

“I CAN’T EVEN WALK, YOU’RE EXPECTING ME TO CLIMB A MOUNTAIN?” AN
EXPLORATION OF SERVICE PROVIDERS PERCEPTION OF VULNERABILITY
AMONG INDIVIDUALS EXPERIENCING HOMELESSNESS

A DISSERTATION

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DEDICATION

For the men and women that work tirelessly every day to make a difference in the lives of the invisible and easily forgotten members of our society.

For my family, thank you for your love, support, and patience.

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ABSTRACT

ELIZABETH W. WACHIRA

I CAN'T EVEN WALK, YOU'RE EXPECTING ME TO CLIMB A MOUNTAIN?" AN EXPLORATION OF SERVICE PROVIDERS PERCEPTION OF VULNERABILITY AMONG INDIVIDUALS EXPERIENCING HOMELESSNESS

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Those experiencing homelessness (IEHs) are more likely to have more health issues, more unmet health needs, higher occurrences of excess morbidity and mortality, have less control over manageable chronic health conditions, and are three to four times more likely to die prematurely than their housed counterparts. The causes of these health disparities are deeply rooted in the social context surrounding everyday life, where the interplay of various identity factors determines one's vulnerability. Vulnerability thus represents the multiplicity and convergence of risk factors inherently tied to individuals marginalized identities and lived experiences. Therefore, in order to comprehensively understand the pathways leading to health disparities, a deeper understanding of the social context of vulnerability as a determinant of health is needed. The injustices experienced by IEHs happen in their everyday lives where interactions with the domiciled populations further influence the occurrence and impact of marginalization. Research well supports how these occur from the homeless populations perspectives, but insight from service providers (SPs) is lacking in regards to understanding how vulnerability among IEHs manifests in the lived context, specifically the service provision setting.

The goal of this study was to understand how vulnerability manifests in the lived context by allowing study participants the opportunity to tell their story. Through interviews and digital storytelling, this study proposes to understand service providers' perception of vulnerability as experienced by IEHs. Guided by an intersectionality framework, knowledge production was informed by eliciting SPs descriptions and viewpoints regarding IEHs experience with their primary identity of "being homeless" while allowing for other influential categories to be determined that lead to more occurrences of marginalization. The data collected included 8 ethnographic fieldwork participant observations, 7 semi-

structured SP interviews and 5 digital stories and reflection interviews. This data was analyzed using standard content analysis and constant comparison to construct themes pertaining interactions between SPs and IEHs, and how vulnerability manifests in the service provision context. Three themes emerged from the data, focused on the “navigating” IEHs and SPs have to do in the service and lived context. These include navigating the meaning of time, navigating the system and navigating change.

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CHAPTER I

INTRODUCTION

The most persistent manifestation of inequality has been the ever growing disparity in health (Shi, Stevens, Faed & Tsai, 2008). A health disparity is defined as

a particular type of difference in health or in the most important influences in health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups systematically experience worse health or greater health risks than advantaged groups (Braveman, 2006, p.180).

Health disparities still persist albeit the numerous studies aimed at detecting, understanding , and eliminating pathways to disparities (Penman-Aguilar, Talih, Huang, Moonesinghe, Bouye & Beckles, 2016; Thomas, Quinn, Butler, Fryer & Garza, 2011).

The persistence of health inequities among marginalized groups calls to attention the need for comprehensive methodology , and analysis of health disparities, specifically, an understanding of how these disparity pathways manifest in everyday life. To accomplish this, an emic based study approach looking at the lived experiences of those labeled as marginalized or vulnerable is needed. An emic perspective disregards prior normative assumptions about a phenomenon , and relies instead on an insider's perception , and understanding (Spiers, 2000).

Statement of Purpose

The purpose of this qualitative, exploratory study was to examine service providers' perceptions of vulnerability as a determinant of health among the homeless population. The homeless population experiences numerous vulnerabilities, such as having increased exposure to health risks, and high unmet service needs due to their marginalized status of homelessness (National Health Care for the Homeless Council [NHCHC], 2011). Vulnerability is defined as the level of susceptibility for experiencing a negative health outcome based on one's marginalized status (Viruell-Fuentes, Miranda & Abdulrahim, 2012). The majority of health disparity research approaches vulnerability from a normative etic perspective, assigning certain populations higher probability of disparities based on racial-ethnic or socio-

demographic characteristics (Spiers, 2000; Thomas et al., 2011). This etic based approach views vulnerability epidemiologically, as a population-based relative risk or deficit-oriented measure, where the culmination of internal and external normative deficits makes one susceptible to illness, and disparities (Penman-Aguilar et al., 2016; Rogers, 1997; Spiers, 2000). Though these deficit-oriented approaches do capture the presence, and magnitude of health disparities, ambiguities still remain as to how or why these disparities persist. This uncertainty sheds light on the fragmented methodological approaches used to study health disparities as it fails to clarify disparity pathways, and how these manifest in everyday life.

This study utilized semi-structured interviews, and digital storytelling, guided by service providers' perceptions of vulnerability as present in individuals experiencing homelessness's lived experience. This emic approach allowed for an understanding of those nuanced differences related to how the phenomenon of vulnerability manifests, and is perceived. This understanding will offer insight on how to best identify key constructs related to social vulnerabilities as determinants of health (Spiers, 2000).

Research Questions

The three research questions guiding this study were:

1. How do individuals experiencing homelessness perceive their vulnerability?
2. How do service providers define the vulnerability of individuals experiencing homelessness?
3. How do service providers perceive the vulnerability of individuals experiencing homelessness?

Delimitations

Delimitations for this study related to things the Principle Investigator (PI) controlled about the study participants which include: SP's age , and place or residence -- must be at least 18 years old, be able to read, write , and work , and reside in Texas; work in an agency that provides services to individuals who self-identify as experiencing homelessness , and who self-identify with at least two other marginalizing social categories on the basis of race/ethnicity, gender, sexual orientation, religion, , and disease or disability status; lastly, have at least three years of experience working with individuals experiencing homelessness.

Limitations

Study limitations are mostly related to the use of a qualitative research approach. Therefore, the sample size, and use of purposive, and snowball sampling may result in the exclusion of potential study participants. Another limitation is self-reporting, where the data collected will rely solely on what the participant chooses to share. Lastly, the uniqueness of the study population limits the generalizability of the study to other populations or contexts.

Assumptions

The study was conducted in a safe setting where study participants understood , and wrote in the language used (English), they understood the research concepts, consented to participate in the study , and followed the agreed upon research protocol (Appendix A - B). Study participants were able to write narratives, and take or find pictures in an honest, open yet respectful manner. Albeit short, the connection with the investigator, and study participants was respectful of each other's lifestyle, cultures, and background.

Importance of the Study

The presence of social inequalities in society leads to the creation, and perpetuation of health disparities. Health disparities are differences in health or determinants of health that are amenable to policies, and increase disadvantages faced by marginalized social groups. Through digital storytelling, this study proposed to understand service providers' perception of vulnerability as experienced by the homeless population, a well-known, and observed marginalized group. Study findings will expand the current body of literature by guiding the creation of empirically driven typologies of vulnerability , and allowing those working with specific populations such as the homeless a way to accurately assess vulnerability, , and create effective disparity interventions. An immediate study outcome was the information sharing forum conducted at the conclusion of the study with participating service providers, and the general public. This meeting was crucial in providing service providers pertinent insight on study findings, and most importantly how these results can inform their current practices, and policies related to service planning,

and provision. In addition, the digital stories presented provided an emotional perspective that they could all relate to, and were able to use in raising awareness of the barriers IEHs face in everyday life.

CHAPTER II

REVIEW OF LITERATURE

The review of literature examines the presence, and impact of health disparities among individuals experiencing homelessness. Specifically, it discusses how the occurrence of marginalization through social adversities lends insight to how vulnerability is experienced. The first section defines key terms, and concepts used in health disparity research. The second, and third sections discuss the presence, and impact of health disparities among individuals experiencing homelessness (IEHs) respectively. The fourth section discusses the causes of health disparities through occurrences of marginalization, and vulnerability, and how these have been studied. The sixth section describes the theoretical framework used in this study to explore vulnerabilities. The final section discuss the implications for research by discussing how an intersectional approach of vulnerability as a fundamental cause of health disparities can add to the existing body of literature aimed at conceptualizing vulnerability. This section also explores the need to include service providers' insight on how vulnerability manifests in the lived context.

Definitions

Disparities/inequalities, Inequities, Equity

The Centers for Disease Control and Prevention (CDC) defines health disparities as preventable differences in the burden of disease, and opportunities to achieve optimal health that are experienced by socially, and economically disadvantaged populations (2013). In the United States (US), the term “health disparity” is used almost exclusively, while in Europe, and globally, the term “health inequality” is used (Braveman & Gruskin, 2003; Carter-Pokras & Baquet, 2002; Isaac, 2013; Whitehead, 1991). Another commonly interchangeable term for health disparities is “health inequity”, preferred when denoting a moral or ethical judgment about the occurrence of a health disparity as unnecessary, avoidable, unfair, and unjust (Braveman, 2006, 2014; Braveman & Gruskin, 2003; Isaac, 2013; Whitehead, 1991).

In contrast, health equity is defined as the “attainment of the highest level of health for all people” (Healthy People, 2020, n.d.). One of the national goals for improving health for all is achieving health equity by eliminating health disparities (Braveman et al., 2011; Healthy People 2020, n.d.). Health

disparities are the metric used to measure health equity, and therefore must be well understood, and operationalized. This assures that corresponding research, and interventional efforts strategically target not only the most important influences in health, but those social groups disproportionately burdened by these disparities (Braveman, 2006, 2014; Hodgetts, Radley, Chamberlain & Hodgetts, 2007; Isaac, 2013).

The operational definition of a health disparity used in this research study is:

A particular type of difference in health or in the most important influences in health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups systematically experience worse health or greater health risks than advantaged groups (Braveman, 2006, p. 180).

Existence of Health Disparities

Nationally

In the 2013 *Health Disparities and Inequalities Report*, CDC published key findings on some of the factors affecting health that lead to health disparities. Although improvements have been made, certain population groups still continue to experience worse health compared to others. For instance, in cardiovascular disease, the leading cause of death in the US, non-Hispanic black adults are 50% more likely to die from heart disease or stroke prematurely than their non-Hispanic white counterparts (CDC, 2013). Diabetes is higher among Hispanics, non-Hispanic Blacks, and those of other races than among Asians, and non-Hispanic whites (CDC, 2013).

When comparisons are made based on socioeconomic status (SES), diabetes prevalence is higher among adults without college degrees, and those with lower household incomes. Overall, individuals with low SES were more likely to be affected by diseases such as diabetes, hypertension, and HIV (CDC, 2013).

The aforementioned differences represent a small fraction of the numerous health disparities, and their impact on those individuals affected disproportionately, nationally. Though the majority of the disparities mentioned appear to be mainly based on race, and ethnicity, assumptions should not be made that health disparities are only associated with these factors. The use of these two factors is mostly due to easy data availability, and existing social equity concerns related to the discrimination historical faced by

African Americans, and other ethnic minorities (Adler & Rehkoph, 2007; Braveman, 2006; Isaac, 2013). Furthermore, the over-grouping of health disparities in efforts to compare the most, and least affected group's leads to a polarization of disparities. For example, health disparity comparisons are widely based on racial, gender or SES comparisons which typically compare advantaged versus disadvantaged groups such as: White versus Blacks, men versus women or poor versus rich (Braveman, 2006, 2009; Braveman, Egerter & Williams, 2011; Braveman et al., 2011; Braveman & Gottlier, 2014; CDC, 2013; Dovidio , Gluszek, John, Dittmann & Lagunes, 2010; Isaac, 2013; Pieterse, Todd, Neville & Carter, 2011; Stuber, Galea, Ahern, Blaney & Fuller, 2003; Stuber, Meyer & Link, 2008; White & Borrell, 2011; Williams & Jackson, 2005; Williams & Mohammed, 2009). This "grouping of groups" though important in understanding these differences, can overlook various groups or individuals that may appear in all three groupings, such as individuals experiencing homelessness (IEHs).

Homelessness

The term "homeless" (homelessness) is commonly defined as lacking a fixed, regular, and adequate nighttime residence, where the primary nighttime residence is in a: supervised shelter, an institution that provides temporary residence or a public or private place not intended for regular sleeping accommodation for human beings (National Alliance to End Homelessness [NAEH], n.d.; Nickash & Marnocha, 2009; Zlotnick, Zerger & Wolfe, 2013). There are numerous definitions used to define homelessness resulting in ambiguities on who is really "homeless" (Hodgetts et al., 2007; Lee et al., 2010; Meanwell, 2012; Romeo, 2005; USDHUD, 2015). The definition of homelessness used in this research study will be "lacking a safe, stable, and appropriate place to sleep or live" (Fazel, Geddes & Kushel, 2014; NAEH, n.d.; Nickash & Marnocha, 2009).

The homeless population, a disadvantaged , and heterogeneous social group is made up of numerous demographic or social identities such as race , and ethnicity, SES factors, gender, age, sexual orientation or immigration status (Lee et al., 2010; USDHUD, 2015). IEHs are disproportionately burdened by health disparities, and considered a high risk group when compared to the housed (domiciled) population. Homelessness stems from vulnerability to poverty exacerbated by a combination of traumatic

life events. Once homeless, issues of personal vulnerability intensify the situation resulting in homeless individuals becoming part of a highly visible and stigmatized group (Hodgetts et al., 2007; Lee et al., 2010; Parsell, 2011).

There are three major categories that describe the pattern of homelessness experienced. These categories differ based on the frequency, and length of time or the cause of the homelessness episode (Fazel et al., 2014; Lee et al., 2010). The first category is chronic homelessness, defined as an episode lasting more than a year or with four episodes in the past two to three years (Fazel et al., 2014; Lee et al., 2010). The second category is intermittent homelessness, used to describe individuals cycling in and out of homelessness episodes with alternations between housing, and institutional care such as jails, hospitals, and treatment programs. The third category is crisis homelessness, and is used to describe individuals whose homelessness episodes occur once or twice a year following an unexpected crisis such as job loss, divorce, eviction or domestic violence (Breiding, 2015; Fazel et al., 2014; Shier, Jones & Graham, 2011; Winersjö, Ponce de Leon, Soares & Macassa, 2011). Regardless of the duration, and type of homelessness experienced, the consequences all result in experiencing greater disparities such as higher health risks, disease burden, and unmet service needs (Bharel et al., 2011; Henwood, Byrne & Scriber, 2015; Hodgetts et al., 2007; NHCHC, 2011; Weinstein et al., 2013).

Health Disparities of the Homeless

Acute and Chronic Conditions

The consequences of being homeless range from material deprivation, survival priorities, discriminatory treatment, and policies. These consequences create barriers to consistent care, and treatment related to either medication, dietary or chronic disease management. For example, insulin for diabetes or often abused mental illness drugs need safe, and appropriate storage areas. Similarly, chronic diseases such as diabetes, hypertension, heart disease or chronic kidney disease that require balanced or strict diets become difficult to manage. The types of food available to IEHs are determined by availability in soup kitchens where focus is not on a balanced diet but on providing sustenance to a large group of people. A retrospective study conducted by Hall et al. (2012) followed non-dialysis dependent chronic disease

patients over time , and found that homeless adults were 1.8 times more likely to experience higher rates of death or progression to end stage renal disease compared with housed individuals. The strict dietary, and medical regimen required by chronic disease patients such as those with end stage renal disease is almost impossible to maintain for IEHs. This inconsistency or instability in medication, dietary or disease management further exacerbates an individual's poor health status.

IEHs face significant stressors when living in crowded shelters or on the streets, which is exacerbated by exposure to severe weather. These conditions lead to higher rates of communicable diseases such as tuberculosis (TB), and respiratory illnesses like pneumonia (Hodgetts et al., 2007; NHCHC, 2011; Romeo, 2005). One of the commonly cited causes of acute illnesses in this population is sleeping on cold, wet surfaces during extreme weather conditions (Hodgetts et al., 2007; Nettleton, Neale & Jackson, 2012; Romeo, 2005). In addition, the close proximity of individuals sleeping in shelters coupled with contagious communicable diseases such as TB increases the likelihood of acute illnesses in this population.

Another widely researched communicable disease among IEHs is HIV/AIDS, where homelessness is considered a significant predictor of prevalence (Aidala et al., 2016; American Psychological Association [APA], n.d.; Morell et al., 2014; NHCHC, 2012, 2014). IEHs are more likely than the general population to engage in risky sexual behaviors such as unprotected sex, having multiple sex partners, drug use , and needle sharing (Edidin, Ganim, Hunter & Karnik, 2012; Morell et al., 2014; NHCHC, 2011, 2012). Participation in sexual acts in exchange for money, lodging or protection (survival sex) has been commonly cited in this population especially among women, youth, and transgender individuals (Edidin et al., 2012; Morell et al., 2014; NHCHC, 2011, 2012). Studies show that unstably housed youth have a two to tenfold greater risk of HIV than stably housed adolescents (NHCHC, 2012). A study looking at the prevalence of HIV risk behaviors among homeless adults found that unprotected sex was the most frequently reported behavior with over 50% of participants reporting having sex without a condom (Morell et al., 2014). The significant predictors of unprotected sex were having a mental health status, longer duration of homelessness, a history of incarceration, and substance use (Morell et al., 2014). These predictors are

commonly reported in IEHs , and tied to efforts undertaken to surviving life on the streets (Aidala et al., 2016; Edidin et al., 2012; Hodgetts et al., 2007; Meanwell, 2012; NHCHC, 2011, 2012, 2014).

Hospitalization

IEHs have significant health needs due to the consequences of being homeless where living on the streets alludes to a need to “survive” (Bernstein, Meurer, Plumb & Jackson, 2015; Fazel et al., 2014). Homelessness is a significant predictor of high emergency department use, comprising more than five visits in a year (Fazel et al., 2014). A study conducted in 2010 as cited by Mackelprang, Graves & Rivara (2014) found that an estimated 552,000 emergency department visits were made by individuals reporting homelessness, a rate double that of the general population. In their retrospective study following non-dialysis dependent chronic disease patients over time, Hall et al. found that homeless adults were more likely to use acute care services compared to housed individuals (2012).

The lack of health insurance and competing survival needs result in delaying seeking care until acute needs such as respiratory illnesses or injuries necessitate interventions, and often hospitalization (Bernstein et al., 2015; Gelberg, Andersen & Leake, 2000; Hall et al., 2012; Mackelprang, Graves & Rivara, 2014). IEHs are up to five times more likely to be admitted to the hospital for pre-existing chronic conditions than the general population due to overdependence on emergency services verses primary care services (Bernstein et al., 2015; Fazel et al., 2014). The reasons for hospitalization ranges from issues related to chronic diseases, communicable diseases, mental health, and substance abuse (APA, n.d.; Bernstein et al., 2015; Gelberg et al., 2000). In addition to higher hospitalization rates, compared to the general population, they have longer hospital stays averaging two days longer for acute hospital admissions (Fazel et al., 2014; Gelberg et al., 2000; Mackelprang et al., 2014).

The heavy reliance on emergency departments for medical care coupled with longer hospital stays than the general population calls attention to the severe economic and structural barriers this population faces in their daily lives. IEHs are at increased for poor health due to factors such as being uninsured, and severe living conditions where competing survival needs take precedence over seeking health. In addition to poor health, IEHs are also at increased risk for premature mortality.

Life Expectancy

The average estimated life expectancy for IEHs is 42 to 52 years. This premature mortality becomes even more glaring when considering that the mean age of homeless adults is 57, with a very small portion being older than 62 years (Bernstein et al., 2015). In a study looking at mortality among formerly homeless adults, findings showed that adults experiencing prolonged homelessness had a mortality rate three to four times that of the general population, with the majority of deaths occurring in the 45 to 64 age group (Fazel et al., 2014; Henwood et al., 2015). Homelessness negatively affects health outcomes irrespective of duration, though chronically homeless individuals have worse health outcomes, and premature mortality due to more time spent living in the streets (Fazel et al., 2014; Gelberg et al., 2000; Henwood et al., 2015).

Homelessness: A Public Health Issue

An individual experiencing homelessness is put at risk for poor health, and faces significant barriers to consistent, and appropriate medical care, access, and the ability to adhere to treatment (Aidala et al., 2016; APA, n.d.; Bernstein et al., 2015; Bharel et al., 2011; Henwood et al., 2015; Hodgetts et al., 2007; NHCHC, 2011; Weinstein et al., 2013). Factors contributing to higher morbidity, and mortality, aside from adverse health effects of homelessness are related to living visibly on the streets, include extreme poverty, access to health care, lack of health insurance or financial resources, and difficulty adhering to medication, and treatment therapy (Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000; NHCHC, 2012). To live, and survive on the streets, homeless individuals allocate their time, and effort to meeting basic needs such as food, and shelter, making the seeking of medical care a forgotten priority (Gelberg et al., 2000; Hall et al., 2012).

IEHs are likely to have more health issues, more unmet health needs, higher occurrences of morbidity, and mortality, have less control over manageable chronic health conditions, and are three to four times more likely to die prematurely than their housed counterparts (APA, n.d.; Bharel et al., 2011; Bernstein et al., 2015; Gelberg et al., 2000; Henwood et al., 2015; Hodgetts et al., 2007; NHCHC, 2011; Weinstein et al., 2013). The conglomeration of disadvantages work to further exacerbate existing risks of

illness associated with social positioning (Hodgetts et al., 2007; Meanwell, 2012; Romeo, 2005; Zlotnick et al., 2013). As such, homelessness is a serious public health issue that affects already disadvantaged individuals.

According to the CDC (2013) *Health Disparities , and Inequalities Report*, the burden of illness, premature death , and disability disproportionately affects certain groups. For instance, residents in poor minority communities continue to have lower SES, greater barriers to quality care, greater risk for disease , and higher mortality rates (CDC, 2013). Regardless of the comparison factor utilized, individuals , and social groups disproportionately affected by health disparities have a common denominator; they all experience some type of disadvantage. The disparities experienced by IEHs outlined above are supportive of the disadvantage , and vulnerability associated with such social groups. Aside from personal factors or vulnerabilities, an underlying cause of these disadvantages is inequitable access to resources or opportunities that impact wellness , and health. Therefore, efforts aimed at tackling these disparities first require an understanding of how these inequalities manifest in everyday life.

Health Disparity Principles

The most persistent manifestation of inequality has been the ever growing disparity in health (Shi, Stevens, Faed & Tsai, 2008). Health disparities are not confined to a particular person or place but rather, a phenomenon that denotes an underlying social problem based on the presence , and experience of systematic injustices (Isaac, 2013). As such, to fully grasp the impact of health disparities , and why efforts aimed at achieving health equity is important, clarification on what is meant by a “health disparity” is important. This warrants a historical overview of health disparities , and a discussion of the foundational principles underlying , and unifying the plethora of health disparity efforts undertaken to date.

Historical Overview

The concept of health disparities first appeared in literature with the release of *the Report of the Secretary’s Task Force on Black , and Minority Health* in 1985. This landmark report, was able to describe the gap in health status between African Americans , and whites (Isaac, 2013). Global awareness of health disparities has been credited to the seminal article by Whitehead (1991) which served to stimulate debate in

a wide , and general audience (Braveman & Gruskin, 2003; Carter-Pokras & Baquet, 2002; Whitehead, 1991). Since its introduction in the 1990s, the term “health disparity” has been used numerous times with research aimed at understanding, measuring , and reducing health disparities. It appeared in the literature thirty times in the 1990s , and over 400 times between 2000 , and 2004 (Adler & Rehkoph, 2007; Isaac, 2013).

From the 1970s to now, the term , and issue has steadily increased not only in magnitude but in use, yet the meaning of what health disparities are remains poorly defined , and understood (Adler & Rehkoph, 2007; Braveman, 2006; Isaac, 2013). Braveman (2006) defines health disparities as

A particular type of difference in health or in the most important influences in health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups systematically experience worse health or greater health risks than advantaged groups” (p. 180).

This definition takes into account the moral basis founded on social justice, where health equity represents the value underlying a commitment to reducing , and ultimately eliminating health disparities. Guided by an understanding of the needs to address , and respond to health disparities, social justice refers to the degree of equal opportunity made available to individuals by the social, political , and economic structures” they live in (Van Herk, Smith & Andrew, 2011, p. 29).

In her seminal article, Whitehead (1991) in defining health inequities stated that social justice is a moral , and ethical dimension which numerous authors building on her writing also support. According to Braveman (2006, 2014), the definition proposed , and utilized in most health disparity research fails to account for this moral basis originally intended , and discussed by Whitehead. The term health disparity is not simply a difference in health, but a specific difference related to social justice , and hence a health inequity (Braveman, 2006, 2014; Braveman et al., 2011; Braveman & Gottler, 2014; Isaac 2013). The majority of health disparities commonly reported , and targeted in literature , and program interventions use race, ethnicity or SES comparisons, leading to the inaccurate assumption that health disparities are strictly racial, ethnic or economic based disparities (Braveman, 2006, 2009; Braveman, Egerter & Williams, 2011; Braveman et al., 2011; Braveman & Gottler, 2014; CDC, 2013; Dovidio et al., 2010; Isaac, 2013; Pieterse

et al., 2011; Stuber et al., 2003, 2008; White & Borrell, 2011; Williams & Jackson, 2005; Williams & Mohammed, 2009). This assumption is due to the lack of clarity in defining health disparities coupled with challenges in data collection where availability of data is linked primarily to race, ethnicity or SES (Adler & Rehkopf, 2007; Braveman, 2006; Isaac, 2013).

Disparities or Inequities

The term health “disparities”, “inequalities”, and inequities” are commonly interchanged in the literature, though based on the previous discussion, the concept of equity is to be implied (Braveman, 2006, 2014; Isaac, 2013). Therefore, regardless of the term used, it is important researchers understand either terms can be synonymous or related, and hence inseparable to assure appropriate usage. The relation between these terms is contingent on the guiding foundational principles surrounding the importance, and attainment of health equity.

To achieve equity, everyone must be valued equally, with focus, and ongoing societal efforts aimed at addressing avoidable inequalities, and historical or contemporary injustices (Healthy People 2020, n.d.). Additional key principles related to health equity efforts is acknowledging that health is of importance to both individuals, and society, and lastly, aiming towards nondiscrimination, and equality (Braveman, 2006, 2014; Braveman et al., 2011; Braveman & Gottler, 2014; Derose, Escarce & Lurie, 2007; Isaac 2013). By focusing on social justice, and the equalization of resources as a way of attaining equity, these key principles foundational to health disparity work help unify the majority of health disparity research, and efforts undertaken to date (Braveman, 2006; Braveman & Gruskin, 2003; Isaac, 2013; Whitehead, 1991).

Social justice. Achieving equity denotes a commitment to achieving a more just society with equal distribution of benefits, and burdens in society (Braveman et al., 2011; Sanon, Evans-Agnew & Boutain, 2014). The types of differences identified as health disparities are those viewed as unnecessary, and avoidable, thus making them unfair, and unjust as they put already disadvantaged groups at further disadvantage (Braveman, 2006, 2014; Braveman & Gruskin, 2003; Whitehead, 1991). This unfairness is the moral, and ethical dimension that not only drives health disparity efforts, but makes those efforts part,

and parcel of a social justice agenda (Braveman, 2006, 2014; Braveman et al., 2011; Braveman & Gottler, 2014; Isaac 2013; Whitehead, 1991). Social justice efforts are aimed at promoting change in society by focusing on the social hierarchies or relationships (Sanon et al., 2014). Specifically, working to eliminate the inequitable outcomes resulting from hierarchical social systems that grant one group greater access to resources resulting in differential social advantage.

Social disadvantage. Underlying social advantage or disadvantage refers to wealth, power and/or prestige, and defines how people are grouped in social hierarchies (Braveman, 2006; Braveman et al., 2011; Braveman & Gruskin, 2003). This social grouping determines one's social position, "relative advantage, and disadvantage in social hierarchies (Penman-Aguilar et al., 2016). It refers to the "unfavorable social, economic or political conditions that some systematically experience based on their relative position in social hierarchies" (Braveman et al., 2011, p. S151). For example, IEHs are already economically disadvantaged, and the barriers they face because of this increases their risk for poor health outcomes such as premature mortality. The social disadvantage factors that lead to this outcome include, poor access to healthcare, and resources, or poor treatment received from healthcare staff (Romeo, 2005). These disadvantages are due to the differential access based on one's social position which leads to differential access between the advantaged, and disadvantaged group. In other words, differential power dynamics create health inequities that shape one's access to resources. Therefore, the observed disparity in mortality due to inequitable access is a social injustice as it puts already disadvantaged group at further disadvantage.

Distributive justice. Efforts undertaken to improve the health of socially disadvantaged groups typically focus on distributing resources in such a way eliminates differential health outcomes between disadvantaged, and advantaged groups. This equalization of resources denotes the concept of distributive justice, and is based on viewing health as a human right, where in the absence of discrimination, should be attainable by all. (Braveman, 2006; Braveman & Gruskin, 2003). IEHs for instance experience social discrimination from landlords or employers resulting in inequitable access to housing, and material needs (Benbow, Forchuk & Ray, 2011; Meanwell, 2012; NHCHC, 2015; Shier et al., 2011). Efforts aimed at distributive justice at the institutional, and policy level can help mitigate some of these discriminations

experienced where receipt of resources such as housing, employment or healthcare is determined by need rather than one's social position or identity (Derose et al., 2007).

The foundational commonalities discussed above assure that a focus on social justice is present in all health disparity research. They also help guide the creation of appropriate interventions aimed at striving for the highest possible standard of health for all, while giving attention to the needs of those at greatest risk of poor health. Furthermore, they enable one to truly grasp the impact of health disparities where their presence is a signpost that something is wrong, and action is needed (Isaac, 2013). The creation, and compounding of health disparities among ICHs is tied to the occurrences of social injustices experienced through social day to day living (Caton et al., 2005; Hodgetts et al., 2007; Quesada, Hart & Bourgeois, 2011; Romeo, 2005; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Vasas, 2005).

Causes of Health Disparities

The causal pathways leading to health are many, complex, and interrelated. Jackson, Williams & VanderWeele (2016) define mental health disparities as “avoidable differences” across social categories; it is a difference that is considered unjust even when causes are difficult to document or describe. This “multidimensional” complexity makes health disparity research difficult, and at times ambiguous. This ambiguity is related to the difficulty in pinpointing health disparity causation, though proof of causality is unnecessary when a health difference is judged as being unfair or unjust (Braveman et al., 2011; Jackson et al., 2016). Therefore, though we may not be able to fully describe direct causes of health disparities, focusing on the fundamental causes can lend insight into how health disparities occur. The fundamental causes of health disparities are the conditions in which people are born, grow, live, work, and age inclusive of the fundamental drivers of these conditions (Braveman & Gottler, 2014). These are commonly referred to as social determinants of health.

Upstream and Downstream Determinants

Social determinants of health can be broadly classified into two major types: upstream, and downstream determinants, and include medical, and nonmedical factors (Braveman et al., 2011).

Upstream factors are those distant factors that play a fundamental causal role, and provide most opportunity for improving health, and reducing health disparities. These include the political, social, economic, institutional, and structural factors which influence downstream factors (Braveman et al., 2011). An example of this is the existence of a social hierarchy where preferential treatment is given to advantaged social groups leading to occurrences of discrimination, and inequitable access (Case & Hunter, 2012; Crenshaw, 1991; Major, Mendes & Dovidio, 2013).

Downstream factors are the closer, more visible influencers of health that are commonly targeted for study, and interventions. These include factors such as individual health behaviors, medical care, insurance coverage or access to health services (Braveman et al., 2011). A stellar example of how upstream factors influence downstream factors is the impact of residential segregation on individual behaviors, and health. Individual health behaviors such as physical inactivity, poor dietary habits, and smoking are shaped not only by one's health beliefs, but by the availability of resources in their lived environment. For individuals living in highly segregated, and poor neighborhoods, these unhealthy behaviors are shaped by their poor built environment evident in the limited access, and availability to quality education, health care, healthy food choices, and high crime rates (Pellowski, Kalichman, Matthews & Adler, 2013; Stuber et al., 2008; Williams & Jackson, 2005; Williams & Mohammed, 2009, 2013; White & Borell, 2011).

Another example of a downstream factor is poor access to health, and social services faced by the homeless population, which can be influenced by a structural upstream factor such as discrimination. For instance, an immigrant mother faces discrimination in obtaining housing due to the landlord's preference of non-immigrant tenants who tend to have better or more stable sources of income (Norfeldt, 2012). Therefore, downstream factors such as poor access to resources, and services experienced by the homeless is precipitated by occurrences of upstream factors - individual, and structural discrimination (Benbow et al., 2011; Meanwell, 2012; NHCHC, 2015; Shier et al., 2011).

Oppression

The determinants or pathways of health disparities become evident or embodied in the actual experience or occurrence of a disparity. In other words, those factors that cause health disparities also work to reify those most vulnerable to them. To understand the complexities embedded in the occurrence of health disparities, research must feather out how these differences are created, and manifest. For example, sleeping arrangements in shelters are based strictly on gender – male or female. For transgender males, they may prefer to be in the female section of the shelter, but due to shelter policies, this preference is disregarded. Therefore, to understand why transgender individuals utilize shelter services less frequently, and instead prefer to sleep outside, we must take into account how shelter policies, individual social identity, and position interact, and impact shelter utilization (Meanwell, 2012). Furthermore, to understand why IEHs underutilize healthcare, and rely on emergency services, occurrences of identity-based discrimination when accessing care must be considered. As such, research expanding on this insight to consider how other factors aside from race or gender, such as one's position in society, and marginalization, impacts their livelihood, health, and wellbeing is needed (Viruell-Fuentes et al., 2012). Specifically, how their social position leads to their being excluded to the margins where they experience inequitable access to resources.

To better understand how exclusion or marginalization occurs, and leads to the creation, and reinforcement of vulnerable groups, a discourse on the role of oppression is needed. Oppression is the systematic, and widespread social inequity occurring through the use of power (Case & Hunter, 2012). It involves the existence of a hierarchical social system which grants one group greater access to resources relative to other groups, and creates a marginalized group experience (Case & Hunter, 2012). Oppression designates the disadvantage, and injustice some face in the normal processes of everyday life; the “vast, and deep injustices some groups suffer as a consequence of often unconscious assumptions, and reactions of well-meaning people in ordinary interactions” (Young, 2012, p. 41).

Any group facing oppression, though different share similar commonalities; at some level, they have all been restricted in their ability to develop, exercise, and express their needs, thoughts, and feelings

(Case & Hunter, 2012; Young, 2014). More specifically, they share certain forms of oppression, which Young (2014) divides, and names the “five faces of oppression,” where the presence of any of these is sufficient to call a group oppressed. These include: exploitation, marginalization, powerlessness, cultural imperialism, and violence (Young, 2014). It is this occurrence of oppression that leads to the creation, and reinforcement of marginalization.

Marginalization and Vulnerability

Marginalization excludes a whole category of people “from useful participation in social life, and thus potentially subjected to material deprivation” hence considered the most dangerous form of oppression (Romeo, 2005; Young, 2012). It is a social process where individuals occupy peripheral space away from the norm based on identities, associations, experiences, and environments (Vasas, 2005). The “norm” can be an idea, action or identity that is the most common, the majority or is socially acceptable, and determines who is the “center,” and who is in the “margins” (Vasas, 2005). For example, in a predominantly White or Christian neighborhood, the “norm” or majority group is based on being identified as “White” or as a “Christian.” Another example is, in a predominantly Christian neighborhood, the “norm” is based on one’s religious identity as a Christian. As such, those individuals that “deviate” or are “different” from what is the majority or considered normal identity based on social acceptability are identified as “deviant” or the “minority,” and experience marginalization due to their identity as “other” (Bruce, Stall, Fata & Campbell, 2014). In the above example, those seen or identified as anything other than White or Christian such as being “Black” or “Muslim” are considered the “minority” or the “other.” Therefore, identities can range from physical, and visible to invisible attributes such as race, gender, age, religion, sexual orientation, illness or housing status.

Identities of minority result from living in a world where certain behaviors, beliefs, and group memberships are considered socially acceptable. For example, being white, speaking without an accent, being heterosexual or affiliation with a widely known religion such as Christianity (Derose et al., 2007; Dovidio et al., 2010; Williams & Mohammed, 2009). This grouping or naming of individuals based on various characteristics where there is a “majority”, and “minority group,” a “normal,” and a “deviant”

group results in social categorization (Major et al.,2013). Crenshaw (1991) refers to this naming as the “process of categorizing”; it is an act of power as it reinforces the existence of a social hierarchy.

The existence of this social hierarchy hence creates advantaged , and disadvantaged groups where the advantaged “majority” groups, those at the center, have greater access to resources while the disadvantaged “minority” groups, those at the margins, are excluded. The social exclusion , and experience of marginalization results in the creation of vulnerable social groups who experience inequalities in the distribution of resources , and power. These vulnerable social groups, such as IEHs experience “health vulnerability,” an increased risk or susceptibility to adverse health outcomes (Quesada et al., 2011; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Vasas, 2005).

Vulnerability, as it relates to health , and disparities, is defined as the level of susceptibility for experiencing a negative health outcome based on one’s marginalized status (Viruell-Fuentes et al., 2012). Vulnerability can often manifest within complex constructs such as racism, social disadvantage, social injustice, , and systemic oppression (Hankivsky & Christoffersen, 2008; Viruell-Fuentes et al., 2012). For instance, women face unique health disparities based on genetics , and gender. They earn less, work more “unpaid” hours , and experience higher rates of psychological distress, sexual , and intimate partner violence (IPV) compared to men (Breiding, 2015; Shier et al., 2011; Thoits, 2010; Winersjö et al., 2011). Albeit these notable differences in wages or health outcomes, their marginalized status within society might be difficult to quantify , and measure though linked to socio-economic position (Jones, 2009; Ostrach & Singer, 2012; Shier et al., 2011). In other words, vulnerability alludes to experiencing identity-based marginalization or social exclusion through various pathways or “isms” such as discrimination, stigma, prejudice or bias.

For instance, the homeless population is socially identified based on their experience of material depravity such as lacking a place to live (American Journal of Managed Care [AJMC], 2006; Hodgetts et al., 2007; Parsell, 2011). Unlike housed individuals, where normal everyday activities such as eating, sleeping or drinking is done privately, the homeless live out their day in the public’s eye which creates a negative view of their identity as lazy, dangerous or undesirable. This results in a “naming” process where

the identity “homeless” is socially constructed to be a negative , and deviant identity (Crenshaw, 1991; Major et al., 2013). The creation of this subordinate social identity results in their experiences of marginalization such as bias, prejudice , and stigma.

Marginalization for IEHs can occur through instances of criminalization where these normal “living” behaviors are viewed as illegal based on where they occur (Lee et al., 2010; Parsell, 2011). Overt acts of marginalization include aggressive police enforcement that prohibits loitering, camping or sleeping in public areas (Bowleg, Teti, Malenbranche & Tschann, 2013; Lee et al., 2010).

Risk: The Coupling of Disadvantage and Vulnerability

The causes of health disparities are deeply rooted in the social context surrounding everyday life where the interplay of various factors determine one’s disadvantage , and ultimate vulnerability (Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008;). Health disparities include differences between groups of people who are more , and less advantaged socially (Braveman, 2006). The concept of social disadvantage , and vulnerability helps define , and identify health disparities , and those affected by their occurrence. Social advantage or disadvantage mean’s one relative position in a hierarchy determined by wealth, power , and prestige (Braveman, 2006). Social disadvantage is systematically experienced by individuals with a low social position that have persistently experienced discrimination, , and been marginalized based on a given social identity such as race or ethnicity, SES or position, culture, language, sex origin, immigration or homelessness status (Benbow et al., 2011; Braveman, 2009; Grabovschi, Loignon & Fortin, 2013; Kreiger, Kosheleva, Waterman, Chen & Koenen, 2011; Meanwell, 2012; NHCHC, 2015; Pellowski et al., 2013; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Williams & Jackson, 2005).

The concept of vulnerability has been applied better reifying this disadvantaged group. Vulnerability has been operationalized as increased susceptibility to disparities due to a combination of individual, community or society factors that determine one’s marginalized status (Grabvoski et al., 2013). Therefore, these disadvantaged groups also called vulnerable groups or populations in health disparity

research typically include racial , and ethnic minorities, low income populations, women , and immigrants , and IEHs.

Social Disadvantaged Population

To better depict this vulnerable population, disadvantage can be grouped based on those factors that cause one to be disadvantaged or vulnerable to health disparities. They can also be broadly grouped into downstream , and upstream factors. Social advantage or disadvantage can be material, psychosocial or both (Braveman, 2009; Grabvoschi et al., 2013). Time, though not indicative of advantage is an important dimension to consider since duration or exposure to a certain disadvantage influences the magnitude or impact of that disadvantage or vulnerability (Braveman, 2009).

Material Disadvantage

Material disadvantage is based on material conditions determined by access to resources , and services that affect health (Braveman, 2009). These downstream factors can include aspects of SES such as education, income, adequate nutrition, housing, medical care-related resources such as insurance (Braveman, 2009; Braveman et al., 2011; Derose et al., 2007). Insurance coverage, for instance, impacts one's health by either limiting or improving access to quality medical care. A study looking at the association between health insurance , and quality of care found that those respondents with insurance coverage were more likely to receive quality diabetes care than uninsured individuals (Hu, Shi, Rane, Zhu & Chen, 2014). IEHs are usually unemployed or find employment in temporary or day labor jobs leading to low wages, benefits, irregular hours , and unsafe work conditions (Lee et al., 2010). For the homeless, their greatest material disadvantage is lacking a place to live which calls attention to their economic vulnerability. This results in limited resources related to food, shelter, clothing , and ultimately safety. Their need to survive , and meet their material needs may result in participating in risky behaviors such as survival sex to obtain shelter , and safety (Edidin et al., 2012; Morell et al.,2014; NHCHC, 2011, 2012). Aside from housing, they are usually uninsured resulting in a higher dependence on emergency services as their major form of healthcare (Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000; NHCHC, 2012).

Psychosocial Disadvantage

The second type of disadvantage is psychosocial, based on human relationships, and their psychological effects such as unfair treatment based on one's race or ethnicity status (Braveman, 2009). Psychosocial disadvantage refers to specific intergroup relations that negatively impact the overall wellbeing of an individual or group (Major et al., 2013). These psychosocial disadvantages can also be classified as upstream factors as they stem from differences based on an existing social hierarchy. Examples of psychosocial disadvantage include occurrences of social adversities such as discrimination, stigma, prejudice, and bias.

Social adversities are influenced by multiple factors related to group membership inclusive, but not limited to race/ethnicity, gender, sexual orientation, religious affiliation, homelessness or social status, and religious affiliation (Derose et al., 2007; Dovidio et al., 2010; Hatzenbuehler, Phelan, Link & Tehranifar, 2010; Kreiger et al., 2011; Mulia & Zeng, 2012; Paradies, 2006; Pieterse et al., 2011; Quesada et al., 2011; Skosireva et al., 2014; Stuber et al., 2003, 2008; Viruell-Fuentes et al., 2012; Williams & Mohammed, 2009, 2013; Zerger et al., 2014).

Group membership identities represent those identities of minority that determine one's experience of marginalization, and can therefore be also referred to as "identities of marginalization." Individuals that face any type of adversity such as discrimination share a commonality; they all have certain identities of marginalization. Group membership can be based on various identities inclusive but not limited to the identities of marginalization. As such, IEHs experience of marginalization can encompass numerous, and varying occurrences of social adversities. Therefore, though the following discussion on psychosocial disadvantages refers primarily to specific group "identities" these occurrences represent the various instances of disadvantage that IEHs face.

Multiple Levels of Social Adversities

In addition to multiple group membership factors, social adversities can also occur at multiple levels –interpersonal or individual, institutional or cultural levels, and can also be overt or internalized

(Hall et al., 2015; Hatzenbuehler et al., 2013; Williams & Mohammed, 2009, 2013; White & Borrell, 2011). Following is an overview of social adversities grouped by level, and visibility of occurrence.

Interpersonal Social Adversities

Discrimination. One of the commonly studied social adversities is discrimination, defined as the process where members of a socially defined group are treated differently because of their group membership (Stuber et al., 2003; Williams & Mohammed, 2009, 2013). This differential treatment can be conveyed through opinions, attitudes, and behaviors towards an individual with a particular minority status or attribute (Skosireva et al., 2014). For example, racial discrimination is differential treatment based on one's racial identity, and is the most commonly cited, and studied type of discrimination (Bowleg et al., 2013; Stuber et al., 2003; Viruell-Fuentes et al., 2012; Williams & Mohammed, 2013).

For example, a white employer giving preferential treatment such as a raise to a white employee versus a black employee. Another example is a landlord or healthcare staff giving preferential to domiciled individuals when seeking housing or healthcare services (Romeo, 2005; Norfeldt, 2012).

Research well supports the negative consequences of discrimination inclusive of psychological distress, poor mental, and physical health outcomes such as low self-esteem, depression, hypertension, smoking, low birth weight, excessive tobacco, and alcohol use, more sick days (Derose et al., 2007; Dovidio et al., 2010; Kreiger et al., 2011; Mulia & Zemore, 2012; Paradies, 2006; Pieterse et al., 2011; Quesada et al., 2011; Skosireva et al., 2014; Viruell-Fuentes et al., 2012; Williams & Mohammed, 2009, 2013; Zerger et al., 2014). In a study looking at the association between individual discrimination, and self-assessed mental, and physical health among Latinos, and Blacks, Stuber et al. (2003) found that Blacks reported higher rates of racial, and other domains of discrimination, and that reports of discrimination were associated with poor mental health status.

Other social adversities. Discrimination can occur through other dimensions where dominant advantaged groups portray negative attitudes (prejudice), and beliefs (stereotypes) towards non-dominant disadvantaged groups (Stuber et al., 2008; Williams & Mohammed, 2013). Aside from discrimination, occurrences of stigma, prejudice, and bias are also widely studied, and research well supports the mental,

and physical health consequences of these social adversities (Dovidio et al., 2010; Hall et al., 2015; Harper & Schneider, 2003; Hatzenbuehler et al., 2013; Katz-Wise & Hyde, 2012; Keene, 2011; Major et al., 2013; Mulia & Zemore, 2012; Quesada et al., 2011; Stuber et al., 2008; Viruell-Fuentes et al., 2012; Wen, Hudak & Hwang, 2007; Williams & Mohammed, 2013; Zestcott, Blair & Stone, 2016).

Stigma. Stigma is an attribute that links a person to an undesirable stereotype which leads others to reduce the individual from a whole, and usual person to a discounted one (Stuber et al., 2008). For example, the overall public perception of IEHs is negative or undesirable as they are seen as being dangerous, and responsible for this homelessness status. Therefore, being labeled “homeless” is a negative stereotype that further reinforces the stigma experienced through reactions they receive from the public such as being ignored, stared at or verbally harassed (Lee et al., 2010; Meanwell, 2012; Wolch, Dear & Akita, 1988).

By “doing their living” on the streets, they are deemed lazy, and deviant as they sleep during periods of time when “normal” people are working. The criminalization, and stigma that ensues from actively, and visibly living on the streets leads to their “hiding” in order to perform normal human behaviors such as sleeping, and resting (Lee et al., 2010; Meanwell, 2012; Parsell, 2011). This regulation of social spaces through criminalization or signs that ban “living” on the street results in further marginalization to the periphery (Hodgetts et al., 2007).

In the service context, they receive dehumanizing or disrespectful treatment from service staff when trying to obtain health or shelter services resulting in avoidance or mistrust of staff, and service institutions (Lee et al., 2010; Romeo, 2005; Shier et al., 2011; Wen et al., 2007; Wolch et al., 1988; Zlotnick et al., 2013). In their study examining perceptions of welcomeness, and unwelcomeness among IEHs, Wen et al. found that occurrences of unwelcomeness elicited strong emotional responses resulting in decreased likelihood of seeking care in the future (2007). In addition, these perceptions of unwelcomeness were linked with discrimination, and resulted in feeling dehumanized (Shier et al., 2011; Wen et al., 2007).

Prejudice and bias. Another social adversity usually studied is bias, the conscious beliefs in favor or against an individual. Bias can be emotional bias (prejudice) or cognitive bias (stereotyping)

where beliefs that characterizes an individual are based on group membership (Stuber et al., 2008).

Prejudice is a prejudged evaluation , and an aversive attitude towards a person who belongs to a certain group presumed to have certain qualities. For IEHs, the generalization that the entire group is lazy, filthy , and irresponsible is evident in the treatment they receive from the public , and service providers (Romeo, 2005; Shier et al., 2011).

The social adversities described above though expressed differently, result in similar outcomes to those of discrimination. Stigma, for example is a form of resource-reducing discrimination where employment, housing, quantity , and quality of education , and health care is limited (Hatzenbuehler et al., 2013). For example, IEHs face employment barriers due to stigma , and discrimination faced by employer where not having a job history, a previous incarceration , and a stigmatized “lazy” identity serve as barriers to employment (Lee et al., 2010; Shier et al., 2011).

The occurrence of these social adversities regardless of the factor or discriminatory identity results in the limiting or depletion of resources or services. Social adversities occur in a context where power is exercised hence considered “fundamental causes” of health disparities as it ultimately impacts , and is persistently associated with negative health outcomes. It is an organized system that categorizes groups into races , and uses this ranking to preferentially allocate goods , and resources to those groups regarded as superior, hence considered a fundamental cause of disease (Viruell-Fuentes et al., 2012; Williams & Mohammed, 2009, 2013). An outcome of experiencing social adversities is through instances of social distancing to avoid or cope with certain marginalizing experiences. For example, a homeless youth who identifies as transgender may experience discrimination through verbal or physical harassment from family , and peers which results in running away or social isolation (Bruce et al., 2014; Harper & Schneider, 2003; Kate-Wise & Hyde, 2012). This social isolation or distancing is done to escape shame, mistreatment or keep others from knowing one’s identity as a sexual minority (Hatzenbuehler et al., 2013; Zerger et al., 2014).

Additional outcomes of experiencing these social adversities results in increased distrust of non-marginalized individuals or groups. For example, IEHs often have a deep mistrust of clinics , and hospitals

, and anyone connected with these institutions (Zlotnick et al., 2013). This is because, the non-marginalized usually play “the culprit” intentionally or unintentionally by actively stigmatizing or discriminating the disadvantaged individuals or groups. Social adversity outcomes ultimately result in poor mental , and physical health for the socially disadvantaged due to ineffective coping habits that exacerbate existing mental health issues such as depression, by reinforcing a lack of trust in others , and initiation of unhealthy behaviors such as substance abuse , and risky sexual behaviors (Zerger et al., 2014).

Structural Adversities

The second level of social adversity includes discrimination that occurs at the structural levels which also result in inequitable access to resources , and opportunities (Derose et al., 2007; NHCHC, 2015; Williams & Mohammed, 2013). One widely cited example of institutional racism is residential segregation (Stuber et al., 2008; Williams & Mohammed, 2009, 2013; White & Borell, 2011). Residential segregation has been defined as the degree to which two groups live separately from one another in a given geographical area (White & Borrell, 2011). It is a marker of inequality , and reflects differences in access to services , and resources needed. Residential segregation , and its effects on neighborhood quality is an example of a social disadvantage that is both material , and psychosocial in nature (Williams & Jackson, 2005). Furthermore, the vastly different economic, physical , and social environments adds to the chronic stressors experienced by these individuals as they usually belong to a racial/ethnic minority group or are poor (Williams & Mohammed, 2009).

Residential segregation. Residential segregation shapes one’s SES , and determines one’s exposure to structural barriers, reflective in the lack of resources to be healthy (Pellowski et al., 2013; Williams & Mohammed, 2013). Individuals living in these neighborhoods are impoverished, unhealthy, , and considered vulnerable as their places of residence are areas of concentrated poverty, discrimination , and other social conditions that increase susceptibility to health disparities (Pellowski et al., 2013; Williams & Mohammed, 2013). These neighborhoods typically have higher rates of violence , and crime, limited access , and availability of services , and employment opportunities, low perceptions of neighborhood safety, poor reinforced health behaviors , and higher percentage of tobacco , and alcohol sales. (Bowleg et

al., 2013; Pellowski et al., 2013; Stuber et al., 2008; Williams & Jackson, 2005; Williams & Mohammed, 2009, 2013; White & Borell, 2011). Furthermore, these neighborhoods, as a result of the structural barriers increases risk to cardiovascular disease, cancer , and HIV/AIDS (Braveman, 2009; Williams & Jackson, 2005). These unhealthy environments due to the convergence of numerous vulnerability factors , and multi-morbidity become areas disproportionately plagued with higher morbidity , and mortality rates (Braveman, 2009; Grabovschi et al, 2013; Kreiger et al., 2011; Pellowski et al., 2013; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Williams & Jackson, 2005). Using the HIV epidemic as a case study, the burden of disease is concentrated in socially marginalized , and disenfranchised communities, inclusive of racial , and ethnic minorities, the poor , and uninsured populations (Bowleg et al., 2013). Therefore, critical determinants of HIV spread expand to biological factors , and include poverty, discrimination, inequality , and other social conditions.

For IEHs, the regulation of their lived environment or “social space” can be seen as a form of residential segregation. Normal behavior is barred , and deemed illegal through occurrences of criminalization (Lee et al., 2010; Lurie, Schuster & Rankin, 2015; Parsell, 2011). To escape this criminalization, IEHs opt to camp out in localized encampments away from the public’s eye , and police. As such, this “choice” to isolate themselves is a by- product of their marginalization by the domiciled community as it reflects IEHs attempt to socially distance themselves (Hatzenbuehler et al., 2013; Zerger et al., 2014). Furthermore, this isolation is an occurrence of marginalization as it results in IEHs being pushed out to the margins , and restricted to various poor, resource poor , and unsafe areas of the community.

Institutional discrimination. A second occurrence of structural discrimination is through policies , and practices that guide institutional practice. These policies not only bar access to necessary resources such as employment , and quality health care, but have racialized , and constructed particular groups, such as immigrants, as abnormal, undesirable , and a threat to the nation (Derose et al., 2007; Dovidio et al. 2010; Quesada et al., 2011; Viruell-Fuentes et al., 2012). This structural discrimination, through institutional policies such as marriage rights, immigration , and health insurance or shelter policies reduces or limits resource opportunities, , and has been coined “structural vulnerability” (Derose et al.,

2007; Dovidio et al. 2010; Quesada et al., 2011). Structural vulnerability is based on the idea of structural violence, the indirect violence that results when social arrangements or structures inhibit people from reaching their full potential , and cause injury to people indirectly (Farmer, Nizeye, Stulac & Keshavjee, 2006).

For example, Harper and Schneider discuss the active discrimination of LGBT (lesbian, gay, bisexual , and transgender) populations through laws that fail to protect basic human rights or exclude this group from rights accessible to heterosexual groups such as marriage , and adoption opportunities (2003). These laws leave room for additional discriminatory opportunities at the individual levels such as employment or housing access.

For immigrants, the existing anti-immigration policies result in the construction of negative bias , and stereotypes against certain demographic groups. For instance, Latinos are all seen as illegal immigrants who take away jobs, suppress wages , and contribute to increased unemployment rates that impose unnecessary fiscal burdens on taxpayers (Derose et al., 2007; Dovidio et al., 2010; Viruell-Fuentes et al., 2012). This creates additional burdens for many immigrants seeking stable employment , and even housing.

In relation to healthcare, immigration policies limit health insurance , and Medicaid eligibilities. This serves as a major barrier to service utilization , and treatment adherence due to high out of pocket costs for economically vulnerable individuals. For example, Chinese immigrants that have been smuggled to the U.S face numerous barriers to finding work. Not only are they indebted to their smugglers, the social cultural norms require them to provide for their families. Therefore, any threat to material wealth such as hospitalization endangers their moral life resulting in underutilization of mental health services; in other words the need to survive due to their disadvantaged status supersedes their health , and wellness.

Another instance of structural vulnerability are the numerous shelter acceptance policies that IEHs must meet. Shelter eligibility policies ban individuals presenting with mental health or substance use problems or those with a history of incarceration (Barnes et al., 2007). Furthermore, the obtrusive practices involved such as long , and detailed intakes are viewed as degrading, intrusive , and humiliating for IEHs

(Chard, Faulkner & Chugg, 2009; Meanwell, 2012). Another stellar example previously cited is the low shelter usage rates among transgender individuals due to a lack of appropriate accommodation (Lee et al., 2010; Romeo, 2005; Shier et al., 2011; Wolch et al., 1988; Zlotnick et al., 2013). Lastly, since shelters typically accommodate single adults, mothers with children are usually unable to utilize most public shelters (Meanwell, 2012).

The occurrence of structural discrimination indirectly impacts employment, education, shelter, and healthcare opportunities resulting in the creation of economic vulnerability, and health disparities among marginalized individuals (Derose et al., 2007; Dovidio et al. 2010; Farmer et al., 2006; Quesada et al., 2011). Shier et al. (2011) looked at the sociocultural factors shaping homeless women's vulnerability, and found that the labor market is set to accommodate the needs of permanently housed individuals. As such, IEHs, particularly women reported difficulty getting jobs, and other constraints due to not having an employment or housing history needed by tenants, and employers (Shier et al., 2011).

Covert and Hidden Adversities

Occurrences of covert adversities include unconscious forms of prejudice that have been shown to occur automatically, and unbeknownst to the "perpetrators" (Stuber et al., 2008; Williams & Mohammed, 2013). In today's society, overt occurrences of social adversities have become scarce or not typically acted on (Williams & Mohammed, 2013). What remains are instances of covert discrimination, and implicit bias which are sustained by subtle implicit attitudes that may influence, for instance, health care providers' behavior, and treatment choices. These instances are implicit, and at times done unbeknownst to the "perpetrator." Also referred to as micro-aggressions, they are those brief, and commonplace daily indignities that communicate hostile derogatory or negative insults towards minority groups such as people of color (Bowleg et al., 2013; Dovidio et al., 2010; Kate-Wise & Hyde, 2012; Quesada et al., 2011; Williams & Mohammed, 2013).

For example, in their study Dovidio et al. (2010) found that Latino shoppers were asked for identification, and quoted higher prices compared to White shoppers. These subtle or covert expressions of bias are perceived by marginalized individuals, and have similar, and negative consequences as blatant

discrimination. Romeo (2005) in her ethnographic study looking at demise of IELs in accessing care found that they face degrading, humiliating, and disrespectful treatment from health care staff. This negative treatment results in feelings of hopelessness, and avoidance of recreating these biased interactions by limiting interactions with healthcare staff.

Hidden and internalized adversities. Implicit bias ultimately impacts patient-provider relationships, provider distrust, and health seeking behavior, and medication or treatment adherences. In a study looking at the occurrence of implicit bias among health care professionals found that most health care professionals appeared to have negative attitudes towards Blacks, and positive attitudes towards whites (Hall et al., 2015). Furthermore, in regards to the clinical encounter, compared to whites, Blacks reported poorer treatment, communication, and collaboration with their providers, had longer wait times with short, and less collaborative visits (Hall et al., 2015).

Psychological effects can also be present when overt incidences of discrimination, and stigma are absent. One's awareness of belonging to a group that's historically suffered discrimination can act as a chronic stressor where experiencing racism becomes internalized, and expected (Braveman, 2009; Dovidio et al., 2010; Hall et al., 2015; Kate-Wise & Hyde, 2012; Pieterse et al., 2011; Williams & Mohammed, 2009, 2013; Zestcott et al., 2016). This results in chronic activation of the stress response among marginalized individuals, and impaired social interactions with non-marginalized individuals (Stuber et al., 2008).

Social Adversities Impact on Health

A major pathway in which social adversities impact health is through stress processes activated when interactions between marginalized (non-dominant), and non-marginalized (dominant) individuals are perceived to be discriminatory (Stuber et al., 2008). Stress affects health in three ways: the actual exposure to as stressful situation, through negative behavioral coping responses, and psychologically. Exposure to acute, and chronic stress has been widely studied, and attributed to negative mental, and physical health specifically among minority individuals (Bruce et al., 2014; Thoits, 2010). The minority stress theory

proposes that health disparities that minorities experience can be explained by the stress produced living, for instance, as a sexual minority in a heterosexist environment (Bruce et al., 2014).

Minority stress theory explains the experience associated with a stigmatized social identity such as that of sexual adolescent minorities or IEHs. For example, sexual minority youths are more likely to experience homelessness, report greater risks for mental health, substance abuse symptoms, and victimization than homeless heterosexual youths (Bruce et al., 2014). These occurrences of victimization that lead to additional increased stressors, and include instances of bullying, rejection, verbal, and physical harassment from family, and peers in the home, school, and neighborhood setting. In addition, these stressors lead to further social marginalization through social distancing that can occur by isolating oneself from others, running away or dropping out of school (Bruce et al., 2014; Harper & Schneider, 2003; Kate-Wise & Hyde, 2012).

Effects of Time

Time, though not a type of advantage is an important dimension due to the impact that exposure to either material or psychosocial disadvantages have over time. Psychological, social, and physical stressors alter immune function, and negatively impact health (Pellowski et al., 2013; Thoits, 2010). Chronic exposure to stress is associated with cumulative disadvantage over the life course, and altered physiological functioning which can increase risk to numerous health conditions, and higher AIDS-related mortality rates (Pellowski et al., 2013; Thoits, 2010; Williams & Jackson, 2005). These chronic stressors influence psychological distress over the life course where constant exhaustion leaves individuals unable to cope with ongoing stressors (Thoits, 2010). Krieger et al. found that the more time spent in the U.S by Black immigrants resulted in increased self-reported experiences of racial discrimination, an occurrence linked with higher rates of psychological distress (2011).

The length of time an individual experiences ongoing stressors, such as those faced by IEHs works to sustain, and widen disparities such as increased rates of premature mortality, and quicker health deterioration. For instance, homeless individuals that receive housing priority in Housing First models are considered to be at highest risk for death, and have higher disease rates. Their housing priority is related to

their length or time of homelessness , and occurrence of comorbidity factors (Henwood et al., 2015). Social adversities , and stressors impact individuals not only immediately, but over the life course even extending across generations. For example, stigma experienced by transgender homeless adolescents has immediate , and long term consequences that increase the likelihood of experiencing stressors over the life course into adulthood (Thoits, 2010). This proliferation of stress across time , and generations results in the reinforcement , and reproduction of social disadvantage faced by IEHs.

Another dimension of time is the association between implicit bias , and length of career time among health care professionals. In their study, Hall et al. found that implicit bias was more pronounced as health professionals progressed in their careers (2015). Over time, repeated instances of certain patient situations become engrained as truths which then influenced the patient-provider relationship. Furthermore, continued exposure to bias among peers over time also reinforces , and justifies these biases that influence treatment decisions which become based not on individual factors but racial/ethnic stereotypes based (Hall et al., 2015)

Differential Outcomes

The occurrence of social adversities varies across time , and place but generally, results from societal systems that produce unequal distribution of power , and resources (Paradies, 2006; Thoits, 2010). In certain instances, individuals who face social adversities will have different outcomes based on the presence of an existing social support system that lessens the prevalence , and severity of consequences (Harper & Schneider, 2003; Stuber et al., 2003; Thoits, 2010). Social support is any assistance – emotional, information or practical from significant others such as family, peers or the community , and can be viewed as a material , and psychosocial advantage (NHCHC, 2015; Thoits, 2010).

These social adversity or stress buffers include personal , and social assets such as having a sense of control over life, high self-esteem , and a good social support system (NHCHC, 2015; Thoits, 2010). These factors increase individuals' abilities to cope with stressful demands by encouraging active problem solving or diminishing distress. For instance, having a strong sense of racial/ethnic identity linked with self-esteem was associated with lower effects of self-reported racism (NHCHC, 2015; Paradies, 2006;

Stuber et al., 2003; Thoits, 2010). Individuals with high levels of perceived social support are better able to cope with major life stressors (NHCHC, 2015; Thoits, 2010).

For individuals living with HIV/AIDS (LWHIVA), encountering a lack of psychosocial support was found to be part of the vulnerability creation process in the context of HIV infection (De Santis & Barroso, 2011; De Santis & Deleon, 2013). Study participants reported that the life stressors associated with LWHIVA could be managed if psychosocial support systems were present to mitigate these stressors. Therefore, to avoid losing existing social support systems, and further marginalization, individuals choose to “live in silence”, and in isolation to keep those highly stigmatized disease statuses or sexual identities hidden from their social networks (Bruce et al., 2014; Harper & Schneider, 2003; Hatzenbuehler et al., 2013; Kate-Wise & Hyde, 2012; Zerger et al., 2014). These can include individuals with a mental illness, LWHIVA or identifying as LGBT or experiencing homelessness. Therefore, marginalized individuals such as IEHs usually have lower levels of these coping resources which further increases their vulnerability to poor health outcomes (Stuber et al., 2003).

For IEHs, occurrences of covert, and overt oppression in their lived context is almost inevitable. As such, the presence of social buffers is crucial to surviving, and mitigating the negative, and marginalizing consequences of oppression. How IEHs respond to oppression is crucial to their survival. Though the previous discussions focused primarily on the adverse effects of oppression, it is important to note that IEHs can respond in such a way that those effects are mitigated.

The response to oppressive situations that maintain psychological wellness is called “adaptive responding”, and occurs in specific settings where those facing oppression are empowered, and liberated (Case & Hunter, 2012). These specific settings that promote psychological well-being are called “counter-spaces”. The adaptive responding is a process that occurs through coping, creation of resilience, and resistance. Coping includes those strategies IEHs employ to respond to a stressor in a way that ameliorates the adverse effects. Resilience is the outcome of adaptation to adverse conditions where outcomes are favorable despite experiencing social adversity. Lastly, resistance includes concerted individual, and group efforts aimed at changing oppressive conditions by challenging the “status quo” or creating

psychological , and structural conditions that encourage liberation. This includes individual agency aimed at disrupting the patterns of internalized , and systemic oppressions, a type of horizontal power (Case & Hunter, 2012; Vasas, 2005).

Adaptive responding is an important outcome when facing social adversities that occurs through self-protection , and self-enhancements. Protection includes the individual responses to deal with an oppressive situation. This can occur through individual , and contextual factors such as, having a strong sense of racial/ethnic identity, avoidance or minimization of marginalizing effects (NHCHC, 2015; Paradies, 2006; Stuber et al., 2003; Thoits, 2010). For example, through social isolation, individuals identifying as transgender, that LWHIVA or experience criminalization by law enforcement chose to live in isolation or silence to avoid or escape occurrences of marginalization.

Enhancement occurs through a psychological community of resistance made up of individuals sharing similar adversities that help promote individual , and collective sense of worth. For example, the creation of social networks by IEHs to help support , and encourage one another against criminalization or stigma.

Experiencing Vulnerability

Homelessness stems from both personal vulnerability , and structural factors , and affects people from economic , and socially marginalized backgrounds (Hodgetts et al., 2007). For example, structural factors creating , and compounding the consequences of homelessness include a lack of affordable housing , and poor living wages (Lee et al., 2010). These structural factors create a population of poor people vulnerable to poverty , and at risk for homelessness, who when faced with traumatic life events such as sickness, domestic violence or job loss, the inadequacy of buffers results in the occurrence , and continuation of homelessness (Bowleg et al., 2013; Lee et al, 2010; Shier et al., 2011).

This occurrence of homelessness coupled with resulting identity based marginalization further reinforces the social disadvantages , and vulnerability experienced (Braveman et al., 2011). The more identities of discrimination aside from being homeless further increases an individual's vulnerability; additional marginalizing social identities include having a mental illness, race, nationality or identifying as

transgender (Benbow et al., 2011; Meanwell, 2012; NHCHC, 2015). These identities serve as additional occurrences of discrimination that further increases the vulnerability to poor health. For example, due to their discordant gender identity, transgender women experience social rejection, and marginalization leading to higher occurrences of homelessness, polysubstance abuse, victimization, and physical distress (Brennan et al., 2012; Harper & Schneider, 2003). Homeless transgender individuals have a higher prevalence of depression at a rate six to eight times greater than the general population (NHCHC, 2015). They also have higher attempts of suicide than the general population at 41% versus 1.6% respectively along with increased risk of victimization compared to cis gender victims (NHCHC, 2015).

In their study looking at experiences of oppression in the lives of homeless mothers with mental illness, Benbow et al. found that homeless mothers with mental illnesses faced increased discrimination resulting in being turned down from housing, humiliation, and inappropriate interrogation by landlords, and employers (2011). These discriminatory social policies, and public perceptions result in inequitable access to resource, and opportunities (NHCHC, 2015; Shier et al., 2011). For individuals LWHIVA, the rejection, verbal abuse, and humiliation that comes from disclosing their HIV status to family, and other support systems results in further isolation to escape these negative adversities. These stigmatizing occurrences further impact their adherence to treatment, and likelihood of seeking out other resources for social support (De Santis & Barroso, 2011; De Santis & Deleon, 2013).

The health consequences of being homeless result from experiencing limited opportunity to resources not only due to extreme poverty but the marginalization experienced by this population (APA, n.d.; Benbow et al., 2011; Bernstein et al., 2015; Bharel et al., 2011; Gelberg et al., 2000; Henwood et al., 2015; Hodgetts et al., 2007; Lee et al., 2010; Meanwell, 2012; NHCHC, 2011; Parsell, 2011; Romeo, 2005; Skosireva et al., 2014; Weinstein et al., 2013; Zerger et al., 2014).

The Vulnerable Population

The homeless population experiences various types of marginalization inherent in the identities they represent. Geographically, they are secluded with other poor, and low-income individuals thus living in areas of impoverished locations with limitations on adequate access of services. Socially, they are

excluded as they do not fit the social norm where they are viewed as deviant, lazy, problematic, , and mentally unstable. Economically, they are excluded due to their poor status , and low socioeconomic position. Politically, they are the silenced , and unheard population at high risk for criminalization , and institutional discrimination that bar them from accessing adequate housing , and jobs. These experiences of marginalization result in the creation of unique experiences of vulnerability to health, which is tied to their multiple identities.

IEHs includes individuals , and groups from various races , and ethnicities, ages, gender , and sexual orientations resulting in a very heterogeneous group (Lurie et al., 2015). The demographic characteristics of the homeless population based on the 2015 Point-in-Time (PIT) counts show that this group is not homogeneous, but very diverse by race, ethnicity, gender , and age (U.S. Department of Housing , and Urban Development [USDHUD], 2015). Of the 564,708 people included in the PIT count gender categories included female, male , and transgender, making up 39.7%, 60% , and 0.2% respectively. The largest racial groups were: White, African American , and multiple races, making up 48.5%, 40.4% , and 5.8% respectively. When categorized by ethnicity, non-Hispanics made up 80.1% of the population compared to 19.9% Hispanic. Three age categories were used: under 18, 18-24 , and over 24, making up 22.6%, 9.4% , and 68% respectively (USDHUD, 2015).

Albeit the heterogeneity among IEHs, the underlying similarity between them all is that they embody those in society that are the most vulnerable, be it socially, economically or politically. The demise of being homeless indicates that these individuals were initially vulnerable to poverty , and existing structural injustices resulting in their inability to buffer themselves from becoming homeless , and the consequences of being homeless. It is therefore not surprising that compared to the housed populations, IEHs had higher rates of victimization at 49% compare to 2% (Meinbresse et al., 2014). The more identities of minority individuals have, the higher the likelihood of negative consequences. For example, homeless women are more likely to be victims of rape than men (Benbow et al., 2011; Breiding, 2015; Meinbresse et al., 2014; Shier et al., 2011). Transgender homeless adolescents are more likely to

experience harassment from others (Bruce et al., 2014; Harper & Schneider, 2003; Kate-Wise & Hyde, 2012; NHCHC, 2015).

Vulnerability is What Matters

The health disparities experienced by this disadvantaged group arise from the marginalization or discrimination experienced, whether intentional or unintentional. Furthermore, the numerous social identities they represent must be considered to better understand their vulnerability. Therefore, those pathways that result in the creation of a disadvantaged, and vulnerable group must be understood in efforts to eliminate health disparities.

Experiencing the phenomenon of vulnerability thus underlies a plurality of experience, as it encompasses numerous, and commonly experienced inequities related to identity-based oppressions (Brocklehurst & Laursen, 2008; Derose et al., 2007; Grabvoschi et al., 2013; Jones, 2009; Shi & Stevens, 2005a, 2005b; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Thomas et al., 2011; Viruell-Fuentes et al., 2012). These identity-based oppressions include, but are not limited to, marginalization or discrimination due to one's race, ethnicity, age, gender or class.

The challenges to understanding the phenomenon of vulnerability are inherent in what determines one's vulnerability; the multiple occurrences of factors that leads to an individuals' unique experience of vulnerability, commonly referred to as "multi-vulnerability." Another challenge lies in how to adequately capture or study the convergence of all these "isms" as they are all influential in creating one's unique experience of vulnerability. Lastly, occurrences of these "isms" can be both overt, and covert adding further to the challenge in identifying or quantifying their occurrence, and impact.

Albeit these challenges, approaching the multiplicity, and convergence of social adversities through a vulnerability lens provides a comprehensive or more inclusive approach to studying these isms. Rather than seeing them as independent or simply additive, they should be viewed as intersecting isms based on the various identities an individual represents (Crenshaw, 1989, 1991; Jackson et al., 2016).

Research supports the need to study these adversities by looking at the multiplicative aspects of minority identities (Harper & Schneider, 2003; Jackson et al., 2016; Kate-Wise & Hyde, 2012; Stuber et

al., 2003, 2008; Viruell-Fuentes et al., 2012; Williams & Mohammed, 2013; Zerger et al., 2014). Despite this, research takes a “single- axis” analysis perspective where focus is on one type of adversity experienced or one factor of discrimination such as race only or sexual orientation, , and when multiple factors are studied, the relationship is additive rather than intersectional (Crenshaw, 1989, 1991; Jackson et al., 2016; Williams & Mohammed, 2013).

This unitary approach results in a fragmented understanding of vulnerability , and comes at a cost to understanding how the intersection of multiple disadvantages or minority identities affects health (Derose et al., 2007; Hankivsky & Christoffersen, 2008; Jackson et al., 2016; Jones, 2009; Quesada et al., 2011; Shier et al., 2011; Spiers, 2000; Stuber et al., 2008; Viruell-Fuentes et al., 2012; Williams & Jackson, 2005; Yang et al., 2014). In addition, though the current body of knowledge on discrimination among African Americans or sexual minorities is pertinent, this theoretical knowledge needs to be expanded to understand the unique discriminatory experiences faced by IEHs such as being a Latino woman, elderly, an immigrant, transgender or having a mental or physical illness such as HIV/AIDS (Brennan et al., 2012 Derose et al., 2007; De Santis & Barroso, 2011; De Santis & Deleon, 2013; Dovidio et al., 2010; Quesada et al., 2011; Sarvimäki & Stenbock-Hult, 2014; Yang et al., 2014).

Crenshaw (1989) argues that knowledge or experience about sexism , and racism is defined in terms of White women’s experience with sexism , and Black men’s experience with racism. This singular view of discrimination cannot be used to understand the discriminatory experiences of Black women as it fails to capture the multiple identities , and how they intersect to create their unique experience. Furthermore, this single-axis perspective distorts the unique experiences of Black women , and other individuals with multiple identities , and leads to their being theoretically erased, omitted or made invisible in research , and society (Crenshaw, 1989; Bowleg et al., 2013).

For example, a homeless woman with a mental illness for instance, who identifies as a homosexual may experience discrimination due to race, gender , and sexual orientation status (Benbow et al., 2011; Meanwell, 2012; NHCHC, 2015). Through instances of discrimination, access to affordable housing , and employment is limited due to differential treatment received from landlords or employers

(Benbow et al., 2011; Shier et al., 2011). The combination of multiple identities of minority leads to differential , and unique experiences of adversity faced by marginalized individuals (Harper & Schneider, 2003; Kate-Wise & Hyde, 2012; Stuber et al., 2003, 2008; Zerger et al., 2014).

Aside from fragmented unitary focus on one adversity or marginalized group is the heavy reliance on self-reported assessments of exposure to social adversities (Community Solutions & OrgCode Consulting Inc. [CS&OC]; Cronley, Petrovich, Spence-Almaguer & Preble, 2013; Downtown Emergency Services Center [DESC], 2010, n.d.; Gelberg et al., 2007; Orgcode Consulting Inc.[OCI], 2015; Spence-Almaguer, Cronley & Petrovich, 2013; Stein, Andersen & Gelberg, 2007; Williams & Mohammed, 2013). Research should explore other methods of inquiry to assess the presence , and exposure to social adversities that create vulnerability experiences among IEHs.

To do this, insider insight is needed to elucidate those pathways that lead to marginalization. In other words, how do social adversities among IEHs occur , and in turn shape their vulnerability? To accomplish this, research must find a way to really take into account the intersecting social identities represented in this heterogeneous homeless group , and how these impact their vulnerability to health disparities.

Etic Measurements of Vulnerability and Service Utilization among IEHs

Although research acknowledges the plurality of factors in the creation of vulnerability, ambiguities still remain on how to truly measure , and quantify vulnerability (Brocklehurst & Laurenson, 2008; ; De Santis & Barroso, 2011; De Santis & Deleon, 2013; Gelberg et al., 2000; Grabvoschi et al., 2013 ; Rogers, 1997; Sarvimäki & Stenbock-Hult, 2014; Shi & Stevens, 2005a, 2005b; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Spiers, 2000; Thomas et al., 2011; Viruell-Fuentes et al., 2012; Yang et al., 2014). Efforts to capture the co-occurring multiple factors has focused on additive or accumulative approaches where those with the most deficits or factors are considered most vulnerable to poor health outcomes or face more access barriers (Gelberg et al., 2000; Grabvoschi et al., 2013; Jones, 2009; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Spiers, 2000; Thomas et

al., 2011; Viruell-Fuentes et al., 2012). These deficits are usually those downstream, material disadvantages.

The majority of health disparity research approaches vulnerability from a normative etic perspective, assigning certain populations higher probability of disparities based on racial-ethnic, socio-demographic characteristics or diseases status (Cronley et al., 2013; CS&OC, 2014; DESC, 2010, n.d.; Gelberg et al., 2000; Grabvoschi et al., 2013; OCI, 2015; Office of Policy Development & Research [OPD&R]; Rogers, 1997; Shi & Stevens, 2005a, 2005b; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Spence-Almaguer et al., 2013; Spiers, 2000; Thomas et al., 2011; Viruell-Fuentes et al., 2012). This etic based approach views vulnerability epidemiologically, as a population-based relative risk or deficit-oriented measure, where the culmination of internal , and external normative deficits makes one susceptible to illness , and disparities (Case & Hunter, 2012; Jones, 2009; Penman-Aguilar et al., 2016; Rogers, 1997; Spiers, 2000).

One of the most commonly reported , and studied outcomes of experiencing vulnerability among IEHs is poor health. It is therefore not surprising that a commonly cited , and assessed vulnerability among this group is medical vulnerability. This vulnerability is evident in the significant mental , and physical health issues experienced ranging from acute to chronic diseases, mental health , and substance abuse. Albeit, the medical vulnerability, IEHs have poor , and dysfunctional medical utilization, a recurring , and expensive issue. This has prompted the creation of assessment tools , and models aimed at understanding health service utilization , and working to prioritize those most vulnerable to negative health outcomes such as early death on the streets (CS&OC, 2014; Cronley et al., 2013; DESC, 2010, n.d.; Gelberg et al., 2000; OPD&R, 2012; Spence-Almaguer et al., 2013; Stein et al., 2007). Following is an overview of the approaches commonly utilized in measuring vulnerability , and explaining service utilization among IEHs.

Medical Vulnerability and Prioritization Tools

IEHs medical vulnerability is evident in the high unmet health needs , and premature mortality they experience (Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000; Henwood et al., 2015). Their lives are spent cycling intermittently from the streets, through shelters, emergency rooms , and

prisons where high service utilization rates are associated with more vulnerability , and hospitalization (100,000 HOMES, n.d.; CS&OC, 2014; OCI, 2015; OPD&R, 2012). One viable solution shared by the majority of organizations or programs working with IEHs with demonstrated positive impacts was to focus on housing to improve quality of life. Unfortunately, connecting IEHs with stable , and affordable housing is a difficult feat given the limited resources , and large homeless population, creating the need to assess housing eligibility by prioritizing those with the greatest need.

Vulnerability index. The first assessment tool to identify , and prioritize IEHs for housing was created during this time. The *Vulnerability Index* (VI) was informed by studies conducted with homeless individuals in Boston showing that experiencing homelessness for more than six months , and having one of the common conditions seen among the homeless indicated a high risk of premature death. These conditions included: medical care in the past year, being 60 or older, cirrhosis, end-stage renal disease (ESRD) or renal failure, history of frostbite, immersion foot, or hypothermia, HIV/AIDS , and lastly having co-occurring psychiatric, substance abuse or chronic medical conditions referred to as “tri-morbidity” (100,000 Homes, n.d.; OPD&R, 2012).

The VI quantifies individual risk for mortality based on the presence of the aforementioned pre-determined risk factors. A self-reported survey, the VI score can range from zero to eight depending on the vulnerability factors reported. A person reporting less than six months of homelessness automatically receives a score of zero even if other risk factors are present (Cronley et al., 2013). To date, the VI has been widely used to assess the chronicity , and medical vulnerability of IEHs , and guide prioritization of clients into housing. Though successful in prioritizing the most vulnerable, the VI fails to give additional insight into the situational context or severity of a given issue such as ESRD. This insight is crucial to determining what other factors influenced progression into ESRD , and the level or intensity of case management needed.

SPDAT. The *Service Prioritization Decision Assistance Tool* (SPDAT) was designed to help prioritize housing services for IEHs based on their acuity (CS&OC, 2014; OCI, 2015). It differs from the VI as it provides a more in-depth assessment of individual capabilities , and issues that ultimately

determine the level of assistance needed. Furthermore, it is only used with individuals who meet a given program's eligibility criteria such as being homeless in order to qualify for a Housing First program. The assessment tool is based on fifteen components looking at various skills or functions such as money, rent or medicine management, physical, and mental functioning, history of homelessness, if they pose any risk to self or other, and interactions with legal, and medical services. The assessment can be completed through conversation, observation, and use of other pertinent document that provides information about an individual's level of functioning or health status. The scoring for each component ranges from zero to four, with zero indicating high functionality or no issues so that the higher the score, the more issues of poor functioning an individual has. The recommended interventions, and approach are based on individual score, and guide case managers in not only determining housing priority, but the approach to take in connecting individuals with services. The SPDAT is intended to be re-collected every thirty days to provide a visual progression of client's improvement based on interventions initiated. A strength of the SPDAT is that it gives useful information or insight into the numerous issues IEHs face, yet fails to unveil why these issues are present.

VI-SPDAT. The VI-SPDAT is a combination of the two discussed assessment tools; the VI, and the SPDAT. It is a pre-screening or triage tool designed to quickly assess the health, and social needs of IEHs, and appropriately match them with any available support, and housing interventions. More specifically, it was designed to determine the presence, and acuity of an issue, and identify who to refer for specific housing assessment. The triage tool is based on 4 domains each directly related to one or more components within the SPDAT, and includes: housing risk, risks, socialization, and daily functions, and wellness. In addition to self-report questions, there are also observational questions answered by the surveyor. For example, to assess living skills, and determine if an individual is able to meet their daily living, and hygiene needs, a surveyor is prompted to observe, and check whether clothing is appropriate for the season, wearable or if the person is unclean. The scoring for the VI-SPDAT is completed using sub-totals for each domain category with scores determining the type of housing assessment needed whether

permanent, rapid-rehousing or no housing support for high, middle or low scores respectively. Following the VI-SPDAT most programs will then utilize the SPDAT to determine housing support needed.

VAT. The *Vulnerability Assessment Tool* (VAT) objectively prioritizes IEHs for limited shelter beds, and resources by measuring vulnerability based on individual characteristics, and behaviors. It is guided by the premise that limited resources should be reserved for those vulnerable to continued instability. In other words, it helps determine who is at greatest risk without those services. There are ten domains with each assessing an individual's limitation in meeting their own needs. These include: survival skills, basic needs, risks, mental health, substance use, communication, social behaviors, and homelessness. One strength of the VAT is that it lends insight into the overall set of needs of IEHs, but fails to define those needs or give background information into why these needs or risks exist.

Explaining health service utilization. The high needs coupled with competing survival needs, and access barriers such as lacking health insurance result in an overdependence on emergency services, high hospitalization rates, and longer hospital stays (APA, n.d.; Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000; Mackelprang et al., 2014). The *Gelberg-Andersen Behavioral Model for Vulnerable Populations* (BMVP) has been used to better understand service utilization, and explain challenges faced in obtaining needed services among vulnerable populations such as IEHs (Gelberg et al., 2000; Stein et al., 2007). The BMVP is an expanded model of the Andersen Behavioral Model originally used to explain the general populations' health services utilization by describing relationships among their predisposing, enabling, and need factors (Gelberg et al., 2000; Stein et al., 2007). Predisposing factors include biological, demographic, and social structure factors such as race, gender, age, ethnicity, employment or religion, and lastly health beliefs such as values, and attitudes towards health services. Enabling factors are the resources available inclusive of income, insurance coverage, transportation, and neighborhood resources. Need represents perceived, and actual needs for health care services (Gelberg et al., 2000; Lo & Fulda, 2008; Stein et al., 2007).

The BMVP posits that in addition to known predictors of service utilization in the general population, the special needs, and characteristics reflecting the vulnerability of IEHs are additional

independent predictors of inadequate health service utilization (Gelberg et al., 2000; Stein et al., 2007). These additional predictors include specific vulnerabilities such as substance abuse, mental illness, homelessness severity, victimization, and competing survival needs (Gelberg et al., 2000; Stein et al., 2007). Stein et al. (2007) applied the BMVP to predict health service utilization among homeless women included additional predictors of service utilization such as homelessness severity, substance abuse, psychological distress, barriers to healthcare, and health rating. Findings showed that homelessness severity was associated with more substance abuse, psychological distress, health care barriers, and greater illness. In addition, homelessness severity affected health, and health service utilization as they were less likely to have health insurance, have less preventive care, and reported significantly more barriers to care.

Strengths and Weaknesses of Etic Measures

The medical vulnerability of IEHs is well cited, as is the impact housing has on overall wellness. As such, the primary intervention tactic employed by organizations working with IEHs is stable, and supportive housing. Priority is given to those deemed most vulnerable to death or instability. The vulnerability, and prioritization tools discussed above have been widely used in assessing, prioritizing, and guiding interventions aimed at rehousing IEHs. The inherent strength of each tool is that they all provide a starting point on determining who is at greatest need for housing, and the level or intensity of case-management needed. In addition, they prompt individualized interventions for IEHs rather than assuming that every individual needs or vulnerability is the same.

Although useful as a triage tool in quickly ranking the most vulnerable at a given time, they fail to consider how the multiple marginalized identities IEHs interact to create their vulnerability. For example, individuals completing the VI assessment are “disqualified” or given a score of zero if time of homelessness is less than six months without considering how often an individual cycles in, and out of housing.

A focus on housing prioritization, and medical vulnerability downplays other important social adversities that IEHs face which lend to the creation, and maintenance of the vulnerability they experience. Furthermore, the guiding premise that the most medically vulnerable individuals utilize the most services

can result in missing other equally or more vulnerable individuals as IEHs face numerous barriers to services , and have competing needs that keep them from accessing needed services.

Unlike the vulnerability measurement tools, the BMVP is helpful in predicting health service utilization by accounting for factors associated with IEHs vulnerability such as lacking health insurance or having other competing needs aside from health care. Though the vulnerable domains included multiple identity based factors that determine one's vulnerability, study findings failed to consider how these factors interact synergistically to impact the health status , and medical usage amongst the sample group (Gelberg et al., 2000).

Efforts to capture the co-occurring multiple factors has focused on additive or accumulative approaches where individuals with the most factors are considered to be most vulnerable to poor health outcomes or face more access barriers (Gelberg et al., 2000; Grabvoschi et al., 2013; Jones, 2009; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Spiers, 2000; Thomas et al., 2011; Viruell-Fuentes et al., 2012). The measurement or predictor tools discussed above primarily utilized a self-reporting or surveyor insight assessment approach which relies on their ability to objectively account for certain visible behaviors of illness , and substance abuse. Furthermore, they utilize an etic-based approach to determine one's vulnerability by using pre-determined situational specific factors that may differ based on context , and likely exclude other important variables that determine IEHs vulnerability , and health service utilization (Grabvoschi et al., 2013; Spiers, 2000).

These deficit-oriented or risk-additive etic approaches lend partial insight on how vulnerability creates , and sustains health disparities among IEHs based on health service utilization or medical vulnerability. Importantly, these study approaches focus mostly on downstream material disadvantages to explain the presence , and pathways of health disparities. Though accurate, this unitary perspective lends insight to the ripples caused by fundamental factors of health disparities rather than focusing on the upstream psychosocial disadvantages. In other words, these approaches fail to account for the multiple , and synergistic marginalized identities IEHs represent that lend to their unique experience of marginalization in their lived context. By failing to clarify these upstream disparity pathways , and how

they manifest in everyday life, insight, and interventions aimed at eliminating health disparities among IEHs results in a piece-meal “band-aid” approach that responds to the visible ripples made by those upstream factors

Emic Approaches to Studying Vulnerability

To fully account for the multiple marginalizing identities IEHs represent, an approach that disregards prior assumptions about what factors are most influential in determining an individual’s vulnerability or lived experience is warranted. In addition, an approach that considers primarily the upstream psychosocial disadvantages experienced by IEHs is tantamount. An emic approach is therefore appropriate as it disregards prior normative assumptions about a phenomenon, and relies instead on an insider’s perception, and understanding (Rogers, 1997; Spiers, 2000). The following studies, though not exhaustive, show how emic studies lend insight on important, though commonly overlooked factors that determine one’s vulnerability to poor health outcomes.

For example, to explain why women were at increased vulnerability for HIV, Ostrach and Singer (2012) discuss, and account for the biological, social, and structural factors that create, and maintain gender-based inequalities. They propose that women’s increased vulnerability to HIV is bio political, predicated on not only behavioral or biological factors but social, and political factors inclusive of poverty, gendered power relations, and risk of sexual violence (Jones, 2009; Ostrach & Singer, 2012; Quesada et al., 2011; Shier et al., 2011). Quesada et al. (2011) discuss the importance of considering identity-based oppressions such as class, cultural, gender, sexual or racialized discrimination in the creation of structural vulnerability among Latino migrant laborers. As such, they argue that vulnerability must be addressed in the political domain, and clinical encounter since it is an indicator of inequity thus necessitating action across all spheres, social, and political (Quesada et al., 2011).

Jones (2009) argues that street children living in Trinidad, and Tobago are at increased vulnerability to HIV due to social marginalization shaped by experiencing stigma, and discrimination due to their identity as poor, orphaned, and likely HIV positive street children. As such, their increased risk for HIV is shaped by experiences of social marginalization which lead to occurrences of early sexual initiation,

commercialization of sex, which coupled with limited access to services , and resources results in their early mortality (Jones, 2009).

Yang et al. (2014) aimed to understand how Chinese immigrants' experiences with mental illness stigma shaped their mental health disparities. They found that structural discrimination was experienced through institutional policies such as immigration resulting in their ineligibility for Medicaid or health insurance coverage. The resulting high costs associated with hospitalization shaped their health seeking , and treatment adherence behaviors as the need to make money so as to avoid cultural stigma outweighed their pressing mental health needs. In this example, the stigma of having a mental illness was judged “less” than the cultural stigma of being seen as useless in not being able to provide for your family. Therefore, these social-cultural , and structural factors shaped Chinese immigrant's health seeking behavior , and help explain the mental health disparities experienced.

To adequately tackle these identity-based inequalities such as HIV disparities, premature mortality or poor access to resources, interventions must take into account the multiple , and intersecting factors that create IEHs unique experiences of vulnerability. Furthermore, to not limit the breadth of insight surveys or self-reports by disregarding prior normative assumptions about marginalization , and vulnerability, an emic perspective must be utilized (Rogers, 1997; Spiers, 2000). The studies outlined above, though not exhaustive, show how an emic approach can lend insight to factors that are difficult to quantify yet equally important in determining one's health outcome. For instance, how a Chinese immigrant came into the US or how orphaned children are viewed in society both ultimately influence the access , and availability of needed healthcare resources. Furthermore, how stigma is experienced by an individual can shape their health seeking , and treatment behaviors as Yang et al. (2014) found.

The strengths of these emic studies is the inclusion of individuals closest to a certain experience or phenomenon such as LWHIVA. This is one of the inherent strengths of emic studies; the individual experiencing a given situation is seen as the expert , and the researcher the learner. Albeit these, the various studies look at one identity of experience such as being orphaned, LWHIVA or being an

immigrant. For IEHs, this can result in the exclusion of other important factors that work to impact their experience of vulnerability.

To understand their lived experience as IEHs, the numerous identities they represent as a heterogeneous group must be accounted for. The challenge then is how to account for the plethora of identities or how to determine which one will be the primary “guiding” focus. For example, a focus on a particular disease status such as those LWHIVA, by gender, immigration or homelessness history. To prevent this inclusion or exclusion of factors, an approach that considers these various identities of marginalization is needed.

Theoretical Framework

An understanding of health disparity pathways using concepts of marginalization , and vulnerability is crucial to expanding health disparity research. To better understand vulnerable groups’ marginalized position, the numerous categories that they represent must be accounted for (Bowleg, 2012; Caiola, Docherty, Relf & Carroso, 2014; Crenshaw 1989, 1991). The two theoretical frameworks to inform this research study are Fundamental Cause Theory (FCT) , and intersectionality. The FCT posits that the social forces such as marginalization , and vulnerability underlie social stratification, , and cause health disparities, not exposure to proximal risk factors (Hatzenbuehler et al., 2013; Mackenbach, 2012). Intersectionality provides a framework for capturing the complexity of lived experiences , and the concomitant interacting factors of social inequality which ultimately lead to health disparities (Hankivsky & Christoffersen, 2008; Jackson et al., 2016).

History of Intersectionality

An intersectionality approach takes into account the complex social identities, categories or locations that shape the experiences of health, working to elucidate , and interpret the multiple , and intersectional systems of oppression , and privilege (Hankivsky & Christoffersen, 2008). First coined in 1989 by Kimberly Crenshaw, she argued that intersectionality was not merely an addition of identity categories but a means of analysis to how various identities , and conditions are located in power structures (Crenshaw, 1989). As such, a black woman’s experiences with discrimination cannot simply be informed

by looking at white women's experiences with sexism or black men's experiences with racism. Doing so theoretically erases their experiences as it looks at Black women's discriminatory experience from a single-axis analysis where discrimination is viewed in terms of the experiences of those who are privileged "but for" their racial or sexual discrimination" (Crenshaw, 1989). This "but for" view of discrimination leads to faulty understanding of discrimination where paradigms of racial or sex discrimination are then based on experiences of black men or white women respectively (Crenshaw 1989, 1991; Hankivsky, 2014).

From "inception", intersectionality has gained popularity, and been widely used as a theory, methodology, paradigm, approach, and perspective (Bowleg, 2012; Caiola et al., 2014; Crenshaw 1989, 1991; Greene, Chambers, Masinde & O'Brien-Teengs, 2013; Hankivsky, 2014; Hankivsky & Christoffersen, 2008; Kelly, 2009). As such, over time varying, and numerous definitions, conceptualization, and application of intersectionality in the literature have ensued. Albeit this, basic theoretical tenets characterize much of the literature, and research inclusive of key principles on how to apply an intersectionality approach (Bowleg, 2012; Caiola et al., 2014; Greene et al., 2013; Hankivsky, 2014; Hankivsky & Christoffersen, 2008; Kelly, 2009; Norfeldt, 2012).

Theoretical Tenets of Intersectionality

Intersectionality is not intended to be "prescriptive" but rather aims to bring about change in how researchers understand social categories, their relationships, and interactions through focusing the perspective on specific tenets (Hankivsky, 2012). To do this, attention must be given to the intersecting, and socially constructed multiple categories of individuals, the relationship, and power dynamics between social locations, and processes, specifically how these intersect at the micro, and macro level, and lastly emphasizing social justice, focus is given to historically oppressed, and marginalized individuals. These theoretical tenets are what distinguish intersectionality from the traditional biomedical perspective that fails to examine the broader social, and political causes of disparities.

Intersecting multiple categories. Intersectionality moves beyond a singular or typically favored category of analysis to consider simultaneous interactions between different aspects of social identity (Hankivsky, 2012). These social categories or identities are not independent, and unidimensional but

instead are multiple , and intersecting or mutually constitutive. For example, race , and gender cannot be studied as independent, singular categories but rather, how they constitute each other such that one identity cannot explain an individual's experience or disparate outcomes without the intersection of the other identity (Bowleg, 2012).

For example, the experience of a poor Black mother LWHIV is different from a poor Black father LWHIV because of the gendered difference that places them in different social locations , and ultimately impact their health outcomes (Caiola et al., 2014). In this case, race , and class may be gendered , and contribute to the differential experiences , and outcomes among the two similar, yet different socially located individuals (Caiola et al., 2014). In another example, to comprehensively understand the marginalizing experience of a Latina homeless woman, her identity inclusive of being a woman, an immigrant , and experiencing homelessness must be considered. Specifically, how these identities intersect to create her unique experience of discrimination , and vulnerability.

Synergistic intersections. Expanding the idea that individuals experience multiple forms of identity-based oppression simultaneously is the resulting synergistic effect (Jackson et al., 2016). The intersectional experience contingent on multiple identities results in a synergistic effect that is exponentially greater than the sum of singular experiences of racism or sexism (Caiola et al., 2014; Crenshaw, 1989; Jackson et al., 2016). Therefore, research strives not to add categories together, but to understand what is created , and experienced at the intersection of multiple axes of oppression , and how these interactions shape human experience. (Hankivsky et al., 2010). For example, to understand how immigrant women LWHIVA experienced housing instability, Greene et al. (2014), considered how their identities created unique barriers , and experiences of discrimination when accessing housing. The barriers faced alluded to the intersectional discrimination experiences such that these women faced exponential barriers compared to other homeless women who were not immigrant or LWHIVA. These barriers included non-accommodating housing policies, HIV related stigma , and discrimination from the community, service staff or housing agencies, being victims of domestic violence all while struggling to

meet the needs of their children (Greene et al., 2014). Therefore, intersectionality represents the synergy that occurs when multiple , and mutually constitutive identities of marginalization intersect.

No a priori. The multiple , and constitutive identities an individual represent all influence the synergistic outcomes experienced. As such, human experiences cannot be accurately understood by prioritizing a single factor. For example, using the above example outlining women LWHIVA, it is difficult to identify which category of identity is most important. In other words, there is no predetermined or pre-hierarchical pattern between the categories these immigrant women represent. For instance, it is not immigration first then gender or disease status then gender that determine these unique experiences. Intersectionality rejects hierarchical ordering , and instead encourages a “decentering” of commonly studied factors or combinations of factors such as the “trinity of race, class, gender” (Hankivsky, 2012). Taking such a hierarchical approach obscures other types of experiences , and distorts the unique experiences of individuals with multiple identities (Bowleg et al., 2013; Crenshaw, 1989; Hankivsky, 2012)

Socially constructed categories. The second tenet of intersectionality is that the multiple social identities an individual represents are socially constructed, fluid, flexible , and contextually grounded in a certain historical or geographic location (Caiola et al., 2014). For example, the meaning of motherhood, masculinity or homelessness is deeply embedded in the social context , and is active , and varies across time , and space. Gender is also a socially constructed category that differs based on race, ethnicity, culture or age Masculinity for instance or “looking male” is a constellation of gendered social expectations, responsibilities , and obstacles; these expectations are shaped by race, ethnicity or class , and can in turn shape how an individual behaves (Griffith, Metzl & Gunter, 2011). For example, the endorsement of traditional masculinity among Black men is related to having more sexual partners , and less condom use (Bowleg et al., 2013). As such how gender or masculinity is constructed must be understood as it can lend insight into outcomes such as increased sexual risk in Black communities (Bowleg et al., 2013; Griffith et al., 2011).

Homogeneity. Intersectionality promotes an understanding of human beings as shaped by the interaction of different social categories that are shaped by the lived context. For researchers, this is

important to note as no one social group is homogeneous. Intersectionality challenges universalism , and acknowledges diversity or heterogeneity within a given social group or category. For example, the gendered expectations cited previously allude to how ethnic heterogeneity occurs resulting in various definitions , and behaviors among similarly ethnic individuals.

This concept of heterogeneity should be considered extensively when generalizing or extending knowledge about a given social group to a similar social group in a different spatial or historical location (Kelly, 2009; Norfeldt, 2012). For example, how Latino immigrants experience structural discrimination or vulnerability differs based on the residential location , and on whether the location is a traditional or new destination for immigrants (Delrose et al., 2007). For example, compared to traditional locations, new destinations are less likely to have well-developed safety nets or social networks, community-based organizations that serve this group , and are accommodating of their unique needs (Delrose et al., 2007; Green et al., 2013). Therefore, to understand the unique experiences of a given social group, attention to the local context must always be considered as it shapes their lived realities (Hanksvisky, 2012, 2014).

Intersecting levels of power. The third tenet of intersectionality is how multiple social identities intersect at the micro level to reflect multiple , and interlocking social-structural inequalities (Bowleg et al., 2013). The micro-level power differentials occur through individual experiences or relationships, where one individual exerts power over another. The macro-level power differentials manifest structurally through institutional laws, policies , and practices that benefit certain groups; the dominant advantaged groups.

This calls attention to how social relationships marked by power differentials occur , and result in marginalization leading to various forms of privilege , and oppression at either individual or group level. This power play then creates , and reinforces the existence of dominant , and marginalized groups, resulting in occurrences of social inequalities in health outcomes (Bowleg, 2012; Caiola et al., 2014; Hanksvisky, 2014).

This can help explain how Black men's individual experiences of micro-level experiences as poor Black men reflect interlocking systems of privilege , and oppression, namely racism, sexism , and classism

(Bowleg et al., 2013). In their study looking at the multiple intersections of race, gender, and class among Black men, findings revealed that instances of racial discrimination occurred through structural, and micro-aggressions in various locations. For instance, racial micro-aggressions reported occurred through interactions with police enforcement. These occurrences were described as daily, constant, and unwarranted stops, questions, and frisks by police where as a Black man, one is “always a target” for police harassment (Bowleg et al., 2013).

Structural discrimination occurred when attempting to gain employment where their “being Black” or having a history of incarceration served as barriers (Bowleg et al., 2013). Kelly (2009) illustrates the individual, and structural discriminations abused Latina women with mental illnesses face in accessing services, and resources. For instance, abused immigrants face threats to their safety not only within the home in their relationships with significant others (individual factors), but outside the home (structural factors) due to their immigration status. As such, they experience loss of power resulting in compounded mental health problems (Kelly, 2009). Failing to account for their identities of oppression inclusive of gender, immigration, and family status would result in a fragmented understanding of how these intersect to create their unique vulnerability to mental health (Kelly, 2009).

Another example of how micro, and macro level power dynamics interrelate is looking at experiences of homeless single mothers. At the micro level, their individual experiences of being a single mother, and having an immigration status increased their risk for housing instability related to having limited economic resources, and facing discrimination from landlords, and housing enterprises (Greene et al., 2013; Norfeldt, 2012). At the structural level, families experienced significant difficulties in obtaining rental contracts due to increased eligibility demands by landlords to show income, employment, and credit history. These rental eligibility demands for immigrant, and single mother families are difficult as they typically have limited economic means depending on various kinds of income or material allowances (Greene et al., 2013; Norfeldt, 2012).

The two examples shed light on the dynamic interplay in power relations at various levels. Of importance is that the micro, and macro level power relations are interrelated resulting in the perpetuation

of a social hierarchy that advantages one groups. In other words, the social adversities that marginalized individuals face allude to the persistence , and perpetuation of power at the micro , and macro level. Therefore, in order to understand how social inequalities are created, those fundamental causes or pathways based on power at each level must be uncovered.

Focus on the oppressed , and social justice. The study examples outlined above, though focused on different social groups or power levels all share one important tenet. They all focus on the experiences of historically marginalized individuals or groups , and calls attention to the injustices these individuals face (Bowleg, 2012). Intersectionality strongly emphasizes social justice by focusing on the social processes that generate , and maintain inequalities at the individual , and institutional levels (Bowleg, 2012; Caiola et al., 2014; Kelly, 2009). An intersectional approach includes all people whose micro , and macro level experiences intersect , and manifest as multiple social inequalities.

Principles of intersectionality. Utilizing an intersectionality approach not only challenges how marginalized individuals are viewed but how research is designed , and employed. For example, IEHs make up a heterogeneous group , and represents individuals from historically oppressed , and marginalized groups such as racial/ethnic minorities, sexual minorities, individuals LWHIVA , and other mental illnesses. The multiple intersecting identities that determine their social position at the micro , and macro level intersect to yield experiences of severe oppression that converge to create disproportionate health disparities. To uncover these pathways of injustices , and how they interrelate calls for an intersectionality approach that puts to practice the previously discussed theoretical tenets.

This translation from “theory to practice” can be guided by what Hankivsky (2014) terms principles of intersectionality. These principles encompass aspects of intersectionality tenets such as intersecting multiple categories, how identities are constructed over space , and time, the influence of power in shaping micro , and macro level experiences , and lastly, a focus on social justice , and equity. In addition, other principles of intersectionality that will be discussed in detail include: multi-level analysis, reflexivity, diverse knowledge , and lastly, resistance , and resilience (Hankivsky, 2014).

Multi-level analyses. Power relations occur at every level , and intersect to create synergistic outcome where marginalized individuals experience significant barriers to resources. Therefore, to understand a Black man’s unique experience of discrimination, how his individuals experiences interrelate with the structural experiences must be considered. As such, attention must be given to both levels of power relationships , and how these shape experiences, health behaviors , and outcomes (Bowleg et al, 2013; Greene et al., 2013; Hankivsky, 2014; Norfeldt, 2012).

Reflexivity. Attention to power relationships is not restricted to understanding social group’s experiences but expands to include the researcher’s position in the power dynamics. This reflexivity or acknowledging of power recognizes that there are multiple truths , and diverse perspectives aside from the researchers , and gives extra attention to those perspectives that are typically excluded. An example of reflexive practice is a researcher questioning their assumption , and truths about their work , and if these assumptions give room for other voices or perspectives (Hankivsky, 2014).

Diverse knowledge. An extension of reflexivity is considering the relationship between power , and knowledge production, specifically how power favors certain knowledge traditions. For example, Black men have been historically omitted from most HIV research , and interventions yet they are one of the highest at risk groups for HIV (Bowleg et al., 2013). Therefore, the knowledge development on interventions to reduce HIV sexual risk fails to account for or consider Black men’s experiences or viewpoints. This exclusion also lends insight to the power dynamics at the social level where the preferred “school of knowledge” is constructed from the dominant group’s perspective.

For IEHs, interventions aimed at reducing existing health disparities must include their perspectives in the production of knowledge as this can disrupt any forces of power that are activated in producing knowledge. These forces can include researcher self-assumptions or truths outweighing participants view , and in turn influence study findings , and implications. In other words, their insight on what constitutes vulnerability must be considered in creating assessment tools that adequately measure the existence , and level of medical vulnerability they experience.

Resistance , and resilience. Aside from considering diverse knowledge of truth, resistance , and resilience among marginalized groups can also disrupt power , and oppression. Those norms or practices that further oppress marginalized individuals can be disrupted or challenged through individual , and collective action in a process called adaptive responding (Case & Hunter, 2012; Hankivsky, 2014; Vasas, 2005). This process occurs in “counter-space” settings , and is important in helping individuals maintain psychological wellness in the face of oppressive situations or practices. For example, adaptive responding can include the creation of social networks by IEHs to help support , and encourage one another against criminalization or stigma.

Intersectionality focuses on finding meaning , and relationships between different social categories as well as revealing the dynamics of power. This insight has the potential of providing new knowledge leading to better action aimed at achieving health equity among IEHs (Hankivsky & Christoffersen, 2008). Key features of this theory is that it does not presume a priori in regards to categories , and assumes that numerous factors are always at play (Hankivsky & Christoffersen, 2008). It encourages contextual analysis of various factors to consider in understanding any situation of disadvantage , and lastly sets to uncover the convergence of these experiences (Hankivsky & Christoffersen, 2008). Inclusion of other factors apart from material conditions are needed to fully explain the complexity of power relations in society (Caiola et al., 2014; Crenshaw, 1989; Hankivsky & Christoffersen, 2008; Jackson et al., 2016). Overall, this theory calls for attention to the dynamic interrelationships between the social , and biological determinants of health, inclusive of human resilience , and vulnerabilities (Hankivsky & Christoffersen, 2008).

Fundamental Cause Theory

The social , and structural forces that result in health disparities such as structural discrimination or one’s social position are important to understanding the impact vulnerability has on health outcomes. One such force is SES where its association with mortality has persisted despite changes in disease , and their associated risk factors such as smoking , and lung cancer (Mackenbach, 2012; Phelan et al., 2010). The FCT posits that the social forces underlying social stratification, , and not exposure to proximal risk factors, cause health disparities (Hatzenbuehler et al., 2013; Mackenbach, 2012). In other words, upstream

factors or psychosocial disadvantages rather than downstream material disadvantages cause health disparities. This is an important facet of the FCT that helps justify why focus should include those macro-level “social causes” that result in social inequalities as they put individual’s at increased susceptibility for poor health outcomes.

A fundamental social cause of health disparities has four essential features. It has to: influence multiple disease outcomes, affect them through multiple risk factors, involve access to resources that can be used to avoid risk or minimize the consequences of disease once it occurs , and lastly, the association between the fundamental cause , and disease is reproduced over time (Hatzenbuehler et al., 2013; Phelan et al., 2010). An example of a fundamental cause is SES due to its persistent association with health (Phelan et al., 2010; Rubin, Clouston & Link, 2014). It is important to note that socioeconomic status though considered a downstream factor, alludes to the social economic position of an individual in a given social hierarchy. Therefore, it alludes to the wealth, power or prestige both economically , and socially.

Key concepts of the FCT are flexible resources where regardless of the context, are beneficial , and operate at the individual , and contextual level (Hatzenbuehler et al., 2013; Phelan et al., 2010; Rubin et al., 2014). According to the FCT, compared the disadvantaged, those with less access, those with greater access to resources due to higher SES are better able to utilize those resources to circumvent or mitigate poor health outcomes (Rubin et al., 2014). For example, socially advantaged individuals have higher socioeconomic position or SES , and their advantage is seen in the ease , and unlimited access to key resources based on need. These resources can be new knowledge on prevention or treatment of a certain disease such as lung cancer or HIV/AIDS (Rubin et al., 2014). The inequitable distribution of this knowledge or innovation is what leads to health disparities between socially advantaged , and disadvantaged groups.

This advantage to flexible resources is created through occurrences of oppression where one group is granted greater access to resources relative to other groups (Case & Hunter, 2012; Rubin et al., 2014). As such, the majority, the advantaged group such as domiciled individuals are at the center , and better able to receive , and utilize certain resources. In contrast, IEHs living at the margins of society , and center of

knowledge experience limited access to needed resources through instances of individual , and structural discrimination. Therefore, the availability of flexible resources is determined by occurrences of marginalization.

The FCT has been used to explain why certain large disparities have emerged , and continue to grow in the face of new knowledge , and innovations. The FCT posits that as diseases become more preventable due to increase in knowledge , and technology, socioeconomic disparities emerge since those with access to flexible resources such as the domiciled population benefit more compared to those without further resulting in an increase or emergence of health disparities (Hatzenbuehler et al., 2013; Mackenbach, 2012; Phelan et al., 2010; Rubin et al., 2014).

To explain why or how health disparities in lung , and pancreatic cancer have changed over time, Rubin et al. (2013) applied the FCT. Study findings showed SES-based inequalities in lung cancer mortality were produced after the information linking smoking to cancer emerged (Rubin et al., 2014). In contrast, there were no major innovations in treatment or prevention hence no mortality advantages related to SES ensued, hence no notable disparities in pancreatic cancer mortality (Rubin et al., 2014).

The occurrence of oppression in society is a fundamental cause of health disparities. More specifically, the vulnerability an individual faces through pathways of marginalization such as experiencing stigma is a fundamental cause of health disparities (Hatzenbuehler et al., 2013). Vulnerability meets the four essential features of a fundamental cause as it influences multiple disease outcomes such as HIV/AIDS , and mental illnesses. It affects disease outcomes through multiple risk factors inclusive of both material , and psychosocial disadvantages where access to resources is limited for those most vulnerable. For example, IEHs facing stigma experiences: resource-reducing discrimination when working to obtain employment or healthcare services, social isolation by avoiding being in situations where marginalization occurs , and lastly, coupled with the adverse effects of minority stress instances creates resource poor situations that increase one's susceptibility to poor health outcomes. Lastly, vulnerability as a fundamental cause of health disparities helps explain why the socially disadvantaged , and marginalized individuals systematically experience health disparities over time. In the face new knowledge , and innovations, their

disadvantaged marginalized position limits not only the availability of resources but the rapid uptake of new interventions strategies aimed at prevention or treatment (Mackenbach, 2012; Phelan et al., 2010; Rubin et al., 2014).

Theorizing Health Disparities

There have been numerous debates on how health disparities should be defined, with the general consensus that the definition should be inclusive of social conditions, particularly those that place individuals at a health disadvantage (Braveman, 2006). The agreed upon definition views disparities as differences in health or key influencers on health that can be shaped by policy; not focused solely on disease processes but the social determinants or conditions that influence health outcomes (Braveman 2006; Singer & Clair 2003).

The convergence , and multiplicity of vulnerabilities or social disadvantage develop in conditions caused by marginalization, resulting in the creation of social inequalities that lead to health disparities (Braveman 2009; Farmer et al., 2006; Mackenbach, 2012; Singer & Clair, 2003). A health disparity perspective aims to systematically identify , and understand disparities in health among more , and less disadvantaged social groups highlighting differences to differential vulnerability to disease incidence , and the consequences of disease (Braveman, 2009). Therefore, a research perspective that considers , and analyzes the multiple dimensions of marginalization , and their role in producing disparities is needed (Braveman, 2009).

The aforementioned theories call attention to the dynamic interrelationships between the social , and biological determinants of health, inclusive of vulnerabilities (Hankivsky & Christoffersen, 2008). Furthermore, it draws attention to the fragmented , and normative approaches used to study vulnerability, , and ultimately health disparity pathways. To uncover those often covert , and complex pathways to health disparities, an understanding of vulnerability as experienced in the lived context is crucial (Bowleg, 2012).

This research study will utilize an intersectionality approach to account for the complex social identities, categories or locations that shape IEHs experiences of health (Hankivsky & Christoffersen,

2008). This method of inquiry aims to elucidate , and interpret the multiple , and intersectional systems of oppression , and privilege among IEHs.

Implications for Research

Those experiencing homelessness are more likely to have more health issues, more unmet health needs, higher occurrences of excess morbidity , and mortality, have less control over manageable chronic health conditions, , and are three to four times more likely to die prematurely than their housed counterparts (Bharel et al., 2011; Henwood et al., 2015; Hodgetts et al., 2007; Weinstein et al., 2013).

The causes of these health disparities are deeply rooted in the social context surrounding everyday life, where the interplay of various identity factors determines one’s vulnerability. Vulnerability thus represents the multiplicity , and convergence of risk factors inherently tied to individual’s marginalized identities , and lived experiences. As such, vulnerabilities are social determinants of health. Therefore, in order to comprehensively understand the pathways leading to health disparities, a deeper understanding of the social context of vulnerability as a determinant of health is needed. A better understanding of these pathways guide the implementation of effective interventions aimed at the upstream determinants of health by informing policy initiatives , and national initiatives such as Healthy People 2020.

An intersectionality framework provides a method of inquiry that allows flexibility , and opportunity to discover what factors in the given context lend to vulnerability among IEHS. Guided by tenets that discourage approaching vulnerability based on pre-determined or pre-hierarchical factors, an intersectionality approach leaves room for other factors that may be obscured to materialize (Hankivsky, 2012; Hankivsky et al., 2010). The “de-centering” of commonly studied factors can lend insight to often obscure underlying causes of marginalization among IEHs to better explain how vulnerability manifests in the lived context.

Intersectionality since its inception has become a popular , and widely used method of research , and analysis. Albeit this, there are ongoing challenges on what constitutes intersectionality research or how to conduct intersectionality research. To date, most studies have focused on women’s health or the experiences of vulnerable populations , and lastly how the “trinity of race, class , and gender” as

Hankvisky (2012) terms it, impact health or certain experiences (Bowleg et al., 2013; Caiola et al., 2014; Griffith et al., 2011; Hankivsky & Christoffersen, 2008; Hankvisky et al., 2010; Hinze, Lin & Anderson, 2012). This study aims to expand the lens of intersectional inquiry, to explore how service providers perceive vulnerability among IEHs. This study will expand intersectionality research by utilizing digital storytelling to tell of how vulnerability manifests in the lived context, allowing insight into the interactions between service providers , and IEHs in the service context.

Service Providers Insight

IEHs spend their day , and time seeking material services be it food, clothing, shelter or health (Chard et al., 2009; Romeo, 2005). Time is spent walking to a given location, interacting with service providers , and avoiding criminalization , and public harassment (Meanwell, 2012; NHCHC, 2015; Thoits, 2010). Aside from sleeping , and ambulating, the time spent interacting with service providers is an area worth focusing on. The injustices experienced by this group happen in their everyday lives where interactions with the domiciled populations further influence this marginalization. Research well supports how these occur whether in attempting to live out their day in the public’s eye , and surviving the night. Studies also document the experiences of homelessness in accessing services from their immediate point of view. Insight from service providers (SPs) is lacking in regards to understanding how vulnerability manifests in IEHs lived context (Barnes et al., 20107; Hauff & Secor-Turner, 2014).

This study aims to look at SPs perspective of vulnerability among IEHs by understanding how these interactions take place in the service , and lived context. This insight can help further elucidate where , and how vulnerability manifests , and add to the existing body of knowledge about vulnerability. Specifically, by understanding how SPs perceive this population may bring to light those covert , and hidden occurrences of social adversities that may occur in their daily interactions with IEHs. Guided by an intersectionality framework, knowledge production will be guided by eliciting SPs descriptions , and viewpoints regarding IEHs experience with their primary identity of “being homeless” while allowing for other influential categories to be determined that lead to more occurrences of marginalization.

Capturing Vulnerability

The presence of social inequalities in society leads to the creation, and perpetuation of health disparities. Health disparities refer to a very specific subset of differences deemed worthy of special attention because of the social values, including ethical concepts of distributive justice, and core human rights principles that are foundational to public health (Braveman, 2006, p. 188). Health disparities are present, and continue to systematically put IEHs – an already disadvantaged, and vulnerable group at higher risk for poor health outcomes. Those experiencing homelessness are more likely to have more health issues, more unmet health needs, higher occurrences of excess morbidity, and mortality, have less control over manageable chronic health conditions, and are three to four times more likely to die prematurely than their housed counterparts (Bernstein et al., 2015; Bharel et al., 2011; Fazel et al., 2014; Henwood et al., 2015; Hodgetts et al., 2007; Weinstein et al., 2013).

The above literature review has discussed the presence, and impact of health disparities among IEHs, and how these negative outcomes are based on their experiences of marginalization. The end result of the marginalization process is the creation of vulnerable groups, who experience vulnerability. Vulnerability is an experience of plurality where the synergism of multiple marginalizing identities creates a unique vulnerable identity, such as that represented by IEHs. The disproportionate presence of health disparities among IEHs is therefore not a chance occurrence, but systematic, and a result of experiencing marginalization. In other words, the presence of health disparities among IEHs alludes to their experiencing vulnerability. As such, vulnerability is a determinant of health among IEHs.

To achieve health equity, those pathways leading to health disparities must be clearly identified. Therefore, for IEHs, how marginalization occurs in the lived context is crucial. Specifically, understanding how vulnerability is experienced in the everyday lived context. Though a logical approach, the challenges to truly capture this vulnerability, are many. Primarily, studies have to elucidate, and capture the innumerable, and exhaustive “opportunities” or experiences of marginalization among IEHs. To avoid pre-assumptions or generalization of what identities or marginalization are key, it is crucial to utilize an approach that allows for these overt, and covert occurrences of marginalization to be unearthed.

Furthermore, an approach giving those closest to the experience an opportunity to tell how the various identities of marginalization converge to create vulnerability in the lived context is crucial.

This study proposes to understand how vulnerability occurs or manifests in the lived context by allowing study participants the opportunity to tell their story. Through digital storytelling, this study proposes to understand service providers' perception of vulnerability as experienced by the homeless population, a well-known, and observed marginalized group. Study findings will expand the current body of literature by guiding the creation of empirically-driven typologies of vulnerability, and allowing those working with specific populations such as the homeless a way to accurately assess vulnerability, and create effective disparity interventions. This understanding will offer insight on how to best identify key constructs related to social vulnerabilities as determinants of health (Spiers, 2000). An immediate study outcome will be the sharing forum conducted at the conclusion of the study with participating service providers so as to inform current service planning, and provision methods.

CHAPTER III

METHODS

The homeless population experiences numerous vulnerabilities, such as having increased exposure to health risks, and high unmet service needs due to their marginalized status of homelessness (NHCHC, 2011). The causes of these health disparities are deeply rooted in the social context surrounding everyday life, where the interplay of various identity factors determines their vulnerability. Vulnerability represents the multiplicity, and convergence of risk factors inherently tied to individual's marginalized identities, and lived experiences. As such, vulnerabilities are social determinants of health, and how they manifest in the social context is crucial to understanding the pathways leading to health disparities. A better understanding of these pathways can guide the implementation of effective interventions aimed at the upstream determinants of health by informing policy initiatives, and national initiatives such as Healthy People 2020.

An understanding of health disparity pathways using concepts of vulnerability, and social disadvantage is crucial to expanding this research field. In the current epidemic of health disparities, being able to target those populations groups disproportionately affected is important. IEHs not only suffer from material deprivation or disadvantage, but experience disadvantages due to their social position, and identity. These psychosocial disadvantages created through interactions with the housed or economically privileged results in their experiencing marginalization through occurrences of discrimination, stigma, prejudice, and bias which results in social exclusions, and inequitable distribution of goods, and services (Hodgetts et al., 2007). In order to elucidate those opportunities for action in targeting health disparities, we must uncover those overt, and often covert pathways of inequality that occur in everyday life. In other words, identify how vulnerability manifests in the lived environment by gaining insight on how marginalization occurs in everyday life.

Research Questions

The purpose of this qualitative, exploratory study was to examine service providers' (SPs) perceptions of vulnerability as a determinant of health among the homeless population. The goal of this

study is to expand the current body of literature on where , and how vulnerability manifests in the lived context. Specifically, by understanding how SPs perceive IEHs can bring to light those covert , and hidden occurrences of social adversities that may occur in their daily interactions with IEHs , and lend to their experience of vulnerability.

The three research questions guiding this study were:

1. How do individuals experiencing homelessness perceive their vulnerability?
2. How do service providers define the vulnerability of individuals experiencing homelessness?
3. How do service providers perceive the vulnerability of individuals experiencing homelessness?

Research Design

A pesky requirement , and challenge exists for all researchers, both novice , and experts; making the difficult decision of choosing the most appropriate line of inquiry for obtaining desired results relevant to the objective , and scope of a research study (Starks, 2007). This challenge is further complicated by the numerous approaches included in both quantitative , and qualitative research paradigms. The decision for this research study was based on the desired research product; to understand a given phenomenon from those closest to it. As such, a qualitative line of inquiry will be utilized as this paradigm enables researchers to delve into questions of meaning (Starks, 2007).

Qualitative research is a form of social inquiry that focuses on the way people interpret , and make sense of their experiences , and world they live in (Holloway & Wheeler, 2002). It is an umbrella heading that covers various approaches that differ in the theoretical assumptions , and methodological focus (Flick, 2009; Holloway & Wheeler, 2002). The major assumptions included are ontology – the nature of reality , and existence along with epistemology- the theory of knowledge , and concerned with what is true knowledge guide this paradigm (Flick, 2009; Holloway & Wheeler, 2002; Ng, Lingard & Kennedy, 2014; Patton, 2015). Albeit the different assumptions, sampling procedures, data collection , and analyses the various approaches employ, they are all similar in the objective of inquiry , and the guiding philosophy.

Qualitative research , and the various approaches are guided by an interpretivist paradigm which seeks to understand the perspectives of group, individuals or cultures (Holloway & Wheeler, 2002). More

specifically, this type of social inquiry seeks to understand how individuals experience or perceive a given phenomenon. This inherent strength in qualitative research allows insight into a variety of perspectives about a given phenomenon; a perspective limited to not only the researchers of a phenomenon, but most importantly to those experiencing it, , and those working with the “experiencing individuals” (Flick, 2009; Holloway & Wheeler, 2002; Ng et al., 2014; Patton, 2015). Furthermore, qualitative research acknowledges the depth , and complexity of a given phenomenon by not reducing its occurrence to a single variable, but rather representing it entirety in the everyday context (Flick, 2009).

This research study used an exploratory lens of inquiry to explore SPs perceptions of vulnerability among individuals experiencing homelessness. The data collection methods used included participant observations, service provider interviews , and digital story telling. Participant observations provided an etic perspective of vulnerability, while the interviews , and digital storytelling provided an emic view. The use of these two perspectives enhances the credibility , and validity of study findings. The study was conducted using purposive , and snowball sampling of SPs working with IEHs in a North Texas city.

Rationale for Digital Storytelling

Digital storytelling (DST) is an innovative participatory research method that combines narratives, group work , and technology to facilitate the creation of a two to three minute compelling visual accounts of an individual or groups’ experience (Gubrium, 2009; Lai, Donnelly & Shin, 2014). The product produced as part of the DST process is an amalgamation of visual elements such as pictures or videos, text, music , and personal narratives which provides a way for individual’s to tell a story of particular personal significance. DST has been used as an education intervention tool with health professional students to increase diagnostic , and patient interaction efficacy , and as a component to disease management (Gubrium, 2009; Lai et al, 2014; Lenette, Cox & Brough, 2015).

As a research method, it allowed SPs to express, capture , and represent wholeness about vulnerability beyond facts , and figures , and what is immediately apparent (Gubrium, 2009; Lai et al, 2014; Lenette et al., 2015). DST has been used with various marginalized groups such as homeless women,

refugees, Native Americans , and Latino populations to document , and share their lived experiences (Gubrium, 2009; Lai et al, 2014; Lenette et al., 2015).

The DST process allows flexibility with adaptations made to fit the dynamics or needs of the participating individuals (Gubrium & Turner, 2009). As such, rather than the DST process occurring over the typical three to five day, three-phased workshop setting, this study's DST process took place in one meeting averaging 90 to 120 minutes (Gubrium, 2009; Gubrium & Turner, 2009; Lai et al, 2014; Lenette et al., 2015). This short duration took into consideration the busy schedules of SPs as well as having to be available for emergency crisis situations that commonly occurred with IEHs (Gubrium & Turner, 2009).

The digital stories created provide visible , and authentic narratives into the lived experiences of IEHs bringing insight to their living on the streets, living with a chronic illness, experiences of health , and human services , and many more (Lai et al., 2014; Njeru et al., 2015; Walsh, Rutherford & Kuzmak, 2009, 2010). In additions, DST provided a tangible , and easily disseminated product that can help raise awareness about individual or group experience , and barriers to health faced whilst promoting social change (Lai et al., 2014; Njeru et al., 2015; Walsh, Rutherford & Kuzmak, 2009, 2010). Therefore, as a research , and dissemination method, DST provided a novel way to understand how SPs perceived the lived experience of IEHs while providing rich descriptions , and knowledge that is authentic (Lai et al, 2014).

Researcher Reflexivity

As the researcher, I acknowledge the need to obtain an insider subjective perspective of vulnerability. This lends insight to my knowledge production in understanding how vulnerability is viewed by SPs , and hence manifests in the lived context. Since I have never experienced homelessness, my knowledge or assumptions about the phenomenon of homelessness , and vulnerability experienced is an “outsider” perspective.

My perceptions of homelessness were informed by prior interactions with this population , and existing public perceptions which could influence the data collection procedures , and research findings (Hankivsky, 2014). In addition, my own social position determined the interaction with IEHs , and SPs specifically as it could create instances of further marginalization. As such, it was important for me to

bring to light any explicit or implicit assumptions or stereotypes I had about IEHs , and accept that I was not the expert, but instead a mere student (Flick, 2009; Holloway & Wheeler, 2002; Ng et al., 2014; Patton, 2015)/ For this study, SPs working with individual experiencing homelessness became , and are the expert. This change in role gave voice to those who work closely with , and have a vested interest in this vulnerable population; it lends a unique , and audible voice to this vulnerable population (Flick, 2009; Holloway & Wheeler, 2002).

This reflexivity practice recognized that there are multiple truths , and diverse perspectives aside from mine. As such, I needed to give special attention to these perspectives as they may be excluded from the knowledge production around IEHs experience of vulnerability (Bowleg et al., 2013). In doing so, I realized that a research approach that reduced my voice while increasing study participants was necessary, hence the use of an emic method of inquiry to guide this study.

Protection of Human Subjects

The Institutional Review Board (IRB) at Texas Woman's University (TWU) granted permission to conduct the research (Appendix A - B). Since the study included interacting with a vulnerable population group , and those working with this group, confidentiality , and respect for all was important. Verbal , and written consent from the Director of Giving Hope was given to participate in street outreach services. Verbal consent was given to meeting leaders in the various public meeting that were attended. At the time of interviews, participants were given written consent.

During the data collection process, efforts were taken to maintain confidentiality , and respectability with study participants , and any IEHs present during participant observations. During participant observations, care was taken not to take notes during conversations , and interactions between SPs , and IEHs , and no identifying information was noted or written down in the field notes. To provide a safe environment for participants , and protect their confidentiality during interviews, care was taken to conduct these in as private an area as possible where only the participant , and PI were present.

Setting and Study Population

Setting

The study setting for this study was a city in North Texas , and utilized three data collection procedures: participant observations, SP interviews , and DST. The participant observations provided an opportunity to observe interactions between service providers , and IEHs during street outreach services , and publicly held events such as coalition , and group meetings. The service provider interviews were with SPs working in various local agencies that provides services to IEHs.

Study Population

The target population for this study was SPs working with individuals experiencing homelessness in North Texas. The definition of homelessness used was lacking a safe, stable , and appropriate place to sleep or live (NAEH, n.d.; Nickash & Marnocha, 2009). To ensure responsiveness to context , and safety for all involved, the study , and recruitment activities were guided by ongoing dialogue with agency staff. This precautionary step assured that research was conducted in manner cognizant of the highly specific , and transient target population , and sensitive to the situation , and needs of participants involved (Hodgetts et al., 2007).

Purposive , and snowball sampling was used to recruit service providers for the interview , and digital storytelling component. This assured that the target population was varied , and inclusive of various agencies , and job descriptions with care taken to prevent the over or underrepresentation of certain job descriptions. Information about the research study was disseminated via email to local SPs working in various Denton County agencies that work with IEHs. The SPs contact information was obtained through publicly available contact information data of the various service providers. Information disseminated for recruitment included a recruitment email narrative , and flyer that discussed the study, inclusion criteria , and the Principal Investigator's (PI) contact information (Appendix C –D). Inclusion criteria for the study was SPs who work in agencies that:

1. Provide services to individuals self-identifying as experiencing homelessness – a criterion indicative of the vulnerable social groups' housing , and socioeconomic or class status will be individuals experiencing homelessness
2. Provide services to individuals self-identifying with at least two other marginalizing social categories on the basis of race/ethnicity, gender, sexual orientation, income status, religion, disease or disability status, social identities, associations, experiences , and environments (Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Vasas, 2005; Williams et al., 2012)
3. Provide services to individuals socially excluded , and in turn have increased relative risk or susceptibility to adverse health outcomes hence vulnerable (Pellowski et al., 2013; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Vasas, 2005;)

Interested participants were prompted to contact the PI via email to arrange the initial first meeting. During this first meeting, consent was obtained for each participant , and interviews took place at the participants' location of choice (Appendix E). The interview settings included participants' offices , and a public coffee shop that provided private meeting rooms. Additional participants were also recruited using snowball sampling of initial contacts , and interview participants with a prompt included in the recruitment narrative for them to share study information with other potential service providers.

The sample size for this study included seven participants , and was determined during the interview data collection process. The PI concluded data collection once data saturation was reached , and no new or relevant information emerged from the interviews. The small sample size was acceptable since this was a qualitative study where the breadth , and richness of information gathered adequately contributes to the evidence while offering a variety of experiences , and ideas (Baker & Edwards, 2012; Palibroda, Krieg, Murdock & Havelock, 2009; Ritchie, Lewins, Nicholls & Ormston, 2003; Wang, 1999). Furthermore, in remaining true to the digital storytelling process where close collaboration between the researcher , and participant is needed limited the number of study participants so as to assure adequate time is spent with each participant (Gubrium & Turner, 2009).

The seven service providers worked in five different agencies across Denton County that primarily serve IEHs as well as those at high risk for homelessness such as the very poor , and unemployed county residents. Demographic data is provided in appendix F. Six of the providers worked in the same city limits where the majority of the agencies serving the homeless tend to be located. This particular service provider's agency serves all of Denton County, the agency is based in a different area due to space , and support availability. Two of the service providers worked in the same agency, though in different roles , and with different educational backgrounds. Job descriptions for the sample group ranged from Executive Director to program coordinator or resource navigator. In regards to educational or licensing credentials, three were social workers, one licensed professional counselor, one registered nurse , and two had educational , and leadership experience that enabled them to work in their respective job. The agencies represented provided services ranging from food, hygiene provision, housing connections, physical , and mental health services as well as resource connections.

For the ethnographic component, six observations sites were utilized ranging from public locations such as libraries , and community wide fairs to agency based outreach services. All six sites were in Denton County though one was in a different city limit. Four of the observation sites were centered around activities or services that IEHs attend or access on a daily or weekly basis. The other two observation sites , and times were unique in that, they were special events that occur on a monthly or annual basis.

Methodology

Data Collection, and Instrumentation

The study included three data collection procedures, each utilizing various research procedures. This study's data collection method involved ethnographic fieldwork inclusive of participant observations, service provider interviews , and digital storytelling. Participant observations provided the PI an opportunity to observe individuals in naturally occurring settings while allowing for cultivation of trust between the researcher , and target population. Participant observations rely heavily on the researchers' observation , and understanding of people , and their behavior (Naidoo, 2012).

Procedures

Participant observations. Naturally occurring data are crucial to understanding the lived experience of participants. Participant observations provided insight on how participants behave in their natural settings, make meaning of their experiences, and how they embody this meaning (Starks, 2007). Observations offered the researcher an opportunity to observe the phenomena under study in the everyday context of those experiencing it (Ritchie et al., 2003). These observations though etic in nature, provided insight into how IEHs perceive their vulnerability. More specifically, it afforded the PI the opportunity to both observe, and interact with participants in naturally occurring settings, thus providing an enactment of their everyday lives (Parsell, 2000; Hodgetts et al., 2007; Naidoo, 2012).

The PI used locally appropriate roles such as volunteering in outreach service locations where those experiencing homelessness typically receive material support such as food, on-site medical services, and service referrals. This assured disruptions of the cultural context were minimized while allowing the PI to blend into the cultural background, and become directly involved with the study setting (Carr, 1996; Hill, 2002; Parsell, 2000). Furthermore, this gave the PI additional insight into the relationship between service providers, and individuals experiencing homelessness. Observations also took place in multiple public settings such as grocery stores, local neighborhood parks, libraries, and city streets where IEHs assemble or frequently visit (Giving Hope Inc., n.d.; Hodgetts et al., 2007; Olivet, Bassuk, Elstad, Kenney & Jassil, 2010; Our Daily Bread, n.d; Parsell, 2000). This observation component provided opportunity for the researcher to cultivate trust with agency staff, and IEHs; a crucial, and necessary step. The data collected during the participant observations included field notes, and recordings of the PI describing, and documenting the location, activities taking place, noted interactions between IEHs, service providers, and the domiciled community. To assure that the same information was collected in each observation site, the PI used an observation log template during each observation session (Appendix G).

Service provider interviews and digital storytelling component. The second data collection component included two data collection procedures: service provider interviews, and DST. This data collection component took place in three separate meetings; the first two meeting occurred between the PI,

and individual SPs while the third meeting was in a group setting. The group setting was an information sharing session where preliminary study results were shared with study participants, and local, and state representatives who work with IEHs. To minimize attrition during the research process, and offer structure upfront, the first two meetings between the PI, and SPs were discussed, and agreed upon from the start of the study. The PI, and participants at the end of each meeting determined subsequent meeting times, and location.

Service Provider interviews. The semi-structured interviews occurred during the first meeting between the PI, and SPs following the consent process. The PI first introduced, and discussed the research study, and obtained informed consent. Following this, the semi-structured interviews were then conducted. These interviews were guided by a predetermined set of open-ended questions to gain insight on providers understanding, and perception of the vulnerability, characteristics, and lived experience of individuals experiencing homelessness (Appendix H). This increased the comprehensiveness of data collected while making data collection systematic for each service provider (Patton, 2015, pp. 438).

Although guided, SPs were free to add or pursue additional relevant topics as they arose allowing the PI opportunity to obtain deeper insight on a given topic as needed about their perceptions of the target population (Ng et al., 2014; Ritchie et al., 2003). At the conclusion, the PI wrote a summative write up or “memoing” noting any major themes that came up during the interview (Creswell, 2014; De Santis & DeLeon, 2013). Data collection for these interviews was concluded once data saturation was reached, in that no new or relevant information emerged from the interviews (De Santis & Barroso, 2011).

Digital Storytelling. Following the interview, the researcher gave an overview of DST which included the seven DST elements, and items used to facilitate the storytelling. The seven DST elements represent the basic ingredients of a multimedia story, and are to be considered when writing a narrative, and include: point of view, dramatic question, emotional content, voice, music, economy, and pacing (Gubrium, 2009). Example items typically used to facilitate the storytelling includes photographs, a personal narrative, and music. Pictures can be stock photos from the internet, ones they already have or if desired, can take pictures with the provided disposable cameras. After explaining the DST process, a story

prompt was given to SPs to guide them in writing a short script about their experiences in interacting , and working with individuals experiencing homelessness.

This account of experience included descriptions of lived-through moments, remembered stories of particular experience , and narrative fragments (Patton, 2015). Capturing these narrated descriptions allows the phenomenon of vulnerability to be described in as concrete , and lived-through terms as possible (Patton, 2015). To help tell this story, they were prompted to find existing pictures or take new pictures to accompany the script. The purpose of this DST story prompt was to evoke a comprehensive account of the person's interactional experience , and perception of vulnerability among individuals experiencing homelessness (Patton, 2015).

To avoid offering causal explanations or interpretive generalization of vulnerability, an operational definition of vulnerability was not given to the study participants so meaning elicited was based on their perspectives (Catalani & Minkler, 2010; Patton, 2015). Therefore the story prompt given did not provide them with a certain topic to write about hence promoting autonomy , and agency on all aspects of the DST process (Gubrium & Turner 2009). What SPs chose to share , and how they ordered their DST element represented an active portrayal of how they position themselves in the context of that experience or narrative (Gubrium & Turner, 2009). Lastly, the decision on what they choose to share allows insight into what they deem important or pressing in regards to their lived experience as an individual experiencing homelessness, hence a crucial factor in their vulnerability.

Each participant was given a notecard as a visual of how long the story prompt needed to be. This notecard also served as a “prompt” to start writing down the story. SPs were not given any directions on how to take pictures, since how people take pictures is a rich source of data on the cultural , and social constructions represented by the individual. Further instructions were provided to avoid photographing individual's faces to avoid risk of loss of confidentiality , and anonymity for any individuals that may be photographed. SPs were given up to 48 hours from the first meeting to write their narratives , and take or find pictures. They had the option of sending their narratives , and pictures via email or saving these electronically for the second scheduled meeting. All SPs opted to email their narratives , and pictures prior

to the second meeting. Due to scheduling constraints , and emergency crisis that occurred, the second meetings were typically done one to two weeks following the first meeting.

The DST making process occurred during the second meeting. The PI had on hand the SPs narratives , and pictures. To start, participants first read through , and finalized their narratives. After a few practice readings, the SPs were recorded reading their as a voice-overs (voice recording); these were used as the audio portion of the DST (Gubrium, 2009; Gubrium & Turner, 2009). All components of the DST were now available to be compiled into a digital story. To guide the actual synthesis portion of the DST, the PI adapted a power point storyboard template (Appendix I) that each SP used to lay out their pictures , and corresponding narratives on the PI's laptop (University of Houston, n.d.). This storyboard served as a visual layout or menu , and that helped participants align the oral element of their stories (voice over scripts) with their visual (their photos) elements (Gubrium, 2009; Gubrium & Turner, 2009). This step allowed them to not only decide on the order of their DST but to think holistically about putting their stories together (Gubrium, 2009).

The finalized storyboards were then used as an elicitation device in a similar method to the Photovoice root-cause questioning SHOWed method where each participant describes the meanings they ascribed to each photograph used (Catalani & Minkler, 2010; Cooper & Yarbrough, 2010; Hermanns, Greer & Cooper, 2015; Sanon et al., 2014; Wang, 1999). The storyboards were useful , and aided SPs in reflecting on their pictures , and stories as they answered the DST reflection questions (Gubrium & Turner 2009). Similar to the initial interviews, these DST interviews were guided by a predetermined set of open-ended questions to gain insight on the participants' choice in story topic, their choice of visual materials used to represent the topic , and the sociocultural context of the story (Appendix J). Although guided, SPs were free to add or pursue additional relevant topics as they arose allowing the PI opportunity to obtain deeper insight into the DSTs (Ng et al., 2014; Ritchie et al., 2003). At the conclusion of each interview, the PI wrote a summative write up or "memoing" noting any major themes that came up during the interviews (Creswell, 2014; De Santis & Deleon, 2013).

The third meeting with SPs occurred at the conclusion of the data collection process. The primary goal of this meeting was to disseminate study findings to anyone working with IEHs. Through interactions with some of the study participants, an opportunity to present study findings at the *Denton County Homelessness Summit* was presented. Attendees included participating study participants, as well as local, and state agency representatives who work with or have a vested interest in tackling the occurrence, and impact of homelessness. Preliminary findings from the study were shared during this session with the most impactful portion being sharing the finalized digital stories with attendees. This presentation provided a creative method of member checking preliminary findings as attendees were able to confirm, and relate with the study findings.

This meeting was crucial in providing SPs pertinent insight on study findings, and most importantly how these results can inform their current practices, and policies to guide service planning, and provision. In addition, the digital stories presented provided an emotional perspective that they could all relate to, and were able to use in raising awareness of the barriers IEHs face in everyday life. The findings, and presentation material was made available to the event organizers to disseminate to all summit attendees, and use in their respective agencies.

Data Analysis

The aim of qualitative analytic methods is interpretive analysis, an iterative, inductive process of decontextualization, and recontextualization (Starks, 2007). Decontextualization entails the separation of data from the original context of individual cases, and assigning of codes to units of meaning within the text (Starks, 2007). Recontextualizing involves an examination of the codes for patterns followed by reintegration, organization, and reduction of data around central themes, and relationships drawn across all cases, and narratives (Starks, 2007).

Decontextualization Process

Demographic data collected on SPs were compiled using Microsoft Excel. To establish credibility, and conformability, all interviews were audiotaped, and transcribed verbatim. Written field notes, and audiotaped fieldwork thoughts were also transcribed verbatim. Following transcription, the PI read through

all interviews , and field notes on paper, making notes on thoughts about the readings that came up in the margins. The next part of the process was “bracketing”, organizing the data into manageable chunks , and optimally aggregating the data into themes. (Creswell, 2014). This was done through the use of codes, defined as a word or short phrase that assigns a summative, salient attribute to chunks of data (Creswell, 2014).

Following the first read through, data was then imported into nVivo, a qualitative data analysis software package where the PI read through one interview , and field note log to create general codes. (Bowleg et al., 2013). These initial “deductive” codes were generated from the literature , and semi-structure interview questions. Deductive codes included labels such as “causes of homelessness”, “characteristic of IEHs” , and “determinants of health” codes. These codes represented generalized nodes that were later organized , and arranged with additional sub-theme codes. During this code generating process, the PI also conducted data exploration in nVivo using queries, text search so as to get an idea of what participants were saying in the data , and help with creating relevant codes.

Once deductive codes were established, the PI then read through the remaining data sets , and coded these separately in nVivo using standard content analysis, a method to identify themes , and commonalities contained in the textual data along with narrative analysis of the DST (Catalani & Minkler, 2010; Cooper & Yarbrough, 2010; Hermanns et al., 2015; Mamary, McCright & Roe, 2007; Sanon et al., 2014; Wang, 1999). During this coding process new codes were generated inductively , and based on the data that did not fit into any of the deductive codes. This inductive coding process allows for new insights to emerge from the data.

Recontextualization Process

To help generate , and solidify themes based on the patterns , and commonalities in the coded data, the PI conducted another round of data exploration by performing coding queries to see how the themes were interrelated. This process helped check , and test those initial themes the PI had in mind so as to organize , and reduce the data into four to seven central themes , and relationships. The memoing notes taken during the coding process helped keep track of the PI’s thoughts , and ultimately help visualize the

central themes in the data. Since content analysis was used, the initial process entailed looking carefully at the coded data to identify commonalities within , and across the data. As a result of this process, the analysis process concluded with a set of four overarching themes (Appendix K).

Once all data was coded, comparative analysis was done for the semi-structured interviews , and DST narratives , and reflection interviews so as to note the comparisons , and differences between the two data sets. More specifically, the objective was to determine whether what the SPs said in their interviews matched what they said in their DSTs.

Issues of Trustworthiness

To establish rigor , and minimize researcher bias, reflexivity , and member checking was used. The reflexivity process entailed the PI clarifying any bias or assumptions regarding IEHs , and the target population that could influence study results (De Santis & Barroso, 2011; Hankivsky, 2014). Member checking occurred during the third meeting with SPs where preliminary study findings , and digital stories were shared. This process of member checking also helped demonstrate trustworthiness of analysis since SPs were not involved in the data analysis process.

In addition, transferability , and confirmability aided in demonstrating study trustworthiness (Bowleg et al., 2013; De Santis & Barroso, 2011). Transferability was achieved by providing sufficient description to help readers assess whether study findings can be transferred beyond the study sample. In addition, the PI reported the guiding questions used as well as the semi-structured questions used , and provides a detailed information about the study participant , and ethnography observation sites. Lastly, confirmability was achieved through the provision of detailed descriptions about the study's research design inclusive of the recruitment, data collection , and analysis methods (Bowleg et al., 2013). This detailed methodology enactment enables others to determine whether the PIs' interpretations are grounded in the data

Lastly, to increase the depth of understanding while adding to the coherence , and validity of this study, triangulation was used. Triangulation is a process in which researchers use multiple sources to understand a phenomena (Creswell, 2014). It is frequently used in qualitative studies to check , and

establish validity of studies by analyzing a research question from multiple perspectives. One method of triangulation that was utilized in this study was triangulation of sources (Cohen & Crabtree, 2006). This involved looking at multiple sources of data using the same method to determine consistency. This will be data collected at different times , and in different settings. Doing so increases the representation , and legitimation of data findings allowing for a deeper understanding of the phenomenon under study (Leech & Onwuegbuzie, 2007). In addition to source data, conducting a second analysis of the coded data to compare the SPs initial interviews , and DST reflections interviews presented another triangulation method. This helped the PI to analyze data from more than one vantage point which increases the trustworthiness of data findings (Leech & Onwuegbuzie, 2007).

CHAPTER IV

RESULTS

The purpose of this qualitative, exploratory study was to examine service providers' (SPs) perceptions of vulnerability as a determinant of health among the homeless population. This study utilized participant observations, semi-structured interviews, and digital storytelling to understand vulnerability as present in individuals experiencing homelessness's lived experience. The participant observations provided an etic approach into how IEHs perceive their vulnerability. The interviews, and DSTs provided insight into how SPs perceive the vulnerability of IEHs. This emic approach allowed for an understanding of those nuanced differences related to how the phenomenon of vulnerability manifests, and is perceived. This section will discuss the major themes from the data findings. The section is organized by major themes first, and underlying subthemes, and then verbatim quotes from the participants of the study supporting the themes.

Three overarching themes emerged from the data with the unique feature among them being this idea that both IEHs, and SPs found themselves "navigating" through each day where limited time, and resources shaped the lived, and work experience for IEHs, and SPs respectively. Each interview began with basic introductory questions followed by questions aimed at understanding the typical day for both service providers, and IEHs. The participants all responded in a similar manner, laughing as they said "there is no typical day," "what is typical" or "there isn't a typical day, I mean each individual is very different, and they all present with their unique problems." These atypical day descriptors called attention from the beginning on the importance, and influence of time in the "everyday setting" for both service providers, and IEHs, and how their relationships with 'time' differed. The three themes are therefore centered on this idea "navigating" every day. These include: navigating the meaning of time, navigating the system, and navigating change. Each theme has corresponding subthemes that shed light on how IEHs, and SPs differ in their navigational experiences. The themes, and corresponding subthemes are listed in Table 1 below.

Table 1

Theme and Subthemes

Theme 1: Navigating the meaning of time
1. Meaning of time for IEHs
a) Living homeless means many things
b) Living on borrowed time
2. Meaning of time for SPs
a) Time produces trust
b) Time determines success

Theme 2: Navigating the system
1. The Navigation Process
2. The system weakens you
a) Frustrated , and can't go on
b) Frustrated , and unable

Theme 3: Navigating Change
1. How you live changes
2. How you work changes
a) Changed perceptions
b) Changed approaches , and interventions
c) We are all one paycheck away

Throughout the interviews , and discussions, this idea that time was a determinant that shaped the everyday of IEHs , and SPs became very evident, specifically in how SPs described their daily interactions with the population they served. In their descriptions, they mentioned or alluded to the norm of an “atypical” work day. The lack of a typical day though does not mean there is no “pattern” to their day, but brings to light the uniqueness of IEHs , and the very different situations they find themselves in from day to

day. In other words, the “everyday” lived context or reality of IEHs is always changing to the point it impacts the everyday work context of service providers. One participant portrays this idea of atypical yet typical day very well when she says,

I really don't have a typical day (chuckles) just because every day I have a new client with a new situation , and that can look very different. But my typical day is not typical, it's just always kind of go with the flow, , and be flexible , and meeting people where they are.

The following section discusses each major theme , and subtheme using verbatim quotes from the study participants , and ethnographic field notes to support each them.

Theme One: Navigating the Meaning of Time

The Meaning of Time for IEHs

The first subtheme discusses how time is a determinant in the lived experiences of IEHs. This calls to attention the impact experiencing homelessness has over time, how living homeless can mean many things for both SPs , and IEHs, , and lastly, how “everyday living” is done on borrowed time. This theme of “living on time” for IEHs came about discussions or questions looking at factors that lead to homelessness, specifically those that precipitate chronic homelessness , and what the typical day of a homeless individual looks like.

As mentioned earlier on, there is no typical day for IEHs as every day brings new crisis, new problems or challenges all centered on surviving. One participant describes this very well.

And here's the thing about homelessness too, their needs change every single day. It's not like “okay, I'm going to give you this, and this is what we're gonna give you here on out.” It's a daily thing, that they need something completely different. You know today they may need this, tomorrow they may need something else , and we've got to learn to you know understand that you know where they are , and adapt.

As such, time or the normal “day” is nonexistent for IEHs , and is very different from what the domiciled population as one participant discusses below.

Well I think that the day is not really even in existence, because normally at night we think it's time to wind down , and go to sleep. At night time if you don't have a stable place to sleep, you really, you may have to sleep during the day because you are less visible from being stopped or being harassed.

Living Homeless Means Many Things

Living in the right now. This "living in survival mode" means that all efforts go towards surviving the day, creating a routine , and living in the moment. As such, IEHs typically do not plan for the next day or have time to focus on other things outside of "staying alive," and living in the "right now" as described below.

They're not thinking what about tomorrow. Every time they are out panhandling, if they make \$2 they're going to go get them something to drink, [and not] saving that \$2 you know. Everything is you know "I got money now, this is what I'm gonna go with it." There's no saving, it's like "I've gotta live right now."

Another participant brings up this "focus on survival" when talking through her thoughts on why she does not think IEHs are not capable of thinking of their vulnerability. This inability to not "step away," and be introspective is due to all focus , and effort on simply surviving

When you're in a traumatic, like a domestic violence kind of situation, you're just, all you're focusing on is getting through this next moment , and this next day. You're not really even able to pan out , and get the bigger picture of what is going on with your health , and your mind. It's just, I can't, I can't even think about whether I'm vulnerable or not. I just have to figure out how I'm going to get to the next, the bus stop so I don't miss signing in at the shelter , and not getting a cot.

A part of surviving also includes learning to have a routine. Having a routine seems to lend more stability as was noted in the ethnography field notes.

Most clients that came in at the beginning (early) were more conversant , and willing to fill out surveys than those that came in later. They seemed to "know" or "have" a routine about when to

be at the library, how long to stay , and when to head out in time to arrive at the next agency that serves lunch.

One participant describes two clients who differ based on having a routine that provides a sense of stability for them. The first client does not have a set routine yet which lends to his feeling instability or insecure.

I asked him, "where do you park your car at night?" , and he goes "well it varies," he said "you have to move around because if people know that you're there then they start trying to break into your car," and but he during that assessment, he fell apart with us. Just tears, just bucket of tears , and it was the stress. He said "you having to take care of yourself."

I asked him, "what do you do during the day?" And he said "well sometimes I go to the library, sometimes I'll go to a restaurant, like a fast food restaurant, but that's only if the manager is okay with me being in there." Coz they just go , and sit , and try to regroup a bit. He said that he'll get his services through one of the shelters so he can go take a shower, get a hot meal, get some clean clothes but then once he leaves there, then he has to figure out what he's going to do for the rest of the day , and not get in trouble with the police for loitering.

The second client had been homeless a while longer , and had a routine set out as to where , and how she spent her day.

We have another one off of the list that also lives out of her [car] but she seems to be a little bit, well she's a little bit more stable, so she's a lot more resilient. She's able to, she has kind of her routine of what she does. She goes , and gets a meal, spend some time at the library doing some things, looking for jobs, those kinds of things or whatever it is that she's focused on in any given time. , and then she settles down for the night in her car.

The notable difference between the two clients is one has to figure out what do while the other one knows what she will do on a given day. This routine, though likely to change, lends some stability , and feelings of resiliency for IEHs which in turn helps mentally alleviate some of the stress that comes with coping on the street.

Living in hiding. As SPs described this survival , and acculturation process, it becomes evident that part of this entails staying “out of sight,” and “on the move.” Staying out of sight or “hidden” was a commonly re-occurring part of IEHs daily lives. This part of their day is spent when not accessing or seeking services such as food, healthcare, resource connections or support from SPs. The “hiding” alludes to the negative interactions IEHs have with the community at large , and law enforcement workers. As noted in the ethnographic entries, police seem to know where IEHs live out their day, particularly public places such as the library as described in the field note entries below.

Police car drove by site twice. Social worker very angry about that stating “I can’t stand that, they always come looking for people.” Police know where IEHs congregate , and seem to “patrol” those areas more frequently. Clients , and providers are aware , and get very frustrated when they see them as they are patrolling for “loitering.”

One SP shares an occurrence told to her by one of her clients that had just gotten into housing , and was therefore not “homeless” though still looked like he was , and experienced that stigma.

He told me “I wasn’t going to buy anything, I didn’t have any money” but he was just resting a little bit, taking a drink of water, and he said “one of the store owners came out saying “shoo, shoo, you need to get out from in front of my store,” and he was like “I’m just look...” But the way he told it to me, he became very tearful , and said “I was just stopping to take a break , and take a drink , and look at the window.”

So, rather than be out in public , and under the constant watch of police , and the community at large, they chose to hide away. One participant describes a conversation with a community member about not knowing there were homeless people in Denton.

They are not what you expect, you don’t see the tents on the streets, you don’t see them coz it’s illegal. They don’t sleep on the streets, so they are out in the woods. You don’t see those people, so she had no clue.

Another discusses how they have learned to stay hidden. He goes on to discuss why IEHs are not forthcoming with information about where they live to SPs or others alluding again to the fear they live with of “being found out”

And I mean, even the way they are out there , and they look, I mean, here’s one thing that I can say to them, of their achievement; they are out there , and nobody knows it you know. So they are learning how to basically be still to where you know, because they know if they get discovered, you know they lose their place. If the police find out where they are, they kinda run them off.

This fear of being found pushes them to live in “places not meant for human habitation,” to “just corners of places.” Sleeping in such areas puts them at risk for death as described by another participant in her digital story narrative.

Despite this I regularly would fear that one of my clients would freeze, suffer from a heat stroke, or be trapped in flooding waters in the spillways clients often utilize to be less visible.

As discussed earlier, the “hobo highway” though dangerous is a safe place as it is underground , and IEHs don’t have to be running from police or others who might be “judging them or stigmatizing them.” When SPs described IEHs interactions with the community at large, there was a negative, stigmatizing , and judgmental tone. This becomes more palpable when life-threatening , and isolation efforts as outlined above are taken, so as to hide away , and avoid being with the community at large.

Living in motion. IEHs not only have to stay hidden but have to stay moving in order to stay alive , and safe. This part of their everyday living lends insight into their interactions with other IEHs; their peers. They can only trust their peers to a certain point because the “doing whatever it takes to survive” puts them in danger of being robbed, raped or killed in their sleep. One participant describes this close but guarded relationship below.

They are supportive to each other of course as peers, but there’s just so much, there’s just so much drama , and stress on the streets, that, , and they can’t trust people. You know, I’ve heard people

over , and over talk about their belongings being stolen countless times , and they just can't trust the people even they might hang out with , and spend a lot of time with.

Another participant describes some of the dangers IEHs experience living on the streets , and with their peers. Of interest is how those that can bring you harm are also the ones that can offer them protection.

I have had clients that have been sexually assaulted while they were living on the streets. They have been one of the population in terms of being in fear of reporting crime or doing anything because of the fact that they rely on the streets to protect them , and support them , and you know there is always the risk that if they make a report or if they try to do something that, that it could end up working against them within their own communities that they have developed.

So in order to keep depending on the streets , and maintain peace with those living on the streets, crime is rarely reported because that can create more problems for them. Another participant discusses these conflicting standards of living on the streets where belonging means protection but also harm since those you are living with are also “living in survival mode.”

I went , and found a group , and they told me, they said “when you're sleeping, you know always make sure you're with a group because someone will come , and steal your shoes off your feet while you're asleep.” So they, they kinda get together , and they take turns watching out all night long.

Living on borrowed time. The living that IEHs do on the streets , and in their interactions with peers, SPs , and the community at large is lived on borrowed time. This “borrowed time” raises issues when they are seeking services , and interacting with SPs. For IEHs, time is based or determined by agency service times , and determines whether clients are “welcome,” and “wanted.” During discussions with SPs, they all mention the idea that IEHs have to “manage time well” as this determines whether they will get a certain service, eat or get a spot at the shelter on a given night. As noted in the following ethnographic field note,

Time is outside individual control , and determined by agencies. Individuals are at the “mercy” of this time restrictions , and cannot arrive too early or too late. Being in an area is restricted by the agency. If agency is closed, their being there is seen as “loitering.”

One client attending an outreach service states “X [agency] doesn’t like us around when they are closed , and it’s raining, but we come over , and sleep under the awning , and leave before they get here.” The time restrictions that IEHs live by at times create barriers where clients are not willing to talk with staff when lunch is being served.

One participant describes how restricted , and controlled time in when accessing services. She goes on to discuss how IEHs have to navigate the various agencies time restrictions; welcome at certain times , and loitering at other times.

Having to get your medications if you have medications, you have a certain window of time that you’re supposed to get that, but yet you’re supposed to be getting your shower in , and getting your food , and getting out the door by 7 in the morning or whatever it is. Waiting in line, which you can’t be on property until a certain time, or you’re gonna get shooed away you know.... Even the shelter where you’re accepted to come, you can’t loiter there at certain times.

Another participant discusses how living on borrowed time impacts IEHs.

There isn’t really a time that you can recharge, , and a lot, , and then all the services that you are supposed to access heaven forbid you have a job you’re not going to be able to access them during business hours. Umm but if you don’t have a job just getting from place to place , and knowing what time they are open, it may take multiple visits to get the services, um, it’s just really wake up , and survive.

Living homeless means a life of working to survive day after day not only in seeking services , and resources, but in interacting with others.

The Meaning of Time for SPs

The aim of SPs working with IEHs is to meet the needs of this population. Their work is to improve the lives of those living on the streets with the optimal goal of ending homelessness in Denton

County. For SPs to be effective in meeting the needs their clients, a relationship with IEHs is crucial. Being successful in helping clients through crisis depended on when SPs found out about an issue , and lastly, time spent with this population led to changed perceptions among providers regarding IEHs.

Time Produces Trust

For SPs, time was very crucial in that it determined the presence , and strength of trust between them , and IEHs. Trust is very important to IEHs as described by one participant that “trust is everything with them.” Not having trust means not having a relationship which is equally as important as this participant continued on saying “you have to have that relationship uh , and it, I mean it took me a while uh, for them to get to that point where they could trust you know. They, and they knew I was there to help them.”

SPs working with IEHs work in agencies that are there to provide services, support , and resources to IEHs, yet a determinant of whether they get the chance to do their work is contingent on time, trust , and relationships. As one participant said “if they are in crisis, they tend to come. Uh, early on it’s harder so if there is a crisis, we won’t find out till later.” Trust determines the willingness of IEHs to seek out help from SPs , and their willingness to work with SPs towards a certain task. In addition, trust assures that interventions taking place are focused, effective , and adaptive towards meeting the specific needs of the client. Therefore, this idea of SPs “working with time” so as to get the opportunity to assist IEHs puts cultivating relationships , and trust at the forefront of every interaction between the two group as described below.

That’s the biggest biggest hurdle that takes us about four to five interventions on average with each individual to engage them , and have them learn to trust us. Because they have had so many experiences, at least that’s what they tell us, where they’ve invested uh, only to be disappointed in the end , and so they their defense mechanism now is to be very distant especially with the health care providers or social services, because they’ve been let down so often.

In addition to cultivating trust is working to undo the mistrust from previous experiences as that can become a barrier in providing services or support. This is because individuals may not be forthcoming

with information due to being disappointed in the past , and learning to survive alone. Two different participants describe this mistrust , and importance of trust below.

And if you don't ask that, and take the time to develop a relationship with the individual, they are not going to tell you those intimate or small things not because necessarily they don't want, but sometimes they don't think about it. Their mind is not set in that moment with respect to that. , and so it takes a lot of time , and energy...

I think that is one of the hardest things in dealing with this population. Consistency you know, um eventually if they learn over a period of time that you're safe. Um, but safe means really really really really really really safe. Um then they may begin to tell you where they're scared or what they can't do.

The impact of mistrust is also present among homeless youth , and may be even more damaging as learning early on to survive this way can prevent them from reaching out to available services in the school system where they spend most of their day.

This is a very tricky population to work with because once they've been on the streets , and they've lived with these family situations where you can't talk it is incredibly hard to get information from these kids. Even when they think they're being honest with you, you get very short snippets of what's really going on. Um, and so that survival technique it takes a while to really work with them , and build some trust. Um, for them to be willing to take anybody else's advice , and not think they just have to handle it on their own, so therefore it keeps them from learning a lot , and they have a really hard time asking for help.

Overtime as interactions between SPs , and IEHs continue steadily , and positively, trust is cultivated. This results in a willingness among IEHs to share who they are, which provides SPs opportunities to support them as an individual. These formed relationship also provide SPs an opportunity to know what questions to ask that provide better insight into their experiences , and needs on any given day.

And so since the majority of our folks do have a mental health diagnosis, we also work really closely with our nursing staff , and with our clients to make sure... we can't force them to take their medications but we do a lot of "are you taking your meds, how's that going" (chuckles) or we start seeing behaviors or hearing things that like...you start questioning "are you on your meds?" (Chuckles), and we can do that. As from an intensive case management standpoint, I can ask somebody, how's your meds going?

Lastly, given that the homeless are transient , and more likely to lose touch with SPs, having that trust helps with the continuity of services to where IEHs do not fall through the cracks. As one participant describes, some of the services needed take a while to accomplish.

There's practical things that we are always doing. I mean I'm always assessing for do they have hearing , and vision, , and IDs , and health insurance , and some of those practical things. But that is secondary to the relationship because if we don't have a relationship then they're not gonna continue to come back to where we can follow through on some of those things that are not gonna happen in a onetime meeting (chuckles). It's going to take multiple meetings to get that ID , and we wanna make sure that they feel like they can trust us , and that we are here to help.

By knowing that SPs are there to help, IEHs are more willing to "partner up" with SPs as another participant discusses below.

They don't care how much you know until they know how much you care. , and if they really know you care about them, they're are willing to do whatever you ask them to do because they know you have their best interest at heart , and you're, you're working to help them get out of that situation. You think, if they think that you are just there to exploit them , and make them, you know, use them, they'll step down real quick. You know , and they can tell.

Trust becomes an important determinant in how productive services agencies or SPs are at meeting the needs of IEHs. By building a good working relationship, continuity is established , and the transient nature of IEHs ceases to not be a barrier in providing useful services.

Timing Determines Success

The continuity of care is very important given the everyday atypical context IEHs live in where each new day brings a new problem or crisis. As such, knowing where, and who to go to during the early stages of a crisis determines how effective or responsive SPs are in dealing with those issues. One participant describes this “timing” very well below.

Our doctor gives his cell number to everybody, and so they know how to get a hold of us, but obviously don't know how to or afraid to, don't think it's going to help, whatever the reason is um. But once we have those relationships, they do call. They do call, and if they don't call him they will call the next day over at the office, and make sure that he's aware of it, and that they can get in, and we try to get them in the same day.

This timing allows SPs to be able to take preventative measures in regards to preventing further crisis or consequences. This prevention aspect though, is contingent on knowing about the situation early enough as described below.

And that's kinda what we're able to do here I think at the [agency] is try to catch those things earlier so we're kinda more involved, and they are telling us about things that are going on at work or telling us about physical issues they are having so we can connect them with the resource that might address that hernia or address that back issue so that you don't lose the job.

Another participant shows how important timing is in that it allows SPs to not only be responsive to crisis but prevent the occurrence of homelessness among clients.

And luckily we got [them], coz they next step was going to be homelessness. So we were able to get them payment for other things so that they could save whatever money they had to pay their rent so they wouldn't end up on the street.

The time SPs become aware of a client's crisis is also important as it determines how effective they feel in tackling that issue. There is a preference for clients to come at the early stages of a crisis, and when this does not happen, and instead occurs during or after a crisis, SPs portray a sense of helplessness, a “not able to” or “it's much harder” to intervene as described below.

We are seeing them in the crisis point as opposed to like when they just lost the job. You know so we are not able, or when they are getting closer to losing their job, it's like we are not seeing them often times early enough to try to prevent some of those things from happening.

Another participant reinforces the need to "catch it early" so as they are able to do something.

We have to catch it early, by the time we get people, they've already drained all their resources , and it's so much harder to do anything when they are down to zero income, zero job, car that's falling apart, kids, um.

By not coming in early, situations are made much worse hence becoming "too late" to do anything about a given situation as described below.

I would say that a lot of times people don't ask for help until it's almost too late. Um, I think a lot of our resources are not very visible to the populations who uh have, are experiencing homelessness for the first time, so if they were getting ready to be evicted they may not know who to call or they may be too ashamed to call until it is too late , and then they are in a much worse situation once they become homeless.

This helplessness is further reinforced when SPs feel there are no adequate resources at the given time in their agency or community to tackle a client's specific issue as described below.

They come to me asking me "what should I do?," and I tell them they need to go somewhere like [FoF agency] or something like that , and that time, I feel sorry for them but I don't know what to tell them at a time like that. Because it's like there's nothing you can tell them other than like maybe [FoF agency] or something. Coz there's really not a whole lot in Denton in that territory.

SPs helplessness is also portrayed in terms of outrage at the situation with response being to "learn more about it"

Majority of people think that there is a lot more support , and services than there actually are [is] , and when they find out, they are as outraged as I was when I first started doing this work. Um, or if, I'm still in that outrage but um you know, I've just kind of learned more about it.

The timing surrounding IEHs crisis as illustrated above can create feelings of helplessness among SPs. There are three crisis intervention points that SPs interact with IEHs inclusive of the pre or early-crisis, mid-crisis , and post-crisis. Pre or early-crisis is the time that SPs prefer clients to come to them as they are able to do something before “it’s too late” as they are able to “be more involved”, “able to” help them before the situation worsens. At this stage, SPs can intervene quicker, avoid snowball issues, avoid homelessness , and overall are more involved. The mid-crisis stage is still a time SPs feel able to do something as clients are not “down to zero” as such, severe consequences such as homelessness for some is still avoidable. The post-crisis is the point of no return where IEHs have exhausted all resources , and support systems , and is where most individuals are when they finally reach out to SPs.

Therefore, timing can either facilitate quick intervention or render SPs incapable of acting to help meet the needs of IEHs or those on the verge of homelessness. Furthermore this helplessness as described by another SP can occur through “feelings of being burned out or being overwhelmed” where it becomes difficult to “stay positive when you feel like things aren’t changing”.

For both SPs , and IEHs time plays an influential role as it determines whether there is trust between them which then determines the effectiveness , and continuity of services provided to meet the needs of the homeless client. For SPs time determines whether they feel capable or helpless to assist IEHs with a given crisis , and again how effective that intervention will be.

Theme Two: Navigating the System

The second major theme discusses time spent between SPs , and IEHs , and focuses on navigating the system as discussed in the interviews , and digital stories. This system navigation sheds light on the interactions between SPs , and IEHs that typically happen in the service settings. This time is focused on SPs working to help clients qualify for services provided by various organizations. In addition to describing this navigation process, SPs described the frustration , and reinforcement of hopelessness IEHs had as a result of the navigation process. In addition, frustrations about that process , and the direct impact it had on IEHs. During these discussions, it became evident that SPs also experienced similar frustrations

as IEHs regarding the navigation process. Lastly, the unchanging situation that IEHs found themselves in gradually weakened the resolve of both IEHs , and SPs, hence the idea of “sharing” in this theme.

The Navigation Process

Each SP discussed this interaction process as “helping them qualify,” “working to get them approved” into various agencies though these were typically broadly referred to as “the system.” This navigation process IEHs have to go through to qualify for services was frequently described as “complex,” “complicated,” “impossible,” and “convoluted.” This process entails compiling support, waiting years , and getting stuck; in other words, it’s a long , and arduous process.

Compiling support process. The compiling support entails working with clients to collect , and compile needed documents, a process made difficult as no one knows exactly what is needed as described below.

There’s so much that is required , and it’s so nebulous as to what it is that you really need. , and then there is so much that they need. I mean when my social worker finally showed me the list of elements that are needed just do to an SSI application, it’s no wonder these people give up. Another participant talks about how this part of the process is made complex by how agencies operate based on funding stipulations.

There’s a lot of hoops to jump through in some agencies just by nature of grants that they have , and how they have to operate , and it becomes very cumbersome for a person that’s already under a lot of stress , and just kind of in survival mode to be able to navigate those systems , and so we really like to sort of stand in the gap for people, advocate for them. She goes on to likens this impossible process to climbing “Mount Everest” for someone “who just [had] both of their legs broken. It’s like why even try, you know? I can’t even walk, you’re expecting me to climb a mountain?” The compiling process is made even more nebulous since IEHs , and those working to help them navigate the system do not get help or clear instructions on what is needed of them.

They are too complex, people don’t know where to go or, and they get turned away because they don’t have “X-element” or component. They get turned away rather than someone sitting down ,

and saying “oh this is what you need, this is how you do it.” Now [its] “you don’t have it.

GOODBYE!” you know, it’s so frustrating.

One participant calls this lack of guidance from social workers , and case managers in this “systems” as dropping the ball which creates additional barriers for IEHs.

Social worker [X agency] is in a position, the caseworker to show them.

You know it’s so simple, “here’s the application you complete,” hand them the application say “this is what you need to do” or show them where to go. That’s, that’s all they need to do and, the case workers , and social workers aren’t doing that.

As a result, IEHs in the community come to him for assistance since he has been through such systems , and knows the process.

Waiting years. The compiling process concludes when documents are submitted for approval which then initiates the “waiting years” of the navigation process. The navigating the system process has been personified as this “huddle” that must be crossed,” as a “fight that has to be fought,” a climbing “Mount Everest” for someone with no legs. The impossibilities that must be tackled “tooth and nail” tend to dissipate during the waiting process, where IEHs await to get denied or get approved for a specific service whether it is housing or disability support , and services. This waiting process is a long process as has been described by SPs.

Well , and the thing too is that it takes a long, like I’ve had three people in my home that I’ve tried to get on their feet , and it’s almost impossible. I mean the doors that they have to go through are very heavy laden doors. Um, one woman that stayed with me for a couple of months has been on the connection list for housing as number one for over 2 years.

Another participant describes this long process, where one individual “tried getting disability for three years” all the while living on the streets. These waiting years are long , and even those who have not navigated the process before learn of this “on the streets.” As one participant puts it “the joke on the street is that it takes three times to apply , and before you even have hope of um getting SSI.”

Getting stuck. The “getting stuck” process occurs prior to getting denied or approved for services , and usually occurs due to disruptions in services between SPs , and IEHs or barriers met within the system. One participant describes how this can occur where a client moves to another organization , and an agency loses track of her.

We have one lady that um, all she needed was a letter from the doctor in order to get a voucher for housing. She’d been needing that for six months , and she had moved on to a different organization, was not with us, so we weren’t following her at that time.

Another participant talks about how this “getting stuck” part is what keeps IEHs in their continued situation , and calls attention to the lack of resources , and supports within the various agencies to meet the needs of the homeless.

It’s more if they are still trying to get into a supportive program, they may be at an X[shelter] for a time, , and they are out of there. Then they go , and stay with a friend for a few days, then they are out of there. So I really think that, that cycle has more to do with not having the services completely in place yet. It’s like they get pieces of it, but they don’t have that complete support yet to get in.

The System Weakens You

Navigating the system represents an impossible task for both IEHs , and SPs. The ambiguities about what is needed , and how to fill out those forms creates unnecessary barriers for IEHs. The process impacts both IEHs , and SPs by creating frustrations , and feelings of hopelessness , and helplessness among IEHs , and SPs respectively.

Frustrated, feel worthless , and can’t go on. For IEHs, the systems process results in the depletion of resources , and support systems, reinforcement of “living in survival” where individuals may participate in risky behaviors such as survival sex or stealing to survive. To cope with the feelings of hopelessness, individuals may result to negative coping behaviors such as substance abuse , and alcohol use which may increase likelihood of conflict between peers, SPs , and the community at large. Lastly, the system process reinforces their marginalized , and powerless identity in society which creates feelings of

anger , and frustration towards the “system,” and further increases their vulnerability to poor health outcomes.

The depletion of resources occurs during the waiting time as IEHs are waiting to be get into housing.

They’ll stay at the shelter for a period of time, but there’s limits on that, so then they come back out of there , and are they are like, well I’ll go stay with a friend, but then they burn that bridge , and they can only stay a couple of nights , and then...

Overall the feelings reinforced during this systems process is anger, frustration , and ultimately hopelessness. During the outreach observation sites, an older gentleman experiencing homelessness experienced similar instances of anger , and frustration with the system as outlined below.

[He] was very frustrated with “the system” in trying to access services [housing]. He refused to fill out a survey since he already knew what it was going to ask , and since he’d filled one out “numerous” times. Stating “they know what I need, but still here I am without a place to live , and working odd jobs.”

The anger IEHs feel is aimed at the “system” where the barriers they face , and the difficulties in qualifying are seen as unwillingness to help among society. These feelings of anger never go away as their continued situation of homelessness is a reminder that nobody helped them.

The one thing that is really obvious, it’s it’s that anger you know “why isn’t anybody there for me? Why is it, “now I have a need , and have contributed to society, but now there’s nobody there for me,” and you sort of hear that with the chronically homeless as well is when I had a need, nobody came to my help, or you’ll hear that from you know people with mental health issues or on the verge of depression or you hear that with suicide.

As another participant describes this hopelessness as demoralizing.

Because you get so discouraged, you get so many doors slammed in your face. You get told, well we don’t have any money , and I realize that’s a fact of life , and all of that, but when you don’t

have money to put food on the table for your children, or to provide electricity um, , and somebody's just "giving you the business" it's just so demoralizing it's so hard not to give up. This "giving up" alludes to the hopelessness that is reinforced every time IEHs attempt to qualify for services. This "same hell" or never-ending hopeless situation can become so extreme that it leads IEHs to feelings of suicidal especially passive suicide as described by two participants.

Um, because every single person that I'm meeting with, if they are not having active thoughts of suicide they are at least having passive thoughts of death , and wishing they could go to sleep , and not wake up , and um, because who would want to you know wake up to the same hell everyday (chuckles). You know the same, you're just trying to survive again , and again , and again you know. Um, this never ending cycle which you cannot escape from.

The second participant discussed the "getting away from the day to day sadness" in her digital story reflection alludes to a similar instance of passive suicide in attempts to escape the tough situations.

The feather kind of represented some hope for me , and some like getting away, kind of getting away from the day to day sadness that clients feel , and I know from talking with them , and working [with them] through some hard things.

For IEHs, navigating the system , and facing the numerous barriers that keep them in an unchanging , and hopeless situation can create feelings of anger , and frustration aimed at the system. This anger , and frustration represents the majority response for most IEHs , and the realization that things aren't changing reiterate the need to continue surviving.

Just the sense of like feeling that vulnerability on a constant every day basis. I think it's like, it's like constantly being, having to constantly be alert. Like a constant um watching of your back. You can't rest, you can't really relax. You can't really ever relax entirely, you know truly. Um, because you do know, I mean I don't think, I know that they are aware that they are vulnerable, maybe just not contemplating it all the time, but I think that maybe translates for them maybe in the sense of having to just be, like I said be on alert all the time. So, um, you're more

guarded, you're the lens that you're viewing the world through is kind of a skeptical lens. It's a jaded kind of a lens because things uh, things didn't work out. You know.

Frustrated , and unable to do. For SPs, the constant barriers that IEHs face in navigating the system coupled with their depleted resources over time further reinforces their own feelings of inadequacy or helplessness. As IEHs become hopeless , and “give up,” SPs also experience some of that as one participant describes when discussing her everyday life as a SP.

Um, I think it shows the, the barriers that we're up against. and, I think, I think it definitely shows the emotional side of things quite a bit because um working as a service provider you know even though, (chuckles) I guess I should say the emotional, the relationship that you offer to someone is, is free in the sense there is no monetary being associated with it per se, but it's not free because it's, it's a giving of yourself to someone else. So there's that aspect.

Another participant brings up the issues of lack of time in fostering relationships with clients when discussing why things are hard working with this population.

I think most this time we're in, we're having to do so many things at one time that we don't get to. Um, it's kinda like let's hurry up , and get this done so we can get to the next thing , and not intentional. I mean we're still trying to take care needs , and help but um what some of these people needed is just for us to sit down , and eat a meal with them...on a regular basis.

This lack of time alludes to the constraints she may feel as a SP that render her inadequate by limiting her effectiveness working with IEHs. This inadequacy may also be expressed through frustration where this frustration is not aimed at IEHs but the “system” as a whole as one participant describes.

It's very, its overwhelming for us. I mean I'm sitting over here like wanting to pull my hair out (chuckles) , and just feeling so frustrated, and feeling angry, and "why's it have to be like this?." This just makes no sense to me. Um, but it is, it's kind of, it is the way it is you know that's how people will say that.

The previous sections in this theme discuss the tedious process of navigating the system , and how this impacts feelings of frustration among IEHs , and SPs. Over time, being in an unchanging situation is

what reinforces these feelings of hopelessness , and helplessness , and denote a “weakening” of one’s resolve. One participant describes this below.

I think they definitely feel trapped, even if there’s a sense of positivity in some way, there’s beneath it an um, a deeper sadness of being stuck. And, I think a lot of times they view their situation as hopeless , and sometimes see themselves as worthless. Kind of the general sense is “why am I even here? What’s the point in me being alive, I’m just a burden to everybody else.”

For SPs, the feelings of helplessness occur when SPs feel inadequate to do anything to help the navigation process go faster or smoother or assist an IEH with an ongoing issue. These feeling are similar to the hopelessness that IEHs experience described by this participant when reflecting on her digital story.

And even how I sometimes feel um feeling like I’m not making enough of a difference, it’s like fly away from the problem, look up to the sky, something positive um that’s really small , and simple that we might take for granted in our day to day.

This feeling of hopelessness where SPs consider “flying” away from the problem denotes a “weakening” of their resolve.

Theme Three: Navigating Change

This theme focuses on changes that occur for both IEHs , and SPs over time. For IEHs, their experience of homelessness over time changes how they live. For SPs, perceptions about causes , and solutions to homelessness change how they work , and interact with IEHs.

How You Live Changes

The commonality in the typical day for IEHs is the unpredictability that they have learned to live with. As one participant describes below when asked what she thinks lends to the chronicity among IEHs.

The ones we talk to , and ask that question, the type of answers we get is “what’s the use?” you know, they are quite, it becomes a lifestyle. The same way we all have our lifestyles, for the homeless, the chronically homeless, it’s a lifestyle. That’s the way they live, it’s their culture, they know how to. It’s predictable , and to a certain degree, they’ve learned to live with unpredictability.

This “learned to live with it” adaptation phenomena was mentioned by all SPs , and lends to this idea of acculturation that takes places among IEHs where they learn, adapt to living a life of “unpredictability” where they are always” moving in order to survive. One participant likened this acculturation among homelessness to the institutionalization that occurs among prisoners.

And here’s the thing, , and it may sound crazy, but sometimes I compare homelessness to people who are in prison because really they’re in their own prison. They don’t realize it; they’re not locked up in a cage, but they are in prison. So you look at somebody who’s been in prison; when they’ve been in prison for 20 or 30 years, how much has changed over time. Same thing with a homeless person, when they were part of society, they remember you know, “oh we used to write letters” or whatever, but if they have never been, they’ve you know, they’re not in contact with it like we are...

Time plays a role here in that the longer they live this lifestyle, the harder it is to “go back” to “normal society” as they would have to re-learn, re-experience living “normal” again as described below.

Yeah there are some that through learned behavior, have learned “well you know life is much simpler this way, why should I rack my brains?” Um, but are they truly happy? Interestingly enough, the ones that I have had enough of a relationship, that I’ve pushed the envelope a little bit, they are not. , and yesterday I was talking to low-income lady who a couple of times has been on the verge of homelessness , and can’t remember if she’s been homeless at some point in her life, but um , and I was asking her, “ you know all these people in this situation, you know them very closely what could we as a society do?” and she said “they just need to re-experience the comforts of having a home, having people who care, being able to trust people, so that they learn that this simple life is really not what they want.”

For IEHs, living on the streets calls for them to learn how to survive day to day by doing whatever is necessary to survive. This may mean becoming tougher, more aggressive or doing things that you would normally never do under different circumstances as one participant discusses below.

They've had to use their body to get a dollar, you know so they're very vulnerable. What they would normally would have done had they been in a different situation, they are having to do things that they don't really necessarily wanna do, they have to do this.

Changed Perceptions

How SPs see IEHs influences what or who they "blame" for the occurrence of homelessness, their actions towards IEHs , and efforts aimed at preventing or ending homelessness. In discussions with SPs, the occurrence of changed perceptions materialized as SPs were giving their thoughts on causes of initial , and chronic homelessness , and solutions to homelessness. To note, these changes occurred with five of the seven SPs. The first three alluded to this change in their interviews , and as an afterthought in their responses while the other two discussed it in their digital stories narratives or reflections.

The perceptions of SPs differ strongly from those of IEHs , and the general community in that they are mostly positive , and focus on the strengths or resiliency of IEHs. As one participant states "they are not what people perceive them as. They're some very smart people that they really, they're working hard to try to change you know their lifestyle, what their circumstances." SPs discussed some of the struggles or weaknesses IEHs have to help explain the difficulties faced. This was done in a way that was not demeaning, negative or hostile.

Perceptions on causes of homelessness. SPs would allude to their changed perceptions before or after responding to questions about what factors they think lead to homelessness or solutions to tackling homelessness as described below. The following excerpt shows how this SPs perception changed in regards to what causes homelessness among adolescents. She continues on to explain this misconception was based on previous work experience , and what she now thinks about the causes of homelessness among adolescents.

Um, , and then a lot of um people in our area like don't believe that there's homelessness , and they often, including myself, I thought the majority of the kids that were homeless were juvenile delinquents. That they were gonna be drug users. Coz that's really over at the other shelter, more of, um...some of what I was running into. But what we have to realize is that their parents put

them around crappy people you know , and they can be in really crappy neighborhoods which exposes them to people that don't make good choices.

Perceptions on solutions to homelessness. Another participant discusses what he thinks IEHs need the most , and mentions the “before,” and “after” solution calling attention to a change in perception that came about with interacting , and getting to know IEHs.

Um, you know I would have said um “a home” at first. But there's a lot of them that have a lot of issues um, mental issues, health issues , and giving them a home first is not gonna correct, and actually we may be setting them up for failure by giving them a home first.

He goes on to discuss focusing on other issues or solutions aside from a “home.”

So I think, really the services that they [need] most is definitely health, addressing you know the health issues, addressing the mental illness issues , and even teaching them how to you know budget money, how to set a budget, you know so preparing them uh. Even giving them training to where they can get a better job. You know because everybody says “oh they just need a home” but if you do that, I say you may be setting them up for failure. They're not ready for that. It should be a process , and that should be really, almost the last thing, coz once you get the process, then now, you get to go , and enjoy the fruits of your labor [chuckles].

Another participant alludes to this change in perception when talking about how IEHs “view” their situation of homelessness.

If I listen to, we have a group that meets every Thursday , and they've been meeting for a year , and a half. If you listen to them , and they are pretty much the [speakers] for their group [homeless] most of them it's not that they like being homeless, it's now a way of life, it's something that happened to them, um that they now blame society for, because its society's fault that they couldn't get out of it , and at first when they started [saying] that I went “why would you say that?!”

This change in perception came about after she had worked with IEHs for a while , and had seen two types of individuals become homeless, the chronically homeless , and the “new homeless” who were educated , and wealthy , and had “no reason to be homeless except circumstances.”

But now that I have this new population that have no reason to being homeless except circumstances like I said, the six-figure salaries, , and their first reaction is anger. I’m going “oh my God, now I can put two and two together, that’s why the people who are now chronically homeless still have that anger because when it first happened, probably, using the example of the recent one, nothing, nobody helped them.” They only met obstacles, even now, they go to social security, they don’t get an answer, they, they file their application once, it comes back but it doesn’t really say what’s wrong with it, they just got denied.”

Working with the Homeless

The two other changes in perception occurred or were mentioned only in the digital stories narratives , and reflection. One of the two SPs discussed her change in perception about IEHs with her role changing from one of fearing the problem to working to solve the problem as described below.

Fast forward the same 16 years...you will no longer find a frightened mom just wanting the light to change to green. Now I partner with community agencies searching for ways to solve the problem of homelessness in our community.

She goes on to explain this transition in her digital story reflection focusing on how prior to knowing, IEHs caused her fear to now, the issue pushes her to raise awareness.

How much things have changed. Really it was about, it was kind of more of that introspection of finding it so important to really raise awareness. Um, about you know the people that are on the streets, or not able to find a bed, or are not in a safe environment. So it was really, it started to be more about coming from that fear place, to more of a, we need to really get the word out.

The second SP mentions this change when reflecting on her digital story , and why she chose a certain picture to portray where IEHs like to “hide it.” This alludes to an awareness that comes about from interacting , and dealing with IEHs. Prior to this, to her, a spillway was just a gutter that catches water.

This awareness denotes new insight about her clients , and their need to stay out of sight due to the stigma faced as IEHs. So now, the spillway is a “place of tragedy,” and “safety.”

When I actually used to think of just a gutter (chuckles) where water flows through. So it’s like, you know, you think of it one way your whole life , and you realize it’s so much more than that, and that’s kind of powerful... I have clients refer to it as a hobo highway because it’s kind of a safe place, even though it’s a dangerous place to be in, it’s a safe place to be in my clients’ mind. To be kind of underground , and not to be running from police, or um you know whoever might be judging them or stigmatizing them.

Changed Approaches, and Interventions

Aside from changed perceptions about causes of homelessness, the approaches SPs took in working to meet the needs of IEHs also changed. When asked about services the agency offered , and how these met the needs of IEHs, SPs described services that could be broadly grouped in three ways. The first grouping was on the approach SPs take to deal with the issue of homelessness; either holistically or by focusing on the issues. The last two grouping describe the various types of services provided. The first grouping was “hand up” or “hand out” services , and the second grouping was tangible or intangible services.

Holistic vs. focused approach. The approach that SPs take in tackling causes of homelessness , and in turn working to solve that issue could focus strictly on a given item such as “housing” where all efforts undertaken to work with IEHs are on housing only. The second approach is a “holistic” or “whole person” approach where even though efforts were on getting an individual housed, SPs worked to look at other areas that IEHs need help or support.

As one participant describes below, the “whole individual” was assessed.

I have trained the staff in this facility to try , and look at the whole individual. So if somebody comes in , and is just a regular diabetes check, but they look like they are bothered by something, the staff are not to ignore that they look bothered, they are to address it.

The holistic approach entails working to meet the needs of the whole individual as described by another participant “we provide care coordination, counseling, social services, connection to resources, just anything that the individual needs to be healthy in all areas of life.”

The majority of SPs work in agencies that provide “focused services.” Albeit this, SPs commonly alluded to taking efforts above , and beyond to help clients with other issues outside of those they as an agency were working on with them. For example, one SP worked in an agency that only provides housing assistance (rental assistance). Therefore, they may not be able to offer health services, but they can connect a client to other agencies that do so.

If we’ve got someone that’s not working right now, and they want to get a job, then we can focus that treatment plan on towards helping them find a job, connecting them with um with DARS - which is no longer called DARS right now but, with a workforce commission through DARS. We have a great relationship with them. So if their goal is working, we can do that. If their goal is um, to get their health better, then we can help them, we can then gear them towards that. Now we don’t necessary provide the services all the time, but we provide all the connections to where, who to refer to how to get that [them] connected.

Regardless of the job descriptions the SPs had, they all took on the role of “resource navigator,” and facilitated connections with other agencies as described above.

Adaptive and Individualized Interventions

Hand out approach. The second and third approaches that SPs can take relate to the types of services offered, which can either “hand up or hand be out” or “tangible or intangible. “ Hand “out” services focus on meeting a need but not the actual need the client needs. Here, the interaction between the SP , and IEHs is demeaning, leads the individual to feeling powerless where they have no control or choice in the service they are receiving.

This participant describes this “hand out” service very well by stating it is simply giving out something, but that “something” is not useful to that particular individual. In addition, it takes away their choice , and control.

One of the things that I told, talked about on the food pantries that feeds them, you got people out there who already have some really bad health issues, maybe diabetic whatever. We're feeding the homeless whatever we wanna feed them. We don't understand that some of them need to be on a special diet. It could be very expensive. Once again, it comes back to that money thing. We don't, we don't wanna um, accommodate all this, but then we weren't feeding them so it's almost like we're saying "either you could eat this or you gonna go hungry." So it's like you know, there's a lot of things that's been unaddressed, you know issues that you know they're facing you know, or maybe they're allergic to certain types of food. But once again, they have no choice, they have to eat what they can get. So, even if they're allergic, they may just have to deal with that, and hopefully it doesn't kill them. I mean how bad, it, it gets to where you okay "it's either I eat this, and I'm not hungry or eat this, and I'm allergic, and it may kill me anyway."

This "hand out" approach does not focus on the individual, and instead on the program, on meeting the program's goals.

"Oh yeah, here's an apartment, now we can check you off," we've put you in house, and then something happens, and then they lose their apartment again, so now we've reinforced their low self-esteem now they are feeling even lower. You know it's like we just don't understand how people work, we just don't understand. No wonder there's so much mental illness now. People have just not been helped.

Hand up approach. In contrast, a "hand up" approach is adaptive, and considers the person as a whole, but most importantly as an individual case where the support provided to one may differ from the support given to another client. One participant describes this approach below.

I think all, all they need is a little "hand up" not really so much as a "hand out" just someone to say "hey you know what, I see that you're trying, I'm gonna come kinda be that support, kinda help you know hold you up, and walk with you, and whatever you have you know, questions, or you stumble there'll be somebody here that kinda guides you." And, and because they don't want

someone to fix their problem, they want someone to help them, to, or guide them. It's a big difference.

It's a "one on one" hook up where you walk "them through the steps as much as they need. Some people need a lot of help, and some people can be really independent." As described by another participant "you find out what they need first, and then you meet them at their need; you meet their need, whatever they say they need."

Tangible and intangible services. The second grouping of services is based on whether they are "tangible" or intangible." Tangible services can be "logged" or itemized such as "resources on housing provided," "helped client fill out forms," "and provided meals to the hungry." These services are usually specific to an agency such as a health clinic where services are health related. Other services that SPs provide, are difficult to itemize or log, though equally important. These include "listening to the client", "providing moral support during an interview" or "just sitting with them."

One participant describes how both tangible, and intangible services are provided. The tangible service was doing a home visit, while the "intangible" part was "sat with her" to "break out her day."

She has a new born, and a five year old, so we went to meet with her today, and just check in, see how she was doing um. So we sat with her for quite a while, really just kinda break out her day coz she has the five year old in kindergarten, and the baby at home, and she's not working so just really kind of a check in, and you know to see what's going on with her.

Throughout the interviews, most SPs talked about providing both types of services almost simultaneously. One "intangible" service that has been mentioned previously is efforts undertaken to cultivate trust between SPs, and IEHs as described by one participant.

I would say I do a lot of listening, and a lot of relationships, and rapport building with them.

Um, a lot of just hearing their stories. There's practical things that we are always doing. I mean I'm always assessing for do they have hearing, and vision, and IDs, and health insurance, and some of those practical things. But that is secondary to the relationship because if we don't have a

relationship then they're not gonna continue to come back to where we can follow through on some of those things that are not gonna happen in a onetime meeting (chuckles).

This reiterates the importance of time as a determinant in the interactions between IEHs , and SPs. Over time as perceptions change, as discussed above, solutions , and services change too. They change from being “everybody is doing it” repetitive services that are “issue focused,” tangible only , and a “hand out.” Instead, solutions , and interventions provided become adaptive to the individual’s needs, holistic , and provide a hand up to each individual. In other words, interventions are individualized rather than prescriptive where everyone must “fit the dress” as described below.

When a women goes , and buy this dress. Oh, “I’m going to make it fit.” No, it’s not gonna fit (chuckles) you may have to lose a little bit of weight. You’ve gotta adjust to the dress, the dress is not gonna adjust to you. That dress is what it is , and it’s never gonna change. You either have to get a bigger dress or whatever. But that’s what we are doing with the homeless. We say “you have to fit.” No, they can’t, they can’t fit into something that doesn’t you know fit their, their personality, their characters, everything.

We Are All One Paycheck Away

Another change or awareness that comes about from working with IEHs is the realization about how easy it is to become homeless. Throughout the interviews , and discussions about causes , and solutions to homelessness, SPs mentioned the inevitability of becoming homeless that anybody can go through. For all SPs, the underlying causes of homelessness was occurrence of a major crisis, not having the familial , and financial support needed to provide a buffer during transition times. To note, most alluded to the issue of “being a paycheck away” indirectly or directly as discussed by two different participants.

You know it’s the phrase everyone throws out “we’re all one paycheck away from homelessness but people are truly one paycheck away from homelessness.” Don’t laugh about it, it’s not a joke. There are so many more people that are at that stage

Another SP said,

You know basically for the most part, the average person, is one paycheck away from being homeless, and when you really stop, and think how many people are doing the Suzie Orman thing where you have three to six months in savings for you for your expenditures.

Aside from living with economic vulnerability, SPs discuss other the pre-existing vulnerabilities IEHs tend to have prior to experiencing crisis that also determine their likelihood of becoming homeless. These include family or social issues, and not having a social support system as described below.

Their foundation if you look at their social development, and, and um, and the abilities, and social history, they already don't have very strong foundation, and so as soon as certain things start happening, its starts eroding at that, and then when they become homeless, then forget it. That's why they see it as a point of no return.

Another SP said,

I've seen kids that got some home to home, and every time they go, people don't realize this.

Each home that they went in to had a different set of rules; their identity was compromised each, and every time, and by the time they get out of Foster care, they don't know who they are.

These two factors were commonly tied to reasons why IEHs had no life-skills such as budgeting, cooking or coping skills that determine how well they manage the everyday stressors they face living on the streets. The lack of life skills was talked about frequently as SPs discussed causes, solutions, and barriers to ending homelessness as shown below.

And so you have a lot of people that don't have the skills. Can't you know hold a job because it's stressful. They have to deal with different personalities, they don't know how to deal with different personalities. They can't deal with being told off, with being reprimanded, getting criticized, receiving criticism, um they don't know how to budget, they don't know how to plan, whatever they have they spend.

Um, for them to get a fighting chance, like adults, often times the, the adults that we deal with that are homeless are the same teens that, that we have now. You know? Nobody takes the time to

really put in their lives, to teach them the life skills. To um, help them set up a bank account, to um, to really give them a chance to start adulthood. I mean, they are in such survival needs that it's hard to function in another way.

Lacking these life skills also creates barriers when SPs are working to re-integrate them back into housing or a job setting. As such, most of the services provided focus on teaching them life skills , and growing their support system.

They've got case workers, judges, you know all these people , and then when they turn 18, you say "okay, now you've gotta make decisions for yourself." I've never made a decision, so I'm afraid to make a decision, what if I make a decision , and it doesn't work out?" and then you know, they're, they're kinda taught on that. So it's like, you know they chose to live that. Coz they don't wanna fail.

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

The purpose of this qualitative, exploratory study was to examine service providers' perceptions of vulnerability as a determinant of health among the homeless population. The three research questions guiding this study were:

1. How do individuals experiencing homelessness perceive their vulnerability?
2. How do service providers define the vulnerability of individuals experiencing homelessness?
3. How do service providers perceive the vulnerability of individuals experiencing homelessness?

This study's data collection method involved ethnographic fieldwork inclusive of participant observations, service provider interviews, and digital storytelling. The participant observations provided an etic approach into how IEHs perceive their vulnerability. The interviews, and DSTs provided insight into how SPs perceive the vulnerability of IEHs. This emic approach allowed for an understanding of those nuanced differences related to how the phenomenon of vulnerability manifests, and is perceived by SPs.

The data collected included 8 ethnographic fieldwork participant observations, 7 semi-structured service provider interviews, and 5 digital stories, and reflection interviews. This study used an exploratory qualitative study approach. The analysis of the datum utilized standard content analysis, and constant comparison to construct themes pertaining to service providers' perceptions of vulnerability among IEHs.

Discussion of Findings

In order to understand what factors lend to IEHs vulnerability, insight into the social context that reinforces this vulnerability was needed. Research to date well supports how IEHs live out in the "open," but insight on the service context is scarce especially as described by service providers. Albeit this existing knowledge about the lives of IEHs, the study wanted to locate these to the specific geographic context of Denton County. Therefore, the participant observations were used to inform, and ultimately validate what research shows about living homeless by providing insight into how IEHs perceive their vulnerability. The context of paramount interest was the service context where IEHs access, and rely on for food, shelter,

and other services , and interact with SPs. Insight in to the service context was informed by the interviews , and digital story narratives , and gave service providers the opportunity to tell their side of the story in a way that allowed them flexibility to discuss what was most important to them. The use of both data collection methods provided greater insight into how IEHs live out their day , and how they interact with society , and service providers.

Guided by an intersectionality framework, this study examined SPs perceptions of vulnerability as a determinant of health among IEHs by using an multiple approaches, primarily an emic approach that disregarded prior normative assumptions about what defines vulnerability (Rogers, 1997; Spiers, 2000). This allowed the opportunity to understand how vulnerability is experienced , and perceived by IEHs , and also how SPs define , and perceive vulnerability. The remainder of this discussion section explores each research question independently.

RQ 1: How Do IEHs Perceive Their Vulnerability?

The lived experience of IEHs has been well studied in the literature , and from the viewpoint of those living on the street. This study lends additional insight into this knowledge by including SPs perspective, specifically how they define , and perceive the vulnerability of IEHs. A look at the everyday experience of IEHs calls attention to the impact experiencing homelessness has over time , and how the “everyday living” consists of living in hiding, in motion , and on borrowed time.

SPs discussed how the acculturation of IEHs occurs over a period of time where they “learn to live” in survival mode. This acculturation not only puts them at risk for greater mortality , and morbidity, but makes it harder for them to become integrated into society. Time is an important dimension due to the impact that exposure to either material or psychosocial disadvantages have over time. The longer an individual experiences homelessness, the greater the impact on negative health consequences. Psychological, social, , and physical stressors alter immune function , and negatively impact health (Pellowski et al., 2013; Thoits, 2010). The chronic exposure to stress is associated with cumulative disadvantage over the life course , and altered physiological functioning which can increase risk to numerous health conditions (Pellowski et al., 2013; Thoits, 2010; Williams & Jackson, 2005). The

acculturation occurrence that SPs discuss calls attention to the “surviving nature” that IEHs learn to live with.

This living in survival is then what shapes their everyday context inclusive of interacting with their peers, society as large , and SPs. The everyday life of IEHs is spent not only interacting with SPs in seeking services but hiding from society , and staying moving to stay protected from their peers living on the street with them. This “life of hiding , and in motion” has been well cited in that IEHs spend their day , and time seeking material services be it food, clothing, shelter or health (Chard et al., 2009; Hauff & Secor-Turner, 2014; Barnes et al., 2007; Romeo, 2005). Time is spent walking to a given location, interacting with service providers , and avoiding criminalization , and public harassment (Meanwell, 2012; NHCHC, 2015; Thoits, 2010).

This type of living also calls attention to the psychosocial disadvantages IEHs face on a daily basis inclusive of discrimination, stigma, prejudice , and bias. These refer to specific intergroup relations that negatively impact their overall wellbeing (Major et al., 2013). These adversities are influenced by group membership solely based on “being homeless” , and shapes the interactions IEHs have. To escape the negative stereotypes, stigma , and criminalization from society, IEHs opt to “hide out in the woods”, spend their days underground in the “hobo highways.”

This “choice” to isolate themselves is a by- product of their marginalization by the domiciled community as it is an attempt to socially distance themselves (Hatzenbuehler et al., 2013; Zerger et al., 2014). Furthermore, this isolation is an occurrence of marginalization as it results in IEHs being pushed out to the margins , and restricted to various resource poor , and unsafe areas of the community. For homeless youth, they opt to “blend in” , and not tell others of their homeless situation for fear of being bullied or stigmatized. This is a similar occurrence for individuals LWHIVA or transgender youth who to avoid losing existing social support systems , and further marginalization they choose to “live in silence” , and in isolation to keep their highly stigmatized disease status or sexual identities hidden from their social networks (Bruce et al., 2014; Harper & Schneider, 2003; Hatzenbuehler et al., 2013; Kate-Wise & Hyde, 2012; Zerger et al., 2014).

This choice to live in silence then serves as a barrier to accessing services that are put in place to help them get out of their homelessness situation. Again, this is a similar occurrence for individuals LWHIVA opt to not disclose their HIV status to family , and other support systems which impacts their adherence to treatment , and likelihood of seeking out other resources for social support (De Santis & Barroso, 2011; De Santis & Deleon, 2013).

Vulnerability among IEHs manifest through their actions, how the “live” out in public , and in isolation. Out in the open, their actions are focused on seeking services , and shelter in attempts to survive. When away from the public, as one SP describes, they “have their own communities,” and instance where they “establish their own government.” This establishment of community , and government represent occurrences of “counter-spaces,” those settings where those facing oppression are empowered , and liberated (Case & Hunter, 2012). In surviving, IEHs show their resiliency, the outcome of adaption to adverse conditions where outcomes are favorable despite experiencing social adversity. Lastly, resistance includes concerted individual , and group efforts aimed at changing oppressive conditions by challenging the “status quo” or creating psychological , and structural conditions that encourage liberation. This includes individual agency aimed at disrupting the patterns of internalized , and systemic oppressions, a type of horizontal power (Case & Hunter, 2012; Vasas, 2005).

The acculturation process , and living in hiding , and in motion for IEHs calls attention to their vulnerability based on their status as “homeless”. The actions that they take to survive such as panhandling, hiding out, living in motion so as to not be a target alludes to their vulnerability. In other words, their vulnerability does not only manifest in the poor health , and wellness, but in their living. It calls attention to the occurrences of everyday marginalization that pushes them to the “hobo highway” the corners of places” where resources , and opportunities to thrive are limited, yet they are “safe.” Furthermore, living “on borrowed time” also calls attention to their marginalized status. The idea that they are “in their own prison” denotes a life of no control, no choice, no time

RQ 2: How Do SPs Define the Vulnerability of IEHs

The majority of interactions between SPs , and IEHs typically happen in the service settings , and are focused on SPs working to help clients qualify for services provided by various organizations. Aside from providing food, hygiene products, resources or health services, this “navigation process” is where most effort , and interaction take place. This process provides new insight into the interaction , and relationship between SPs , and IEHs.

The idea of having a “common goal” or “shared” experience or outcome represents the study’s greatest finding. Baker et al. posit that this shared connectedness could create feelings of closeness between clients , and workers (2007). The common goal is seeking , and qualifying for services or support from the various agencies, though the terminology used is “the system”. This process results in similar experiences of frustration with the barriers IEHs face that further reinforce feelings of hopelessness , and helplessness for IEHs , and SPs respectively. For SPs this creation of helplessness during the navigation process further increases the likelihood of professional burnout due to feeling ineffective given the limited resources , and barriers they face assisting IEHs (Acker, 2010; Baker et al., 2007; Gary-Stanly & Muramatsu, 2011).

Some of the barriers faced represent occurrences of structural discrimination through policies , and practices that guide institutional practice (Quesada et al., 2011; Viruell-Fuentes et al., 2012). For example, some IEHs faced discrimination seeking out jobs due to lack of a permanent address which denotes their homelessness status. Another example of structural discrimination through practices is the socially constructed practice that those seeking jobs need to “look professional.” This expectation at various public job search sites can bar access to IEHs who do not have the clothing or resources to “appear professional.”

These policies , and practices not only bar a necessary resource, but construct this demographic group as abnormal, lazy , and uncaring. This is a similar occurrence for Latino immigrants who through anti-immigration policies, have been racialized , and constructed as abnormal, undesirable , and a threat to the nation (Derose et al., 2007; Dovidio et al. 2010; Quesada et al., 2011; Viruell-Fuentes et al., 2012).

As a result of experiencing numerous barriers in attempts to qualify for services, obtain shelter or employment, anger towards “the system” is experienced by both IEHs , and SPs. The blaming or anger towards the “systems” calls attention to the occurrence of structural violence in the everyday life of IEHs. Structural violence, is the indirect violence that results when social arrangements or structures inhibit people from reaching their full potential , and cause injury to people indirectly (Farmer et al., 2006).

The descriptions , and analogies used when describing the lived experience of IEHs allude to their definitions , and perceptions of vulnerability among IEHs. The SPs definition of vulnerability is represented in how they describe or personify the everyday lives of IEHs using terminology such as a “life of loss,” “ a type of “prison,” “hell every day,” “getting to zero,” life of “shunning” or “total loss.” These descriptive analogies portray a life of constant struggle , and impossibilities , and shed further light into how SP perceive the vulnerability of IEHs.

RQ 3: How Do SPs Perceive the Vulnerability of IEHs

Studies looking at “time” especially in reference to IEHs focus on the negative outcomes that ensue from experiencing homelessness. Although this came up in the findings, it was interesting to see how time also had an impact on SPs perceptions about homelessness in general. The occurrence of changed perceptions came up as SPs were discussing their thoughts on causes , and solutions to homelessness.

The public’s perception of IEHs had a negative connotation where they were seen as responsible for their homeless situation therefore “too lazy,” and “don’t care” or want to do anything to change their situation. Therefore, being labeled “homeless” is a negative stereotype that further reinforces the stigma experienced through reactions they receive from the public such as being ignored, stared at or verbally harassed (Lee et al., 2010; Meanwell, 2012; Wolch et al., 1988). For SPs, this was their initial view of IEHs , and influenced what they thought about causes , and solutions to homelessness.

Over time, as they got to “know” this population, they changed their perceptions on what causes homelessness , and in turn solutions to homelessness. Therefore, rather than reinforce the negative stereotypes SPs had, these changed perceptions positively impacted the relationship with IEHs which

increases the likelihood of clients “coming back” to seek care. SPs mention that “clients would come back” to the service settings alludes to the “welcomeness” clients feel, which has been found as a determinant in the service seeking behaviors of IEHs (Romeo, 2005; Wen et al., 2007). A conflicting occurrence of welcomeness , and unwelcomeness as perceived by SPs , and IEHs materialized here. The unwelcomeness that IEHs feel based on “living on borrowed time” is an instance of this micro-aggression that occurs unbeknownst to SPs. Although overt occurrences of discrimination are rare in the service settings, the covert micro-aggression that communicate hostile or negative insults towards individuals have been shown to occur at times unbeknownst to the “perpetrator” (Bowleg et al., 2013; Dovidio et al., 2010; Kate-Wise & Hyde, 2012; Quesada et al., 2011; Williams & Mohammed, 2013). These covert occurrences have similar consequences as blatant discrimination that reinforces feelings of hopelessness , and avoidance of SPs (Davido et al., 2010; Romeo, 2005).

In their study looking at changes in implicit bias among health care professionals, Hall et al. found that implicit bias was more pronounced as health professionals progressed in their careers (2015). Over time, repeated instances of certain patient situations become engrained as truths which then influenced the patient-provider relationship. In direct contrast to this study was that SPs perceptions changed to differ strongly from those of IEHs , and the general community. The continuous interactions , and awareness of IEHs positively influenced SPs attitudes, an occurrence that supports the contact hypothesis. This hypothesis posits that contact between in-group (dominant) , and out-group (marginalized) is expected to improve attitudes towards marginalized groups (Hauff & Secor-Turner, 2014; Lee, Farrell & Link, 2004). Therefore, interactions between SPs (dominant) , and IEHs (out-group) fostered a positive change in SPs perceptions about IEHs , and homelessness in general. SPs reported in both the interviews , and digital stories a change in perceptions towards causes , and solutions to homelessness. This change in perception as one would expect changes the approaches , and solutions they employ in working with IEHs. Specifically, the approaches , and interventions employed when working with IEHs , and the idea about the inevitability surrounding becoming homeless

The solutions employed take on a holistic approach that looks at the “whole person.” This “holistic” approach to meeting the needs of IEHs calls attention to the numerous issues this population faces. By taking a holistic approach, SPs take efforts to know the individual so as to be able to adapt interventions based on their needs, and the level of support they may need in comparison to another client. This adaptive, and individualized approach also represents the “hand up” services they provide. Services that are specific in meeting a certain need rather than simply providing a service. Furthermore, services included both tangible, and intangible services where practical services were provided in conjunction with services that “affirmed” or “valued” the individual.

The adaptive, and hand up approach taken by SPs represent “intersectionality practice” where the whole individual is considered while care is taken not to be “prescriptive” in providing services. One participant in describing how services should be implemented allude to the need for individualized care by stating that “we’ve got to be willing to, as a society, to look at them as an individual, and work with them on an individual basis, don’t put them in a box, and say, you’re part of this group.” Intersectionality challenges universalism, and acknowledges the diversity or heterogeneity within a given social group or category (Bowleg, 2012; Hankivsky, 2012, 2014; Hankivsky et al., 2010; Lurie et al., 2015). By considering an individual’s context, and their uniqueness as an individual, SPs apply basic tenets of Intersectionality. Specifically, they look at the numerous factors that influences one’s lived experience such as a mental illness, physical disabilities, lack of social support, lack of life skills needed, and marginalization status in society (Caiola et al., 2014; Crenshaw, 1989; Hauff & Secor-Turner, 2014; Jackson et al., 2016).

One participant in describing their daily interactions with IEHs allude to this complexity among their clients stating that “each individual is very different, and they all present with their unique problems, and once we develop a relationship with these individuals we become their source of support.” By considering how IEHs interact with the general public, and law enforcement leads to their life of exclusion considers various level of power relationships, and how these shape their lived experience. In their study looking at the multiple intersections of race, gender, and class among Black men, racial micro-aggressions

reported occurred through interactions with police enforcement , and were described as daily, constant , and unwarranted stops, questions , and frisks by police (Bowleg et al., 2013).

As SPs interacted with IEHs , and got to know their stories, their awareness that “we are all one paycheck away” from becoming homeless came about. This raises awareness to the personal vulnerabilities as well as structural factors that cause initial , and chronic homelessness (Hodgetts et al., 2007). The awareness that we are all “one paycheck away” sheds light on the structural factors creating , and compounding the pathway , and consequences of homelessness including a lack of affordable housing , and poor living wages (Lee et al., 2010).

In addition to economic vulnerability, SPs discussed other pre-existing vulnerabilities IEHs tend to have prior to experiencing crisis, that determine their likelihood of becoming homeless. These include family or social issues , and not having a social support system. As such when faced with traumatic life events such as sickness, domestic violence or job loss, the inadequacy of buffers results in the occurrence , and continuation of homelessness (Bowleg et al., 2013; Lee et al, 2010; Shier et al., 2011).

The SPs perceptions of vulnerability allude to both the strengths , and weaknesses of IEHs. Their resourcefulness or resiliency in surviving represents both the strengths , and the vulnerability that they face in their everyday lives. The weaknesses allude to the existing economic , and social vulnerabilities that they have experienced prior to becoming homeless , and during their situation of homelessness. For example, the mistrust of service providers , and unwillingness to share information with SPs denotes this “attempt to stay isolated.” The change in perceptions among SPs is a transition from negative to positive perceptions of IEHs where the weaknesses they have are explained as being due to having a dysfunctional childhood or family lifestyle as well as being victims of the system. For example, SPs explain the reason IEHs have no life skills is because they did not learn this growing up are due to growing up in the Foster system.

Focusing the Findings

Experiencing the phenomenon of vulnerability underlies a plurality of experience, as it encompasses numerous , and commonly experienced inequities related to identity-based oppressions

(Brocklehurst & Laurenson, 2008; Derose et al., 2007; Grabvoschi et al., 2013; Jones, 2009; Shi & Stevens, 2005a, 2005b; Shi, Stevens, Faed & Tsai 2008; Shi, Stevens, Lebrun, Faed & Tsai, 2008; Thomas et al., 2011; Viruell-Fuentes et al., 2012). The challenges to understanding the phenomenon of vulnerability are inherent in what determines one's vulnerability; the multiple occurrences of factors that leads to an individuals' unique experience of vulnerability, commonly referred to as "multi-vulnerability." The struggles they face on a daily basis calls attention to the powerlessness, and disadvantage where navigating the system to access services becomes impossible. As one SP said, "it's like a Mount Everest for someone "who just [had] both of their legs broken. It's like why even try, you know? I can't even walk, you're expecting me to climb a mountain? You know, that's impossible!" Through their descriptions, SPs were able to capture the lived experience of IEHs, and in doing so, showed how experiences of vulnerability manifest.

SPs were able to describe the lived experiences of IEHs in such a way that allowed the numerous identities, and life histories represented among the homeless to be accounted for (Crenshaw, 1989, 1991; Jackson et al., 2016). Avoiding a priori identity such as a "type of homeless" individual or identity, allowed for other instances of social adversities that create vulnerability experiences among IEHs to manifest. For example, insight into how IEHs interact with each other, and with society as a whole.

Crisis Time and Burnout

Trust becomes an important determinant in how productive SPs provide are at meeting the needs of IEHs. In addition to being successful, is the timing at which clients present to the service agencies with a crisis. The three crisis intervention points that SPs interacted with IEHs include of the pre or early-crisis, mid-crisis, and post-crisis. Pre or early-crisis is the time that SPs prefer clients to come to them as they are able to do something before "it's too late" as they are able to "be more involved," "able to" help them before the situation worsens. SPs feel they can intervene quicker, avoid "snowball issues," avoid homelessness, and overall are more involved. The mid-crisis stage is still a time SPs feel able to do something as clients are not "down to zero" as such, severe consequences such as homelessness for some is

still avoidable. The post-crisis is the point of no return where IEHs have exhausted all resources , and support systems , and is where most individuals are when they finally reach out to SPs.

In reality, most clients present to the providers when they have exhausted all other means such as savings or family support , and are either on the verge of homelessness or new to crisis homelessness. The complexity of needs, limited resources , and coming “too late” negatively impacts SPs. This occurrence, occurred frequently as one SP states “same story second verse” alluding to this. The reactions to these “constant , and repetitive” realities create feeling of helplessness in that they feel unsuccessful or unable “to do anything”. This helplessness as described by another SP can occur through “feelings of being burnout or being overwhelmed” where it becomes difficult to “stay positive when you feel like things aren’t changing”.

The negative psychological experience that as a result of job-related stress , and exhaustion is termed “burnout” , and affects employees in all occupations (Acker, 2010; Baker, O’Brient & Salahuddin, 2007). Professional burnout can be expressed through emotional exhaustion , and feeling of low personal accomplishment (Acker, 2010; Baker, O’Brient & Salahuddin, 2007). Therefore, worker burn-out among the SPs manifested through feelings of inadequacy.

In a quantitative study with 591 social workers, Acker (2010) found that workers with high self-perceived competence reported lower levels of emotional exhaustion. This competence enabled them to problem solve , and respond successfully to complex , and changing tasks. In a quantitative study with 123 female shelter workers, Baker et al. identified low levels of self-efficacy as predictors of emotional exhaustion (2007). Therefore, given the complex , and constantly changing needs that IEHs present with, the feelings of inadequacy that ultimately lead to worker burnout can negatively impact client’s outcomes.

Commonly reported causes of professional burnout are work-overload lack of on the job social support, limited resources, unpleasant or unsafe working conditions, limited time in accomplishing tasks (Acker, 2010; Baker et al., 2007; Gary-Stanly & Muramatsu, 2011). For SPs, the mention of clients coming in “too late” or not “early enough” call attention to a new factor that may influence worker burnout.

Therefore the “crisis time” encompasses aspects of work load , and limited time that are commonly reported , and studied as determinants of worker burnout.

Limitation of the Study

The major strength of this study was the use of a qualitative approach to examine service providers’ perception of vulnerability as a determinant of health among IEHs. The decision to use qualitative research was based on the desired research product, to understand vulnerability as understood by service providers (Starks, 2007). This research approach acknowledges the depth , and complexity of vulnerability by not reducing its occurrence to a single variable, but rather representing it entirety in the everyday context (Flick, 2009).

The second strength of the study was the service providers that participated in the study. Their close , and frequent interaction with IEHs especially in the service provision context gives them a close look into their lived experience (Patton, 2015). The number of years represented collectively by SPs in working with IEHs provides over twenty years of experience , and interactions. Furthermore, their stories , and recollections of interactions with IEHs represent interactions , and stories of numerous clients that due to study limitations, would be impossible to reach them all.

This study’s limitations are mostly related to the use of a qualitative research approach. Therefore, the sample size , and use of purposive , and snowball sampling may result in the exclusion of potential study participants. The small sample size was acceptable since this was a qualitative study where the breadth , and richness of information gathered adequately contributes to the evidence while offering a variety of experiences , and ideas (Palibroda et al., 2009; Ritchie & Lewis, 2003; Wang, 1999). Furthermore, in remaining true to the digital storytelling process where close collaboration between the researcher , and participant is needed, this further limits the number of study participants so as to assure adequate time is spent with each participant (Gubrium & Turner, 2009).

Another limitation is self-reporting, where the data collected solely relied on what the participant chooses to share. Lastly, the uniqueness of the study population limits the generalizability of the study to other populations or contexts. Focus on the local context was important so as to understand the unique

experience of IEHs in Denton County (Hankvisky, 2012, 2014). Intersectionality challenges universalism, and acknowledges diversity or heterogeneity. As such similar studies conducted in different contexts are needed to generate a comprehensive understanding of vulnerability among IEHs.

These studies should utilize both quantitative, and qualitative methods with mixed-methods as this allows for the inherent strengths in both methodologies to be realized (Creswell, 2014). Typically, these marginalizing identities are isolated, and studied individually. The difficulty is determining how to go about studying these synergies comprehensively. Looking at one's vulnerability offers a comprehensive approach at studying the synergism of multiple identities of marginalization (Bowleg, 2012; Caiola et al., 2014; Crenshaw 1989, 1991). Therefore, studies that allow flexibility in studying synergies comprehensively rely more on qualitative emic approaches that give voice to those individuals closest to the experience (Caiola et al., 2014; Patton, 2015; Spiers, 2000).

The Power of Digital Storytelling

The digital stories created provided visible, and authentic narratives into lived experiences of IEHs bringing insight to their living on the street, and their interactions with society, and service providers (Lai et al., 2014; Njeru et al., 2015; Walsh, Rutherford & Kuzmak, 2009; 2010). They provide a tangible, and easily disseminated product that can help raise awareness about IEHs while promote awareness aimed at fighting the stigma they experience (Lai et al., 2014; Njeru et al., 2015; Walsh, Rutherford & Kuzmak, 2009; 2010). In addition, based on the contact hypothesis, this awareness represents an "interaction" or exposure that can aid in changing the attitudes, and perceptions of the domiciled population (Lee et al., 2004). Therefore, as a research, and dissemination method, DST provided a novel way to understand how SPs perceived the lived experience of IEHs while providing rich descriptions, and knowledge that is authentic (Lai et al, 2014).

These stories also helped facilitate the information sharing forum conducted at conclusion of the study. This forum provided findings on the lived experiences of this population, and pertinent information that can be used to inform service planning, and provision methods. To date, the DSTs that were created have been disseminated to various agencies, and individuals interested in working with the homeless

(Appendix L). This lends additional support of the usefulness of DSTs as a creative, timely , and applicable method of study disseminations. Lastly, by providing study participants the opportunity to share their perspectives, DSTs provide insight in a way beyond facts , and figures that not only adds depth to a study, but can be understood by the general population.

Implications for Research

Until we understand how one's identity, specifically social identity impacts their everyday living, solutions employed to avoid , and decrease health disparities continue to simply tackle the visible ripples seen rather than the root causes of those ripples. By understanding vulnerability, we can appropriately tackle the social inequities imbedded in society , and ultimately work to achieving health equity.

An intersectionality framework provided a method of inquiry that allowed flexibility , and opportunity to discover what factors in the given context lend to vulnerability among IEHS. Guided by tenets that discourage approaching vulnerability based on pre-determined or pre-hierarchical factors, an intersectionality approach leaves room for other factors that may be obscured to materialize (Hankivsky, 2012; Hankivsky et al., 2010). This study aimed to expand the lens of intersectional inquiry, to explore how service providers perceive vulnerability among IEHs. Service providers used interviews , and digital storytelling to tell of how vulnerability manifests in the lived context by focusing on the interactions with others in the service context. Doing so lends guidance to how interventions should be targeted , and provided.

Adaptive Interventions

More adaptive , and individualized intervention programs should be developed to address those specific needs that IEHs have. The challenge is that these needs change from day to day, making it difficult to create certain programs. Albeit this challenge, efforts to understand the specific needs of the population being served calls for time spent interacting with IEHs outside the service setting (Harper & Schneider, 2003; Kate-Wise & Hyde, 2012; Stuber et al., 2003, 2008; Zerger et al., 2014). By taking "services" into the "communities" barriers that IEHs face in accessing services such as transportation , and time constrictions can be minimized or eliminated (Hodgetts et al., 2007; Lee et al., 2010; Olivet et al., 2010;

Parsell, 2011). This can also facilitate trust between SPs , and IEHs which is crucial to increasing the likelihood of care continuity among this group (Romeo, 2005; Zerger et al., 2014; Zlotnick et al., 2013). In addition, when trust is present, assessments done during outreach events such as the VI-SPDAT can provide accurate measures of who is truly vulnerable as IEHs will be more forthcoming with information.

Most interactions with IEHs occur in the service context where clients reach out to SPs for certain services or needs. These clients usually have a deep mistrust of clinics , and hospitals inclusive of anyone connected or working with these institutions (Zlotnick et al., 2013). Therefore, for SPs the importance of time in cultivating relationships , and trusts tend to take precedence as this helps undo some of the mistrust from previous interactions with other SPs. In addition this relationship can foster a strong working relationship that makes “continuity of care” possible. This is crucial given the transient nature , and numerous barriers IEHs face in accessing services (Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000). When trust exists, SPs have reported the increased likelihood that clients will come back especially given the nature of time. The presence of trust denotes the existence of a relationship which is crucial for IEHs as it makes them feel wanted or welcome. Wen et al. (2007) found that this feeling of welcomeness increases the likelihood of seeking care in the future.

In creating adaptive , and individual specific solutions to tackle homelessness, care should be taken when implementing a “housing first” approach which prioritizes individuals based on length of homelessness , and medical (Henwood et al., 2015). Vulnerability assessment tools such as the VI or VI-SPDAT are used to determine housing priority (Cronley et al., 2013; CS&OC, 2014; DESC, 2010, n.d.; Gelberg et al., 2000; OPD&R, 2012; Spence-Almaguer et al., 2013; Stein et al., 2007). These assessment tools are widely used since IEHs medical vulnerability is evident in the high unmet health needs , and premature mortality they experience (Bernstein et al., 2015; Fazel et al., 2014; Gelberg et al., 2000; Henwood et al., 2015).

In the study, SPs allude to the idea that “housing first” approach sets IEHs up for failure since they lack the life skills to manage the housing provisions given. Care should be taken that the intervention of “housing first” is most appropriate for an individual. Furthermore, those that have been homeless longer

have learned to “live a certain way”. As such, they may need to go through a process of support , and re-integration where they “re-experience” having a home , and being part of the domiciled society. In other words, a re-orientation back into society , and into living in a home should be included in the intervention model (Hauff & Secor-Turner, 2014).

Anti-Oppression Interventions

Solutions that tackle the impact , and occurrence of oppression for IEHs are needed to help prevent or mitigate the negative health impacts. Interventions aimed at empowering IEHs to participate in tackling some of the barriers they face interacting with others is crucial. Creating “counter-spaces” in various setting provides opportunities for IEHs to adaptively respond to oppression , and mitigate their consequences through collective action , and groups that challenge the stigma they face with society. This response to oppressive situations that maintain psychological wellness is called “adaptive responding” (Case & Hunter, 2012). This response can disrupt or challenged those norms or practices that further oppress marginalized individuals (Case & Hunter, 2012; Hankivsky, 2014; Vasas, 2005).

The digital stories that were created provide an example of how efforts to “normalize” IEHs in the publics’ eye can occur (Lee et al., 2004). Service providers mention this as a solution to tackling the stigma IEHs face by raising awareness of the struggles IEHs face , and how these impact their health , and wellbeing. IEHs can also share their lived experience through digital stories to raise awareness of their “normalcy” as human beings , and active members of society.

Prevention Solutions

Solutions aimed at preventing homelessness are needed. SPs allude to the “preventability” of homelessness through early interventions , and “catching” people earlier in the crisis. These early interventions can take place by raising awareness of services available to people on the verge of homelessness, an issue that was raised frequently. Individuals that became homeless did not know there were services such as rental assistance, medication assistance or employment support that they could have utilized prior to loosing housing. This shows a lack of cohesion in not only the visibility of services but the availability of the information to the general public. Also, one SP suggested the idea of “first responders,”

those individuals in the community that are the “first to know” that something is wrong. These include teachers, bankers or landlords. By providing these responders with information they can disseminate, they can facilitate the “early intervention” process for people in crisis that are at risk for homelessness who don’t have the necessary economic , and social support resources to buffer them during a crisis (NHCHC, 2015; Thoits, 2010).

Most clients present to the providers when they have exhausted all other means such as savings or family support , and are either on the verge of homelessness or new to crisis homelessness. The complexity of needs, limited resources , and coming “too late” negatively impacts SPs. This occurrence, occurred frequently as one SP states “same story second verse” alluding to this. The reactions to these “constant , and repetitive” realities create feeling of helplessness in that they feel unsuccessful or unable “to do anything.” This helplessness as described by another SP can occur through “feelings of being burnout or being overwhelmed” where it becomes difficult to “stay positive when you feel like things aren’t changing.”

The negative psychological experience that as a result of job-related stress , and exhaustion is termed “burnout,” and affects employees in all occupations (Acker, 2010; Baker, O’Brient & Salahuddin, 2007). Professional burnout can be expressed through emotional exhaustion , and feeling of low personal accomplishment (Acker, 2010; Baker, O’Brient & Salahuddin, 2007). Therefore, worker burn-out among the SPs manifested through feelings of inadequacy.

In a quantitative study with 591 social workers, Acker (2010) found that workers with high self-perceived competence reported lower levels of emotional exhaustion. This competence enabled them to problem solve , and respond successfully to complex , and changing tasks. In a quantitative study with 123 female shelter workers, Baker et al. identified low levels of self-efficacy as predictors of emotional exhaustion (2007). Therefore, given the complex , and constantly changing needs that IEHs present with, the feelings of inadequacy that ultimately lead to worker burnout can negatively impact client’s outcomes.

Commonly reported causes of professional burnout are work-overload lack of on the job social support, limited resources, unpleasant or unsafe working conditions, limited time in accomplishing tasks

(Acker, 2010; Baker et al., 2007; Gary-Stanly & Muramatsu, 2011). For SPs, the mention of clients coming in “too late” or not “early enough” call attention to a new factor that may influence worker burnout. Therefore the “crisis time” encompasses aspects of work load , and limited time that are commonly reported , and studied as determinants of worker burnout.

To circumvent SP burnout , and helplessness, the need to early interventions through education , and awareness is tantamount. This provides an opportunity for the community to play a role in tackling the presence , and impact of homelessness as well as raise awareness about who the homeless are. As discussed earlier, IEHs make up a heterogeneous group , and have varying causes of homelessness. In addition, their acculturation into a life of survival is important for SPs , and the community working to end homelessness. Therefore, education , and training for SPs working with this group is crucial to implementing interventions that are relevant , and culturally competent.

Future Studies

Experiencing vulnerability through processes of marginalization create social inequalities among individuals experiencing homelessness. Experiencing vulnerability is tied to both identity, location , and social position; in other words vulnerability is unique to each individual , and setting. Therefore, future studies should focus on expanding knowledge on vulnerability as a determinant of health among other marginalized groups. Specifically, how marginalization occurs in a given social context , and how an individual’s social identity influences this experience.

Lastly, a major pathway in which marginalization impacts health is through the stress processes, activated when interactions between IEHs , and the domiciled groups that are perceived to be discriminatory (Stuber et al., 2008). The length of time an individual experiences ongoing stressors, such as those faced by IEHs works to sustain , and widen disparities such as increased rates of premature mortality , and quicker health deterioration. Stressors proliferate over the life course , and generations leading to more health disparities (Thoits, 2010). This brings attention to the need to focus on children , and adolescents experiencing homelessness individually or as part of family homelessness. Given the acculturation that occurs among IEHs, the likelihood that they will experience lifelong homelessness lends

insight to the severe vulnerability they will experience as a result. Considering early life stressors, lack of life skills, and experiences of marginalization stress, they represent a new vulnerable group that experiences “triple vulnerability”, and more health disparities.

Summary

The purpose of this study was to understand how vulnerability occurs or manifests in the lived context by allowing service providers working with IEHs the opportunity to tell their story. Specifically, the purpose was to understand service providers’ perception of vulnerability as experienced by the homeless population, a well-known, and observed marginalized group.

This study expands intersectionality research by utilizing digital storytelling to tell of how vulnerability manifests in the lived context, allowing insight into the interactions between service providers, and IEHs in the service context. These findings add to the current body of literature as it provides insight on the service provision context as depicted by service providers. To date, the body of knowledge about the lived experience of IEHs has, as to be expected come from the perspectives of the homeless. Albeit crucial, including service providers’ insight, not only adds to a comprehensive understanding of how vulnerability manifests in the lived environment but lends insight into other factors that can influence these experiences of vulnerability. The interaction between service providers, and IEHs afford opportunities for social adversities that further marginalize this population to manifest. This study provided insight into how interactions with IEHs can create positive change among service providers leading to adapted, and effective intervention strategies.

Conclusion

The findings from this study also lend insight on creating context specific typologies of vulnerability that allows others working with this specific population a way to accurately assess vulnerability, and create effective disparity interventions. This understanding would offer insight on how to best identify key constructs related to social vulnerabilities as determinants of health (Spiers, 2000). Insight into how vulnerability is experienced by IEHs, and perceived by SPs provided an operational definition of vulnerability that is context specific. This definition takes into account the “living” done by

IEHs , and is defined as “a life of struggle where IEHs live a life of hiding, in motion , and on borrowed time”. This definition is specific to the local context , and the various identities of marginalization IEHs represent. It provides a way for SPs to determine who is most vulnerable by looking at who lives a life of hiding, always in motion , and has no control of time? As one SP said, “they are embedded in our schools , and our neighborhoods , and we have no clue how many there are”. In other words, it challenges the idea that the most vulnerable is not the one who seeks out services, but the one you never see.

Additional studies are needed to help inform knowledge production on vulnerability as a determinant of health among marginalized individuals. Since experiencing vulnerability is tied to both identity, location , and social position, its expected there will be variations of this. Albeit these variations, the underlying concepts remain inclusive of one’s identity, occurrence of marginalization , and an oppressive environment. Vulnerability occurs in the everyday lived context , and is not isolated or always obvious. The presence of social inequalities in society leads to the creation , and reinforcement of health disparities.

Therefore, the presence of health disparities can be described an expression of vulnerability among marginalized individuals. Said another way, an individuals’ marginalized identity coupled with an oppressive environment leads to the creation , and perpetuation of health disparities. As such, the health disparity pathways are the same pathways that lead to good health. The difference is the experience of oppression by one group , and supports the concept of fundamental cause theory that vulnerability is a determinant of health among IEHs. This experience creates disadvantages that ultimately lead to differential outcomes. By understanding how vulnerability manifests among historically marginalized groups such as IEHs those often covert micro aggressions can be identified , and solutions enacted to either eliminate their occurrence or mitigate their impact.

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APPENDIX A
IRB Approval Letter



Institutional Review Board

Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX
76204-5619 940-898-3378
email: IRB@twu.edu
<http://www.twu.edu/irb.html>

DATE: August 18, 2016

TO: Ms. Elizabeth Wachira

Health Studies

FROM: Institutional Review Board (IRB) - Denton

Re: Approval for The Emic-ization of Health Disparities: An Exploration of Service Providers' Perception of Vulnerability among Individuals Experiencing Homelessness (Protocol #: 19138)

The above referenced study has been reviewed and approved by the Denton IRB (operating under FWA00000178) on 8/18/2016 using an expedited review procedure. This approval is valid for one year and expires on 8/18/2017. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A copy of the approved consent form with the IRB approval stamp is enclosed. Please use the consent form with the most recent approval date stamp when obtaining consent from your participants. A copy of the signed consent forms must be submitted with the request to close the study file at the completion of the study.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc.

Graduate School

APPENDIX B

National Institutes of Health IRB Certification



APPENDIX C

Study Participants Recruitment Email Narrative

Greetings,

My name is Elizabeth Wachira and I am a doctoral candidate at Texas Woman's University in the Health Studies Department. I am conducting research exploring what factors increase the likelihood of poor health among individuals experiencing homelessness and how these factors occur or appear in their everyday life.

Current health data on individuals experiencing homelessness shows that they continue to experience poor health outcomes. As such, this study looks to better understand your view and opinion of the characteristics and factors that describe the life of individuals experiencing homelessness and how these factors affect their health. This understanding can help service agencies and providers better target the most at risk population and apply successful interventions that improve their health and wellbeing. To make sure this research is meaningful to those working with individuals experiencing homelessness, an information sharing meeting will be conducted at the end of the study to share the research findings.

In order to participate in the study, you must be aged 18 or older and work in an agency that serves individuals experiencing homelessness in Denton County and have at least three years working experience with individuals experiencing homelessness. If you do not meet this criteria or know others who may be interested, please feel free to forward and share this email and flyer with them.

Attached is a research recruitment flyer that gives an overview of the study and participation details. Participation in this study is voluntary and can be withdrawn at any time. Your participation includes three sessions with the researcher. The first will be a 60 minute interview to discuss the following topics: causes of homelessness, needs of individuals experiencing homelessness, and factors that affect the health of those experiencing homelessness. The second meeting will be to create your digital story and the third will be to meet with other service providers to view all digital stories and share study findings. The total time commitment for this study including the three meetings and picture taking will be approximately 52 hours.

If interested in participating or for additional study information, please contact the Principal Investigator via email or telephone listed below. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

Elizabeth Wachira, BSN, MPH, CHES
Doctoral Candidate, Department of Health Studies
Texas Woman's University
ewachira@twu.edu 254-xxx-xxxx

APPENDIX D
Study Participants Recruitment Flyer

Ever wanted to share with others your work experiences?

What's Risk got to do with it?

Individuals experiencing homelessness continue to experience poor health outcomes despite efforts taken by various community organizations such as yours to improve their health and wellbeing. This study aims to understand what factors increase the likelihood of poor health among individuals experiencing homelessness and how these factors occur or appear in their everyday life. This understanding can help service agencies and providers better target the most at risk population and apply successful interventions that improve their health and wellbeing

WHO: Service providers with at least three years of experience working with individuals experiencing homelessness. Participation in this study is voluntary and can be withdrawn at any time.

WHAT: 3 sessions with the principal investigator

1. One 60 minute interview by phone or in person
2. One 90 minute digital storyboard making session and interview in person
3. Attend one 90 minute information sharing session to hear about study findings

WHERE: First two sessions at your location of choice. Third session in a local public location

Brief Requirements:

- Be able to meet with principal investigator at least 3 times
- Take pictures, write a short story and put together a digital storyboard

INTERESTED? Contact EWachira@twu.edu 254-xxx-xxxx

Want more information: Please contact the Principal Investigator: Elizabeth Wachira

Dr. Kimberly A. Parker – Faculty Mentor Texas Woman's University

There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions.

APPENDIX E
Service Providers Consent Form

Service Providers Consent Form

**TEXAS WOMAN’S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH**

Title: The Emic-ization of Health Disparities: An Exploration of Service Providers Perception of Vulnerability Among Individuals Experiencing Homelessness

Investigator: Elizabeth Wachira.....ewachira@twu.edu
Faculty Advisor: Kimberly A. Parker, PhD..... kparker6@twu.edu 940/898-2899

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Wachira’s dissertation at Texas Woman’s University. The purpose of this research is to examine what factors increase the likelihood of poor health among individuals experiencing homelessness and how these factors occur or appear in their everyday life. You have been asked to participate in this study because you work in an agency that serves individuals experiencing homelessness and have at least three years of experience working with individuals experiencing homelessness.

Description of Procedures

As a participant in this study you will be asked to meet with the researcher three times. The first meeting will be a one hour interview with the researcher, the second meeting will be 90 minutes to arrange and then reflect on your digital story. The third meeting will be a 90 minute group meeting with other service providers. You and the researcher will decide on meeting times and locations for the two sessions. In the first meeting, the researcher will go over the research study, answer any questions and obtain your consent to participate if you chose to. Afterwards, the researcher will ask you questions so as to better understand your view and opinion of the characteristics and factors that describe the life of individuals experiencing homelessness and how these factor affect their health. Following this interview, you will be asked to write a short story about your experience and interaction working with individuals experiencing homelessness and to find or take pictures to help tell this story. You will have approximately 48 hours to find or take pictures using your own camera or the disposable camera provided. If you chose to use the disposable camera, a short meeting with the researcher will be scheduled to collect your camera so pictures can be available for the second meeting. The second meeting will be 90 minutes where you will record your short story, and arrange this story and your pictures on a board so that it can be used to create a short video. Once arranged, the researcher will ask you questions about your storyboard and how this helps tell your story. The interview will be audio recorded and then written down so that the researcher can be accurate when studying what you have said. The third meeting will occur at the conclusion of the research study, where all service providers will be invited to an

_____ Initials Page 1 of 3

information sharing meeting where the researcher will share the research findings and digital stories. The total time commitment for this study including the three meetings and picture taking will be approximately 52 hours.

In order to be a participant in this study, you must be at least 18 years of age, work in an agency that serves individuals experiencing homelessness and have at least three years of experience working with individuals experiencing homelessness.

Potential Risks

The researcher will ask you questions about your experience working and providing services through your agency as they relate to individuals experiencing homelessness as well as write a story about these experiences. A possible risk in this study is discomfort with these questions you are asked. If you become tired or upset you may take breaks as needed. You may also stop answering questions at any time and end the interview. A list of national state and local agencies that provide counseling and emotional support is provided below to help reduce the risk of emotional discomfort.

Emotional Support Agencies

National Agency Resources

American Psychological Association

<http://www.apa.org/helpcenter/wellness/index.aspx>

Texas Psychological Association

<http://www.texaspsyc.org/?PublicEducation>

Mental Health America

<http://www.mentalhealthamerica.net/living-well>

Local County Resources

Child and Family Resource Clinic at University of North Texas

<https://www.coe.unt.edu/child-and-family-resource-clinic>

Phone: 940-565-2066

1115 W. Chestnut

Denton TX 76201

Counseling & Family Therapy Clinic at Texas Woman's University

<http://www.twu.edu/family-sciences/counseling-family-therapy-clinic.asp>

Phone: 940-898-2600

304 Administration Drive

Denton TX 76201



Counseling and Human Development Center at University of North Texas

<https://www.coe.unt.edu/counseling-and-human-development-center>

Phone: 940-565-2970

425 S. Welch St.

Welch Street Complex 2

Denton Bible Church Support Groups

<http://dentonbible.org/care/support-groups/>

Psychology Clinic Agency at University of North Texas

<http://psychology.unt.edu/clinics-and-centers/psychology-clinic>

Phone: 940-565-2631

PO Box 311280

Denton TX 76203

United Way of Denton County (Mental Health Resources)

<http://www.unitedwaydenton.org/FindHelp>

For Helpline, dial: 2-1-1 or 940-566-2688

Another risk in this study is loss of confidentiality. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions. Confidentiality will be protected to the extent that is allowed by law. A code name, not your real name, will be used during the interview. No one but the researcher will know your real name. The tapes and the written interviews will be stored in a locked cabinet in the researcher's office. Only the researcher and her advisor will hear the tapes or read the written interview. The tapes and the written interview will be shredded within six months after the study is finished. You will have the option to complete the interview and sessions at a location of your choice to allow privacy and opportunity to ask questions. The results of the study will be reported in scientific magazines or journals but your name or any other identifying information will not be included.

Another risk in this study is loss of anonymity while participating in the research. Anonymity cannot be guaranteed if one chooses to complete the interview questionnaire in a public location. No personal identifiable data will be collected. Consent review with the Principal Investigator will be done individually. You will be able to ask questions one-on-one with the Principal Investigator and have the option to meet for the interviews and digital storytelling component in your location of choice allowing for privacy and opportunity to questions.

Initials
Page 3 of 3

Another risk in this study is loss of time. The researcher will review the study and estimate time commitments for the entire research process at the beginning of the study and at each session. Your participation in the study is voluntary and you can stop at any time you chose to. The total time commitment for this study including the three meetings and picture taking will be approximately 52 hours.

Another risk in this study is coercion to participate in the study. Your participation in the study is voluntary and you can stop at any time you chose to. Even if you chose not to participate in the study, you will be given the opportunity to attend the information sharing session at the conclusion of the study.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. If you cannot make the information sharing session and would like to know the results of this study I will mail them to you.*

Questions Regarding the Study

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researchers; their phone numbers are at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

Signature of Participant

Date

*If you would like to know the results of this study tell us where you want them to be sent:

Email: _____

(or)

Address: _____

APPENDIX F
Service Providers Demographic Data

Part 1

Service Providers	Gender	Years of Experience working with IEHs	Years at Current Agency	Interaction Frequency
SP1	Male	3	2	Weekly
SP2	Female	8	1	Weekly
SP 3	Female	5	5	Daily
SP4	Female	20	2	Weekly
SP5	Female	16	1	Weekly
SP6	Female	18	1	Weekly
SP7	Male	3	2	Weekly

Part 2

Service Providers	Job Credentials	Job Title at Current Agency	Service Focus
SP1	Lay Worker	Executive Director/President	All
SP2	Social Worker	Community Navigator	Resource Support
SP 3	Registered Nurse	Executive Director/President	Health
SP4	Social Worker	Program/Care Coordinator	Housing
SP5	LPC - Counselor	Program/Care Coordinator	Mental Health Wellness
SP6	Not Applicable	Program/Care Coordinator	Education/Support
SP7	Lay Worker	Peer Support	Resource Support

APPENDIX G

Ethnography Observation Log Template

Date:

Time:

Site:

Length of Observation:

PRE-OBSERVATION

1. The research setting:

Where will we go to be able to observe setting aspects of how disempowered positions in society are formed and reinforced based on the variables?

Activity =

Participants =

2. **Gaining access:** How are we going to gain access to the population and the setting

3. **Presenting yourself:** Are we going to be actively engaged in the observation (emic) or be outside observers (etic)?

4. **Data recordings:** Based on the setting, what will be the best way to record or collect data? Why? (Pictures etc.)

OBSERVATION: On Site

5. **Observations at field site:** (who, what, when, where, how)

Descriptive: (objective) *ex: 5 students, 2 sleeping, one distant, no coffee, no one is coming*

Interpretive: (value-laden, subjective, and evaluative) *ex: IEHs are always thankful for presence, but weary of newbies*

Reflexive: (introspective/my commentary/analytical) *ex: OC- Denton seems pro-homeless and many IEHs always seem to return. One issue is lack of collaboration b/n agencies*

6. **Summary:** One paragraph of day's events:

POST-OBSERVATION:

7. **Personal reflections:** Your personal reflections matter when conducting ethnographic research.

8. **Emerging questions/thoughts:** Questions/things to follow up with

RECORDING LOG (transcription):

APPENDIX H

Service Provider Interview Questionnaire

Service Provider Interview Questionnaire

Hello, my name is Elizabeth Wachira and I will be interviewing you so as to gain insight on the characteristics, needs and lived experiences of the population your agency serves in Denton, particularly individuals experiencing homelessness.

During the interview, I would like to discuss the following topics: causes of homelessness, needs and perceptions of vulnerability among those experiencing homelessness.

Research Questions:

1. How do individuals experiencing homelessness define vulnerability?
2. How do service providers define the vulnerability of individuals experiencing homelessness?
3. How do service providers perceive the vulnerability of individuals experiencing homelessness?

Corresponding Research Question (RQ)	Interview Questions	Possible discussion/clarifying discussion Questions
General/ Introductions	<ul style="list-style-type: none"> • What is your role in this agency? • How long have you worked with this agency? • What services does your agency offer? • Can you describe your (1) typical day (2) typical client 	<p>(Education/training background needed?)</p> <ul style="list-style-type: none"> • Demographic characteristics (R/E, age, length of homelessness) • Health status
RQ #3	<ul style="list-style-type: none"> • How often do you work with individuals experiencing homelessness? • How do the services your agency offers meet the needs of individuals experiencing homelessness? 	<ul style="list-style-type: none"> • Years of experience working with individuals experiencing homelessness • What services do <u>you</u> mostly provide? • What are their greatest needs? <p><i>Is there anything else you would like to add?</i></p>
RQ #3	<ul style="list-style-type: none"> • What factors do you think lead to their being homeless? • How would you say their being homeless affects their health and well-being? (work, mental status) • What do you feel needs to happen to (1) prevent homelessness (2) get them out of homelessness 	<ul style="list-style-type: none"> • Any common/usual factors? • Initial or chronic homelessness? • What does their typical day look like? • Can you give me some examples • Can you expand a little on this? <p><i>Is there anything else you would like to add?</i></p>

	(3) Avoid chronic occurrences?	
RQ #1, 2	<ul style="list-style-type: none"> • How do you think individuals experiencing homelessness see their “being homeless” • Do you think they view themselves as being vulnerable due to this? (health, overall) 	<ul style="list-style-type: none"> • Can you expand a little on this? • Can you give me some examples <i>Is there anything else you would like to add?</i>
DST Prompt	Write a short story about your interaction or experiences working with individuals experiencing homelessness	Your best, worst or most memorable day of working *Find or take pictures to help tell this story

Next meeting: _____

APPENDIX I

Digital Storytelling Storyboard Template

Images/Screenshots

Tap icon to add picture



Video/slide description

Description: (what will be seen?)

What needs to happen (ex: Zoom in a part of the picture)

Script(voice over)

*If not voice-over , what other audio? (music, sirens etc)
(Indicate duration: for whole picture or half or extend to next screen?)

Production Notes

Ex: Transitions? Effects? Slide duration?

Indicate Transition if any to next slide

APPENDIX J

Digital Storytelling Reflection Interview Questions

Digital Storytelling Reflection Interview Questions

Now that you have arranged your storyboard, I would like you to reflect on it and give additional insight into your story. Specifically, what message do you want to share through your digital story and how your narrative and pictures help you get this message across?

Research Questions:

1. How do individuals experiencing homelessness define vulnerability?
2. How do service providers define the vulnerability of individuals experiencing homelessness?
3. How do service providers perceive the vulnerability of individuals experiencing homelessness?

Corresponding Research Question (RQ)	Interview Question	Possible discussion/clarifying discussion Questions
RQ #1, 2, 3	What is your digital story about?	Can you tell me about the story behind your digital story?
RQ #3	What is happening in your digital story? (What is the unseen story behind the pictures?)	What made you chose these particular photos? What was going through your mind when you wrote your narrative? What was going through your mind when you took these photographs?
RQ #1, 2, 3	What does this story (storyboard) tell us about your experience working with individuals experiencing homelessness?	(How does this relate to (1) your experiences working with individuals experiencing homelessness (2) their life? Overall is this a good, bad or common experience or occurrence?
RQ #1, 2, 3	Why are things this way? (Why does this experience, situation, concern, or strength exist?	What control do you have about (this situation)? Do you feel in control or effective in your interactions with individuals experiencing homelessness?
RQ #1, 2, 3	How could this digital story educate people about (1) your experience working with individuals experiencing homelessness (2) the lived experience of individuals experiencing homelessness?	Can you tell me how your digital story captures your everyday life as a service provider? Describe a typical day at work. - Describe your best day in the past month - Describe your worst day in the past month

RQ #3 (Optional)	What can we Do about it?	If the digital story is a fantasy or positive vision of the future, what is blocking this dream from becoming a reality? <i>Is there anything else you would like to add?</i>
General	Who should see this digital story?	How can it be used?

Interview adapted from the SHOWeD Method used in Photovoice (Wang & Burris, 1999; Catalina & Minkler, 2010; MAPC, 2015).

APPENDIX K
Overview of Findings

Characteristics of IEHs	
Descriptors	Needs
Diverse	Transportation
Middle - Older age	Health Needs
Gender – evenly distributed	Shoes
Chronically Homeless	Information
Educated	Support
Uneducated	
Immigrants	
Families	
Physical/Mental disabled	

About Homelessness		
Overall	Causes of Chronicity	Impact of Homelessness
Family/Social issues	Learned to Live This way	Dietary Issues
Snowball Issues	Systems Barriers	Poor Health
Mental Illness	Hopelessness	Stress
No Support		Overall
No life skills		Loss of Social Support
Health Crisis		
Unemployment		

Tackling Homelessness	
Solutions to Tackling Homelessness	Barriers
Individualized/Adaptive Interventions Collaborations with Others Fight Stigma Early Intervention First Responders Long Term Support Family-School System Outreach Based Life Skills Tackle Underlying Issues First Housing First Employment Support	Agency Level Community Level Interpersonal Relationships

Determinants of Health	
Material Disadvantages	Psychosocial Disadvantages
Economic Information - Resources Shelter Insurance Transportation Lack of Identification	Interpersonal Stigma Stereotypes Criminalization Fear of IEHs Discrimination - Landlords Structural Agency Times "welcomeness" Agency Policies - Shelter

APPENDIX L
Digital Stories Links

Digital Stories Links

Working on the Margins. <https://www.wevideo.com/view/864723340>

The Light Changed. <https://www.wevideo.com/view/864753200>

I am Need. <https://www.wevideo.com/view/864760747>

Long Walk Home. <https://www.wevideo.com/view/781438094>

More Not Less. <https://www.wevideo.com/view/781377489>