

Balancing on the Edge: Understandings of Hope Amongst  
Women Experiencing Homelessness

by

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## **Abstract**

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Women who experience homelessness are faced with a myriad of challenges and struggles. Compared to women with housing, they endure higher than average rates of physical illness, mental health challenges, and substance use issues. They are often victims of physical and sexual violence and are subjected to daily experiences of deprivation, isolation, powerlessness, and marginalization.

Given the immensity of these struggles, it is essential to better understand those aspects of their experiences and beliefs that promote endurance and resilience. Hope is readily acknowledged, across disciplines and across diverse populations, to be an experience that offers strength to individuals when faced with difficulty. It is understood to be a key component of well-being and quality of life and has been shown to provide protection from despair, grief, and harmful behaviours.

In this research, women who have recently experienced homelessness were asked to speak to their unique understanding of hope. The study participants were also asked to discuss what prevents and supports hope in their lives and finally, were requested to speak of how registered nurses foster or prevent hope. The approach used to guide this research was interpretive description. The use of this

approach ensures that the generated knowledge not only addresses the study research questions but also that the data analysis is contextually placed within the clinical setting. This study involved interviews with nine women who had experienced homelessness within the preceding twelve months.

Four major themes and multiple subthemes emerged through the process of analysis. Three major themes describe the complexity of living with hope for these women: 'balancing on the edge', 'pushed to the edge' and 'pulled from the edge'. 'Nursing on the edge' captures the multiple understandings of how registered nurses impact the experiences of hope and hopelessness. Findings from this research explicate the unique struggles, strengths, capacities, values, and beliefs of women who are homeless. Furthermore, the findings shed light on the delicate balance of hope and how easily, often without thought and attention, registered nurses can upset this balance. These findings have implications for nursing practice and nursing education and provide considerations for policy development and future research.

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## **Acknowledgments**

“For hope, which is just the opposite of resignation, something more is required. There can be no hope that does not constitute itself through a we and for a we” (Marcel, 1962, p. 32).

This research project could not have occurred without the support and love of my family and friends. In particular, the encouragement and patient listening of my partner and parents helped me maintain my focus and enthusiasm throughout the challenges of balancing life, school, and work. The guidance and support of my supervisor, Bernie Pauly, was equally invaluable throughout this undertaking.

Above all, I must acknowledge women everywhere who are struggling with homelessness. For years they have honoured me by sharing their goals and dreams and have taught me so much about resilience and perseverance. In particular, I would like to acknowledge the nine women who agreed to participate in my research study. I hope that each of them moves away from their experiences of despair and moves towards their preferred version of self.

## **Dedication**

I dedicate this work to my younger brother, Joseph Alan Markel. While working on my thesis, Joe passed away suddenly and tragically. As I struggled to maintain my balance, his memory pulled me from the edge of hopelessness. His struggles with despair, his unwavering pride in my accomplishments, and his unrelenting hopefulness in the face of life barriers propelled me forward. I only wish he was here...

## Chapter 1

During my years as a registered nurse working with residents of the Downtown Eastside of Vancouver I developed many meaningful relationships with the women I encountered in my work. While walking alongside them, I witnessed first hand their struggles to maintain hope while immersed in lives fraught with poverty, deprivation, and isolation. Their complex mental and physical health challenges, that I was often called on to address, only seemed to further exacerbate their experiences of hopelessness and despair. There are so many individuals that I recollect from my days working in the single room occupancy hotels but it was one person in particular who raised my interest in hope.

Candace (pseudonym) was a young woman who had lived in the Downtown Eastside of Vancouver for over twenty years. She was diagnosed with HIV and hepatitis C and was prescribed a variety of antidepressants and antipsychotics for an undiagnosed mental health challenge. She struggled with polysubstance use and made ends meet by selling sexual services and drugs. Candace was challenging to work with, as she was quick to anger and aggressive. Equally as challenging were her frequent articulations, often in a loud voice and accompanied by tears, of the injustices she was experiencing.

Candace would often speak of her desire for a different life, one in which she was reconnected with her children, living on a farm, and living with a nurturing partner. It was easy to be dismissive of these hopes when they were being expressed amidst either tears or with swinging fists. One day, Candace was using the soaker tub that was adjacent to my office and while on the telephone with another community agency I heard her voice raised in song. I can't remember what she was singing in particular, a country or folk song I

believe. But as I heard the beauty of her voice, I felt ashamed for my previous inattention to her hopes and opened myself to viewing the image of Candace that she was striving for. As she continued to sing, I was clearly able to see her working in her garden on a farm, surrounded by her family, and momentarily free from the struggles of her life.

It was this experience and many others that caused me to reflect on hope and how it plays out in the lives of the women that I work with. Furthermore, I was forced to evaluate how I, as a registered nurse, could impact a person's experience of hope. I know now that disregarding Candace's dreams of a preferred life could not have conceivably fostered hope for Candace. In fact, on retrospect, I suspect that this disregard may have caused her to feel worthless and pushed her towards hopelessness. These experiences sensitized me to both the potential negative and positive consequences of how nurses respond to expressions of hope.

As I became more and more cognizant of the experiences of hope amongst this population, I became more and more curious. I began to engage with my clients around their hopes and asked questions about the meaning and experience of hope. I also began to ask clients what I could do to foster hope in their lives and how I could assist them with achieving their hopes. I began to speak to my colleagues about hope and noticed that many of them had never thought about this before.

As my attention shifted towards hope, I came to realize that my relationships with clients also shifted. There seemed to be an increased level of trust and an increased willingness to reach out for assistance being afforded to me. As well, some of the women that I was working with began to move forward on their goals of alternate housing, reduced

substance use, and reconnections with family. I realized that an understanding of hope for this population had potential implications for nursing, healthcare organizations, research, education, and program development. This understanding could only be gathered through research and after many years of reflecting on hope I embarked on my research study to explore hope.

In this chapter, I briefly discuss women experiencing homelessness and their unique strengths and challenges. I also describe current understandings of hope and the impact of homelessness on hope, identify the statement of the problem and present research objectives. I conclude this chapter by articulating researcher assumptions and the potential significance of this project.

## **Background**

Women experiencing homelessness are faced with tremendous challenges. Compared to women in the general population, homeless women experience higher rates of acute and chronic health challenges, substance use issues, and mortality (Cheung & Hwang, 2004; Hwang et al., 2009; Teruya et al., 2010). Mental health struggles are also prevalent amongst women who are homeless. Affective disorders, including major depression, anxiety disorders, and posttraumatic stress disorder, have been documented at alarming rates (Hwang, 2001). In addition, victimization and trauma are reoccurring challenges for women who are homelessness.

Despite their documented need, women who are homeless are less likely to access shelters (Hwang et al, 2009) and community health agencies and are less likely to have a regular source of health care compared to women with housing(Cheung & Hwang, 2004).

Barriers to healthcare services include lack of transportation, competing priorities to secure food and shelter, long wait times, and feeling stigmatized by health care professionals (Hwang et al., 2010). Decreased access to shelters and medical care has significant implications for health and social outcomes including quality of life.

Given the challenges that women who are homeless experience it is paramount that research focus on the experiences of this group and capture the rich meaning of hope in their lives. An understanding of the values and beliefs of women experiencing homelessness will highlight and bring to the fore both strengths and challenges. Homeless women are often seen as victims and even without hope. However, little is known about the role that hope plays in their lives and how this impacts coping, capacity, quality of life, and the promotion of health.

Despite general lack of understanding or agreement on definitions, hope is readily acknowledged as an essential component of being human. "Hope is the act by which the temptation to despair is actively overcome" (Miller, 2007, p. 13) and in the face of chronic and acute health challenges hope is often pivotal in moving towards recovery (Harris & Larsen, 2008). Hope is believed to empower individuals when faced with illness and promote adherence to treatment and self care regimens (Harris & Larsen, 2008; Milne, Moyle, & Cook, 2009). Hope is known to be an essential element of quality of life and a powerful factor in health and healing (Delmar et al., 2005; Hammer, Mogensen, & Hall, 2009). In the face of illness and life stressors, hope is pivotal to the desire to carry on with living.

Research about how homelessness effects hope is conflicting. There is evidence that hope persists amidst homelessness and there is equal evidence that the marginalization and bleakness associated with homelessness interferes with hope and may cause hopelessness (Hughes et al., 2010). Youth experiencing homelessness have been known to avoid hope as a means to prevent failure (Nalkur, 2009). Rather than rely on themselves to achieve goals they may externalize hopes and rely on a person or resource to bring about change (Nalkur, 2009). Amongst homeless youth low levels of hope have been linked with decreased access to service and decreased satisfaction with health care interactions (Hughes et. al, 2010).

Amongst adults who are homeless, hope is found to involve connections with others, expectations, and persistence (Hughes et al., 2010; Nalkur, 2010). However, samples involving homeless adults are often composed of male and female shelter residents and do not involve a gender specific lens. There is a significant lack of research that specifically explores the phenomenon of hope amongst women who are homeless despite their documented health and socioeconomic challenges.

### **Statement of the Problem**

Despite diversity in values, beliefs and opinions, hope is almost universally acknowledged as important to health, healing, and quality of life (Delmar et al., 2005; Hammer et al., 2009). Hope has also been found to serve a protective function, promote resilience, and preserve the will to live amongst a variety of diverse populations (Delmar et al., 2005; Hammer et al., 2009). Amongst homeless persons, similar understandings have been discovered (Hughes et al., 2010; Nalkur, 2010). However, very little research exists

that involves a sample that is composed solely of women who are homeless. This is a gap in existing research concerned with hope, as women who are homeless are amongst those marginalized and face tremendous struggles (Radher, 2006). Given what is known about hope's protective functions, an understanding of how women who are homeless understand and experience hope is essential. This understanding could serve to combat the stressors and challenges associated with their daily existences. Furthermore, an understanding of how women who are homeless define hope and what hopes they carry is essential to the creation of therapeutic nursing relationships. As well, these understandings could promote the development of appropriate resources for women who are homeless and thus, improve well-being and prevent illness, injury, and death.

### **Purpose of the Study**

The purpose of this study was to develop an understanding of how women who have experienced homelessness perceive hope. The research questions guiding this study are:

- a) What is the meaning of hope for women experiencing homelessness?
- b) What do women experiencing homelessness perceive as barriers and supports to hope?
- c) What nursing actions support or create barriers to hope?

### **Assumptions and Beliefs**

I entered this study with a variety of assumptions and beliefs related to the experience of hope for women who are homeless. Although some of these beliefs aligned with the understandings of the study participants, the details and characteristics of my

assumptions were often challenged throughout the research process. One of the initial assumptions that I brought to this study was the belief that the women I spoke with would have very little hope. As I discovered throughout my interview process, many of the women who participated in this study were able to speak to their understanding of hope eloquently and tightly held onto their individual experiences of hope.

I also assumed that substance use would play a part in hope and hopelessness for the study participants. Specifically, I thought that substances would reduce hope; however, I came to realize that the relationship between hope and substance use was much more complex. I also assumed that registered nurses had the capacity to impact hope through their actions but was shocked to discover the unique ways that this was understood by the women I dialogued with. Each and every one of these assumptions was challenged during this study.

### **Potential Significance**

In this study, the meaning of hope for women who are homeless is explored. As well, insight into potential barriers and supports, including the actions of registered nurses, is probed. This qualitative research project provides new knowledge pertaining to hope amongst this population. As previously mentioned, women who experience homelessness face unique and diverse challenges, including poor access to health care, high rates of mental and physical health struggles that include higher than average morbidity rates, victimization, poverty, and isolation. Given that hope, amongst diverse populations, has the potential to improve quality of life and foster resilience and perseverance, it may have the capacity to mitigate or reduce the burden of the challenges endured by homeless women.

An understanding of what prevents and fosters hope for homeless women, including how registered nurses impact hope, is significant for the delivery of healthcare services. Individual healthcare providers, program coordinators, policy makers, and nursing educators could utilize this understanding to increase nursing capacity to foster hope while working with marginalized populations. Furthermore, this study may inadvertently illuminate areas in which future nursing research should be conducted so as to increase current knowledge about hope.

Finally, I believe that it is essential that the voices of those receiving healthcare services inform the nature and quality of said services. This almost always ensures more beneficial outcomes for those receiving services (Gelberg, Browner, Lejano, & Arangua, 2004). The perceptions of homeless individuals are very rarely factored in during the development and evaluation of healthcare services (Daiski, 2007). This study invites women who have experienced homelessness to share their intimate and unique perspectives about their lived experiences of homelessness and hope. Furthermore, this study invites the participants to share their experiences of working with registered nurses and how these experiences can and do impact hope. Given that homeless women face many health challenges, it is important that their opinions and perspectives inform the actions of registered nurses and shape healthcare programs.

## **Summary**

In this first chapter, the background of the project, as well as the objectives and the aims of the project, were described. The purpose of the study was explored, researcher assumptions and beliefs were explicated and potential significance of the study was

discussed. There are four subsequent chapters that will provide further detail pertaining to this study.

In the next chapter, I review existing literature regarding homeless women, hope, and the relationships between homelessness and hope. The methodological approach is discussed in chapter three; research findings are presented in chapter four, and discussed in chapter five.

## Chapter 2

In this chapter, I review existing literature that informs current understandings of the strengths and challenges faced by homeless populations. As well, I provide an overview of existing research and knowledge pertaining to the experience of hope and hopelessness. Based on this discussion I identify gaps in existing literature and lay out the foundation upon which my research rests.

### **Women Experiencing Homelessness**

Homelessness is a global issue of pressing concern due to its significant correlation with individual mortality and morbidity (Hwang et al., 2010). Women represent a rapidly growing subpopulation of homeless individuals in North American and internationally (Radher, 2006). Not surprisingly female homelessness looks different than male homelessness (Sikich, 2008). Homeless women are typically younger than their male counterparts and report higher rates of domestic violence and sexual abuse compared to women with housing (Sikich, 2008). There are many ways of being homeless for women; couch-surfing; living in unsafe buildings; living on the street; staying with a violent partner because she can't afford to leave; residing in crowded shelters; or being bound to a dealer or pimp (Scott, 2007). Thus female homelessness is often less visible than male homelessness, despite growing incidences locally and globally.

There are many factors that contribute to female homelessness within Canada; however, it is important to evaluate the socioeconomic and political developments that have contributed to this issue over the last three decades. Prior to 1996, the federal government upheld the Canada Assistance Plan Act, which ensured that all Canadians had

the right to a reasonable standard of living (Scott, 2007). However, in 1996 the federal government revoked this Act and since this change, individuals and families on social assistance are often forced to divert large portions of their monthly income towards rent payments (Scott, 2007). In the following year, the unemployment insurance system was re-titled as Employment Insurance (EI) and with this renaming came increased difficulty for part-time workers, 80% of whom are women, to meet the qualifications for benefits (Scott, 2007). These changes represent a rapid shift in the availability of affordable rental properties and a rapid decrease in the availability of social assistance.

Although there may be many events that push women closer to homelessness, such as experiences of violence, mental health challenges, struggles with addiction, and separation from family, lack of affordable housing and reasonable levels of income keeps them there. A survey of ninety-seven homeless women in Toronto conducted in 2007 supports this statement; a third of respondents became homeless and remained homeless due to an inability to afford rent (Khandor & Mason, 2007). As well, 65% of the respondents remained homeless due to a lack of income or the cost of rent being unaffordable (Khandor & Mason, 2007). Poverty not only creates homelessness but also sustains it. And the burden of living without safe housing comes at a cost.

Morbidity and mortality rates amongst women without housing far exceed rates experienced by women with safe residence. Furthermore, the severity of health challenges that women without housing experience are often high due to the interplay of the following factors: homelessness itself, delayed access to healthcare, extreme poverty, difficulty adhering to prescribed treatments, and impaired cognition (Hwang, 2001). Homeless

women experience medical conditions, such as diabetes, chronic obstructive pulmonary disease, epilepsy, hypertension, human immunodeficiency virus, and hepatitis at an alarming rate (Hwang et al., 2010). Respiratory and skin infections and other acute health challenges are prevalent (Hwang et al., 2010). Homeless women commonly experience foot problems, bed bug bites, seizures, and pneumonia (Khandor & Mason, 2007). Conditions associated with advanced age appear decades earlier than expected in women who are homeless.

Mortality rates amongst homeless women are greatly increased compared to women with housing (Cheung & Hwang, 2004). A recent study that evaluated mortality among residents of hotels, shelters, and rooming houses in Canada provides more insight into mortality rates amongst marginally housed women (Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009). The authors compared mortality rates amongst marginally housed men and women, people living within the poorest income fifth, and people living within the richest income fifth (Hwang et al., 2009). The probability that a 25 year old woman living in hotels, shelters, or rooming houses would survive to the age of 75 was 60% compared with 72% for women in the lowest income fifth (Hwang et al., 2009). The authors highlight the significance of mortality rates amongst homeless women by stating that homeless "women had about the same probability of surviving to age 75 as women in the general population of Canada in 1956 or women in Guatemala in 2006" (Hwang et al., 2009, p. 6).

Alarmingly, preventable diseases and accidents contribute significantly to increased rates of mortality amongst women without housing. Amongst homeless women under the

age of 45 years within Toronto, the most common causes of death have been documented as drug overdose and HIV/AIDS (Cheung & Hwang, 2004). Death caused by smoking related diseases, respiratory diseases, ischemic heart disease, and deaths amenable to medical intervention occur more frequently than within the housed population (Hwang et al., 2009).

Struggles with substance use are common amongst women who are homeless (Hwang et al., 2009; Teruya et al., 2010). A recent study of Canadian women experiencing homelessness found that 82% of the study sample had at least one type of substance use disorder (Torchalla, Strehlau, Li, & Krausz, 2011). Within this study of 196 women more than two thirds met criteria for drug dependence and greater than one third met the criteria for alcohol dependence (Torchalla et al., 2011). These rates are disturbing when compared to women amongst the general Canadian population (Rush et al., 2008).

As well, women experiencing homelessness are known to endure high rates of mental health challenges, trauma, and violence. Common mental health diagnoses include depression, anxiety, and post traumatic stress disorder. In a recent survey of homeless women residing in Toronto more than 55% of the respondents reported having a mental health diagnosis; depression (29%), anxiety (19%) and post-traumatic stress disorder (10%) were most commonly identified by the respondents (Khandor & Mason, 2007). Diagnoses of schizophrenia and bipolar disorder, although not as common, are more prevalent than amongst housed populations (Edens, Mares, & Rosenheck, 2011). Although there is very little data available that documents suicidal ideation and actions amongst

homeless women, depression is a strong predictor of suicide and the most common psychiatric disorder of both men and women attempting suicide (Grewal & Porter, 2007).

Childhood trauma and poor attachment are recognized as antecedents to adult homelessness (Partis, 2003; Teruya et al., 2010)). Ongoing violence is commonplace for women who are homeless; often both streets and shelter are perceived as dangerous. A 2001 study involving homeless women in Toronto documented that 21% of the participants had been sexually assaulted within the previous year and that 40% of participants (male and female) had been physically assaulted (Hwang, 2001).

In a recent study on health care access for homeless persons residing in Toronto, single women reported the highest rate of unmet health care needs within the sample population (Hwang et al., 2010). Access to healthcare has been found to be decreased for homeless women due to transportation and scheduling challenges, decreased priority of health, and stigmatization by health care providers (Gelberg et al., 2004). Common reasons that women have felt discriminated against include their homeless status, engagement in alcohol and drug use or because of their gender or ethnic background (Khandor & Mason, 2007). As well, many women experiencing homelessness do not have a regular source of health care and may be forced to use the emergency department as their usual source of care (Khandor & Mason, 2007). Furthermore, women who are homeless are typically less satisfied with medical care than women with a fixed address (Swanson, Andersen, & Gelberg, 2003).

Homelessness is characterized as “both an acute trauma and a chronic stressor that taxes the physiological and physical resources of those who experience it”

(Partis, 2003, p. 9). Not surprisingly, the challenges associated with lack of a geographic address are not limited to those of physical origins. Homelessness has been associated with challenges securing employment, difficulty maintaining relationships, and increased involvement with the criminal justice system (McGuire & Rosenheck, 2004). Women who are homeless experience daily struggles to meet their basic needs of shelter, food, and clothing. They endure stigmatization, deprivation, repeat loss, and isolation (Martins, 2008). Financial, physical, and emotional insecurity are a constant struggle for women without safe residence.

Women who are homeless experience high rates of physical and mental health challenges, substance use disorders, violence, and isolation (Cheung & Hwang, 2004; Edens et al., 2011; Hwang, 2001; Khandor & Mason, 2007; Radher, 2006). Enduring homelessness has complex implications for a women's sense of safety, self-esteem, and quality of life (Radher, 2006; Teruya et al., 2010). It is important to gain an understanding of hope for this population as it has the potential to mitigate or decrease the effects of these struggles. Hope is intrinsically connected to quality of life, coping, health promotion, and futuristic thinking. Conversely, hopelessness has the potential to add weight to the burden of homelessness and compound the experiences of suffering, isolation, and self neglect.

## **Hope**

Interest in hope as a concept central to human wellbeing has exploded over the last three decades. Hope has been defined by many disciplines and in many differing ways. Nevertheless, it has been suggested that there is a "core meaning of hope that transcends personal and group differences" (Baumann, 2004, p. 343). Regardless of prevailing

definitions, hope is often accepted as fundamentally important to both health and quality of life (Folkman, 2010; Harris & Larsen, 2008). Hope has been understood as motivating, sustaining, pervasive, and necessary to life (Turner, 2005). Consequences of hope include increased energy or life spirit, renewed purpose, self-transcendence, and improved physiological and psychological functioning.

Hope, during difficult life circumstances, assists individuals with coping (Milne et al., 2009; Rustoen et al., 2010). During illness, hope encourages health promoting lifestyles (Harris & Larsen, 2008; Milne et al., 2009) and mediates psychological stress (Rustoen et al., 2010). High hope is thought to decrease depression and increase self esteem (Davidson, Wingate, Rasmussen, & Slish, 2009). Hope enables a sense of freedom and control and a release from the pain and struggle of adjustment to illness induced restrictions (Harris & Larsen, 2008; Kylma, 2005; Rustoen et al., 2010). In this way, hope contributes to an individual's desire to continue living and their pursuit of an enjoyable existence (Kylma, 2005; Milne et al., 2009).

Lack of hope is understood by many to be a deviation from wellness (Klotz, 2010) and is connected to suffering (Kylma, 2005). Hopelessness is associated with engagement in high risk behaviors (Kylma, 2005), social isolation, and increased risk of self harm and suicide (Grewal & Porter, 2007). The belief that one can reach personal goals is intertwined with quality of life; this subjective wellbeing is paramount to life satisfaction and significantly reduces suicidal ideation and action (Bailey et al., 2007).

The philosopher Gabriel Marcel (1962) stated, "hope is for the soul what breathing is for the living organism. Where hope is lacking the soul dries up and withers. It is no

more than a function” (p. 11). Hope is dynamic and fluid (Elliott & Olver, 2009); it is a constant companion throughout life. However, hope is most often palpable during times of life stress and challenges to one’s equilibrium (Elliott & Olver, 2009). Although hope has been understood in many different ways by many different academic traditions, the concept of hope is associated with key characteristics.

Firstly, hope is about possibility (Hammer et al., 2009; Turner, 2005); the possibility that life can occur with the absence of despair, sickness, and current struggles (Harris & Larsen, 2008). In this way, hope can serve to buffer the effects of illness and unhappiness (Elliott & Olver, 2009). Hope also serves to provide multiple routes to a desired goal (Snyder, 2002), thus generating choice.

Secondly, hope is active and involves moving towards short and long term goals (Turner, 2005). Hope is future-oriented and identifies possibilities (Turner, 2005). Engaging in hope allows a person to articulate desires, wants, and needs. Hope is the subjective probability of a good outcome for ourselves or for a significant other (Hammer et al., 2009). In illness, hope’s future possibilities are often conceived of as a cure of disease or illness (Elliott & Olver, 2009; Hammer et al., 2009) or improved quality of life (Hammer et al., 2009; Rustoen, Cooper, & Miaskowki, 2010).

Hope, for all persons regardless of their life circumstances, is critical to goal attainment (Miller, 2007). The possibility and choice implicit to hope serves as a motivating force (Turner, 2005). As options present themselves, an individual or group naturally becomes conscious of the necessary steps for attainment (Cutcliffe, 2009). In this

way, hope can serve as the impetus towards change and can provide sustenance during life (Turner, 2005).

Thirdly, hope entails optimism (Smith, 2007; Turner, 2005) but is distinct from this closely related construct (Bailey, Eng, Frisch, & Snyder, 2007). Hope is not always grounded in intellectual reality; rather, hope reaches out to the yearnings that people hold dearest (Harris & Larsen, 2008). Hope is not always directed at tangible goals but embraces the transcendent (Harris & Larsen, 2008; Marcel, 1962). Transcendent hope involves the belief that the future can be good and full of possibilities. Similarly, optimism involves the belief that a desired goal will be achieved or that everything will work out (Bailey et al., 2007). Although this perspective may be central to the experience of hope, optimism, unlike hope, does not motivate an individual to move towards goals (Bailey et al., 2007)

Fourthly, hope involves human relationships and interconnectedness (Harris & Larsen, 2008; Milne et al., 2009; Nalkur, 2009; Turner, 2005). Regardless of an individual's life circumstances, the concept of interrelatedness presents in many studies exploring hope (Hammer, Mogensen, & Hall, 2008; Hammer et al., 2009; Nalkur, 2009; Turner, 2005). The desire to develop, maintain, and nurture significant relationships is key to the process of hope (Hammer et al., 2008; Hammer et al., 2009; Nalkur, 2009; Turner, 2005).

Interpersonal connections can serve as a source through which hope is derived (Partis, 2003) or as a force that propels hope (Milne et al., 2009). Parse (1999) understood the connection between hope and relationships as "fortifying the persistence of expecting in day-to-day living" (p. 288); relationships can simultaneously give and take hope.

Lastly, hope comes alongside despair and hopelessness (Hammer et al., 2009; Smith, 2007; Vaillot, 1970). Hope has been known as the fight against hopelessness (Hammer et al., 2009). In fact, the experience of hopelessness is often the catalyst for hope (Hammer et al., 2009) and can prompt greater reflection on the meaning and importance of hope (Parse, 1999). Personal loss, life experiences, and crisis have been acknowledged as antecedents of hope. Conversely, hope has been known to shift to hopelessness and despair when an individual can no longer endure their suffering (Harris & Larsen, 2008). Vaillot (1970) summarized the reciprocal relationship of hope and despair when she stated, “there is no hope unless the temptation of despair is possible” (p. 271).

### **Hope and Nursing**

Since the 1970s, nurse researchers have utilized both quantitative and qualitative methods to develop a substantive understanding of hope and its relevance to health and well-being. Hope has been explored within nursing literature amongst a variety of populations, including those experiencing chronic illness, terminally ill individuals, and healthy people (Delmar et al., 2005; Hammer et al., 2009). Despite the diversity of sample populations and the discipline from which research is generated, there is agreement that hope is intrinsically tied to quality of life and health.

Vaillot (1970) was amongst the first nursing scholars to explore the concept of hope and its relationship to nursing. Nursing practice is intimately involved with persons, families and communities that are in the process of change. Whether due to adaptation to illness or upheavals in life circumstances, many of the individuals nurses care for are immersed in the experiences of resisting and rolling with change. Vaillot (1970) defined

hope as an internal process that looks externally to others as a means to an end; the author notes, “to inspire hope would be the nurse’s specific task” (p. 292). Research involving various client populations have documented that nurses are pivotal in increasing hope and decreasing despair. Knowledge, acceptance, competence, and positivity are acknowledged as increasing hope (Herth, 1996; Klotz, 2010). Conversely, nurses who demonstrate judgment and lack of knowledge have been documented to decrease hope (Klotz, 2010).

Vaillot (1970) drew heavily on the thoughts of the philosopher Gabriel Marcel and differentiated hope from similar conditions. Hope is not optimism, nor desire, and it is in direct opposition to hopelessness and despair (Vaillot, 1970). Perhaps most importantly, Vaillot (1970) raised nursing interest in the concept of hope and initiated the profession’s contemplation of the meaning of hope and methods in which to foster hope.

The phenomenon of hope is of increasing concern to nursing and other care providers as it is closely connected with quality of life and health. Given the scale of homelessness amongst women and that registered nurses from a diverse range of contexts will likely provide care for homeless women, it is important that nursing develop a more comprehensive understanding of the needs of this population. This understanding should not only focus on increased knowledge related to commonly experienced physical and psychological health challenges but should also include information pertaining to the meaning and value of hope for women experiencing homelessness.

### **Hope for the Homeless**

A broad understanding of hope raises questions about the experience of hope and hopelessness for women who are homeless. Homeless women tolerate high rates of

physical health challenges, mental health issues, and substance use struggles.

Furthermore, they endure social isolation, fear, vulnerability, poverty, and stigmatization.

Under the weight of these burdens, perceptions and experiences of choice and the ability to successfully meet goals is impacted. Connections with friends and family and understandings of optimism and despair may be influenced by the unending struggle to secure daily needs and manage life challenges. However, very little research has been performed that explores the experience of hope for women who are homeless.

A review of the literature revealed limited research about the meaning of hope as understood by people experiencing homelessness. Nalkur (2009) investigated the differences amongst hope conceptualizations for Tanzanian youth. She found that youth experiencing homelessness or unstable environments avoid hope as a means to prevent failure and instead view success as a result of luck or other external factors (Nalkur, 2009). Hughes et. al (2009) explored the relationships among mental health, hope, and service satisfaction amongst homeless youth and identified that those with low levels of hope are least likely to access services and are least satisfied with health care services. These results have significant implications for health care providers; those experiencing homelessness have a higher prevalence of physical and mental health challenges than the housed population and thus, require access to appropriate and sensitive services.

Cody and Filler (1999) found that the lived experience of hope amongst women residing in a shelter in North Carolina was composed of three concepts; “picturing attainment, persisting amid the arduous, and trusting in potentiality” (p. 221). These core concepts capture envisioning success and happiness, persevering through difficult times,

and believing in tomorrow (Cody & Filler, 1999). Partis' (2003) phenomenological study of hope amongst the homeless, composed of both male and female participants residing in a cold weather shelter, identified similar themes. Expectancy, connectedness, emotionalism, brokenness, and a view from the street were the five key themes attributed to hope (Partis, 2003). The participants in Partis' (2003) study experienced hope through meaningful connections with others and a belief in the future while enduring the challenges of homelessness.

### **Summary**

Due to the diversity of defining features and components of hope, it is presumptuous to believe that an understanding of hope could ever be universal and applicable to the masses. "Hope belongs to the arts as much as it does to the sciences; its meanings range from the ordinary to the transcendent" (Folkman, 2010, p. 907). Hope is known to increase quality of life and promote futuristic thoughts and actions; both of which are in direct opposition to hopelessness and therefore, can decrease self harm and suicide. An understanding of hope for women experiencing homelessness is essential. This understanding could contribute to interventions aimed at decreasing morbidity and mortality rates amongst this population. This research project intends to contribute to knowledge in this area.

### Chapter 3

The purpose of this study is to understand how women who have endured homelessness perceive hope. The goals of my research study are to gain an understanding of the following; (1) how women who are or have recently experienced homelessness understand hope, (2) what supports and prevents hope for them, and (3) what role can or do registered nurses play in limiting or fostering hope for the participants. A constructivist paradigm shaped my choice of method and methodology; central to my research design decision-making was the understanding that reality is subjective, multiple, and constructed (Thorne, 2008).

Within this chapter, I first describe the constructivist paradigm. Then, I discuss interpretive description methodology and describe my methods for recruitment, data collection, and analysis. Finally, I describe the measures taken to enhance the rigor of my findings.

#### **Constructivist Paradigm**

A paradigm is a worldview or set of beliefs that are shared by communities of researchers; paradigms address philosophical questions pertaining to the nature of reality, the relationship between a researcher and the knower, and the means by which a researcher should gather knowledge (Lincoln & Guba, 1985). It is these unique understandings of a paradigm that shape all aspects of decision-making within the research process, particularly those pertaining to methodology and methods.

The constructivist paradigm is one that I found to align with my personal understanding of what constitutes knowledge and how it is created. This paradigm, as

described by Lincoln and Guba (1985), is informed by key philosophical assumptions. So as to highlight and support my research decision-making, I briefly discuss each of these assumptions and how my project is coherent with these principles.

The constructivist paradigm is informed by a relativist ontology in which it is believed that there are multiple realities that are influenced by an individual's social interactions and experiences (Appleton & King, 1997). This ontological positioning informs methodological decision-making; the researcher adopting the constructivist paradigm is not interested in capturing a single understanding of reality but instead, strives to capture the multiple and divergent understandings that present within the data (Appleton & King, 2002). Throughout my research process, I have been mindful of capturing the many distinct understandings of hope and the importance of context in relation to these experiences.

The second assumption that informs the constructivist paradigm is the rejection of causality. Lincoln and Guba (1985) contend that it is impossible to prove cause and effect as there are so many different factors at play that impact a person's understanding of any given subject matter. Furthermore, the constructivist paradigm is underpinned by the belief that seeking generalizations is not meaningful and that the generation of knowledge should account for context and relationships (Lincoln & Guba, 1985). These principles are implicit in qualitative research and this understanding shaped my research question.

Constructivism also endorses a subjectivist epistemology in which the researcher and the participant cocreate knowledge (Lee, 2012). Prior to embarking on my research project I engaged with colleagues and clients about my area of interest so as to narrow my

realm of questioning. And as I began to work with my site of recruitment I dialogued with many staff members so as to gain their support for my project and to elicit criticism and feedback. A subjective epistemological stance informed all of this initial work and directed my subsequent interviewing of participants.

The final assumption that informs the constructivist paradigm is the recognition that values are essential to the creation of knowledge (Lincoln & Guba, 1985). This understanding is evident throughout many different aspects of my research. Initially, I was drawn to my area of interest due to my own values and certainly my methodological and theoretical choices were influenced by these beliefs. While engaged in my research, the values of the recruitment site influenced both my methods of data collection and ethical considerations.

### **Methodology**

As noted above, the purpose of this study was to develop an understanding of hope as described by women experiencing homelessness and to identify barriers and supports, including nursing actions, to the lived experience of hope. Due to my research intention of gaining an understanding of the phenomenon of hope for this population, a qualitative methodology was an appropriate choice. Qualitative methodology is interested in capturing the *meaning* of a particular phenomenon (Hesse-Biber & Leavy, 2006) and is both a “holistic and engaged process” (Hesse-Biber & Leavy, 2006, p. 33). I chose to utilize interpretive description methods for this research project due to the nature of the research questions and the purpose of the research.

Interpretive description developed in the 1990s as a qualitative methodological approach that would generate better understandings of complex phenomena within nursing (Thorne, 2008) and other applied disciplines. Borrowing from aspects of ethnography, phenomenological approaches, and grounded theory, interpretive description developed as a distinct qualitative methodology in response to the perceived need for the development of nursing knowledge that is applicable to practice (Thorne, 2008). As described by Thorne, Reimer Kirkham, and O'Flynn-Magee (2004), interpretive description "assumes nurse investigators are rarely satisfied with description alone and are always exploring meanings and explanations that may yield application implications" (p. 6).

Interpretive description is philosophically aligned with interpretive naturalistic orientations and as such includes the following philosophical underpinnings (Thorne et al., 2004). Firstly, theory must be grounded in or emerge from the existing knowledge (Thorne, Reimer Kirkham, & MacDonald-Emes, 1997; Thorne et al. 2004). Secondly, reality is contextual, complex and subjective (Thorne et al., 2004). Lastly, the researcher and the research participant interact to influence each other (Thorne et al., 2004). These underpinnings are congruent with those of the constructivist paradigm.

Interpretive description involves two distinct but interwoven objectives. Firstly, this design allows for the generation of a systemic analysis of a phenomena by answering questions related to the *what* of events (Sandelowski, 2000) and secondly, interpretive description encourages the placing of this analysis back in the clinical setting (Thorne, 2008). Generation of data related to a particular phenomenon of interest may be collected

through a variety of means; however, questioning should always be informed by existing knowledge (Thorne, 2008). In this way, the researcher approaches the process of data generation with a comprehensive understanding of the area of research but generates new knowledge through critical analysis of interview data (Thorne et al., 2004). During the process of analysis, the researcher attends to the multiple tasks of coding, understanding, synthesizing, and recontextualizing data into findings (Thorne et al., 2004).

### **Limitations of Approach**

Methodological approaches come with inherent limitations that must be addressed by the researcher. Within my study, the limitations of both constructivism and interpretive description must be acknowledged and addressed. As previously stated, constructivism is informed by the ontological perspective that there are multiple realities (Lincoln & Guba, 1985; Lee, 2012). This perspective could be viewed as contrary to my research purpose of developing a single understanding of how multiple women who have experienced homelessness perceive hope. Throughout my research process I was mindful of this tension and attempted to generate data that reflected both the similarities and differences amongst the participant's experiences of hope.

The epistemological positioning of constructivism can also be viewed as a limitation given the population engaged in my research. Cocreation of knowledge does not occur without individuals, both the researcher and participant bringing their own values, historical experiences, and beliefs to the interaction. As a woman with housing, loving relationships with family, and financial security I may have been viewed by the participants as someone in a position of power or privilege. How could this or any alternate

understandings shape the narratives that were shared with me? And how could this shape my subsequent analysis of data? Ultimately, the research findings are my analysis of what I was told by the participants that developed through an interpretive process. Consistent with the assumptions that inform interpretive description methodology, my professional experience working with women experiencing homelessness and my personal situatedness shaped both the narratives that were shared with me and my subsequent interpretations.

The use of an interpretive description methodology also posed challenges. Interpretive description is a relatively new methodology and I had limited texts and resources to rely on when I was uncertain about design decisions. As well, tension exists between the goals of interpretive description; the researcher aims to create a qualitative description that is both descriptive and interpretive but not theory or absolute truth (Thorne, 2008). This creates the potential risk that interpretations may be insufficient or that findings may be limited in their usefulness. Both of these areas of concern were addressed through dialogues with my supervisor, committee member, and colleagues so as to ensure that my interpretations were adequately developed and that my findings were applicable to clinical practice.

## **Methods**

### **Sampling.**

For my study, a purposive sampling strategy was utilized. This was an appropriate choice as I hoped to capture an in-depth understanding of hope for women experiencing homelessness and avoid generalizations of these lived experiences. As well, purposive sampling allowed me to engage with women who had knowledge and experience specific to

my research objectives (Haber & Mingh, 2009). I relied on participants to refer future participants. Snowball sampling was a fitting additional sampling strategy as it “takes advantage of social networks and the tendency of friends to share characteristics” (Haber & Mingh, 2009, p. 266). I did not recruit for variety in age, ethnic background, or other demographic criteria.

**Criteria for inclusion.**

Inclusion criteria for this study is as follows:

- a) self identifies as female
- b) nineteen years of age or older
- c) ability to communicate in English, willingness to be interviewed, and ability to consent
- d) currently homeless. Homelessness was defined according to the definition proposed by the European Federation of National Organizations working with the Homeless (2011). Homeless people are classified according to their living situation:
  - *rooflessness* (without a shelter of any kind, sleeping rough)
  - *houselessness* (with a place to sleep but temporary in institutions or shelter)
  - living in *insecure housing* (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
  - living in *inadequate housing* (in caravans on illegal campsites, in unfit housing, in extreme overcrowding)

**Recruitment.**

Recruitment involved postering at a shelter located within the Downtown Eastside of Vancouver (Appendix A: Recruitment Poster). This site of recruitment is run by a non-profit organization that provides services to both men and women who are homeless or marginally housed. The shelter provides private female beds to women who are homeless and offers a range of services that include meal programs, assistance with securing permanent housing, on-site access to nursing support, and a medication administration program.

Written posters included inclusion criteria, contact information for the researcher, details about the research study, and information related to research honorarium. Prior to recruitment, I met with the site program manager to dialogue about the purpose of my research, methods of data collection, and staff role. I also provided a written invitation to participate to the site program manager and staff for review and to document signed permission of site access (Appendix B: Information Letter for Triage Shelter). Following this initial meeting I set up two informal sessions in which I met with staff to engage with them around my research project and address any questions or concerns they may have.

I established routine times in which I was present within the shelter. My presence on site, for approximately two–four hours/week, ensured that I was available to screen (Appendix C: In Person Recruitment Script) and interview interested participants in their moment of interest and availability. As well, I connected with staff during this time to inquire if they had any individuals that they would recommend for study participation (Appendix D: Recruitment Script for Agency Staff). Although I did recruit a few women

simply via postering, the majority of the study participants were interviewed due to staff recommendation, routine hours, and recommendation by other participants.

### **Description of participants.**

I interviewed a total of nine participants who self-identified as female. Their age ranged between twenty-eight and seventy-one years. Although not all of the women were staying at the site of recruitment, all of the participants were accessing the shelter for a multitude of support services. All of the participants had been without housing for greater than seven days within the last year, seven of the participants had spent at least one night on the street within the last year and three of the women had slept in an abandoned car or building within the preceding year. Two of the participants had been in legal custody and hospital overnight within the last year; an additional participant had been in either custody or hospital. A further two participants had resided in a recovery setting within the preceding year.

Eight of the participants were on some form of provincial or federal funding system; the remaining participant derived her sole form of income from sex trade work. Two further participants were engaged in sex trade to generate income; one woman identified “borrowing” as a means of revenue generation and another participant “hustled”. All of the participants were born in Canada, only four of the women were born outside of British Columbia. The participants identified as either Métis (1), First Nations (4), or Caucasian (4). Level of education achieved was broad, ranging from grade six to university level courses. All of the participants identified as single; seven of the women had children,

between two and five, although none of the participants currently had custody of their children.

### **Data collection.**

The data was collected in personal interviews with each participant that occurred within the site of recruitment. Location of interview was codetermined by myself and the participant and included shelter rooms, the shelter's dining room, and available office spaces. All interviews began with the collection of demographic information (Appendix E: Demographic Information Questionnaire) and then transitioned to semi-structured interviews (Appendix F: Interview Questions).

Interviews ranged in duration, one interview was just under ten minutes and all other eight interviews ranged from thirty minutes to fifty-three minutes. Although all of the participants were open to discussing their experiences, for some of the women it was challenging for them to provide detailed information pertaining to hope. Dianne spoke with me for less than ten minutes during her interview, eyes downcast, her responses to my questions lacked spontaneity and were very brief. Despite the brevity of her interview she shared her unique understanding of hope but was unwilling to engage at length.

Initially, I began the interviews with an open ended question pertaining to the participant's understanding of hope, such as 'How would you define hope?' However, following the first two interviews I realized that this was a challenging question for the women I met with and subsequently began interviews by asking the participant to share an experience in which they had experienced hope or hopefulness. Open-ended questions

were used throughout the interviews to ensure the discussion of specific topics and to promote story telling from the participant's perspective.

The interview questions were initially reviewed with my supervisor prior to entering the field and revised based on her feedback and suggestions. Further revisions to the interview questions occurred as my supervisor reviewed recorded interviews and based on her recommendations to enhance the quality of interviews. As the interviews ensued, I adapted my questions slightly so as to address the similarities and differences that were unfolding within the data. For example, the relationship between hope and substance use presented very early on in my interviews. In subsequent interviews, I specifically asked participants to share their thoughts about the relationship between hope and the use of substances so as to further develop this potential theme. A further example was the understanding that maintaining or achieving hope involved balance; this sentiment was also discussed early in my interviews and was explicitly explored throughout further dialogues with participants.

Each interview was audio-recorded and transcribed verbatim. Following each interview, I documented my initial impressions so as to capture my emotional responses to the information shared. As well, these notes captured developing themes and methodological questions. These personal reflections were captured in three documents and organized into analytic, methodological and reflexive reflections.

### **Data analysis.**

Data collection and analysis occurred simultaneously. This was central to my study design; I was starting with the assumption that hope for women experiencing

homelessness has a multitude of meanings and understandings and to uncover this knowledge I must compare and contrast the various manifestations of the phenomena (Thorne, 2008). Simultaneous collection and analysis of data ensures that “researchers continuously modify their treatment of data to accommodate new data and new insights about those data” (Sandelowski, 2000, p. 338).

As mentioned previously, I documented my initial impressions following the completion of each interview. Thorne (2008) describes this initial phase of analysis as a time in which a researcher allows her or himself to react to the data and document responses. Following this initial documentation I transcribed each interview verbatim, typically within three – five days following each respective meeting. The process of transcribing each interview allowed me to reflect on my responses to the data and pay attention to the nuances of the words and phrases each participant used.

Thorne et al. (2004) recommends that a researcher strategically immerse oneself in the data interspersed with periods of immersion in the field. This promotes refinement of the research question and testing of the developing conceptualizations (Thorne, 2008; Thorne et al., 1997; Thorne et. al., 2000). With this recommendation in mind, I tended to avoid conducting an interview prior to the completion of transcribing the previous one. In this way, I was able to reflect on the accumulating data and themes and make shifts to my interview questions so as to capture developing themes in upcoming interviews.

Each interview was read an average of three to five times and coding moved from broad based coding to more refined analysis in which I developed thematic images. Broad based coding was used initially to capture possible themes and involved placing marginal

memos on my transcripts that flagged certain data elements that may possibly be meaningful. These various groupings were collected in a word document and organized under which research question each data unit addressed. As well, I summarized what I thought was being said in each of these data sets, rather than coding data line by line.

Initially, my analysis involved organizing the data bits into various groupings. This organization occurred individually with each interview as well as across all interviews. Upon completion of all of the participant interviews, I read and reread the transcripts and researcher memos to obtain an overall sense of the data. I then summarized the data into interpretations and identified emerging themes (Wojnar & Swanson, 2007).

I next analyzed paradigmatic transcripts as a group to identify themes while constantly returning to the data to clarify my thematic development (Wojnar & Swanson, 2007). Paradigmatic transcripts were those that stood out as having detailed descriptions of the areas being researched. These transcripts were reviewed so as to draw my attention to various aspects of the participant's experience and to assist with further refinement of emerging themes.

Contrasting and comparing participants' narratives assisted me in identifying common meanings and recognizing patterns that link themes. These developing themes and patterns were documented in my analytical notes and displayed visually in numerous mind maps. During this phase of analysis, my understanding of the data was constantly being assessed and the relationship between different data elements were tested across interviews. A key component of data analysis and the testing of emerging themes involved

ongoing dialogue with my supervisor; following the generation of my initial themes and then with subsequent revisions we discussed the findings and revised appropriately.

### **Evaluation of Interpretive Description Research**

Thorne (2008) contends that “research within the health sciences properly extends beyond mere consideration of adherence to the methodological rules” (p. 223) and moves toward evaluation of what meaning can be attributed to the research findings. Interpretive authority, analytic logic, representative credibility, and epistemological integrity are key to the credibility of an interpretive description project (Thorne, 2008). Therefore, these four categories of evaluative criteria, which collectively contribute to rigor of an interpretive description research study, were attended to within my research.

Interpretive authority refers to assurances that a researcher’s interpretations are “trustworthy, that they fairly illustrate or reveal some truth external to his or her own bias or experience” (Thorne, 2008, p. 225). Within my research project, interpretive authority was demonstrated through journaling. My reflective journal documented my personal biases and assumptions and demonstrated that I consistently returned to the data for illumination of truths. As well, I confirmed my initial impressions and understandings of the experiences of the participants by summarizing their knowledge within interviews and by integrating these developing ideas into subsequent interviews.

Meeting the criteria of analytic logic requires that the researcher explicate their reasoning (Thorne, 2008; Thorne et al., 1997). This was demonstrated through the explicit documentation of all steps of the research process, including data analysis. Representative

credibility requires that claims made throughout the research process are consistent with the manner in which the study is conducted (Thorne, 2008). True to the intentions of interpretive description, the findings that developed from my research not only capture the experiences of the participants but also provide clinical direction for nursing.

Epistemological integrity was demonstrated through the consistency with which my research process and question aligned with the philosophical assumptions of my stated methodology and methods.

### **Rigor.**

Lincoln and Guba (1985) propose similar criteria for rigor in qualitative research and although dated these criteria still persist as acceptable conditions for evaluation. Credibility, transferability, dependability, and confirmability are recommended as the four categories of evaluation (Lincoln & Guba, 1985). Credibility and confirmability have been addressed in the previous review of Thorne's (2008) recommended evaluative criteria. However, the criteria of transferability and dependability warrant further consideration.

Transferability refers to the ability of research findings to be applied to different but similar contexts and requires that the researcher provide context rich descriptions of data (Lincoln & Guba, 1985). I addressed the criteria of transferability through presentation of thick descriptions of the experience of hope, composed of direct quotes and summarized narratives. As well, specific details pertaining to the context of the participants were described in the section entitled "description of participants". This is congruent with the constructivist paradigm as it assumes that context is integral to experience.

Dependability responds to the query of whether or not research findings could be reproduced if a researcher were to engage with more participants in similar circumstances (Lincoln & Guba, 1985). Dependability was achieved throughout my research process through the documentation of an audit trail, which is available for review by interested investigators and peer reviewers. However, it is important to understand the research findings within the context in which the data was generated. The findings are not intended to represent the collective experiences, values, and meanings of women whom are homeless but instead are representative of my interpretation of the perspectives of the nine homeless women who participated in study interviews.

### **Ethical Considerations**

Ethical approval was obtained through the Human Research Ethics Board (HREB) at the University of Victoria prior to the initiation of my study. As well, I met with the Program Manager at the site of recruitment and the team prior to initiation of my research. Team members raised concerns about possible psychological and/or emotional harm to potential participants and we collaborated on means by which to mitigate this risk. Collectively, we developed a plan so that at the completion of each interview I informed each participant which staff members would be available if they should need support.

Each participant was provided an informed consent prior to her interview (Appendix G: Informed Consent). The informed consent form was read out loud to participants while they followed along. I prompted each individual to ask any questions prior to and during their interviews. As well each participant was made aware that their participation in my research project was entirely voluntary and their decision to

participate or not participate would in no way impact the provision of services from the recruitment site. All participants were offered a twenty-dollar honorarium for participation in the study.

**Potential for harm and benefit.**

Although the time required to participate in the study was typically less than one hour, this commitment may have presented an inconvenience for study participants. As many of the women in the study were preoccupied with struggles to secure their daily needs, including acquiring illicit substances, the time commitment of the interview was significant. All participants were provided with a beverage and a snack during the interview and offered access to shelter staff upon completion so as to address any housing needs.

Of utmost concern, was the potential for psychological or emotional harm due to the personal nature of the questions. Many of the women shared stories of isolation, loneliness, and separation. Furthermore, many of the participants reflected on and shared traumatic events from the past. This challenge was addressed in numerous ways.

Firstly, consent was an ongoing process within the interview. Women were encouraged to ask for breaks or to discontinue the interview as needed and if I observed signs of distress these options were offered. Secondly, women were encouraged to decline to answer questions that were too challenging for them. And thirdly, all participants were apprised of which staff were working following the completion of their interviews and directed to approach them immediately if they required any support or assistance. Although none of the participants discontinued the interview, two of the women I spoke

with asked for a break during our dialogues. Many of the participants requested that we skip questions or return to a particular area that was being explored later in the interview.

Benefits to the participants included the opportunity to share their lived experiences with others and to speak to how health care interactions can impact their well-being. Benefit to state of knowledge includes a more substantive understanding of the meaning of hope for women who are experiencing homelessness. By sharing their stories, the participants in this study have contributed to recommendations for change in practices and health care programs.

### **Confidentiality.**

Confidentiality was assured through a variety of mechanisms. Numerical identifiers were assigned to each recorded interview and individual participants were subsequently identified by pseudonyms. All personal information, such as specific locations, and names of family and friends were removed from transcriptions. A cross-reference list was stored as a password protected computer file on my computer. Contact information provided to clients who were interested in participating in the study including a password protected cell phone number and email.

Within the study's informed consent, I outlined situations in which confidentiality would be breached and this was reviewed with each participant. Significant risk of harm to self and others, as articulated by the participant during the research interview, would necessitate intervention and thus, would require a breach of confidentiality. This context, however, did not occur during my research process.

Participants were often identified due to engagement with persons outside of the research team and all were interviewed at the recruitment site. Although staff at the engagement site or referring participants may have been aware of an individual's participation in the study, no information gathered during data collection and analysis was shared in any manner that may breach the confidentiality of an individual. As I did not have a professional nursing relationship with the participants, I was not in a conflict of interest or significant imbalance of power.

### **Limitations**

Many of the limitations of this study are implicit aspects of qualitative research. The limitations that may prevent the study results from being applicable to other similar populations include sample size, recruitment process, and sample characteristics.

#### **Sample size.**

Initially I had proposed to recruit between ten and fifteen study participants. However, due to the richness of the data I completed participant recruitment following my ninth interview. My study's sample size could be viewed as a limitation; however, this perception is misguided and not aligned with the philosophical understandings of qualitative research. In fact, Munhall (2012) points out that merely by indicating that sample size may be a possible limitation of a qualitative study perpetuates the impression that qualitative methodologies are best served by a large sample size. Thorne (2008) argues that interpretive description studies can be conducted on samples of almost any size. Time and resources certainly played a role in my decision to cease recruitment but ultimately, my decision to conclude interviewing after nine participants was due to the

belief that I had collected enough data so as to generate a meaningful description of the phenomenon of interest.

### **Recruitment process.**

A further potential limitation of my study relates to the recruitment process that I utilized. Firstly, I chose to recruit from one location rather than a variety of locations offering resources to women struggling with homelessness. Secondly, my recruitment site was rich in resources. Therefore, the vast majority of the women who participated in my study were engaged in the process of seeking out shelter, nutritional resources, and advocacy supports. It is difficult to state whether this impacted these individual's experiences of hope and hopefulness; however, I did not interview any women who were currently sleeping on the street and isolated from resources.

Recruitment site staff referred many of the women who participated in my study and this may have posed a limitation. Although I met with staff frequently to review my recruitment criteria, staff may have been motivated to refer particular women. Possible motivators could include staff perception of worthiness of honorarium, ability to speak to the research area, or positive regard. Dependence on staff referrals for study recruitment may have been reduced if I was able to increase my onsite availability.

### **Sample characteristics.**

As mentioned during the discussion of limitations related to the study recruitment process, all of the study participants were currently accessing supports from the recruitment site. Presumably, this demonstrates individual capacities to seek out assistance related to securing shelter, nutritional resources, and advocacy supports. This

may create homogeneity within the study sample and limit the transferability of study findings to women who are street homeless or more significantly isolated. However, with interpretive description methodology, study results are always connected to the time and situation in which they are generated (Thorne, 2008) and cannot be viewed outside of contextual experiences. Therefore, the findings of my research are only truly representative of my interpretation of the experiences and stories of the study participants.

## Chapter 4

Chapter Four provides a presentation of the research findings. The purpose of this research study is to gain insight into the experience of hope as understood by women who had past or present experience with homelessness. My goal is to provide insight into what facilitates or acts as a barrier to hope and how registered nurses contribute to building hope and can avoid actions that foster hopelessness. Each woman interviewed for this study shared her individual experiences of hope during a one-on-one interview. There were both similarities and differences in how the women in this study understood hope, as demonstrated by the findings presented in this chapter. Four main themes arose from the analysis: balancing on the edge, pushed to the edge, pulled from the edge, and nursing on the edge. Each of these themes and associated subthemes will be presented.

### **Balancing on the Edge**

One of my research objectives is to develop an understanding of the meaning of hope for women who are or have recently experienced homelessness. When asked about hope, all of the women that I spoke with shared personal narratives replete with hopelessness and struggled to articulate their understandings of hope. The theme of 'balancing on the edge' emerged throughout my dialogue with the participants. As I immersed myself in these women's stories, I started to visualize their experiences of hope as though they were standing on a steep cliff face, overlooking crashing ocean waves. This image continued to rise to the surface of my thinking throughout my interviews and during data analysis. I came to envision each of the participants teetering on the cliff's edge, acutely aware of the jagged rocks hidden beneath the waves and struggling to ensure that

they did not fall to the rocky floor below. Many of them spoke to the delicate “*balance*” that is required to maintain hope while enduring the isolation and deprivation of homelessness. The notion of hope as a balancing act as understood by the participants is explored within the following subthemes that arose. These subthemes include: something to hold onto, get everything back and, drugs: a double-edged sword.

### **Something to hold onto.**

All of the women who participated in my study spoke eloquently about their unique understanding and importance of hope in their life and lives of others. When asked about hope, many of the women stumbled to find the words to explain their understanding of hope and often grounded their stories of hope within the context of enduring hopelessness. As Sally struggled to find the words that expressed her experience of hope she laughed and shared:

*It's a huge question!*

Conversely, when asked about hopelessness, the participants were quick to share daily experiences that exemplified this phenomenon in their lives.

While enduring hopelessness, hope was vastly important for many of the women I spoke with. For some of the women, hope served to support their resiliency and capacity to endure. For others, hope preserved their will to carry on with life and reduced their engagement in high-risk behaviors. Given that many of the women I interviewed had limited experiences with fulfillment of their hopes, it was often viewed cautiously and some of the women treated hope with caution so as to protect themselves from disappointment. Despite the differences in understandings of hope, it played an essential role in each

participant's capacity to survive the challenges of homelessness and to hold hopelessness at bay. Thus, each individual that I spoke with was able to maintain her balance while perched on the cliff's edge and able to sustain hope, no matter how tentative, within her life.

Lucy shared her belief that hope is similar to dreams and that these are essential to quality of life. Her hopes sustained her through struggles with obtaining housing, substance use issues, and health care challenges. They strengthened her resolve to carry on despite adversity and propelled her towards making change in her life. She shared that:

*Having hope is very, very...it's very big for me because without hope you have nothing. You know, it's like a dream. We gotta have our dreams.*

Michelle's interview was awash with stories of loss and hopelessness. When asked about the role of hope in her life she succinctly stated:

*Hope is all I have is what I say.*

As with Lucy, Michelle's tight grasp on hope helped preserve her will to live and stood in stark contrast to her current experience of hopelessness.

Dianne echoed this sentiment when she declared:

*It's really important to have hope in your life, like to have hope for the future.*

Many of the participants shared how hope encouraged them to carry on despite struggling to escape homelessness and its associated challenges. When asked about the importance of hope, Adella shared her experience of holding on to hope throughout her life.

*Once you lose that you've lost it and it's just like, like...To me, once I lose my hope it's...I don't know where I'm gonna end up. I could end up just about anywhere and it's really*

*rough. It's not a good way; it's not living anyway. So I always have it no matter how bad I get.*

Hope served as a protective factor for many of the women I interviewed; hope supported perseverance and kept hopelessness at bay. For Sally, hope provided a reason to get up every morning and to pursue her aspirations and dreams. Sally shared that:

*...without hope I don't have um, any reason to get out of bed, basically. It means um, the difference between totally giving up and not caring about anything at all. Um, hope and faith for me are...I wouldn't be alive if I didn't have them basically.*

Hope was almost universally acknowledged as significant in the lives of the women that I interviewed. Dreams, goals, and faith were adverbs most often used by the participants when discussing their understanding of hope. For many of the women I spoke with, hope was something to hold onto so as to maintain equilibrium in their lives.

Despite the apparent importance of hope for many of the women whom I spoke with, several of the participants expressed caution when speaking about hope. Rather than clearly deny the value of hope in their lives, they spoke of how hope can promote vulnerability in their lives. Michelle talked extensively about her “frustrations” related to being homeless and was quick to deny the importance of hope in her life:

*Yeah, like it can blow up in your face at any time. Like, you have too much hope for something to come and it doesn't then you're just letting yourself down.*

Marnie echoed lack of trust in hope when she stated:

*Hope...well, you know, what do they say about hope. It springs eternal. Um, but I think you know there is...there is a time when you lose hope in hope. And you think oh well, you know, hoping is not getting me anywhere...*

She carried on later in the interview to state:

*I don't know. I've hit the wall or I've realized before today uh, that I have something I think, like my going around and filling out applications has gotten me very little...Uh so, I think, you know, there's something in me that has kind of run out. I don't know if it's energy or hope, you know.*

Both Marnie and Michelle's statements appear to be a reflection of their inability to achieve their hopes within the context of homelessness. The abandonment of hope following the perceived inability to change one's life circumstances was a common thread throughout many of these women's stories.

Homelessness is an exhausting experience that taxes the emotional, psychological, and physical well-being of individuals and communities. The women who participated in my study had endured various degrees of homelessness for a multitude of years and their eventual loss of shelter was often the end point of a long journey. Within the context of these struggles, hope was essential to their individual capacity to persevere and carry on. However, hope could be risky and exposed each person to disappointment and hurt. Therefore, it was important for each woman to create a balance between hope and no hope.

### **Get everything back.**

When asked to speak of their understandings of hope, many of the women spoke of their desire to regain what had been lost. The subtheme of 'get everything back' captures the wide range of tangible and intangible items and achievements that the participants aspired for. All of these aspirations and dreams were rooted in historical experiences in which they were happier and more fulfilled.

When asked about the meaning of hope, the participants talked about their individual journeys and the accumulation of loss and grief. These losses were bigger than,

but intimately connected, with their eventual loss of housing. Separation from loved ones, loss of employment, struggles with addictions, marginalization, and neglect were mentioned by each of the participants that I interviewed. And when asked to speak of their understanding of hope, many of the women shared times in their lives in which these losses and injuries were not present. For the women in my study, the balance of hope and hopelessness was sustained while holding onto dreams of regaining what had been taken away.

Many of the women I spoke with shared their longing to abandon the labels and judgments that they understood to be interconnected with their experiences of homelessness. These labels represented not only how the women came to view themselves but more importantly, are reflective of how they know themselves to be viewed by others. Perhaps these labels are reflective of how they previously viewed others when they were free from their current challenges of poverty, substance use, and homelessness.

A variety of phrases were used by the participants to capture the breadth of their hopes to move away from their current understanding of themselves. Lucy shared her desire to no longer be a *"liability"* and to become a *"productive member of society"*. She shared this while talking about her aspirations to gain paid employment and spoke to the shame that she felt for being on social assistance. Furthermore, her hope of being a *"productive member of society"* speaks to the societal value placed on individuals who are gainfully employed and conversely, intimates the disdain and disregard afforded to those on social assistance.

Further terminology used to encapsulate these women's hopes included "*stability*", "*something better*", and to get "*balance again*". This languaging was always used in reference to the past by the participants and referred to a time in which they would have defined or described themselves using these words. Thus, the women wanted to regain these identities.

The desire to return to a previous time in life was strongly reflected in Michelle's voiced hopes. She stated:

*Um, I'm hoping to uh, I'm hoping to get everything back that I lost. Everything, everything and more.*

She went on to share that:

*...I have a lot of regret that I lost everything that I worked hard for.*

These losses included "*stability*", a "*home*", a "*business*", and freedom from "*addictions issues*".

For those women who previously had custody of their children, reestablishing custodial relationships was central to their hopes of regaining what had been lost. Michelle spoke of this desire when she shared:

*Um, well yes I have, I hope that us, that I'll regain everything, especially my children. I have hope that we'll be together again.*

Regaining custody of her children not only represented reclaiming her losses but also exemplified her desire to have a second chance at her previous or more preferable life.

Dianne spoke to her understanding of new beginnings and hope when attempting to describe this phenomenon. She shared that her young daughter was representative of hope to her. When asked to elaborate on this she shared:

*She's young, fresh. She has...I don't know, she has her own beginning.*

Although Dianne described her relationship with her daughter as “not very close” she held onto the three years in which she had custody. Her daughter represented opportunity and purity; a life yet untarnished from the grief and sadness that Diane knew. In many ways, Dianne’s daughter represented her personal hopes of returning to a place full of hope and devoid of life’s losses.

Marnie’s experience of hope involved becoming the person she used to be.

*And I hope that I can get back to my nice phlegmatic sort of, I mean, I use to, I mean I use to take a lot, a lot of things to disturb me.*

After experiencing two physical assaults from strangers, living over two years in the shelter system, and losing connections with loved ones, Marnie struggled to recognize herself. The person she remembered was outgoing and social, passionate about academic studies and volunteering. However, after years of balancing on the edge between hope and hopelessness Marnie came to see herself as increasingly “paranoid” and frightened. And ultimately, unable to visualize a path back to the self she hoped to be.

As well, both Marnie and Allison talked about their experiences of watching others striving to regain what they had lost and how this related to hopelessness and hope. Marnie questioned the difference between foolishness and “extreme” hope while watching one of her friends spend all of her time preparing for a legal hearing. Marnie believed that

her friend was pursuing an “*unrealistic hope*” while seeking justice for the loss of herself and loss of control following a lengthy psychiatric hospitalization. In her own struggles to maintain hope, Marnie understood that “*sometimes...you have to give up certain things*” and could not comprehend her friend’s desperate pursuit to regain her losses.

Similarly, Allison reflected on residing in the shelter system with a “*grumpy old fellow*” who had lost hope. She stated:

*...it's just a given that he knows that he'll be on the street for the rest of his life. It's, it's pretty sad but it's a given, you know. Like when you grow accustomed to something for such a long time it becomes such a pattern in your life that you, you succumb to it...*

This person that Allison was speaking of was no longer chasing after what he had lost, nor was he pursuing other hopes and dreams. Allison understood this man to have grown “*accustomed*” to homelessness and substance use struggles and to have become “*numb*” to the inequity of his situation. According to Allison’s understanding, he had succumbed to hopelessness and his grumpiness represented both loss of self and loss of hope.

Women who experience homelessness are forced to cope with a multitude of losses, not least of which are the loss of identity and relationships. The yearning to “*get everything back*” was central to the participants’ experience of hope and was understood in a variety of ways. Regardless of the specific presentation, the longing to regain and overcome losses was identified by many of the participants as a key component of the meaning and experience of hope. Not only did the losses that these individuals experience compound to represent hopelessness, but the pursuit of these losses was key to the experience of hope. Many of the women I spoke with held onto memories of better times in their lives; times in which they were connected with their children, employed, housed, and stable were held

onto fiercely. Moving towards the recapturing of that which has been taken away or stripped from them helped each of the women I interviewed to maintain hope in their lives. As Alison reflected, when a person succumbs or ceases to fight against their losses s/he loses hope.

**Drugs: a double-edged sword.**

For the women in this study, the relationship between substance use, hope, and hopelessness was extremely complex and played a pivotal role in maintaining balance. The experience of hope reduced the urge to engage in substance use and similarly, decreased use of illicit drugs fostered hope for many of the women I spoke with. As well, drug use was clearly identified by many of the participants as a way in which they could push away their feelings of hopelessness and despair. But the use of substances also contributed to hopelessness. Thus, engagement in drug use was like swinging a double-edged sword; the sword was heavy to wield, both sides of the blade were sharp, and each reprieve from hopelessness achieved through using drugs came with a hidden cost.

The lived and active experience of hope reduced engagement in high-risk behaviors for several of the participants in this study. Lucy discussed the relationship between drug use and hope as experienced in her life.

*Yes, well, when you are feeling a little more hopeful than it's like, for me anyways, when you're feeling like really hopeful the drugs are not so, not as important, they don't have such an impact on me. 'Cause you're not feeling hopeless.*

When filled with hope for her future, Lucy was able to reduce her use of substances. Initially, this reduction involved a decrease in the daily amount she injected intravenously

and just prior to her participation in this study she had abstained from substance use for nine months.

Similarly, abstaining from substances was identified as hope inspiring by Michelle:

*Um, uh, well, I experienced hope when, when I, when I got off addictions issues that I had.*

Understanding the relationship between hope and substance use is important as illicit substance use carries unique risks that include mortality by overdose and contraction of infectious diseases such as hepatitis C or HIV. Furthermore, over half of the women that I interviewed had recently engaged in income generating activities such as sex trade as a means to increase their disposable income. If hope has the capacity to impact substance use habits, then hope may also have the capacity to reduce engagement in other high risk behaviors associated with illicit drug use.

Sally spoke to the connection between substances and keeping hopelessness at bay very early in our interview. In her life, substances were medicine that could be used to soothe the pain of hopelessness and despair. She stated:

*...if I hadn't had drugs I probably would have committed suicide [Laughing]. I mean that's that reality of it. I use drugs so that I don't hurt, right?*

She experienced relief from her hopelessness following the death of her partner, struggles with poverty, and extreme feelings of loneliness through the use of intravenous heroin. Despite the temporary reprieve from hopelessness that substances offered, ultimately struggles with substance use pushed Sally away from hope. She shared her dreams of managing her addiction issues and how this could impact her well-being.

*A friend of mine for a week gave me my dose three times a day regularly, um, and I didn't have to you know, freak out about how I was going to get my next fix, you know what I mean? I was functioning. I was...I would have been able to hold down a job, you know? Um, that's what I hope for.*

Adella shared that substances managed to “slow [it] down” her hopelessness. Allison understood the relationship between drugs and hopelessness in a similar way. As she moved away from her “addiction” to heroin and cocaine she gained insight into the reasoning behind her years of substance use.

*The thing is with drugs all it does is it makes you feel numb and you don't wanna let your feelings out. You know, certain things that you would normally feel as normal human being that doesn't use drugs.*

For several of the women I spoke with, a sense of hopelessness increased risk behaviors associated with substance use. Lucy shared that:

*When you are feeling hopeless than it's like, for me anyways, like I say, you don't care. You don't care anymore, so like fuck who cares. You do a lot more.*

As well, engagement in substance use seemed to cause some of the participants to berate themselves and thus, prevent hope. When asked what contributes to the experience of hopelessness, Michelle immediately mentioned addictions. She elaborated and spoke both of the hope she felt when free from her addictions and the hopelessness she was currently experiencing while using substances.

*Well, my ad- addictions has a whole lot to do with the barriers that I um, going through to get you know...But then again you know that's just, that's just me. I know, I know I can do better. I just have to apply myself and focus. Right now I'm not doing that.*

The subtheme ‘drugs: a double-edged sword’ highlights the difficult balancing act that the study participants were engaged in. Substances were often used as a tool to push

hopelessness away; however, if only slightly off balance the participants could easily and quickly fall off the edge of the cliff. Addiction issues were almost uniformly identified as a barrier to hope and a contributing factor to hopelessness. Many of the women in the study were attempting to renegotiate their relationship with substances as they began to realize how drug use impacted their experiences of hope.

However, the double-edged nature of substance use created many challenges to moving away from drug use. Without substances, what tools would these women have to push away their daily experiences of hopelessness? Despite the fact that the use of drugs provided only temporary relief from their sadness and despair, *“getting high”* afforded the participants a break from hopelessness. Unfortunately, this temporary break came at a cost and the price was the loss of equilibrium, looming hopelessness, and shame.

### **Pushed to the Edge**

The balance of hope and hopelessness was delicate for these women. An understanding of balance cannot be viewed in isolation from their daily experiences of living without safe and secure residence. Many of the struggles associated with homelessness, such as substance use, isolation, loss of control, discrimination, and marginalization, posed barriers to hope and pushed these women closer to the edge of hopelessness. During our dialogues, the women I interviewed shared stories of hopelessness with ease while they often stumbled and struggled to recollect experiences of hope. Leah’s response to my request that she share an experience of hopelessness was succinct and to the point; *“everyday”*, she stated. In response to this query, Michelle simply stated, *“right now”* and fell into tears.

A similar situation occurred when asked about what or who stands in the way of hope. Most of the women that I spoke with were able to quickly recite a list of those things and people that prevented hope in their lives. The subthemes of (1) being denied by friends, and (2) losses that crush were common threads throughout the interviews I conducted and although these themes were interconnected they also stood alone. Alarming, a consequence of being pushed from hope for many of the participants was an increase in high risk behavior and the loss of will to live.

### **Being denied by friends.**

The inability to secure assistance, financial, emotional, and social, from others significantly impacted hope for the women I interviewed. Being denied assistance, whether sought after or not, was often interpreted as being disregarded and discounted. Feelings of aloneness and worthlessness were amplified by situations in which the participant's were unable to secure aid. As well, these situations reinforced the sense that people were unreliable and untrustworthy. Given that these thoughts and feelings were often a chronic component of living without permanent housing, the additional intensity caused by an inability to gain help pushed women closer to hopelessness.

Lack of support from others was identified as a key factor in preventing hope for many of the women I interviewed. Michelle labeled unsupportive relationships as "*negative*" in her life and shared that they contributed to her current feelings of hopelessness. Sally identified support as central to her capacity to achieve her hopes of securing housing, getting away from substance use, and pursuing her vocational dreams.

However, she often struggled to secure support from her friends. She shared a story of reaching out for assistance and being denied and the subsequent consequences.

*And I sat on the corner crying 'cause I thought the only girlfriend I had at the time... Well, I thought she was my friend.... And she wouldn't let me come over there because I was a threat to her. So basically I spent Christmas night on the street alone and sad, crying. I don't think I've ever felt that hopeless in my life.*

Donna also experienced being denied help from a person she had previously relied on and offered up this story as a demonstration of her understanding of hopelessness. She shared:

*So I called my, my friend that lives down in the West End so um, I was asking him if it was okay if I spent the night over there. And he always helps me out, like always but this time I don't know what happened, he said no, not tonight, maybe some other night.*

Both Sally and Donna's stories demonstrate feelings of disappointment and isolation. Those that they had previously relied on were unwilling to offer the support needed in desperate moments. Allison's experiences of hopelessness ran parallel to those of Donna and Sally. Central to her understanding was the perception of being misunderstood and blamed.

*I had a situation where um, I wasn't at fault and two different individuals in one day um, really it hurt my feelings in the fact that they thought that I did something wrong to them and um, it uh, ended up, um, I felt really alone and by myself and I was crying.*

Although Allison was not denied help, she was deprived of the supportive judgment she anticipated that she would receive. Similarly, Adella spoke of her tendency to refrain from asking for help or to request "things" from others. Thus, when she is offered support this inspires hope and when denied support, even when not requested, she is pushed away from hope.

The majority of the women that I interviewed were unable to identify personal relationships in their lives in which they felt supported and cared for. For those women, who had existing relationships with others, being denied assistance when requested had significant implications for their experience of hopelessness. Not only did this denial deprive individuals of their basic need for shelter or acceptance but it also amplified feelings of isolation, worthlessness, and being misunderstood. The feeling of being “*really alone*” caused unsteadiness in their balance and pulled these study participants away from hope.

### **Losses that crush.**

Loss was a common experience for all of the women that I spoke with. These losses pulled women away from residing in a place of hope and pushed them towards hopelessness. When sharing their stories, many of the women spoke of the accumulation of repeat losses and how this contributed to their present state of homelessness. Other women talked of more recent losses that they associated with being homeless and impoverished. These losses made the women feel separated, as though they had been forced apart from those they loved and the lives they sought, as though they were no longer worthy of the simplest of dignities.

Loss of loved ones and the subsequent feelings of isolation were significant to the loss of hope in these women’s lives. Sally spoke of her experiences of hopelessness following the death of her partner.

*I've been high ever since...so. I wouldn't...I wouldn't commit suicide I don't think because it would hurt too many people but...Man, there are sometimes when I'm just [sigh]. I just feel like not being here anymore.*

Lucy mirrored this sentiment. She spoke of suddenly losing her fiancé and when asked if this represented an experience of hopelessness she replied, *“Yes, big time. Really, really big.”* She went on to share that the loss of her hope for *“happiness and love”* was *“horrible”* and this feeling of hopelessness *“crushed”* her.

All of the women that I interviewed were separated emotionally and often geographically from their children and family. Not one of them was currently involved in a romantic relationship or actively involved in the lives of their children. This separation from loved ones contributed to their experiences of loss and isolation and ultimately, contributed to feelings of hopelessness. Sally spoke of the impact of being separated from her family and how this affected her ability to persevere.

*Um, it was Christmas day and my whole family was in Nelson and...I was standing on the street corner at Cordova and Dunlevy. And I just felt like I should just give up, and that it wouldn't make a difference if I was here or not. Nobody would notice.*

Their sense of isolation and loneliness was not only related to separation from loved ones but for many of these women, was a daily aspect of their lived experience as homeless women. Leah's understanding of aloneness was poignant and bitter. She talked about being on the outside of the world that she longed for and how this distance between her life and dreams contributed to her hopelessness.

*Alright. Fuck, fuck, fuck. [Laughter] Honestly, when I'm standing on the corner – I know this is depressing, I'm going to start crying – 'cause you know I see these hot guys with nice cars and these fucking thousands and...it's just hard. You know, because I want that but I'm lucky if I can keep a week clean. [Crying]*

The experience of loss for the participants also included the dispossession of control in their lives which contributed significantly to feelings of aloneness. All of the participants

spoke to enduring loss of privacy and autonomy during their days on the streets or within shelters. Simple decision making, such as who would be your guest, whether you could lock your door, or when you could prepare food, was removed from their existence. As well, the women I interviewed often were forced to rely on others for basic sustenance and were unable to control the outcome. This loss of control contributed to their sense of hopelessness but was counteracted by their resilience and ability to endure.

All of the women I spoke with talked of the difficulties they encountered securing even temporary shelter. Often this time was spent on the streets constantly alert and vigilant. Michelle had spent nights on the street and within both abandoned buildings and cars. During these periods she hoped that she would “*bump into somebody hanging out*” but shared that “*sometimes I got nowhere to go.*” Lucy endured five days without shelter following her discharge from recovery. Her description of these days follows.

*Yeah, I was fucking...I started hallucinating, fucking doing the Hastings shuffle, fucking it was horrible. It was raining too.*

While reflecting on her previous residence within a single room occupancy hotel she talked about the challenges sharing common spaces.

*I'm used to that anyways like I said, living in all these hotels, everything is shared. Shared bathrooms, shared showers and stuff like that. I've gotten used to that so...I don't like it but it's...I'm used to it.*

She was not the only one who commented on having to persist in situations that were less than ideal. Many of the women spoke to being unhappy or unsafe in their previous residences. Even Donna, who had previously occupied a one-bedroom apartment in East Vancouver, was forced to leave following an incident with her landlord. All of the

women that I spoke with were deprived of choice; restricted and disadvantaged they were often forced to accept less than they needed or wanted.

Marnie's experience of feeling "trapped" while residing at a large inner city shelter is representative of loss and resonates with the notion of restricted choices. She had spent numerous years residing in temporary shelters and suffered the loss of control over basic decision making within her daily life. This lack of control in her environment depleted her of the energy required for change and impacted her experience of hope. Marnie summarized these losses in the following statement.

*Living in a room, a dormitory with eleven women who all have different lifestyles and uh, they don't keep hours you know, like that are sensible... It's uh, so it's always an argument over the lights, whether they should be off or on or uh, and then of course when people are high they don't really care whether they're disturbing people. Uh, there's a lot of fighting, a lot of stealing, uh, you know, the violence thing.*

As the only woman I interviewed who denied substance use issues and the oldest participant, Marnie lived with a chronic fear of violence. Having endured two physical assaults while homeless, this was a reasonable fear. When I interviewed Marnie, she spoke of her dream of returning to her "nice phlegmatic" self, however she was unable to place hope in achieving this aspiration as she was forced to be constantly vigilant. She identified herself as "mental" and shared:

*I have some outrageous things I hear coming out of my, I mean, you know I, when I say things I don't always mean them. And it's just desperate.*

The loss of her sense of safety and security pushed her away from hope and almost made her unrecognizable to herself. She felt as though she no longer had control over both her thoughts and actions.

For Adella, her recent HIV diagnosis shook her sense of control. Her feelings of powerlessness when faced with this health diagnosis were overwhelming and she was only able to regain hope when she felt empowered.

*I don't, I totally did, I felt like no matter what control I had in my life, it, something still got in to kick me when I was down...So it was, it was really, I don't know, it was really hard to deal with but now that I found out that you can actually do something to change the course and to bring it to some level of, of non-detectable. That meant something to me because before that I was really hopeless.*

Adella, when learning of her new health challenge, let go of her sense of control and lost the belief that she was able to shape her life. It was only when she learnt about her diagnosis and what steps she could take to impact the course of her disease that she was able to regain “control”. This sense of “control” was central to her understanding of hope; without control she was hopeless and with it she had hope.

The study participants shared stories replete with loss and separation. Criteria for recruitment meant that they had lost permanent housing and the losses that preceded and followed were extremely intense. Loss took many different shapes within these women’s narratives; loss of loved ones, distance from a preferred life, and loss of control were common elements to the participant’s understanding of hope. Regardless of the nature of loss, this experience had the capacity to consistently push each and every participant towards hopelessness.

### **Pulled from the Edge**

The lives of these participants fluctuated between hope and hopelessness. The women I interviewed described times of both hopefulness and hopelessness within their lives and spoke of the various factors and people who support and prevent these

experiences. When asked who or what supports or fosters hope within their lives, all of the women shared rich stories of meaningful relationships with others. As well, many of the women spoke to the complex interactions between hope and faith. The subthemes of (1) getting found, (2) support and love, (3) something bigger, and (4) always housing captures the people and beliefs that foster hope in the lives of the participants.

### **Getting found.**

While enduring hopelessness, many of the women spoke to the importance of receiving assistance from others so as to regain balance and rise from their despair. Often this assistance came from professionals working within community agencies, volunteers at resource centers, or individuals whom the women had a working relationship with. Regardless of the source of help, participants shared stories in which other people fostered hope within their lives through acts of kindness and assistance.

Within the preceding twelve months many of the women that I interviewed had spent nights on the street, without access to shelter or refuge. Many of them shared stories of staying awake for days on end, often under the influence of stimulants, fearful that they may have to sleep outside. While on the streets, women held onto the hope that someone would assist them in securing shelter. While talking about a five-day stretch on the streets, Lucy stated:

*I kept hoping that fucking, that somebody would fucking invite me or things, into their home or sleep or offer me something to eat. It was horrible.*

This experience mirrored Allison's narrative of homelessness. She alternated between staying on the street, hoping that one of her "friends" would offer her a couch or

the floor for the night. Adella shared her most recent experiences of living behind a community bank and how a mental health worker from a nearby nonprofit organization approached her and offered her a room within a single room occupancy hotel. She talked about her experience of “*getting found*” and how the offer of help gives her hope.

*... it's just in the weirdest places when I'm really feeling bad and I'm really thinking what am I doing and what's going to happen. All these questions come and then all of a sudden somebody out of the blue shows up and says hey, do you, you know, do you need some help and it's just really weird.*

For Allison and Sally, receiving a temporary shelter bed fostered their experiences of hope. Allison viewed this as creating an opportunity for change.

*I can say that um today I have more hope though cause you know with places like this that give me the initiative and help me push forward to do things 'cause if I don't follow through with what I say I'm gonna do then I wouldn't have a place to stay so obviously there is hope.*

When asked to share a situation in which she experienced hope, Sally shared the following:

*Yesterday- big time. When I got a room here [laughing].*

Unlike Allison, Sally did not relate the receipt of shelter with the potential to make change in her life. For Sally, having a secure place to stay, albeit temporary, was enough to foster the feeling of hope.

Despite the apparent importance of help from others in fostering hope, many of the women waited passively for someone to offer assistance. This apparent lack of effort to seek out help can be understood in the context of having been deprived of assistance repeatedly. As well, the perception of repeat failure at achieving hopes prevented goal-oriented actions. Leah spoke of this relationship when she shared:

*I do not...I've honestly lost all hope. I've been down here so long so why try. I'm done.*

Only Sally and Marnie spoke of their assertive efforts to secure help to avoid staying on the streets. On Christmas Eve, Sally spent most of the night engaged in sex trade work without a safe place to go to. While struggling with feelings of worthlessness and loneliness, she reached out to a “*date*” for money to secure a room and was able to move from a place of hopelessness to hope when he came through for her. Marnie reflected on the help that she had received from a volunteer at a women’s only drop in center as she tried to secure residence for the night. From a place of “*helplessness*”, Marnie transitioned to feeling hopeful.

Unlike many of the women that I spoke with, Marnie had connections with her family and was able to secure help from them in times of need. Her ex-husband would occasionally offer her shelter and while alive, her father had provided her with some financial support. However, even she found it challenging to secure help and struggled to maintain hope within her life. She spoke of the importance of helping others as a means of fostering hope within her life. Her volunteer work at a variety of community centers inspired hope as it gave her a sense of identity and usefulness.

The subtheme of ‘getting found’ played out in the lives and experiences of the women that I interviewed in distinct ways. However, for many of these women ‘getting found’ involved receiving help from others, particularly assistance with securing residence and financial support. Faced with homelessness and poverty, the offer of shelter pulled these individuals away from hopelessness. Not only did this assistance ensure that these

women had safe shelter but it also served to acknowledge their individual struggles and personal value. Thus, they were able to move towards hope and hopefulness.

### **Support and love.**

Meaningful relationships were central to the experience of hope and hopelessness for the women I spoke with and formed a key piece of the theme of 'pulled from the edge'. The unique and intimate connections that the women I interviewed had established with partners, family, and friends fostered their sense of hope. Although these individuals did often offer tangible help in securing basic needs, more importantly they offered intangibles. The emotional support and acceptance offered by these individuals propelled the hopes of these women.

Many of the participants identified individuals within their lives who represented their preferred existence. These people functioned as a bright light within a dark night, shining of the possibility of another chance or an escape from homelessness and associated challenges. For many of the women that I spoke to, these relationships served as a way of finding self and helped them to hold onto their hopes while dealing with their day-to-day existence.

When asked what encourages hope in her life, Leah talked about her best friend who had managed to abstain from substances for over two years. She shared that Tammy encouraged her hope *"because she got what I want"*. Tammy served as a reminder that it was possible for Leah to change her life and achieve her hopes despite her perception that she had repeatedly failed. Adella drew on her memories of her family and how they survived to support her hopes.

*Just maybe teachings, like the teachings from my parents, like they always had hope no matter what. And they taught me that 'cause like I don't need to have a certain gemstone, or a certain pearl or keep this, this my grandmother's diamond ring or something I don't know. It doesn't, it doesn't land in anything, it's just in people and what they taught me and being able to hold onto that.*

Marnie also relied on role models to encourage her hopes. Unlike Leah and Adella, the women that she looked towards were volunteers within the various community centers that she accessed. She spoke at length about the different women she had met in the community and noted that these connections and the associated respect and admiration she had for the women helped foster hope. When asked what encourages her hope she also shared:

*Uh, well, you know, there are a lot of really nice people and uh, they're people also that I see that have come through a great deal and are uh, uh, better people for it.*

Both Lucy and Sally shared their experiences of being in long-term intimate relationships and how that impacted their lives. Lucy talked about being with her partner for over three years, hoping for "happiness and love" and the shift to hopelessness when he passed away suddenly. This loss led her down a path of "hopelessness" in which she didn't care if she "lived or died". Sally shared a very similar story of loss of a loved one. While with her partner she lived with hope, abstained from substances, and was focused on the future. For both Sally and Lucy, the intimate connection with another person fostered their hopes.

Michelle shared her story of being reconnected with her children many years ago. When she shared this story with me, she no longer had custody of her children and her desire to reestablish this relationship was a goal of hers. Having lost and then regained this

relationship previously, Michelle was able to hold onto this memory. Her memory of when she “got off addictions issues that I had. When I was getting my life together, going to college” served to propel her hope. She stated:

*I hope that uh, that I'll regain everything, especially my children. I have hope that we'll be together again.*

Reliability was an important aspect of how relationships could foster hope for Sally. Furthermore, this reliability directly related to her perception of being loved. When speaking of her understanding of hope, she shared:

*I felt hopeful quite a bit lately because a lot of people that said that they would help me one way or another have actually come through and done it. So, you know, I feel supported and loved by the people who are around me.*

Marnie spoke to a similar phenomenon when dialoguing about her relationship with her father. Only after he passed away did she realize how much she depended on him and how his support helped her to maintain her hope while living with poverty and isolation.

Connections with others was immensely important to understanding hope for the women that I interviewed. These connections served to combat isolation and loneliness and for many of the women these relationships allowed them to remain future focused while faced with homelessness. Meaningful relationships, whether past or present, served as a reminder that the future is full of distinct possibilities and supported the experience of hope.

### **Something bigger.**

Many of the participants spoke to the intricate relationship between faith and hope. Faith presented in a multitude of ways within the data collected but for many women

seemed to support their experiences of hope. For some of the participants, faith involved a belief that everything would work out or a belief in their individual capacity to make change. These beliefs often formed a foundation upon which hope could rest and informed the participants' understanding of hope.

Allison shared her insights into the relationship between faith and hope in the following excerpt:

*Cause I have faith and faith and hope pretty much come in one. Yeah. 'Cause I have faith that you know I'll make it through and that everything will be okay so yeah, I do have hope.*

For Allison, faith served as the fuel to propel her towards her hopes. Marnie shared that her faith encouraged her hope. As well, faith provided her reassurance that everything would work out for her. Donna echoed this sentiment when she shared

*Like, let's say you're in a place where something really good happens to you it's like, it's like how did this come upon me? It's like the right place, the right time. It's just faith.*

Similarly, Adella and Sally relied on faith to hold onto hope. Adella stated:

*Something's gotta give 'cause no matter what I've done it over and over. Something's always gotten better somehow.*

This sentiment was evident throughout Sally's interview. She struggled with a lack of hope but held onto the conviction that things would improve. She shared:

*I barely have any hope these days, like seriously. Like, I know and I hope that there's better things out there for me. Like I think this can't be all my life has.*

Sally also talked about how belief in herself and her capacity helped her to hold onto and move towards hope. Faith in herself enabled Sally to persevere despite her current challenges and remain future focused.

*There is something bigger, there's something bigger. I believe that for sure. I'm supposed to give back in some way and uh, I have faith in that. I have faith in myself...*

Faith rarely presented as religious within these interviews. Marnie was the only participant who identified herself as having religious beliefs; she identified herself as a Christian but was uncertain if her involvement in the Christian faith supported her hope. Like many of the stories shared by these women, her connection to this faith not only pushed her towards hope but also pulled her away from hope.

*There's a food bank at my church and I'm embarrassed to be seen in the line up because I used to be an advocate for that church.*

She spoke of the importance of “*faith, hope and charity*” but felt that charity was the most important of the three. However, her current state of homelessness deprived her of being able to seek charity even when readily available.

For many of the women I interviewed faith in the world and self served an important function. For some of the participants, faith and hope were interchangeable and were experienced in tandem. Often participants were challenged to articulate any distinction between the two. However, for many of the women I spoke with faith was a distinct experience that supported hope. Faith encompassed the belief that everything would work out and that change was possible. Hope encompassed the dreams, aspirations, and goals that the participants strived for.

The role of faith in supporting hope was key. While holding onto faith in the future and personal potential, some of the women were able to relinquish their fears and abandon themselves to hope. Faith served to decrease the vulnerability some of the women

associated with hope and supported them in moving away from hopelessness. As well, faith strengthened hope when faced with adversity. The inability to achieve hopes has the potential to upset a person's equilibrium and plunge them into despair. However, a firm grip on faith prevented utter hopelessness for many of the women I spoke with and thus, preserved and propelled hope.

### **Always housing.**

The most commonly identified hope amongst the participants was to secure independent housing. However, all of the women were faced with a multitude of barriers in this pursuit and the inability to attain adequate housing impacted their experience of hope and the achievement of other goals. Further symbols of hope for the participants in this study included employment and healthier relationships with illicit substances, however, these hopes were often voiced secondary to articulated hopes for housing.

Lucy identified housing as "*one of my biggest hopes in my life*". Amongst the women I spoke with, they were consistently seeking housing that was affordable, had a private bathroom and kitchen, and that was secure. Adella summarized this hope nicely when she stated:

*I just want my own self-contained unit. Like I don't want to have to like, right now I don't have a fridge or I don't have anything like a kitchen. I don't even have a bathroom in the room but I don't know it's still, it's a small step, you know?*

Many of them women articulated their hope to secure housing outside of the Downtown Eastside. However, they were all quick to speak to the challenges to even find single room occupancy residences. Barriers to achieving this hope included waitlists, "*availability*", the ability to present as acceptable to potential landlords, and the "*price*". Numerous women

spoke of the impossibility of receiving funds for a damage deposit for new housing until they had paid back previous government debts. Marnie, an elderly woman who had been sleeping in a shelter for over three years, shared that being “*burned out*” and lacking “*energy*” was interfering with her pursuit of housing. As well, the complex needs of this population, which included physical health challenges and substance use struggles, made it difficult for many of the women to identify a goal and follow through with the necessary steps to achieve it. As stated by Sally:

*It seems like there’s a lot of hoops I have to jump through to get basic things.*

These “*hoops*” presented a significant barrier to securing housing for all of the women interviewed.

Hopes were not only limited to housing but included dreams of pursuing education, securing employment, and abstaining from substances. However, these hopes were diminished by many of the participants and often only mentioned when I prompted for more details. Sally shared that she hoped for the “*possibility*” that she could go to school. Her use of the term possibility is intriguing as it implies that currently this is completely out of her reach. Some of the women shared that they hoped to find a job that they “*enjoyed*”.

Dianne shared that her biggest hope was to maintain her abstinence from heroin. The desire to establish a healthier relationship with substances was echoed by Sally; she did not aspire to quit using heroin but she was hoping to have it prescribed so she could improve her “*functioning*”. Despite the plethora of hopes that these women articulated,

housing consistently presented as key to moving forward in their lives. Michelle summarized this when she said:

*Always housing. It, it...you gotta have a decent home to feel good about yourself. To have...to have um, the proper, the environment for you to do the rest uh, and work on yourself to better yourself.*

The subtheme of 'always housing' encompasses not only the aspirations and dreams that these women hold onto but also the barriers they identify to the achievement of these hopes. While balancing on the edge, the women I spoke with are forced to navigate a complex network of systems so as to achieve their hopes for housing and more. Furthermore, each of them endures a life of deprivation and poverty and their energies are consumed by attempts to secure basic necessities. These barriers have the capacity to push each individual towards hopelessness and many of the women I spoke with resided in a place where they held onto hope despite being faced with so many challenges.

### **Nursing on the Edge**

Given the potential for hope to alleviate the stress and challenges of homelessness and associated struggles for the women I interviewed, I was curious about how they understood the role of registered nurses in relation to this phenomenon. I asked each participant to reflect on health care interactions and share their perspectives related to how registered nurses can impact hope and hopelessness. Due to my concern that individual participants may be challenged to differentiate between registered nurses and other health care professionals, I ensured that I used the terms nurse and registered nurse during our dialogues. Furthermore, if I was uncertain that the individual was speaking about a registered nurse I confirmed the professional affiliation with the participant.

As many of the women I interviewed had both chronic and acute health challenges, they were well poised to speak to this area of interest. Adella summarized the potential importance of the nursing role to the experience of hope and hopelessness.

*But, but you get your, you get your energy from them. Like when you're all drawn out they're the ones that you feed off of, like you do feed off of energies so if there's nothing there for you, somebody's only just, you know, it's just really hard to heal. You need that energy to heal.*

Two subthemes pertinent to how nurses impact the experience of hope and hopelessness presented during my dialogues with these women; (1) just their attitude and, (2) the extra mile.

### **Just their attitude.**

The subtheme of 'just their attitude' captures both the material and immaterial attributes that nurses bring to their interactions with the women I interviewed. These attributes have the potential to foster personal hope, however, they also have the capacity to prevent hope. For many of the participants it was difficult to find the words to express what nurses do to inspire or prevent hope but their personal narratives were replete with exemplars.

Lucy talked at length about her hospital experience following her diagnosis with endocarditis and how the "attitude" of the nursing staff affected her understanding of her illness. When asked what nurses do or say to make her feel more hopeful she replied:

*Just their attitude, the way they are, they try to do everything to brighten their day, right? Which is kind of nice.*

However, her narrative quickly shifted to how she is impacted by the "bitchiness" of nurses. She understood this as being unable to secure assistance from a nurse and shared how at

times she “*couldn’t get anyone to help*” her. Lucy summarized this interaction by stating, “*just her whole attitude made me feel hopeless*”. Adella also spoke of an inability to get help from nurses when asked about her experiences of hopelessness with nurses.

*...they keep themselves at a distance for their patients cause they don’t want to see or meet with the patients.*

Sally, following frequent visits to the emergency department for treatment of an abscess, understood this “*snarky*” and “*rude*” attitude to be a judgment against her involvement in sex trade and substance use. Furthermore, she perceived this as a clear message that “*nobody gave a shit*”. Donna also spoke about the dichotomy between the “*really nice*” nurses and the “*cranky*” nurses when asked how nurses impact her experience of hope. For Donna, the “*nice*” nurses that fostered her hope made an extra effort to engage with their clients.

*They’re always saying hi to everybody and they’re always interested in how they’re doing and stuff like that. They just tend to spark conversations up with everybody.*

The importance of registered nurses being interested and engaged with clients was identified as an important component of an overall attitude that increased hope. Leah spoke to this understanding when she shared:

*You can get a hold of them almost any time you need them.*

Michelle echoed the importance of availability in her interactions with nursing.

*And she’s always there, she’s always there to talk to. Listens to people, supportive.*

Listening was also central to Leah’s experience of hope while interacting with nurses.

*You know what they do, they listen. Like when I need to vent because there sure as hell ain’t anyone on that street that’s willing to fucking listen.*

Both Michelle and Leah struggled against the isolation and stark loneliness of homelessness and the available ear of community nurses were central to fostering hope.

For Sally, she experienced hope when nurses abandoned efforts to be seen as an “*authority figure*”. She spoke of a nurse who made her feel hopeful while in the hospital.

*‘Cause she talked to me like she would talk to everybody else, right?*

Sally interpreted this lack of pretension as a respectful interaction and thus, was able to recollect this interaction in vivid detail.

*And...and it was just that she let her personality come out and she didn't care about looking like the authority figure. She didn't...she just wanted to make sure that I was okay and that I got well, you know?*

Given that many of the women I spoke with were hesitant to assertively seek out health care treatment or put off accessing care due to competing priorities, the attitude of registered nurses is important to assist with the creation of a welcoming environment. Being available, helpful, and interested were identified as key components of a nursing attitude that increased hope. Conversely, a perceived absence of these characteristics pushed women closer to hopelessness.

### **The extra mile.**

The women that I interviewed were sensitized to any indication that the registered nurses they worked with viewed them with disregard or disrespect. Whether intentional or not, nurses were easily perceived as dismissive and unavailable. Conversely, many of the women that I dialogued with identified the importance of caring and advocacy as key to fostering hope within their healthcare interactions. Alarming, these characteristics were

often viewed as extraordinary; these aspects of the nursing role are encompassed within the subtheme of 'the extra mile'.

Leah shared her experiences of working with community nurses during two pregnancies and a variety of infections related to substance use. She used the words "*fantastic*" and "*awesome*" to describe the nurses she had developed relationships with and often referred to particular individuals by first name. She affirmed that acceptance of how she lives her life was essential to hope inspiring relationships with nurses. Michelle's understanding of how nurses foster hope in her life was similar; she shared how a particular nurse always made her feel hopeful by being "*supportive in whatever it is that you're dealing with*".

For Adella and Sally, this theme played out in their lives when they received emotional support and caring from nurses. Adella talked of the importance of the visits from community nurses while in hospital.

*Just the little things like that make a big difference cause I never ask for it or ask them to come by. Just to check on me and make sure I'm okay cause it's, I can feel it and they're just trying to stabilize me, like my mood basically. They just want to make sure that I, you know, that I haven't given up before you know, something else happens.*

Sally's experience was similar; she spoke of the impact of working with a nurse who "*just wanted to make sure that I was okay and that I got well*". Marnie's understanding of the complex relationship between nurses' actions and her feelings of hope ran parallel to both Sally's and Adella's. Following a hip fracture, Marnie was hospitalized for three weeks and endured residing in a four-bed room with three men. As she struggled to maintain her dignity and independence, she became immersed in hopelessness.

*...I made a mess in the washroom. And I was so embarrassed and uh, the nurse came in and she picked up my clothes and she put it in a bag and stuck it in my closet and she said, "Your family can come and do your laundry."*

This interaction caused her to reflect on her isolation and forced her to face the fact that she did not have anyone in her life that would clean her soiled clothing. Shortly after this experience a "special" nurse offered to do her laundry for her. When asked, Marnie acknowledged that this nurse was going the extra mile and that these actions gave her "hope in humanity".

The role of nurse as an advocate was essential to fostering hope for both Sally and Adella. Although it could be argued that advocacy is an integral role of registered nurses, these participants identified this as something extraordinary and unexpected. Advocacy for these women was not simply about speaking up for what they needed but included respecting and defending their unique and intimate knowledge of self. Both of these participants spoke of the challenges getting their voices heard within the hospital setting and how this affected hope.

Adella shared her experience of presenting to the emergency room with depression and suicidal ideation caused by a drug interaction and the response of the staff.

*But they kept arguing you know, it's just, she just doesn't want to take this drug. Like it had something to do with like, I had a spider bite and it was swelling and I wouldn't take the drug because it was an anti-inflammatory and I'm not supposed to take an anti-inflammatories so I said I wouldn't take it.*

Sally shared a similar experience in which she was forced to argue for intravenous antibiotics.

*...and I said, "Listen, I'm still feeling really sick, this isn't working." I came back and I said, "Look, I know that I need IV"...This is after I've been honest about being an addict, right? And I said, like, "Why are you treating me so differently?"*

Both of these experiences were offered as examples of healthcare interactions in which they each experienced hopelessness. And for both of them, individual registered nurses were central to regaining their equilibrium between hope and hopelessness. They each spoke of nurses who respected their understanding of health and wellness and who believed in their capacity to recognize when something within them was amiss.

For both these women, nurses *"backed"* them up in their efforts to have their voices heard. Adella spoke of the importance of nursing advocacy when she had *"lost hope"*.

*She backed me up and just said that um, she would go along with anything that I said and I said that I think that I need to stay here but I don't know what to say.*

Sally talked of her struggles convincing hospital staff to leave an intravenous in situ so that she would not have to endure a painful reinsertion when she next presented for antibiotics. Her sense of injustice and insult was palpable during our interview.

*Just because I'm an addict doesn't mean I'm stupid.*

While engaged in a heated argument with a nurse, another approached and advocated for Sally's capacity to care for self.

*This particular nurse stepped in and said, "Wait a minute! Wait a minute, she's right." And she said, "I've also seen her and she's been coming here for months and there's no...she's not once ever done anything to any of her IVs. She takes very good care of them..."*

By speaking up for her, this nurse demonstrated respect for Sally's ability to care for herself and more importantly, refrained from making a clinical decision based on Sally's engagement in intravenous drug use. Sally offered this experience as an example of how

registered nurses have contributed to her feeling hopeful while receiving healthcare and this story serves to highlight the importance of nursing advocacy.

### **Conclusion**

The participants in this study have described hope as a complex and multi-faceted lived experience in their lives. The understandings and experiences of the women I spoke with have been captured in the four themes of (1) balancing on the edge, (2) pushed to the edge, (3) pulled from the edge and, (4) nursing on the edge. Each individual struggled at maintaining balance within their lives so as to avoid utter hopelessness and to ensure that they held onto hope.

While striving to maintain equilibrium, lack of support, loss, and substance use pushed many of them towards the cliff's edge. Conversely, assistance, faith, and meaningful relationships pulled many of them back to the safety of hope. Within the context of healthcare experiences, registered nurses were identified as important to experiences of hope for these women. Nursing attributes of availability, listening, respect, caring, and support were essential to increasing hope amongst these women. Given the multiplicity of healthcare challenges that women who are homeless face and the protective nature of hope, it is of the utmost importance that registered nurses walk alongside this population and foster hope inspiring interactions.

## Chapter 5

In this chapter, I discuss the findings of this research. First, I provide a brief overview of the study and highlight key findings. Second, I discuss the findings in relation to previous research. And finally, I explore the implications of these research findings for nursing practice, nursing education, program and policy development, and future research.

### Overview of the Study

I worked as a registered nurse within the community for years and came to contemplate the role of hope in the lives of marginalized populations. When I began my graduate studies at the University of Victoria, my intention was to conduct a research study that explored hope amongst this population. After much consideration and numerous dialogues with my research supervisor, I decided to pursue a qualitative exploration of the meaning of hope as understood by women who are homeless. My research proposal began to take shape quickly following the further development of my research questions.

The research questions that I decided to pursue were as follows:

- a) What is the meaning of hope for women experiencing homelessness?
- b) What do women experiencing homelessness perceive as barriers and supports to hope?
- c) What nursing actions support or create barriers to hope?

The final research question developed as I identified the importance of grounding my research project within the discipline of nursing. I wanted to ensure that the findings from this project would benefit my future nursing interactions with women experiencing homelessness and hoped that I could extend this benefit to other members of the discipline.

The women who I interviewed spoke eloquently of hope and their unique understandings. The complexities of living with hope while faced with poverty, oppression, and marginalization were captured within the themes of 'balancing on the edge', 'pushed to the edge' and 'pulled to the edge'. 'Nursing on the edge' captures the multiple understandings of how registered nurses impact the experiences of hope and hopelessness within the lives of the study participants. My research findings are discussed in detail in chapter four and although all of the findings were new to me, I was surprised by particular details of the research findings.

I was amazed to discover the complexity of the relationship between substance use and hope within the lives of the women I interviewed. From both personal and professional experiences, I presumed that I came to the research process with a sophisticated understanding of substance use and hope. However, I quickly realized that my understanding was superficial. Not only did hope reduce the urge to engage in substance use but decreased substance use fostered the experience of hope. Furthermore, substance use helped many of the participants manage feelings of hopelessness and despair while contributing to hopelessness itself. The relationship between substance use, hopelessness, and hope illustrates the extreme difficulty of maintaining balance while faced with the struggles associated with homelessness.

Another area of the research findings that surprised me was the ways in which registered nursing prevented hope in healthcare interactions. Although I suspected that women experiencing homelessness would be sensitized to subtle, and often unintentional, messages of disregard and disrespect, I was surprised by the importance of these

interactions for the participants. I understood many of the stories that were shared as being reflective of high client workload and staffing shortages; however, these external factors did not mitigate the psychological and emotional consequences for the women I spoke with. Each of the women interviewed desperately wanted to be acknowledged for their strengths and capacities and invited into a collaborative working relationship with registered nurses. When this was lacking, hopelessness and despair was fostered.

### **Strengths and Limitations**

The findings from this research contribute to the growing body of knowledge pertaining to the complex experience of hope. More importantly, the findings from this research contribute to specific understandings of hope among women who are homeless. To the best of my knowledge, this research is the only study with women who are homeless that explores the meaning and understanding of hope. Thus, this research provides a unique contribution to the body of knowledge on hope as well as homelessness.

Not only did this study afford participants the opportunity to speak of the meaning of hope in their lives but it also encouraged them to reflect on how registered nurses can foster or limit experiences of hope. Consistent with qualitative research approaches, the opportunity to speak of their concerns and interactions with service providers may have had benefits for the participants. However, the opportunity to share their individual perspectives may have also posed psychological and emotional challenges for the participants as they were each asked to reflect on and share deeply personal experiences.

For this research project, nine women who had experienced homelessness within the last twelve months were interviewed. The findings, although possibly representative of

a shared understanding, can only be applied to the participants at the moment of their individual interviews. All participants were recruited from one site, which provides services for both homeless men and women. However, this study only focuses on the perspectives of women and it is not known whether men would have different or similar perspectives. Although each of the participants were currently homeless, all of the women were accessing community resources to meet basic needs for shelter and nutritional support. The study sample was not inclusive of women who were incapable or unwilling to access basic services. Given the socially constructed nature of hope the findings may not be representative of the experiences of women who are not accessing shelters, who are couch surfing, or who are persisting in undesirable circumstances.

### **Links to Scholarly Literature**

Below I discuss how the research findings from this study relate to other scholarly literature in four distinct areas; hope as a protective factor, the concept of vulnerability, substance use issues, and the advocacy role of registered nurses. Following this, I discuss implications of these understandings for nursing practice, nursing education, program and policy development, and future research. As with all interpretive description studies, the interpretation of the findings and subsequent recommendations are reflective of the research data and analysis but have also been shaped by my many years of experience working with women experiencing homelessness.

#### **Hope as a protective factor.**

All of the women that I interviewed spoke of the challenge of maintaining hope in their lives. Many of them spoke of the difficulties holding onto hope while faced with

isolation, poverty, and struggles with substance use and how this imbalance impacted their will to live. Although the intent and purpose of my research was not to evaluate or understand thoughts of suicide or self-harm amongst women experiencing homelessness, I was surprised by how many of the women that I interviewed expressed thoughts of giving up. Furthermore, I was struck by how hope played a protective role in their lives and bolstered their capacity to carry on.

Despite the lack of research that demonstrates the important role of hope for women who are homeless, there is considerable research that demonstrates the importance of hope for other populations. The findings from many studies involving cancer patients indicate that hope is essential so as to mitigate psychological and emotional stress, enhance quality of life and wellness, and to assist with adjustment and change (McClement & Chochinov, 2008). Conversely, hopelessness is associated with the desire for hastened death and is correlated with suicidal thoughts and actions (Khan et al., 2010; McClement & Chochinov, 2008). Although the struggles faced by cancer patients are different from those endured by women who are homeless, perhaps one of hope's universal aspects is its protective capacity.

Existing research, although sparse, indicates that homeless women experience higher rates of suicidal ideation and attempts, compared to their housed counterparts (Eynan et al., 2002; Strehlau, Torchalla, Li, Schuetz, & Krausz, 2012). Eynan et al. (2002) conducted a study involving 330 homeless men and women in Toronto, Canada that assessed the prevalence of suicidal ideation and attempts and explored which factors associated with homelessness predict suicidality. Within their study, 78% of the female

participants espoused suicidal ideation and 57% disclosed previous suicide attempts; these rates were significantly higher than those of the male participants (Eynan et al., 2002). Benda's (2005) study involving homeless veterans also found increased rates of suicidal ideation and attempts amongst the female participants as compared to their male counterparts.

An American study involving homeless men and women struggling with mental health illnesses had similar findings; over 50% of the participants had attempted suicide at least once and 35% percent of the sample had experienced thoughts of suicide within the preceding thirty days (Desai, Liu-Mares, Dausey, & Rosenheck, 2003). These high rates of both suicidal ideation and attempts amongst homeless individuals have recently been supported by a Canadian study. Strehlau et al. (2012) found that, amongst a sample of one hundred and ninety-three homeless women, 50% of study participants had at least one suicide attempt in their lives, 26% had had suicidal thoughts within the last year and 22% of the women had current high or moderate suicide risk.

It is important to contextualize these findings by comparing these rates to those of women who are housed. The prevalence of suicidal ideation amongst the general female population in Canada is 3.8% (Strehlau et al., 2012) and the rate of suicide attempts between 1.5% and 4.2% amongst the general population in Canada and the United States of America (Eynan et al., 2002).

Despite the scarcity of research concerning suicidality amongst homeless women, there is an overwhelming amount of information pertaining to risk factors for suicidality amongst the general population. Risk factors or predictors of suicidal ideation and self-

harm are commonly divided into categories that encompass a broad range of cultural, social, physiological, and psychological factors. Serious mental illness, past suicide attempts or ideation, and substance abuse are considered strong predictors of suicide attempts (Bonner & Luscombe, 2009). Psychiatric illness or a family history of suicide are also connected to increased risk of suicide (Bonner & Luscombe, 2009). As well, it is believed that decreased social support, stressful life events, poor nutritional status, gender, age, and race are connected to suicide risk (Bonner & Luscombe, 2009).

Many of the risk factors associated with suicide identified above are also associated with the experience of homelessness. The intersection of past and present stressors and risks may explain the high rates of suicidal ideation and suicide attempts amongst homeless women. High rates of mental health issues and substance use have been thoroughly documented amongst homeless populations, both of which are associated with increased suicide risk (Khandor & Mason, 2007). Reduced access to care may further affect rates of suicidality amongst women who are homeless as barriers to healthcare prevent appropriate and timely assessment of suicide risk and intervention as needed. Factors such as history of child abuse and neglect, disconnection from family, and family history of mental illness often contribute to homelessness and also are known to increase risk of suicide (Bonner & Luscombe, 2009). These factors are all known to be high amongst homeless populations (Martins, 2008; Partis, 2003; Teruya et al., 2010). The social deprivation, poor nutrition, poverty, and lack of social support that often occurs within the context of homelessness may also be connected to higher than average rates of suicidal

ideation and attempts amongst homeless women. Finally, homelessness may in and of itself present a life stressor that precipitates a suicide attempt.

It is challenging to understand the complex relationships between risk factors for homelessness amongst women and predictors of suicidal ideation and attempts. However, it is clear that homeless women have higher rates of both thoughts of self-harm and suicidal attempts. This cannot be viewed in isolation from those experiences that led to enduring homelessness or the daily experience of homelessness. Many of the women I interviewed, spoke of the cruelty of their experiences while homeless and how this marginalization and deprivation prompted thoughts of ending their lives. Conversely, many of the participants expressed the importance of hope in preserving their will to live.

Joiner (2005) proposes a theory of suicidal behavior that is significant to understanding the role of hope as a protective factor amongst women who are homeless. Joiner (2005) contends that there are three key components that converge to lead a person to suicidal actions; isolation, perceived burdensome, and the acquired ability to harm self are key to suicide attempts. Throughout my dialogues with the study participants, many of the individuals referred to feeling utterly alone and as though they were a burden on others. These perceptions presented as barriers to the experience of hope and if understood within the theoretical work of Joiner (2005) would contribute to suicidal risk.

As well, many of the women I spoke with commented on their engagement in risky and harmful substance use behaviors. While in the midst of hopelessness and despair, the quantity and quality of substances they were using would gradually adjust so as to mitigate these negative experiences. For the study participants, drug use habits shifted over years

and often involved increasingly reckless and dangerous behavior. While involved in our conversations, many of the women reflected on the danger they had put themselves in and expressed appreciation for surviving these experiences. They talked about how hope, achieved through connections with others or through holding fast to their dreams, often pulled them back from these experiences and protected their will to live. Despite their appreciation for surviving these experiences, many of the women repeatedly engaged in dangerous substance use; thus, acquiring ability to engage in self-harming behaviors.

There is very little empirical evidence to support the notion that hope serves a protective function in suicide prevention amongst women who are homeless or that hopelessness is associated with suicidal thinking amongst this population. However, the women who I interviewed clearly identified the importance of hope in promoting individual resiliency and perseverance. Given what is known about hope and hopelessness, and the elevated rates of suicide amongst homeless populations it certainly warrants further investigation.

In a recent study conducted by Davidson et al. (2009) it was found that “people with high hope tend to have lower levels of burdensomeness and thwarted belongingness and higher levels of acquired capability which, overall, buffers them against suicidal risk” (p. 504). Furthermore, hope is known to stand in stark contrast to hopelessness and despair, both of which are predictors of suicidal action. Lastly, hope is essential to the development and pursuit of goals and encourages an individual to maintain optimism and a focus on the future. Due to these accepted understandings of hope, it is evident that hope has the capacity to protect against thoughts and actions of self-harm. Given the elevated rates of

suicidal thinking and actions amongst women experiencing homelessness it is paramount that those individuals and organizations working with this population focus on fostering hope for individuals. Registered nurses can be key to this process and implications for nursing practice, program development, and research will be discussed shortly.

### **Vulnerability.**

Vulnerability is a term that is often used to describe marginalized populations within nursing discourse. Certainly, this language has been used by the nursing profession to describe the high rate of health challenges endured by women who are homeless. Perceptions of the vulnerability of women experiencing homelessness have most often been framed by the belief that individuals are responsible for the choices that increase risk. Within the nursing literature, very little attention has been paid to the social, political, and economic structures that contribute to this vulnerability.

Within this section of my paper, I first discuss the prominent understanding of vulnerability within nursing literature and research. Secondly, I explain the need to shift this understanding to one that embraces a critical social theory or structural perspective on vulnerability. This shift in understanding is necessary so as to encourage nursing to embrace a broader collective and structural conceptualization of vulnerability.

Within nursing research and literature, the term vulnerability is rarely defined adequately and there is little consensus about its utilization and meaning (Nichiata, Bertolozzi, Takahashi, & Fracoli, 2008). Implicit in many prevailing definitions of vulnerability is the belief that vulnerable persons represent an aberration from normalcy and thus, are damaged or deficient in how they live their lives (Nichiata et al., 2008). In

other words, the deficit is within the person and implies a sort of personal failing. An epidemiological perspective has typically shaped contemporary understandings of vulnerability within healthcare; thus, there is significant focus on individual or behavioral risk factors. This view ensures that responsibility for vulnerability primarily resides with the individual and prevents careful evaluation of the multitude of social, political, and economic structures that create and reinforce vulnerability.

More recently, nursing scholars have begun to criticize this individualistic understanding of vulnerability. Nichiata et al. (2008) propose that the distinction between vulnerability and risk must be articulated and embraced. The authors propose that “risk represents probabilities, vulnerability is an indicator of social inequity and inequality” (Nichiata et al., 2008, p. 925). Within this framework, vulnerability precedes risk and thus, diminishing or modifying social, economic, and political inequities can reduce risk.

Flaskerud and Winslow (1998) proposed a similar conceptual framework in which vulnerability is understood as the interplay between three distinct variables. Resource availability, relative risk, and the health status of a community all intersect to produce vulnerable communities or persons (Flaskerud & Winslow, 1998). Resource availability is an umbrella term that captures a variety of socioeconomic and environmental resources; income, employment, education, housing, social connectedness, and status intersect to impact vulnerability (Flaskerud & Winslow, 1998). Due to a lack of socioeconomic and environmental resources, populations may have increased “relative risk” (Flaskerud & Winslow, 1998). Finally, increased risk generates increased morbidity and mortality in a group (Flaskerud & Winslow, 1998).

These two conceptualizations are important in framing my understanding of the experiences of the study participants. The women I interviewed did not self identify as vulnerable but spoke at length about being deprived of basic resources, economic security, and adequate housing. They talked about loss of social connections, and experiences of discrimination and stigmatization. These experiences, in and of themselves, are essential components of vulnerability (Flaskerud & Winslow, 1998; Nichiata et al., 2008) and pushed the women I interviewed closer to the edge of hopelessness. However, the women I worked with refused to own conventional understandings of vulnerability and forced me to look at the oppressive social, political, and economic circumstances of their lives.

It is generally accepted that vulnerable individuals must accommodate, adjust, or assimilate to their situation (Tomm-Bonde, 2012). However, many of the women I interviewed appeared to reject this expectation and instead fought against oppression. For some of the women, this rejection happened silently as they smoked or injected illicit substances. For others, it happened loudly as they spoke out against those attempting to disempower them within healthcare settings. The refusal to adjust to vulnerabilities did not come without cost; the lived experience of social, economic, and political inequities impacted each participant's balance of hope and hopelessness. The move away from an individualistic understanding of vulnerability necessitates that registered nurses become more actively involved in advocacy and policy development so as to address distal factors that impact health.

**Substance use.**

Many of the women who participated in this research shared their experiences and struggles with substance use. The prevalence of this issue was not surprising to me given my professional experience working with this population and my review of existing literature pertaining to women who are homeless. Consistently, research evidence indicates that homeless women are more likely to use alcohol and drugs than other women (Galea & Vlahov, 2005; Wenzel et al., 2009). However, I was deeply struck by the complex manner in which substance use intersected with hope and was shocked to discover that illicit drug use both fosters hope and hopelessness while often simultaneously preventing hope and hopelessness.

Within my study, many of the participants spoke of how being denied assistance and the loss of loved ones and friends pushed them towards the edge of hopelessness. Substances were commonly used to prevent experiencing utter despair and hopelessness and at times, the use of illicit drugs pushed away feelings of loneliness and isolation. As well, many of the participants spoke of the use of stimulants as a method to ensure their individual safety while street homeless. These findings support the importance of social contextual factors as contributing to high rates of substance use amongst homeless women and highlight the importance of the development of robust and diverse social networks for this population.

Given the importance of substance use in the lived experience of hope amongst the research participants and the fact that these findings are not documented within existing research or literature, this subject warrants further discussion. Within this subsection, I

will discuss the prevalence of substance use issues amongst women who are homeless and the connections between social support, hopelessness, and substance use for the study participants.

For many years, it has been believed that homeless men have significantly higher rates of drug use disorders than their female counterparts. Although research evidence has contributed to this understanding, it has also been criticized as for decades most studies assessing homeless individuals have predominantly been composed of men. As the research community began to recognize increasing rates of homelessness amongst women and the unique needs of this population, specific attention has been paid to women who are homeless.

A growing body of research indicates that there are significant differences between homeless men and women and their engagement in substance use (Torchalla et al., 2011). In a study by Stein and Gelberg (1995) women who are homeless were found to have stronger associations between illicit drug use and criminal activity and between co-occurring alcohol and drug use than homeless men. In another study, younger homeless women were also found to have a higher risk for alcohol disorders than men (Beijer & Andréasson, 2010). Although comparing the experiences of homeless men and women generates useful knowledge, it is equally important to focus on capturing the nature and characteristics of substance use amongst homeless women without feeling compelled to compare these experiences to those of their male counterparts.

Without question, substance use rates amongst women who are homeless are considerably higher than the rates of substance use for women within the general

population. One area of particular concern is the high rates of crack cocaine use amongst this population. A recent Canadian study that recruited homeless women from three cities indicates that amongst this sample crack cocaine is the most commonly used drug (Torchalla et al., 2011). This result has been found in other studies amongst homeless women (Nyamathi, Longshore, Keenan, Lesser, & Leak, 2001) and may be related to the accessibility and affordability of the drug within Canada (Fischer et al., 2006) and the United States of America. As the use of crack cocaine is associated with high risk sexual practices and increased risk of HIV infection (DeBeck et al., 2009) the rate of crack cocaine use amongst women who are homeless is concerning.

Within Canada, women who have a history of suicide attempts have been found to be nearly three times more likely to be drug dependant and women living on the street were twice as likely to engage in severe substance use as compared to women living in shelters (Torchalla et al., 2011). These findings are particularly alarming given the high rate of self-identified struggles with substance use amongst the women in my research sample. Furthermore, given the articulated difficulty maintaining hope in the face of homelessness (even when living in shelter) for the study participants and the interconnection between hope and suicide, it would be extremely challenging for the women I interviewed to move away from engagement in substance use. They all struggled with hopelessness and despair, thus potentially increasing their risk of suicide. Substance use was one of the most common means through which the women I spoke with managed to keep hopelessness at bay; when enduring such extreme hopelessness and despair, how could the study participants possibly restrain themselves from the comfort of illicit drugs?

Engagement in problematic substance use significantly threatens the health of homeless persons. Although already at increased risk for a variety of acute and chronic health challenges, increased use of substances places homeless women at risk for hepatitis C and HIV (Rosenblum, Zlotnick, & Westerfelt, 1997; Spittal et al., 2006). As well, homeless individuals with problematic substance use have a higher occurrence of mental health challenges than homeless persons who do not use substances (Beijer & Andréasson, 2010). Furthermore, it is thought that increased rates of morbidity and mortality amongst women is connected to high rates of substance use (Hwang et al., 2009). In Vancouver, females engaged in intravenous drug use have mortality rates almost fifty times higher than the general female population (Spittal et al., 2006). Spittal et al.'s (2006) study of homeless women in Vancouver found that involvement in sex-trade, HIV infection, and unstable housing were associated with increased mortality rates.

In order to better understand high rates of substance use amongst women experiencing homelessness, it is important to explore the role of social contextual factors. These factors may play a key role in preventing women who are homeless from engaging in substance use treatment programs and thus, interfere with an individual's capacity to move away from harmful substance use. For women who are homeless, the use of alcohol and drugs by members of their social networks has been found to increase their engagement in problematic substance use (Wenzel et al., 2009; Williams & Latkin, 2007). Social network barriers to engagement in substance use treatment include involvement in street culture, in which a woman garners much of her social support from relationships developed on the street (Tucker, Wenzel, Golinelli, Zhou, & Green Jr., 2011). As well, women with a

protracted history of homelessness have been found to have a decreased likelihood of accessing treatment (Tucker et al., 2011).

All of the women who I spoke with talked extensively about challenges securing and maintaining housing and their individual hope that they could secure safe and affordable housing outside of the Downtown Eastside of Vancouver. They also spoke at length about the barriers and challenges achieving this hope and how their inability to obtain housing threatened their equilibrium and pushed them towards hopelessness. 'Support and love' were key to maintaining hope and while homeless, intimate connections were developed on the street with individuals who were often engaged in substance use. Furthermore, all of the women I interviewed had endured a lengthy history of homelessness, which impacted their experience of hope and may have prevented engagement in substance use treatment. Thus, the experience of homelessness and efforts to maintain hope in the face of challenges necessitated the development of relationships that may pose barriers to changing substance use patterns. This understanding highlights the need for safe and affordable housing for women faced with homelessness so as to address problematic substance use issues.

### **Advocacy.**

Nursing advocacy was identified as one of the ways in which registered nurses fostered hope in the healthcare experiences of the women I interviewed. For these women, advocacy involved speaking up for them when other healthcare professionals refused to listen. Nursing advocacy also involved respecting and defending each woman's unique understandings of their health and health care needs. This feeling of respect and

understanding stood in opposition to their perception that they were being dismissed due to lifestyle choices and engagement in substance use.

Advocacy for clients is considered to be an essential component of the nursing role. However, there is a diversity of understandings pertaining to the nature of advocacy and how this role is enacted within the nursing profession (Curtin, 1979; Gadow, 1980). Advocacy within the healthcare arena has typically been defined as an active process of supporting and promoting client's health care rights. The focus of nursing advocacy is not limited to the individual person but encompasses health and policy initiatives that focus on equity and quality of care. A nurse advocate is seen as empowering, representative, therapeutic, and as a protector of basic rights (Hanks, 2007).

The Canadian Nurses Association (2008) identifies the promotion and respect of informed decision making as one of seven primary values that guide ethical nursing practice. The Canadian Nurses Association (2008) also states that "nurses uphold principles of justice by safeguarding human rights, equity and fairness and by promoting the public good" (p. 17). Included in this ethical value is the responsibility to refrain from discriminating or judging a person based on lifestyle choices, economic status, gender, culture, ethnicity, or any other attribute (Canadian Nurses Association, 2008).

Within the western world, the nursing profession began to speak out about health advocacy during the patient rights movement of the 1970s (Lamb, 2004). Initially, the central focus was on the rights of clients to be informed about treatment or to refuse treatment (Lamb, 2004). Although the underlying premise for this interest has shifted from legal rights of clients to the moral obligations of the nursing profession, concern for

informed decision-making and autonomy within healthcare remains a central tenet of professional nursing practice.

Various nursing philosophers have shaped contemporary understanding of nursing advocacy. Curtin (1979), Kohnke (1982) and Gadow (1980) are most commonly referenced within nursing literature as significant contributors to the development of the role of advocacy amongst the nursing profession. A brief examination of each of these authors' perspectives will follow so as to elucidate the definition of nursing advocacy and key components of this role.

Curtin's (1979) understanding of advocacy is upheld by the assumptions that the focus of nursing is the welfare of human beings and that human rights are shaped by the needs of human beings. Thus, the foundation of the nurse-patient relationship is human advocacy (Mallik, 1997). Similar to Curtin's (1979) understanding, Kohnke (1982) believes that clients have a right to self-determination. The role of the nurse advocate is to both inform clients of their options and support their decision-making (Hanks, 2005).

Of particular importance to nursing advocacy amongst marginalized populations is the work of Sally Gadow (1980). Gadow's (1989) understanding of advocacy, called existential advocacy, acknowledges that only the client can know what is or is not in their best interest, and that the nurse engages in assisting the client through a fluid process of discovery and rediscovery. Furthermore, the nurse as an advocate is concerned with a client's self-determination and recognizes the complexity of his or her experiences and meanings (Gadow, 1989). Finally, Gadow (1989) contends that advocacy is a moral

imperative for nurses who work amongst persons who are unheard and that they are keenly positioned to enhance individual and community autonomy.

Consequences of advocacy have been well documented with a variety of client populations and from the perspectives of registered nurses and clients, but primarily in theoretical literature. The outcomes of nursing advocacy, as explored in theoretical literature, include client empowerment, improved well-being and nursing autonomy and empowerment (Vaartio & Leino-Kilpi, 2004). Research studies documenting the aforementioned client outcomes relating to nursing advocacy are limited (Vaartio & Leino-Kilpi, 2004). Research studies that explore nursing outcomes of enacting client advocacy imply that nurses may have perceived empowerment and autonomy but also that client advocacy may place a nurse in opposition with colleagues and employer (Vaartio & Leino-Kilpi, 2004).

Despite the importance of advocacy to the experience of hope for the women who participated in this study, it was identified as something unique and unexpected and stood in opposition to the more common experiences of feeling judged and discriminated. Perceptions of stigmatization and unwelcomeness amongst homeless women attempting to access healthcare has been well documented (Butters & Erickson, 2003; Gelberg et al, 2004; Wen, Hudak, & Hwang, 2007) and indicates that registered nurses are not always able to uphold the ethical values outlined by professional bodies. The importance of nursing advocacy for vulnerable populations should not be diminished as enactment of this role has the capacity to impact quality of life and health at the individual, community and

global level. Furthermore, nurses advocating for clients with other health care providers has the capacity to challenge stigma and discrimination.

### **Implications for Nursing**

In this section, given the discussion above, I explore implications for nursing practice, nursing education, program and policy development, and potential areas for further research evaluation.

#### **Implications for nursing practice.**

The importance of thoughtful and skilled communication when working with women who are homeless cannot be stressed enough. In fact, this is critical for all nurses working with any person experiencing homelessness. Registered nurses must engage with these clients in an open and accessible manner so as to establish therapeutic relationships that promote timely access to health care. Accessibility and openness can be demonstrated by simply calling a client by their name, stopping to ask how they are doing, and remembering and commenting on details from previous conversations.

Recognition that women who are homeless experience increased rates of suicidal thoughts and actions warrants a shift in current nursing practices. The importance of risk assessments should not be underplayed with this population. Registered nurses must increase their comfort and skills in assessing thoughts of self-harm amongst this population. Assessment skills must be accompanied by competencies related to suicide intervention and prevention. It is important that risk assessments are built into interactions so as to avoid threatening clients or appearing intrusive; integrating questions pertaining to thoughts of self-harm into general assessments of well-being and health

ensures that clients feel open to share their feelings and experiences. As well, registered nurses must be alert to verbal and non-verbal expressions of hopelessness that might cue the need for further, more detailed assessment.

Presuming that hope has the capacity to prevent suicidal thoughts and actions, registered nurses must also begin to actively engage in dialogue about hope with female clients who are or have experienced homelessness. The use of open-ended questions and empathic listening coupled with a non-judgmental attitude are essential to these conversations. Not only should this dialogue involve inquiries into the current hopes of the clients but it should also involve collaborative efforts at generating ideas on how these hopes can be achieved. The use of strength-based assessments to highlight the capacities and skills of individuals is a beneficial way to frame these interactions (Rapp & Goscha, 2012). The identification of individual strengths and hopes lends itself to the articulation of client goals and ways in which these can be achieved. Furthermore, it is important that registered nurses begin to engage in conversations with women experiencing homelessness about how their professional actions can impact experiences of hope and adjust behaviors accordingly.

Along with this focus, registered nurses should also move towards inquiries related to the meaning and importance of advocacy with this population. The women who participated in this study were highly sensitized to words or actions that they perceived as discriminating or stigmatizing and conversely, their experience of hope was fostered by registered nurses who stood up for their unique understanding related to health and wellness. This understanding can only be gained through engagement in individual

conversations with female clients who are homeless. Ultimately, it becomes the professional responsibility of individual registered nurses to exercise caution when working with homeless women so as to ensure that their verbal and non-verbal communication does not inadvertently contribute to experiences of hopelessness. The women I spoke with talked extensively about the importance of being acknowledged for their unique understanding of health and wellness; creating safe space for the articulation of these understandings and standing up to others who opposed individual values and meaning inspired hope amongst the study participants.

The use of skilled communication and respectful curiosity could also ensure that registered nurses gain a better understanding of the factors that intersect within a women's life to create and sustain the experiences of homelessness. Given that many of the participants in this study felt unheard and disregarded, the cocreation of health care interactions in which she feels heard is essential for women experiencing homelessness.

Nursing advocacy must extend beyond the issues of the individual and should involve advocacy actions that address the social conditions that create vulnerability and address the need for basic resources such as food and housing. Within settings of employment, registered nurses can increase awareness of the social determinants of health and inequities amongst team members, managers, and organizational leaders. As well, nursing advocacy can challenge discrimination and stigma in their practice. Outside of workplace settings, registered nurses can become involved in local or international groups that focus on addressing health inequities, such as anti-poverty groups. Regardless of the

nature and type of involvement in advocacy, registered nurses are well positioned to integrate their social justice mandate into direct clinical practice.

### **Implications for nursing education.**

Women experiencing homelessness are faced with a diverse range of challenges and thus, registered nurses who engage with this population require an equally broad education. However, this is challenging as homeless women often present as clients within a variety of generalist and specialized healthcare areas and nursing interest in this population may vary across sites. Therefore, I will discuss essential nursing education offered by schools of nursing to prepare newly graduating registered nurses for a variety of settings prior to discussing the need for more advanced and specific education.

Within the schools of nursing offered in Canada, there is no comprehensive list of proposed competencies for graduating nurses that address the needs of marginalized populations. However, community placements are a common component of clinical preparation of graduating student nurses and may provide some beginning experiences with healthcare delivery to homeless populations. Alongside these clinical placements, it is important that nursing faculty engage student nurses in education pertaining to the social determinants of health, social justice theories, and harm reduction philosophies. As well, conveying an understanding of the prevalence of homelessness may encourage nursing students to become aware of their clients who are living in or threatened by homelessness.

Focused education should be provided to practicing nurses who are engaged in work with women who are homeless. Settings that may benefit from these educational initiatives could include community health care centers, emergency departments, and

acute medical units within hospitals. Educational initiatives could focus on advancing the skills recommended as a key component of basic preparation of registered nurses and also providing increased educational inservices pertaining to current treatment modalities for health challenges commonly experienced by women who are homeless. Education related to conflict resolution, non-violent crisis intervention, and various communication techniques could further enhance a registered nurses capacity to engage with homeless women.

Given the diversity of health challenges that women who are homeless face, there is the need for advanced practice nursing (APN) involvement with this population. APNs with focused and specific clinical expertise would be well positioned to address the multitude of health challenges experienced by women who are homeless. As well, the leadership and research competencies that are developed during post-graduate nursing education would be of great benefit to this population and are necessary attributes so as to address the intersecting factors that perpetuate health inequities.

### **Implications for program and policy development.**

There is a need for projects and programs that specifically address the needs of women who are homeless. The development of comprehensive programs that provide low-barrier access to health care, housing, financial and substance use support are essential so as to mitigate the challenges associated with poverty and homelessness. However, programs need to address much more than just the immediate securing of basic needs and should focus on assisting with the realization of dreams and goals. Development of such programs requires a philosophical orientation that includes, but is not limited to, an

understanding of strength-based assessments, cultural competency, harm reduction, social justice, feminism, and trauma-informed care.

All of the women I spoke with talked about their difficulties navigating systems while enduring complex health and substance use issues. Housing was identified as a priority by all of the women. However, many of them were unable to access safe and affordable housing. The importance of housing was also identified as an initial but necessary step in moving forward on other personal goals. The need for the development of low-cost, sustainable, and safe housing for women who are homeless is essential for the improvement of their health and well-being. Registered nurses not only could be involved in local and provincial advocacy for the development of housing but could also push for the integration of health care resources and nutritional programs within these sites.

Health care organizations that provide services for women who are homeless need to embrace a harm reduction approach. Strategically, this would mean that organizations made available harm reduction equipment, such as clean syringes, condoms, and crack pipes. The adoption of a harm reduction philosophy would also ensure that each client was treated with respect, included in decision-making, and viewed without judgment. The further integration of equity-focused strategies, such as cultural competency and trauma-informed care, would be of significant benefit. The cocreation of cultural safety within an organization could be used to reduce stigma and marginalization and thus, foster the experience of hope for women who are homeless. This may require a significant shift from traditional approaches and registered nurses could be key to the articulation and realization of these transitions. As well, the importance of assisting with the pursuit of

individual hopes should be pursued as an integral component of the role of the registered nurse regardless of whether they are directed at conventional health goals. Not only will this assist with the development of therapeutic alliance but also this assistance, in and of itself, may foster the experience of hope for an individual.

The reduction of health inequities is often the goal of nursing interactions with clients. However, a neo-liberal perspective in which individuals are understood to be autonomous persons capable of free decision-making commonly informs this purpose. Within this context, women who are homeless are often denigrated and blamed for their situation. Health care interactions shaped by this understanding address the most immediate and pressing concern of an individual rather than examining the complex social and structural conditions that intersect to create inequities.

Broader social policies such as housing policies and drug policies perpetuate the marginalization and oppression of women who are homeless. As discussed previously, housing insecurity within Canada is a consequence of a series of policy developments over the last thirty years. These policies effectively reduced income levels and affordable housing options. Income and housing insecurity is associated with increased food insecurity, which further challenges a person's health and wellbeing. Nursing involvement in housing, food, and income policy is necessary so as to address the health needs of women who are homeless. Advocacy for increased income for those on social assistance, improved access to employment insurance for women employed part-time, and increased development of affordable housing is an ethical imperative for nursing.

Current drug policy further exacerbates the oppression, poverty, and marginalization of women who are homeless and engaged in substance use. The criminalization of substance use means that women are forced to engage in sex trade to generate income and often use substances in unsafe situations to avoid legal repercussions. Furthermore, women are pushed to the margins of society and unable to retreat from living within unfavorable and undesirable living circumstances. The impact of drug policies on women who are homeless are far-reaching and diverse, but always increase health and healthcare inequities. Nursing involvement in drug policy is imperative so as to speak out against the inequities that are created by the ongoing criminalization of substance use (Pauly, 2008; Pauly, Goldstone, McDall, Gold, & Payne, 2007).

#### **Implications for future research.**

This research study can prompt both qualitative and quantitative investigations that further explore the meaning and experience of hope as understood by women who are homeless. I propose that the following areas of research warrant further exploration; the role of registered nurses as a barrier and support to hope, the relationship between substance use and hope, the protective capacity of hope, and the connection between housing and hope. As well, I suggest that future research that pays particular attention to diversity among women experiencing homelessness and focuses on exploring potential differences among Aboriginal and non-Aboriginal women would be of great benefit. The following list is not meant to be exhaustive but rather to provide examples of areas of future research that would build on the findings from this study.

The role of registered nurses in preventing and fostering hope has been explored in various populations. However, very little is known about how registered nurses impact this experience for women who are homeless. The participants in my study drew upon their experiences within both the hospital and community setting when speaking to this area. An area for future research would be to distinguish the setting in which interactions occurred with registered nurses so as to gain a better understanding of what specifically fosters hope. As well, this could help identify structural features intrinsic to each setting that affect the phenomenon of hope.

The complexities of the relationships between substance use and hope for women in this study were overwhelming and warrant further attention. Future research could focus on the realization of a specific hope, such as housing, and the subsequent impact on substance use struggles. A further area of research inquiry could include an evaluation of whether registered nurses' actions that foster hope affect substance use patterns for women experiencing homelessness.

There is very little empirical evidence to support the existence of a relationship between hope and suicide. However, many of the participants in my study shared their understandings that hope helped them persevere with their struggles. As homeless women experience increased incidences of suicidal thoughts and actions as compared to their housed counterparts, developing an understanding of the connection between hope and suicide is very important. Quantitatively, this could be explored through the administration of both hope and suicide scales to assess the relationship. Qualitatively,

researchers could engage women who are homeless to discuss their understandings of hope's role in preventing suicidal thoughts or actions.

Housing was identified as the most significant hope amongst all of my study participants. Interestingly enough, the women I spoke with were able to maintain hope in their lives despite being deprived of this aspiration. Research that further addresses the connections between housing and hope for this population could focus on interviewing recently housed women and discussing the impact on their experience of hope.

### **Conclusion**

The meaning and value of hope for women experiencing homelessness is complex. The women who participated in my study provided insights into their unique experiences and understandings. The challenges that women who are homeless face are multiple and overwhelming and these struggles shape their understanding of both hope and hopelessness. Maintaining balance, while faced with the experience of homelessness, requires amazing strength and resilience.

The women in my study have inspired me to be more mindful and reflective of my professional actions and inactions. I have gained a deeper understanding of the meaning and value of hope in their lives and the ways in which I can foster hope for women who are experiencing homelessness. As well, through this journey I gained insight into the value and meaning of hope in my life. As I conclude this research project I hold onto the hope that the women I interviewed are able to move towards their preferred versions of self. I hope that there will be an end to homelessness, an end to oppression, and an end to the

structural conditions that support health inequities. And I wish that all persons experiencing homelessness will be able to maintain their equilibrium and grasp onto hope.

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**Appendix A  
Recruitment Poster**

EXPERIENCES OF HOPE  
AMONGST HOMELESS WOMEN

Are you interested in  
participating in a research project  
exploring the meaning of hope  
and how registered nurses  
limit and support hope?

Are you?

- Female
- Nineteen or older
- Homeless within the last twelve months

Please contact **Kim at (xxx) xxx-xxxx** or via email  
at \_\_\_\_\_ to discuss possible involvement. An  
honorarium will be provided  
as compensation for your time and effort.

UNIVERSITY OF VICTORIA  
SCHOOL OF NURSING  
GRADUATE STUDENT RESEARCH PROJECT

## **Appendix B**

### **Information Letter for Triage Shelter**

#### **Experiences of Hope Amongst Homeless Women**

University of Victoria  
School of Nursing

*Agreement to Participate*

#### **Background**

As part of my graduate studies at the University of Victoria School of Nursing I am required to conduct a research project. The purpose of my research study is to develop an understanding of how women who are homeless experience hope. Research objectives include:

- a) obtaining a description of the meaning of hope for women experiencing homelessness
- b) describing supports and barriers in the promotion of hope
- c) describing the role of registered nursing in fostering or limiting hope

#### **Who is the research team and what is the timeline?**

I will be the sole investigator for this research project. I can be contacted at (xxx)-xxx-xxx or via email at \_\_\_\_\_ if you have any questions or concerns. I will be working under the supervision of Dr. Bernadette Pauly. Dr. Pauly can be contacted at (xxx)-xxx-xxxx or via email at \_\_\_\_\_.

Data collection at your site would take between one and four months and likely would begin in February 2012.

#### **What is Being Asked of Staff?**

Staff will not be asked to participate in any interviews or observational sessions. Staff will play a key role in recruitment of potential participants and facilitation of interviews. Recruitment strategies will involve postering at your site and establishing routine on-site hours for screening potential participants and interviewing women who have been referred by staff or other participants. I anticipate that interested women may connect with staff to discuss the research project and arrange interviews. Staff will be provided with a recruitment script that concisely outlines the purpose of the research project, details pertaining to participant involvement and compensation. Some participants may experience emotional and psychological stress during and following the interview and if this does occur, an individual may rely on staff for support or intervention. I will require the use of a private space in which to conduct interviews.

#### **What is Being Asked of Participants?**

Women who are interested in participating in this research project will be asked to meet with the researcher and be interviewed. All interviews will be audio recorded and field

notes will be collected during the interview. Interviews will last approximately forty-five to sixty minutes. Participants will receive an honorarium in appreciation of their time and effort.

**What is in it for your site?**

Women are a rapidly growing subpopulation of those experiencing homelessness. This research will provide an opportunity to develop understanding about the experience of hope for homeless women and will highlight supports and barriers to the experiences of hope. Women experiencing homelessness will be afforded the opportunity to speak to their understanding and this dialogue, in and of itself, may have therapeutic value. Research findings will be shared with the sites of recruitment in the form of a short written summary. This summary will also be shared with interested participants. This summary could be utilized to adapt service provision so as to promote hope.

By signing below, I agree that Kim Markel can utilize Triage Shelter as a site of recruitment and interviewing for the research project *Experiences of Hope Amongst Homeless Women*.

---

*Printed Name*

---

*Signature*

---

*Date*

## **Appendix C**

### **In Person Recruitment Script**

I understand that you may be interested in participating in this study about the meaning of hope for homeless women. I'd like to take a few moments of your time to tell you about the study and discuss the guidelines for participating and answer any questions you may have. First, I need to ask you a few questions to make sure that you are able to participate in this study.

#### Recruitment Criteria Questions

1. Do you identify as female?
2. How old are you?
3. Have you been homeless within the last twelve months?

#### Purpose and Details of Study

I am completing my Master's in Nursing at the University of Victoria; this research study is a key focus of my program. The purpose of my research study is to develop an understanding of hope for women experiencing homelessness. In particular, I am interested in understanding what supports or prevents hope for homeless women and describing the role of the registered nurse in fostering or limiting hope. This understanding could contribute to improving nursing practice and could be used to shape program and service development. Participation in this study involves an interview, which will last approximately one hour. Interviews will take place within the community and will be audio recorded. Your confidentiality and anonymity will be assured. An honorarium of twenty dollars will be provided as compensation for your time and effort. Do you have any questions about the research project?

#### Interview Location

If you are interested in participating in this study, I would like to set up an interview time and location. Are you available now? If not, is there a location and time that you would suggest? Is there any way in which I can contact you, before then, if needed?

## **Appendix D**

### **Recruitment Script for Agency Staff**

Kim is a university student who is doing a research project as part of her studies. She is interested in interviewing women nineteen years and older who have been homeless within the last twelve months. The interview takes between thirty to sixty minutes. She will ask you questions about your experiences of hope while homeless and in particular, will ask you what supports or prevents hope for you. Some of her questions will be related to your experience of hope within healthcare interactions with registered nurses. Your interview will be audio recorded, however, all information you share will remain confidential.

If you chose to participate, Kim is offering a twenty-dollar cash honorarium in appreciation of your time and effort. If you are interested in participating or have any questions or concerns, you can call Kim at (xxx)-xxx-xxxx or email her at \_\_\_\_\_.

As well, Kim will be here (specify day of the week) from (specify hours) to screen and interview interested individuals.

## Appendix E Demographic Information Questionnaire

1. Do you self-identify as female? Yes/no
2. How old are you?
3. Have you slept in a shelter bed within the last twelve months? Yes/no  
If yes:
  - When were you staying in a shelter (month/year)?
  - How long did you stay in shelter (days/months)?
4. Have you slept on the street within the last twelve months? Yes/no  
If yes:
  - When were you sleeping on the street (month/year)?
  - How long did you sleep on the street (days/months)?
5. Within the last twelve months have you slept in an abandoned building or vehicle?  
Yes/no  
If yes:
  - When were you sleeping in this location (month/year)?
  - How long did you sleep there (days/months)?
6. Within the last twelve months have you been in custody or hospital and had no place to go upon discharge? Yes/no  
If yes:
  - When were you released from hospital/jail (month/year)?
  - How long did it take you to get a safe place to sleep (days/months)?
7. What has been your source/s of income over the last twelve months?
  - employed
  - employment insurance
  - basic income assistance
  - income assistance (persons with disabilities)
  - pension
  - panhandling
  - other activities
8. Where you born in Canada? Yes/no  
If yes:
  - Were you born in British Columbia?
  - If no:
  - What province were you born in?

- When did you move to BC (month/year)?

If no:

- Where were you born?
- When did you move to Canada (month/year)?
- When did you move to BC (month/year)?

9. What ethnic group or family do you identify yourself as?

- White
- Chinese
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Filipino
- Latin American
- Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- Arab (e.g., Arabic speaking, Maghrebi)
- West Asian (e.g., Afghan, Iranian, Israeli, Turk, etc.)
- Japanese
- Aboriginal (e.g. North American Indian, Metis, Inuit)
- Black (e.g. African, Jamaican or Caribbean)
- Other
- Don't know
- Refused

10. What is your highest level of education?

- university/college
- completed grade twelve
- other

11. Do you have children?

If yes:

- How many?

12. What is your marital status within the past twelve months?

- single
- common law
- married
- separated/divorced

## Appendix F Interview Questions

### Interview Questions

*The purpose of this interview is to get your perspective on the meaning of hope and to explore what supports and prevents hope for women experiencing homelessness. There are no right or wrong answers. I'd ask you to be honest and open, and please remember that what you say is confidential. The interviews will be recorded and then transcribed, but all names will be removed from the written transcripts. If you don't feel comfortable answering a question, or don't want to answer, that's not a problem.*

Questions	Probes
<ul style="list-style-type: none"> <li>• Please tell me about your current housing situation.</li> </ul>	<ul style="list-style-type: none"> <li>• When did you last have housing?</li> <li>• Where are you currently staying or sleeping?</li> <li>• What stands in the way of you securing safe housing?</li> <li>• How do you feel about your current housing situation?</li> </ul>
<ul style="list-style-type: none"> <li>• Can you share with me a situation in which you experienced hope/hopefulness?</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me more about this</li> <li>• And what happened then?</li> <li>• What was it about this situation that made you experience hope/hopefulness?</li> </ul>
<ul style="list-style-type: none"> <li>• Can you share with me a situation in which you experienced hopelessness?</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me more about this</li> <li>• And what happened then?</li> <li>• What was it about this situation that made you experience hopelessness?</li> </ul>
<ul style="list-style-type: none"> <li>• What does hope mean to you? How do you understand hope?</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me more about this</li> <li>• Is hope important to you? Why/why not?</li> <li>• How would you describe/define hope?</li> <li>• What about hopelessness?</li> <li>• How would you describe/define hopelessness?</li> <li>• What do you think contributes to hopelessness?</li> <li>• How do you think hopelessness impacts your life and the lives of</li> </ul>

	others?
<ul style="list-style-type: none"> <li>• What do you currently hope for?</li> </ul>	<ul style="list-style-type: none"> <li>• How do you imagine achieving these hopes?</li> <li>• What or who stands in the way of hope?</li> <li>• What or who encourages hope?</li> </ul>
<ul style="list-style-type: none"> <li>• Now I would like to ask you about your experiences of hope in healthcare.</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me about a health care experience in which you felt hopeful.</li> <li>• Tell me about a health care experience in which you felt hopeless.</li> <li>• What about these experiences made you feel hope/hopelessness.</li> <li>• What do you think would make it easier for you to go to the hospital or the clinic when you're sick?</li> </ul>
<ul style="list-style-type: none"> <li>• How do nurses impact your experiences of hope in healthcare?</li> </ul>	<ul style="list-style-type: none"> <li>• Tell me about a time or experience when a nurse did something that made you lose hope.</li> <li>• What did this nurse do/say that made you feel hopeless.</li> <li>• Tell me more about this.</li> <li>• Tell me about a time or experience when a nurse did something that made you feel hope or hopeful.</li> <li>• What did this nurse do/say that supported your experience of hope?</li> <li>• What was it about this nurse/nursing action that impacted your experience of hope?</li> </ul>
<ul style="list-style-type: none"> <li>• Is there anything else I should know about your experience of hope that I didn't ask?</li> </ul>	

## **Appendix G Informed Consent**

University of Victoria  
School of Nursing

*Participant Consent Form*

### **Experiences of Hope Amongst Homeless Women**

You are invited to participate in a study entitled *Experiences of Hope Amongst Homeless Women* that is being conducted by Kim Markel.

Kim Markel is a Master's student in the School of Nursing at the University of Victoria and you may contact her at (xxx) xxx-xxxx or via email at \_\_\_\_\_ if you have further questions.

As a graduate student, I am required to conduct research as part of the requirements for a Master's degree in Nursing. It is being conducted under the supervision of Dr. Bernadette Pauly. You may contact my supervisor at (xxx) xxx-xxxx or via email at \_\_\_\_\_.

#### **Purpose and Objectives**

The purpose of this research project is to develop an understanding of hope for women experiencing homelessness. The main goals of this research are to:

- a) obtain a description of the meaning of hope for women experiencing homelessness
- b) describe supports and barriers to the experience of hope for women experiencing homelessness
- c) describe how registered nurses' actions impact the experience of hope

#### **Importance of this Research**

Research of this type is important because women are a growing group amongst homeless people. Hope is generally accepted as being essential to health and well-being. An understanding of hope for homeless women is important. This understanding could improve nursing practice and could be used to shape programs and services.

#### **Participant Selection**

You are being asked to participate in this study because you have self-identified as a woman over the age of nineteen years old that has been homeless within the last twelve months.

**What is involved?**

Participation in this study is voluntary. If you agree to participate, there will be a face-to-face interview, which will last between thirty and sixty minutes. The interview will occur at Triage Shelter or at another place in Vancouver.

The interview will be recorded and written notes may be taken. The recording from the interview will be changed to a written form.

**Inconvenience**

The interview will involve questions that are personal and could cause you to feel stressed or upset. As well, the interview may get in the way of work hours or family duties.

**Risk**

There are some possible risks to you by participating in this research and they may involve stress, fatigue and/or discomfort. You may ask to skip certain questions or ask for a break at any time during the interview.

**Benefits**

This research will allow you to share your personal experiences of hope and homelessness. The findings will be shared with others and could help shape programs and services. As well, the findings could help improve the way that registered nurses work with homeless women.

**Compensation**

You will be given twenty dollars cash after your interview. This money is not meant to convince you to do an interview. If the money is the only reason you wish to participate, then you should say no.

**Voluntary Participation**

Your participation must be completely voluntary. If you do decide to participate, you may withdraw at any time for any reason. You may decline to answer any questions; however, your other answers will be used for this research with your consent. There will be no changes to services and/or supports at Triage Shelter if you withdraw from the study at any point in time.

**Anonymity**

When results are shared, they will not include any information that can be used to identify you.

**Confidentiality**

Confidentiality will be protected throughout the research process. Participants will be identified by a number and no identifying features or information will be shared. All interview data will be stored in either a locked filing cabinet or as a password protected

computer file. All data will be destroyed once the research project is done and the results are published, a period not exceeding five years.

The only time that your confidentiality will not be protected is if you present as a risk of harm to yourself or others. If this occurs, emergency services such as the ambulance or police may be contacted.

### **Dissemination of Results**

The results of this study will be shared with others via thesis presentation and potential publication. Study results, as per University of Victoria procedure, will be posted on the Internet. A written summary of results will be provided to recruitment site/s and is available for any and all interested participants. To request study results, please contact me via telephone at (xxx) xxx-xxxx or via email at \_\_\_\_\_.

### **Disposal of Data**

Paper notes from this study will be shredded and electronic data will be erased following presentation and publication.

### **Contacts**

Individuals that may be contacted regarding this study include the researcher and supervisor. Contact information is listed at the beginning of this consent form.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria ((250) 472-4545 or [ethics@uvic.ca](mailto:ethics@uvic.ca)).

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

\_\_\_\_\_  
*Name of Participant*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*A copy of this consent will be left with you, and the researcher will take a copy.*