

THE MEANING OF HOMELESSNESS TO HOMELESS WOMEN VETERANS

by

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ABSTRACT

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Homelessness in America continues to be a pervasive problem, with veterans being disproportionately represented in this population. As the Iraq/Afghanistan war soldiers return to civilian life, worries about this population and the risk of homelessness is growing. Female soldier's roles in the military have expanded throughout the years and now include many combat roles, thus exposing them to the risks associated with combat. Female soldiers are twice as likely to have Post Traumatic Stress Disorder (PTSD) than their male counterparts and are three to four times more likely to become homeless. Female homeless veterans have typically been excluded from participation in research due to their small numbers, but with the increasing population of female soldiers, it is important to understand the risk factors for homelessness in this population. Utilizing a modified framework for studying vulnerable populations, a qualitative descriptive study was conducted to explore the meaning of homelessness to female homeless veterans, the risk factors for homelessness and services necessary to help exit the homeless cycle. Six homeless women veterans participated in private, audio taped interviews using a semi-structured interview tool. Risk factors consisted of abuse or trauma and broken trusts. Resources necessary to end their homeless state consisted of a job or some form of income and permanent housing. For all of the women, becoming homeless consisted of overwhelming loss.

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CHAPTER 1

INTRODUCTION AND SIGNIFICANCE OF THE PROBLEM

1.1 Introduction to the Problem

On any given night, there are at least 500,000 homeless veterans are sleeping on the street in the United States. This number is expected to continue to grow with the number of returning Iraq and Afghanistan Veterans (Olszyk & Goodell, 2008). It is estimated that at least one quarter of all homeless persons and 40% of the total male homeless population are veterans (National Coalition for the Homeless, 2008). Although studies have suggested that military service alone does not increase the risk for homelessness, veterans have high rates of alcohol/drug abuse problems, mental and medical health problems, and social issues which have been shown to increase risk for homelessness (Mares & Rosenheck, 2004). Homeless veterans have numerous co-morbidities, which can include medical or psychological illnesses. Many homeless veterans suffer from tuberculosis, Human Immunodeficiency Virus infection, chronic obstructive pulmonary disease, eye disease, hepatitis, and orthopedic problems in addition to having psychiatric difficulties (Goldstein, Luther, Haas, Gordon, & Appelt, 2009).

Homelessness among women is growing at a rapid rate, with approximately one third of all homeless persons being women. Homeless women are at higher risk for death, illness, injury and violence than their housed counterparts. They frequently engage in unprotected or risky sex in order to survive or meet their basic needs and have high rates of substance abuse (Stein, Anderson, & Gelberg, 2007). Just as there is a high rate of homeless veterans among the general homeless population, homelessness among women veterans is increasing. Women

veterans are three to four times more likely to become homeless than non-veteran women (Washington et al., 2010). Homeless women veterans suffer from many of the same comorbidities as do the male homeless veteran population. Although the homeless women veteran population is growing, there is little available research as to the reasons for the increase in homelessness, risk factors for homelessness or the meaning of homelessness to homeless women veterans. Understanding the risk factors and meaning of homelessness to women veterans and integrating this information into assessment of female veterans may assist providers with identifying women veterans who may be at risk for becoming homeless (Washington et. al, 2010)

1.2 Background and Significance

Homelessness in America continues to rise despite the funding and programs offered by individuals, communities and the federal government. Homeless persons have increased rates of illness and an age-adjusted mortality rate that is three to six times higher than it is in those that are housed (Savage et. al, 2006). Health care problems among the homeless include psychiatric illnesses, tuberculosis, chronic obstructive lung disease, hepatitis, HIV and substance abuse issues (Schanzer, Dominguez, Strout, & Caton, 2007). The homeless female population has continued to expand rapidly with as many as one third of the homeless population being women with minor children (Stein, Andersen & Gelberg, 2007). Many women have become homeless due to violence in their current relationship and many of these same women have histories of childhood abuse (Anderson & Rayens, 2004).

Veterans are disproportionately represented in the homeless population and although military service in itself does not seem to increase the likelihood of homelessness, many social issues, mental health problems and multiple medical diagnoses play a role in increasing the

likelihood of homelessness (Kline et. al, 2009). Research has shown that 70% of homeless veterans have alcohol or substance abuse problems (Cunningham, Henry & Lyons, 2007) and 45% have one or more mental health/illness diagnoses (U.S. Department of Veterans Affairs, 2003). These social and mental illnesses contribute to the likelihood of veterans becoming homeless (Cunningham, Henry & Lyons, 2007).

Era of military service does not appear to be a factor in homelessness. It was previously proposed that Vietnam veterans (drafted soldiers) would have a higher risk than other service eras (all volunteer force). Yet, research shows it is the volunteer force that has the higher risk of homelessness, and that homelessness may be due to self-selection (Rosenheck, Frishman, & Chang, 1994; Tessler, Rosenheck & Gamache, 2002; Olszyk & Goodell, 2008). Those with little life or employment skills entered the military due to the inability to gain or maintain employment. These same soldiers were then discharged without gaining the skills necessary to gain or maintain employment, thus, the higher rate of homelessness in the all volunteer force.

The numbers of female homeless veterans continues to grow just as the numbers of women veterans are growing. Currently, 14% of all military personnel deployed to Iraq and Afghanistan are women (Department of Defense, 2011). In the past, women were not allowed in combat roles but served in medical or administrative roles. Regulations restricting women from combat support assignments were relaxed after the Gulf War ended (Murdoch et al, 2006). Along with the increase in females being in combat support roles, the numbers of women being injured or killed in action while deployed are also increasing. According to the Department of Defense (2012), 635 women have been injured and 143 women killed during the Afghanistan and Iraqi operations. Post deployment illnesses in women veterans are increasing as the numbers of females in combat roles grows (Vogt et al., 2006). Current research shows that diagnosis of post-traumatic distress disorder may be twice as high in women as in their male counterparts (Ghahramanlou-Holloway, Cox, Fritz, & George, 2011; Tolin & Foa, 2006). With

little information being available on post deployment illness in the female soldier, Street, Vogt and Dutra (2009) suggest gender specific research should be conducted to determine post deployment problems in order to adapt treatment modalities for women veterans. Yet, research with the female veteran population has been under addressed. According to Yano et.al (2009), female veterans must be included in studies in order to represent them in meaningful analysis to design programs that will meet their needs.

The increase in the number of women soldiers and women veterans has been followed by an increase in the homeless women veteran population. An abundance of research has been conducted with homeless veterans, but, with the exception of a small number of studies, female homeless veterans have been excluded from the research, due to the small numbers. In a study conducted by Gamache, Rosenheck, and Tessler (2003), female veterans' risk for homelessness was two to four times higher than non-veteran women, although the reasons for this increased risk were unclear.

The current study provides important information regarding homeless women veterans as few research findings are available to describe either the homeless women veteran experience or the risk factors for homelessness. In order to design and implement programs for the homeless woman veteran, one must first understand the meaning of homelessness to this population and the risk factors for homelessness.

1.3 Philosophical/Theoretical Perspective

The overarching framework used to guide this study is the framework for studying vulnerable populations (Aday, 2001). Using the vulnerable populations' conceptual model, one must look at both the macro (community) and micro (individual) characteristics and their inter-relationships. Macro level perspectives include community resources and community health needs, including physical, psychological and social needs. Micro level perspectives include the

individual resources and individual health needs. According to Aday, the risk of vulnerability can be predicted by social status (age, sex, race, and ethnicity), social capital (marital status, social network, family structure) and human capital (schools, jobs, income, and housing). The vulnerable population model proposes an inverse relationship between community and individual resources and risk of vulnerability.

Today, the word *vulnerable* has the connotation of being susceptible to health or mental problems, harm or even neglect (Leight, 2003). Vulnerable populations are social groups who are at increased risk of morbidity and mortality due to social factors such as low socioeconomic status and lack of resources (Flaskerud & Winslow, 1998). Groups that typically fall into this category are women and children, ethnic groups, gay men and lesbians, immigrants, homeless persons, chemically dependent persons and elders. Homeless persons fall into this category as they are at increased risk of mortality, multiple co-morbidities, limited resources and low socioeconomic status. Shi and Stevens (2005) discuss five reasons to focus attention on vulnerable populations: their health needs are greater; their numbers continue to grow; vulnerability is a societal rather than a personal problem; the increasing number of vulnerable impact the nation's health resources; and there is a growing concern regarding disparities and health.

The vulnerable populations' conceptual model finds interrelationships between resource availability (both personal and community), relative risk, and health status. Resource availability includes both socio-economic resources as well as environmental resources. Relative risk concerns the ratio of poor health in those who do not have access to or receive resources and are compared to risks, compared to the health status of those who do have resources and are not exposed to those risks (Aday, 1994).

Health status has been defined by the World Health Organization (WHO) as a “state of complete physical and social well being, not merely the absence of disease” (<http://www.who.int/mediacentre/factsheets/fs326/en>). This definition goes beyond the more western definition which merely views the mind, body and society as separate to reflect a more holistic view of health. Populations are considered vulnerable when they are subject to unequal risk and increased health burden than are others in their community. They may be marginalized because they are different, discriminated against, and underserved due to political, social or economic differences (Wilson & Neville, 2009).

Using an individual perspective of the origins of poor health status, one might assume personal life style choices and poor health outcomes are the result of failures of the individual to assume responsibility for his/her own health and well being. Thus, the individual would have the primary responsibility in decreasing health risk. Using the community perspective focuses on risks that exist for different groups due to the availability or lack of availability of opportunities and/or resources to maximize health. A result of the community's failure to invest in or assume responsibility for the members of the community will be increased risk of vulnerability and poor health (Aday, 1994).

Individual resources include social status, social capital and human capital. Social status is an individual characteristic (age, sex, race and ethnicity) which defines the roles people play in society and the opportunities they may have as a result of their social status. Social capital involves the quantity and quality of interpersonal relationships between people, such as family ties. Social support is a vital resource for people who are experiencing negative life events. Human capital refers to the investment in one's skills and abilities that will enable them to enhance their contribution to society. The assumption of the vulnerable population framework is that social and economic programs and policies are necessary to address the health and health care needs of vulnerable populations. According to Flaskerud (2010), in the

current economic environment where many states are decreasing their social services budget, it is very clear that those without resources, power and status are the ones that are most vulnerable and at risk.

The framework for vulnerable populations has been used to study various populations considered to meet the definition of vulnerability. Leight (2003) used the vulnerable population framework to discuss the opportunities and resources necessary to achieve and maintain health in rural communities. She discussed human capital as it applies to rural areas such as decreases in employment in rural areas, demographics of the rural areas (mostly elderly), absence of housing, and limited income. In regards to social ties and social status, the loss of employment in many rural areas has had a great impact on the infrastructure of family and community life. Many of the children in rural areas have gone to metropolitan areas to find employment and are often forced to enter the work force earlier, thus diminishing their educational opportunities. Relative risk increases when there is a lack of socioeconomic and environmental resources. For those in rural areas, there is frequently a lack of optimal nutrition, exercise and sleep as well as a reduction in normal preventive health care. Two of the indicators for health status utilizing the vulnerable population framework are morbidity and mortality. Although rural mortality rates are generally lower than those in urban areas, accidental injury and infant mortality rates can be higher in rural areas. Accidental injuries in rural areas are generally motor vehicle or occupational injuries. Occupational injury rates are higher in rural areas due to the normal type of employment in these areas (i.e., farming, ranching, mining, or logging). Infant mortality is higher in rural areas secondary to the socioeconomic status of the mothers and lack of available resources.

Using the vulnerable populations' model, Spears, Stein and Koniak-Griffin (2010), examined changes in substance abuse use during pregnancy among adolescent girls utilizing secondary analysis of data from 305 ethnic minority females. Young females from an

ethnic/minority background may have limited resources and resulting increased risk for health problems such as depression and substance abuse compared to other pregnant populations. Resource availability indicators used were family stability and religious beliefs, whereas relative risk indicators were low self esteem, partner drug abuse, and previous history of drug or alcohol abuse. Pre-pregnancy use of alcohol, drugs and tobacco were indicative of quicker resumption of substances during the post-partum, period although in lower numbers than in previous studies as cited by Spears et al, 2010 (Gilchrist, Hussey, Gillmore, Lohr, & Morrison, 1996; Teagle & Brindis, 1998; Wiemann & Berenson, 1998). Past history of physical or sexual abuse as a child was also predictive of resumption of substance abuse in the post-partum period as was having a partner who used substances. Religious beliefs were found to be a protective factor in resumption of substances during the post-partum period. As described in the vulnerable population framework, there was an inverse relationship between resource availability and relative risk factors for the teens in this study. Although neither of these studies was conducted with homeless persons, they both point out the correlation between resources and relative risk of vulnerable populations.

The current study has been framed by a modified framework to explore the individual perspective of risks and resources (See Figure 1.3.1). Using this modified framework, an assessment of the homeless veteran's perspective of the community and individual resources that may have led to the current situation was conducted. Understanding what community and individual resources, or lack of, contributed to the homeless situation may lead to knowledge of what resources must be strengthened to assist homeless women veterans in breaking the homeless cycle, and may provide information that is crucial to protecting at risk women veterans from becoming homeless in the future. Community resources may consist of housing (whether shelters or transitional housing), food banks, community clinics, or available social services. Individual resources may consist of funds, insurance, support network (family or friends), and

personal strengths. A decrease in individual resources will increase the relative risk for vulnerability, which will in turn increase the individual's health needs.

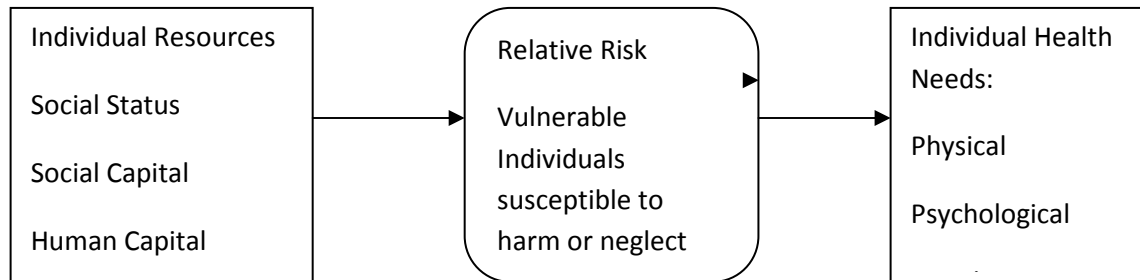


Figure 1.3. Modified Framework for Studying Vulnerable Populations Based on Individual Perspective

1.4 Statement of Purpose

The purpose of this descriptive study was to explore the meaning of homelessness among the female veteran homeless population as well as risk factors for homelessness. An exploration of current health care utilization and personal perspective of personal or community resources necessary to break the homeless cycle was conducted as well.

1.5 Study Questions

The questions explored in this qualitative study were:

1. What is the meaning of homelessness to homeless women veterans? (over-arching question to explore the homeless experience).
2. What individual resources (social capital, human capital, social status) increased the relative risk for these particular participants?
3. What individual (social capital, human capital) or community resources are needed to end their homeless situation?

4. Where do the participants primarily receive their health (physical or psychological) care?

5. How did the military prepare them for life after military (human capital)?

1.6 Essential Assumptions

The researcher assumed there were macro and micro deficiencies that contribute to homelessness. Through exploration of these deficiencies, the risk factors for the participants' homeless situation and resources necessary to end their homeless situation may be discovered.

The researcher assumed the participants would be able to or wish to share with the researcher the risk factors for their homelessness as well as the resources they feel are necessary to end their homelessness state.

1.7 Chapter Summary

Homelessness in the United States continues to grow regardless of the resources that are used to end unwanted homelessness. Veterans are disproportionately represented among the general homeless population. Homelessness among women is growing at a rapid rate, with approximately one-third of all homeless persons being women. Homeless women are at higher risk for death, illness, injury and violence than their housed counterparts. The female presence in the military is growing and as such, the female veteran population will continue to grow. As the female veteran population continues to grow, there is an increased concern regarding the risk of homelessness in this population, although the reason for the increased risk is not yet understood. Women veterans are three to four times more likely to become homeless than are non-veteran women. Although the homeless veteran population is growing, there is a gap in the literature regarding homeless women veterans, as the population is small and normally

excluded from research. Exploring the meaning of homelessness to homeless women veterans will provide an understanding of what it is to be homeless and how homelessness affects the physical, social and psychological health of women veterans. Determining individual resource factors that increase relative risk for homelessness among female veterans as well as individual or community health services or resources that are necessary for exiting homelessness may assist the Veterans Administration (VA) in designing programs for the homeless female veteran population.

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

2.1 Introduction

The female homeless veteran population is growing. Research has shown female veterans have higher rates of Post Traumatic Stress Disorder (PTSD) and other combat related mental health problems than their male counterparts which may have an impact on the homeless rate in the female veteran population. Although there is an abundance of veteran research and homeless veteran research, women veterans have normally been excluded due to their small numbers. As these numbers continue to grow, they must be included in research in order to adequately represent their population in meaningful analysis. The ability to design and implement useful programs for this population requires understanding the meaning of homelessness, risk factors for homelessness, current service utilization, and resources required to end the homeless cycle. The review of literature is organized in the following manner: women in the military, women veterans, homelessness in the United States, known risk factors for homelessness, homeless veterans, homelessness among women veterans, programs provided for homeless veterans, and known unmet needs of homeless veterans.

2.2 Women in the Military

The history of women in the military begins with the American Revolution. Although the military was primarily male, by 1783 there were more than 20,000 women in the military who provided support or active service. Those that actively served in the military dressed as males in

order to fight alongside their husbands. During the Civil War, thousands of women served as nurses and organized unofficially to provide food and clothing for the soldiers (Small, 1998). Because of the roles women played in the Civil War in maintaining acceptable levels of care, the Nurse Corp was established (Perlin, Mather & Turner, 2005). In 1948 the Women Armed Services Act was passed granting women permanent status in both the regular and reserve forces of the Army, Navy, Marines and Air Force, and entitling them to veterans' benefits (Huynh-Hohnbaum, Damron-Rodriguez, Washington, Villa, & Harada, 2003). Although women's numbers in the military continued to expand, during the Vietnam era, their enlistment was capped at two percent of the total forces and those that were in the service served primarily as nurses and clerical staff (Murdoch et al., 2006).

During the Gulf War, 1990-1991, roles for women were expanded to include indirect combat roles such as plane or helicopter pilot, supervision or oversight of prisoners of war, repairing fighting equipment and leading engineering battalions (Murdoch et al., 2006). During this period, approximately 11% of the total soldier population was female, with less than half serving in clerical or combat support positions. Data from the Gulf War showed approximate equal numbers of men and women experiencing at least one exposure to combat (Carney et al., 2003). By the end of the gulf war, more than 33,000 women were in combat support positions such as truck driver, pilot, port security and POW camp oversight (Murdoch et al., 2006).

In the current Iraq and Afghanistan operations, women are still barred from serving in direct combat roles, such as in the Marine and Army infantry units, armored units and small amphibious vessels, but this does not negate their exposure to combat situations (Titunik, 2000). The Iraq and Afghanistan operations lack a true *front line*, meaning enemy attacks can occur anywhere, thus increasing women soldiers' exposure to combat and combat related

injuries (Street, Vogt, & Dutra, 2009). In 2009 it was estimated that women comprised approximately 14.6 % of the total Armed Forces, 21% of which are in the military reserves (Agazio & Buckley, 2010).

The increase in female soldiers has led to a complication and expense for the military as approximately 10% of female active duty service members become pregnant each year. Pregnancy complicates how and where a soldier can be assigned, as pregnant females are considered non-deployable to combat areas and are normally not assigned overseas. Should a female soldier become pregnant in a combat zone they must be reassigned, leading to significant costs for the U.S. military, not only in transportation to another assignment, but in replacing the female soldier overseas. Pregnant females have the option of continuing to serve, request a temporary leave from service or separation from service. (Ponder & Nothnagle, 2010). The change in the demographics of the military and resulting change in healthcare needs, has led to a new focus in the Department of Defense (DOD) and VA in establishing women's health as a priority (Perlin et al., 2005).

In order to explore the new challenges in health care posed by the changing demographics of the military, Agazio and Buckley (2010) conducted a study to explore health promotion in active duty and reserve women, with and without children. The study was guided by Pender's Health Promotion Model and included two factors: personal factors and behavior specific cognitions. A total of 491 women participated in the study, 287 on active duty and 204 reservists, with all branches of the military being represented. The main significant finding of the study was that active duty women with children were found to be significantly more engaged in health promotion activities than those without children or those in the reserves. This may be in part due to the requirements placed on active duty soldiers to meet specific height/weight requirements to remain in the military. This finding can also be attributed to the time management skills that the soldier may have developed in order to balance significant work and

home responsibilities particularly in a wartime era. Self-efficacy was high among all groups and was reported as a determinant to engaging in healthy behaviors. Participants in the study reported on-site facilities that are available before, during and after work hours as being the most beneficial to their ability to maintain their physical activity and health promotion. The researchers suggested that military officials reinforce self-efficacy among military women in order to increase their engagement in health promotion activities.

As the female presence in combat support units grows, there is also an increase risk for morbidity, including mental health disorders. Although there has been an abundance of research with active duty males and the recurrence of mental health disorders there has been very little research with active duty females in combat support units to discover impact on mental health. This may be in part due to the greater combat exposure for males on active duty. Lindstrom et al. (2006) conducted a preliminary, yet large study with active duty Navy and Marine Corps women in both combat support and noncombat support units to determine if those in combat support units were at higher risk for hospitalization due to a mental health disorder. The study included 10,299 women in combat support units and 63,478 women in non combat support units. They found that women in combat support units were less likely to be hospitalized for a mental health disorder than women in all military occupations. The researchers suggested caution with the findings in that the findings may be related to the fact that women who are selected to or choose to enter a combat support related occupation are more physically and mentally fit than those in other occupations. In addition to physical and mental condition, the pressure in serving in a combat support unit and the associated stigma with seeking mental health care may lead those in non-traditional occupations to be less likely to seek out mental health care while on active duty. These findings are in contrast to the study conducted by Luxton, Skopp, and Maguen (2010) who conducted a retrospective review of a pre and post-deployment data base with 516 women and 6427 male active duty soldiers. In this particular

sample, combat exposure was a strong predictor of PTSD and depression in the female soldiers when compared to the male soldiers.

Increased numbers of women in the military has also increased the number of traumatic experiences that are experienced by women while on active duty. Unfortunately not only are women exposed to combat related trauma, but there is also increasing evidence that they are being subjected to sexual harassment and sexual assault while on active duty. Kimerling et al. (2010) conducted a study with 125,729 male and female soldiers returning from Iraq and Afghanistan and found that among this sample, 15.1% of the women reported military sexual trauma. In addition, the researchers also found that those who screened positive for military sexual trauma were significantly more likely to have a mental health diagnosis to include PTSD, anxiety disorder, depression and substance abuse disorder.

2.3 Women Veterans

The mission of the VA is to “care for him who shall have born the battle and for his widow and his orphan” (Department of Veterans Affairs, 1959). The VA was developed to provide care to veterans, who in the past have been primarily male. As the number of women in the military increases so does the number of women veterans (Perlin, Mather & Turner, 2005). Women veterans, especially those from minority backgrounds, are the fastest growing veteran population (Huynh-Hohnbaum, et al., 2003). The increase in this population has changed the type and number of services the VA must provide. Along with changes in services, the focus of veteran research is changing to include more research on women veterans, as in the past, veteran research has typically excluded women due to their small numbers. Research priorities include how participation in military service may impact reproductive health, mental health, substance abuse and how exposure to environmental hazards will impact future health of the

women. In addition, current VA research is focusing on how to build capacity in the VA system for women's programs, utilization rates, and reasons for non-use of services (Yano et al., 2009).

With the changing face of the VA patient population, there is a focus on the veteran provider or health care worker and his/her knowledge of female patients. Prior research has found that one in five women do not feel welcome in the veteran's health care system as the programs were designed for males, have remained geared toward the male veteran and VA staff lack knowledge regarding female veteran needs (Skinner, 2000). One would assume that this lack of knowledge regarding how to care for female veterans may have implications for the future of the VA and the veterans that they serve. To address this issue, Salgado, Vogt, King and King (2002) conducted a study with 619 health care workers from two VA medical centers to develop and test the new Gender Awareness Inventory-VA which can be used as a tool in health care systems to determine staff knowledge regarding women veteran issues and needs. Respondents in the study were 60% female and 40% male, with 37% being in the age range of 41-50, which is representative of the VA health care worker population. Their research has found the psychometric evidence of the test to be sound. Using the assessment tool the researchers discovered a lack of knowledge among VA staff members regarding female patients or their specific needs. This lack of knowledge may very well be the reason for unwelcomeness women veterans feel in the VA system. Thus far, the assessment tool has not been widely used in the VA system, although nationally the woman veterans' program managers are conducting education of VA staff regarding women veterans' needs.

Washington, Yano and Simon (2006) conducted a large study to determine what influences female veterans use or non-use of the VA healthcare system utilizing The Behavioral Model of Health Services Utilization framework. The participants in the study consisted of 2,174 female veterans, 1081 of which were users of the VA healthcare system. The non-VA users perceived the VA physicians as not being skilled in treating women and perceived the VA

environment as being geared towards males and unwelcome towards women. Younger female veterans were also more likely to perceive the care in the VA to be of poor and inconvenient. The researchers suggest that women veterans may prefer outpatient care in women's health clinics rather than the male dominated primary care clinics, especially for those women with a history of military sexual trauma.

Because of the increase in female veterans and research findings that 87% of female veterans do not use the VA system (Washington et al., 2006), several researchers have conducted research to determine the barriers to care for females. Vogt et al. (2006) conducted a national study utilizing the VA national registry of women veterans to determine the perceived or actual barriers to care for this population. The researchers conducted focus groups with 942 current or former female users of the VA healthcare system. The barriers and future challenges for the VA consisted of lack of services specific to women issues, logistics to obtaining care (waiting time, continuity of care), and issues related to physician insensitivity to female needs. The findings provide important information to the VA in designing programs for women veterans. The researchers did not find the previously mentioned feeling of unwelcomeness due to staff knowledge (Salgado et al., 2002; Washington et al., 2006).

Frayne et al. (2007) conducted a retrospective review utilizing the VA's national patient care data base to determine how health care utilization among female and male veterans differs. The findings suggest that women use more outpatient services than do their male counterparts, and had lower total adjusted costs. Women veterans were in general younger, so their inpatient costs were much less than the male veterans. Eighty percent of women veterans are less than 65 years of age compared to less than 50% for male veterans, meaning health priorities and needs will be different. The findings showed that women with mental illness were more likely than men to use private mental health care providers rather than VA providers. The researchers suggest with the high rates of mental illness being found in those recently returning

from Iraq and Afghanistan and low rates of VA mental health usage, an increase in private mental health providers may be necessary to provide the necessary care to female veterans. The results of this study may have an impact in mental health care beyond the VA health care system.

In designing programs for women veterans one of the growing problems that many VA facilities are responding to is military sexual trauma (MST). Military sexual trauma is defined as sexual assault or repeated threatening sexual harassment while on active duty. Up to 22% of female veterans screened for MST have been positive (Kimerling, Gima, Smith, Street & Frayne, 2007). Females who have experienced MST are at higher risk for PTSD, depression and unhealthy life style behaviors (Suris, Lind, Kashner, Borman, & Petty, 2004). In a study conducted by Rowe, Gradus, Pineles, Batten and Davison (2009) with 232 female veterans, 163 reported MST. Consistent with the literature, the researchers found the women who experienced MST to experience more psychological symptoms and identify themselves as disabled than those who did not experience MST. Although the researchers hypothesized an increase in eating disorders among those who experienced MST, this did not hold true with the exception of starvation. Those who experienced MST were more likely to engage in starving behaviors than those who did not experience MST.

The above research describes the changing face of the veteran population demographics and associated perceived need in changing health care priorities for the VHA. The research shows that although the VHA has made progress there is still progress to be made in staff knowledge of women veterans' needs, women veterans knowledge of the VHA healthcare system, and provision of quality care to women veterans.

2.4 Homelessness in the United States

Although defining homelessness would seem to be a straightforward task, this has not been the case. Many different definitions have been used by researchers, with the most commonly used definition, and the one used by this researcher being the definition included in the McKinney Act of 1987:

People are homeless when they lack a regular, fixed and adequate nighttime residence or have a primary residence that is a private or public shelter, an institution that provides temporary residence for those meant to be institutionalized, or a public or private place which is not designed for sleeping accommodations for human beings. (Stewart B. McKinney Homeless Assistance Act (P.L. 100-7).

As previously stated, determining the actual number of homeless persons in the United States is difficult. Available data on the prevalence of homelessness is generally based on numbers during nightly counts, homeless shelters and requests for emergency shelter (Coker et al., 2009). These numbers leave many homeless uncounated, so the numbers presented are normally just estimates of homeless. According to the National Alliance to End Homelessness (2007), there were approximately 800,000 people in the United States who were homeless in 2007 with approximately 38% of those being families with young children. It is estimated that 46% of the homeless population is African Americans; 34% European Americans, 15% Hispanic, and 4% American Indian. Eighty percent of homeless adults are between the age of 18 and fifty, with less than 5% being over 60 years of age (Toro, 2007).

Homeless persons are at risk for increased morbidity and mortality as they expend significant energy just trying to satisfy the most basic of needs such as food and shelter. Lack of nutrition and warmth makes them susceptible to many illnesses and lack of access to health care can turn a minor illness into a devastating one. The living conditions of life on the street,

such as fights, loneliness, lack of sanitation, exposure to the climate, and lack of social support place homeless persons at risk for health problems (Munoz, Crespo, & Perez-Santos, 2006). Homeless persons often suffer from chronic illnesses, such as hypertension, poor oral hygiene, peripheral vascular disease, gastrointestinal disorders, neurological impairments, tuberculosis and Acquired Immune Deficiency Syndrome (AIDS). Acute illnesses often consist of trauma, pneumonia, skin ailments, parasites and cold related problems such as hypothermia and frost bite (Martins, 2008). The prevalence of HIV/AIDS among the homeless has been estimated at 5% to 15%, much higher than the housed population (Robertson, 2004). Hepatitis B and C risk in the homeless population is estimated to be at least 22 % higher than in the housed population (Munoz, et al., 2006). Hwang (2001) found the mortality rate among homeless persons to be two to four times higher than that of the general population and the life expectancy to be 20 years less than people with a home. In addition to the high rate of physical illness, the homeless have high rates of mental illness and substance abuse. The prevalence of mental illness among the homeless population is typically three to four times higher than that in the general population (Shelton, Taylor, Bonner, & van den Bree, 2009).

In addition to increased physical and mental health problems, the homeless have many barriers to medical care, including not knowing where to go for care, lack of insurance or money, confusing paperwork, long waiting times, and feeling too sick to seek care (Lewis, Anderson, & Gelberg, 2003). When presenting for care, they usually have complex complaints that can be difficult and very costly to address and require more than one practitioner or service to meet their needs, thus placing a large burden on the hospital or clinic where they are presenting (Wen, Hudack, & Hwang, 2007). Feelings of being discriminated against when seeking health care has been well documented as a barrier to care (Ensign & Panke, 2002; Montauk, 2006; Wilson, 2009). These studies have found that homeless persons often delay care due to feelings of being discriminated against or feeling unwelcome. When the homeless

finally do present for care, they have often delayed their care for so long that their illness has advanced to a point where they must be admitted to the hospital. The homeless generally use busy Emergency Departments (ED) for primary health care and often return for repeat care. Their utilization rate of the ED is at least three times the ED utilization rate of the general population (Savage, et. al, 2006).

A high percentage of homeless persons suffer from some form of mental illness or cognitive disability with estimates being as high as 25% to 30% of the total homeless population (Kim et al., 2007). The history of homeless persons shows the increase in mental illness among the homeless began in the 1980's when states began deinstitutionalizing the mentally ill and discharging them to the streets. Recent estimates of homeless persons with mental illness range from 150,000 to 200,000 in the United States, yet it is difficult to determine an accurate number since they tend to hide from authorities (Gittelman, 2006). Although the reasons for the high percentage of mentally ill homeless has been blamed on a lack of inpatient psychiatric beds, a study by Odell and Commander (2000), found mentally ill patients were homeless for a variety of reasons, some of which led back to their childhood. These research findings indicated many different reasons for homelessness among their sample, such as antisocial behavior that persisted beyond teen years, alcohol and drug problems, criminal activity, and loss of social support.

Mentally ill homeless persons generally do not receive adequate medical or psychiatric care since they tend to avoid the medical care system and often have an underlying belief that they can heal themselves. Other reasons for not seeking either physical or mental health care includes lack of access and perceived stigma or fear of social rejection (Kim, et. al, 2007). When the homeless do use the health care system, it is usually through the emergency department or psychiatric hospital, where the focus is stabilizing their mental health condition rather than providing holistic care. Discharge for these patients is frequently to the streets, where

compliance with their psychiatric medication regime is highly unlikely thus perpetuating the cycle of continued homelessness (Lauber, Lay & Rossler, 2006). On the streets, mentally ill homeless persons are often arrested for loitering, stealing food or breaking into buildings while seeking shelter. Fischer, Shinn, ShROUT and Tsemberis (2008) found that non-violent criminal activity for mentally ill homeless persons decreased as their shelter and nutritional needs were met in public shelters, yet there was an increase in violent criminal activity due to the closeness or crowding within the shelters.

Padgett, Hawkins, Abrams, and Davis (2006) explored the life experiences of homeless women with serious mental illness. Their study consisted of life history interviews with 13 formerly homeless females with mental illness and substance abuse problems. Five themes emerged from the interviews, betrayal of trust, horrific nature of traumatic events, anxiety related to getting out and speaking up, the desire for a place of one's own, and status loss as related to gender. The discussion of status loss and gender pointed out significant differences between the experience of being homeless as a male and that of being female. Homeless men have opportunities to earn income while being homeless through pimping, drug dealing, and gambling, activities that are often depicted and valorized in movies (Higate, 2000). Homeless women on the other hand are typically confined to earning money through activities such as prostitution and shoplifting, neither of which is portrayed in our society as either acceptable or heroic. Women who are homeless are often considered unladylike or unfeminine whereas homeless men are not considered to be unmasculine. The study is significant in that the information depicting the female perspective of social status changes after becoming homeless points out the higher vulnerability of female homeless persons over that of their male counterparts. Higate (2000) concurred with the gendering of the homeless population in that homeless women are considered "doubly deviant" (p. 332) due to the inability to fit the normative image of house and domesticity.

2.5 Risk factors for Homelessness

There are many different risk factors for homelessness including socio-economic causes such as loss of employment or transportation, lack of affordable housing, and family disruptions such as divorce. Approximately 25% of the homeless youth have suffered from physical or sexual abuse, 33% are runaways, and 27% had been in the foster care system and have reached the age of emancipation (Martins, 2008). Those exiting the foster care system are at increased risk not only for homelessness but for negative psychosocial outcomes, behavioral problems, and victimization (Fowler, Toro, and Miles, 2009). Other factors that have contributed to homelessness are a lack of a social network, anti-social or offensive behavior, and lack of education (Shelton, Taylor, Bonner & van den Bree, 2009). In addition, substance abuse and alcohol problems are frequently found to be contributors to homelessness (Koegel, 1998; North & Smith, 1994).

In a study conducted by North and Smith (1994), non-white males (n=260) generally reported high rates of substance abuse and frequently listed substance abuse as the reason for their homelessness. They found that non-white women (n=241) frequently were mothers and had children in their custody and were frequently on welfare, although this was not enough to keep them off of the streets. In their sample, there was a high rate of psychopathology among the white females, which contributed to their homelessness.

A significant proportion (25 to 30%) of homeless persons has one or more mental illnesses. The reasons for the high number of homeless with mental illness are related, in part, to structural functions of our society, such as high unemployment, family disruptions, decreased availability of affordable housing and decrease in number of inpatient psychiatric beds. Odell and Commander (2000) conducted a study with 49 homeless persons with one or more mental illness diagnoses to determine the risk factors for this population. Risk factors for their subjects

consisted of substance abuse, lack of social support and lack of affordable housing. For one third of the homeless in this study, onset of psychosis did not occur until after their first episode of homelessness, meaning psychosis may not have been a contributing factor for homelessness.

Lack of a social support system increases the risk of homelessness for women and in particular, women with children. The fastest growing segment of the current homeless population in the United States is families. Of these homeless families, 90% are headed by women (Anderson & Rayens, 2004). According to Anderson and Imle (2001), homeless women not only have limited support but are also less likely to use their social support system for assistance. Anderson and Rayens (2004) conducted a descriptive, correlational study with 94 homeless women, and 88 never before homeless women to examine the current social support networks of homeless and never before homeless women. As hypothesized, the never before homeless women had much stronger social support networks with less conflict than did the homeless women. Homeless women had the highest levels of conflict with family members and were less likely to access their social network for assistance. The researchers suggest early identification of women at risk will allow for interventions to support healthy support networks.

Studies have shown child abuse to be a risk factor for homelessness and those who have been abused report low self-esteem, a lack of social support and depression (Martine & Sharp, 2006; Johnson, Rew, & Sternglanz, 2006). Women who have experienced domestic or sexual abuse are at higher risk for becoming homeless as well (Anderson & Rayens, 2004; Tischler, Rademeyer, & Vostanis, 2007). Hudson et al. (2010) conducted a secondary analysis with 202 homeless females in the Los Angeles area to assess predictors of homelessness. Of the 202 homeless females, approximately 33% had been raped as an adult, 20% reported childhood sexual abuse and over one-third had been sexually harassed or physically abused as an adult. Depression was highly correlated with assault as an adult, while self-esteem had a

high inverse relationship with assault. The women who reported a physical abuse history also reported low self-esteem, fear and loneliness. The researchers suggested development of a brief risk assessment with these factors for homeless women so the necessary services can be provided to homeless women who have experienced these forms of abuse.

2.6 Homeless Veterans

Approximately one-third of the entire homeless population is composed of those who swore to defend the constitution and many of those have served in combat. Although one-third of the homeless populations are veterans, veterans comprise approximately only 11 percent of the total adult population, meaning they are disproportionately represented among the homeless population. The majority of homeless veterans is male, single and most come from disadvantaged families. Approximately 45% of homeless veterans suffer from one or more mental illnesses and approximately 70% suffer from alcohol or substance abuse issues. Researchers have found one in ten homeless veterans is disabled, with most disabilities resulting from experiences during active duty, including combat wounds (Olyzyk & Goodell, 2008).

Despite high level commitment and the investment of millions of dollars each year the efforts of the VA to end unwanted homelessness has not been enough. A growing concern is that the current military operations (Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF)) will increase the numbers of homeless due the young age of the average soldier and their lack of job skills. Of the 205,000 OIF/OEF veterans who sought help during the year 2006, 73,000 have been diagnosed with a mental health disorder, with at least half of those related to trauma or traumatic brain injury (TBI). This large increase in mental health/trauma associated illnesses, and the correlation between mental illness and

homelessness, is the catalyst for great concern about this particular group of veterans (Garcia-Rea & LePage, 2008).

Veterans become homeless for the same reasons as the general homeless population; rising foreclosure rates, the shortfall of available affordable housing, and high unemployment rates. Yet, some veterans are homeless for reasons that are specific to being a veteran. Many homeless veterans are compensated by the VA for specific ailments attributed to military duty. This compensation provides them just enough income to preclude them from receiving public housing assistance, but is not enough to sustain permanent housing. A high percentage of these veterans are also in arrears for child support and thus have had arrest warrants issued for them. Many have gambling problems, or have spent time in prison (Henderson et al., 2007).

Homeless veterans have a high rate of being either separated or divorced and approximately 76% of homeless veterans have served in wartime service (Chen, Rosenheck, Greenberg, & Seibyl, 2007). Homeless veterans are likely to be more educated than the general homeless population, consider their health status to be better than their non-veteran counterparts and are more likely to have a regular source of care. Desai, Rosenheck, and Agnello (2003) found homeless veterans aged 20-59 were ten times more likely than non-veterans in the same age group to be infected with Hepatitis C. When it comes to access care, homeless veterans are more likely to use a community or shelter based clinic as their source for care while their non-veteran counterparts use the emergency department (O'Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003). Although the specific reason for this is unknown, the researchers assumed it may be due to veteran's familiarity with using an ambulatory care model or clinic based model of care prior to becoming homeless.

Tessler, Rosenheck and Gamache (2003) conducted a study with 1691 homeless males to determine if an All Volunteer Force (AVF) versus use of the draft had increased or

decreased homelessness among veterans. Findings from this research showed lower employment, marriage, alcohol and psychiatric problems among the AVF group (post Vietnam). The AVF group was also more likely to be receiving money from parents or other relatives than their older counterparts and yet had also experienced longer periods of homelessness. Comparing non-veterans with veterans showed the veterans were more educated, comprised of less ethnic groups, and had higher rates of divorce or separation than the non-veterans. The drafted veterans were also more likely to have psychiatric problems but less likely to have been admitted to a mental or psychiatric facility. Although there were differences between the AVF and draft era veterans, the AVF did not seem to seem to change the risk of homelessness among veterans.

2.7 Homeless Women Veterans

The number of homeless female veterans is low in comparison to the male homeless veteran, thus they are normally excluded from research. Gamache, Rosenheck, and Tessler (2003), found female veterans were two to four times higher in risk for homelessness when compared to female non veterans. Unlike male homeless veterans, female Viet Nam veterans were found to be more at risk than the all volunteer force female veterans. The reason for increased risk of homelessness among women veterans was unclear in this particular study but was proposed by the researchers to be related to characteristics such as lower income, PTSD, substance abuse, high rates of child abuse, and decreased social ties due to military service.

Washington et al. (2010) conducted a case control study of non-institutionalized homeless female veterans in the Los Angeles area to determine risk factors for homelessness among the female veteran population. The study consisted of 33 homeless female veterans and 165 age matched non-homeless women veterans and used the Behavioral Model of Vulnerable Populations to contrast health and health care use between the two groups. The homeless

measures consisted of length of current homelessness and number of times homeless. Measures of health care were self report, presence of 12 particular diagnosis (cancer, heart attack, chronic lung disease, congestive heart failure, diabetes, pneumonia, stroke, osteoporosis, urinary incontinence, hypertension, arthritis, tuberculosis) and pregnancy status. Measures of health care use consisted of use of any medical provider, mental health care use, VA health care use, or being hospitalized in the previous 12 months, all of which was self report. Veteran specific measures included era of military service, service connected disability rating, and military sexual assault history. The results showed an average of being homeless four times and an average length of homelessness (over the woman's life time) of 2.1 years. The frequent entries into and exits out of homelessness suggest there may be a large at risk, yet housed population of female veterans. The homeless women were more likely to be unemployed, in fair to poor health, to have experienced military sexual trauma and to screen positive for anxiety disorder, PTSD, or tobacco use. They were less likely than the housed women to have used mental health services, VA health care or to have been hospitalized in the previous 12 months.

Significant risk factors for homelessness included being unemployed, unmarried, being in poor health, having experienced MST or screen positive for PTSD. Fifty-three percent of the homeless female veterans had been exposed to MST and as such the researchers suggest programs for female homeless veterans should include services to address MST. Of the controls, a small portion reported the above risk factors for homelessness as well, suggesting that they may be at risk for future homelessness as well. Although there are numerous programs available for homeless veterans, most of the programs are geared towards the male homeless veteran and are not sensitive to female needs. The researchers suggest further research regarding risk factors for homelessness, services necessary to end female veteran homelessness and cost effective methods to provide those services. Although this study was

specific to female veterans, the risk factors of mental health diagnosis and sexual assault show similarities to the general homeless population. The researchers did not collect data for substance abuse or social support, which in the general population has shown to be significant risk factors for homelessness.

2.8 Veterans Administration Programs for Homeless Veterans

In 1980 the VA Health Care for the Homeless Veteran (HCHV) program was developed to assist homeless veterans with different types of VA services available via community outreach. These services consisted of pension and compensation benefits, inpatient and outpatient medical treatment, inpatient and outpatient mental health programs, substance abuse services and vocational rehabilitation programs. HCHV programs are available in almost every VA hospital, regardless of the number of homeless veterans in the catchment area, and are offered to those veterans who meet the definition of homelessness according to the McKinney Act. In addition, in the 1990's, most HCHV programs began providing outreach services to many veterans in prisons, in an attempt to decrease the number of veterans who become homeless after release (McGuire, 2007). Although many homeless veterans receive a pension, in 2009 28% of the HCHV veterans remained homeless (United States Department of Veterans Affairs, 2010a).

In 1992 a memorandum of agreement was established between the Housing and Urban Development programs (HUD) and Veterans Affairs Supported Housing program (VASH) (O'Connell, Kaspro, & Rosenheck, 2008). This memorandum of agreement provided housing subsidies and intensive case management to homeless veterans with psychiatric illness or substance abuse disorders. HUD provided Section 8 housing to enrolled homeless veterans while the HCHV program provided case management, including weekly contact, outreach services, health care services, substance abuse counseling and employment assistance. This

program has been renewed each year with approximately 10,000 HUD vouchers being funded in 2007 (O'Connell, et al., 2008). Of the 15,906 homeless veterans who were placed in housing in fiscal year 2009, 26% had successfully gained employment and were able to find permanent housing. Of those who gained employment and were able to find housing, 7% remained in the HUD/VASH program for over 2 years (United States Department of Veterans Affairs, 2010a).

The Domiciliary Care for Homeless Veterans (DCHV) program provides mental, physical and vocational rehabilitation assistance to homeless veterans in a residential program. Most of the veterans remain in the DCHV program for one to four months. Prior to leaving this program, the veterans are offered outreach services and post-discharge community services. This program has served up to approximately 5,000 homeless veterans each year since the program's inception and is considered to be successful (O'Connell et al., 2008). In fiscal year 2009, 45% of these veterans were discharged to their own apartment or room, whereas 46 percent were discharged to a half-way house. The program is still considered to be a success, due to the decrease in alcohol and drug problems. In 2009, the success rate for decreasing alcohol or drug abuse dropped from 57% in fiscal year 2008 to 52% in fiscal year 2009 (United States Department of Veterans Affairs, 2010a).

In addition to housing programs, many HCHV programs assist local homeless coalitions in conducting yearly stand down programs. These programs provide homeless veterans with clothing, food, medical and psychiatric care as well as one to three days of shelter. In addition, to the clothing and care provided, these veterans are provided information on VA benefits and other programs from which they may be able to receive help. During homeless stand downs, excess government property is distributed to the homeless to include coats, sleeping bags, combat boots, socks, etc. Many HCHV programs offer drop-in centers where a veteran can come in for a bath, wash their clothes, and receive medical/or psychiatric outpatient care (United States Department of Veterans Affairs, 2008).

2.9 Unmet Needs for Homeless Veterans

Although numerous programs are offered to homeless veterans, the numbers of homeless veterans is not decreasing. Each year, the HCHV programs conduct a Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) survey to determine physical and health related unmet needs for the homeless veteran. These surveys continue to show homeless veterans in need of permanent housing, jobs, medical and psychiatric care, glasses, and dental care. In the last couple of years, child care has become an identified need, which may be in part due to the increasing number of homeless women veterans (United States Department of Veterans Affairs, 2010).

Applewhite (1997) conducted an exploratory qualitative study regarding the perceptions of homeless veterans and the obstacles to utilizing the available services. The participants consisted of 60 homeless male veterans ranging in age from 25 to 68, with 34 being the average age. Three different types of problems emerged from the interviews, health and mental health problems, resource related problems, and public perception problems. The resource related problems consisted of employment and wages, lack of housing and transportation, and lack of public hygiene facilities. The public perception problems consisted of public rejection, dehumanization, prejudice, lack of respect and fear of other veterans. Themes discovered from discussion centered on barriers to service use entailed insensitive service providers, negative policies and procedures and social services system problems. Social services problems consisted of long waits, getting the runaround, inadequate services for homeless, and a discouraging system. Although this exploratory study was conducted in 1997, it is still very relevant to today's homeless veteran, as they are still exposed to the same bureaucracy described by this group of homeless veterans. It is unfortunate that there were no female homeless veterans included in this study as the female perspective is missing from this important study.

2.10 Summary

The homeless population in the United States has continued to grow despite the government and private funding provided to combat homelessness. Veterans are over represented among the homeless population and with the growing female veteran population there has been an increase in the homeless woman veteran population. Risk factors for homelessness in the general homeless population include loss of employment, lack of affordable housing, and family disruptions. Veterans become homeless for many of the same reasons as the general populations but also have risks that are germane to the veteran population. Risk factors for homelessness among women have been understudied, but in the few studies conducted, are very similar to the general homeless population with the exception of military sexual trauma.

The VA has many different programs designed to end homelessness in veterans, and although homelessness among male veterans decreased slightly in 2011, homelessness among female veterans is growing. Research regarding the homeless population, causes of homelessness and programs for the general homeless population is abundant. The current research priorities for homeless veterans consist of discovering risk factors and needs to end homelessness. Very little research has been conducted with homeless veterans using a qualitative method in order to understand the perspective of the homeless veterans. Just as qualitative studies are limited with homeless veterans; female homeless veterans have rarely been included in research, which has led to little information being available for this population.

CHAPTER 3

METHODS AND PROCEDURES

3.1 Introduction

In order to determine the meaning of homelessness to female homeless veterans, the risk factors for homelessness and the services or programs necessary for ending their homeless situation, a descriptive qualitative study was conducted. The study was conducted at the Central Texas Veterans Health Care System (CTVHCS) with participants being recruited from Temple, Waco, and Austin, Texas homeless veterans programs. The participants in this study were limited to homeless females with prior military service who were veterans and over the age of 18. Once inclusion criteria had been met and informed consent received, a private audio taped interview was conducted using a semi-structured interview tool. Demographic data were also collected. Six homeless women veterans participated in the research study. Taped interviews were transcribed in the words of the participants and reviewed prior to each new interview by the researcher and qualitative nurse researcher on protocol. Codes and themes were extracted from the interviews to determine meaning of homelessness to the participants, personal risks, and resources needed to end their homeless situation.

3.2 Research Design

Qualitative research attempts to understand the life experiences or world view of the subjects in order to fully understand the phenomenon under investigation. There are several different qualitative research methods and the method should be determined by the problem to be studied (Sandelowski, 2010). Popular qualitative research methodologies consist of

phenomenology, grounded theory, ethnography and discourse analysis (Nicholls, 2009). All of these qualitative methodologies were reviewed prior to determining which methodology was appropriate for exploring homelessness among women veterans and none were deemed appropriate for the current exploration of risk factors for homelessness and resources necessary to end the homeless cycle.

Descriptive research can be used with both qualitative and quantitative research, but is one of the less popular or used methods, although much of qualitative research is truly descriptive. Researchers who conduct qualitative descriptive studies present a complete summary of the events being explored or a candid account of the events that most of the participants would agree are accurate (Sandelowski, 2000). Using a qualitative descriptive method, the phenomena of interest is explored with the participants using a specific framework. The relationships or interactions of a particular social group are investigated and the participants are selected from the specific population the researcher wishes to study in order to understand the phenomena of interest (Parse, 2001). Qualitative descriptive studies are dissimilar from phenomenological, grounded theory, or narrative studies in that they are not based on a specific methodological framework rather are more naturalistic. Naturalistic inquiry simply consists of studying phenomena in its natural state. Qualitative descriptive studies may begin with a theory or a framework to collect and analyze data, but it does not mean one must remain within that framework or theory (Sandelowski, 2010).

A qualitative descriptive method was used to explore the meaning of homelessness, risk factors and resource needs of homeless women veterans. Beginning with a modified framework for studying vulnerable populations, an exploration of the participant view and experience was sought.

3.3 Identification of Sample

A purposeful sample of six homeless female veterans was used for this study. Purposeful sampling is used to obtain a sample of cases that will provide information specific to the study criteria (Sandelowski, 2000). Female homeless veterans are a small, yet growing population and can be difficult to identify. In order to identify participants, a flyer (Appendix D) was developed by the researcher describing the study and how to participate. These flyers were posted in the homeless veteran social worker's offices in Waco, Temple and Austin, Central Texas Veteran Health Care System domiciliary and emergency department, local homeless shelters and Salvation Army offices.

Although a minimum sample of ten participants had originally been set, interviews were conducted until data saturation was achieved. Data saturation is considered the point to where additional interviews are not expected to reveal new information (Brod, Tesler, & Christensen, 2009). To determine data saturation, a grid of major themes (appendix F) was developed by the researcher and reviewed by a qualitative expert per research protocol. This grid was developed after the first interview, added to with each interview as new themes emerged and reviewed prior to each subsequent interview. Based on this technique of reviewing themes prior to each interview, data saturation was reached after five interviews. The process of developing a data saturation grid is described by Brod, Tesler and Christensen (2009) and is designed to assist in determining data saturation. A sixth interview was conducted to ensure no new information would be revealed, but no new themes emerged from the sixth interview.

3.3.1 Inclusion Criteria

Inclusion criteria consisted of being female, veteran, considered homeless, over 18 years of age and able to understand and sign the consent form. Veteran was defined as one having served in the Armed forces to include Army, Air Force, Marines, Navy or Coast Guard or Reserves. War time service was not a requirement for being interviewed. Homelessness was defined as being without a roof over one's head, living in a shelter or transitional housing, with a friend or family, in the domiciliary homeless program or in an automobile. Length of homelessness was collected but there was no limitation on length of homelessness to be included in the study. Inclusion of those who have been homeless for a short period can allow capturing data from those that are frequently in and out of the cycle of homelessness, which may provide information on risk factors for those at risk for the homeless cycle.

3.3.2 Exclusion Criteria

Exclusion criteria consisted of acute physical or mental illness requiring transportation to a treatment facility. The researcher watched for signs of acute psychiatric problems such as inability to focus, talking to oneself, paranoia, disclosure of thoughts of suicide or harming oneself. Any of these signs would have excluded the veteran from participating in the study and assistance would have been sought. With the high rate of psychiatric illness in the homeless population, those with a psychiatric diagnosis were not excluded.

3.4 Description of Setting

The Central Texas Veterans Health Care System (CTVHS) is located in Temple, Texas with a large outpatient clinic in Austin, acute and chronic mental health care facility in Waco and Community Outpatient Based Clinics (CBOC's) located in Brownwood, Bryan-College Station, Palestine, and Cedar Park. CTVHCS serve a veteran population of over 252,000 and covers

over 35,000 miles in 39 counties. Located close to the largest military base in the United States, CTVHCS collaborates with Fort Hood and the Department of Defense on many different research projects, including Post Traumatic Stress Disorder and Traumatic Brain Injury. CTVHCS has a large homeless veteran program with program managers in Temple, Waco and Austin. CTVHCS uses the HUD-VASH program to provide housing for homeless veterans and has a large inpatient substance abuse program. As part of the substance abuse program, CTVHCS operates a program that provides the substance abuse residents with the opportunity to work within the facility and gain tools for future employment as well as offering them a place to stay while they are enrolled in the program (domiciliary). Many of the veterans enrolled in the substance abuse program are homeless veterans.

The Temple VA facility lies within Bell County, which has a large homeless population. The Texas Homeless Network conducts a point-in-time homeless survey each year to determine the demographics and needs of homeless persons in the Bell County area. The point in time surveys which are conducted throughout the nation are not an accurate count of the homeless population, but are used to estimate the homeless population and their demographics. At the time of the survey, Bell County consisted of 286,446 persons, of which 62,613 lived in the city of Temple. The median family income in Bell County was \$54,000 with a poverty rate of 13.4% and unemployment rate of 7.6%. The point-in-time survey found a homeless population of 715 and from this number, estimated approximately 966 homeless in Bell County. The median age of the homeless in Bell County was 49, with 76% being male and 23% female. Veterans made up 65% of the homeless respondents during the point in time survey, which was much higher than found in point in time surveys in other parts of the country. Of those veterans, 28% were Vietnam veterans, 14% served during Desert Storm and 7% served during the Iraq/Afghanistan wars. The median length of homeless was 12 months, and

for 50% of the respondents, this was the first time they had been homeless (Bell County point in time survey, 2010).

CTVHCS also encompasses Austin Texas and Travis County. The population of Austin is over 783,000, with another 645,000 living in the surrounding Travis county area. Austin conducts a point in time survey every two years, with the last count being in January 2009. During the 2009 survey 2585 homeless persons were counted in the city of Austin alone. Of the 2585 homeless persons counted in this one point in time, 33% were single males and 40% were families with children (<http://www.caction.org/homeless/documents/Homelessness.htm>). There was also a large homeless veteran population in the Austin area, with the point in time count being 372.

In 1993 the VA began Project CHALENG for veterans. This program is designed to enhance services provided by local VA health care facilities and their local community agencies. CHALENG provides an approximate count of homeless in the area and is conducted each January. Although the count is only “point in time” and is not a true count of homeless veterans, this count is used to determine the number of homeless veterans in the Central Texas area, to include Temple, Waco and Austin areas. In January 2010, the estimated number of homeless veterans in Central Texas was 1200, 3% of which are female (United States Department of Veterans Affairs, 2010a).

3.5 Data Collection Method and Tools

Data were collected during private audio taped interview sessions, each lasting approximately one hour. Demographic data were collected from each participant for sample description and eligibility status. Qualitative interviews were conducted using a semi-structured interview tool.

3.5.1 Demographic Data

Each participant was required to fill out the demographic data form (Appendix A). Demographic data for each participant included age, race, highest education level, marital status, branch of service, period of service, length of service, length of homelessness, and number of times homeless. The demographic questions are questions that are typical of any demographic data form for research with the homeless population. Receipt of this information answered questions about veteran status, ensured the participant met age criteria, and provided information as to how long and how often they had been homeless. This information provided the sample description and eligibility status.

3.5.2 Qualitative Interviews

Interviews are the main data collection approach in qualitative, descriptive, exploratory methods. During the interview, reflection, clarification and requests for examples are often employed to fully understand the experience of the participant (Flood, 2010). One of the advantages of using interviews is that they draw from the participant a true picture of the participant's experience, leading to a shared understanding of the phenomena (Mapp, 2008).

A semi-structured one-to-one interview process, guided by an interview tool, was used (Appendix B). The interview tool consisted of one main question for each area to be pursued with potential follow-up or clarifying questions. These follow up or clarifying questions were asked of each participant unless they talked about the subject without being asked. A semi-structured interview was used as this process allows one to begin with specific themes or questions to guide the interview, yet maintains the flexibility to pursue new or interesting leads or themes (Banner, 2010).

The questions on the semi-structured interview tool were derived from the literature search and were designed to obtain information about risk factors (personal and community) for homelessness and the resources (personal and community) necessary to end their homeless state. Information regarding health status prior to becoming homeless in contrast with the participant's health status after becoming homeless was also discussed as well as where they normally receive their healthcare. The overarching question was the meaning of homelessness to the participant. Probing questions were added to the interview tool to allow clarification and assist with eliciting responses.

3.6 Procedure

Once IRB approval was gained from both the VA and University of Texas at Arlington (UTA) IRB, a flyer describing the study was placed in all VA homeless social workers offices, VA emergency room, VA domiciliary, Salvation Army offices, and local homeless shelters in Austin, Waco and Temple. All VA homeless social workers, domiciliary staff and ER staff were given a verbal description of the study as well as inclusion and exclusion criteria. The staff members in all areas were asked to provide the flyer to women presenting for care that met study criteria and/or telephone the researcher to allow discussion of the research with the veteran. For most participants a phone call or email was received by the researcher from the social worker asking to make contact with an interested homeless veteran and all were interested in participation in the study. Appointments were made with all interested parties for follow-up by the researcher. The researcher met privately with the veteran either in her Temple or Waco office, or Austin conference room to describe the study and determine if the interested female met As a qualified participant had been approached about the study, found to meet inclusion criteria, and stated interest in participating in the study, informed consent was obtained in private area. Prior to taped informed consent, the purpose of the study, explanation of the procedure, assurance of confidentiality, compensation for participation and how to withdraw was

explained. All questions from the participant were answered and then the participant was left alone in the room with the consent for audio taping and information pertaining to the study to decide if they were interested in proceeding. Each participant was allowed at least a 30 minute waiting period after discussion of informed consent prior to moving forward, although some participants asked for the researcher before the 30 minute waiting period ended. The researcher ensured the participant understood the purpose of the study, risks and benefits, how to end the interview or skip any question and how to dis-enroll in the study. Each participant was asked to explain to the researcher their understanding of the study, why it was being conducted and risk factors for participating prior to beginning the interview.

All participants were referred by a homeless veteran social worker or mental health staff, all met inclusion criteria, all agreed to participate, and thus were enrolled in the study. After the potential participant had decided she wished to participate in the study and eligibility was determined, a VA consent form for use of picture and/or voice (Appendix C) was signed by the participant and researcher. Verbal consent to participate in the study was audio taped, transcribed and is maintained in the researcher's files. Per research protocol, each participant was given an IRB approved short-form which provided them with information on how to reach the researcher should she have questions at a later date (Appendix E). The approved short form was provided to the participants rather than a copy of informed consent which would normally be provided to research participants at CTVHCS. This short form was required by the CTVHCS IRB due to the vulnerability of the participants and not having a way to secure a written consent form. A progress note was made in the participants VA medical record detailing participation in the study.

To maintain consistency in data, only the researcher conducted the interviews. Interviews were conducted from November 22, 2011 through December 29, 2011 with homeless women veterans from the Temple, Waco and Austin area. During interviews the

participant was offered a snack and drink as well as a break if needed. Data were collected in private offices (previously described) to ensure confidentiality. If family members were present with the veteran, they were asked to wait in the waiting room. All interviews were taped by the researcher after ensuring the participant consented to taping. It was explained to the participant that notes would be taken by the researcher during the interview, these notes were reviewed as the audio tapes were transcribed and prior to next interview for clarification. The notes are maintained in the researchers file for future audit trail. At the end of the session, the participant was asked if she had any questions or wished to review her interview. Once the participant stated she had no further questions she was provided with the short form and given her choice of either an HEB or Wal-Mart gift card for her participation. She was informed that she may contact the researcher at the number on the short form should she think of any questions or wish to dis-enroll in the study.

Rigor and credibility with qualitative research has been a concern and many scientists question the scientific merit of qualitative research (Ryan-Nicholls & Will, 2009). Yet, there are methods to increase credibility and dependability in qualitative studies. Keeping field notes is one method to increase credibility, as they become an added data source, and can be used as an audit trail for coding and theorizing (Tuckett, 2005). Field notes were used during the study, were reviewed during data transcription and are maintained along with the consent forms and original audio tapes.

After each interview, a qualitative nurse researcher at CTVHCS who had agreed to be part of the research team, reviewed the transcribed interviews individually and then met with the researcher to discuss her thoughts on the interviews and themes. The researcher discussed major themes she had extracted from the interviews to determine if the expert agreed with the themes and/or saw new directions to pursue. This procedure was conducted for interrater

reliability. Prior to beginning a new interview the researcher reviewed previous transcribed interviews and field notes, listened to taped interviews, and reviewed previous themes.

3.7 Ethical Considerations

There are federal regulations that apply to conducting research with vulnerable populations. These regulations are designed to protect vulnerable populations from the research abuses that previously occurred, such as the Tuskegee syphilis study. These regulations were put into place to provide extra scrutiny and protection during the consent process (Beattie & VandenBosch, 2007). The basic foundations for ethical research, as described in the Belmont report, are respect for persons, beneficence, and justice. Respect for persons entails treating each person as an autonomous person and providing protections to those with diminished autonomy. Informed consent must be obtained from each participant. Informed consent allows the participant the time to determine if he/she wishes to participate in the study, have all questions answered, and must not feel pressured or coerced to participate.

All participants involved in this study were provided information which included description of the study, risks and benefits of the study, a statement regarding the voluntary nature of participation, the researcher's name and contact information, who to contact for questions or information, how to dis-enroll in the study, medical liability of the VA should problems arise from the study, and what is required to participate in the study. Each participant was provided with the time to ask questions of the researcher and allowed a 30 minute waiting period between consent and beginning the interview process. Each participant was instructed how to dis-enroll or discontinue participation in the study if desired and was given a short-form (Appendix E) with the researcher's information. Interviews did not begin until the participant had asked all questions she wished to ask, stated she had no further questions, the waiting period had lapsed and the consent for taping had been signed.

3.7.1 Research Oversight

Prior to CTVHCS and UTA IRB approval, the researcher completed the basic training modules of the human research curriculum from the Collaborative Institute Training Initiative (CITI), human research training module for CTVHCS and all privacy and HIPPA training required by the VA. The training records were included in the IRB application for CTVHCS and are updated as required.

3.7.2 Potential Risks

Risks to the participants were minimal but included reliving upsetting circumstances during the interview process as well as risk of identification. Emotional risks were minimized by the participants' right to refuse to answer any question or stop the interview. Participants were notified prior to the interview that they could refuse to answer any question that they did not wish to answer. All interviews were conducted either in the researcher's office in Temple or Waco, or in a private conference room at the Austin Southgate VA building. Information was available regarding referrals to a mental health provider if necessary. In order to decrease risk of identification, no identifying information was collected other than the consent for audio tape, which is maintained in a locked cabinet in the researcher's office. Demographic data is reported in ranges to decrease the likelihood of identification. Each participant was given a fictitious name to further decrease the likelihood of identification and those fictitious names are used throughout the study.

3.7.3 Potential Benefits

Benefits to the participants included the opportunity to share their stories and having a sense of helping others. Risks for homelessness and services that are necessary to assist homeless female veterans in breaking the homeless cycle may benefit others as this

information may assist the VA with determining priorities for programs to assist homeless female veterans.

During the taped interviews, two participants became emotional and began to have tears in their eyes. At this point the tape was stopped to allow them to regain composure and/or stop the interview. They were asked if they wished to discontinue the interview or not answer the particular question. Both participants stated they wanted to continue and wanted to answer the question. They were asked if their social worker could be contacted by the researcher and both stated they were fine and did not need assistance. In both instances a break was taken until they determined they were ready to continue. At that point the interview resumed with assurances from the researcher that they could stop at any time or refuse to answer any question that was upsetting to them. There were no other adverse events or psychological distress noted during the remaining interviews.

3.8 Data Analyses

3.8.1 Qualitative Data

All interviews were taped and the original tapes are maintained by the researcher. Each interview was transcribed and reviewed several times for themes or codes prior to the next interview (Flood, 2010). A field journal was kept by the researcher to allow documentation of observations, relationships, or impressions which were used during data analysis. Maintaining a reflective or field journal has been shown to be a strategy to facilitate reflexivity, as well allowing examination of personal assumptions and goals or increase transparency in the research process (Ortlipp, 2008). Prior to each new interview, the previous interview transcripts, audio tapes and identified themes were reviewed by the researcher to assist in refining further interviews and ensuring consistency in the interview process as well as true data saturation. A

grid was developed and expanded after each interview was transcribed and used for theme/code identification by the researcher.

3.8.2 Method and Procedure for Data Analysis

Data analysis was conducted by the researcher without the use of software other than Microsoft Word. All taped interviews were transcribed verbatim by the researcher. Transcribing the interviews required listening to the interviews over and over to ensure each word was captured and inflection of voice was noted on the transcripts. Transcribing the data herself allowed the researcher to become completely immersed in the data. Once the transcripts were completed, the researcher read and re-read the transcripts while listening to the audio tapes to acquire a feeling for the participants and their comments. Data was then examined line by line. The researcher underlined and extracted significant statements that were considered pertinent to the phenomena being described. The statements were the beginning of themes or codes, which were re-reviewed with the original transcripts for further refinement. Once themes were identified, the transcripts were further reviewed for connections or meaning from the participants. A grid was developed by the researcher based on the themes and subsequent codes, which was reviewed before and after each interview. Themes were then organized by research question and concepts from the modified framework which guided the study.

The qualitative nurse researcher on the research protocol met with the researcher after independently reading each of the transcribed interviews to reach interrater reliability and discuss agreement with themes/codes and data saturation. This procedure of data analysis is very similar to data analysis used by Martins (2008) in her descriptive, phenomenological study of homeless person's experiences in the health care system.

An audit trail has been maintained through use of the researcher's field notes, transcribed interviews, and audio tapes. All remain available for further data analysis and are

considered an acceptable source for an audit trail (Tuckett, 2005). The field journal, transcribed interviews, and audio tapes are now maintained in a locked cabinet in the researcher's office. The qualitative nurse researcher has been provided access to the field notes, audio tapes, and written transcripts.

3.9 Summary

Homelessness among the female veteran population has begun to grow; understanding the meaning of homelessness to this population, risk factors and resources necessary to end homelessness may assist VA providers with assessment and help design programs that meet the needs of this population. In order to discover this information, a qualitative, descriptive study was conducted with a purposive sample of homeless women veterans in the Central Texas area. Participants were referred to the researcher either by a homeless veteran social worker or through the Salvation Army. The referred homeless women all met inclusion criteria and all agreed to participate in the taped interview. All interviews were conducted on VA property either in the researcher's office or a conference room. All interviews were taped and transcribed by the researcher and the transcribed interviews were reviewed by a qualitative nurse researcher. Interviews were completed with six participants after there was no new information received from the sixth interview. Themes were then aligned by study question and concepts from the modified framework for studying vulnerable populations, which guided the study. Risk factors for homelessness and resources necessary to end the homeless cycle were revealed by the participants and can be used by the VA to identify those women at risk for homelessness and assist those who are already homeless.

CHAPTER 4

FINDINGS

4.1 Introduction

This study sought to explore the meaning of homelessness to homeless women veterans, the risk factors associated with their homelessness and the resources necessary to end their homelessness. A qualitative, descriptive study was conducted at the CTVHCS, using a modified framework for studying vulnerable populations as the over-arching framework. Conducting a qualitative study allowed the participants to describe the risks for their homeless situation, the resources they feel are necessary to end their particular situation and the meaning of homelessness in their own words.

Interviews were conducted until data saturation or no new information was received. The researcher conducted one more interview after data saturation to ensure no new themes would emerge. Each interview lasted between one and one and a half hours, was audio taped, and transcribed by the researcher. The findings are reported using the participants own words and are organized according to themes which emerged from the data. The data is reported using fictitious names to protect the identity of the participants.

4.2 Sample Characteristics

The participants in the study were all homeless, female and veterans. Their homeless situation varied from living in a shelter, housed with a friend, or housed in VA paid transitional housing. All participants were required to meet inclusion criteria, be able to provide informed consent to participate and sign written consent for audio taping. A total of six homeless women veterans agreed to participate in the semi-structured private interview session.

Demographics requested from all participants and are reported in ranges (See Table 4.2). Participant demographics are being reported in ranges rather than specifics to help decrease the likelihood of participant identification. Participants ranged from 41 to 60 years of age with a mean age of 50.3. Four (67%) of the participants were white and two (33%) were African American. Four (66%) of the women were divorced, one was single (16%) and one (16%) was married, but separated from her spouse. Two (33%) of the participants were high school graduates, two (33%) had some college and two (33%) participants had college degrees. All (100%) participants had children, although only one (16%) had children living with her. The number of children was reported in ranges, with three (50%) stating they have between one and two children and the remaining three (50%) stating they have two to four children.

Three (50%) of the participants were army veterans, one was an Air Force veteran (16%), one Navy (16%), and the other had been in both the army and air force (16%). Years of service was reported in ranges with four (67%) serving between one and five years, one (16%) serving between 11 and 15 years, and one (67%) serving between 16 and 20 years. Two (33%) had been homeless less than one year while the other four (67%) had been homeless between one and three years during this episode of homelessness. Number of episodes of homelessness was split with three (50%) being homeless between one and three times, and three (50%) being homeless between four and six times. There were no discernible differences noted in the answers to the questions based on demographic data other than the youngest participant having children with her. All other participants had children that are older and live on their own.

Table 4.2 Participant Demographics

Age	41	46	60	46	49	60
Race	AA	AA	White	White	White	White
Education Level	Some college	Some college	College	HS	College	HS
Marital Status	M	D	D	D	S	D
# of children	2-4	1-2	2-4	2-4	1-2	1-2
Branch of Service	Army	Army/Air Force	Air Force	Army	Navy	Navy
Years of military service	16-20	11-15	1-5	1-5	1-5	1-5
Length of homelessness	<1 Year	1-3 Years	1-3 Years	1-3Years	1-3 Years	<1 Year
# of times homeless	4-6	1-3	4-6	4-6	1-3	1-3

4.3 Results

After each interview the researcher listened to the interviews, transcribed the interviews verbatim, and then reviewed the taped interview along with the transcribed interview looking for themes. These themes were placed in a table (appendix F), and reviewed by both the researcher and qualitative nurse researcher as part of the data analysis procedure and to assist with determining data saturation. The themes that emerged will be discussed in the words of the participants as they relate to the modified vulnerable populations framework.

4.3.1 The Path to Homelessness

The path to homelessness consisted of two themes, loss of career and broken relationships. All of the participants described the first episode of homelessness as “unexpected” and something they were unprepared for. For two of the women, the first episode of homelessness was attributed to unexpected military discharge. Amanda counted on her military service and had plans of retirement. She was proud to be a member of the military and talked of helping younger soldiers with family or spouse problems, who she felt were at risk for becoming homeless. She never envisioned becoming homeless herself. Her plan for her future was to remain in the military until she was eligible for retirement. Amanda described her involuntary discharge as being “due to a problem with my military spouse”, requiring her to discharge at an unexpected time. Although she was barred from re-enlistment, she was considered ineligible for unemployment because she did not re-enlist, thus the employment commission considered she had voluntarily resigned. Because she was ineligible for unemployment and was unsuccessful in finding employment, she lost her apartment and was forced into her car with her son.

“I wasn’t expecting it. My goal was to retire, you know, and continue my military service and I was also a civil service employee. That was my goal; continue that and that was my safety net. It was not my choice, I would still be in if I could. It was involuntary. I lost everything it seems right at that moment. Because that saying of living paycheck to paycheck.”

Iris described her military discharge as the entire reason she became homeless, as discharge was unexpected for her as well. According to her, the first episode of homelessness came from unexpected military discharge due to an unplanned pregnancy that resulted from military sexual trauma. Not only was she discharged from the military and left without a career,

but she also had to deal with the emotional and physical consequences of the military sexual trauma. She attempted to work while caring for her daughter, but found it too difficult with Post Traumatic Stress Disorder (PTSD), a result from the sexual trauma.

“Basically the whole reason behind me being discharged has taken me down that path. Cause, I was, I was forced into a situation where I became homeless and discharged because I was having a child that I was not ready to have and in that state I took care of my child first, and then the navy went away and then homelessness took its place. You have a job, and you expect to stay there for awhile and you hope to be in that position for a while. When you are in the situation, you see it happening, but you don’t realize until it hits you that it has occurred, because you don’t expect it to happen.”

Sam described serving in the military and counting on military retirement, which was a dream that was not realized. She blames her homelessness on the military and lack of retirement. According to Sam, a portion of her 20 years was spent in the military reserves, which made her ineligible for retirement due to not having 20 years of *active* duty. She was unaware prior to discharge that she was going to be deemed ineligible for retirement and did not have a “back up plan”. She and her husband moved to Texas at discharge to be closer to his family. Her husband was unable to work due to a physical condition and she had difficulty finding employment. When she finally did find employment, her VA appointments for a military related physical condition cause her to miss work and thus she was fired. The lack of income led to marital problems, and subsequently she and her daughters were put out on the street. She lived in her truck for a short period but was able to move in with a friend while seeking help from the VA.

“Well, I did 20 years. And they told me that my 20 years did not count towards retirement because I did 10 in the reserves and 10 active duty, so they said it didn’t

count. Which I don't agree, with because it shouldn't matter if you do it part time or full time. 20 years is 20 years. And, um, you do 20 years and you put your life on the line, however many times they ask you to and then at the end of it, it's like you have nothing to show for it, which is my case now. I blame it on the military."

For other participants, it was broken relationships that began their path to homelessness. Rose described her entry into homelessness as unexpected, not due to military discharge, but an abusive marriage. Prior to becoming homeless, she had a civil service job and nice home. Due to domestic violence she not only fled her home, but felt she needed to leave the community and state so her husband would not find her. She moved to Texas to be closer to her son, but was unable to remain in his home and had lived in her car intermittently the last two years.

"I only have what I could fit into my vehicle to escape an abusive situation. Because of the past trauma that I have experienced, being very apprehensive about being in a shelter, so I have just stayed in my car. Because of the domestic violence, I have a lot of teeth missing, which has had a big impact on my self-esteem and my employability."

Daisy described the reason for homelessness as broken family relationships as well. She recently moved to Texas after leaving a shared home with her mother and having problems with her family. She described her sister as working for a bank, being given legal control over her money by a judge and then her sister "stealing" her money. Unable to deal with the family problems, she fled the situation and came to Austin to live with her son, who she described as a "drug dealer". Unable to live with her son and losing her vehicle to him, she attempted to find shelter in the Austin area. According to Daisy, there is a lack of beds in the Austin area, so she went north to Waco and has lived in different shelters in Waco. She now resides in a Salvation Army shelter that has a separate area for women.

“The main reason is that my sister stole all of my social security, so I was going to visit my grandchildren, so I came here without a home. My son is in Austin, he’s a drug dealer, and he stole my car. So, I ended up here in Waco because in Austin it was horrible because of the availability of beds.”

For each participant, becoming homeless was unexpected and because it was unexpected they did not have a plan to react to their circumstances. Each participant relied on having their military career, military retirement, or other position and thus were not preparing for the future. Several of the women talked about the inability to save money, living paycheck to paycheck and relying on their jobs. For others it was the broken relationships with family members that caused them to be on the streets unexpectedly and unprepared.

The reasons for their homelessness can be attributed to deficiencies in social status, human capital and social capital. Being female had both a positive and negative effect on their homeless situation. Several of the women felt that resources were easier to gain when they had their children with them, as “people tend to feel sorry for those with children”, but once their children were no longer with them, those same resources were no longer available to them. Being a veteran opened up resources to them that non-veteran homeless persons do not have access to, although according to the women, there is much bureaucracy involved in getting those resources. Human capital relates to the skills and abilities of the individual and each of these women felt that military service would help them later in their lives, either because of retirement or job skills gained while in the military. Unfortunately this plan for their future was not realized and because they were so invested in the military plan, they had not made other arrangements, leaving them unprepared for their future. Social capital relates to the individuals relationships, which has had a profound impact on each of the women’s homeless situation. For some of the participants, their interpersonal relationships can be directly attributed to their

homeless situation. But for others, the abandonment from those they counted on when they needed someone to support them, left them physically, emotionally and mentally vulnerable.

4.3.2 The Meaning of Homelessness

The meaning of homelessness was different for each participant, yet for most of the participants becoming homeless was very unexpected and left them with a feeling of overwhelming loss. Each participant was unprepared, and did not have a plan for recovery. Sam, who had spent 20 years in the military, described being homeless as

“Not having, uhm, your own roof over your head or having to depend on somebody else to provide some type of shelter for you and your family. Because ,my husband put us out, me and my daughters. Yeah, so homelessness is not having anything of your own.”

For Amanda, homelessness meant being on the streets and overwhelmed. She described staying in the car with her son and being in a crisis situation.

“I picture homelessness as you are on the streets, with no place to go. And you just try to survive by however means, um staying in shelters, pretty much roughing it. I felt that I was in a crisis, I was overwhelmed and I think me and my son had been in the car for about three nights, and it was just overwhelming.”

Jasmine described homelessness as “hopeless, empty”. While Rose described homelessness as a “dark downward spiral” that left her feeling like a “failure, regretting decisions I have made”. For Rose, homelessness is a “sort of helplessness, because you feel like you don’t have any control over where you are going or any control over your life.”

Leaving homelessness had special meaning for the participants as well. Amanda described leaving homelessness as a “ray of sunshine”, where as for Sam, leaving homelessness meant her daughter having her own room and a roof over her head. Iris felt

leaving homelessness would mean “having control” over her life again, as she currently has nothing to order her day.

Homelessness was described as an overwhelming loss for the women, loss of belongings, loss of a career, loss of trust, and loss of relationships. Becoming homeless left each of these women feeling vulnerable, isolated and without any control over their lives. The vulnerability and loss they have experienced has had a profound effect on both their physical and psychological health.

4.3.3 Themes

Beyond the individualized meaning of homelessness and path to homelessness, several themes emerged from the data. These themes consist of abuse of person, broken trusts and trying to survive. Each of the participants suffered some form of abuse, whether military sexual trauma, extreme military sexual harassment, or spousal abuse. The women all described broken trusts, either from family members or military promises that were broken. These broken trusts greatly affected not only their homeless situation but their ability to interact with others, which for some has been so great that it has affected their employability. All of the participants described trying to survive the streets, looking for available resources, the bureaucracy of gaining those resources, forming relationships with other veteran women, and the effects of homelessness on health status.

4.3.3.1 Abuse of Person

Each of the participants endured some form of abuse, whether military sexual trauma, extreme military sexual harassment or spousal abuse. Daisy described the military sexual trauma that she endured during basic training and then again as she was in school for her military occupation (MOS). She revealed the military sexual trauma to her commander during

basic training but the information fell on deaf ears and then she later endured rape by a fellow soldier before finally leaving the military.

“It was my drill sergeant that actually attacked me in basic training and I tried to get out then. He assaulted me at night fire, he grabbed me by my breast and I didn’t know who it was. It was pitch black. He was having sex with my roommate every night anyway, I found out later that he was doing the company commander. I remember telling her what happened, and her response was “just get the hell out of my office”. So, then I was raped during my MOS.”

Iris discussed military sexual trauma as the entire reason that she had to leave the military and the profound effect it has had on the rest of her life.

“Military sexual trauma, MST, which is a trigger for PTSD and it’s something I’ve gone through in my life. The fact that triggers come from MST, which is the, it, was very sensitive to be in the military as a female. And treatment by males didn’t always, it wasn’t always a platonic relationship, they wanted, some of them wanted more, and some of them just were just going to take more, even if you said, “no you can’t have that”. They wanted it anyway, and that right there has, is a big risk factor because it makes it hard for me as a female to trust any men out there, because I could not trust some of my co-workers in the military, it’s hard for me to trust these same people, whether they are veterans or not, in the community.”

Rose described the physical and emotional trauma that she experienced at the hands of her Viet Nam veteran husband and having to flee, leaving behind everything she had with the exception of what would fit in her car.

“Well, I was, in uh, emotionally and physically abusive marriage. And I had a home that was completely paid for, I feared for my life so I left everything behind except what I could fit in a vehicle.”

Sam was put on the street with her young daughters by her husband, who had begun dealing drugs to support them after she had lost her job. She lived in her truck with her daughters until a friend took them in.

“So, now my husband is mad because now there’s no money coming in. Like, now we have no money, we’re living with his dad and so everybody is just agitated right now. So, he goes out to sell drugs now, not a good look. I, I didn’t like it, and I told him about it cause he was out all kinds of hours of the night and up and down and in and out and everybody is in and out the house. I didn’t like it and I told him about it. Well, he said he was going to do that until he found a good job. What could I do? I have nowhere to go, I have nobody here, so one day he told us to get out, me and my daughters. Just you know, cause I was bitching at him. So, we packed up our stuff and we left, had no place to go.”

Although Jasmine was not subjected to military sexual trauma, she described the extreme sexual harassment endured during her military career and how it affected her self esteem.

“I was getting treated pretty bad by the guys, they don’t think much of women, they didn’t then and they still don’t now. They all go ahead and talk to you nice, but they always want something, or they, and every single duty station that I went to, not only was it just one guy that tried to pick you up in my duty area, but almost all of them. The E5’s, E6’s, they was all over us, the lieutenants, I mean it’s ridiculous and no one ever says anything about it, ever. Nobody treats women like a woman should be treated;

they just treat them like they are a piece of meat. Everything boils down to just self esteem where you don't ever think you are good enough for anything."

The abuse, trauma or extreme sexual harassment endured during military service and after has had a great affect on the women's physical, emotional, psychological health and the way they interact in society. For Iris, Rose and Daisy, the trauma they experienced has left them distrustful of others and has greatly affected the way they interact with others. All of the women have been affected by their interpersonal relationships since entering the military.

4.3.3.2 Broken Trusts

A common theme of broken trusts was revealed from the data as each woman discussed their military career and interpersonal relationships with their spouse or family members. These women put great faith in their military career, trusting that they would have a military retirement for their future or marketable skills that they could fall back on once out of the military. This trust was broken though as they were discharged either involuntarily, denied retirement, or found their military skills did not help them gain employment. As previously mentioned, Sam was in the military for 20 years, and trusted that she would have a retirement, only to find out that her 10 years in the military reserves did not count towards her retirement. She had placed her trust in the military, only to have that trust violated as she exited the military.

For those that suffered military sexual trauma, they put their trust in military superiors and fellow soldiers, only to have that trust broken. A large part of the military culture is relying on each other as you prepare for battle, putting your full trust in those who may have to protect you in battle. Yet for some of these women, that trust that should have supported them in their career was the reason for sexual trauma. As with Daisy, who trusted in not only her drill sergeant who sexually abused her, but in her female commander who she confided in after being sexually abused. Iris trusted in her Navy co-workers as well and then suffered rape,

unintended pregnancy and subsequent military discharge. The inability to trust in those around her has left Iris with an inability to cope and have normal relationships with those around her, which has ultimately affected her ability to maintain employment.

“My MST is a big risk factor because it make it hard for me as a female to trust any men out there, because I could not trust some of my co-workers in the military, it’s hard for me to trust these same people, whether they are veterans or not, in the community. Because, you don’t know who is going to be that trigger, who is going to be the one that is going to want to push you into a relationship that you don’t want.”

Amanda trusted that her military career and training would help her find employment after discharge, but discovered that her military training didn’t help her qualify for positions. She described applying for jobs and waiting for calls from employers that never came, finally coming to the conclusion that her military career had only prepared her for war.

“I *thought* it would help me because I felt that it’s, it’s a you know, it’s a pretty open area and also have a medical background. And with all those things I still was unable to find a job, and a lot of times I wasn’t even getting call backs and I would call the people back and they would even get frustrated and say we’ll call you if we get something. You keep calling them and they give you the same story and it’s, it’s very frustrating, but I’ve heard a lot of female veterans say today they have been down that same road, trying to find work. So, I don’t think that just, just having the training and the background any female veteran, you know we could probably survive a war much easier than surviving the streets.”

Each of the women described broken family relationships. Relationships that they should have been able to count on, but instead pushed them further down the road to homelessness. For Jasmine the physical abuse and trauma that she experienced in her

marriage has caused her to mistrust almost all of those around her and it has had a large affect on her physical, emotional and mental condition.

“It’s hard for me to describe the stress and the fear and anxiety that I experienced to be around people in a shelter situation, uh, I found myself becoming hyper-vigilant as far as being ever watchful, um, even now, I lock my door while I am driving down the street if I have my window down at a stoplight, I put it up. While I was living in my car, I was uh, found it difficult to sleep, desperately needing rest, but yet afraid to go to sleep because I was afraid for my safety.”

Jasmine also discussed the disappointment that she has felt after escaping the abusive situation and coming to Texas, hoping to live with her son and not being able to because of problems with her daughter in law. “I’ve found it upsetting that for various reasons I haven’t been able to stay with my children. My oldest son lives in the Austin area and I was able to stay there for a little while, but his wife didn’t like me there, so I had to move out. So, over the past two years I have lived in my car a number of times.”

Daisy not only experienced military sexual trauma and rape while in the military, but then suffered from broken family relationships. She described her relationship with her sister, a banker who was given control over her money by a judge. After losing access to her money and realizing that she was just going to need to let go of her money and relationship with her sister, she left her home state to come to Texas. Daisy moved to Texas to be closer to her son, but the relationship with her son was unsuccessful and after losing the last true possession she owned, and with no one else to turn to, she ended up on the streets.

The broken trusts and damaged interpersonal relationships experienced by each of these women not only left them vulnerable but affected their future relationships and ability to

sustain employment. Their trust in the promise made to them by the military, either through career preparation or retirement funds left them without a viable income.

4.3.3.3 Trying to Survive

Another common theme found throughout the interviews was that of trying to survive, which correlates with resources. Each of the participants spoke of resources and the struggles of obtaining those resources and the bonds they formed with other veterans. The cohesion and camaraderie learned during their military career has been continued with other women veterans, providing them with a social support system in absence of family members.

Sam described looking for resources from every source possible and the bureaucracy faced when trying to find those resources. Because she has small children with her, transitional housing is not available for her through the VA, but she has been able to move in with a friend. Trying to obtain community resources has become a source of frustration for her.

“I have reached out to everybody that I possibly can in the VA system, even outside the VA system, um like the health and human services, I’ve tried them. Um, just everybody that I can, I’ve applied for help. I find it hard to believe that the health and human services, when you tell them you have nothing. I mean I guess they are getting, I don’t what is the word that I am looking for, but people tell them they have nothing and they don’t believe it. And I went there looking for help and they told me that I did not qualify, because my vehicle costs too much and I was donating plasma just to get a little bit of money so me and my girls could eat. That was an income as far as they were concerned. Yup, they told me I didn’t qualify for any monetary benefits so I asked about the food stamps, I guess it is. And they asked me to give them all this stuff and I brought it in to them and I still have nothing and I don’t think it is right at all. Because now we are still hungry, we still have no money, and I still have no answers. I have a

job starting on Monday, but the problem I may have with the job is transportation, because it is so far away.”

Amanda described the trials of trying to get assistance from community resources after military discharge. But the bureaucracy involved with obtaining those resources made the situation of being homeless much more stressful and eventually put her in a crisis situation.

“Because I had my youngest son was with me and a senior in high school at the time and it was just very traumatizing. I was overwhelmed and I think me and my son had been in the car for about 3 nights, and it was just overwhelming. as a single parent, and at that point when I had to give up that job and I did the research and did everything that I was supposed to do, like apply, apply for unemployment, they denied me and I appealed it but they still denied it, uh because they said I did not re-enlist, but I couldn’t re-enlist. They are not always there when you need them, and there is just a lot of things that has to be done, like, there wasn’t a public transit system in the city that I was in, and so you pretty much had to walk probably 8-10 miles to get to the public transit just to catch a bus or a train to get to the place to do the paperwork, it’s, it’s overwhelming. And then you have to be able to take your child out of school, because your child has to be there. It’s just a lot of things that gets you *crazy*. I have vocational rehab to help me get a permanent job; I have a temporary job right now.”

Daisy spoke of utilizing homeless shelters in both Waco and Austin and having to play the game to keep a bed in the shelter. She also described engaging in VA services and what is required to get the services she felt she deserved. Daisy currently uses the food stamp program, lives in a Salvation Army shelter and relies on the city bus system to get to her medical appointments. She considers herself unemployable because she has had many jobs in the past year. She is fighting to have her service connection increased because of her PTSD,

an outcome of military sexual trauma, and feels this increase will allow her to get a small apartment.

“Some people think there are not as many programs for female veterans, but I don’t believe it’s true. You just have to be the squeaky wheel in the VA if you want services, like when I wanted to see a psychologist as well as a psychiatrist; I just had to ask several times for it. The VA doesn’t come to your house; you have to go to them. I’m in a house right now, and you know they have a TV and a microwave. I didn’t even know these existed in shelters, because in the other homeless shelters, it’s not a big deal as long as you have a place to sleep. You know, people put you down excessively and if you don’t kiss their ass you are out on the street. I can’t work because I’ve had at least 150 jobs. So, you know, I mean my housemates say I should go to social services and take a resume writing class, but I mean that would be a joke because I can’t put down the last 20 jobs I had in the past year. My attorney is working on getting back my 50%, and I don’t need a lot of money to live”.

Finding social support through VA programs and through camaraderie with other veterans was discussed by all the women. They expressed enjoyment of being with other veterans, because they understood what they were going through. Iris talked about her support network as being other veterans and the connections she has made online.

“Most of the immediate social network is through veterans either through the VA or fellow veterans that I’ve met and socialized with. I find out about different events and things that I am interested in and I go to those events and I meet new people and most of them are also veterans. Or they do have something in common with me and that connection is there. I also connect online with people, I’ve been connecting with people that way for about 10 years.”

Amanda discussed the veterans that she has met in the CTVHCS domiciliary and how they all have common bonds.

“I meet a lot of great people over here in the Dom, you know we are all veterans we all problems, we are trying to better ourselves to get past those problems, but we’re all veterans. We all have that in common and we all seem to understand each other and we all seem to have the same problems. It’s kind of interesting because I do a lot of classes. It’s interesting but it’s also comforting to hear that a lot of problems you are dealing with, they are dealing with the same problems. Like for instance, your family not getting the support you expect to get from your family. A lot of veterans, that’s a problem with other veterans, so it’s kind of comforting because then you, know you are not alone.”

Although Rose has had problems with trusting other people since her abusive marriage, she is now in transitional housing and has two roommates, both of whom are homeless women veterans. She discussed them as part of her current support network “Well, I enjoy the friendship that I have started with my housemates, I find that helpful. They have been through similar circumstances in their lives.”

Coping skills are important to survive the extreme struggles the women have experienced, yet several discussed their inability to cope with things that have happened to them in the past. As already discussed Amanda is has had problems coping with spousal abuse and it has affected the way she approaches and interacts with others. Rose described the alcoholic environment that she grew up in and uses alcohol and drugs herself as a method to cope, “Everything boils down to self-esteem where you don’t even think you are good enough for anything. Yeah, and I grew up with my family drinking and everything.”

Surviving homelessness has been a struggle for all of the women. They have been vulnerable, and as Amanda described “stigmatized”. The struggles of obtaining the resources to survive, whether community or VA resources, has added an extra strain on these already mentally and physically exhausted women. Having experienced broken trusts and dysfunctional family relationships, forming bonds with other veterans who understand what they have gone through is seen as a positive aspect in their lives.

The relationships they have formed with other veterans, or their social capital, has had a positive impact on their psychological and social health, being able to share their stories with others who understand what they are going through. For those women living in the homeless program in the CTVHCS Dom or in transitional housing with other female veterans, there seemed to also be a feeling of physical security, nor longer being vulnerable on the streets. Investment in human capital by the VA and community agencies has allowed these women to find the resources necessary to survive, such as food stamps, housing and health care, yet the bureaucracy they have had to go through to gain these resources added to the burden of being homeless.

4.4 Health Care

All of the participants received their health care through the VA and yet all describe their health as worse than it was before becoming homeless. Sam described being “drained” prior to leaving the military, but then that energy was “snatched away” as she got out of the military and began trying to survive. She further discussed having asthma and having back problems.

“um, my back is jacked up. That is about the only main issue that I have is my back. And it’s like I am telling everyone about it and I am telling the VA doctors about it and they are just giving me x-rays, and medicine, and nothing is helping. It’s just driving me crazy because I want to know what is wrong with my back.”

Jasmine described her health as worse than before in part due to her missing teeth. She receives her care at the VA and was to have her remaining teeth removed two days after her interview. Jasmine would then be receiving false teeth and felt that this would help improve her overall health and self-esteem. Iris describes being “grateful” that she is able to get her healthcare and medications from the VA. She continued to discuss her health and the roller coaster effect of unemployment and homelessness “the environment changed around me and I had someone else with me at the time that helped me financially and it was a struggle with the employment roller coaster and the financial roller coaster and my health kind of went the same way.”

Although they each felt their health is worse since becoming homeless, several of the women felt their health would improve now that they were receiving care through the VA. They are all receiving physical, mental and social healthcare through the VA system and all expressed feeling that the VA healthcare system is a great resource for them.

4.5 Military Preparation

Military positions for the women consisted of supply, administration, or communications. None of the women felt their military career prepared them for life after the military. Each of the women felt that the skills gained would help them after they left the military and were surprised that they had difficulties finding positions. Sam received no special training while in the military but felt the military experience had made her a better person and improved her office skills but had not helped her gain employment since discharge. Iris described her military positions as electronics and communications. Although her military training has not helped her gain or maintain employment since leaving the military she felt that “general leadership training and discipline” she received were characteristics that people would look for in an employee. Rose was in the supply field while in the military and was disappointed with the training she received

on active duty, “when I got out you know they said this will help you when you get out, but no, because the only thing you could really do back then was put up a tent”.

Military preparation for life after military represented a broken trust for the women. They all volunteered for the military and felt they would gain skills and knowledge that would increase their employability after discharge, but this was not the case. They continue to have difficulties finding stable jobs which, has been a contributor to their homelessness.

4.6 Summary

A total of six homeless women veterans were interviewed to explore the individual meaning of homelessness, risk factors for homelessness and resources necessary to end the homeless cycle. Using a modified framework for studying vulnerable populations, the affects of social status, social capital and human capital on their vulnerability was discovered. The meaning of homelessness for each of the participants was different, but for each of them the onset of homelessness was sudden and something for which they were unprepared. The path to homelessness consisted of unexpected military discharge, unrealized military retirement, abuse or trauma, and broken family relationships.

The interviews revealed several common themes, abuse of person, broken trusts, and trying to survive. Abuse of person consisted of experiencing military sexual trauma, extreme military sexual harassment, or spousal abuse. Broken trusts consisted of broken promises from military service, either due to unrealized military retirement, military preparation for employment post discharge, inability to trust military colleagues and dysfunctional family or interpersonal relationships. The theme of trying to survive consisted of finding the struggle to find resources to help them survive and forming new bonds with other veterans.

Social status, human capital, and social capital all had an effect on their risk for vulnerability. The participant's social status, that of being a woman and a veteran placed them at higher risk for becoming homeless. Their struggles prior to and after becoming homeless had a greatly affected their physical, mental and social health. Their interpersonal relationships, or social capital, had both a negative and positive effect on their lives and their risk of homelessness. Their personal human capital has had a profound effect on their ability to find employment and exit homelessness permanently.

CHAPTER 5

DISCUSSION

5.1 Introduction

The purpose of this descriptive study was to (a) explore the meaning of homelessness to homeless women veterans, (b) identify risk factors for homelessness and (c) discover resources necessary to end the homeless cycle. Utilizing the Framework for Studying Vulnerable Populations (Aday, 1994) as an over arching framework, personal risks/resources as well as community risks/resources were explored. In addition, health care utilization was also explored.

Six participants were interviewed using a semi-structured interview tool with questions that were gleaned from the literature. Each interview was conducted in private, audio taped and transcribed by the researcher. Demographics for each participant were collected and are displayed in ranges in order to decrease the possibility of identification of the participants. The participants provided rich understanding of the meaning of homelessness, resources needed to end their homeless state and personal risk factors for homelessness. Interpretation of the research findings in relation to published studies, limitations, conclusions and recommendations for research are discussed.

5.2 Interpretation

Interpretation of the data was compared to current research literature and is detailed below. Qualitative data from the present study is interpreted and discussed by themes, research question and relation to modified framework for studying vulnerable populations.

5.2.1 Demographics

Demographics were collected from all participants and consisted of age, race, branch of service, length of military service, marital status, whether or not they had children, length of homelessness and number of times homeless. The demographics of the current participants were different than those found in the Washington, et al. study (2010) in that the homeless women veterans in the current study were primarily white (67%) and in the 2010 study they were primarily black (54.6%). Differences in race may be explained by the area in which they were conducted, Los Angeles versus the Central Texas area. The mean age in the 2010 study was 49.7 years of age, while the mean age in the present study was slightly older at 50.3 years of age.

In the study conducted by Gamache, Rosenheck and Tessler (2003) the highest risk of homelessness among women was found in the 45-54 year range and in those who were not married. The findings of the current study are similar to those in the above mentioned study as three (50%) of the participants fell in the 45-54 year range and most were not married.

The current demographics are similar to those that were found in the 2010 Bell County homeless population estimate. The median age of the homeless population in Bell County was found to be 49. The participants in the current study were primarily white as they were in the Bell County homeless population estimate. The average length of service for the veterans in the Bell County estimate was 4 years, which fits with the range of service of the current sample.

5.2.2 Meaning and Path to Homelessness

Six homeless women veterans participated in the study with the meaning of homelessness having a different meaning for each. Homelessness ranged from being a “dark, downward spiral” to meaning a loss of everything they owned. The women felt stigmatized and

vulnerable, with Rose feeling like she had failed and regretting decisions she had made in the past. The stigmatization discussed by the current participants is very similar to the findings of Applewhite (1997) and Wen, Hudak, and Hwang, (2007). Both researchers described homeless persons as feeling rejected, stigmatized and marginalized.

For all participants in the current study, becoming homeless the first time was very unexpected and unanticipated; they were unprepared and did not have a backup plan. Becoming homeless unexpectedly is very similar to the results of Crane and Warren (2010) who found that among a group of persons experiencing their first episode of homelessness, the reasons for homelessness were related to unexpected job loss and inadequate public assistance. Other reasons cited by the researcher's for homelessness in their study was rising housing costs, unstable job market, lack of job skills, and weak support systems. These same problems were experienced by the current participants as they all discussed weak support systems, lack of job skills, and inability to afford housing.

5.2.3 Risk Factors

Risk factors for the participants were identified during interviews and data analysis. They consist of abuse/trauma, broken trusts and ineffective coping skills. Abuse/trauma is described as abuse of person. Broken trusts consist of broken promises and relationships. Each risk is discussed according to theme and relevant literature.

5.2.3.1 Abuse of Person

Prior abuse was identified as a risk factor for all six participants, with all but one having experienced some form of trauma either in the military or after military discharge. Although there has been little research conducted to determine risk factors for homelessness in women veterans, there have been several studies to determine risk in the general homeless population

(O'Connel, et al., 2008; Odell & Commander, 2000). O'Connel et al.(2008), described risk factor for homelessness in the general homeless population as dysfunctional childhood environment, lack of education and employment, decreased social support, and substance abuse. Decreased social support and lack of employment were risks that were present in all of the current participants. Victimization, spousal abuse or violence from one's partner has been shown to put women at risk for homelessness as they are fleeing an abusive relationship (Hudson, et al., 2010; Padgett, et al., 2006). This risk was present in two of the women who participated in this study. Rose described the abusive relationship that she was trying to escape, throwing anything she could into her car, leaving a civil service position that she had been in for several years and leaving the state. Because of the domestic violence she incurred and escaped, she became unemployed and homeless all at once. The physical scars of what she had been through are very evident as she has very few teeth due to the violence she experienced at the hands of her former Viet Nam veteran husband. Sam also described the victimization and spousal abuse experienced as she was put out on the street with her three children by her drug dealer husband. Hudson, et al. (2010) reported homeless women having suffered some form of abuse or trauma as being fearful, having low self esteem, and being socially withdrawn. This was true for Rose who discussed her fears of being in a shelter or on the street.

Military sexual trauma is another form of sexual abuse experienced only during military career or deployments. Military sexual trauma consists of rape, sexual assault, sexual coercion and unwanted sexual attention (Kimerling, Gima, Smith, Street & Frayne, 2007). The exact numbers of women who experience military sexual trauma is unknown as many female soldiers and veterans do not wish to report it, but the estimates of military sexual trauma range from 15.1 percent (Kimerling, et al., 2010) to 27 percent (Kimerling et al., 2007). In the study conducted by Washington et al. (2010), comparing homeless women veterans to non-homeless women veterans, the homeless veterans were more likely to have suffered military sexual

trauma than the non-homeless women, and was considered a significant risk factor for homelessness among women veterans. Three (50%) of the six participants in the current study had experienced military sexual trauma during their military career. Although this is a higher percent than found in some studies, it correlates with the sample in the Washington et al. study, who found an overall rate of 53% positive for military sexual trauma. The higher percentage in Washington's study and current study may be due to the recent focus on military sexual trauma and the participants feeling that they can now discuss their experiences, whereas in the past survivors of military sexual trauma may have been reluctant to discuss their experiences due to embarrassment or perceived threat of military retribution.

Sexual trauma in itself can be devastating to the person experiencing it, but in the military there are additional issues that affect the victim. A large portion of the military experience is the camaraderie and trust that the soldier puts in their fellow soldiers. With military sexual trauma, the perpetrators are most often fellow soldiers and the victim must continue to work with them daily, thus increasing the emotional distress. To maintain unit cohesion, the victim is frequently encouraged to remain silent about what has occurred to them, or their reports are simply ignored (Kimerling et al., 2007). The current study found this to be true, as with Daisy who reported her military sexual trauma, only to have her report ignored by her superior officers. This put her at risk for further victimization, being raped later on in her short military career.

5.2.3.2 Broken Trusts

Each of the participants was affected by broken trusts, whether due to family problems or failed military promise. Several of the participants moved from one area of the county to Texas so they could be closer to family members, and have physical or emotional support from their family. Other participants' family members played a large part in the path to homelessness

for the participants. Failed military promise was another broken trust for the participants, either due to unplanned military discharge or the inability to obtain employment based on their military training and position.

Current literature describes separation from family members and lack of family support to be a significant risk factor for homelessness (Gamache et al., 2003) and lack of family support was found to be significant among the current participants as well. The detachment and separation from family members during military service has shown to increase the risk for family problems after military service and this separation from family members continues during homelessness (Higate, 2000). Mares and Rosenheck (2004) surveyed 631 homeless veterans across nine large VA sites and found that 43% contributed separation from family and social support to be a risk factor for their homelessness. Military service in itself and mobility of the service member often disturbs family and social ties during normal times which may make it even harder for the veteran to gain family support during hard times. Anderson and Rayen (2004) found that women who are connected to their families as less likely to become homeless. Washington et al. (2010) found the majority of homeless women veterans to be unmarried, as were five of the six participants in the current study, with the one who was currently married being physically separated from her spouse. Being married was considered a protective factor against homelessness in the study conducted by Washington et al.

In this study all of the participants were separated from their family members for one reason or another. Each had children, yet none with the exception of the one with young children, were able to live with their children. They each discussed the relationship with their children and how their relationships caused emotional distress in their lives. Several described taking the few things they had and leaving one area of the country for another, which further supports the transient nature of homeless veterans reported by Higate (2000). Five of the six women moved to the Central Texas area to be closer to family and yet for various reasons

found that they would be unable to live with family members, or had lived with family members for a short time and were asked to leave. When asked if they considered their family members to be part of their social support network, all with the exception of one replied that their family is not part of their social support.

Military service was also considered a broken trust as prior to entering the military; each participant felt military service would provide them with the skills and abilities to gain employment in the future. Yet none of the participants felt military service has helped them, other than with gaining some general leadership skills. For some of the participants the promise of military retirement, which did not come to fruition and the promise that serving in the military, would help them gain life skills and employment after military service was nothing more than a dream that did not come true.

Numerous programs are available to assist veterans with finding employment, including the current priority for the VA in employing a larger percentage of veterans. In 2008 the Veterans Employment and Training Service (VETS) of the Department of Labor (DOL) published guidance on priority of service for persons covered under a DOL program (Department of Labor, 2008). This rule became effective on January 19, 2009 and gave priority for DOL job placement and training to veterans and their families. Yet, with the emphasis on hiring veterans and their families there is very little research available to describe how military service has prepared soldiers for employment after military service. There is, however, an abundance of research available on how military service effects the life/career of a military spouse (Baptist, et al. 2011; Verdeli, et al., 2011), how to reintegrate deployed National Guard and Reservists back into civilian life (Tully, 2008) and how Vocational Rehabilitation assists injured soldiers in finding employment after discharge (Boutin, 2011; Olson, 2010; Resnick & Rosenheck, 2008).

Rosenheck and Mares (2004) conducted a study to determine if military service influenced or increased homelessness. During the study the researchers queried 631 homeless veterans as to if military service had impacted their homelessness. One third of the participants felt their military service had an influence on their homeless situation due to substance abuse during their military career, lack of preparation for civilian employment and loss of a structured life style. The results of the current study were very similar to Rosenheck and Mare's study in that the majority of the participants did not feel the military experience prepared them for employment. One of the participants did discuss the general leadership experiences gained and that the computer skills gained as part of her position in the military were transferrable to civilian employment, although she is not currently employed. Jasmine discussed the alcohol abuse that she experienced while on active duty and that drinking is "what we did". Her alcohol abuse continued after discharge from the military and contributed to her being homeless. Cooney et al. (2003) described military service as decreasing the employability and income for women veterans, which seems to hold true for the current participants.

Two of the women felt that women veterans are at a disadvantage in gaining employment because of the skills gained in military employment and that maybe employers do not understand what veterans are actually qualified for. Most branches of the military offer discharging soldier's some assistance in preparing resumes but overall, the participants did not feel that this service helped them acquire employment. In addition, Sam discussed going through the employment services offered prior to discharge, but being unable to interview for a position because she was still in the military and unable to get off for interviews or accept a position if offered.

The women in this study reported an inability or altered ability to cope with life circumstances. There is a high rate of alcoholism, drug abuse, depression, anxiety, mental health problems in the general homeless population and it is the same among the women in this

study. According to Benda (2004), there is a high prevalence of substance abuse, depression, low self-esteem, stress, fear, guilt and problems in relationships with family or friends among homeless women. The participants in this study all discussed feelings of depression, guilt, fears, alcohol abuse, and/or problems with family and friends. Applewhite (1997) found that low self esteem among his all male veteran population was the result of decreased family interaction, loss of autonomy, and social stigma.

Broken trusts due to military service and family problems left each of these women at increased risk for homelessness. The lack of preparation for jobs experienced during their military career and the promise that they considered broken left them without the skills necessary to gain permanent employment. Broken family ties either directly pushed these women into homelessness or left them without a support network that could have kept them from living on the streets. The failures of human and social capital left them vulnerable and at increased risk for homelessness.

5.2.4 Resources

Information on resources used in the past and those necessary now and in the future was sought from the participants. Each participant described the importance of resources to their survival and their struggles in obtaining those resources. The struggle for resources coincides with trying to survive.

5.2.4.1 Trying to Survive

Each participant discussed trying to gain the resources necessary to help them survive the streets. The participants each described what type of community or VA resources they have obtained or tried to obtain in order to survive. They also discussed the social network they have built for camaraderie in absence of their family members, as they considered friends an

important resource to survival. Information on resources or lack of resources is necessary in order to design programs that meet the needs for homeless women veterans and this was explored in the current study. There is very little literature available that describes the resources necessary to end homelessness, although the VA and local communities continue to spend large amounts of money to end homelessness. In fiscal year 2011 the VA spent \$217,639,000.00 on grant and per diem housing and another \$201,069,000 on the HUD-VASH program (GAO, 2011). Four of the six interviewed were in transitional housing but stated they needed a permanent roof over their head. One lived with a friend and described leaving homelessness as having “me and my daughter having our own bed”. Daisy was currently in a community shelter and felt that as long as she had a roof over her head she was fine, but stressed that she needed a permanent house or apartment.

Acosta and Toro (2000) surveyed a group of 301 homeless adults to determine what resources were required to end their homelessness. The researchers found job training, transportation, and health care were just as important as housing needs in their sample. Women in the present study described the need for employment or other form of income as their immediate need, this need was previously cited in a study conducted by Daiski (2007). Transportation was an identified need for Sam, who had just recently gained employment but anticipated having problems with transportation due to lack of gas money until receiving her first paycheck.

These women’s difficulty with bureaucracy encountered in trying to obtain VA and community resources was similar to that reported by Applewhite, (1997) and Nyamathi, et al., (2003). Sam discussed being turned down for community resources because she was selling plasma to feed her children and had a vehicle that was worth too much. Amanda described having to walk eight to ten miles to get to public transit after losing her car so she could apply

for aid. This required taking her son out of school because he had to be with her to prove that she had children, thus causing him to miss school.

O'Toole et al. (2003) compared homeless veterans to non homeless veterans in a large urban area and found that the homeless veterans were in need of VA resources or were unaware of VA resources. The need for VA resources was not found in the current study, as all participants seemed to be aware of available VA resources and was utilizing VA services. The difference in findings could be attributed to the recruitment process of the current study in that most of the participants were referred to the researcher by homeless veteran social work staff.

Another resource for the women in their attempt to survive homelessness was the camaraderie experienced with other veterans, or those that had experiences similar to their own. This camaraderie among veterans may stem from military service, as according to Griffith and Vaitkus (1999), unit cohesion among military members is encouraged to promote combat effectiveness and unit performance. Cohesion between unit members continues to be encouraged throughout the military career and seems to continue as one reaches veteran status. Each participant in the current study described their social network as the VA, friends, or other veterans rather than family members as each was estranged from their family. Amanda described her experiences in the military and group cohesion that was formed within her unit as a "big family and you have all the support you need there." For Amanda the same type of cohesion and support has been found with the veterans she encountered while staying in the CTVHCS domiciliary. This cohesion and support of veterans was echoed by several of the other participants as well.

Findings of the current study revealed that all participants were actively engaged in trying to end their current homeless situation, whether through community resources or VA resources. All discussed intermittent employment and that they had difficulty maintaining

permanent employment for one reason or another. Several of the women felt that being unable to maintain permanent employment decreased their options in finding jobs, feeling that as employers looked at their resume they would see an unstable work history and not be willing to offer them a position. Amanda had temporary employment due to the holiday season, while Sam was to start a job the next week. Community resources used by the participants ranged from local churches to food stamps, food banks, shelters, and unemployment. All of the women described permanent housing as a resource necessary to end their homeless situation. Social support from other veterans was considered an important resource to help them survive and they all described bonding with other veterans, or those that understood what they were going through as important to them since they did not have a relationship with family members.

5.3 Modified Framework for Studying Vulnerable Populations

The modified framework for studying vulnerable populations was an appropriate framework for use in this study. Using the framework to guide the research and research questions, the effects of social status, social capital and human capital on the risk of vulnerability was discovered.

5.3.1 Social Status

Social status consists of age, race and ethnicity and positions occupied in society and can have a profound effect on one's vulnerability or risk. Veterans are at increased risk for becoming homeless and one of the fastest growing populations of the homeless population is women (Washington, 2010). Women veterans are two to four times at higher risk for homelessness than their non-veteran counterparts (Gamache, Rosenheck & Tessler, 2003). The social status of the women in the present study, being female and a veteran may have made them more vulnerable for homelessness.

5.3.2 Social Capital

Social capital consists of interpersonal relationships and the quality of those interpersonal relationships can place one at higher risk for vulnerability and have a positive or negative effect on one's physical, psychological or social health (Aday, 2004). The abuse and trauma suffered by each of these women is reflected of diminished social capital and had a negative effect on their health. This was very evident in Rose, who had broken teeth from the marital abuse she had suffered and the effect that those broken teeth had on her physical and social health. That same abuse had psychological consequences on her which was evident as she discussed being afraid and hyper-vigilant. The consequences were evident on Daisy and Iris as well, who both suffered military sexual trauma and the long term psychological and physical effects. The women's personal relationships with their family members had an effect on their risk of vulnerability, as all were separated or estranged from their family members.

There were positive bonds between the women and other veterans and several of the women discussed how they enjoyed the friendships and bonds they were making with veterans. Having someone who understood what they had gone through was having a positive effect on their social and psychological health. The social support offered by the VA homeless veteran social workers was important to each of the women and they all described the VA as part of their social support network.

5.3.3 Human Capital

As discussed by Aday (2004), there is a direct relationship between the availability of low cost housing and the number of homeless. This was found in the current study as each participant needed permanent housing but due to lack of income could not afford housing. Other factors for homelessness discussed by Aday are marital problems and family violence, also found in the current study. On an individual level, human capital refers to the skills and abilities

of the individual or the contributions to society. Each of the women had diminished human capital as they had no particular skills or abilities that allowed them to obtain and maintain employment. Daisy described having many different jobs over the past year, while Iris thought her skills abilities should have assisted her with finding employment. Each of the participants described having a job or some form of income as their number one resource need to end their current homeless state. As previously discussed, all of the participants thought their military service would allow them to either have a retirement income or increase the opportunities offered to them after military service. Instead they are left without jobs or an income and this has had a large effect on their risk for homelessness.

5.4. Effect of Homelessness on Health Status

Homeless influences not only the personal health practices but also interactions with health care providers. Homelessness is often synonymous with declining health and health related morbidity. There is an abundance of literature that discusses health care and homeless persons, but little available research on how homeless persons view their health status or what resources are needed to improve their health. The participants in the current study were asked to compare their current health status to before they became homeless. The participants all stated their health status was better prior to becoming homeless, but two felt they were improving due to the care being provided by the VA. These results are different than those in a study conducted by Anthony and Barry (2009). The participants in the 2009 study were non-veterans and rated their health as being above average, although they had very little contact with any type of healthcare provider in the prior six months. It could be possible that the veterans in the current study rate their health status as worse due to the fact that they are all enrolled in VA healthcare and are aware of their current health status, whereas the sample in Anthony and Barry's study may have been unaware of any ongoing health problems. Washington et al. (2010) reported that 72.7% of the women veterans in their study used the VA

for care, had a usual provider for care and reported their condition as fair or poor. One hundred percent of the homeless women in the current study use the VA for their primary health care.

Daiski (2007) explored the perspective of homeless persons on their health status and health needs. The homeless participants in her study described their health status as worse, and many had chronic illnesses. All of the participants in Daiski's study discussed experiencing some form of emotional distress and the impact of that distress on their homeless situation. In the current study, participants described their emotional and mental distress as well, and the impact on their homeless situation. Two participants discussed problems with PTSD and their inability to maintain a job because of it. PTSD among women who have been sexually assaulted or who have suffered sexual harassment while in the military is common with up to 99% of those with PTSD having been experienced sexual assault and 63% experiencing sexual harassment (Feczner & Bjorklund, 2009).

5.5 Limitations

This study sought to explore the meaning of homelessness to homeless women veterans, risk factors for homelessness and resources necessary to end homelessness. Limitations consisted of sample size and geographic range. Data saturation was reached at six participants and focused only on women veterans; therefore the information gained may only be relevant to those who participated.

The results presented here are strictly the experiences of these six homeless women veterans; results may have been different with other female homeless veterans. The study was conducted in the Central Texas area and may have had different results or be strengthened if it had been conducted with multiple sources of information or in other parts of the country. In addition, all participants were enrolled in CTVHCS health care and were aware of services to

which they were entitled. The results may have been different if participants were not being provided health care and enrolled in homeless veteran programs.

There was a high rate of military sexual trauma among this group of participants, higher than reported in the literature. Although the DOD developed the Sexual Assault Prevention and Response office in 2004, the women in this study who experienced military sexual trauma had served prior to the development of this office. Conclusions should not be drawn about current military sexual trauma in today's military based on these results. In addition, with the current focus in the VA on military sexual trauma it may be that women who have experienced this form of trauma are now more comfortable discussing their experiences than in the past. The participants may have also been comfortable in discussing their experiences with the researcher because she is a female, and may not have discussed their experiences had the researcher been a male.

5.6 Conclusions

The VA is committed to ending homelessness among veterans and is investing millions of dollars to do so, yet homelessness among women veterans is growing. With the growing number of women in the military and thus increasing women veterans, identification of those women at risk for homelessness should be considered a priority rather than the current focus on providing resources to those who are already homeless. Risk factors for homelessness among the current participants consisted of some form of trauma: Military sexual trauma, extreme sexual harassment while in the military or spousal abuse. Women who have suffered this type of trauma appear to be at higher risk for homelessness especially when coupled with lack of family or social support. Decreased coping skills, whether due to alcohol or substance abuse, PTSD or other mental health problems, appears to increase the risk for homelessness among women veterans as well. Risk assessment of these women at military discharge, on entry to the

VA system, and with each care provision is essential. Women entering the military should be assessed for trauma prior to entering the military as well as during their military service so they can be provided the appropriate treatment prior to discharge. Education for providers on conducting a thorough risk assessment should be provided to both military and VA providers

The federal government and community agencies are spending millions of dollars each year to decrease homelessness. Funds are used to provide temporary housing, food, clothing, and health care to the homeless. The VA is heavily invested in providing these same resources to homeless veterans. Although the participants in this study appreciated and were thankful for transitional housing, each stated a need for employment. There is a notion that homeless persons are homeless because they are lazy or do not want to work, yet five of the participants placed employment as their highest priority. A focus needs to be placed on more job training and job placement for those at risk for becoming homeless or those already homeless. As female soldiers transition from military to civilian life, job placement assistance is needed so they transition to a career rather than to unemployment and possible homelessness.

For the participants with a history of sexual assault or abuse history feeling *safe* is a challenge. Several discussed not trusting those around them and this mistrust making it difficult to stay in shelters, on the street and even in maintaining employment. With many of these women in the grant and per diem program and housed in traditional housing, maintaining their feeling of safety adds an additional challenge to the VA. According to a new report from the Government Accountability Office (2011), many of the homeless women that they interviewed discussed safety concerns in the grant and per diem program, with many reports of sexual assault while in the program. At this time the VA does not have gender specific security or safety standards for grant and per diem housing, which may put these women at further risk. Expanding capacity for gender specific housing is crucial to ensure homeless women veterans and their children are safe.

The participants in this study described the importance of the other female veterans in their social network. Because of the high rate of military sexual trauma and spousal abuse, opportunities for homeless women veterans to engage with other women veterans should be increased. Although several VA health care systems offer groups for homeless women veterans, these groups should be increased to allow the social ties and camaraderie between these women to form.

The participants in this study were aware of VA services available to them but had difficulties in getting the services when needed. The VA has increased outreach services into the community and this outreach must continue to expand. Community service providers must be aware of services provided by the VA to homeless women veterans in order to make appropriate referrals and assist those in the community with engaging in VA care.

5.7 Implications for Nursing

Development of an increased understanding of both the physical and mental health problems facing women veterans is essential. Nurses should be aware of the resources and programs available to women veterans and be able to provide information to them or assist them with finding the appropriate resources. Although the history of care in the VA has focused on the male veteran, nurses within the VA must provide gender specific care in order to increase women veterans comfort with and use of the VA system.

Two of the participants in this study voiced and the literature shows, homeless persons are often stigmatized and treated with disdain when presenting for care. Nurses need to be more aware of the plight of homeless veterans and what resources are available to them; ensuring resources are considered and offered prior to discharge. Because of the embarrassment and feeling of failure that homeless persons often feel, they may not be forthcoming with resources or services required. Nursing staff must be able to and take the time

to perform a thorough assessment of homeless women when they present for care. Homeless women who present for care may bring their children with them, requiring nursing staff in the VA who are unaccustomed to having children in the clinic or emergency department to provide care to the female with children present. A family approach needs to be adopted to include children in the assessment of needs as well.

5.8 Recommendations for Additional Research

As the number of female veterans grows, additional research into the risks associated with homelessness among women veterans should be conducted. This study should be replicated in other areas of the country and with a larger sample size. Further research should be conducted to determine the impact of MST on at risk female veterans. Although VA outreach services have expanded, further research needs to be conducted to determine how to reach at risk women who are not enrolled in the VA system. Additional resources for job training and education for homeless women veterans are needed so additional research should be conducted to determine how to provide these services while remaining cost effective.

5.9 Summary

Using a modified framework for studying vulnerable populations, a qualitative descriptive study was conducted to explore risk factors for homelessness, resources necessary to end homelessness and health care status among homeless women veterans. Themes were revealed through interviews and were discussed in the words and experiences of the participants. Risk factors for these participants include some form of trauma or abuse, separation from family or lack of family support, and decreased coping skills. Resources necessary to end their homelessness included employment or some other form of income and permanent housing. All participants felt their health status had decreased since becoming homeless and were all enrolled in VA healthcare. Social capital, social status and human capital

were discussed in regards to the participant's relevant risk and affects on their individual health needs. Exploring the individual perspective on their personal social status, social capital and human capital and comparing it to current literature, one can understand the increased risk for vulnerability in these participants. There are many limitations to this study to include a small sample size, all participants from one region, all enrolled in VA healthcare and study design. The participants provided description of the personal meaning of homelessness, risk factors (both personal and in the community) for homelessness, and resources they feel are necessary to end their homeless state.

APPENDIX A
DEMOGRAPHIC FORM

Age:

Race: White African-American Hispanic Other

Highest Education Level: GED High School Some College College Graduate

Marital Status: Married Single Partnered Divorced Widowed

Children Y N

Branch of Service: Army Navy Marine Air Force Coast Guard National Guard

Years of Service: 1-5 6-10 11-15 16-20 over 20

Length of time homeless: Below 1 year 1-5 years 6-10 years Over 10 years

Number of episodes of homelessness- 1-3 4-6 7-10 >10

APPENDIX B

INTERVIEW QUESTIONS

Describe homelessness:

1. Describe what being homeless means to you.

Follow up probes:

2. What actions have you already taken to end your homelessness?
3. What will ending homelessness mean to you?
4. Describe how has being a female veteran impacted your homelessness?
5. What happened after military discharge that led to your homeless situation?

Resources

1. Describe how resources or lack of resources have contributed to your homelessness.

Follow up probes:

2. Describe your current social support network. Do you have family members to assist you?
3. What resources do you feel are necessary to end your homelessness?
4. What was your job in the military? How has your military career helped you find employment since leaving the military?
5. How far do you normally have to go for healthcare? How do you get there?
6. Where do you normally receive your health care?
7. Have you used the VA health care system or social services in the past 12 months?
What type of services?

Risk Factors

1. Describe what events occurred in your life prior to becoming homeless.
2. What do you consider the risk factors for your homelessness were?

Follow up probes:

3. Describe your health before becoming homeless.
4. Describe your health now.
5. Do you have a social support network in this area?

APPENDIX C

CONSENT FOR USE OF PICTURE/VOICE

Consent For Use of Picture and/or Voice

Consent of (Name)

I hereby voluntarily and without compensation authorize pictures and/or voice recording(s) to be made of me (or the above name individual if the individual is legally unable to give consent) by Central Texas Veterans Health Care System. While I am participating in an interview for the research study entitled "The Meaning of Homelessness to Homeless Women Veterans".

I authorize disclosure of the picture and/or voice recording to the University of Texas at Arlington, who will receive study results but not specific detailed data.

I understand that said picture, video and/or voice recording is intended for the following purpose: Voice recording will be utilized to compile data for dissertation of Robin Keene, RN.

I have read and understand the foregoing and I consent to the use of my picture and/or voice as specified for the above described purpose. I further understand that no royalty, fee or other compensation of any character shall become payable to me by the United States for such use. I understand that consent to use my picture, video and/or voice recording is voluntary and my refused to grant consent will have no effect on any VA benefits to which I may be entitled. I further understand that I may at any time exercise the right to cease being filmed, photographed or recorded, and may rescind my consent for up to a reasonable time before the picture, video or voice recording is used.

SIGNATURE OF INDIVIDUAL OR OTHER LEGALLY AUTHORIZED PERSON DATE

PERMISSION OBTAINED BY (NAME, TITLE, ADDRESS)

SIGNATURE OF INTERVIEWER OR INDIVIDUAL OBTAINING CONSENT DATE

INDIVIDUALS NAME AND ADDRESS

APPENDIX D

FLYER

The Meaning of Homelessness to Women Homeless Veterans Research Study!

Recruiting **female homeless veterans** to participate in a current research project. This project is being conducted to describe homelessness among female veterans, risk factors for homelessness and resources necessary to end homelessness. These research findings will assist the Veterans Administration in designing programs specific to the female homeless veteran population and/or identifying early risk factors to decrease homelessness among female veterans.

If you are a women veteran (Army, Navy, Air Force, Marine or Coast Guard), are homeless and interested in participating in this research project please contact the below number or ask your health care provider or social worker to contact the number below. If selected to participate in this research project you will receive a \$30.00 gift card for your participation. All identifying information will remain confidential. Interviews will be conducted privately either in the researcher's office in Temple/Waco VA Campus or in the VA Southgate building (Austin). The interview will last approximately 1 hour.

Robin Keene, RN (VA employee)

Cell: 254-534-0440

Work Phone: 254-743-2913

APPENDIX E
RESEARCH SHORT FORM

You have participated in a research study entitled “The meaning of homelessness to homeless women veterans”. Should you have questions or wish to dis-enroll from the study you can contact the researcher, Robin Keene, at 254-743-2913.

APPENDIX F

THEMES/DATA SATURATION TOOL

Path to Homelessness	Unexpected Military retire.	Unexpected Military disch.	Unexpected Spousal abuse	Unexpected Family/alcohol	Unexpected Military disch.	Unexpected Family relation
Meaning	Nothing of own	Lost everything in one minute	Left everything behind Failure Dark stigma	Hopeless Empty Nobody cares	Vulnerable Loss of control Nothing of own	Lack of own bed Nothing of own
Risks	Family support Spouse abuse	Family support Military Spouse problems	Family support Spouse Abuse	Family support Bad relationship Sexual harassment Coping Low self esteem	Family support MST Sexual harassment coping	Family support MST coping
Resources needed	Job Income Support team	Job income	Job Steady income	Income Job Support team	Job Income Support team	Income
Health care	VA	VA	VA	VA	VA	VA
Social Support	Friends VA	VA Veterans	Friends Veterans	Friends Veterans	VA Veterans	VA Veterans

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BIOGRAPHICAL INFORMATION

Robin Keene began her nursing career in 1994 after graduating from Louisiana State University at Alexandria with her ADN. She began working for the Veterans Administration Hospital in Temple Texas in 1995 and continues to work there. She received her Bachelor of Science in Nursing degree from the University of Texas at Arlington in 1999 and her Master's of Science in Nursing in 2003 from the University of Texas at Arlington. She has held various positions at the VA Hospital in Temple to include staff nurse, nurse manager, Associate Chief Nurse, and now Deputy Associate Chief of Staff/Education. Dr. Keene graduated from the VA Executive Career Field program in 2011 and was given the Secretary's Award for Excellence in Nursing in 2003. She became interest in homeless veterans during her tenure as Nurse Manager of the Emergency Department at the VA Hospital. At this time she became acutely aware of the growing number of homeless veterans and the problems incurred by them. She later became interested in the homeless female veterans after watching the number begin to grow. Dr. Keene plans to continue to research risk factors for homelessness among the female veteran population and is currently developing a research team for a large VA nursing research grant.