

Everyone Deserves a Sanctuary: Alienation as a Barrier to the Health and Healing of Older
Women Who Experienced Homelessness

by

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B.Sc., University of Calgary, 2017

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Social Dimensions of Health Program

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University of Victoria

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stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with
the land continue to this day.

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Abstract

Experiences of homelessness can result in social exclusion through stigmatization, discrimination, and displacement. Stress from lack of community integration for people who have been homeless can result in poorer health outcomes, including: higher rates of mental illness and chronic physical health conditions, substance dependence, loneliness, and suicide. This may be particularly true for older women who experience multiple intersections of marginalization. However, there is a lack of research that addresses how to facilitate a sense of belonging for and promote the health and healing of older women who have been homeless, and it is unclear what environmental conditions would help these women to transition out of homelessness and into a place of home that is stable, secure, and safe. This thesis stems from a larger community-based qualitative study that explores the experiences of older women who have been homeless and service providers in the homeless-serving sector, with the goal of building priority recommendations for system improvements.

My research aims to address two research questions: 1) how have older women been marginalized and rendered invisible within homeless environments; and 2) how do homelessness experiences and environments shape older women's behaviour? The theoretical frameworks of intersectionality and alienation guided this thesis, focusing on and developing insights into older women's experiences of stigma and social exclusion and the impacts this marginalization has on their health. My findings derived from a secondary analysis of 11 out of 20 existing qualitative interviews with older women who have been homeless in Victoria, British Columbia, which revealed that older women were marginalized in homeless environments through a lack of safety and autonomy that contributed to high levels of alienation. Alienation prevented the development of a sense of home and belonging after homelessness that in turn impacted older women's health

and wellbeing. The recommendations from this analysis suggest that greater consideration to the concept of therapeutic landscapes for older women after homelessness would offer more opportunity for them to develop a sense of home and belonging. Overall, this project aims to fill a current gap in the literature on the social exclusion and subsequent health outcomes of older women who have experienced homelessness in Canada.

Table of Contents

| | |
|---|------|
| Supervisory Committee | ii |
| Abstract | iii |
| Table of Contents | v |
| List of Tables | vii |
| List of Figures | viii |
| List of Abbreviations | ix |
| Acknowledgements | x |
| Introduction..... | 1 |
| Research Objectives and Questions | 5 |
| Literature Review..... | 7 |
| Homelessness and Older Women..... | 7 |
| Health Impacts of Homelessness on Older Women..... | 12 |
| Social Impacts of Homelessness on Older Women | 16 |
| Theoretical/Conceptual Frameworks | 21 |
| Summary | 28 |
| Methodology | 31 |
| Positionality..... | 31 |
| Research Approach | 35 |
| Ethical Considerations..... | 38 |

| | |
|---|-----|
| Sampling and Recruitment | 42 |
| Data Collection..... | 44 |
| Data Interpretation and Analysis..... | 46 |
| Knowledge Translation and Mobilization..... | 49 |
| Findings..... | 51 |
| Lack of safety for older women to express vulnerability while experiencing homelessness ... | 51 |
| Performing and hiding vulnerability: Older women’s acts of resistance | 64 |
| Discussion | 73 |
| The consequences of alienation..... | 79 |
| Alleviating alienation through safety in space | 82 |
| Limitations and Conclusions..... | 87 |
| References..... | 94 |
| Appendix A..... | 109 |

List of Tables

| | |
|--|----|
| Table 1: Demographics of Participants Included in Secondary Thematic Analysis..... | 48 |
|--|----|

List of Figures

| | |
|--|----|
| Figure 1: Coding Structure of Theme 1..... | 58 |
| Figure 2: Coding Structure of Theme 2..... | 71 |

List of Abbreviations

| | |
|----------|---|
| CBPR | Community-Based Participatory Research |
| COVID-19 | Coronavirus (SARS-CoV-2) disease 2019 |
| CRLEH | Community Researchers with Lived Experience of Homelessness |
| SHHOW | Solutions to Housing and Health for Older Women |

Acknowledgements

This thesis would not have been possible without the time, dedication, and expertise of my supervisory committee. In particular, I thank my supervisor, Dr. Denise Cloutier, for her consistent patience and support. She took me under her wing and allowed me to take off when I was ready to fly through writing this thesis as I was (and still am) grieving the loss of my father just over a year ago. I have much appreciated her understanding and guidance during this time, and throughout my thesis and graduate student experience. It has been both a once-in-a-lifetime and transformative adventure. As well, I also thank my co-supervisor Dr. Cecilia Benoit for offering her vast amount of knowledge in working with stigmatized populations.

In addition, I would like to thank the team of the Solutions to Housing and Health for Older Women (SHHOW) project. Specifically, I thank my colleague and friend Audrey Tung who has been a source of understanding and support throughout the project. We have shared many laughs and rants together that provided comfort and strength during what was otherwise an isolating and arduous graduate school experience in the midst of the COVID-19 pandemic. This work would not have been possible without her support and brilliance, and I feel privileged that we had the opportunity to grow together through the SHHOW project. I would also like to thank Ruth Kampen for her heartwarming optimism and tireless efforts in keeping us all informed of project activities. Finally, I thank our community researchers, Tracee, Blanche, Lynda, and Christy, for their incredible compassion, infinite wisdom, and powerful passion that kept this project going. I dedicate this work to them, along with all of SHHOW's participants, because of the fierce spirit and astonishing strength these women have showed in sharing their knowledge and experiences that has allowed me to learn and grow. May those who have passed on rest in peace knowing their spirit continues to improve the lives of women that follow them.

I also thank my former professor and mentor, Joe Kadi, whose heartfelt guidance and empathetic ear encouraged me through grim times when I had nowhere else to turn. He somehow knew exactly what I needed to hear in those moments, and I cannot thank him enough for his vast knowledge, brave sincerity, and continued support. Additionally, I thank my friend and mentor, Tamara Koltermann, whose light and love showed me the end of a dark tunnel so that I can now see a bright and optimistic future. Our informative chats have been powerful, inspiring, and healing, and I also cannot thank her enough for the vibrancy and heart that her glow has added not just to my work, but to my life as well.

I also thank my classmates, professors, and conference speakers that I had the privilege of learning from and sharing ideas with during the course of this thesis. Specifically, I want to thank Ashley Mollison who helped me feel welcomed in the Social Dimensions of Health program and whose gentle and kind support and encouragement with my proposal helped kickstart my ideas into the following thesis.

Finally, to all my friends and family who listened to my rants and offered me the laughs, comfort, and encouragement I needed to see this work through until the end, I offer my utmost thanks. In particular, I thank my mom, who I learn a great deal from in witnessing her continued bravery and endless care. I admire her strength in what has been the most challenging three years of our lives. This thesis represents the closing of this chapter for me, and I am excited to share some of the learnings I have gained with the help of each and every one of these incredible supporters that enrich my life and work.

Introduction

Despite the Canadian Housing Strategy Act (Government of Canada, 2019) that declared that “adequate housing is a fundamental human right affirmed in international law” (p. 2), homelessness, or living in precarious, substandard, unsafe, or unaffordable housing, persists in Canada (Gaetz et al., 2012). Estimates indicate that approximately 35,000 Canadians are homeless on any given day, and that yearly, 250,000 Canadians experience homelessness (Gaetz, Gulliver & Richter, 2014). Researchers in the area of homelessness report that in the 1980s and 1990s, the Canadian government pursued neoliberal policy shifts that defunded the national housing program and provided the foundation for the current prevalence of homelessness across Canada (Aubry, Nelson & Tsemberis, 2015; Navarro, 2009). Funding cuts to social services with a simultaneous reduction in the affordable housing stock resulted in a growth of the homeless population that continues to the present (Gaetz, 2010).

Canada’s history of settler colonialism is fundamental to understanding the issue of contemporary homelessness. According to Thistle (2017), individuals who are Indigenous are eight times more likely to experience an instance of homelessness than non-Indigenous people. Central to both colonialism and homelessness is dispossession from land, and the persistence of homelessness in modern settler societies for Indigenous communities provides evidence of the ongoing impacts of colonization (Thistle, 2017). While researchers Gaetz and colleagues (2012) from the Canadian Observatory on Homelessness articulated the conventional Canadian definition of homelessness that acknowledges the structural factors contributing to the issue, it remains focused upon the individual, and does not address how entire Indigenous communities and ways of life have been displaced through colonization (Thistle, 2017). By neglecting to name colonialism, the conventional definition of homelessness obfuscates its historical harms that

permeate into present day, and fails to consider how reconnections to land, language, community, and culture are necessary to address in resolving homelessness, particularly Indigenous homelessness.

While Indigenous peoples are disproportionately affected, people who lose their housing are not a homogenous group. Before the 1980s, homelessness was generally considered a male phenomenon, with the majority of those experiencing homelessness being men with alcohol dependence (Bassuk & Gerson, 1978; Mostowska & Dębska, 2020; Zlotnick et al., 2013). However, largely due to neoliberal policies and the deinstitutionalization of mental health facilities in the 1980s without appropriate community service options, the homeless demographic shifted to include a greater variety of people (Zlotnick et al., 2013). Currently, the homeless population is more diverse, with marginalized groups contending with broader social and structural inequities (i.e., sexism, racism, classism, ableism, ageism, homophobia, transphobia, or other forms of discrimination) (Alberton et al., 2020). This trend appears to be growing (Gaetz et al., 2016; Crane & Joly, 2014).

The demographic characteristics of those who experience homelessness are also changing as the Canadian population ages. More older adults are losing their housing, a trend that researchers have attributed to the accumulating effects of stressful and traumatic life events for some individuals in conjunction with growing social service gaps (Crane & Joly, 2014; Crane et al., 2005). Therefore, it is increasingly important to research the lived experience of older adults who are homeless to ensure that policy responses are appropriate for their needs (Dickens et al., 2020). The negative consequences of homelessness on social, mental, and physical health are numerous and varied, and the effects are more pronounced for older adults. Researchers have consistently found that individuals who have experienced homelessness have an increased risk of

comorbid health complications related to hypertension, respiratory illness, tuberculosis, HIV and other infectious diseases (Zlotnick et al., 2013; Zlotnick & Zerger, 2009).

The literature commonly identifies age fifty and above as constituting older age for individuals who have experienced homelessness because of the complexity of health conditions affecting this population (Brown et al., 2017; Grenier et al., 2016). Harsh living conditions, inadequate access to health care and basic necessities, exposure to the elements, disrupted sleep, chronic stress, and poor nutrition are all likely to exacerbate pre-existing physical and mental health conditions that older adults may have when they experience homelessness (Crane et al., 2005; Washington & Moxley, 2008). Further, compounding the direct physical health effects, research has shown that social factors such as discrimination, stigmatization, social exclusion, and loneliness compound to threaten the mental health of older individuals who have been homeless (Hwang et al., 2009a). These negative social factors associated with the loss of housing also serve to maintain an individual's homelessness through preventing their connection to housing and homelessness services, thus potentially increasing their risk of poorer health outcomes (Mayock, Sheridan & Parker, 2015). Additionally, more older adults are losing their housing for the first time in later life because of a rapid deterioration of their health, finances, and relationships without adequate social services to support them during these losses (Burns & Sussman, 2019; O'Neil et al., 2020). In this case, housing loss then compounds and complicates what older adults are already grieving, and can become a source of internalized shame when there is an expectation for older adults to "age in place" with stability and independence in neoliberal societies (Burns, Sussman & Bourgeois-Guérin, 2018).

Women, in particular, face unique structural disadvantages compared to men and are more likely to lose their housing due to gendered reasons, such as the accumulation of gender-

based disadvantage throughout the life course as devaluation of their labour results in reduced financial independence (Darab, Hartman & Holdsworth, 2018). Older women are increasingly at risk of becoming homeless and the reasons for this include a greater risk of experiencing domestic violence and abusive partnerships than men, spending more time out of the workforce than men to perform unpaid domestic labour such as childrearing and caregiving for ill relatives, and aging out of the workforce with inadequate savings or retirement plans that threatens their financial independence (Sutherland et al., 2022). For older women in particular, homelessness is more than the loss of housing, but also the potential loss of social roles such as the caregiving and domestic labour that women have traditionally performed within the home, causing additional existential disorientation if homelessness occurs (Gonyea & Melekis, 2017). Additionally, multiple studies have indicated that older women who are experiencing homelessness are at greater risk of chronic physical and mental health conditions than older women who have not lost their housing (Chung et al., 2018; Garibaldi, Conde Martel & O'Toole, 2005; Zlotnick et al., 2013) and are also more at risk of death (Hwang et al., 2009b).

Overall, however, there is a lack of research on the phenomenon of older women's homelessness. Much of the current literature available focuses on older adults without taking a gendered perspective, which may reinforce the invisibility of older women (Dickens et al., 2020; Brown et al., 2017; Grenier et al., 2016). Furthermore, service providers working within the homeless-serving sector will not know the most effective changes to implement to address the growing proportion of older women using their services. The significance of this current work is to further illuminate the experiences of older women in homeless environments to gain a better understanding of how to meet their needs and improve their health outcomes.

Research Objectives and Questions

My thesis project will explore the impacts of homelessness and alienation on the health of older women through a secondary analysis of existing qualitative interviews. In addition, this project seeks to connect how structurally embedded inequalities inherent in a class-based society manifest in the personal narratives and subjective experiences of individual older women who experience homelessness. This research aimed to broaden our understanding of the intersecting forms of oppression that affect the health of older women who have experienced homelessness, and theorized how developing therapeutic spaces that facilitate belonging for older women who have experienced homelessness may improve their health outcomes. This project also aimed to reveal a narrative of older women's homelessness that centered their experiences of stigmatization and social exclusion as they navigate the homeless service environment with a focus on identifying the impact this alienation has upon their health and wellbeing. In this case, alienation is the loss of a sense of self and one's social connectedness (Younger, 1995). The ultimate goal of this research was to generate an awareness of older women's experiences with an intention of developing a richer understanding of what changes are required to address their challenges with stigma, social exclusion, and alienation to improve their health outcomes.

My research was embedded within a larger project that explores the overall experiences of older women's homelessness through qualitative interviews of older women as well as service providers within the homeless-serving sector. The larger project, entitled *Solutions to Housing and Health for Older Women (SHHOW)*, utilized a participatory research approach that collaborated with older women who have experienced homelessness to amplify their perspectives and voices in the research project outcomes. The aims of the larger study were to identify current gaps in community services and develop priority recommendations for effective

system-level changes. The objective of the SHHOW project was to work with community researchers with lived experience of homelessness, partner organizations, service providers, and policymakers to implement effective social change through developing previously unrecognized knowledge at the systems level.

The unique contributions of my thesis were to develop a secondary analysis using sensitizing concepts such as loneliness, stigma, discrimination, and alienation to gain a greater understanding of older women's experiences of homelessness through a thematic analysis of 11 the 20 existing interviews from the SHHOW project. The aim of this work was to further understand how participants made sense of their social lives during and after instances of homelessness. Consequently, this work explored connections that exist between a sense of belonging and health outcomes for older women who have experienced homelessness.

The research questions that guided my work were as follows:

1. How have older women been marginalized and rendered invisible within homeless environments?
 - a. How has this contributed to older women's alienation from social life?
 - b. What impact does this have on their health and wellbeing?
2. How do homelessness experiences and environments shape older women's behaviour and identity?
 - a. In what ways have older women resisted marginalization after housing loss?

Literature Review

Homelessness and Older Women

As evidenced throughout the literature, the homeless population in Canada is aging along with the general population (Aubry, Nelson & Tsemberis, 2015; Gaetz, 2010), and more older adults are losing their housing (Crane & Joly, 2014). Researchers have attributed the continued existence of homelessness to multiple converging factors, including: budget reductions of government programs for low-income Canadians, an increase in the privatization of government services, and a depletion in the affordable housing market because of the gradual elimination of a national housing program in the midst of simultaneous population growth (Gaetz, 2010; Young, Abbot & Goebel, 2017). This corresponds with a global shift toward neoliberal policies in the 1980s that sought to encourage privatization of previously public services and deregulate the economy to allow for free market capitalism (Navarro, 2009). Since then, market forces have been major drivers of social policy with a focus on the wellbeing of individuals rather than communities (Brown et al., 2012). In turn, the rise of neoliberalism has promoted narratives of personal responsibility rather than public responsibility for health outcomes and other social issues (Navarro, 2009).

The baby boom generation has lived through these neoliberal political shifts that reduced government interventions with a simultaneous rise in economic insecurity due to a decline in full time employment opportunities (Gaetz et al., 2016). As a result, marginalized members of this population are now exposed to a shifting sociopolitical landscape rife with the consequences of deinstitutionalization and the restructuring of the economy and labour market concurrent with changes in the traditional family structure (Waldbrook, 2013). For some individuals and groups, these transformations in the sociopolitical sphere have resulted in an increased risk of

homelessness in later life. Gentrification and renovictions have also displaced impoverished individuals from neighbourhoods that have been traditionally low cost, further depleting the stock of affordable housing available for individuals at risk of homelessness (Wyndham-West, Odger & Dunn, 2022; Zlotnick et al., 2013). This has contributed to a housing crisis, in which rental and housing costs are rapidly increasing without corresponding increases in average wage earnings (Wyndham-West, Odger & Dunn, 2022). Lack of affordable housing is particularly pertinent in Victoria, British Columbia, which has the second most unaffordable housing market in Canada after Vancouver (Young, Abbot & Goebel, 2017).

Crane and colleagues (2005) have delineated two pathways into homelessness in later life: chronic and episodic. Older adults who experience chronic homelessness entered homelessness at a younger age and their homelessness results as a progression of an impoverished life course wherein they have been unable to maintain permanent housing (Crane et al., 2005). In contrast, episodic homelessness is defined as single or recurrent instances of homelessness that are shorter in duration and have a definitive end with an exit out of homelessness into housing (Crane et al., 2005; Burns & Sussman, 2019). Providing further nuance to this distinction in homelessness experiences, Hodgetts and his colleagues (2011) argue that individuals in the chronic homelessness category often come from lower class backgrounds and drift gradually into homelessness. “Drifters” from the chronic homelessness pathway are likely born in poverty and have developed the skillset to navigate adverse environments and conditions, and are thus better positioned to adapt to housing loss and street living (Hodgetts et al., 2011). However, drifters also have much greater difficulty exiting out of homelessness once it has occurred, and can become “entrenched” into homelessness, unable to secure stable, permanent housing (Crane et al., 2005; Hodgetts et al., 2011).

Homelessness in later life is more likely to be an episodic, first time experience (Crane et al., 2005; Burns & Sussman, 2019). That is, the proportion of individuals who age into homelessness later in life is relatively small. Instead, it is more likely that the accumulating effects of life stressors and service deficiencies precipitate homelessness in later life (Burns & Sussman, 2019). Hodgetts and his colleagues (2011) define individuals experiencing this type of homelessness as “droppers,” or those from middle class backgrounds who fall on hard times and have greater difficulty adapting to life without housing. Moreover, homeless-serving systems are generally a middle class response to integrate lower class individuals into the domiciled mainstream and is therefore structured in a way that is generally more effective and tends to provide more positive outcomes for those situated in the droppers group (Hodgetts et al., 2011). However, older adults are a unique category of droppers that many service providers have not yet accounted for (Burns & Sussman, 2019). Thus, older adults less readily access shelter services, often due to: inaccessible shelters that were not designed to accommodate their mobility limitations, fear of the shelter system, lack of knowledge of existing services, and difficulties with system navigation (Canham et al., 2020; Davis-Berman, 2011; Weeks & Leblanc, 2010).

That later life homelessness is associated with the accumulation of life stressors and service deficiencies across the lifespan is particularly true for older women. Exclusion from paid labour and lower wages has made older women vulnerable to homelessness through relationship breakdown, family violence, or widowhood that results in the decline in, or loss of social and financial supports (Dickens et al., 2020; Kisor & Kendal-Wilson, 2002). Further, older women tend to experience challenges and barriers as they attempt to navigate the homeless-serving system and this can impede their exit out of homelessness. For instance, Davis-Berman (2011) indicated in findings from her qualitative interviews that older women experienced confusion

navigating the social services system, thus slowing their transition out of homelessness.

Compounding these disoriented feelings was what participants described as chaos within the shelter, which derived from noise, disruption, verbal and physical fights, and issues with staff (Davis-Berman, 2011). Overall, the researchers documented difficulties adapting to the service environment, with little sense of community or support, and this likely further hampers older women's attempts to exit homelessness.

Additionally, despite changing demographics, the majority of those who experience homelessness have historically been men, i.e., visible homelessness, or rough sleepers and shelter users (Gonyea & Melekis, 2017; Zlotnick et al., 2013). As a result, women, including older women, more often experience 'hidden' homelessness and tend to utilize informal supports, and thus their needs are less known to service providers in the homeless-serving sector (Petersen, 2015). In part this is because researchers have found that older women who experience homelessness tend to have stronger social support than older men that thus can allow them to rely on informal resources rather than shelter services for assistance for at least a time (Winetrobe et al., 2017). However, the experiences of older women who have been homeless in Canada have not been adequately articulated in the academic literature while the current homelessness services available underserve them, even though they are also at high risk of negative health outcomes (Dickens et al., 2020; Brown et al., 2017; Grenier et al., 2016).

Indeed, past research has indicated that more informal, non-familial supports are associated with reduced instances of visible homelessness for women in particular (Zugazaga, 2008). However, it is unclear whether this is the case for older women after the loss of their housing, who tend to have more fragmented social networks (Gonyea & Melekis, 2017; Sullivan, 1991). Sullivan (1991) reports that while the older women in her study appeared interested in

social connections through engagement in social activities, relational disaffiliation, or a lack of connectedness to society through social roles, was still a common experience for her participants. This is also evident in estrangement from familial relationships. Older women who have been homeless have expressed dissatisfaction with the low frequency of contact and lack of intimate relationships in their social networks (Davis-Berman, 2011; Gonyea & Melekis, 2017). However, very little research explores the reasons behind this relational disaffiliation and family estrangement, and thus it is unclear how to bridge these social connections.

There are multiple gaps in the literature, and a particular need to incorporate research highlighting the perspectives of older women of colour and older Indigenous women. A review of the literature reveals that the effects of contemporary homelessness in general are not experienced equally across Canadian society (Alberton et al., 2020). The starkest example of how pre-existing structural inequities affect who becomes homeless is the disproportionate number of Indigenous individuals across Canada who cannot access or lose their housing (Alaazi et al., 2015; Alberton et al., 2020; Thistle, 2017). The unequal impact of homelessness upon Indigenous people is also reflected at the local scale. In Victoria, 35% of participants surveyed for the local Point-in-Time count were Indigenous, even though Indigenous people make up only 5% of the general Greater Victoria population (The Greater Victoria Coalition to End Homelessness, 2020). Discrimination by landlords, particularly race-based discrimination, is a contributing factor to the disproportionate number of Indigenous individuals who experience homelessness in Canada (Alberton et al., 2020). Further, Indigenous and other marginalized individuals experience unique intersections of oppression and are at increased risk of homelessness and the negative health impacts associated with homelessness (Alaazi et al., 2015; Alberton et al., 2020). However, at the time of writing, this literature review found no articles

that examine the experiences of older Indigenous women who have been homeless, and no literature specific to the experiences of older women of colour in Canada.

Health Impacts of Homelessness on Older Women

Contrary to colonial conceptions of health that use biomedical models focusing upon the physical absence of disease, holistic understandings of health assert that it encompasses overall physical, mental, social, and spiritual wellbeing (World Health Organization, 2007). Because environmental factors affect health outcomes, the unequal social, economic, and cultural conditions in which people live comprise the social determinants of health and contribute to health inequalities (Marmot et al., 2008). Thus, the material and social circumstances that make individuals at risk of homelessness are comorbid with detrimental effects on their health. Instances of homelessness, too, can have wide-reaching health effects. Researchers have argued that the stress and environmental conditions endured during episodes of homelessness can be conducive to an accelerated process of physical decline that is associated with aging, the effects of which include an increased prevalence of multiple chronic health conditions (such as cancer, Crohn's disease, diabetes, chronic pain, STIs, mood disorders, and cognitive impairment) at younger ages than people who have not experienced homelessness (Brown et al., 2017; Chung et al., 2018; Dickins et al., 2020; Grenier et al., 2016). Significantly, Brown and her colleagues (2017) reported that adults aged fifty and over who are homeless often have health conditions that are associated with people who are chronologically twenty years older.

Homelessness can impact health outcomes not only through prolonged exposure to the elements, chronic stress, and an increased risk of violence and assault, but also because of barriers to adequate health care that exist in the service environment, which are detrimental to health during instances of homelessness as well. Lack of medication storage and difficulty in

attending follow-up appointments are just two ways that researchers have found that homelessness often interferes with health maintenance activities and access to needed medical care (Zlotnick et al., 2013). Previous research has identified that older adults experiencing homelessness tend to confront issues with inaccessible homeless shelters, incomprehensive mental health and counselling addictions services, and inadequate support for wound, ear, eye, foot, and dental care (Canham et al., 2020; Davis-Berman, 2011; Dickens et al., 2020; Weeks & Leblanc, 2010). However, health care providers that offer services that are appropriate for and acknowledge the limitations of homelessness are primarily accessed through emergency shelters (Canham et al., 2020). Despite this, shelter services have instituted operational policies that thwart holistic healing, such as shelter closures that displace people using shelter into the community during daytime hours (Burns, 2016; Canham et al., 2020). Daytime shelter closures are an example of a punitive and paternalistic policy intended to encourage individuals using shelter facilities to find employment and housing in community, yet this policy neglects the fact that older adults are often ineligible for employment and they may have mobility limitations that hinder their ability to move about the community (Burns, 2016; Weldrick & Canham, 2023). In this way, service providers in the homeless-serving sector can inadvertently contribute to and reinforce existing health inequalities for older people, acting as a social determinant of their health (Zlotnick et al., 2013). This indicates a need to better understand the health impacts that shelter policies have on older adults and how the homeless-serving system can be better equipped to meet their needs and reduce these negative health effects.

There are multiple ways that existing shelter policies neglect the unique needs of older individuals who experience homelessness (Darab, Hartman & Holdsworth, 2018). As another example, maximum stay policies in emergency shelters that dictate how long someone can

remain sheltered are constraining to individuals who face additional barriers because of multiple intersecting forms of marginalization and slows their ability to secure permanent housing (Burns, 2016). The inflexibility of these policies causes a displacement from shelter to shelter that interrupts healing, makes adaptation to new living conditions more arduous, and hinders the transition out of homelessness (Burns, 2016; Canham et al., 2020). This is similar to daytime closure policies that constrain autonomy and punish people for their lack of housing (Burns, 2016). Therefore, emergency shelters need to reconsider how their policies affect older adults in unique ways that threaten their safety and health.

Similarly, the design of shelter facilities and supportive housing for individuals who have been homeless also often overlooks the needs of older adults. While literature that discusses accessibility in design features for shelter and housing services is limited, Burns (2016) indicated that elevators and other structural features that consider mobility aids and cognitive impairment need to be planned in the design of emergency shelters and supportive housing developments for improved accessibility. This recommendation will be increasingly important as more older individuals with chronic health conditions and physical disabilities are experiencing homelessness (Grenier et al., 2016). Burns and colleagues (2020) have recommended that permanent housing facilities developed for formerly homeless individuals consider implementing similar features as long-term care facilities.

There was little literature that investigated whether there was a gendered component to the health impacts of homelessness on older adults. According to Nusselder and colleagues (2013), there does not appear to be a significant gender difference in the physical health impacts of homelessness because the mortality rates of older men and women who experience homelessness are similar. However, homelessness can negatively impact mental health and enact

social harms for either gender, and this may be where gender differences are more visible. While there is a lack of data on the mental health of older women experiencing homelessness, reports indicate that in general, women who have been homeless have higher rates of documented psychiatric conditions relative to domiciled women with low income, including mood disorders, post-traumatic stress disorder, and substance dependence (Chambers et al., 2014; Duke & Searby, 2019). Furthermore, when compared to older men who are unhoused, older women without housing are 2.5 times more likely to report a diagnosis of chronic mental illness, and to have more mental health conditions in general (Winetrobe et al., 2017). However, this could be because of different mental illness diagnosis rates between genders (Ali, Caplan & Fagnant, 2010), rather than a difference in mental health symptoms. In either case, women who have experienced homelessness are significantly more likely to receive a mental illness diagnosis when compared to women who have not experienced housing loss (Duke & Searby, 2019).

Experiences of trauma resulting from instances of violence and abuse are also prevalent both before and during instances of homelessness among women (Duke & Searby, 2019; Hemphill, 2020). For example, there is a higher prevalence of women who are homeless and have experienced sexual violence compared to men (Weinrich et al., 2016). Further, instances of family violence, physical assault, or sexual abuse can often precipitate women's housing loss (Kirkman et al., 2015). Because researchers hypothesize that traumatic events are underreported, estimates of the exact prevalence of lifetime violence for women who have been homeless vary, but are higher than the rates of violence that housed women living in poverty have reported (Hempill, 2020). Researchers have indicated that the stress of experiencing violence is also associated with poorer health, such as mental illness, substance dependence, and poorer social connectivity and supports (Duke & Searby, 2019; Chambers et al., 2014; Hempill, 2020). This

indicates a need for an increased capacity of trauma-informed procedures and protocols that are gender and age sensitive as older women take up a greater proportion of individuals using homelessness services (Duke & Searby, 2019).

Rather than focusing upon individual symptomology, however, Kisor and Kendal-Wilson (2002) note from this trend that there is a broader social and political context that puts women at greater risk of financial precarity and exploitation that in turn can predispose them to homelessness, particularly in older age when they may be lacking adequate social supports (Sullivan, 1991). Similarly, Clark (2012b) and Reynolds (2020) both speak of the danger in locating structural problems within the individual by focusing on mental illness diagnoses and trauma narratives that label and pathologize the individual without naming or addressing the colonization, class oppression, and patriarchy that allows structural violence to occur. Further, it can encourage government interventions that may cause additional harm through subjugation to policies that lack a full understanding of the problem and thus risk reinforcing paternalistic, middle class and colonial solutions (Clark, 2012b; Hodgetts et al., 2011). In addition, Reynolds (2020) warns that this narrative can promote victim blaming.

Social Impacts of Homelessness on Older Women

Overall, people with histories of homelessness tend to have restricted social networks, both prior to and during episodes of homelessness (Addo & Ivey, 2022). Although women who lose their housing may have bigger social networks on average than men in the same circumstance, they still tend to have less social supports than domiciled women (Anderson & Rayens, 2004) and research has indicated that lack of connection to others and to homelessness services is associated with longer instances of homelessness (Mayock, Sheridan & Parker, 2015). Thus, social connectedness appears to be an important factor in the occurrence and maintenance

of homelessness. Additionally, research on loneliness, a negative impact of relational disaffiliation and social exclusion, indicates that humans are social beings with social needs (Hawkley & Cacioppo, 2010; Jones, 2020; Rokach, 2005). Social networks and community integration not only fulfill a vital need for socialization, they can also increase social capital through access to resources and connections to services, improved self-efficacy, emotional support, and protection from victimization (Gaetz, 2004; Groton & Radey, 2017; Hwang et al., 2009a).

The literature indicates that community is important for individuals who have experienced homelessness, and for humanity as a whole. Community entails connectedness through a common need to survive (Younger, 1995). As a multidimensional construct, community integration includes physical, psychological and social integration into peer networks, and is defined as: a sense of belonging, engagement with community building activities, utilization of community resources, and protection from victimization (Cummings et al., 2022). With community, we can gain power through being a part of something greater than ourselves (Younger, 1995). As evidence of the social component of community that is apparent in facilitating a sense of belonging and home, Young, Abbot and Goebel (2017) found that maintaining community connection was a strong incentive to remain unhoused in an outdoor encampment, or Tent City, for participants in their qualitative study in Victoria, BC. Individuals experiencing homelessness developed these encampments both as an alternative to using shelter services and as a protest against the housing services available within the homeless-serving sector that they viewed as inadequate or institutional (Young, Abbot & Goebel, 2017). The lack of availability and dissatisfaction with local shelter and housing options motivated individuals to join and remain in Tent City. Apart from a lack of affordable housing options for the

marginalized individuals within Tent City, negative experiences with services in the homeless-serving sector, such as invasions of privacy and lack of autonomy, were also reported as motivating factors to remain unhoused (Young, Abbot & Goebel, 2017). Additionally, Hodgetts and colleagues (2011) have reported that participants without housing often returned to living unsheltered on the streets or in encampments for their emotional wellbeing because these environments were better able to accommodate their lifestyle and facilitate social connections that are otherwise difficult to maintain due to the stigma associated with that lifestyle. However, for older women with mobility issues, encampments may not be accessible or provide safety. Unsheltered environments are often not suitable for older adults with mobility issues, particularly for older women who are more at risk of victimization (Sutherland et al., 2022), and thus their options for shelter and community connections may be limited even further than other groups who experience homelessness.

The importance of community for individuals who have lost their housing is likely elevated due to the stigmatization and exclusion they experience from domiciled society. Social exclusion, or the dynamic social factors that affect a person's ability to experience a sense of belonging, limits social networks and can impede attempts to secure permanent housing (Burns et al., 2020). This social exclusion generally derives from the stigma associated with homelessness, in which middle and upper classes define themselves through their distance and distinction from lower class individuals whose lifestyles, appearances, and behaviours are delegitimized and perceived as strange and disruptive (Hodgetts et al., 2011). Stigmatization also derives from neoliberal narratives that individualize and pathologize the phenomenon of homelessness, in which there is an assumption that people are responsible for the circumstances that contributed to their homelessness, and thus blamed for the loss of their housing (Belcher &

DeForge, 2012; Young, 2011). These narratives protect the middle class from threats to their social position through normalizing the belief that homelessness occurs from poor life choice and is thus within an individual's own control (Belcher & DeForge, 2012). Exclusion, displacement, and erasure of people without housing are often the result of this stigma in an effort to reassert social order and control (Belcher & DeForge, 2012; Hodgetts et al., 2011). Additionally, the stigma of homelessness can become internalized and function in both directions (Belcher & DeForge, 2012). For instance, in qualitative interviews with adults who had been homeless, Addo and Ivey (2022) found that lacking social connection was often a choice participants made because of their mistrust of others and the sense of shame associated with homelessness that made them reluctant to socialize. This is an issue because high levels of disaffiliation for people experiencing homelessness impedes connection to housing services and transitions into permanent housing (Addo & Ivey, 2022; Vandemark, 2007).

Although there is no literature that details the social networks of older women who have experienced homelessness, researchers Gorton and Radey (2017) conducted a qualitative study that illustrates the variety of positive and negative effects of social networks for women of all age groups after homelessness has occurred. The women in their study described their social networks as: a coping mechanism to support them when confronted with the challenges of homelessness; a contributor to instances of homelessness when these informal social supports are lost; a drain on their own resources; and a way of offering meaningful support, even at times to their own detriment (Gorton & Radey, 2017). Overall, Gorton and Radey (2017) concluded that the needs of women experiencing homelessness often exceeded the capacity of their social networks, thus indicating an opportunity to facilitate services that can provide adequate supports for community integration to support women in transitioning out of homelessness. Moreover,

network size alone provides no information on network composition, or the quality and frequency of contact of relationships within the network, which previous research has argued may be more important than network size (Gonyea & Melekis, 2017).

Thus, social networks can be a source of harm, abuse, and stress, particularly for women who tend to perform more emotional labour in relationships than they receive (Groton & Radey, 2017), and even more so for older women who often assume roles as caregivers in unhoused communities, even at the risk of their own needs when they have depleted energy and resources to give (Rosenwohl-Mack et al., 2019). However, lack of social connectedness is a source of stress and ill health as well. For instance, one of the negative consequences of social isolation can be loneliness, a complex subjective phenomenon that indicates a discrepancy between desired and actual meaningful social relationships that contributes to poorer mental health and suicide (Hawkley & Cacioppo, 2010). Furthermore, an inability to fulfill the cultural expectations of relational responsibility and caregiving adds complexity to the phenomenon of loneliness for women, who can feel a sense of inadequacy and shame if unable to fulfill these gender roles (Rokach, 2005; Sullivan, 1991). Older women who have experienced homelessness are particularly susceptible to feelings of social isolation and loneliness due to a lifelong accumulation of alienating forces such as ageism, sexism, ableism, and reduced social welfare supports compared to men (i.e., men often have higher wages and more time of employment to contribute to larger pension plans) (Sullivan, 1991). Additionally, declining health and deaths within their own aging social networks can result in significant losses of social connections for older adults in general (Gonyea & Melekis, 2017).

Overall, however, there is a lack of understanding of how social exclusion may influence the health of older women who have been homeless, as well as a lack of information regarding

how service providers can facilitate community connections that are beneficial rather than a drain on older women with limited resources. Secure housing traditionally fulfills basic needs by creating an environment of safety, self-determination, ownership, and privacy (Burns, 2020). Yet it is apparent that consideration of more than the physical structure is necessary to make a dwelling into a home and resolve homelessness; social factors such as a sense of belonging within a community are crucial as well (Chan, 2020). However, because there is a lack of literature that explores the connection between community and home for older women who have been homeless, it is unknown how to create a space for them that balances the private, intimate aspects of home with the social and community aspects wherein which older women could create a home for themselves.

Theoretical/Conceptual Frameworks

To explore the experiences of older women who have been homeless, their meanings of home and community, the health impacts of homelessness, and recommendations for change, the theoretical concepts of alienation and intersectionality provide useful scaffolding to reveal and explore older women's experiences with a particular focus on social exclusion and isolation. I utilized the theory of alienation because of its historical basis in class analysis. Research that specifically considers class analysis has been largely absent in contemporary academic literature (Navarro, 2009), including in research on homelessness. However, Navarro (2009) argues that this is not because class analysis is no longer relevant, and in fact the absence of class only serves to obscure the basis of economic inequalities within capitalist societies, which homelessness is a stark example of. Further, the erasure of class from academic discourse corresponds with late stage capitalism and the rise of neoliberalism, which Navarro (2009) asserts is connected because the increasing privatization of government services benefits the

upper class at the expense of the health and wellbeing of lower classes, thus widening the health inequalities between social classes. Within that time, rates of homelessness have also increased (Gaetz et al., 2016).

In turn, intersectionality will draw attention to how older women's experiences of oppression were unique due to their gender, class, and age. Intersectionality will allow my analysis to attend to these nuances through providing the basis of understanding how multiple marginalized identities can produce unique experiences of oppression. In addition, intersectionality is important to consider for this research because of the need to gather more information about how the experience of older women who have been homeless compares to that of older men. Below, I will discuss each of these frameworks as they relate to older women's homelessness in further detail.

Alienation

Alienation as a human phenomenon has its roots in early philosophy and medieval theology (Younger, 1995). For example, existentialists like Sartre (1956) used the term to describe how humans can view themselves as objects lacking an autonomous free will. As a sociological concept, alienation developed from Karl Marx's study of the early effects of capitalism on human experience that encapsulated the disillusionment with society and the separation from others and self that resulted (Kalekin-Fishman, 2009; Younger 1995). According to Marx (1964), alienation is the inevitable result of capitalism as people become separated from control of their labour. In addition, the difficulty in finding meaningful employment that provides fulfillment and allows for expression of one's interests and skills perpetuates and exacerbates alienation (Kalekin-Fishman, 2009; Marx, 1964). Historically, application of alienation theory has been restricted to studies of labour and materialist discussions (Yuill,

2005). However, as Kalekin-Fishman (2009) explains, contemporary ideas of alienation have evolved over the years as a result of a variety of scholars in different disciplines building upon the construct. From a psychological perspective, alienation is a form of subjective experience that occurs under certain conditions of social deprivation (Kalekin-Fishman, 2009). Recent studies in the literature indicate that alienation can be useful to better understand health inequalities as well (Øversveen & Kelly, 2022). This is because it offers a way of conceptualizing how structural, materialist conditions manifest in subjective, psychological experiences which in turn affect health (Øversveen & Kelly, 2022; Yuill, 2011). In this way, alienation identifies the psychosocial factors, such as social isolation and powerlessness, that result from class inequalities.

There is some debate whether alienation is indeed inevitable within a capitalist system (Kalekin-Fishman, 2009; Seeman, 1967). For instance, in social work research, alienation is understood as a response to trauma that occurs as people learn how to adapt to adverse conditions for their survival. In this case, social work researchers understand alienation as a product of particular circumstances such as childhood neglect and unhealthy attachment styles, and thus view it as not necessarily inevitable (Kalekin-Fishman, 2009). However, what may be more accurate is that we all experience alienation to varying degrees (Yuill, 2011). According to Marx's original conception, alienation is the result of a separation from the labour process. Marx (1990) argued that humans are unique in our ability to interact with our environment in conscious, creative, and meaningful ways that can change our external reality and create new forms beneficial for our future development. In other words, Marx (1990) argued that humans are unique in our ability to produce. Our subjective needs and desires dictate what we create and support our skills development, in which production serves as a means of self-expression

whereby we gain an understanding of our individual agency, as well as our relation to others and our environment through our labour (Øversveen, 2022).

Moreover, Marx conceptualized production as a social activity because our ability to create relies upon cooperation and our capacity to produce for each other through the unique skills we develop while labouring in our environments (Øversveen, 2022). However, a capitalist system seeks to divorce us from this process in the commodification of our labour, replacing the intrinsic fulfillment we receive from the act of production with external, abstract motivation in the form of currency (Øversveen & Kelly, 2022; Yuill, 2011). In essence, through exploitation of our labour, we become alienated from it, an act that is a core part of how we relate to our environments and one another (Øversveen 2022; Øversveen & Kelly, 2022). Further, particular groups experience more alienation than others. Research in the social determinants of health provides evidence that stress resulting from oppression, such as the working class in Marx's original conception of the theory, contributes to worsened health outcomes (Elstad, 1998); thus, it follows that groups experiencing greater degrees of marginalization are likely more susceptible to alienation and the negative health risks associated with it (Øversveen & Kelly, 2022). This is because alienation is related to powerlessness and estrangement from others and oneself—conditions that both capitalism and oppression as a whole produces due to the unequal distribution of social power (Øversveen & Kelly, 2022).

People experiencing homelessness, then, are at risk for high levels of alienation because of the stigma associated with their social class. Attempts to exclude, displace, and erase people without housing isolate and estrange them from our social fabric and underscores their lack of control of their social circumstances, thus increasing feelings of powerlessness (Hodgetts et al., 2011; Vandemark, 2007). Individuals without housing are often relegated to derelict and

neglected urban spaces, and the negative perception of these spaces can extend to the people occupying them as well (Hodgetts et al., 2011). Additionally, if living unsheltered on the streets, private activities such as bathing, sleeping, or using substances now must be conducted in public, further contributing to the stigma that derives from their deviation from domiciled life (Hodgetts et al., 2011). Trespass and loitering laws also seek to control how people use public spaces, and encounters with law enforcement are common for individuals without shelter conducting their domestic activities in private spaces, again emphasizing the lack of control they have over their lives (Amster, 2003; Hodgetts et al., 2011; Weldrick & Canham, 2023). Moreover, hostile architecture, such as metal spikes to deter sleeping on benches, also serves to displace people without housing from urban centres, and would have a disproportionate impact upon older adults with health and mobility challenges (Weldrick & Canham, 2023). Older women experiencing homelessness are at particular risk for alienation because of their exposure to volatile market forces, shrinking government pension programs, and an inability to integrate both in domiciled society as well as in street communities (Øversveen, 2022). Below I expand on the intersection of oppression that older women who are homeless experience.

Intersectionality

Kimberly Crenshaw (1989) is a critical race scholar who coined the term intersectionality during the third wave of feminism to describe the interaction of race and gender in accounting for the unique experiences of oppression that black women endure in the United States. As a theoretical concept, intersectionality considers the interaction of multiple social positions and their social power or lack thereof simultaneously (Crenshaw, 1989; Hankivsky, 2012; Bauer et al., 2021). The ability to make sense of multiple simultaneous forms of marginalization through intersectionality is necessary for a holistic understanding of the experiences of older women who

are homeless in Canada, where dispossession of land and home, along with the structural intersections of class, gender, race, age, and other facets of diversity connected to power and disadvantage, compound and influence each other to produce a unique experience of oppression, as well as a unique set of needs. In addition, intersectionality can draw attention to the ways in which individuals are connected through similar experiences of oppression, despite differing identities, and allows us to notice commonalities in the experiences of difference (Hirschmann, 2012).

A more recent term in the literature to encapsulate how multiple forms of marginalization can compound on each other is intersectional stigma (Logie, James & Tharao, 2011). Thus, experiences of stigma and discrimination associated with ageism, classism, sexism, and ableism can shape when and why older women experience homelessness and how older women navigate the service environment, even discouraging connections with community supports altogether (Gonyea & Melekis, 2017; Mostowska & Dębska, 2020). In particular, women are vulnerable to becoming homeless later in life because of relationship breakdown or family violence, illness, or employment issues that lead to a loss of social and economic supports (Dickens et al., 2020). For example, research has shown that long-term exposure to structural inequalities and racism is particularly onerous for older women of colour, and these increased risk factors predispose them to negative life outcomes, such as housing insecurity and homelessness (Washington & Moxley, 2008). The intersections of marginalization that older women who have experienced homelessness occupy can also yield certain advantages over men in the same social position because women tend to have stronger relational networks and may be able to access more social supports for provisional shelter during instances of housing loss, such as couch surfing with family or friends (Darab, Hartman & Holdsworth, 2018). However, if women are reliant upon

their own social networks to resolve instances of homelessness, this can put them at risk of exploitation and abuse (Gorton & Radey, 2017).

These networks, however, are understudied because invisible forms of homelessness such as provisional sheltering are difficult to access through research. Scholars Mostowska and Dębska (2020) argue that women's homelessness is a contentious issue in general because it challenges the patriarchal conception of women's domesticity that associates women's labour with the private domicile of the home. This contributes to the invisibility of women's homelessness because the homeless-serving system was first developed while considering the needs of men who have been displaced from their homes (Mostowska & Dębska, 2020). In contrast, women have tended to adopt strategies outside of the service system to secure housing, including relying on informal social networks, sleeping rough or in encampments, or engaging in sex work as a means of securing shelter (Mostowska & Dębska, 2020). However, there is a lack of understanding of how older women navigate instances of homelessness and what strategies they use to cope, if and when their social networks become more limited than younger women's (Sullivan, 1991).

Moreover, the ageism that older adults experience interpersonally and structurally within homelessness environments can also complicate experiences of homelessness (Weldrick & Canham, 2023). Examples of ageism within homeless environments include: younger individuals targeting older adults for harassment and exploitation; discrimination from landlords due to both their age and housing status; inaccessible shelter spaces and ageist shelter policies (e.g., daytime shelter closures); and an overall lack of age-specific services in the homeless-serving sector (Weldrick & Canham, 2023). These issues and the lack of attention they have thus far received within the academic literature and from service providers likely permeated from ageist cultural

norms (Kane, Green & Jacobs, 2013). However, there is a gap in the literature that explores how age and gender intersect in homelessness marginalization, and how older women may be uniquely impacted. Understanding the nuances of older women's experiences and how they differ from those of younger women and others who experience different forms of marginalization is why there is utility in employing an intersectionality approach when studying older women's homelessness. Further, linking feminist intersectionality theory and alienation theory allows for an enriched understanding of the homelessness experiences of older women and the study of the comorbid effects of multiple stressors that result from oppressive structures imposed upon older women, such as financial strain, gender-based violence, and other forms of structural inequality that older women often endure. Intersectionality will therefore inform the application of alienation theory to illustrate how older women experience the separation from social life.

Summary

To conclude, the population of Canada is aging, and older women are increasingly experiencing homelessness (Crane et al., 2005; Dickens et al., 2020). The literature I have reviewed underscores that government cutbacks in the 1980s have undermined the existing service environment, which impedes healing and, in fact, can contribute to and exacerbate the negative health outcomes that older women experience from homelessness today (Canham et al., 2020; Davis-Berman, 2011; Gaetz, 2010; Waldbrook, 2013). The population that homeless-serving agencies now assist is diversifying without the evidence-based supports to effectively address their homelessness and housing insecurity (Zlotnick et al., 2013). This, coupled with the invisibility of older women's homelessness, creates a support environment that inadvertently can

subjugate older women even further and lead to greater exclusion and alienation (Sullivan, 1991).

The effects of stigma and social isolation experienced by older women who have been homeless are not well understood, despite the fact that older women tend to endure multiple forms of discrimination and social exclusion through ageism, classism, and sexism (Sutherland et al., 2022; Sullivan, 1991). The literature has indicated that the fractured and limited social networks that individuals without housing typically experience contribute to loneliness and poor mental and emotional health (Hawkey & Cacioppo, 2010; Rokach, 2005). However, less is known about the needs of women compared to men because women more often rely on informal social supports rather than housing services when homeless, although these can become exploitative and abusive (Groton & Radey, 2017). Further, literature on the meaning of home for individuals who have experienced homelessness indicates that social inclusion and community are important considerations to restore a sense of belonging and promote healing in home spaces (Alaazi et al., 2015). Because older women are understudied in this literature overall, however, it is unknown how to support them in creating a sense of home, community, and belonging without an adequate understanding of their current health needs and coping strategies.

My research utilized the theoretical frameworks of alienation and intersectionality to explore the health needs of older women and what changes are necessary for spaces in the homeless-serving sector to prevent the exacerbation of pre-existing health conditions they may have to instead promote their healing. Because of the detrimental impacts of social exclusion and loneliness on overall wellbeing, I will be using a holistic definition of health that includes physical, mental, social, and spiritual wellness within these frameworks to consider how to

facilitate social inclusion and a sense of belonging for older women who have experienced homelessness that reduces the negative impacts of alienation.

Methodology

Given the marginalization of older women within settler society, particularly within the context of homelessness, the research paradigm for the Solutions to Housing and Health for Older Women (SHHOW) project sought to acknowledge and reduce the power differential between researchers and participants in an effort to include older women with experiences of homelessness in the research process rather than reinforcing their social exclusion and marginalization (Serrano et al., 2023). This was achieved through the use of a community-based participatory research (CBPR) approach and witnessing methodology in the context of qualitative methods. In this section, I will explain the methodology of this thesis and how it relates to the SHHOW project from which I derived my data. This will start with an explanation of my positionality and intentions within this research before a detailed account of the research approach, sampling and recruitment, data collection, data analysis and interpretation, and lastly, knowledge translation and mobilization.

Positionality

In an effort to decolonize academic research with an Indigenous research methodology, Wilson (2008) encourages the practice of researchers situating themselves within our writing and to be explicit about our intentions when we are conducting our research. Relationality is foundational to decolonized research, and Whetung and Wakefield (2018, p. 155) state that “good relations emanate out of your own ability to locate your position, the place you come from, and the people you belong to.” Distancing myself from the research I am interested in is a colonial mode of thought, where, as Whetung and Wakefield (2018) argue, knowledge is disembodied from its context in a sterile academic setting. Sharing who I am, however, is essential to any reciprocal relationship, even in the research context (Wilson, 2008), and I am

committed to self-growth and continual reflection to understand and convey how my social position shapes my passions and biases, as well as the power I hold socially and within a research context as an academic (Serrano et al., 2023). In doing so, I make an effort to remove the colonial guise of the objective researcher and to work at reducing the hierarchy between myself and the community I wanted to build a reciprocal relationship with, who already shared parts of themselves through the very basis of their participation in the research study.

As a third-generation settler on Turtle Island from European ancestry (primarily Irish, Scottish, and English), I am an uninvited visitor to the land that my home is situated upon and have benefited from the history of colonization that formed Canada. First Nations, however, are and have been in relation with these lands and waters since time immemorial, and I am grateful for their care for and knowledge of the land I live on. Without this, I would not have been able to complete the work for this thesis. Specifically, the research for this project had been conducted on the unceded lands of the Lək'wəḡən-speaking peoples, including the Songhees and Esquimalt Nations. This land is also the traditional home to the W̱SÁNEĆ peoples, including the Tsartlip, Pauquachin, Tsawout, Tseycum, and Malahat Nations. Additionally, my internship with the Alberta government in the Housing and Homeless Supports branch also informed my thesis. This work was conducted in *Moh'kins'tsis* (traditional Blackfoot name for where the Bow and Elbow rivers meet) located in Treaty 7 territory and the Metis Nation of Alberta Region 3, which is the ancestral land of the Blackfoot Confederacy, the Tsuut'ina First Nation, and the Stoney Nakoda. Paying respect to the lands and waters and its Indigenous caretakers is particularly important for homelessness research because of the history of colonization that contributes to the continued displacement of Indigenous peoples from their lands (Alberston et al., 2020; Thistle, 2017), and it is my aim to illuminate some of these impacts through my project. As part of my commitment to

colonial research practices, I will continue to acknowledge the colonial roots of homelessness in my work to avoid its erasure, advocate for Indigenous sovereignty, and share my findings with local communities, which I will discuss further in the knowledge mobilization section.

In an effort to examine my own biases, I frequently engaged in reflexivity throughout the project and will continue to do so in my future work to understand how my personal characteristics as a researcher (including my age, gender, sexuality, class, ability, and race) affected rapport with participants and my interpretations of their data (Bourke, 2014).

Additionally, I have experience in homelessness research prior to this project from my work in Alberta during a provincial government internship in Housing and Homeless Supports. Since then, I have become increasingly aware of the pervasive nature and severity of homelessness and housing insecurity. Further, I have developed personal relationships with individuals who are unhoused or insecurely housed, deepening my motivation to investigate this topic. With my personal investment in this research, I acknowledge that I cannot approach it from an objective standpoint. However, I also argue that a relational approach enhances qualitative research in unhoused communities, particularly with older women, because of the ongoing silencing they are subjected to in their lives, and the social harms this causes (Norman & Pauly, 2013; Serrano et al., 2023). In fact, a relational approach to work with unhoused communities is needed because it can reduce power imbalances between academic researchers and participants that can reproduce the very exclusion and marginalization academics are studying to minimize (Boilevin et al., 2019; Serrano et al., 2023). A separate section below will provide additional discussion of the ethical considerations of conducting research with unhoused communities.

In addition, as a qualitative researcher in this project, I intended to be a story weaver through my secondary analysis. The act of cedar weaving in coastal Indigenous communities can serve as a metaphor to explain this concept:

“An important aspect of working with cedar is working together and knowing that at all stages we must work with a good mind and a good heart [...] Weaving cedar is a purposeful activity; the pulling together of cedar strands to weave a headband, a basket, a cape, a rope or a hat requires weaving together many strands to create a stronger, more durable and lasting tool that will serve the community.” (*Indigenous Plan*, 2017)

Through the concept of story weaving, participant narratives were the medium with which I pulled commonalities from their interviews together to create a meaningful, cohesive whole that can identify the various factors contributing to the social injustice of older women’s homelessness and the health impacts of alienation that result. I also used my academic knowledge from various social science disciplines, such as psychology, sociology, linguistics, women’s studies, and geography, combined with my passion for social justice, to identify the barriers to resolving older women’s homelessness with the intention of this knowledge benefiting my local community. Additionally, I used my own experiences of marginalization as a queer and disabled woman to aid me in understanding how marginalization affects health. Through this thesis, I aimed to develop reflexive, participatory, and relevant research that sought to transform both the researcher and participants. I therefore view this thesis as an act of labour and love.

While I am not Indigenous, the use of Indigenous methodologies and perspectives offers much value to relational, community-based research, particularly within unhoused communities

which are comprised of a disproportionate amount of Indigenous people as a result of ongoing colonial violence that leaves Indigenous communities at greater risk of housing loss (Alberton et al., 2020; Thistle, 2017). Although my intentions were to use these ideas in an intentional, decolonial way, I recognize that intention does not absolve me from unintended harm, and I welcome criticism of my research approach.

Research Approach

Utilizing a participatory methodological approach that was inclusive of older women who have experienced homelessness was an important aspect of the SHHOW project. Community-based participatory research (CBPR) is a research paradigm in which community researchers direct the research process because CBPR acknowledges that this process is as important as the knowledge product (Kendon, 2016). Thus, the aim of the SHHOW project was to use a CBPR approach, in which older women with lived experience of homelessness were part of the research team as co-researchers with the assumption that their experiential knowledge and skillset were just as valuable as the knowledge and skills of academics. Shifting the power dynamics in community-based research is valuable from both a theoretical and social justice standpoint. Theoretically, researchers with lived experience can contribute both in research question development and data analysis (Van der Riet, 2008). Differing positionalities promote the co-construction of knowledge in an intersubjective way, and encouraged findings that would not have been possible without collaborative interaction (Van der Riet, 2008).

In addition, as a means of social justice praxis, participatory research methods promote social inclusion in the process of knowledge development and help to ensure that research findings will be of benefit to the community to prevent exploitive research practices (Kendon, 2016). As well, participatory action methodology emphasizes shared learning (Kendon, 2016),

and the involvement of the researchers with lived experience of homelessness developed their research skills as they engaged in different stages of the project, such as data collection, analysis, and knowledge mobilization. Moreover, since learning in CBPR reciprocal, the academic researchers on the team also gained valuable local community knowledge, as well as skills in working with sensitive subject matter discussed in data collection and analysis (Norman et al., 2015).

Witnessing

In addition to CBPR, I engaged in a reflexive practice during my secondary analysis termed witnessing. Witnessing can be a therapeutic practice as well as a research approach (Reynolds, 2020). As a research methodology derived from Indigenous worldviews, witnessing is a concept that encompasses more than observation; rather, witnessing an event or phenomenon evokes a social responsibility to provide an accurate accounting of what was witnessed, particularly in instances of violence when those experiencing the harms themselves may not have the safety to recount what they experienced (Hunt, 2018). Witnessing acknowledges our interconnectedness and the influence we have upon one another even through minimally invasive acts such as observation (Hunt, 2018). It resists the ways in which marginalized groups have been isolated through narratives of personal responsibility and pathologization by instead naming the structural origins of oppressive violence and invoking relational accountability (Clark, 2016; Hunt, 2018; Reynolds, 2020).

Thus, witnessing is a relational approach that can provide the basis for reconnection, belonging, and solidarity of isolated and marginalized individuals to community (Hunt, 2018; Reynolds, 2020). As a form of research activism and resistance practice, witnessing involves more than making space for the retelling of violence, as it also invokes a commitment to move

beyond individual suffering to address the structural inequities and unjust distributions of power that allow for oppressive forms of violence to take place (Clark, 2016a; Hunt, 2018; Reynolds, 2020). In the case of this project, through deeming older women's homelessness worthy of study, the SHHOW research team acknowledged and affirmed the suffering of our participants, as well as their acts of survival and resistance (Clark, 2016a; Reynolds, 2020). Similarly, becoming immersed in the narratives participants shared about their lives changed me as I realized the impact that violence and homelessness has had on their health and wellbeing. As a witness to the harms older women who lose their housing endure and their strength in resisting their oppression, I recognized the responsibility I have to convey and disseminate an accurate and fulsome account of these women's lives and the structural factors that contributed to the best of my ability, while recognizing it cannot be an impartial or complete rendering as I have interpreted what I have seen and heard through my own lenses (Hunt, 2018). Utilizing methodology that is attentive to the structural forces of oppression at play was of particular importance for this project because before the conclusion of SHHOW, two community researchers on our team died due to health complications related to their experiences of homelessness. Through their participation in our research and as peer support workers, these women had incredible passion to support others out of similar circumstances they had been in, and it is in this spirit of recounting some of their experiences and continuing their legacy of compassion that I am presenting my thesis. As a witness to their narratives, I bear responsibility to ensure that their work lives on (Hunt, 2018).

Part of what can be called witnessing methodology means not only making space for the suffering of people experiencing marginalization, but also to observe and make sense of their acts of resistance to the oppression they experience (Reynolds, 2020). For instance, Goffman

(1961) described how responses to institutionalized powerlessness in psychiatric facilities and prisons of the time were not overt acts of resistance, but subtle defiant behaviours that sought to resist institutional control and restore a measure of autonomy and dignity. Witnessing methodology encourages the witnesser to make sense of the behaviour of the witnessed in a similar way, situating seemingly irrational behaviour within a broader social context to understand the ways in which an individual or group may be responding to structurally oppressive forces in covert ways that achieve a balance of maintaining their autonomy and safety in environments or circumstances where they otherwise have little control (Reynolds, 2020). Given the inquiry of this thesis to explore the manifestations of alienation for older women in environments where they have little social power, witnessing methodology provided a foundation from which to contextualize their behaviour as potential acts of resistance (Reynolds, 2020). For example, Gonyea and Melekis (2017) described in their qualitative study how older women experiencing homelessness engaged in identity work as a way to resist the label of “homeless” and the stigma associated with it. This thesis sought to further reveal older women’s experiences of homelessness, as well as the acts of resistance they may exhibit to resist powerlessness within homeless environments with the use of witnessing methodology.

Ethical Considerations

The University of Victoria Human Ethics Review Board granted ethics approval for the SHHOW project, and it sought to achieve a high ethical standard in its work. Nonetheless, researchers can wield an inordinate amount of power over study participants and communities, and research practices have been extractive in the past, particularly when academic researchers were working with marginalized groups (Norman & Pauly, 2013). For example, community members of Vancouver’s Downtown Eastside (DTES), where academic researchers have

conducted a wealth of studies on topics such as homelessness and substance use, have reported that research can perpetuate inequality and stigma, exploit pain and trauma, and misrepresent community members while simultaneously exhausting their resources (Boilevin et al., 2019). Community members of DTES have called upon academic researchers to prevent these harms through engaging in relationship building, conducting research in a way that is inclusive of researchers with lived experience of the topic under study, and ensuring research findings are disseminated within the community (Boilevin et al., 2019). The community-based participatory research (CBPR) approach of the SHHOW project aimed to address these concerns.

A review of the literature indicated that individuals who have experienced homelessness are generally excluded in the research process due to stigmatization and discrimination (Norman & Pauly, 2013). However, Norman et al. (2015) conducted a study that identified the benefits to including community members with lived experience of homelessness as part of the research team using participatory methods, which include: relationship building, earning trust and respect, and promoting feelings of social inclusion. As another example, older women with a history of homelessness who participated in Washington and Moxley's (2008) qualitative study reported that they benefited from the storytelling process during knowledge translation because they took ownership of their own stories and this process restored a measure of autonomy and allowed them to express emotions in an authentic and cathartic way. The sense-making that narrative allows is often the first step in transforming and alleviating suffering (Younger, 1995).

Because of the prevalence of abuse, discrimination, and other forms of violence that occur in the population we worked with, Dr. Jeannie Carriere from the University of Victoria's School of Social Work facilitated a half-day trauma-informed research workshop for the SHHOW team to provide strategies on how researchers can aim to prevent re-traumatization

during the interview process (Goodwin & Tiderington, 2022). The safety of our older women participants and our research team was the utmost priority. Establishing a foundation of trust with the community we worked with through consistent communication and the development of rapport before proceeding with interviews was important both for relationship building as well as for ensuring that our participants were comfortable bringing any concerns about the research process forward (Goodwin & Tiderington, 2022). During the relationship building phase, potential participants were forwarded a copy of the consent form through email that informed them of the SHHOW project and its objectives, the procedure of the interview, and discussed how we used the data collected. We then answered any questions they had about the research process before obtaining informed consent and proceeding with data collection.

My Current Project

My study was nested within a larger community-based research project that Dr. Denise Cloutier and other researchers at the University of Victoria conducted. This larger project was entitled 'Solutions for Homelessness and Health for Older Women' (SHHOW). The SHHOW project was funded through the Canadian Institutes of Health Research (CIHR) and the Social Sciences and Humanities Research Council (SSHRC). I contributed to this project as a research assistant, along with one other student researcher in geography, and other academic researchers from geography, sociology, and nursing. Additionally, we had four community co-researchers with lived experience of homelessness (CRLEH) that guided our work as part of the primary research team. The CRLEH were community leaders seeking to benefit other older women who have been homeless through articulation and dissemination of their stories in the research process. This thesis derived from some of the data collected in the SHHOW project.

In my secondary analysis of the interviews collected in the SHHOW project, I employed a constructivist ontological perspective, meaning that I worked under the assumption that we construct our social realities through interactions with our environment and people within it (Burr, 1995; Charmaz, 2014). A constructivist perspective is well suited for generating knowledge about social phenomena that are understudied because it can capture a range of experiences (Charmaz, 2014). While I utilized a Marxist theory that derived from a materialist orientation, alienation represents an embodied material ontology that lends itself to the study of subjective experience (Yuill, 2005). As well, I was mindful of how material conditions influenced these subjective experiences and exercised caution in not attributing my findings to individual subjectivities alone. As well, I was mindful of how material conditions influenced these subjective experiences and exercised caution in not attributing my findings to individual subjectivities alone. Further, my epistemological stance for my thesis was that knowledge is subjective, so our individual contexts and experiences affect how we interpret our lives and construct knowledge. Additionally, not only is knowledge subjective, but it is also intersubjective in that it is through the social process of dialoguing with one another that we create meaning. This is in line with symbolic interactionism which is a sociological theory that maintains that meaning is co-created through interactions with people and objects in particular contexts and environments (Blumer, 1969; Denzin, 1995). In this way, the perspective of each researcher and participant added to and developed my findings, no matter their positionality or primary knowledge source (whether experiential or academic).

Due to the focus of my research questions on subjective accounts, my inquiry was well suited for qualitative methods. My secondary analysis utilized interview transcripts gathered during the SHHOW project, which my literature review informed and my research questions

guided. The analysis section will provide further details on my approach for the secondary analysis.

Sampling and Recruitment

The larger SHHOW study collected 20 interviews of older women who had experienced homelessness. The 20 participants were older women who have experienced homelessness and who resided in Victoria, British Columbia, a midsized Canadian city on Vancouver Island. Four of these interviews were with the project’s community co-researchers (CRLEH) and 16 were older women with lived experience of homelessness (WLEH). Participants were aged fifty or older and identified with the term “woman”. The SHHOW project had one participant who was a transgender woman, while the others were cis women. Additionally, instances of homelessness could be past or current, for any length of time, and occur at any point in their lives, as the SHHOW project was interested in the long-term health impacts homelessness has on women as they age. Thus, age at the first instance of homelessness was varied. Further, almost half of the sample had obtained some level of post-secondary education ($n = 12$), some with more than one degree. Additionally, 7 participants disclosed a racialized identity, and among those, the majority were Indigenous ($n = 5$). Lastly, all of the WLEH and CRELH reported struggling with a physical or mental health issue at some point in their lives, the majority disclosing at least one chronic health condition. For my secondary analysis, I used data from 11 of the 20 SHHOW participants. For a more detailed breakdown of the participant demographics of these 11 participants, see Table 1.

Table 1.

Demographics of Participants Included in Secondary Thematic Analysis

| Pseudonym | ID | Demographics |
|-----------|----|--------------|
|-----------|----|--------------|

| | | |
|---------|--------|---|
| Aster | CRLEH1 | 50s, chronic health conditions, Indigenous, past abusive ex partnership, past substance use, housed in supportive housing, died in 2023 (RIP) |
| Katrina | CRLEH3 | 60s, chronic health conditions, has mobility limitations, has university education, housed in supportive housing |
| Claire | CRLEH4 | 50s, chronic health conditions, evicted from market rent housing, substance use, post-secondary education, died in 2022 (RIP) |
| Justine | WLEH4 | 60s, chronic health conditions, Jewish, trans woman, had an abusive ex-partner, has university education, living in subsidized temporary housing |
| Winona | WLEH5 | 60s, chronic health conditions, experienced childhood neglect, was a caregiver, has some university education, living in supportive housing |
| Hannah | WLEH6 | 50s, chronic health conditions, racialized, immigrated from African country, had abusive ex-husband, living in temporary supportive housing |
| Leah | WLEH7 | 70s, chronic health conditions, Indigenous, has university education, living in sheltering hotel |
| Ella | WLEH10 | 50s, chronic health conditions, Métis, has university education, had abusive ex-partners, used substances and engaged in sex work, experiencing insecure housing in market rent apartment |
| Jenna | WLEH13 | 60s, chronic health conditions, had abusive ex-partner, has post-secondary education, living in supportive housing |
| Siobhan | WLEH14 | 60s, chronic health conditions, had abusive ex partnerships, living in sheltering hotel |
| Iris | WLEH16 | 60s, chronic health conditions, has university education, living in sheltering hotel |

Recruitment occurred in partnership with homeless-serving non-profit organizations in Victoria, which included the Greater Victoria Coalition to End Homelessness (GVCEH) and the Community and Social Planning Council (CSPC). Since data collection for the SHHOW project took place in late 2020 and in 2021 during the COVID-19 pandemic, our ability to meet face-to-

face was limited, and required amendments to the ethics protocol for the recruitment and data collection process. To reduce viral exposure, recruitment involved our primary research team sending out recruitment posters electronically through email to service providers that housing staff then posted in communal spaces of the facilities they operated for residents who had been previously unhoused or who had previously experienced homelessness. These posters provided contact information that allowed interested individuals to reach out through phone or email if they were interested in participating.

Data Collection

The SHHOW team developed a semi-structured interview guide (Appendix A) to collect qualitative data from our community researchers and participants. The interview guide contained questions about individual life experiences precipitating instances of homelessness, as well as experiences with the homeless service environment. These questions guided a conversation with participants and contained probes to explore older women's experiences with homelessness while also allowing space for participants to guide the conversation, which I describe in further detail below.

After discussion of the consent form and obtaining informed consent for participation, the interview would begin under the direction of an interview guide. The interview guide opened with general questions that become more sensitive and specific as the interview unfolded and rapport had been established. The first probes were to ascertain their current living situation, which were followed with questions about meaning of home, meaning of community, and sense of belonging. Then the guide focused in on personal experiences to ask participants about their identity, their mental and physical health and wellbeing, and the impacts of COVID-19. Finally, the guide asked older women about their experiences in the homeless service environment and

the challenges and supports they encountered therein. Before concluding the interview, we asked general questions with demographic details regarding the participant's age, ethnicity, marital status, education, employment, and sources of income. Each interview ranged from approximately 90 to 120 minutes in length.

During data collection, active listening and mindfulness were an important aspect of the interview process, particularly when allowing the participant to choose and control the direction of the conversation (Archibald, 2008). Although interviews were semi-structured, we were comfortable with silence and followed the participant's direction, allowing for flexibility in how we progressed through the interview guide to increase participant control (Charmaz, 2014). Increasing participant control where possible is an important consideration for maintaining a trauma-informed approach to the interview process and shifting power dynamics away from researchers toward participants (Goodwin & Tiderington, 2022).

However, safety precautions during the COVID-19 resulted in limiting the opportunities for choice in how the research team was able to conduct interviews for the SHHOW project. To eliminate the risk of viral exposure to our participants, we conducted interviews using Zoom or over the phone rather than face-to-face. A potential benefit of our data collection protocol during COVID-19 was that it also allowed participants to remain in familiar locations of their choosing during interviews. As an additional measure to maintain privacy and confidentiality, participants also had pseudonyms associated with their data. Depending upon the participant's comfort and preference, we audio recorded interviews and later transcribed them. We provided an honorarium as compensation for the participant's time (delivered through cash to their shelter or housing facility following the interview), and the participant was informed that they can skip any question and end the interview at any point without consequence. Should a question or topic

trigger distress during the interview, data collection stopped and we provided the participant with resources and information on how to access the peer support workers at the GVCEH.

As an iterative process, the SHHOW project collected data until theoretical sufficiency was reached. Typically this is referred to as theoretical saturation in qualitative research, which is the idea that the maximum depth of analysis has been reached such that additional interviews would not reveal new information (Dey, 1999). Rather than use the theoretical saturation construct, however, theoretical sufficiency is consistent with a constructivist ontology as it recognizes the different lenses each researcher brings to the data collection and analyses, so acknowledges the possibility of differing interpretations of the same data (Dey, 1999). Thus, it is not possible to know when saturation was reached given the multiple ways to interpret the data, so instead data collection stopped when no new codes were added to the coding structure after multiple rounds of interviews.

Data Interpretation and Analysis

As noted above, the SHHOW project developed from a community-based participatory (CBPR) approach. In accordance with participatory methodology, data analysis for the SHHOW project was a collaborative, intersubjective process, in which knowledge was co-constructed as a research team through discussions and negotiation of our coding schemes and thematic codes (Kindon, 2016). As Braun and Clarke (2006) note, thematic analysis is a method for identifying and organizing repeating patterns in data. Developing analytic codes through thematic analysis is a formalized way of interpreting social data (Cope, 2016). Researchers can utilize thematic analysis in a constructivist approach to examine the ways in which we construct and interpret experiences and develop an understanding of the sociocultural conditions and structural contexts present to produce these accounts (Braun & Clarke, 2006). As a collaborative process with

another student researcher on the team (PhD Candidate Audrey Tung), we used NVivo transcription software to develop a preliminary coding structure of all the WLEH and CRLEH interviews for initial analysis of the SHHOW project. We began with an inductive coding process to produce preliminary codes and a coding structure. We then developed our codes into broader themes through thematic analysis. Through thoughtful, reflective, and consensus-based discussion that accounted for differing interpretations of the data, we came to agreement of our interpretations of codes and preliminary themes. If necessary, lines of interviews were categorized into multiple codes if we reached consensus on multiple interpretations of the data.

After coding our first interview for the SHHOW project, we grouped together similar, related codes under broader themes to develop a coding structure. We then discussed our codes and preliminary coding structure with the primary research team in relation to our own knowledges, whether that was through lived experience or familiarity with academic literature from various disciplinary perspectives. In this way, differing positionalities promoted the co-construction of knowledge that was intersubjective, encouraging findings that would not have been possible without collaborative interaction (Van der Riet, 2008). Additionally, there was a diversity of backgrounds within our academic research team (e.g., psychology, human geography, sociology) and a variety of life experiences that also enhanced our theoretical sensitivity during analysis, allowing us to view the same data from various perspectives (Charmaz, 2014).

Following this discussion, Tung and I further consolidated our codes into broader themes and ensured that our collaborative coding structure was applicable to multiple interviews. This process was repeated after each interview, and we continued to revisit our coding structure at monthly meetings with our academic research team, Dr. Denise Cloutier and Ruth Kampen, to

ensure consensus. In addition to the interview data, we also developed case summaries and recorded observations following each interview, logged memos during data collection and analysis, and kept field journals throughout the process to maintain an audit trail that recorded our thought processes during data collection and analysis discussions. These methods were a way to reinforce the rigour of the data as they were considered alongside the transcripts during analysis (Charmaz, 2014).

I conducted a secondary analysis of the existing interviews from the SHHOW project to further develop themes related to the concept of alienation and its fit with this inquiry. In this secondary analysis, I utilized purposeful sampling to select interviews that discussed alienation or its components in greater depth (Suri, 2011). To maintain my focus on older women's health and the intersections of oppression they encounter in homeless spaces, I also selected interviews where instances of powerlessness were evident to explore deeper. Finally, I looked for acts of resistance, such as identity performance and the development of street personas, to further understand participant reactions to powerlessness.

Sensitizing concepts represent ideas and trends that emerged during interviews and initial coding, and where more focused analysis would encourage theme development (Charmaz, 2014). For my secondary analysis, I explored alienation and acts of resistance in greater depth using sensitizing concepts that included: isolation, exclusion, invisibility, stigma, discrimination, powerlessness, fear, shame, self-reliance, and performance. I selectively coded these interviews using the initial codes from the SHHOW project to identify data related to these sensitizing concepts. Through my familiarity with the data during the SHHOW project analysis, I then assessed which interviews would be meaningful to include in my secondary analysis based on case summaries and my pre-existing knowledge of each participant. This process resulted in the

selection of interviews from 11 of the 20 participants (see Table 1). These participants tended to be individuals who had additional marginalized identities that would affect their social life, such as being part of an oppressed racial or gender group. Additionally, most participants selected for reanalysis had a post-secondary education ($n = 8$) and were able to articulate their experiences with greater richness.

While the initial coding for the SHHOW project was a collaborative process, I conducted the secondary analysis for this thesis independently. For this secondary analysis, I also used NVivo to further explore initial codes from the SHHOW project that were related to my research questions and sensitizing concepts to guide my interpretations. My coding process began with descriptive codes that I selected from SHHOW, which remained close to the data and grouped information together based on obvious qualities, actions, and conditions (Cope, 2016). Codes became richer and more analytic as I began to attend to the processes and context of the data (Cope, 2016). I then developed a separate coding structure by grouping similar codes together according to their similarities, substantive content, and conceptual links (Cope, 2016). I analyzed this structure in relation to the alienation literature to consolidate codes and develop my themes. As such theme development was abductive in that I sought to extend a theoretical concept from sociological literature to a new context (Muthukrishna & Henrich, 2019). Visualizations of these coding structures are provided in Figures 1 and 2 located in my Findings chapter.

Knowledge Translation and Mobilization

In line with CBPR methodology, the SHHOW project also focused on the knowledge mobilization aspect of the research through dissemination of our research findings (Kindon, 2016). In this way, SHHOW sought not only to gain understanding of the experiences of homelessness for older women, but also to create meaningful, systems-level social change

through our work that aimed to have a positive impact for older women who have experienced homelessness. Evidence from the literature indicates that effective knowledge translation occurs through integrative knowledge translation (KT) strategies, when researchers, participants and partner organizations are involved in KT throughout the research process (Jardaine & Furgal, 2010), and SHHOW engaged in knowledge dissemination throughout the project. In addition to our CRLEH, we also kept community partner organization and stakeholders informed of project activities and preliminary findings through research updates to receive community feedback and direction in turn. Moreover, the SHHOW project presented initial evidence with service providers, which findings from this thesis contributed to. Findings from my project also contributed to a publication in a local independent newspaper and a grey literature community resource. Additionally, I have presented on my findings in the SHHOW project at three conferences to community and academic audiences. I also supported composite story development for social media with the aim of utilizing art and storytelling to humanize the experiences of older women and generate awareness of their narratives in a way that encouraged connection with general public viewers (Washington & Moxley, 2008).

Overall, the aim of my thesis was to provide a secondary analysis that focused in particular on identifying barriers to the health and healing of older women who have experienced homelessness and exploring how to facilitate improved social connections to reduce their sense of alienation and displacement.

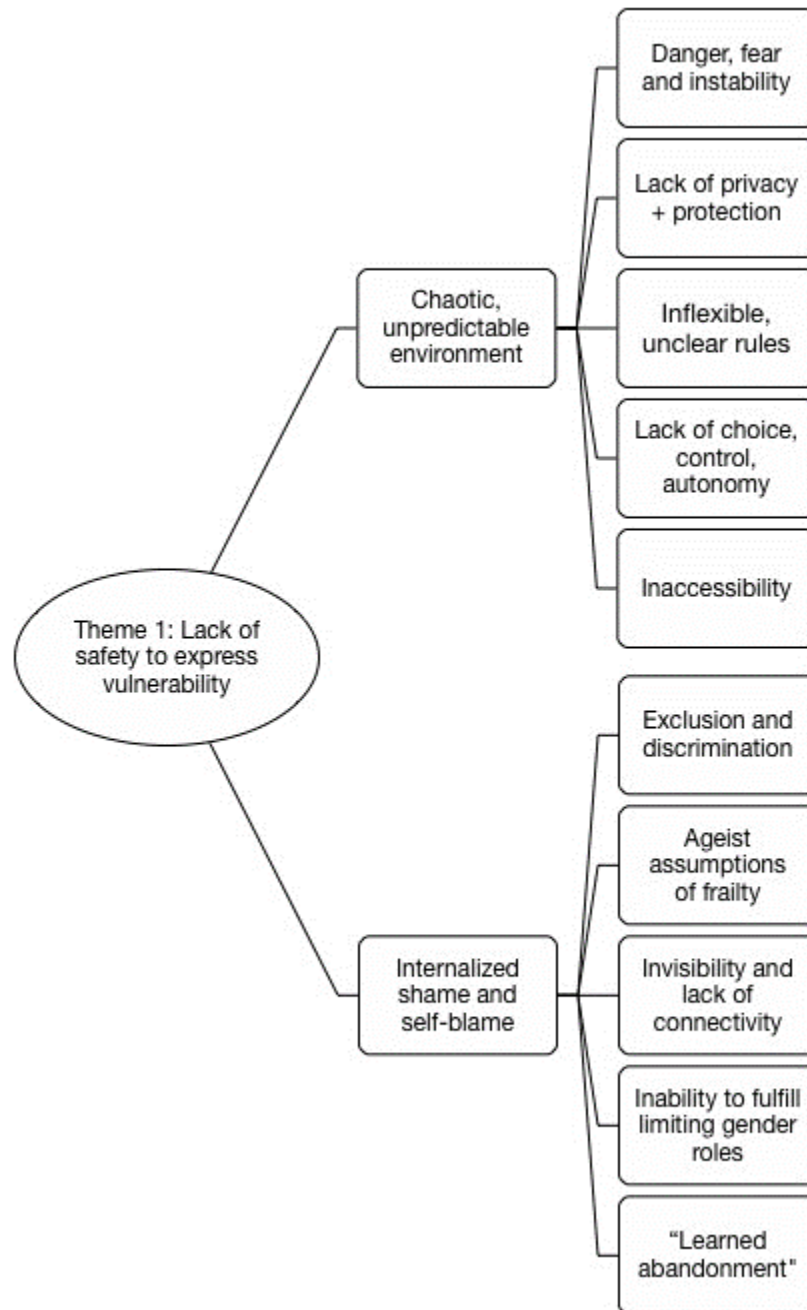
Findings

As researchers using witnessing methodology have suggested (Hunt, 2018; Reynolds, 2020), I sought to understand participant responses to their environments while homeless during my secondary analysis of 11 of the SHHOW participants (see Table 1). In the first section of my findings, I reveal how the often unstable and hostile environments participants navigated during instances of homelessness threatened their safety and neglected their health needs through the selection of interview quotes that depict the variety of factors (both external and internal) that contributed to their lack of safety. I called this theme: lack of safety for older women to express vulnerability while experiencing homelessness. The environments older women experienced during and following instances of homelessness included: unsheltered street environments, emergency shelters including sheltering hotels opened as a response to the COVID-19 pandemic, and supportive and/or subsidized housing spaces. Figure 1 provides a visualization of this theme. In the second section, I reveal how participants responded to these environments. I entitled this theme: performing and hiding vulnerability: older women's acts of resistance. Exploring the experiences of older women in the service environment once their housing is lost shows how the intersections of oppression they contend with play out in their lives as they enter into homelessness. Figure 2 illustrates this theme. Awareness about how older women are oppressed in these environments also allows for understanding their responses to homelessness and how alienation may present in their subjective experiences.

Lack of safety for older women to express vulnerability while experiencing homelessness

Figure 1

Coding Structure of Theme 1: Lack of Safety for Older Women to Express Vulnerability



Theme 1. This figure shows the various codes that contributed to the lack of safety theme. As depicted, women had both external reasons (in their environment) and internal reasons (reinforced through social interactions) not to express their vulnerability.

As described above, the spaces participants of this secondary analysis occupied once they lost their housing were harsh, chaotic, and not often frequented by older women. Some participants described how they felt invisible once they lost their housing, in which they were unable to meet basic needs within spaces that were inaccessible to people with chronic medical conditions or mobility issues, as the following quote describes:

I saw more homeless women than ever before, and I just wanted to be heard. There were things like nobody letting me use the fridge to refrigerate my insulin. It's like okay, so you just let me take bad insulin because I'm carrying it around unrefrigerated? There were bathrooms that weren't accessible to me. And the mat program, all you get is a gym mat, and sometimes a thin blanket that's sprayed with disinfectant. If you want a pillow, you roll up your jacket if you have one. And that's it. (Katrina)

This participant reveals that while living in emergency shelter, she was unable to maintain adequate, consistent medical treatment for her diabetes, a potentially life-threatening chronic illness, due to shelter spaces lacking medication storage. Further, because Katrina used mobility aids, washrooms and sleeping spaces at this shelter were inaccessible for her. Her exclusion from the space contributed to a sense of fear and instability because she now needed to find other means of meeting her needs at a time when her own resources are already severely limited due to the loss of her housing. In this way, the invisibility of older women in homeless-serving environments contributes to a lack of safety because service providers neglect their needs.

Some participants described other instances in which they felt unsafe during episodes of homelessness, both while accessing emergency shelters and in unsheltered environments.

Whether threats to safety and wellbeing were real or perceived, a lack of safety affected older women's experiences of these spaces. There was a danger of "not fitting in" in these environments because 'othering' can occur, in which an individual difference is noted and can be the basis for ostracization and exploitation, as in this example:

I don't know, I couldn't stick together with any women there 'cause they all hated me. They all hated me and I don't know why but they did and it was just crazy. I don't know who it was. There was one staff member that said to me, "You're gonna be a real target here because you don't fit in." (Siobhan)

Older women are likely targeted in homeless environments due to both their age and gender. One participant describes the basis of her fear well:

So I have a hard time with the idea of being seen as older and frail but the reality is that people are probably more likely to take advantage of an older woman unfortunately. That's a big part of it. [...] I think people on the streets obviously see a woman more likely to be easily taken advantage of, especially for money. I think women are more likely to give and older women, they just automatically, you know. And just they're seen as probably more frail so they're more likely to be seen as a victim. (Jenna)

In this quote, the participant identifies that she feels more vulnerable because of ageist assumptions from others that older age is synonymous with frailty and weakness. Because of a scarcity of resources during instances of homelessness and the competition for shelter that can result, individuals who are unhoused may target and exploit others whom they perceive as more

marginalized and vulnerable than themselves. Within this environment, older women may experience exploitation and victimization. Interestingly, Jenna also identifies a gendered component to this interaction, in which there is an expectation for women to give. When she states that older women give “automatically,” it suggests that there is a lack of agency in this interaction, perhaps because she feels it is a societal expectation that there may be consequences in rejecting.

Another participant describes how expressions of vulnerability are discouraged while living unsheltered on the streets:

Yeah, I had to get thick skin out there real fast – real quick. I’m not kidding. You guys can meet people who you see crying and alone and they’re like, ‘Everybody picks on me. Everybody robs me, everybody does this,’ and yes, they *do* do that because they see you’re weak, and they do do it. Certain people, not all, depending on where you’re going through. It’s just like, say, walking through a neighbourhood and you go from [emergency shelter] where there’s people eating and you could go up the block, half a block up and you could walk into people using. You could see people and you drop something and they pick it up and not tell you. People jump you. People give you a hug and snatch out of your pocket – and just, really, things like that really happen in that little bit of that block. So yeah, it’s really different. I don’t think you guys... Yeah, it’s a really tough situation out there and you have to be tough in order to live out there. (Aster)

Not only is there a perception of a lack of safety for older women after losing their housing, but there are instances of theft and violence that occur to reinforce this view as reality. The competition for limited resources produces an environment where lateral violence between individuals experiencing homelessness occurs, and participants described suffering multiple forms of victimization, including instances of theft, harassment, and physical violence. This occurred not only in unsheltered street environments, but also within homeless-serving facilities. For instance, one participant disclosed that she felt unsafe because of the history she had with other people in the sheltering hotels that were established following the COVID-19 pandemic restrictions:

I'm glad to be... behind my door here, I feel like I check my door a lot with hands on both sides of the door to make sure it's shut really tight. And yeah—but the stuff that goes on out in the hall or the loud music and somebody is fighting, it's scary and threatening. But, you know, so it's really hard to be here, but it's better than being on the street. But it's not a forever home, that's for sure. And I'm a senior. [...] You need to be in a quiet environment that's safe and makes you feel better and you're not worrying about somebody hurting you again, right. And a lot of the people that have hurt me are here, you know? [...] All the same people that were there just were put in different COVID shelters such as this one. There's so many people here. They're all from there. So it's still very threatening, right. [...] Like, you gun it from down the hall and you choose not to go on the elevator at the same

time as the other people 'cause you don't know what they're gonna do, especially if it's somebody you recognize has hurt you before, right. You wait for the next elevator. You have to be really always aware. You know you can't make any mistakes or you can get hurt.

(Siobhan)

In this quote, Siobhan describes how she feels trapped in the same building as people who have harmed her. Unlike in unsheltered environments where physical distance can protect older women from victimization, older women have little choice in what space they occupy when provincial government COVID-19 mandates displaced all unsheltered individuals into the same hotel. In this case, when older women are in common areas, they may share space with other individuals who have victimized them. To cope with threats to her safety, Siobhan maintains a constant vigilance in shared spaces, and believed that if she can conduct herself without "any mistakes," she will avoid the victimization she was fearful of. Because she cannot control her environment or the other people within it, she stated that she must control her own behaviour, and that conducting herself in the "wrong" way would invite violence to occur.

Not only do older women note that they must be mindful of their own behaviour in an effort to protect themselves, but they also must control their emotions. The same participant describes how she copes with the constant state of fear that results from a lack of safety:

You can't let these things get to you because, you know, if you do, you can't, because you'll go insane, right. Somehow you have to feel safe yourself. You have to make yourself say, 'I'm just gonna feel safe and that's my decision.' You know, there might be a lot of crap going on that makes me unsafe, but if I don't start feeling safe

somehow... I have to be strong and I have to try and survive and there has to be a light at the end of the tunnel. There has to be, maybe. I don't know. Maybe not, right. I hope so. (Siobhan)

As revealed within this quote, living in a constant state of fear and hypervigilance is exhausting and unsustainable. Because participants cannot control their environments within the homeless-serving system to make their living situations safer, they must control their emotions instead through not allowing themselves to feel their fear. This may be harmful, though, because the purpose of fear is to protect and warn us when we are in danger (Gullone, 2000). Becoming desensitized to it in this manner, then, may be maladaptive. Yet Siobhan states that it is necessary to do so because she has no recourse to address her safety concerns in a housing system that does not account for her needs. This situation potentially places her in further danger if she disregarded fear that was well-founded.

Additionally, cramped spaces and a lack of privacy in shelter facilities were perceived to increase aggression among people using shelter services:

People are too close together. They're not in their own room like we are now with our own door and privacy. They're so close together that they get really agitated and they get violent, right, and they hurt you, right. Like holy smokes, a lot of violence. So being in here [in my unit], it's like okay, I can breathe. No one is gonna hurt me. Maybe out in the hall I might get scared but I can usually phone staff. They're kind of accountable—the people live here 'cause they don't want to lose their room, really. (Siobhan)

Here, Siobhan describes how a lack of space in emergency shelter contributes to agitation and aggression among people using shelter services, and how she now feels she must enclose herself within her unit at the sheltering hotel to avoid potential victimization. In this way, she closed herself off to protect herself.

Indeed, participants in these environments often indicated that they must protect themselves because there can be a lack of accountability and protection from staff in these shelter facilities:

I have a room that is accessible through the window ‘cause it’s close to the ground where you had to crawl up onto the roof and then come right through the roof to my window and I’ve been broken into like 4 times. And I’ve asked to be moved and they don’t seem to want to move me and they’ve moved everybody else in this hotel and [...] you know, that was about 18 months ago or so, I haven’t been moved. And I just got broken into again a couple weeks ago. (*Emotional*) (Iris)

The lack of accountability within shelter facilities when participants reported harm to staff helps to maintain an environment that is unsafe for them. Another participant expressed a similarly distressing incident in another housing facility, in which a staff person not only disregarded her concerns about other residents in the building, but actively perpetuated harm in claiming she was being dishonest in her reporting of them:

I asked them if they could move me up there to [...] where all the old people are living and they couldn’t do that. So the best thing they could do was to put me on the second floor and put me in this

room. [...] Because I told them all these issues that were happening and the manager, he ignored me and he told me I was a liar. He was not on my side as far as having me have a safe, quiet, home. [...] They didn't do anything about it unless they harmed me or my dog. And they never did harm me or my dog until this guy hit me on the head in my car. Then I had to phone the police and get the police involved because the staff would do nothing because there's no tenancy... There's nothing about tenancy here. (Leah)

Here, Leah describes how she had no recourse when there was staff inaction to her safety concerns because residents of supportive housing facilities do not fall under the Residential Tenancy Act in British Columbia. This act serves as a legal means to protect the rights of both landlords and tenants, but in this case, residents of supportive housing must rely on staff to respond to their concerns with no means of making them accountable to do so.

Another participant describes a similar incident in which she was assaulted and required police involvement:

This guy—I was out in the parking lot, and this younger guy, he's about 30 and I'm 60 almost, and he comes up and punches me right in the head, okay. The police witnessed it because he didn't see the police there, and so the police quickly jumped out of their car, arrested him and charged him and brought him to court and I never showed up at court or anything, 'cause I didn't have to, 'cause they saw it all. They put a restraining order out on him and he's not allowed within 100 yards of the [sheltering hotel]. (Iris)

Fortunately, police were already present to witness this incident and responded. However, even when there was police involvement, there may still be a lack of accountability for harms committed against older women. Iris went on to explain:

Well, two of my friends from the [sheltering hotel] came down and told me that they saw the man in question crawl through his girlfriend's window several nights in a row. So that means he was in the hotel on the property and then he was across the road yelling obscenities at me the other day. And so the police told me when this happens, start a paper trail, call the non-emergency line, and call us and let us know what's happening. So finally—he'd done it about 3 or 4 times—so finally, when I heard he was in the hotel last time, I phoned. I phoned the non-emergency police. Well, they had gone and talked to the office first. The office had lied to them. Straight up lied to the police and said that they had done their own investigation and saw nothing on video of the man on the property, which is an outright lie because he was on the property. I did see him for myself, as well as why would these other people come and tell me that they had saw him as well? Why? Why would I have called the police if none of this had happened? I wouldn't have. I absolutely wouldn't have. (Iris)

In this case, even when Iris filed a restraining order against someone who had physically assaulted her and followed the appropriate procedure that police had directed her to follow—and

even when police themselves had witnessed the first act of violence take place—she still was marginalized and her suffering and experiences silenced and made invisible. She continued:

So when the police come down to my door they sat there and belittled me, humiliated me, and basically called me a liar, and I was the victim. I'm the victim here, and basically called me a liar and I said, 'What are you talking about? It happened.' Well, they interviewed the staff and they said that basically they checked all the video and they never saw anything like that. And I said, 'Really, did you talk to the people that came and told me?' No, they didn't. Did they talk to the two ladies that I was out with when [the man] accosted me in the street across from the [sheltering hotel]? No, they didn't talk to them either. So what bloody investigation did they do? I feel very unsafe here because of this as well. (Iris)

Although staff members may not have found evidence of this man in the sheltering hotel, they prevented further investigation from police while at the same time not investigating it further themselves, effectively ensuring that there was no accountability for a physical assault committed against an older woman. Additionally, not only were Iris's safety concerns dismissed and ignored, but she was also penalized for reporting it and accused of dishonesty. In this way, the inaction of staff members maintained the status quo, and served to make an older woman who reported violence or threats of violence viewed as the problem for speaking out.

This behaviour from staff indicates a lack of care that also contributes to a lack of safety for older women in the homeless-serving system. A caring, trauma-informed response would

seek to prevent retraumatization of older women, and ensure there were adequate safety measures in place to protect them from further violence. That there was a lack of trauma-informed care within the homeless-serving system was also highlighted by another participant:

[Staff] can enter my suite at any time and it's like, you know, if I go without... when regular staff is on holiday and there's casual staff and they don't know me, there's that threat of them coming in and I've gone for months where I've locked my door so that they couldn't come in. When you're dealing with someone who's been traumatized by sexual assault, barging in on them is not the thing to do, and the fact that they don't know that, that's a really fundamental bit, I would think, of information that they should have from their training. (Winona)

Thus, communication breakdowns among staff members and inadequate training can retraumatize older women in these environments. This emphasizes the importance of consistency in care and the need for adequate supports and training for staff to prevent compassion fatigue, burnout, and staff turnover (Kerman et al., 2023). Consistency in care was particularly important when older women have identified that stability was necessary for their healing and recovery from homelessness to take place. As one participant explained:

It's so important to be able to be stable and stay in your home for like ten years when you're a kid or whatever. And that's the kind of idea I was trying to explain about not wanting to be uprooted out of here right away, right. Yeah, it's a thing you need to do to heal. You need to just to be stable and the continuity of knowing you're

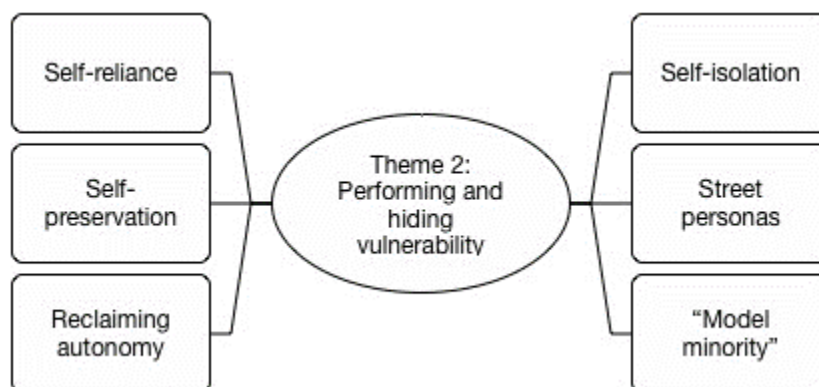
in the same place for awhile and not having to make a change. You don't want to have changes all the time. (Siobhan)

Together, these threatening experiences from staff members and other individuals who are unhoused or insecurely housed contributed to an environment that can be unsafe for participants to express their vulnerability during a time of upheaval and uncertainty in their lives. This hindered help-seeking behaviours when older women were in need of support to exit out of homelessness because they have encountered difficulties asking for support, and at times experienced backlash when they do advocate for themselves. In this way, there was risk associated with older women asking for the support they needed from the homeless-serving system, thus reducing the likelihood that they will do so. Instead, the strategies older women tended to adopt in homeless service environments included making their needs smaller and themselves less visible so they did not appear in need of help, or surviving until they reach a crisis point when they have no choice but to seek additional support. The challenges in asking for support in an unsafe landscape during instances of homelessness are described further in the section below.

Performing and hiding vulnerability: Older women's acts of resistance

Figure 2

Coding Structure for Theme 2: Performing and Hiding Vulnerability



Theme 2. This figure depicts the coding structure for the performing and hiding vulnerability theme. There were three main ways participants responded to a lack of safety (right side of figure) and they all contributed to the ways in which participants were motivated to perform or hide their vulnerability (left side of figure).

The second theme that I observed as critical in my secondary analysis was older women's responses to homelessness environments. One coping strategy for many participants while navigating unsafe environments was to hide their vulnerability to avoid being targeted and exploited:

When you live by yourself and they know you are single as a woman, I mean, they will take advantage. I mean, take advantage of you if you are not strong enough to say, 'No this, and this – no.' So you have to be really strong as a single woman, especially when you live by yourself. Yeah, you have to be strong. (Hannah)

Because of this, participants expressed the desire or expectation to be self-sufficient when navigating the homeless-serving sector, either because they were reluctant or unable to reach out for support, or because they were distrusting of the supports available to them, so they tended to withdraw and depend upon their own skills and capacities instead. For instance, Justine described how adept she became at hiding her vulnerability:

I'm really good at looking happy and healthy. I'm really good at being calm and in control which is part of the reason why I don't get health services because I'm not breaking down and crying. I'm not being brought in handcuffs anywhere. I'm not having to be so

medicated that I'm drooling. I am not 'deserving' mentally ill.

(Justine)

However, the treatment of mentally ill individuals that this participant described is also unpleasant with the use of physical (handcuffs) and medical (medication) coercion. This fate is just as undesirable as being denied needed services, if not more so. Thus, participants were encouraged to perform their vulnerability, but in the "right" way so as to avoid appearing "hysterical" and inviting an undue use of force or coercion to control their behaviour. This put older women in a double bind where they may be punished for expressing vulnerability, while at the same time, hiding vulnerability may mean their needs were neglected. For instance, the same participant described her inability to reach out for the support she needed:

I put on a really good face and in fact I went to a shrink a government shrink, a long time ago with a friend. I was in shreds. I was coming apart. I could barely walk. I was stuttering. I was in a fugue state almost and I sat in front of that shrink and I was in control and, as far as he was concerned, I did not require his services. My friend said to me afterwards... I came out of it and I collapsed and I was sobbing uncontrollably. And she said, 'You know, I know you don't want to hear this, but if you'd done that in his office, it would have been different.' But I am so used to having no support or feeling like if I'm not on my feet nobody is gonna put me on them. And it also becomes a sense of learned both helplessness and capacity. It's a sense of learned abandonment that nobody is on my side even when people are on my side. And it's

another thing that people in enfranchisement and privilege have to understand that when we feel alone it's because we've been taught to be alone. We have been habitually abandoned and left alone.

(Justine)

In what Justine described as “learned abandonment,” she relied upon her own knowledge and skills because of past experiences of neglect, in which she only had herself to rely upon. Thus, participants may not recognize genuine offers of support or seek them out because genuine support may be unfamiliar or suspicious. In this way, the notion that participants can depend on no one else but themselves is reinforced. There was also a gendered component in the desire for independence because older women often adopt the role of caretakers in social settings, or “givers” (Rosenwohl-Mack et al., 2019). This can make donning the role of “receiver” when in need of support, such as during instances of homelessness or housing insecurity, unfamiliar and uncomfortable. Thus, this complicated and at times prevented help-seeking behaviour.

Ella provides a similar example of how censoring herself and her own needs was so habitualized that she did not know how to reach out for support:

I didn't really have friends at that point. Once I lost my job as a massage therapist people basically went running for the hills. So, it was more an internal stigma and I didn't realize how powerful that was as a phenomenon, like that really wore me down. I felt that people knew what I was doing [sex work] even though I wasn't telling anybody. I thought that I was like wearing it on my sleeve basically. So, I'd be walking down the street and I'd be feeling like everybody knows and they're looking at me and I have to act

normal—whatever normal is. So, it was very internalized and just like wearing me down mentally and emotionally...I'm just a very deeply shame-based person and a very embarrassed, you know, always feeling humiliation kind of person. My modus operandi at that time is just to run and hide and I still don't really know how to reach out and ask for help. (Ella)

These quotes from Justine and Ella illustrate how older women have learned to withdraw from social situations to avoid harm, even at their own detriment when they are in need of additional support. This quote from Ella also speaks to how hiding her vulnerability was initially employed as a survival mechanism in response to avoiding stigma and rejection, but it was now internalized to the point where it has become a familiar way of coping that, at the same times, was exhausting to maintain.

Other ways older women hid was through attempting to “blend in,” or adopting a toughened, self-reliant facade that they believed would serve them while navigating life on the streets: “I tried to fit in as well as I could. So I wore a black skull cap and a hoodie and, you know, that kind of thing so I wouldn't stick out like a sore thumb.” (Claire) This community researcher described how she employed changes to her appearance to avoid being targeted by others in her environment, presumably because she perceived them as potential threats. Additionally, not only was there a cultivated appearance associated with street personas, but different behaviours as well, as some participants sought to maintain their street personas through aggressive actions. As another of our community researchers describes, “I had to get tough on the streets... you have to be tough, in order to live out there. Yeah, you get picked on, you get robbed... I had a reputation on the streets for being a scrapper.” (Aster). Here, Aster

described how she maintained her self-reliance through defending herself and her possessions with, at times, physical acts of aggression and hostility. Thus, while performing these street personas, older women do not appear vulnerable or in need of support to resolve their homelessness.

To add another layer of complexity, these identity performances are dependent upon the environment older women find themselves in. When on the streets, they may adopt a toughened street persona, but while attempting to access services, participants were often required to act in ways that exemplified their level of need. In the service environment, participants have described how they were not taken at their word, but rather, that they must enact the appropriate appearance and behaviours to prove that their need is enough to service providers for access to formal, institutional support. One participant best describes the characteristics of this paradox:

I am both rewarded and penalized for my vulnerability and my invulnerability. I can't... the system is designed only to reward the most [...] visibly deserving people. It's not that the system is breaking down. The system is working exactly as it's designed to work in the puritan Christian model; in the church model that we serve [the] deserving poor... It's all prejudiced – nice white, older, Christian women. 'Oh, well, they deserve it. White families – they deserve it.' And there is an aspect of racism that's also built into the system. My Black friend, she tried to find a place to live and she's in her late thirties. She was refused apartment after apartment because she was Black. (Justine)

Importantly, Justine identified that this was not an indication of the homeless-serving system malfunctioning, but that it is how it was intended to function as the system itself is rooted in charity and religious puritan ideology that creates a hierarchy between the “deserving” and “undeserving” poor (Mitchell, 2011). Additionally, the participant in this quote identified structural racism present within the homeless-serving system, which may pose additional barriers for older Indigenous women and older women of colour in accessing services. For racialized older women, the expectation that they behave appropriately may be more stringent as they are faced with a greater degree of scrutiny and discrimination. For example, the description of one participant was reminiscent of the notion of acting as a “model minority” to avoid discrimination and the stigmatized treatment: “My pride is a factor. So I’ve always presented myself very professionally and I know I’ve got a good vocabulary... So I know that I can present in a professional manner, and in doing so, I feel like I’ve been met in that place.” (Ella)

The tension older women experience as they balance hiding their vulnerability with performing it in the “right” way was in part institutionalized through eligibility criteria that gatekeeps services because of funding constraints limiting the number of people who can utilize them. This created a competition for resources in which individuals who appear the most eligible were rewarded with access to services (Mitchell, 2011). However, eligibility requirements can differ from organization to organization, and it was not always clear what these criteria were. Thus, how participants were expected to act when accessing services can be confusing and contradictory. Justine was able to articulate this contention well:

The only way I came to deserve—to be deserving enough to get [housed] was domestic abuse. I certainly didn’t deserve it being disabled or living with disabilities. That never made a difference. I

was never offered any housing as a disabled woman. But once I was disabled and domestically abused, all of a sudden I ticked off that box and I went to the top of the list. I became important because I was domestically abused. I'm not happy that happened but in a way I'm grateful. I'm grateful I met her and she fucked up... and she messed my life up seriously because she got me in here. (*Laughs*) I mean how messed up is that, that I have to be thrown around? I had to be beaten on to deserve a place to live? Then I become deserving for it; as disabled, as a woman with disabilities unable to work, with brain injuries – no, I wasn't deserving enough. (Justine)

Although Justine is able to describe how she became eligible to access the housing she was residing in at the time of her interview, the intricacies of such eligibility criteria were often invisible for other participants when they are denied services. The obscurity of why some were granted access while others were not contributed to a sense of competition among service users, and an informal social hierarchy was created of the “deserving” and “undeserving” poor. For example, the following participant often sought to differentiate herself from people using substances. As illustrated with her quote, older women can act strategically to access services, and at times can perpetuate stigma themselves when doing so may grant them access to shelter and to resources that other marginalized individuals may not receive:

The only reason that the lady brought me was because [...] She knew who I was. I mean she knew who I was. She knew I wasn't a drug addict. I wasn't an alcoholic. I wasn't a screw ball. I wasn't

crazy – what people think a homeless person living in their car is like. She knew I was pretty straight. (Leah)

In this case, Leah used stigmatizing language as a means of distancing and differentiating herself from people using substances and people with mental illness, two groups that also experience stigmatization. This shows how participants can also play into social hierarchies to position themselves as “deserving”.

Because of the perceived vulnerability of older women, they are similarly at risk of exploitation and lateral violence from others that would further encourage them to hide any needs they may have. Thus, they were caught in a double bind that was largely context dependent, but knowing when and where was appropriate to perform each fragment of their identity can be disorienting and exhausting to maintain. So it is little wonder, then, why older women often withdraw in street and shelter environments to avoid navigating the complexities of oftentimes unfamiliar and potentially high stakes social situations. However, when older women hide themselves away, they were also precluding themselves from support, and further obscuring their needs from service providers.

Discussion

As described earlier, alienation is a sociological concept that encapsulates more than loneliness; rather, it is the estrangement from others, the world, and oneself despite the longing for connection and search for identity (Younger, 1995). In this section, I expand upon the concepts in alienation theory to argue that the confusing and at times contradictory environments participants navigated after losing their housing resulted in their alienation from others and themselves. As Seeman (1959) described, alienation includes five components: powerlessness, meaninglessness, normlessness, social isolation, and self-estrangement. I discuss each of the concepts and how they relate to the homelessness experiences of the 11 participants that my secondary analysis focused on. Additionally, I identify ways in which the unique and understudied intersection of older women's homelessness differs from other groups that have been discussed in the homelessness literature, and how service providers may need to adapt to meet their needs.

Alienation: Erasure as violence

I chose the theory of alienation to conceptualize my findings because of its ability to illustrate the psychosocial impacts of class oppression (Crimson & Yuill, 2008). Focusing solely upon individual psychosocial factors can be reductionist, neglecting to name and address the structural conditions that gives rise to them. Therefore, further developing the theory of alienation can show the negative impacts of capitalism and make them tangible through lived experience (Øversveen & Kelly, 2022; Crimson & Yuill, 2008). Following from this, it makes sense, then, that exploring the subjective accounts of those who experience more class oppression, such as older women who have lost their housing, would be able to inform us of the most salient psychosocial consequences of alienation and the capitalist system that produces it.

Alienation draws attention to how the effects of capitalism are unevenly distributed across capitalist societies (Crinson & Yuill, 2008). Additionally, use of alienation theory shows how change can occur at the interpersonal level as well as the structural level. Seeman (1959) provides the most comprehensive and systematic definition of alienation that has influenced subsequent literature, and this definition is what I will be building off of.

According to Seeman (1959), one of the components of alienation is powerlessness. Clark (1959) defines this as lacking the means to enact a desired role or self, where the individual is instead forced to take on a role that is not of their own choosing. Many participants experienced powerlessness within homeless environments because they often were unable to exert control over their shelter or housing conditions, nor the circumstances that put them there. For example, participants spoke of their placement into housing that they had no choice in selecting, and were often unable to establish feelings of home within them because of stringent regulations that controlled their behaviour, particularly within emergency shelter and supportive housing facilities. Multiple participants expressed frustration that they were unable to make minor modifications to their supportive housing units, or worse, shared that there were major barriers to their autonomy, such as a lack of a stovetop in their unit. Additionally, participants were often powerless when they lost their housing, unable to fight the structural forces that caused their homelessness or to access services that would have prevented housing loss. In sum, participants experienced powerlessness before, during, and following instances of homelessness.

Meaninglessness is also part of alienation (Seeman, 1959). In applying this concept in my secondary analysis, meaninglessness refers to how intelligible the environments they were in once housing was lost. However, the complexity of navigating between service providers with different expectations and regulations, along with the lack of transparency from staff when rule

enforcement occurred, made comprehending the expected conduct in these environments difficult. As a result, participants reported feeling confused within homelessness spaces that they described as chaotic and contradictory. This reflected the findings in the study Davis-Berman (2011) conducted. Additionally, navigating unspoken social rules between other unhoused individuals added to this complexity with the need to learn how to conduct oneself in a way that was socially appropriate in a potentially unfamiliar lifestyle. As well, it was often not clear what structural forces were at play when homelessness occurs, and in wanting to find meaning, participants expressed self-blame for their housing loss. Because of the existing narrative within neoliberal societies that individuals are responsible for their homelessness, blame becomes easily internalized (Aubry, Nelson & Tsemberis, 2015; Navarro, 2009).

If not addressed, this leads to normlessness, in which communication has broken down to such an extent that the social rules that regulate behaviour within homeless environments are obfuscated. Participants of this secondary analysis often expressed that they were unsure how to act within homeless environments because of the varied and at times conflicting messages they would receive from service providers and other individuals experiencing homelessness about how they were expected to behave. Navigating chaotic spaces with unclear expectations promoted uncertainty, which made participants unable to predict with confidence the consequences of their actions. This can result in a paralysis that left participants stuck and unsure how to act. Some participants also indicated that they navigated multiple identities within homeless environments, resulting in an increased fragmentation of the self. For example, multiple participants described their street personas. At times, these personas were even differentiated from an older woman's authentic self with another alias. Often, these personas were associated with shame because the persona and the context it was developed within allowed

participants to act in ways they would otherwise consider immoral. However, participants crafted these personas to adapt and survive adverse and violent environments. In other words, aggressive street personas were a means of protecting themselves from further victimization, and in essence became a tool that older women embodied to navigate unsafe environments.

Through the development of street personas, then, participants could commit the very same harm they were attempting to avoid themselves, promoting reciprocal distrust and further disconnection through perpetuating stigmatizing views towards other groups experiencing homelessness. For example, some participants expressed frustration or disapproval of people using substances or of people with mental illness that they sometimes encountered within homeless environments and perpetuated negative perceptions and misassumptions through stigmatizing language. Bardwell and his colleagues (2018) make sense of these social hierarchies and inequalities that can appear within emergency shelters as structural vulnerability that positions groups with additional intersections of marginalization at greater risk of stigmatizing attitudes and harm.

Another term for groups of homeless individuals who experience additional marginalization from others without housing is “intra-group stigma,” in which it is possible to perpetuate stigma toward the same social group that an individual is a part of (Thomas & Menih, 2021). In other words, when participants distanced themselves from other individuals without housing, particularly those who use substances or have mental illness, they were displaying a form of intra-group stigma. Although alienation and stigma are related, Younger (1995) defines stigma as an expression of alienation in which an individual is unable to attain full social acceptance due to a shamed social identity. Thus, stigma produces the social conditions that result in alienation (Younger, 1995).

Based on these findings, older women themselves are likely another group that experiences higher structural vulnerability within homeless environments and were themselves targeted for intra-group stigma. Thus, participants tended to be socially isolated in normless homeless environments because they were unsure they would act in an appropriate way in social situations, and feared additional harms should they deviate. This may be why some participants withdrew from homelessness services and social activities with others in these environments to protect themselves from further harm and exploitation. Moreover, remaining isolated in this way further perpetuates the invisibility of older women within homeless spaces, reinforcing the likelihood that their needs will continue to be unmet in homelessness services because there is not an opportunity for older women to voice them.

Exclusion and invisibility of marginalized groups in this way is not a new phenomenon, nor unique to older women in homeless environments. In fact, Purdie-Vaughns and Eibach (2008) have coined the term “intersectional invisibility” to describe what occurs when an individual embodies more than one marginalized identity, thus differentiating them from prototypical members in either marginalized group. In this case, older women experiencing homelessness would be at risk of intra-group stigmatization, which can include exclusion and erasure, and results in their invisibility within either group (Thomas & Menih, 2021). The term intersectional invisibility, then, helps to explain participant experiences of invisibility and shows that it is not simply the result of their own actions, but also is the result of intersectional oppressive forces at play.

Taken together, Seeman (1959) argues that powerlessness, social isolation, and meaningless and normless environments lead to self-estrangement. Rae (2010) states that the occurrence of alienation implies the existence of an authentic self, or an actual self that informs

us of what one ought be, what to strive for, and how we would behave under ideal circumstances. However, self-estrangement entails a disconnection from one's authentic existence, thus rendering it alien (Younger, 1995). In this way, alienation can become internalized through enacting fragmented identities and ignoring one's own needs and values to navigate unsafe environments (Seeman, 1959). Thus, when experiencing self-estrangement, participants were not only unable to express their authentic selves, but they were so disconnected from their bodies and identities that they were no longer aware of their needs or authentic identity. When a participant was unable to meet her own needs through interacting with her environment, the message received may be that her needs have been neglected because they are unimportant. This message can become internalized to the point that participants ignore their own needs because they lack the means to satisfy them. Furthermore, there were multiple examples from participants in which individuals in positions of power, such as housing staff or law enforcement officers, punished older women for advocating for their needs, thus discouraging them from using their voices within these environments.

Additionally, personas that were once a tool for survival can become entangled to such an extent that differentiation was no longer clear, and she became alienated from herself, experiencing herself as her street persona rather than who she was before homelessness occurred. Younger (1995) termed this form of self-estrangement as the "despised self," in which people struggle to reconcile their behaviour in survival conditions because it was so disparate from their desired self that they were unable to express. Moreover, when alienation became so entrenched that it is internalized through self-estrangement, participants in essence silenced their own voices, and were thus unable to find environments that would fulfill their needs not only because they may be afraid to voice them, but because they were unaware of what their own needs were.

Younger (1995) terms this form of self-estrangement as the “disguised self,” a state of false consciousness in which an individual is out of touch with their feelings. Further, this disconnection from one’s emotions and intuition in self-estrangement encourages the usage of numbing coping mechanisms to remain disconnected and encourage detachment (e.g., substance use). In this way, the internalization of alienation through self-estrangement reinforced structural oppressive forces at play in a participant’s life, as the erasure of older women within homeless environments led to participants silencing themselves. This is an issue because service providers cannot meet the needs of the people using their services if they do not express them, and thus a negative feedback loop that reinforces older women’s erasure and suffering is established.

The consequences of alienation

Alienation has profound psychological impacts that in turn affects older women’s health and wellbeing. As illustrated through these findings, alienation negatively affects mental health, self esteem, and older women’s ability to ask for support when they need it. Further, alienation for older women without housing derives from intersectional stigmatization due to ageism, sexism, and ableist assumptions. This can cause older women to feel shame about their identity and experiences, encouraging them to further isolate themselves through self-estrangement. They may begin to detach from others and must instead rely on their own skills and abilities to exit out of homelessness. In this way, social isolation becomes a means of self-preservation to avoid further harm, yet also prevents older women from receiving support while negatively impacting their health.

Despite the long-term health consequences of alienation, however, there are short term gains to social isolation and self-estrangement. One of the assumptions of witnessing methodology is that individuals act in ways to keep themselves safe, even when those actions

appear irrational or self-destructive (Reynolds, 2020). In this case, the withdrawal of participants from harsh environments endured during and following instances of homelessness reduces the unpredictability of what was otherwise a chaotic space and helped to ensure their safety. While older women have few ways to maintain their autonomy within homeless service environments, isolating themselves is a choice that I interpret as an act of resistance (Reynolds, 2020).

Withdrawal as a survival strategy becomes an issue, however, when participants' access to needed supports is tied to the emergency shelter and supportive housing facilities within the homeless-serving sector and dependent upon their ability to navigate them. Thus, participants chose to isolate themselves even while their health continued to decline. Even so, in these cases, participants showed their incredible resourcefulness and survival skills in their self-reliance and ability to secure their own housing. However, this risks the continued deterioration of their health, and they may reach a crisis point where additional support is required before they are able to resolve their own homelessness.

Additionally, many participants distanced themselves from their homeless experiences, either due to stigma they themselves associated with homelessness that they desired distance from, or through emphasizing that homelessness was an event that happened to them and is not representative of who they are. This is a common phenomenon with suffering where we desire distance from what causes us pain (Younger, 1995). In fact, it is possible to conceptualize alienation as a form of suffering, as Cassell (1991) defines suffering as anguish that is the result of a threat to our integrity and lack of fulfillment of our intentions in which we instead must submit to circumstances that are out of our control. Thus, Younger (1995) argues that suffering derives from an intrusion upon our autonomy such that we are no longer our desired, authentic self. Different from pain, suffering often occurs when pain is chronic and out of one's own

control. For participants of this study, losing their housing to instead live in spaces that were often institutionalized and unsafe with no clear end caused them to suffer. If perceiving their loss of housing as a personal failure the way neoliberalism encourages (Navarro, 2009), any identity as independent or view of themselves as self-sufficient and able to provide for themselves and fulfill the gendered role of homemakers may have had to change to accommodate the circumstances that homelessness had placed them in (Gonyea & Melekis, 2017). Moreover, the lack of autonomy they experienced within these environments often pulled them further from the ability to express their desired self.

However, suffering also demarcates periods of change and transition (Younger, 1995). Recognizing their suffering for what it was—an inability to control their environments and act in ways of their choosing to express their authentic selves—can indicate to participants what in their circumstances needed to change to alleviate alienation and suffering to instead restore wholeness and healing. Such transformation would begin with ensuring that older women have the safety to explore and express their authentic selves, which they cannot do when alienation has oriented them toward independent survival and endurance of suffering. Thus, alienated older women must be able to acknowledge that their suffering can and should end before they are able to exit out of homelessness (Younger, 1995). To that end, the ability to express their experiences through narrative is often a healing activity that can support older women in articulating the causes of their pain, which is necessary to relieve it (Washington & Moxley, 2008; Younger, 1995). As a mode of creation and self-exploration, narrative is a form of storytelling that involves the development of new ways of knowing and connection, allows for identity formation and self-advocacy, and provides a way of restoring autonomy through self-expression and articulation of marginalized experiences (Betts et al., 2023). In this case, being able to make

sense of their housing loss would allow older women to acknowledge the transition from housed to homeless that has occurred so that they could articulate how the experience may have changed them or their view of themselves, thus promoting self-acceptance.

Re-engagement with the self in this exploratory way can allow older women to reintegrate their fragmented identities and restore a sense of belonging within their own selves (Younger, 1995). Simultaneously, sharing their experiences with people and in places that are equipped to handle them without blame or judgement would allow for connection and solidarity in what is otherwise an isolating experience of alienation. Moreover, fuller knowledge of themselves could allow alienated older women to seek out what fulfills them, thereby creating a sense of belonging within their environments as well through finding others engaged in similar interests and enacting similar passions, thus forming the basis of community. Safety to explore and connect in this way would also re-establish older women's autonomy, which would be necessary for older women to function outside of institutionalized housing services. How the homelessness service environment can assist older women in restoring their sense of belonging within themselves and in their communities is through building older women's capacity to express themselves and creating spaces foster a sense of safety to do so while accommodating their agency and ability to choose and control the spaces in which they live (Chan, 2020).

Alleviating alienation through safety in space

Rae (2010) has identified the ability to express one's desired, authentic self as the main mechanism through which alienation is ameliorated. The existence of alienation indicates that the individual is living out of alignment with their desired self, and motivates them to seek the conditions that would allow them to enact their desired self. Thus, experiencing alienation is not inherently negative as it can serve as the impetus for change (Rae, 2010; Younger, 1995).

However, there must be the social conditions that would allow an individual's desired self to exist. Participants from this secondary analysis indicated that safety is a chief concern, and a crucial unmet need within homeless environments. Reconnection with oneself requires a safe environment to express oneself and the autonomy to enact one's desires (Younger, 1995; Jones, 1999), and safety for older women was lacking in unsheltered and homeless-serving environments. Thus, it follows, then, that older women's alienation will continue while residing in these spaces, and may continue indefinitely if a sense of safety is not achieved through secure housing. Given the importance of community in establishing a sense of belonging for individuals who have been rehoused after experiencing homelessness (Young, Abbot & Goebel, 2017), these spaces also must consider how they can facilitate social connections to prevent individuals returning to homelessness because they lack community once rehoused.

A theoretical framework that can provide the foundation for creating such spaces is therapeutic landscapes. Therapeutic landscapes are a strand within health geography that ties a holistic view of health (which takes into account mental health, social wellbeing, and spirituality in addition to physical health) to appreciate the ways that the environments in which people live can either promote or constrain health and wellness (Gesler, 2017). This is also a useful approach to understanding the impacts of homelessness on older women. Researchers have reported that conventional approaches to housing facilities in the sector have been little more than a roof over one's head and their therapeutic potential as a community service has not been developed (Sullivan, 1991; Alaazi et al., 2015). However, because therapeutic landscapes of home are a concept that incorporates a holistic definition of health and healing (Gesler, 2017), this could present a new avenue of understanding how to design spaces in the homelessness service environment. For example, Bignante (2020) discusses how individuals experiencing homeless

engage in spiritual practices to promote positive social interrelatedness. When passersby approach unhoused vendors for their spiritual advice (such as tarot readings) on the boardwalk in Venice Beach, California, Bignante (2020) argues that this creates a therapeutic landscape through shaping the affective experience of space, and shifting the normative power dynamics such that the voice of the individual without housing is sought out and heard, thus promoting a sense of belonging and social recognition, self-esteem and wellness. Therefore, Bignante (2020) asserts that the boardwalk is a space that allows for an individual experiencing homelessness to perform their desired self. As a therapeutic landscape, the boardwalk represented a space where the individuality, humanity, and agency of individuals experiencing homelessness were recognized and supported, therefore challenging attitudes around stigma and negative self-perceptions. Determining how to create therapeutic landscapes for older women could similarly allow them to embody their desired self.

As another example, Alaazi and his colleagues (2016) defined the concept of a therapeutic landscape of home from an Indigenous perspective, in which the home is traditionally viewed as a cultural space of healing. While non-Indigenous conceptions of home prioritize the physical property and private land ownership, an Indigenous definition refers more to the relationships and responsibilities held within a space, including connections to land, animals, and traditional stories. Christensen (2013) described it as a sense of “rootedness” in which a metaphysical interconnectedness between one’s relations is maintained and belonging within one’s community is achieved. However, colonization has disrupted this connection because urban dwellings are not often equipped to support Indigenous community activities and healing ceremonies, such as smudging or sweats. When ceremony is displaced from the home, it no longer holds the same meaning, and this disconnection can force a constant “churn” for some

Indigenous people, who oscillate from reserves for cultural connection and relationship with land, to cities for urban infrastructure and resources (Peters & Robillard, 2009). Therefore, Alaazi and his colleagues (2015) argue that having space for spiritual and cultural ceremony is integral to creating a sense of home and rootedness while preventing housing insecurity and returns to homelessness. When these spaces are not provided, it serves as cultural displacement and forms the basis of rootlessness of Indigenous people within the urban Canadian context.

Research on therapeutic landscapes has identified the importance of social interrelatedness and the ability to build and maintain social networks through cultural and spiritual practices, along with connections to land and place as an essential aspect of homelessness prevention (Alaazi et al., 2015; Bignante, 2020; Young, Abbot & Goebel, 2017). Ensuring that buildings are equipped with spaces for prayer, healing ceremonies, and community connection is crucial for housing that allows older women to have the safety and autonomy to call that space home, and for successful exits out of homelessness. However, further consideration for how to create a therapeutic landscape that supports healing in the homeless-serving sector is lacking, particularly for older women whose health and healing needs are understudied and consequently not well understood (Davis-Berman, 2011; Sullivan, 1991). How to develop a therapeutic landscape specific for older women who have been homeless is thus an avenue for further study.

Building a therapeutic landscape for older women requires that service providers first witness and hear their struggle while they attempt to utilize their spaces and services. When we create space for older women to express themselves and speak their truth, we show them that their strength and pain is worthy of our attention, and this helps to disrupt the current narrative that silences and dismisses older women (Hunt, 2018; Younger, 1995). Thus, for the sake of

older women's health, a shift must occur structurally as well as culturally. We need what Clark (2016a) describes as "witnessing spaces" in which older women can share their truths with others in an environment that is free of stigmatizing, neoliberal narratives that locate blame within the individual for the loss of their housing. These spaces can also support solidarity and community building through storytelling, which allows for the recognition of shared experience while inspiring others to create and share their own narratives (Clark, 2016a; Younger, 1995). Although older women may not feel safe speaking directly with service providers, the research context is a space in which older women have the protection of confidentiality and anonymity. Thus, further research to explore what specific recommendations are needed to support the safety and healing of older women would be beneficial.

Limitations and Conclusions

The major objective of this thesis was to gain a richer understanding of the social life, particularly experiences and impacts of social exclusion, stigmatization, and alienation on the health of older women who have been homeless. A related goal of this study was to identify the need for safe environments for these older women that will promote a sense of belonging and return them to a place of home, thus reducing the impact of negative health outcomes associated with their alienation and homelessness. I achieved a greater understanding of older women's experiences of homelessness through a secondary analysis of 11 out of 20 transcripts from the existing SHHOW study to explore how older women's lack of safety within these environments affected their social wellbeing through the lens of alienation and intersectionality. During this secondary analysis, I paid particular attention to my sensitizing concepts that identified data related to the components of alienation. Following from my reanalysis, I developed two themes: older women's lack of safety to express vulnerability in homeless environments, and performing and hiding vulnerability: older women's acts of resistance.

Overall, alienation remains undertheorized and modern interpretations and applications are particularly lacking (Yuill, 2005). This is in part due to controversy that there is some ambiguity on the exact definition of alienation (Yuill, 2011). However, this is common in the early stages of theory development, and does not indicate that the concept ought to be abandoned. Rather, it shows a need for further research that specifically investigates alienation and how it manifests in subjective experiences and influences health outcomes (Yuill, 2011). As Navarro (2009) argues, there is also not enough research that specifically explores class as a social determinant of health in contemporary academic discourse, which likely explains why there are few current inquiries into alienation as well, despite the fact that the current social

conditions under late-stage capitalism are even more conducive to fostering alienation (Yuill, 2011).

The findings of this thesis, therefore, fill a gap in both the alienation literature and homelessness literature. For example, Yuill (2011) calls for more qualitative studies that reveal the range and variation of subjective experiences of alienation to glean a greater understanding of how people make sense of their circumstances in various contexts, as well as how they resist them, which these findings have expanded upon. Moreover, research that explores older women's homelessness and how the intersections of ageism, classism and sexism play out in lived experience is lacking (Davis-Berman, 2011; Sullivan, 1991). My thesis research and the SHHOW project as a whole also contributes to a growing body of work that focuses on older adults who are losing their housing at increasing rates (Crane & Joly, 2014). My findings added to Sullivan's (1991) study on alienation in older women, showing that the issue not only persists, but has also become more complicated as increasing numbers of older women are losing their housing. Additionally, another strength of this thesis was that I applied the theory of alienation to the study of homelessness, which is an area of study where class analysis is also lacking (Hodgetts et al., 2011).

Based on these findings, I conclude that the way forward is to create service environments that promote safety and belonging for older women without imposing any particular lifestyle upon them, or in other words, building therapeutic landscapes for older women who have been homeless. When experiencing powerlessness, particularly within institutions, restoring choice and control becomes a chief concern for health promotion and healing (Chan, 2020; Hodgetts et al., 2011). Specifically, my findings reveal that service providers can assist older women in resolving their homelessness and protect their health through

the following recommendations: greater flexibility in shelter and supportive housing policies that are responsive to the varying genders and ages of the individuals using their services; greater transparency of staff protocols and consequences for rule violations; greater collaboration and consistency across services to reduce the conflicting messaging older women receive when navigating homelessness services; and clarity about behaviours expected from frontline staff and older women. Furthermore, to reduce staff burnout and the subsequent complacency that contributes to the neglect and harm of older women utilizing homelessness services, there needs to be more comprehensive staff training that informs employees of the structural inequities that contribute to the maintenance of homelessness within capitalist, neoliberal societies and makes them attentive to the various ways people are stigmatized, and how they respond to the oppression they experience.

Comprehensive staff training in this way, along with appropriate supports in the form of adequate supervision and comprehensive wages and benefits, would better equip frontline staff with the ability to react appropriately to older women's concerns without reinforcing power imbalances (Kerman et al., 2023; Mullen & Leginski, 2010). According to Younger (1995), compassionate care enables the processing of suffering, in which the mute suffering of alienation can move into expressive suffering that eventually allows for cohesive identity formation and an integration of the self. Similar to other health care professionals, then, housing support workers need adequate training to provide compassionate care to the people they are interfacing with in need of housing services. Thus, frontline staff need higher wages and professional development for the complexity of their work environments and the diversity of people that now need housing services (Mullen & Leginski, 2010).

Further, service providers need to develop accountability measures within their housing services for when misconduct of staff members or law enforcement occurs that harms people utilizing them. Because service providers wield power over the lives of those utilizing their services, it is imperative to ensure that abuses of power can be reported and acted upon with consequences appropriate for the severity of the misconduct. Based on these findings and others (e.g., Belcher & DaForge, 2012), people experiencing homelessness have little protections in place to support their safety and dignity, thus promoting the development of their own survival strategies that may protect them in the short term, but can have long term negative consequences for their health and wellbeing as the choices they made under constrained circumstances can alienate them even further. Thus, systematic protections, similar to a Residential Tenancy Act, are needed in homelessness spaces and services. Moreover, establishing the right to housing within Canadian law would provide additional legal recourse and protections for individuals who lose their housing in Canada (DesBaillets & Hamill, 2022).

These recommendations represent system improvements, but would do little to resolve the phenomenon of homelessness as a whole. In fact, while housing is a social determinant of health, Lyon-Callo (2000) cautions against the medicalization of homelessness because it can encourage pathologizing narratives that locate the cause of housing loss within the individual without challenging the systematic political and economic causes. Although Canada passed the National Housing Strategies Act in 2019, DesBaillets and Hamill (2022) argue that it is not comprehensive; increased social housing and expanded social services are also needed to achieve more affordable housing and prevent homelessness. Additionally, Canadians need to challenge neoliberal politics that diminish our social welfare programs and construe homelessness as an

individual failure (Gaetz, 2010). Housing is not a matter of personal success, but a human right (DesBaillets & Hamill, 2022; Government of Canada, 2019).

A limitation of the SHHOW project overall was that while the project had been developed before the pandemic, funding was awarded while the COVID-19 pandemic restrictions were ongoing. Thus, data collection occurred during the height of the COVID-19 pandemic, which limited the SHHOW team to conducting interviews over the phone or through Zoom. This method may have excluded the participation of many older women for whom these technologies were inaccessible. Thus, due to the shifting recruitment and data collection strategy of the SHHOW project, we were unable to interview older women without pre-existing connections to service providers. Therefore, this study will not reflect the experiences of all older women living with housing insecurity and homelessness, particularly those without connections to services who may have higher levels of social exclusion and alienation.

Despite this, the SHHOW project, along with my thesis, fills some of the gaps in the existing literature on the social life and health of older women who have been homeless. Furthermore, documenting participant experiences during the COVID-19 pandemic was a unique opportunity as there was a general increase in social isolation during this time to reduce viral exposure. Thus, older women's alienation in homeless service environments may have been enhanced while their safety concerns were compounded due to an additional fear of contracting a novel and potentially fatal respiratory illness. Service providers may have also been less able to allow for autonomy and choice of people using their services in order to protect them from viral exposure, since many of people using shelter services had chronic health conditions and compromised immune systems that would make them more susceptible to illness (Dickens et al., 2020; Brown et al., 2017; Grenier et al., 2016).

Limitations of my secondary analysis include that I only included 11 of the 20 SHHOW interviews in the analysis. This was due to my focus on the experiences of social exclusion, which not every participant spoke about in depth in their interview. Thus, it is unclear whether all older women who lose their housing would also experience alienation, or if there were other factors present in the 11 participants selected that contributed to their social exclusion, or alternatively, put them in a better position to be able to articulate their experiences of such. It is also possible that the participants not included in this secondary analysis also experienced alienation, but in subtler forms. An avenue of future research, then, would be to spend time reanalyzing the remaining 9 interviews to identify whether alienation was present for these participants as well, or conduct follow-up interviews with questions that explored the components of alienation, such as experiences of powerlessness, social isolation, and self-estrangement in greater depth. Additionally, given my familiarity with the SHHOW data and homelessness literature, I was unable to bracket off my preconceived ideas and biases before reanalyzing the data. However, rather than a limitation, I view this as a strength of my secondary analysis because my familiarity allowed me to explore the data in greater depth with an awareness of how the findings would fit within the existing homelessness literature.

In the future, the homelessness-serving sector needs to consider housing designs and community services that can facilitate a therapeutic landscape of safety, autonomy, social inclusion, and belonging to address alienation and the impacts homelessness has on mental health and social wellbeing, particularly for older women who can experience additional discrimination such as ageism, sexism, and ableism (Sullivan, 1991). I intend to share my findings with service providers, policymakers, the homeless community, and the general public through the development of this thesis and ongoing knowledge mobilization. In an effort to be

community-engaged, further knowledge mobilization will be determined in collaboration with older women without housing to help to ensure that their voices are heard in addressing community needs. Additionally, my work will remain responsive to Indigenous communities as much as possible. I will aim to ensure that I name and explain how colonization is at the root of the disproportionate effect of contemporary homelessness upon Indigenous communities in knowledge mobilization activities so that the colonial structures that maintain homelessness will be clearly stated. The significance of this work is that it aimed to generate awareness and spur the social change necessary to promote the healing and safety of older women who have experienced homelessness to address their feelings of alienation and incongruence with their environments, and to prevent their worsening health outcomes.

Finally, while there is existing research on homeless transgender youth (e.g., Robinson, 2018), review of the literature for this thesis found no studies that discussed older transgender women. Similarly, there appeared to be no research on the experiences of older lesbian, bisexual, or two-spirit women who have been homeless. Furthermore, despite the legacy of colonialization that contributes to the maintenance of the disproportionate effect of homelessness on Indigenous communities, there were no studies that focused specifically on Indigenous Elders and few that focused on racialized older women (e.g., Washington & Moxley, 2008). Given the intersections of marginalization that racialized individuals and sexual and gender diverse people experience, particularly at older ages, and the emphasis in the present literature not to perpetuate social exclusion upon the homeless population, it is important to ensure that individuals who face additional barriers when accessing homelessness services are prioritized in future research. If older racialized and LGBTQ2S+ adults continue to be overlooked in research studies, then the homeless-serving sector will be unlikely to adequately meet their needs.

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Appendix A

Building Solutions to Homelessness and Health for Older Women (SHHOW) in Vulnerable Circumstances

Interview guide for women who have lived experience of homelessness and housing insecurity

Background Information/Introduction

Thank you for agreeing to this interview, we very much appreciate your interest in participating in this study. To give you some context of the study:

Older women's experiences of being homeless (unhoused) or insecurely housed are often considered to be marginalized, hidden, and/or under-reported, and as a result, are less well understood than the experiences of men and youth living in similar circumstances.

Currently, we have two main goals: (1) to understand women's experiences, successes and challenges and to share these stories with one another; and (2) to promote the development of 'quick-wins'/fast solutions to improve the wraparound supports and resources available to women who are either currently, or who have previously, experienced housing insecurity/homelessness.

We want to remind you that your participation in this research project is **completely voluntary** and we encourage you to share only those aspects of your story that you feel comfortable discussing. There are no right or wrong answers. What you share with us will **not affect your**

current housing and not be shared with managers at your facility. We can skip any questions and move on, or stop the interview at any time if you need or want to. In addition, if you need a break we can reschedule for another time or continue after a short rest. We have a **small honorarium** for you for your participation that we can discuss at the end how best to get it to you.

We **do not want to upset or trigger you** during the interview, but some of the questions may bring up unexpected feelings. The GVCEH is available to offer you peer support and we invite you to chat with them if you need it. We also have a list of resources and contact information we can email you, provide over the Zoom call or give to you when we provide the honorarium.

What you say will be kept in confidence and your answers are anonymous- we **will not use your name**. Do you have a pseudonym (alternate name) you would like us to use? Is it ok if we record this interview? [**Interviewer hits Record on Zoom**]. Do you have any questions for us before we start? Ok, we would like to start with asking you some questions about where you currently live, then move onto your story/experiences and then some questions about your health.

Questions

Individual

1. **Present circumstances with housing.** Can you tell us about where you are currently living? How did you come to live in this [name current place/housing setting] that you are in? How long have you been here?

2. **Home/sense of belonging/possessions.** Do you consider this your home? What do you like about it? Are there things you aren't quite as keen on (challenges) with living here? Is your space shared or private? Does your current space feel safe, supportive, secure, and accessible? *Please elaborate.* If it doesn't feel homey, what would make it more home-like for you? What does 'home' mean to you? (people, structures, good supports/lack of supports, etc.)? Have you lived in other spaces/places that felt more homey in the recent past (last 10 years)? What made them feel that way? Can you tell us a bit about your journey/path of getting into this housing situation (challenges, cycling, waitlist, access, affordability, etc.)?

3. How important is *having a sense of belonging in a community* to you? What does 'community' mean? (*isolation/inclusion/exclusion/belonging & alienation?*) Do you feel you have a community where you currently live? How important are having your own things around you to you? If you had to leave and move to another housing situation, which things [items, possessions, other] would be important for you to take? Why?

Are you okay so far with our questions? Would you like a break now or in a bit?

4. **Personal story.** The next questions are focused more on your and your experience of being unhoused. First off, what would you like people to know about you? Would you be willing to share your own experiences of being under-housed or living with housing insecurity? [Past and present emphasis. Ask about cycling in and out; or whether housing

insecurity is new for them]. The term homeless or unhoused are commonly used in the media, what do you think of these terms?

5. **Health and well-being.** How do you think living without a home, or being insecurely housed impacts ones health and well-being? What does health and well-being mean to you? How would you describe your health and well-being today? (*probe for mental, spiritual and physical well-being*). On what do you base your assessment? Is your health the same or different from what it was five years ago? Why? What has changed for the better or worse?

6. **COVID-19.** How much of an impact did COVID-19 have on your day to day life over the last year and a half since it started?

System/Structural

7. **Helpful people organizations/champions.** Are there people/organizations you can think of who have helped you/been champions/friends for you along the way? When did they help you? What did they do/provide that made a difference to you?

8. **Services/supports.** Thinking about the services you have used, are there certain ones that you benefitted from? What are they? How were they helpful to you? Have you felt treated fairly by service providers? Why or why not? Do you feel that service providers

expect you to act/ behave in a certain way to get support? Do you ever feel you are treated differently for who you are?

9. **Future hopes/Ideal circumstances.** If you had a magic wand to support older women who live with housing insecurity, what kinds of organizations, services/ supports or people do you think would make a difference for (older) women? Is there anything else you can think of about the kinds of individuals, services, resources, etc. that would have made a difference for you and helped you to be more housing secure, what would they be? (could be related to housing or wraparound supports (e.g., housing, health care, food, clothing, counselors, substance use supports, peer support workers)?)

Big Picture Thinking

10. **Talking about older women and housing insecurity and vulnerability generally.** In your opinion, and based on your life experiences, what are the **biggest challenges** that older women face when it comes to their risk of being without a home, or living with housing insecurity in Victoria or British Columbia? [*define terms*]? And, how are older women's experiences unique from others (e.g., men's or youth) in your opinion? Thinking about women's **health and wellbeing**, do you have any thoughts on how older women who have been without a home, or who have lived with housing insecurity can be better supported to live fuller, safer lives?

11. Background/Demographic Information. Can we get a bit of additional information from you - where were you born? When were you born (year)? Have you been married/partnered? Do you have children? Educational background? Income sources?

12. Is there anything else you would like to share with us/ask us?

Final Questions:

After we complete our analysis of all of the stories we collect, would you be interested in coming together to hear what we have learned? YES NO. If YES, how should we contact you?

How would you like your story to be shared? Would you like a summary of your story?

Thank you very much for your time. We have an honorarium for you – is cash best? Can we bring to your place of residence?