic, group, and community relationships that they attributed to worsened mental health outcomes. Many (n = 11) participants discussed their mental health issues beginning around the same time as an incident of abuse. Moreover, participants identified social support as a way to combat mental health issues through both emotional support and the provision of tangible resources (i.e. providing child care, advice, information, etc.).

Participants related changes in their mental health to their relationships with others. Moreover, participants discussed their interactions with others across three of Bronfenbrenner’s ecological levels (microsystem, mesosystem, and macrosystem). The most common relationships discussed were dyadic and within the microsystem. Participants discussed people in their microsystems either abusing them, which they attributed to worsening their mental health, or supporting them, which they attributed to improving their mental health.

Moreover, harmful relationships and trauma existing across multiple microsystems were considered to have a cumulative negative effect on participants’ mental health. This finding

relates to Isvoranu and colleagues' (2016) study's finding that childhood trauma is related to psychosis through the mediation of either general psychopathological symptoms or other traumas. However, it is important to note that the present study relied on self-identification of mental health issues and did not analyze any official diagnoses. Additionally, the present study is qualitative and therefore cannot predict directionality or causality. Isvoranu and colleagues (2016) results indicate that childhood trauma does not directly connect to symptoms of psychosis but is propagated by general psychopathology (i.e. anxiety, depression, etc.) or another trauma. Participants in the present study often discussed mental health issues emerging after a period of repeated abuse or abuse happening across multiple microsystems (i.e. abused at home and bullied at school). Moreover, two participants first discussed their heightened emotional distress after an incident of abuse before the emergence of mental health symptoms. This study expands on Isvoranu and colleagues (2016) recent work to include undifferentiated general mental health issues. In addition, this study specifically highlighted homeless populations and their unique experiences with mental health. Further research is needed to test the statistical significance of these pathways and to differentiate between specific disorders within this population.

The striking number of housing insecure individuals who experienced abuse in their home as a child highlights the need for prevention efforts. Research should be done to test if screening for abuse in primary schools as well as offering interventions like Trauma Informed Care (TIC) could offset the number of homeless individuals in the future.

In addition to abusive relationships, participants also related a lack of relationships to their development of mental health issues. Participants emphasized the importance of social support in relation to their mental health. Notably, Brott and colleagues (2018) found social support to be a predictor of shelter residents successfully graduating from a rural transitional

housing facility. Lam and Rosenheck (1999) found social support to be related to increased service use for housing insecure individuals due to network members offering childcare assistance, transportation, financial assistance, and emotional encouragement. Sheltered participants narratives corroborated these findings. Participants discussed the benefits of having peers offer to watch their children when they needed to decompress, or when they needed to talk with another child. In addition, other participants discussed doing housework together or simply talking to each other. These exchanges offered interviewees emotional support and a sense of comradery. Notably, these phenomena were only found in the sheltered group, even with considerably fewer sheltered participants. Only one unsheltered participant discussed social support improving her mental health; however, she was discussing an online community (i.e. Facebook friends) rather than people physically active in her life. This finding may highlight the discrepancy in community support between sheltered and unsheltered homeless individuals.

For future interventions, housing intervention staff should emphasize relationship building and community support in their programs. Furthermore, more emphasis should be placed on including unsheltered individuals in social support networks. This could be achieved through community outreach, team building activities in day programs, or offering group therapy interventions for homeless individuals. In some cases, social media could be utilized in providing social support mechanisms (i.e. connecting to other homeless individuals or communicating with therapists or case managers).

Furthermore, at the macro level, participants discussed experiencing marginalization due to their housing status. Participants in this study were members of two groups that experienced stigma in U.S. culture: individuals with mental health issues and individuals experiencing housing insecurity. The literature indicates that stigmatic belief systems impact stigmatized

groups' ability to thrive in society (Overton & Medina, 2008; Wilking et al., 2017). From a review of the literature, Corrigan (2004) found that individuals with mental health issues may avoid treatment in order to not be "labeled" and further stigmatized. The literature discusses stigma as playing a role in mental illness by excluding stigmatized groups from occupational, social, and treatment settings (Corrigan, 2004; Overton & Medina, 2008); furthermore, participants of this study indicated a direct connection between marginalization and their mental health issues. More research is needed to test the effects of marginalization on mental health and the directionality of the relationship. A larger sample size will be required to test if this phenomenon is a common occurrence.

Participants also discussed services and coping mechanisms that they deemed most helpful. They highlighted benefits of therapy that seem to be especially valuable for housing insecure individuals. Notably, treatments (i.e. therapy, medication, etc.) in the first three to five years of onset of psychosis have shown to reduce symptom severity and hospital admission (Bird, et al., 2010; Holmes, et al., 2006). Unsheltered housing insecure individuals that have been homeless longer and have more psychiatric difficulties experience higher rates of isolation and lower rates of supportive relationships than other homeless populations (Lam & Rosenheck, 1999). Therefore, therapy may give them the unique experience of building healthy relationships with reciprocal respect. Additionally, since this population experiences a disproportionate amount of isolation, the utilization of group therapy practices might be beneficial (Berzoff, 2013). Group therapy would enable staff to treat more clients at once, helping with the congestion of most mental health agencies, as well as aid housing insecure individuals in fostering healthy relationships (Berzoff, 2013). More research is needed to test the effectiveness of these strategies for homeless populations with mental health issues.

Furthermore, participants discussed novel coping strategies for dealing with the lack of safety associated with housing insecurity: 1) distraction and 2) meditation. Distraction coping and meditation were each only mentioned once. Notably, distraction was discussed as a therapeutic release and an escape from the participant's harsh reality. Meditation, on the other hand, was discussed as a mechanism to calm oneself and to create a mental space of safety when one's physical surroundings were not. These coping strategies were both mentioned by unsheltered individuals, a population known to experience a significant amount of trauma (Coats & McKenzie-Mohr, 2010). These therapeutic interventions could be extremely helpful for housing insecure populations to release tension and create their own safe spaces.

Maddock, Hevey and Eidenmueller (2017) trained homeless adults in mindfulness interventions. Their training included meditation, awareness, and using mindfulness in stressful and social situations. The intervention resulted in participants report of decreased anxiety, depression, impulsivity, as well as enhanced their ability to cope with stress. Participants self-awareness and interpersonal relationships also improved as a result of this intervention. These are pivotal skills for homeless individuals, since they are constantly having to utilize communication strategies in order to navigate services and compete for placements in intervention programs.

There is less research on the effects of distraction coping for homeless groups. However, distraction has been shown to lessen dysphoric mood when participants are ruminating (Broderick, 2005). Yet, no research to date has tested the impact distraction has on populations experiencing extreme stress, such as homeless individuals. Participants of this study related distraction to a therapeutic release. Moreover, the distractions discussed were role-playing games. Thus, the key component might not be the distraction, but rather the disassociation with

one's own reality and fantasizing about another life. Moreover, in the game, players are focusing on goals and achieving milestones, which could elevate one's mood by giving them a sense of achievement and pride.

Furthermore, it is important to provide spaces for homeless individuals to engage in these coping strategies. These spaces could include rooms for meditation with the inclusion of appropriate resources to guide meditation (i.e. books, guided meditation recordings, instructors, etc.), as well as rooms for distraction coping with the inclusion of needed resources (i.e. computers, art supplies, etc.). These particular features could be incorporated into shelter designs.

### **Limitations**

This study has several limitations. First, the sample size was small and disproportionate in representation (i.e. four individuals who were sheltered, and eleven of whom were unsheltered). Thus, it is difficult to accurately compare and contrast the two populations. However, it is important to note that in qualitative research more emphasis is put on the depth of inquiry as compared to the breadth. Second, participants diagnoses were not recorded. This study relied on self-identification. Further analysis is needed to analyze specific disorders associated with housing insecurity and how pathways to mental illness differ in trajectories between disorders. Third, this study is qualitative and thus cannot capture causality. Future quantitative research is needed to test the causality and directionality of the onset of mental health issues in homeless groups.

### **Conclusion**

In sum, housing insecure groups experience a disproportionate amount of trauma and abuse over the course of their life. This particular trauma was often identified within the microsystem. However, social support may buffer the negative effects trauma has on mental health, and serve as a protective factor. Furthermore, participants stress the importance of therapy, meditation, and distraction coping, thereby highlighting future interventions to address mental health for housing insecure individuals.

## References

- Alessi, E. J. (2013). Acknowledging the impact of social forces on sexual minority clients: Introduction to the special issue on clinical practice with LGBTQ populations. *Clinical Social Work J*, 41, 223-227. DOI 10.1007/s10615-013-0458-x
- Alexander, M. (2010). *New Jim Crow: Mass incarceration in the age of colorblindness*. New York: New Press.
- Anyon, J. T. (2018, October 19). Homeless in San Francisco: A resident calls the situation a state of emergency. *The New York Times*. Retrieved from [https://www.nytimes.com/2018/10/19/opinion/letters/homeless-san-francisco.html?rref=collection/timestopic/HomelessPersons&action=click&contentCollection=timestopics@ion=stream&module=stream\\_unit&version=latest&contentPlacement=2&pgtype=collection](https://www.nytimes.com/2018/10/19/opinion/letters/homeless-san-francisco.html?rref=collection/timestopic/HomelessPersons&action=click&contentCollection=timestopics@ion=stream&module=stream_unit&version=latest&contentPlacement=2&pgtype=collection)
- Applewhite, S. L. (1997). Homeless veterans: Perspectives on social services use. *Social Work*, 42(1), 19-30. doi10.1093/sw/42.1.19
- Aubry, T., Goering, P., Veldhuizen, S., Adair, C. E., Bourque, J., Distasio, J.,... Tsemberis, S. (2016). A multiple-city RCT of Housing First with Assertive Community Treatment for homeless Canadians with serious mental illness. *Psychiatric Services*, 63(3), 275-281.
- Bassuk, E. L., Huntington, N., Amey, C. H., Lampereur, K. (2006). Family permanent supportive housing: Preliminary research on family characteristics, program models, and outcomes. *Corporation for Supportive Housing*.
- Berzoff, J. (2013). Group therapy with homeless women. *Smith College Studies in Social Work*, 83(2-3), 233-248.

- Bird, V., Premkumar, P., Kendall, T., Whittington, C., Mitchell, J., & Kuipers, R. (2010). Early intervention services, cognitive-behavioural therapy and family intervention in early psychosis: Systematic review. *The British Journal of Psychiatry*, 197, 350-356.
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 35(4), 376-390.
- Broderick, P. C. (2005). Mindfulness and coping with dysphoric mood: Contrasts with rumination and distraction. *Cognitive Therapy Research* 29(5), 501-510.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32(7), 513-531. doi:10.1037//0003-066x.32.7.513
- Brott, H., Kornbluh, M., Incaudo, G., Banks, L., & Reece, J. (2018). Placing a spotlight on rural homelessness: Identifying the barriers and facilitators to successfully supporting homeless families within rural communities. *Journal of Poverty*, DOI: 10.1080/10875549.2018.1549184
- Brown, J., Cohen, P., Johnson, J. G., Smailes, E. M. (1999). Childhood abuse and neglect: Specificity of effects on adolescent and young adult depression and suicidality. *Child & Adolescent Psychiatry*, 38(12), 1490-1496.
- Brown, M., Vaclavik, D., Watson, D. P., & Wilka, E. (2017). Predictors of homeless services re-entry within a sample of adults receiving Homeless Prevention and Rapid Re-Housing program (HPRP) assistance. *Psychological Services*, 14(2), 129-140.
- Bukowski, K., & Buetow, S. (2010). Making the invisible visible: A photovoice exploration of homeless women's health and lives in central Auckland. *Social Science & Medicine*, 72, 739-746.

Cadenhead, K. S., Addington, J., Cannon, T., Cornblatt, B., McGlashan, T., Perkins, D.,...

Heinssen, R. (2010). Treatment history in the psychosis prodrome: Characteristics of the North American Prodrome Longitudinal Study cohort. *Early Interv Psychiatry, 4*(3), 220-226.

Coats, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness. *Journal of Sociology & Social Welfare, 37*(4), 65-96.

Colman, A. M. (2009). *Dictionary of psychology*. New York: Oxford University Press.

Corliss, H. L., Goodenow, C. S., Nichols, L., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health, 101*(9), 1683-1689. doi10.2105/ajph.test.2011.300155

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

DATA USA. (2015). *Butte County, CA* [Data file]. Retrieved from

<https://datausa.io/profile/geo/butte-county-ca/>

Desmond, M. (2017). *Evicted: Poverty and profit in the American city*. London: Penguin Books.

Fargo, J., Metraux, S., Byrne, T., Munley, E., Montgomery, A., & Jones, H. (2012). Prevalence and risk of homelessness among US veterans. *Preventing Chronic Disease*.

- Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: Systematic review and meta-regression Analysis. *PLoS Medicine*,
- Felton, B. J., & Shinn, M. (1992). Social integration and social support: Moving “social support” beyond the individual level. *Journal of Community Psychology*, *20*, 103-115.
- Fischer, R. L. (2000). Toward self-sufficiency: Evaluating a transitional housing program for homeless families. *Policy Studies Journal*, *28*(2), 402-420.
- Fried, E. I., Arjadi, R., Amshoff, M., Tuerlinckx, F., Bockting, C., Borsboom, D., Cramer, A. O. J., Epskamp, S., & Carr, D. (2015). From loss to loneliness: The relationship between bereavement and depressive symptoms. *Journal of Abnormal Psychology*, *124*(2), 256-265.
- Grabbe, L., Nguy, S. T., & Higgins, M. K. (2012). Spirituality development for homeless youth: A mindfulness meditation feasibility pilot. *J Child Fam Stud*, *21*, 925-937.
- Granerud, A., & Severinsson, E. (2006). The struggle for social integration in the community: The experiences of people with mental health problems. *Journal of Psychiatric and Mental Health Nursing*, *13*, 288-293.
- Greeson, M. R., & Campbell, R. (2011). Rape survivors’ agency within the legal and medical systems. *Psychology of Women Quarterly*, *35*(4), 582-595.  
doi:10.1177/0361684311418078
- Greenberg, G. A., & Rosenheck, R. A. (2010). Mental health correlates of past homelessness in the national comorbidity study replication. *Journal of Health Care for the Poor and Underserved*, *21*(4), 1234-1249.

- Guba, E. G. & Lincoln, Y. S. (1982). 'Epistemological and methodological bases of naturalistic inquiry. *Educational Communication and Technology*, 30(4), 233–52.
- Guba, E. G. & Lincoln, Y. S. (1994). 'Competing paradigms in qualitative research', in NK Denzin & YS Lincoln (eds.), *Handbook of qualitative research*, Sage, London, pp. 105–17.
- Harter, L. M., Berquist, C., Titsworth, B. S., Novak, D., & Brokaw, T. (2005). The structuring of invisibility among the hidden homeless: The politics of space, stigma, and identity construction. *Journal of Applied Communication Research*, 33(4), 305-327.  
doi10.1080/00909880500278079
- Henry, M., Watt, R., Rosenthal, L., & Shivji, A. (2016, November) The 2016 annual homeless assessment report (AHAR) to congress. Retrieved from  
<https://www.hudexchange.info/resources/documents/2016-AHAR-Part-1.pdf>
- Holmes, E., Tsang, T.M., Huang, J., Leweke, F.M., Koethe, D., Gerth, C. W.,... Bahn S. (2006) Metabolic profiling of CSF: Evidence that early intervention may impact on disease progression and outcome in schizophrenia. *PLoS Med* 3(8): e327. DOI 10.1371/journal.pmed.0030327
- HUD 2017 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations*(Rep.). (2017, November 07). Retrieved  
[https://www.hudexchange.info/resource/reportmanagement/published/CoC\\_PopSub\\_Stat\\_e\\_CA\\_2017.pdf](https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_Stat_e_CA_2017.pdf)
- Isvoranu, A., van Borkulo, C. D., Boyette, L., Wigman, J. T. W., Vinkers, C. H., Borsboom, D., & Group Investigators. (2017). A network approach to psychosis: Pathways between childhood trauma and psychotic symptoms. *Schizophrenia Bulletin*, 43(1), 187-196.

- Johnson, G., & Chamberlain, C. (2011). Are the homeless mentally ill? *Australian Journal of Social Issues*, 46(1), 29-48.
- Johnstone, M., Jetten, J., Dingle, G. A., Parsell, C., & Walter, Z. C. (2015). Discrimination and well-being amongst the homeless: The toll of multiple group memberships. *Front. Psychol.* 6(739), 1-9. doi: 10.3389/fpsyg.2015.00739
- Khan, M., Ilcisin, M., & Saxton, K. (2017). Multifactorial discrimination as a fundamental cause of mental health inequities. *International Journal for Equity in Health*, 16(43), 1-12.
- Kloos, B. R., Hill, J., Thomas, E., Wandersman, A., Elias, M. J., & Dalton, J. H. (2012). *Community psychology: Linking individuals and communities* (3rd ed.). Belmont: Wadsworth Cengage Learning.
- Kloos, B., & Townley, G. (2010). Investigating the relationship between neighborhood experiences and psychiatric distress for individuals with serious mental illness. *Adm Policy Ment Health*, 38, 105-116.
- Kornbluh, M. (2015). Combatting challenges to establishing trustworthiness in qualitative research. *Qualitative Research in Psychology*, 12(4), 397-414.
- Lam, J. A., & Rosenheck, R. (1999). Social support and service use among homeless persons with serious mental illness. *International Journal of Social Psychiatry*, 45(1), 13-28.
- Langhout, R. D. (2015). Considering community psychology competencies: A love letter to budding scholar-activists who wonder if they have what it takes. *Am J Community Psychol* 55, 266-278.
- Lincoln, Y.S., & Guba, E. 1985, *Naturalistic inquiry*, Sage, Beverly Hills, CA.
- Mental Illness and Homelessness. (2009). Retrieved December 12, 2017, from [http://nationalhomeless.org/factsheets/Mental\\_Illness.html](http://nationalhomeless.org/factsheets/Mental_Illness.html)

- Maddock, A., Hevey, D., & Eidenmueller, K. (2017). Mindfulness training as a clinical intervention with homeless adults: A pilot study. *Int J Ment Health Addiction, 15*, 529-544.
- Martins, D. C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing, 25*(5), 420-430.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370-396.
- Miller, R. L., & Shinn, M. (2005). Learning from communities: Overcoming difficulties in dissemination of prevention and promotion efforts. *American Journal of Community Psychology, 35*(3-4), 169-183. doi:10.1007/s10464-005-3395-1
- National Coalition for the Homeless. (2009, July). How Many People Experience Homelessness? Retrieved from <http://www.nationalhomeless.org/factsheets/>
- Overton, S. L., & Medina, S. L. (2008). The stigma of mental illness. *Journal of Counseling & Development, 86*, 143-151.
- Paradis, E. K. (2000). Feminist and community psychology ethics in research with homeless women. *American Journal of Community Psychology, 28*(6), 839-858.
- Pearson, C., Montgomery, A. E., & Locke, G. (2009). Housing stability among homeless individuals with serious mental illness participating in housing first programs. *Journal of Community Psychology, 37*(3), 404-417.
- Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology, 23*(5), 795-807.  
doi:10.1007/bf02506992

- Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 76*, 1-22.
- Read, J., Perry, B. D., Moskowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry, 64*(4), 316-345.
- Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*, 330-350.
- Rice, E. & Barman-Adhikari, A. (2013). Internet and social media use as a resource among homeless youth. *Journal of Computer-Mediated Communication, 19*, 232-247.
- Robinson, W. S. (1951). The logical structure of analytic induction. *American Sociological Review, 16*, 812-818.
- Rokach, A. (2007). Loneliness and intimate partner violence. *Social Work in Health Care, 45*(1), 19-31.
- Romney, L. (2010, November 05). San Francisco voters approve ban on sidewalk loitering. *Los Angeles Times*. Retrieved from [articles.latimes.com](http://articles.latimes.com)
- Rosenberger, R. (2014, June 19). How cities use design to drive homeless people away. *The Atlantic*. Retrieved from [theatlantic.com](http://theatlantic.com)
- Rosenheck, R. A., Lam, J., Morrissey, J. P., Calloway, M. O., Stolar, M., & Randolph, F. (2002). Service systems integration and outcomes for mentally ill homeless persons in the ACCESS program. *Psychiatric Services, 53*(8), 958-966.

- Russell, R. T. (2009). Veterans treatment court: A proactive approach. *New England Journal on Criminal and Civil Confinement*, 35(2), 357-372.
- Shern, D. L., Tsemberis, S., Anthony, W., Lovell, A. M., Richmond, L., Felton, C. J., . . . Cohen, M. (2000). Serving street-dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health*, 90(12), 1873-1878.
- Stefancic, A., & Tsemberis, S. (2007). Housing first for long-term shelter dwellers with psychiatric disabilities in a suburban county: A four-year study of housing access and retention. *The Journal of Primary Prevention*, 28(3-4), 265-279.
- Thomas, Y., Gray, M. A., & Mcginty, S. (2012). An exploration of subjective wellbeing among people experiencing homelessness: A strengths-based approach. *Social Work in Health Care*, 51(9), 780-797. doi:10.1080/00981389.2012.686475
- Toro, P. A., & Oko-Riebau, M. (2015). Social support and stress among homeless adults in southern Poland. *Journal of Community Psychology*, 43(4), 430-446.
- Townley, G., Kloos, B., & Wright, P. A. (2009). Understanding the experience of place: Expanding methods to conceptualize and measure community integration of persons with serious mental illness. *Health Place*, 15(2), 520-531.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651-656.
- Wechsler, H., & Pugh, T. F. (1967). Fit of individual and community characteristics and rates of psychiatric hospitalization. *American Journal of Sociology*, 73(3), 331-338.

Wilking, J., Roll, S., Philhour, D., Hansen, P., & Nevarez, H. (2017, May). Impacts of public safety approach to homelessness. Retrieved December 12, 2017, from

[http://www.bing.com/cr?IG=E4E3F894AC344CF3ABB26727465C5E20&CID=14455D67B051660B2C365631B1FE6747&rd=1&h=pP9jQhS6zG-BhYwIBfKkuuHHKE-wdtLYwLZ4vYWQ8BQ&v=1&r=http%3a%2f%2fbuttehomelesscoc.com%2freports%2fmisc%2fimpacts\\_of\\_public\\_safety\\_approach\\_to\\_homelessness\\_community\\_report\\_2017.pdf&p=DevEx,5066.1](http://www.bing.com/cr?IG=E4E3F894AC344CF3ABB26727465C5E20&CID=14455D67B051660B2C365631B1FE6747&rd=1&h=pP9jQhS6zG-BhYwIBfKkuuHHKE-wdtLYwLZ4vYWQ8BQ&v=1&r=http%3a%2f%2fbuttehomelesscoc.com%2freports%2fmisc%2fimpacts_of_public_safety_approach_to_homelessness_community_report_2017.pdf&p=DevEx,5066.1)

Wong, Y. I. & Piliavin, I. (2001). Stressors, resources, and distress among homeless persons: a longitudinal analysis. *Social Science & Medicine*, 52, 1029-1042.

Ybarra, M. (1996, May 19). Homily to the homeless; Don't ask, don't beg, don't sit. *The New York Times*. Retrieved from nytimes.com

Zeanah, C. H. & Humphreys, K. L. (2018). Child abuse and neglect. *J Am Acad Child Adolesc Psychiatry*, 57(9), 637-644.

Zugazaga, C. (2004). Stressful life event experiences of homeless adults: A comparison of single men, single women, and women with children. *Journal of Community Psychology* 32(6), 643-654.

Table 1

## Demographics of Participants

	<b>Sheltered</b>	<b>Unsheltered</b>
<b>Age</b>	<i>Range: 18 - 56</i> <i>Mean: 31.61</i> <i>SD: 6.573</i>	<i>Range: 18-65+</i> <i>Mode: 25-34</i> <i>Most prevalent age groups:</i> <i>24.7% : 45-54;</i> <i>25.9% : 25-34</i>
<b>Gender</b>	<i>71.8 % Female</i> <i>28.2% Male</i>	<i>31.4% Female</i> <i>61.6% Male</i>
<b>Source of Income</b>	<i>Government Assistance: 86.1%</i> <i>Wages: 23.6%</i>	<i>Government Assistance: 15.2%</i> <i>Wages: 11.3%</i>
<b>Mental Illness</b>	<i>Diagnosed: 44.7 %</i>	<i>Mental Illness Acts as Barrier to Services: 7.0%</i>

Table 2

Frequency of Abuse and Trauma Associated with Mental Health Issues

	<b>Types of Abuse/Trauma</b>						
	War	Mental / Emotional Abuse	“Abuse”	Bullying	Grief / Bereavement	Sexual Abuse	Physical Abuse
<b>Frequency of Individuals</b>	1	2	4	1	4	3	3

Table 3

## Assertion 2 Break Down of Abuse and Trauma

<b>Participant</b>	<b>Childhood</b>	<b>Adulthood</b>	<b>Type of Abuse / Trauma</b>	<b>Perpetrator</b>
Jess	X	-	“Abuse” (general)	Mother
	X	-	Bullying	Classmates
Pat	X	-	Sexual abuse	Father
Wayne	-	X	Bereavement,	N/A
	X	-	Sexual abuse	Parents
	X	-	Mental abuse	Parents
	X	-	Physical abuse	Parents
Alex	-	X	Trauma of the war	N/A
Quinn	-	X	“Abuse” (general)	Romantic partner
	-	X	Bereavement	N/A
Marge	X	-	Physical abuse	Sister
Kami	X	-	Bereavement	N/A
Billy	X	-	“Abuse” (general)	Parents
James	X	-	Sexual abuse,	Not stated
Amy	X	-	Bereavement	N/A
	-	X	“Abuse” (general)	Romantic partner
Dave	X	-	Physical abuse	Step mother
	X	-	Emotional abuse	Step mother

Figure 1. Population Samples: Qualitative and Quantitative

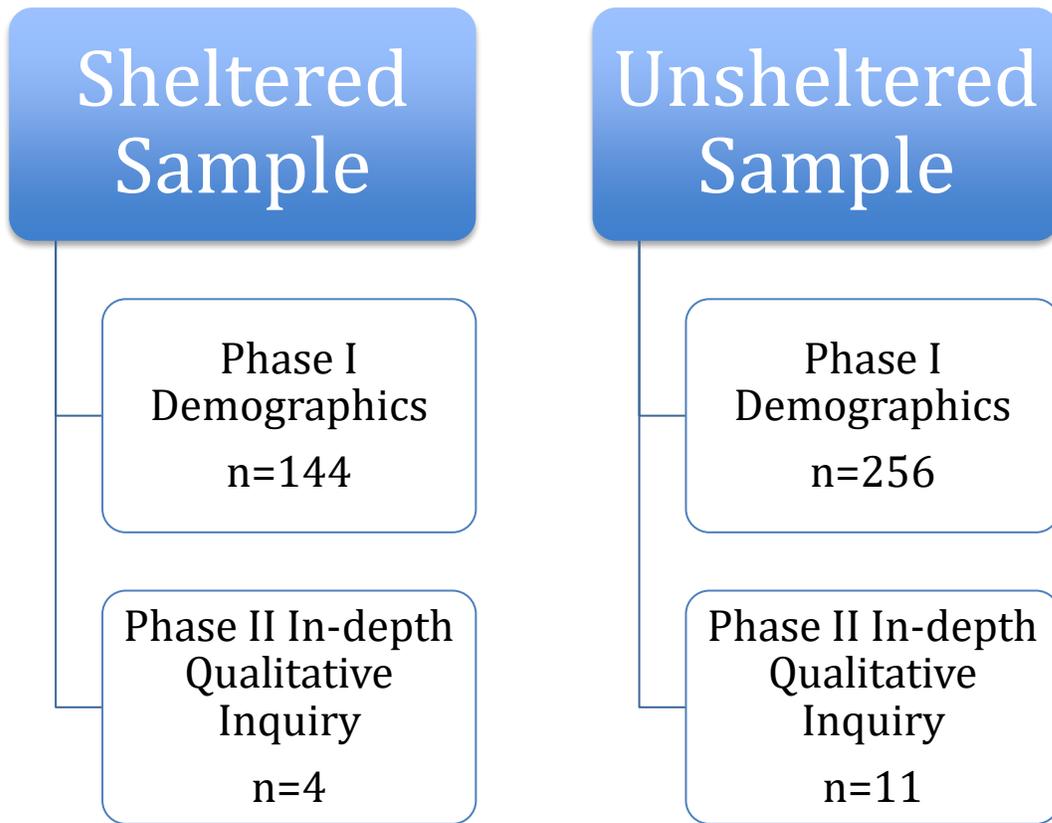


Figure 2. Assertion 1 Visual of Ecological Model

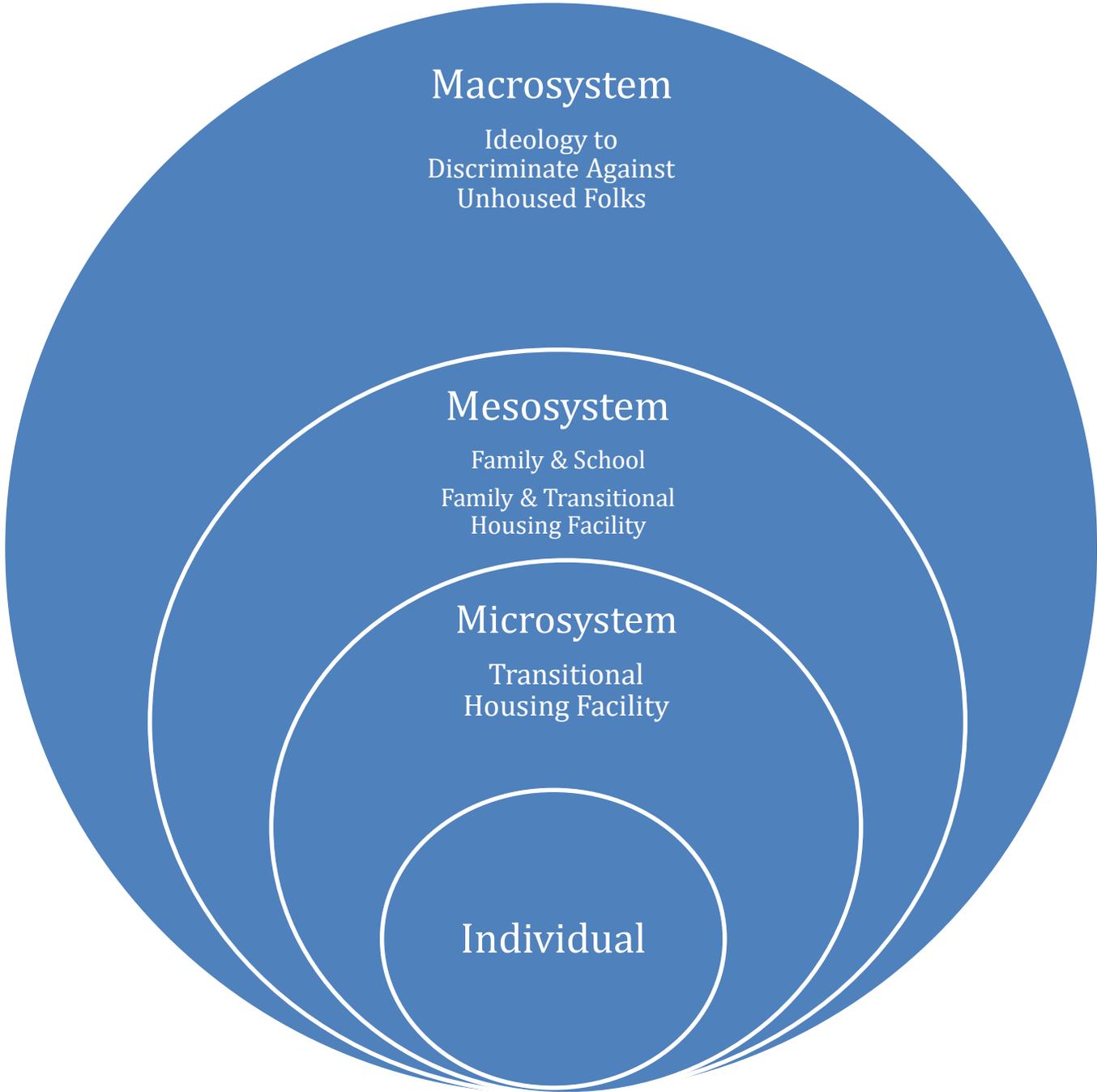


Figure 3. Assertion 2 Visual of Ecological Model

