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A QUALITATIVE EXPLORATION OF THE LIVED EXPERIENCE OF BEING HOMELESS

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General Abstract

Homelessness is a complex problem which has significant implications on an individual and societal level. There is strong evidence to suggest that amongst the contributory factors to becoming homeless, mental health problems and an increased vulnerability to substance misuse and addiction feature highly. Furthermore, traumatic events are often seen as contributory factors to mental health difficulties and substance misuse, whilst trauma experience has been identified as a risk factor for homelessness. Prevalence rates for psychological disorders related to trauma in high risk groups, such as war veterans, are significantly higher than the general population and as many as 6 per cent of homeless people are ex-Armed Forces personnel. The first section of this thesis is a narrative literature review summarising the existing literature linking trauma and homelessness and examining the current research for an association between trauma experienced during military service and homelessness. In addition, the clinical implications linked to the present diagnostic process and treatment approaches for trauma-related disorders are considered.

The second section of this thesis is a qualitative study undertaken to explore the experiences of ten individuals, seven males and three females, residing in a homeless hostel who gave their accounts during semi-structured interviews. Interpretative Phenomenological Analysis was utilised in an effort to gain insight into the meaning of trauma within the lived experience of homelessness. The themes produced relate to the construal of the homelessness pathway, the impact of homelessness, and coping; with additional overarching themes of trauma and responsibility. The findings illustrate that the factors that influence the onset and maintenance of homelessness are complex and multifaceted and reflect the uniqueness of individual participant's accounts whilst recognising the commonalities of their experiences. The clinical implications of the research findings are discussed including directions for future research.

Contents

Disclaimer Statement

I, the undersigned, confirm that the work that I have presented as my thesis is entirely my own work. Reference to, quotations from, and discussion of the work of any other person has been correctly acknowledged with the work in accordance with University of Southampton guidelines for production of a thesis.

Melissa Watts

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Literature Review Paper

THE ROLE OF TRAUMA IN THE HOMELESSNESS OF MILITARY VETERANS: A NARRATIVE REVIEW

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Abstract

In addition to mental health problems and substance misuse, the experience of trauma is often implicated as a contributory factor in the onset and maintenance of homelessness, with a large percentage of homeless individuals found to have trauma related disorders. Whilst evidence suggests that exposure over the lifetime to traumatic events is relatively common, for the majority of people recovery is spontaneous although prevalence rates for psychological disorders related to trauma in high risk groups, such as war veterans, are significantly higher. This narrative literature review therefore evaluates the current literature regarding the relationship between trauma experienced during military service and the risk of homelessness after discharge, given the significance of an estimated 1,100 homeless ex-service personnel living in London on any given night. The research indicates that although trauma experienced during military service may have a detrimental effect on mental health, trauma experienced pre-enlistment is a more positive predictor, alongside extant demographic features such as age, education, and relationships status, for later homelessness. Factors also connected with an increased risk for homelessness amongst ex-military personnel include substance and alcohol misuse and, whilst these may arise in relation to mental health and adjustment difficulties, it is suggested that the link with trauma exposure during military service is indirect. This important area requires further research attention, as does the diagnosis and treatment of trauma disorders and symptomology.

Introduction

Homelessness is a complex problem which has significant implications on an individual and societal level. There are over 43,600 bed spaces for single homeless people in emergency hostels and supported accommodation in England (St Mungo's, 2009a). The Department for Communities and Local Government cite figures for Autumn 2011 showing a total of 2,181 people sleeping out across England on any given night (CLG, 2012), a rise of 413 (23%) from Autumn 2010 where the figure was 1,768. Resources were for many years directed at examining the social, economic and housing trends which contribute to the homelessness problem (Lister, 1998; Powell, 2000). However, more recent research is now examining the individual personal factors implicated in homelessness (Buhrich, Hodder & Teesson, 2000; Goering, Tolomiczenko, Sheldon, Boydell & Wasylenki, 2002; Goodman, Saxe & Harvey, 1991). There is strong evidence to suggest that amongst the contributory factors to becoming homeless, mental health problems (Buhrich et al., 2000, 2003; Fischer & Breakey, 1991; Kamieniecki, 2001; Randall, Britten & Craig, 2007; Rees, 2009; Scott, 1993) and an increased vulnerability to substance misuse and addiction feature highly (Goering et al., 2002; Fischer & Breakey, 1991; McCarty, Argeriou, Hueber & Lubran, 1991). Furthermore, traumatic events are often seen as contributory factors to mental health difficulties and substance misuse, whilst trauma experience has been identified as a risk factor for homelessness (for example, North & Smith, 1992; Taylor & Sharpe, 2008).

Up to 92% of homeless people have been found to have trauma related disorders (Bassuk, Buckner, Perloff & Bassuk, 1998; Buhrich et al., 2000). Lifetime prevalence rates for exposure to trauma range from 64 – 90%, with variance noted due to geography and issues of definition (Creamer, Burgess & McFarlane, 2001; Frans, Rimmo, Aberg & Fredrickson, 2005; Ozer, Best, Lipsey & Weiss, 2003). Not all of those individuals exposed to trauma go on to develop psychological disorders linked to their traumatic experience, with lifetime prevalence rates for conditions such as Post Traumatic Stress

Disorder (PTSD) estimated at 6.8% in a US study (Kessler et al., 2005). The reasons suggested for why people may go on to develop psychological disorder following traumatic experiences are linked to the past and present socio-cultural environment of the individual (de Vries, 1996) as well as risk factors such as lack of education and pre-existing disorders such as anxiety or depression (Ehlers, Mayou & Bryant, 1998; Macklin et al., 1998). Issues of social support, severity of the trauma, and other life stressors are also factors that are implicated in the development of PTSD (Brewin, Andrews & Valentine, 2000). Previous exposure to trauma and prolonged or repeated trauma can produce difficulties above and beyond those experienced following single incident trauma events, such as that linked with PTSD (Ford, 1999; Janoff-Bulman, 1992). Research looking at the coping styles of individuals following traumatic events has found that the way in which individuals emotionally and cognitively process such events may also influence the way in which they recover from the experience (Lazarus & Folkman, 1984; Moos & Schafer, 1993), with homelessness associated with avoidant coping and traumatic life events (Votta & Manion, 2003).

A population of people viewed as vulnerable to exposure to trauma are those who serve in the military. The role of the British military in peacekeeping, humanitarian aid operations, and disaster relief tasks has increased in recent times and in the last 20 years the UK armed forces have seen active involvement in conflict in former Yugoslavia, Iraq, and Afghanistan. Consequently the likelihood of experiencing events that may be classified as traumatic is increased. Whilst the factors linked with exposure to trauma may increase the risk of becoming homeless, additional risk factors include substance abuse problems that began in the military, inadequate preparation for civilian employment, and loss of a structured lifestyle (Mares & Rosenheck, 2004); all socio-cultural issues that may influence recovery from trauma, as discussed above. According to Defence Analytical Services and Advice (DASA) figures, in the 12 months prior to 30th September 2010, 18,240 people left the regular military forces in the UK (DASA, 2010). Prevalence estimates of 4% for PTSD amongst UK veterans (HLPR, 2010)

means that this equates to a figure of in excess of 700 individuals a year being discharged from the military who may fulfil the diagnostic criteria for PTSD. An evaluation of the number of veterans who do not fulfil the diagnostic criteria for PTSD, but nonetheless may struggle with the transition to a civilian lifestyle which is further compounded by the effects of combat trauma, is problematic. The relationship between PTSD and other symptoms associated with prolonged trauma has received scant attention (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005) with psychiatric problems that do not fulfil PTSD diagnostic criteria generally referred to as "comorbid conditions", which may have implications for the efficacy of treatment interventions (Spinazzola, Blaustein & van der Kolk, 2005).

It is reported that an estimated 6% of London's current single homeless population have served in the Armed Forces which equates to approximately 1,100 homeless ex-Service personnel living in London on any given night, as predominantly hostel residents but including some rough sleepers (Johnson, Jones & Rugg, 2008). Despite research interest linking trauma and homelessness, there is no narrative literature review which assembles and connects the current empirical evidence for the increased trauma that is encountered during military active service with an increased rate of homelessness among ex-service personnel. The main goal of this review is therefore to construct a comprehensive account of the available research findings related to the trauma history of military veterans and the consequent perceived risk for homelessness. Such research is needed in order to improve knowledge regarding the psychological mechanisms underlying homelessness and to further an understanding of the role of trauma in this. In order to address this gap in knowledge, this literature review explores the recent empirical evidence with the specific objectives of:

1) Clearly summarising the existing literature linking trauma and homelessness;
2) Determining if there is an association between trauma experienced during military service and homelessness;

3) Considering the clinical implications linked to the present diagnostic process of trauma-related disorders.

Methodological Approach

This literature review utilises a narrative approach and generates a qualitative overview of research related to the impact of trauma experienced during military service and subsequent risk of homelessness. The primary purpose of the narrative literature review is to provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of positive results or inconsistencies in the body of available knowledge (Cronin, Ryan & Coughlan, 2007). The review method utilises a descriptive format, producing a narrative account summarising the available literature. Searches for relevant literature and resources were undertaken using the databases *PsycInfo*, *PsycArticles, Medline* and *Web of Knowledge*. Keywords in various combinations were used to identify articles and included: homeless, homelessness, trauma, PTSD, military, veteran, combat, stress. The inclusion criteria required that the articles were published in a peer reviewed journal in the English language and were quantitative and/or qualitative data in nature. The articles identified were then examined for relevance before inclusion, with the reference lists of included resources also appraised for any applicable studies. Applying these inclusion and exclusion criteria, from the studies that were generated from the searches, 30 articles were included in the review. All other studies referred to that were not identified within this search strategy offer contextual information and theoretical content to the review.

Following the initial literature searches the decision was made to focus mainly on articles pertaining to the UK Armed Forces, where possible, with comparative information included from research with military services in other countries purely to provide clarity or additional information, where needed. This was done to reduce the corpus of data to a manageable quantity in order to focus the narrative of the review and was seen as a means of avoiding any confusion regarding differences in terminology, military service structure, and healthcare delivery. Furthermore, as the two main countries viewed as the foremost contributors to the body of research

evidence in these areas, UK and USA researchers report differences in prevalence rates for both homelessness and trauma disorders. Retaining a focus on research pertaining to the UK therefore reduces any ambiguity about research conclusions which may occur when examining the empirical evidence provided by researchers from both countries. Initial literature searches also identified a corpus of research exclusively examining military sexual trauma (for example, Hyun, Paveo & Kimerling, 2009; Kimerling, Gima, Smith, Street & Frayne, 2007; Kimerling et al., 2010; Suris & Lind, 2008) but as this research related to sexual assault experienced whilst serving in the armed forces, rather than focusing on combat trauma or impact of military deployment, it was decided these papers were not appropriate for inclusion. Whilst the impact of military sexual trauma has undoubted far-reaching implications for those involved, the rationale for excluding these papers from this review was connected to the fact that the nature of the trauma is seen as separate to that experienced during active military service and has indirect links with combat experience itself. As such, it is more closely aligned to previous research directly examining sexual assault trauma per se and homelessness.

Review synopsis

The initial section of this review introduces theoretical and empirical information regarding psychological reactions to trauma, first presenting an overview of the definition, epidemiology and diagnostic criteria of trauma symptomology and disorders to provide contextual understanding. Where possible this overview will include relevant available information pertaining to the populations forming the basis of this review; namely the homeless and military veterans. This will be followed by a consideration of the available literature that specifically addresses the trauma experiences of homeless people. Literature linking trauma with military service will be then presented before taking an explicit focus on the available evidence identifying military or combat trauma as a risk factor to later homelessness, following discharge from the armed forces. Issues of comorbidity will be presented throughout and discussed together with an examination of the methodological and conceptual limitations of the research, with future directions suggested. This will highlight the need for more investigations into the causal and maintaining factors of homelessness in order to enhance current services and to facilitate a greater understanding of the emotional and psychological needs of populations that, because of their trauma experiences, may be vulnerable to becoming homeless.

Results

Post Traumatic Stress Disorder

In order to elucidate a contextual understanding of how trauma may be implicated in the onset and maintenance of homelessness the following two sections present theoretical and empirical information that underpins current understanding about trauma disorders, commencing with an overview of Post-Traumatic Stress Disorder (PTSD). PTSD is classified as an anxiety disorder and characterised by the development of a range of distinguishing symptoms following exposure to a traumatic event. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) such traumatic events may include combat, sexual or physical assault, being a witness to another being killed or injured, and natural or accidental disaster or extreme adversity. Such events are perceived to be of sufficient severity to induce a response of fear, helplessness, or horror. The symptomology experienced comprises of intrusive re-experiencing of the event, avoidance of stimuli associated with the traumatic experience, emotional dysregulation, and persistent physiological arousal. For a formal diagnosis of PTSD to be made the symptoms must be present for at least a month and cause significant distress and impairment to an individual's social or occupational functioning. Mild or occasional symptoms not fulfilling these criteria are viewed as normal reactions to stressful events and therefore do not warrant diagnosis. A diagnosis of Acute Stress Disorder may be made if, following a traumatic incident, significant impairment to social or occupational functioning occurs, with such disturbance lasting more than two days and a maximum of four weeks after the traumatic event (APA, 2000). If symptoms persist for longer than this period a diagnosis of PTSD may be applied.

The lifetime prevalence of PTSD had previously been estimated between 8-14% in the general population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), with a more recent examination of diagnostic figures finding lifetime prevalence among adult Americans to be 6.8% (Kessler et al., 2005).

Kessler et al. (1995) found gender differences in PTSD rates following a traumatic event, with figures of 20% of women and 8% of men, attributing these differences to the fact that the trauma women were more likely to experience was associated with a higher probability of PTSD, such as personal and sexual assault. Prevalence rates for PTSD in high risk groups, such as war veterans, are significantly higher (Hoge, Auchterlonie & Milliken, 2006; MacDonald, Chamberlain & Long, 1997) with increased rates of both current (up to 15%) and lifetime (up to 31%) prevalence for veterans exposed to war zone trauma (Card, 1987; Kulka et al., 1990). Whilst these prevalence rates reported are from US studies the reported rates of PTSD amongst UK military veterans are lower at 4% (Howard League for Penal Reform (HLPR, 2010). The reasons for the discrepancies in these figures may be connected to differences in routine screening practices for personnel leaving military service and disparities in the healthcare systems of the two countries. As discussed previously, the focus of the remainder of this review will be with UK research findings. US prevalence rates have been included here, however, to illustrate the disparity that exists and which contributes to difficulties achieving international consensus in this area which may have implications when considering issues of diagnosis, a point returned to shortly.

Rosen, Spitzer and McHugh (2008) highlight that the definition of PTSD rests on the assumption of a specific aetiology; that is, exposure to a traumatic life-threatening event causing intense fear, helplessness, or horror. This assumption has been questioned (Breslau & Davis, 1987) and further undermined by reports that the disorder can develop after a variety of non-life-threatening events (Scott & Stradling, 1994) with PTSD symptoms also occurring among people with depression who had not experienced significant trauma (Bodkin, Pope, Detke & Hudson, 2007). Ozer et al. (2003) offer further support to the critical appraisal of the magnitude of presumed aetiological trauma being solely responsible for post-trauma morbidity, arguing that it is vulnerability factors such as psychiatric history prior to the trauma event and post-incident social support that have more of a

contributory role to subsequent disorder (Brewin et al., 2000). In addition, an objective assessment of the degree of trauma exposure may be less predictive of PTSD than the individuals' evaluation of the trauma and its perceived threat to safety (Ehlers & Clark, 2000; Ozer et al., 2003). Such appraisals have been shown to supersede objective trauma severity (Halligan, Michael, Clark & Ehlers, 2003). Brewin et al. (2000) conducted a meta-analysis on risk factors for PTSD and found three categories of risk emerged. The first contained factors that predicted PTSD in some populations but not in others, such as gender, age at trauma, and race. Education, previous trauma, and general childhood adversity were found to predict PTSD more consistently but the extent was variable according to populations and study methodology. The third category, which had more uniform predictive effects, comprised of factors such as psychiatric history, reported childhood abuse, and family psychiatric history. The literature therefore indicates that credence should be given to past events and premorbid experiences when examining the development of symptomology, a point that will be discussed in the next section when considering the recent advancements concerning trauma disorder aetiology and the consequences of extended exposure to traumatic events.

Complex trauma

Whilst a diagnosis of PTSD requires that a single traumatic event has been experienced involving being witness to actual or threatened death, injury, or a threat to the physical integrity of the self or of another person, the emphasis on a single occurrence does not take into account multiple traumatic events and extended exposure (De Jong, Kompose, Spinazzola, van der Kolk, van Ommeren, 2005). Whilst the distinguishing features of PTSD are related to cognitive, emotional and behavioural reactions to a single event, psychological disorder arising from sustained exposure to traumatic events has been termed Complex Trauma (Herman, 1992) or Disorders of Extreme Stress, Not Otherwise Specified (DESNOS) (van der Kolk, Roth, Pelcovitz & Mandel, 1993). Symptomology of complex trauma is

not captured in the PTSD diagnostic criteria and has been described as “the lasting personality changes following catastrophic stress” (World Health Organisation, 1992, p.91). Symptoms of complex trauma include alteration in attention and consciousness; self-perception; systems of meaning; and somatic disorders (Cloitre, Tardiff, Marzuk, Leon & Portera, 2001; Dorahy et al., 2009; Dube et al., 2001; Kilpatrick et al., 2000; Luxenberg et al., 2001; Margolin & Gordis, 2000) with functional impairments including difficulties in tolerating and regulating negative emotions and impulses, and interpersonal functioning (Briere & Rickards, 2007; Cloitre, Miranda, Stovall-McClough, & Han, 2005; Ehring & Quack, 2010; van der Kolk et al., 2005). Difficulties regulating anger may result in aggressive or violent behaviour, sometimes directed towards the self (Pelcovitz et al., 1997; Scoboria, Ford, Lin, & Frisman, 2008), whilst an inability to understand, process, and describe emotion (Cloitre et al., 2005) contributes to relational difficulties and experiential avoidance, in which the individual attempts to avoid negative or painful emotions (Batten, Follette, & Aban, 2001; Marx & Sloan, 2005).

Clinical and research consensus links complex trauma with a history of “interpersonal victimisation, multiple traumatic events, and/or traumatic exposure of extended duration” (Luxenberg, Spinazzola & van der Kolk, 2001, p.375). Complex trauma has been found to be experienced by individuals who have experienced severe stressors during childhood, such as abuse, neglect, or domestic violence (McLean & Gallop, 2003). Childhood trauma is linked with the development of personality disorders, with a core feature of Borderline Personality Disorder (BPD) being disturbances in relationships with others, associated with dysfunctional attachments and invalidating environments during childhood. Complex trauma may also be encountered in adult life, such as that experienced by military veterans (Ford, 1999), whilst others have histories throughout their lives of a large variety of traumatic events with on-going, repeated, and chronic exposure to untenable environments (Luxenberg et al., 2001). Although the conceptualisation of complex trauma allows for the inclusion of personality and relational difficulties to a greater extent than considered for ‘pure’ PTSD, difficulties remain within the literature when attempting to reach

agreement on how the current diagnostic criteria manages the intricacies of aetiology and the theoretical knowledge that underpins this. The consequences of this in clinical practice, when establishing a correct diagnosis and subsequent treatment interventions, will now be considered within the next section.

Diagnostic and treatment implications

Individuals with complex trauma histories are likely to experience a variety of posttraumatic symptoms, as discussed previously, with such heterogeneity having significant implications for the process and content of psychological assessment (Briere & Spinazzola, 2005). In order to assess for complex trauma clinical instruments have been developed for use in clinical practice and research, such as the Structured Interview of Disorders of Extreme Stress (SIDES; Pelcovitz et al., 1997) and the Self-Report Inventory for Disorders of Extreme Stress (SIDES-SR; Spinazzola, Blaustein, Kisiel & van der Kolk, 2001). Additional measures such as the Traumatic Antecedents Questionnaire (TAQ; Herman & van der Kolk, 1989), the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), and the Inventory of Altered Self-Capacities (IASC; Briere, 1998) may also be used to assess particular components (Luxenberg et al., 2001). For a comprehensive review of the measures that assess a wide range of generic (i.e. non-trauma-specific) psychological symptoms and those that directly examine various forms of posttraumatic disturbance, the reader is directed to Briere and Spinazzola (2005).

Complex trauma has a symptom constellation listed under the ‘associated features’ of PTSD within the DSM-IV (APA, 2000) meaning that individuals with symptoms that satisfy these criteria must also meet the criteria for PTSD (APA, 2000). The implications of the reliance on a single event as a causative factor for a PTSD diagnosis are that clinicians “may downplay or even ignore crucial pathogenic features that are to be found in the broader

context of a patient's personality, developmental history, and situational context" (Rosen et al., 2008, p.4). Whilst the diagnosis of PTSD in some cases may be beneficial in terms of gaining access to services and support, the repercussions of a diagnosis, and thus access to appropriate services, being dependent upon an identifiable single traumatic event means that the needs of people who have experienced multiple or prolonged trauma may not be met. Psychiatric conditions that do not fulfil PTSD diagnostic criteria are generally referred to as "comorbid conditions", inferring isolated independence from PTSD symptomology, with Saxe et al. (1993) highlighting that trauma-related disorders are therefore grossly underdiagnosed. By treating such symptoms as connected to apparently unrelated "comorbid" conditions clinicians may run the risk of applying treatment interventions that are reduced in their efficacy as a consequence (Spinazzola et al., 2005). The phenomenological differences between complex trauma and PTSD mean that treatment focusing on the processing of explicit and defined traumatic memories, specific to PTSD, neglects the treatment of other problems such as loss of emotional regulation, dissociation, and interpersonal difficulties experienced by those patients with histories of early abuse and/or prolonged trauma exposure (van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Such symptoms may cause more functional impairment and affect quality of life to a greater degree than PTSD symptoms and care should therefore be taken to view the management of such symptoms as the first priority (Cloitre, Koenen, Cohen & Han, 2002; Ford, Courtois, Steele, van der Hart & Nijenhuis, 2005; Pearlman & Courtois, 2005).

The literature indicates that responses to trauma reflect the wide variety of potential biological, social, cultural, and psychological variables that moderate the impact of these experiences. Briere and Spinazzola (2005) highlight that, in this context, the notion of a "one-size-fits-all" diagnosis (e.g. PTSD) often is untenable. Instead the clinician should consider an individual's responses to trauma in the context of their history and risk

factors. What some of the literature fails to make explicit is that this may require the administration of a wide range of psychological tests, both generic and more trauma-specific, followed by, or concurrent with, other tests relevant to the individual's specific presentation. This then informs both diagnosis and assist with the development of appropriate treatment interventions. More thorough and comprehensive assessment would allow for trauma symptoms within more generic syndromes (e.g. dissociative symptomology in the context of a major depressive disorder) to be identified, or the recognition of generic symptoms within a stress disorder (e.g. significantly distorted cognitions in PTSD) (Briere & Spinazzola, 2005). More thorough assessment, reflected in a greater research focus in this area, may help determine the relative extent of posttraumatic symptomology, rather than solely the presence or absence of a DSM-IV disorder, examining trauma symptoms as continuous variables.

Trauma and homelessness

Homeless individuals have been found to have a higher than average exposure to physical and sexual violence, both preceding homelessness and occurring during their time spent homeless (Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Martijn & Sharpe, 2006; Smart & Ogborne, 1994), with homelessness viewed as a potential source of trauma in itself (Fitzpatrick, Gory, & Richey, 1993). The high rates of exposure to traumatic events that have been reported amongst homeless people (Sacks, McKendrick & Banks, 2008) and the number of homeless people that have experienced adverse early childhood experiences contribute to such trauma experiences being conceptualised as risk factors for homelessness (Herman, Susser, & Struening, 1994; Herman, Susser, Struening, & Link, 1997; Koegel, Melamid, & Burnam, 1995; Piliavin, Sosin, Westerfelt, & Matsueda, 1993; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Smart & Ogborne, 1994).

Adverse early experiences include physical and sexual abuse, neglect, and/or the loss of a parent or significant carer, whilst factors such as

domestic violence in adulthood often precipitate homelessness (Bassuk, Perloff & Dawson, 2001; Zorza, 1991). Gwadz, Nish, Leonard and Strauss (2007) report discrepancies regarding differences in overall rates of trauma exposure during childhood according to gender, although repeated exposure to traumatic events is common for both genders (Horowitz, Weine & Jekel, 1995). Evidence from the literature highlights that physical assault is generally experienced more by boys, whilst girls are subjected to sexual assault more frequently (Acierno et al., 2000; Boney-McCoy & Finkelhor, 1995; Breslau, Davis, Andreski & Peterson, 1991; Cuffe et al., 1998; Giaconia et al., 1995; Kilpatrick & Saunders, 1999). Whilst maltreatment, often at the hands of caregivers (MacLean, Embry & Cauce, 1999; Whitbeck, Hoyt & Ackley, 1997b; Wolfe, Toro & McCaskill, 1999), can be found in the developmental histories of those that become homeless it is often as adolescents that such experiences contribute to young people leaving home and becoming homeless for the first time (Whitbeck, Hoyt & Ackley, 1997a). The focus of much of the literature regarding exposure to trauma and homelessness is concerned with women or families (Banyard, Williams & Siegel, 2001; Bassuk et al., 1998; Bassuk, Dawson, Perloff & Weinrub, 2001; Bean & Moller, 2002; Gully, Koller & Ainsworth, 2001, Ryan et al., 2000; Tyler & Cauce, 2002). This is despite the fact that women account for only 30% of users of homelessness services, although an accurate number that may be sleeping rough is unknown (Homeless Link, 2011). Homeless men also experience greater lengths of time homeless with more repeated cycles of homelessness (Grimm & Maldonado, 1995; Kim, Ford, Howard & Bradford, 2010; Sumerlin, 1999).

Traumatic events such as child abuse, neglect and disrupted attachment (Browne, 1993) are seen as providing “a subtext for the narrative of many people’s pathways to homelessness” (Hopper, Bassuk & Olivet, 2010, p.80). People who are homeless frequently experience mental health difficulties (Buhrich et al., 2000, 2003; Fischer & Breakey, 1991; Kamieniecki, 2001; Randall, Britten, & Craig, 2007; Rees, 2009; Scott, 1993). Whilst homelessness may have a negative impact on an individual’s mental health,

poor mental health can also be a contributory factor in becoming homeless (Martijn & Sharpe, 2006; National Mental Health Development Unit (NMHDU), 2010). Up to 76% of homeless people accessing services have been identified as experiencing mental health difficulties (St Mungo's, 2009a; 2009b), including personality disorders, anxiety, depression and PTSD, as well as psychoses (Fischer & Breakey, 1991; Folstom & Jeste, 2002; Rees, 2009; Scott, 1993; St Mungo's, 2009a).

Mental health and substance misuse problems are often comorbid (Goering et al., 2002; Fischer & Breakey, 1991; McCarty et al., 1991; Rees, 2009; St Mungos, 2009a) and whilst comorbid symptoms may develop independently to trauma reactions, they can also be viewed as maladaptive coping strategies in reaction to traumatic events. Substance abuse in particular has been shown to be comorbid with PTSD. Research findings suggest that up to 52% of men and 28% of women who meet the criteria for PTSD also meet the diagnosis for alcohol abuse (Kessler et al., 1995) whilst, compared to patients without a co-occurring diagnosis, homeless patients with a diagnosis of major depressive disorder or PTSD participated in more substance misuse (Austin, McKellar & Moos, 2011). Rhoades et al. (2011) report the use of crack cocaine by homeless men is as high as 40% with a diagnosis of PTSD more common among those who use this drug. Normative social ties, such as contact with family, being employed, and maintaining friendships outside of the homeless situation, were associated with a decreased likelihood of crack use, providing evidence for the relationship between the protective factors for PTSD being connected with a reduction in the likelihood of Class A usage. Whilst Rhoades et al. (2011) explored the severity or degree of substance misuse with trauma factors this is an area which has been relatively neglected within the field.

Within the literature there are difficulties establishing causal relationships for the onset and maintenance of homelessness but coping style has been offered as one explanation that offers strong evidence for the degree of

comorbidity in difficulties amongst homeless populations. The reasons for the comorbidity of trauma and substance misuse, for example, are suggested to be connected with the coping style of those affected. Avoidant coping is most closely linked to substance misuse with the associated tendency to avoid thinking about the consequences of high-risk situations, and to utilise substances to numb and avoid emotions (Levin, Ilgen & Moos, 2007). Avoidant coping is an important predictor of re-victimisation (Foster, 2009), although the causal relationship between trauma symptoms and avoidant coping is unclear. Experiences gained whilst homeless such as affiliation with deviant peers, risky sexual behaviours, and substance misuse are seen to amplify the effects of earlier trauma on victimization and depressive symptoms for young women (Whitbeck, Hoyt & Yoder, 1999), and are found to significantly increase the likelihood of serious victimization over and above the effects of early family history for gender (Whitbeck et al., 1997a; Whitbeck et al., 1999). Whilst the literature indicates that the development of disorder following a traumatic event is typically the result of an interaction of a variety of factors there remains a need for a research focus on how these risk factors may interact and contribute to the potential for future revictimization and how such variables may influence responses to later traumatic events. In the next section the research relating to trauma experienced during military service will be presented and discussed, including an examination of the rationale behind existing procedures in use to attempt to manage the effects of such trauma, in the context of current practices regarding diagnosis and treatment.

Trauma and military service

The psychological implications related to military service is an area that has recently received much research interest. It has been demonstrated that personnel involved in active service involving exposure to trauma are at increased risk of suffering a variety of mental health and adjustment difficulties in the immediate and long-term following deployment (for example, Greenberg, Jones, Jones, Fear & Wessely, 2011; Harvey et al., 2011; Iversen et al., 2008; Jones, 2011; Jones, Burdett, Wessely & Greenberg, 2011; Jones & Fear, 2011; Jones, Wink et al., 2011; Mulligan, Fear, Jones, Wessely & Greenberg, 2011; Sundin, Forbes, Fear, Dandeker & Wessely, 2011). This section of the review examines how exposure to trauma during active military service and the prevalence of PTSD and behavioural and relational problems associated with trauma experience is described and reported in the literature. Associated with this is an examination of what is being done by the Military of Defence and related organisations to reduce or manage the risk of psychological/emotional problems following trauma exposure during military service and the research that underpins such interventions.

Experiences of combat and trauma during deployment have been significantly associated with violent behaviour following homecoming, with mental health problems and alcohol misuse also associated with increased violence (Macmanus et al., 2011) and aggression within intimate relationships (Monson, Taft & Fredman, 2009). The most recent statistics estimate a 4% prevalence of PTSD amongst UK military veterans (HLPR, 2010) with deployment in a combat role or in a forward area in contact with the enemy associated with PTSD (Iversen et al., 2008). A high proportion of reservists have served in roles that many did not anticipate when joining the military (Schnurr, Lunney, Bovin & Marx, 2009) with an increased risk of PTSD found for reservists who deployed to Iraq compared with reservists who did not deploy (Browne et al., 2006; Hotopf et al., 2006; Iversen et al., 2009) and regular personnel. A recent increase in the number of reservists

taking part in combat action and their increased risk of PTSD may therefore confound the prevalence figures (Browne et al., 2006) and is not always adequately reported within the literature reviewed. Since many are reluctant to disclose mental disorders within the military environment (French, Rona, Jones & Wessely, 2004; Greenberg, Henderson, Langston, Iversen & Wessley, 2007) this causes problems with regards to the accurate detection and recording of trauma disorders, especially with those studies that have dealt exclusively with self-report measures of psychological distress following deployment. Furthermore, when the recovery environment after trauma exposure may act as a protective factor, with social support found to be associated with lower PTSD risk in the general population (Brewin et al. 2000; Ozer et al. 2003) and amongst military personnel (Solomon, Weisenberg, Schwarnvald & Mikulincer, 1988), difficulties accessing such support may be encountered, related to the stigma of reporting or discussing any problems experienced.

The association of childhood adversity with PTSD has been found in the general population (Brewin et al., 2000; Ozer et al., 2003) and is also described in both the UK (Iversen et al. 2007) and the US military population (Bremner, Southwick, Johnson, Yehuda & Charney, 1993; Cabrera, Hoge, Bliese, Castro & Messer, 2007). Other studies examining trauma and military service have included pre-enlistment vulnerability in their assessment and found strong associations between PTSD and younger age, low rank, low educational attainment, and not being in a relationship (Iversen et al., 2007, 2008). In addition, MacManus et al. (2011) found prevalence of violence amongst military personnel returning from deployment was strongly associated with pre-enlistment antisocial behaviour. Such research demonstrates the importance of including demographic information related to individuals' lives before military service in studies examining combat trauma, when such historical information is known to influence mental health outcomes. This demographic information is not included with all research in this area, however. There have been reported differences in difficulties with psychological adjustment according to trade within the armed forces, with deployed military medics subjected to considerable stress because of their

increased exposure to the death or injury of others, for example, thus corresponding to some of the diagnostic criteria of PTSD (Carson et al., 2000). Jones et al. (2008) found neither PTSD nor heavy drinking symptoms were associated with a medical role per se, however; rather it was traumatic medical experiences, lower group cohesion and preparedness, and post-deployment experiences that explained the positive associations with psychological ill health. In addition, medics made greater use of medical facilities so were likely to report problems than those employed in other trades. No evidence was found, during the review of comparative studies that examined difference in the type of military service, with controls made for length of service and other variables such as time spent on active duty and the like, although it has been identified that prevalence rates for PTSD are higher for those that have served in the Army than in other military services (MacManus et al., 2011). This lack of comparison has meant that enlistment practices of all the services cannot be examined in this context. It is therefore unclear whether the general practice of the Army to recruit personnel who may derive from social and economically challenged environments, with recruits who have poor educational attainment, may lead to a vulnerability to adverse responses to trauma as the literature regarding risk factors for trauma disorder predicts.

It may be assumed that length of deployment is associated with an increased risk of trauma exposure, such as seeing comrades killed or injured, and/or increased chance of incurring mortar or rocket fire. Whilst Iversen et al. (2008) found that increased length of deployment in a 'forward area' was predictive of a greater risk of PTSD, this risk was greater for those of lower ranks compared with commissioned officers. Time away from home itself may detrimentally influence the mental health of military personnel. There is the suggestion by Ursano, Benedek and Engel (2007) that research should therefore focus on real-time assessments of traumatic events and efficacy of social support in order to examine how stressful a deployment is, as well taking into account deployment length. However, no such research approaches have been found in the literature. The adverse effect of long deployments may be related not only to events that occur in the warzone but

also to stress factors outside of the military arena, such as concern for family members and difficulty in maintaining family relationships with subsequent losses in support (Buckman et al., 2011).

It is unrealistic to assume that exposure to potentially traumatic events can be eliminated from occupations such as the military (McGeorge, Hacker Hughes & Wessely, 2006) but efforts have been made in an attempt to reduce the risk of psychological problems following exposure. For UK armed forces Third Location Decompression (TLD; Hacker Hughes et al., 2008) is the post-operational stress management process through which military personnel, returning from combat operations, begin to psychologically 'unwind', taking place over a 24 – 36 hour period in Cyprus. Decompression comprises of welfare activities, such as contacting home; social events; psycho-educational briefings; and a controlled reintroduction to alcohol (Jones, Burdett et al., 2011). The process was developed to aid the transition from active service to the peacetime setting and civilian life. Whilst it was not designed as a specific mental health intervention, the psycho-educational briefings are intended to benefit long-term mental health (Iversen et al., 2008), whilst the recreational actives are aimed at facilitating social support and the sharing of operational experiences (Greenberg et al., 2003; Pietrzak, Johnson, Goldstein, Malley & Southwick, 2009).

Whilst decompression is currently the standard procedure aimed at reducing post-deployment distress or ill-health there is mixed evidence for its efficacy. It is often perceived negatively by personnel who report frustration at having to attend, and boredom with the process (French & Dandeker, 2005). Other research has indicated that whilst the majority of surveyed attendees subjectively reported that decompression was helpful to them, those who did not were individuals who had been through the process before, combat troops and non-commissioned officers, with 6% reporting residual PTSD symptoms (Jones, Burdett, Wessely & Greenberg, 2010). This indicates that for some personnel, decompression may not be related to better post-operational adjustment (Sharpley, Fear, Greenberg, Jones & Wessely, 2008). However, the evidence provided is based on self-report measures

and, as such, may be subjected to bias regarding response rates of those surveyed as well as the possibility of over- and under-reporting residual symptoms.

When evaluating current attempts to manage psychological adjustment following deployment there appears to be some confusion in the literature regarding the content and intent of psycho-education briefing interventions, with psycho-education intended as a means of providing information about trauma symptoms, self-help techniques, and sources of support (Mulligan, Fear, Jones, Wessely & Greenberg, 2010). The purpose of psychological debriefing, while information may be contained about trauma symptomology, is for personnel to emotionally process the traumatic event more effectively via a detailed recollection of the experience (Krupnick & Green, 2008). It has been found, however, that psychological debriefing immediately after trauma is ineffective with more than one study finding that it may significantly increase the risk of psychological distress (Devilly, Gist & Cotton, 2006; van Emmerik, Kamphuis, Hulsbosch & Emmelkamp, 2003). Whilst decompression is not intended as a treatment for trauma-related symptoms per se, without accurate assessment prior to such interventions phenomenological phenomena that may interfere with effective adjustment cannot be identified; a point that is neglected in much of the literature reviewed.

Mulligan et al. (2012) utilised a post-deployment psycho-educational cognitive and skill-based intervention, 'Battlemind', adapted from a similar US intervention, as a comparison with the standard decompression process in a cluster randomized controlled trial. The recollection of specific trauma events experienced during deployment was not encouraged during this intervention, to avoid the risk of re-exposing participants, with an emphasis instead on normalising reactions and building resilience. Whilst predominantly utilising PTSD symptomology as an outcome measure, secondary outcomes included alcohol misuse and binge drinking. Mulligan et al. (2012) found that those who received the Battlemind intervention versus the standard decompression were less likely to report binge drinking at 6

month follow-up, although the effect size was small. There was no evidence found for any improvement in mental health although, as the primary outcome measure was the Posttraumatic Stress Disorder Checklist (PCL-C), if other specific self-capacity, cognitive disturbance, dissociation, or dysfunctional behaviour measures to assess domains linked with complex trauma were used there is the possibility that the results reported could have provided alternative evidence.

There is evidence to suggest that an individual's sense of unpredictability and uncontrollability during a traumatic situation increases the risk of PTSD (Başoğlu et al. 2005) with Iverson et al (2008) finding that perceived threat to life and ill-preparedness for the experiences during deployment strongly related to PTSD. This may correspond with the greater incidence of PTSD amongst reservists when faced, unexpectedly, with a combat role. Iverson et al. (2008) therefore suggest that psycho-education should be attempted as an intervention *prior* to deployment, to increase awareness of the protective factors such as sources of support and advice, and to encourage group cohesion. This ideally should be implemented in combination with the systematic preparation of personnel for the tasks ahead to increase role clarity, self-efficacy and job engagement (Britt, Davison, Bliese & Castro, 2004), and thus mitigate the extreme stress of combat and lessen the psychological impact of deployment which, in turn, may have implications for the continued welfare of military veterans who are at greater risk of homelessness because of their trauma experiences.

Veterans and homelessness

As has been discussed in the previous section, considerable research attention has been directed at the psychological implications of military service although there is less of a focus research on the homelessness of British ex-military personnel, arising as a result of the trauma they have experienced during service deployment. This is perhaps surprising given the research findings that have been discussed throughout this literature review linking trauma with mental health difficulties, substance misuse and homelessness, and the acknowledgement that active service in the military involves exposure to traumatic events. Research carried out with homeless veterans in the USA is more prolific but, for reasons stated previously, the focus of the remainder of this review will be on examining literature pertaining to UK studies. Theoretical conclusions from research conducted with ex-military homeless people outside of the UK will, however, be included where appropriate, with additional evidence from trauma-informed homeless research involving civilians, in order to illustrate research findings and to assist in achieving the review objectives.

It is reported by Johnsen, Jones and Rugg (2008) that approximately 6% of the homeless population in London have served in the Armed Forces. According to Defence Analytical Services and Advice (DASA) figures, in the 12 months prior to 30th September 2010, 18,240 people left the regular military forces in the UK (DASA, 2010). Prevalence estimates of 4% for PTSD amongst UK veterans (HLPR, 2010) means that this equates to a figure of in excess of 700 individuals a year being discharged from the military who may fulfil the diagnostic criteria for PTSD. Homeless Link (2011) highlight that funding cuts within the UK Government's Strategic Defence and Security Review during 2010 will result in a further 11,000 military personnel being made redundant. It is therefore estimated that the numbers of ex-military personnel that become homeless following discharge from the UK armed forces may rise.

Whilst the factors linked with exposure to trauma may increase the risk of becoming homeless, additional risk factors include substance abuse problems that began in the military, inadequate preparation for civilian employment, and loss of a structured lifestyle (Mares & Rosenheck, 2004); all socio-cultural issues that may influence recovery from trauma, as discussed previously. However, homeless veterans essentially have the same homelessness risk factors as other homeless: poverty, joblessness, mental illness, and substance abuse (McGuire, 2007; Rosenheck & Koegel 1993), whilst Garcia-Rea & LePage (2010) describe similar trauma-associated effects of child abuse with substance-dependent homeless veterans, as are found in the general population (McLean & Gallop, 2003). Rosenheck, Frisman and Chung (1994) report clear associations of poor mental health with social exclusion (including homelessness) in US veterans whilst PTSD also is related to repeat homelessness. A study of formerly homeless veterans found that PTSD was associated with an 85% greater risk of becoming homeless again (O'Connell, Kasprow, & Rosenheck, 2008) which may be linked with issues of psychiatric comorbidity (Keane & Wolfe, 1990) and substance abuse, as highlighted in the literature concerning civilian homeless populations (Goering et al., 2002; Fischer & Breakey, 1991; McCarty, Argeriou, Hueber & Lubran, 1991).

When considering routes into homelessness in more detail for military veterans, in general they are seen to follow the same pathways as the general homeless population (Homeless Link, 2011). A small percentage of ex-military personnel are unable to cope with the return to civilian life following Armed Service but Iversen et al. (2005) highlight that only a minority of veterans fare badly following discharge, even amongst those who have undertaken active tours of duty. Veterans with mental health problems during service seem to be at higher risk of social exclusion after leaving (Iversen et al., 2005) which ties in with literature discussed previously in this review, linking mental health difficulties with increased risk of homelessness (Buhrich et al., 2000, 2003; Fischer & Breakey, 1991; Kamieniecki, 2001; Randall, Britten & Craig, 2007; Rees, 2009; Scott, 1993).

When ex-armed forces personnel do become homeless it appears that their support needs may be different to that of the general homeless population which may, in part, be linked with their occupational history. Homeless Link (2011) highlight that homeless veterans show a greater reluctance to seek help, which may be a reflection of the stigma contained within the military ethos of not discussing problems and an emphasis on self-reliance. Homeless ex-military personnel have a higher likelihood of alcoholism, which again may be linked to social drinking that started as part of the military lifestyle, with a greater need for dual diagnoses care along with a higher likelihood of anger management issues (Homeless Link, 2011). In order to achieve a greater understanding of the reasons for homelessness with this population of people there needs to be a focus on the social and demographic characteristics pre-enlistment, as has been highlighted in the research examining the psychological impact of military service (Magruder et al., 2004).

Methodological considerations

During the review to explore the relationship between trauma experienced during military service and later homelessness, a number of methodological limitations were identified. These included a neglect of the geographical spread of homelessness, how access to samples was achieved, and a lack of participant information regarding age, gender, ethnicity, time employed in military service, and the manner in which they were discharged. There is marked geographical variation in the rates of homelessness across the UK with most homeless numbers concentrated around major cities and it is argued that undertaking larger-scale, longer-term studies which cover a number of geographical 'hot spots' may lead to a more nationally representative sample. For those studies that did partially supply some of this information there was considerable variability and, whilst it could be argued that this allowed for a broad review of the effects of trauma, these factors, combined with variable definitions of trauma, made comparing some of the literature difficult.

A further limitation of the studies was the lack of longitudinal designs, most choosing cross-sectional designs at one time point, either rating psychological distress or trauma symptomology at time of discharge from the military or taking a retrospective stance reflecting on homeless veterans' past experiences. Similarly, the assessment of the impact of current initiatives targeted at reducing psychological distress amongst military service personnel would require a prospective longitudinal follow up with regards to their functioning post-discharge in order to measure for the effectiveness of such interventions, which is currently not reported on in the literature. Alternatively, a focus on homelessness centres accessed by high numbers of ex-military personnel would provide a rich data set in terms of detailed quantitative and qualitative material. Whilst it has been found that military veterans may take up to 10 years to ultimately present as homeless a longitudinal tracking of personnel leaving the military would allow an investigation of the profile of those that do and do not become homeless. No such research design was reported in the literature.

The wide variability of measures used to assess trauma symptomology makes it problematic to compare some studies, or to extrapolate their findings. In addition to the variability, although all the studies utilised validated measures, few reported psychometric properties, making issues of reliability and validity hard to evaluate. Examining pathways to homelessness retrospectively can provide an enhanced understanding of risk factors and vulnerability for homelessness. However, retrospective accounts may pose problems in attributing causal links in those pathways with a reliance on self-report data being subject to systematic bias, as results may not apply to those who did not take part in the studies. Furthermore, there is the possibility of variability in the self-reporting and self-assessment of trauma symptomology, and under- or over-reporting of negative experiences. No studies had attempted to control for this, for example, by using multiple reporters. In addition, the difficulties with achieving a diagnostic consensus regarding trauma symptomology made the comparison of some studies difficult, with some measuring so-called 'risk factors' such as alcohol consumption, as potential indicators for later psychological

maladjustment, whilst others specified alcohol use as a positive marker for the presence of psychological disturbance.

The literature examined for this review was largely investigated and compiled by small groups of authors in the areas of trauma, homelessness and the mental health of military personnel. Although these authors' endeavours can be viewed as critical to the creation of a valued evidence base, there is the potential that the opinions and interests of such research groups may influence their research focus. A wider group of researchers investigating these areas would be highly beneficial in avoiding such issues and to bring about a perhaps more balanced investigation of the available evidence.

Clinical implications and areas for future research

This review of the research confirms the existence of a link between armed service and homelessness but suggests that the link is partly explained by the types of people more likely to join the armed forces, with many having a complex trauma history pre-enlistment that may make them more vulnerable to psychological disturbance following exposure whilst serving with the military. Some features of military life that may result in ex-service personnel experiencing difficulty with trauma exposure and adjustment to civilian life following discharge include the 'dependency culture' of the armed forces leading to limited self-reliance; heavy alcohol use; and a perception that their difficulties may not be fully understood by civilian NHS services (Walker, 2010). Accordingly, the vulnerability and the high level of need of military veterans with mental health problems is highlighted. The benefit of further research in this area is two-fold, by seeking to improve the lives of those already homeless and creating an evidence-base to support work to prevent future homelessness from occurring. This may be achieved by helping mainstream and mental health NHS services identify and support the health needs of veterans so that the access and quality of the care and services that the NHS provides to them is improved, following Government initiatives

calling for greater NHS engagement to support the physical, mental and social wellbeing of Armed Forces veterans. In addition, enhanced training for those that are assessing for vulnerability when decisions are made regarding the support required by personnel on discharge from the military would be beneficial to 'signpost' those individuals felt to be at risk of social isolation. This needs to be facilitated in tandem with an increase in the awareness of what existing support is available to veterans, informing them of their entitlement to support as a means to overcome the stigma that may currently discourage ex-service personnel to access services that are available.

McKenzie-Mohr, Coates and McLeod (2012) argue that the complex psychological, relational, and social challenges experienced by many homeless individuals are not taken into consideration with current methods of assessment and intervention. This results in a failure to adequately account for the effects of trauma in their lives with the therapeutic approaches taken neglecting the negative effects of trauma and thus failing to adequately respond to the consequences of traumatic life experiences. When a prolonged trauma history is significantly associated with more mental health problems in the homeless population the implications for service provision are that a more proactive and specialised approach should therefore be adopted in order to address the abuse and victimisation experienced in their past (Kim, Ford, Howard & Bradford, 2010). In the case of military veterans, as Schnurr et al. (2009) argue, because PTSD onset in many of the veterans from the wars in Iraq and Afghanistan has been relatively recent, it may be possible to reverse or even prevent a downward spiral of interaction between poor quality of life and PTSD by effectively treating PTSD and associated complex trauma and other areas of mental health with improved quality of life prioritized as a goal of treatment. However, in order to achieve this goal changes may be required to the current diagnostic criteria that, at present, may lead to the misdiagnosis of complex trauma with subsequent inappropriate or ineffective interventions. In addition, enhanced preparatory training for military staff before they enter the field may better prepare them

for the psychological stress of active duty, whilst changes may be implemented to ease the transition to civilian life upon discharge.

References

Acierno, R., Kilpatrick, D. G., Resnick, H. S., Saunders, B. E., De Arellano, M. & Best, C. L. (2000). Assault, PTSD, family substance use, and depression as risk factors for cigarette use in youth: Findings from the National Survey of Adolescents. *Journal of Traumatic Stress*, 13, 381–396.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Publishing.

Austin, J., McKellar, J.D. & Moos, R. (2011). The influence of co-occurring axis I disorders on treatment utilization and outcome in homeless patients with substance use disorders. *Addictive Behaviours*, 36, 941 – 944.

Başoğlu, M., Livanou, M., Crnobarić, C., Frančišković, T., Suljić, E., Đurić, D. & Vranešić, M. (2005). Psychiatric and cognitive effects of war in former Yugoslavia: Association of lack of redress from trauma and posttraumatic stress reactions. *The Journal of the American Medical Association*, 294(5), 580 – 590.

Bassuk, E.L., Buckner, J.C., Perloff, J.N. & Bassuk, S.S. (1998) Prevalence of mental health and substance abuse disorders among homeless and low income housed mothers. *American Journal of Psychiatry*, 155(11), 1561 – 1564.

Bassuk, E.L., Dawson, R., Perloff, J.N. & Weinrub, L.F. (2001). Post-traumatic stress disorder in extremely poor women: Implications for health care clinicians. *Journal of the American Medical Women's Association*, 56(2), 79 – 85.

Bassuk, E.L., Perloff, J.N. & Dawson, R. (2001). Multiply homeless families: The insidious impact of violence. *Journal of Housing Policy*, 12(2), 299 – 320.

Batten, S. V., Follette, V. M. & Aban, I. B. (2001). Experiential avoidance and high-risk sexual behaviour in survivors of child sexual abuse. *Journal of Child Sexual Abuse*, *10*, 101–120.

Bean, J. & Moller, A.T. (2002). Posttraumatic stress and depressive symptomology in a sample of battered women from South Africa. *Psychological Reports*, 90, 750 – 752.

Bernstein, E.M. & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727 – 735.

Bodkin, J.A., Pope, H.G., Detke, M.J. & Hudson, J.I. (2007) Is PTSD caused by traumatic stress? *Journal of Anxiety Disorders*, 21, 176–82.

Boney-McCoy, S. & Finkelhor, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. *Journal of Consulting & Clinical Psychology*, 63(5), 726–736.

Bremner, J., Southwick, S., Johnson, D., Yehuda, R. & Charney, D. (1993). Childhood physical abuse and combat-related stress disorder in Vietnam veterans. *American Journal of Psychiatry*, 150, 235 – 239.

Breslau, N. & Davis, G.C. (1987). Posttraumatic stress disorder: the stressor criterion. *Journal of Nervous and Mental Disease*, 175, 255–64.

Breslau, N., Davis, G.C., Andreski, P. & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48(3), 216 – 222.

Brewin, C., Andrews, B. & Valentine, J.D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68(5), 748 – 766.

Briere, J. (1998). *Inventory of Altered Self-capacities (IASC): Professional Manual*. Odesa, Florida: Psychological Assessment Resources.

Briere, J. & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequels of childhood versus adult victimisation processes. *Journal of Nervous and Mental Diseases,* 195, 497-503.

Briere, J. & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of Traumatic Stress*, 18(5), 401 – 412.

Britt, T.W., Davison, J., Bliese, P.D. & Castro, C.A. (2004). How leaders can influence the impact that stressors have on soldiers. *Military Medicine*, 169, 541 – 545.

Browne, A. (1993). Family violence and homelessness: The relevance of trauma histories in the lives of homeless women. *American Journal of Orthopsychiatry*, 63, 370.

Browne, T., Hull, L., Horn, O., Murphy, D., Fear, N., Greenberg, N., French, C., Rona, R., Wessely, S. & Hotopf, M. (2006). Explanations for the increase in mental health problems in UK Reserve Forces who have served in Iraq. *British Journal of Psychiatry*, 190, 484 – 489.

Buckman, J.E., Sundin, J., Greene, T., Fear, N.T., Dandeker, C., Greenberg, N. & Wessely, S. (2011). The impact of deployment length on the health and well-being of military personnel: A systematic review of the literature. *Occupational and Environmental Medicine*, 68, 69 – 76.

Buhrich, N., Hodder, R., & Teesson, M. (2000). Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry*, 34, 963 – 966.

Buhrich, N., Hodder, R., & Teesson, M. (2003). Schizophrenia among homeless people in inner-Sydney: current prevalence and historical trends. *Journal of Mental Health*, 12(1), 51 – 57.

Cabrera, O.A., Hoge, C.W., Bliese, P., Castro, C.A. & Messer, S.C. (2007). Childhood adversity and combat: Effects on depression and post traumatic stress. *American Journal of Preventative Medicine*, 33, 77 – 82.

Card, J. J. (1987). Epidemiology of PTSD in a national cohort of Vietnam veterans. *Journal of Clinical Psychology,* 43, 6 - 17.

Carson, M.A., Paulus, L.A., Lasko, N.B., Metzger, L.J., Wolfe, J., Orr, S.P. & Pitman, R.K. (2000). Psychophysiologic assessment of posttraumatic stress disorder in Vietnam nurse veterans who witnessed injury or death. *Journal of Consulting and Clinical Psychology*, 68(5), 890 – 897.

Cloitre, M., Koenen, K.C., Cohen, L.R. & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, 70, 1067 – 1074.

Cloitre, M., Miranda, R., Stovall-McClough, K.C. & Han, H. (2005). Beyond PTSD: Emotional regulation and interpersonal problems as predictors of functional impairment in survivors of childhood abuse. *Behaviour Therapy,* 36(2), 119-124.

Cloitre, M., Tardiff, K., Marzuk, P.M., Leon, A.C. & Portera, L. (2001). Consequences of childhood abuse among male psychiatric inpatients: Duel roles as victims and perpetrators. *Journal of Traumatic Stress*, 14(1), 47 – 61.

Creamer, M., Burgess, P.M. & McFarlane, A.C. (2001). Post-traumatic stress disorder: Findings from the Australian National Survey of Mental Health and Well-Being. *Psychological Medicine*, 31(7), 1237 – 1247.

Cronin, P., Ryan, F. & Coughlan, M. (2007). Undertaking a literature review: A step-by-step approach. *British Journal of Nursing*, 17(1), 38 – 43.

Cuffe, S. P., Addy, C. L., Garrison, C. Z., Waller, J. L., Jackson, K. L., McKeown, R. E. & Chilappagari, S. (1998). Prevalence of PTSD in a community sample of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(2), 147–154.

Dandeker, C., Thomas, S., Dolan, M., Chapman, F. & Ross, J. (2005). Feasibility study on the extent, causes, impact and costs of rough sleeping and homelessness amongst ex-Service personnel in a sample of local authorities in England. KCMHR, Kings College.

DASA (2010). *UK Armed Forces Monthly Manning report at 1 October 2010*. London: Ministry of Defence.

Davidson, J.R.T., Hughes, D., Blazer, D.G. & George, L.K. (1991). Post-traumatic stress disorder in the community: An epidemiological study. *Psychological Medicine*, 21, 713 – 721.

Davis, J. & Kutter, C.J. (1997). Independent living skills and posttraumatic stress disorder in women who are homeless: Implications for future practice. *The American Journal of Occupational Therapy*, 52(1), 39 – 44.

De Jong, J.T.V.M., Komproe, I.H., Spinazzola, J., van der Kolk, B.A. & van Ommeren, M.H. (2005). DESNOS in three post conflict settings: Assessing cross-cultural equivalence. *Journal of Traumatic Stress*, 18(1), 13 – 21.

Department for Communities and Local Government (CLG) (2012). Rough Sleeping Statistics England – Autumn 2011 Experimental Statistics. Accessed 02/06/12 from http://www.communities.gov.uk/documents/statistics/pdf/20936571.pdf

Devilly, G., Gist, R. & Cottion, P. (2006). Ready! Fire! Aim! The evolution of psychological debriefing services and intervention outcome research. *Review of General Psychology*, 10, 318 – 345.

Dorahy, M.J., Corry, M., Shannon, M., MacSherry, A., Hamilton, G., McRobert, G. et al. (2009). Complex PTSD, interpersonal trauma and relational consequences: Findings from a treatment-receiving Northern Irish sample. *Journal of Affective Disorders, 112,* 71-80.

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman, D.P., Williamson, D.F. & Giles, W.H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*, 286(24), 3089 – 3096.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319 – 345.

Ehlers, A., Mayou, R.A. & Bryant, B. (1998). Psychological predictors of chronic post-traumatic stress disorders after motor vehicle accidents. Journal of Abnormal Psychology, 107, 508 – 519.

Ehring, T. & Quack, D. (2010). Emotion regulation difficulties in trauma survivors: The role of trauma type and PTSD symptom severity. *Behaviour Therapy, 41,* 587-598.

Engel, C.C., Liu, X., McCarthy, B.D., Miller, R.F. & Ursano, R. (2000). Relationship of physical symptoms to posttraumatic stress disorder among veterans seeking care for Gulf War-related health concerns. Psychosomatic Medicine, 62, 739 – 745.

Escobar, J.I., Randolph, E.T., Puente, G., Spiwak, F., Asamen, J.K., Hill, M. & Hough, R.L. (1983). Post-traumatic stress disorder in Hispanic Vietnam veterans. Journal of Nervous and Mental Disease, 171, 585 – 596.

Fischer, P.J. & Breakey, W.R. (1991) The epidemiology of alcohol, drug and mental disorders among homeless persons. *American Psychologist*, 46(11), 1115 – 1128.

Fitzpatrick, K. M., Gory, M. E. & Ritchey, F. J. (1993). Criminal victimization among the homeless. *Justice Quarterly,* 10, 353–368.

Folsom, D. & Jeste, D. (2002). Schizophrenia in homeless persons: A systematic review of the literature. *Acta Psychiatrica Scandinavica*, 162(6), 404 – 413.

Ford, J.D. (1999). Disorders of extreme stress following warzone military trauma: Associated features of Post-traumatic Stress Disorder (PTSD) or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology*, 67(1), 3 – 12.

Ford, J.D., Courtois, C.A., Steele, K., van der Hart, O. & Nijenhuis, E.R.S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress*, 18, 437 – 447.

Foster, M.D. (2009). Perceiving pervasive discrimination over time: Implications for coping. *Psychology of Women Quarterly*, 33(2), 172 – 182.

Frans, O., Rimmo, P.A., Aberg, L. & Fredrickson, M. (2005). Trauma exposure and post-traumatic stress disorder in the general population. *Acta Psychiatrica Scandinavica*, 111, 291 – 299.

French, C., Rona, R.J., Jones, M. & Wessely, S. (2004). Screening for physical and psychological illness in the British Armed Forced: Barriers to screening – learning from the opinions of Service personnel. *Journal of Medical Screening*, 11(3), 153 – 157.

Friedman, M.J., Schnurr, P.P. & McDonagh-Coyle, A. (1994). Post-Traumatic Stress Disorder in the military veteran. *Psychiatric Clinics of North America*, 17(2), 265 – 277.

Giaconia, R. M., Reinherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K. & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(10), 1369–1380.

Goering, P., Tolomiczenko, G., Sheldon, T., Boydell, K. & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services*, 53(11), 1472 – 1475.

Goodman, L.A, Saxe, L. & Harvey, M. (1991). Homelessness as psychological trauma. *American Psychologist*, 46, 1219 – 1225.

Greenberg, N., Henderson, A., Langston, V., Iversen, A. & Wessely, S. (2007). Peer responses to perceived stress in the Royal Navy. *Occupational Medicine*, 57(6), 424 – 429.

Greenberg, N., Jones, E., Jones, N., Fear, N.T. & Wessely, S. (2011). The injured mind in the UK Armed Forces. *Philosophical Transactions of the Royal Society of London, Series B, Biological Sciences*, 366(1562), 261 – 267.

Greenberg, N., Thomas, S., Iversen, A., Unwin, C., Hull, L. & Wessely, S. (2003). Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. *Journal of Mental Health*, 12, 565 – 573.

Grimm, K. & Maldonado, J.C. (1995). No home of her own: Gender and homelessness. *Women and Environments*, 14(2), 20 – 23.

Gully, K., Koller, S. & Ainsworth, A. (2001). Exposure of homeless children to family violence: An adverse effect beyond alternative beyond alternative explanations. *Journal of Emotional Abuse*, 2(4), 5 – 18.

Gwadz, M.V., Nish, D., Leonard, N.R. & Strauss, S.M. (2007). Gender differences in traumatic events and rates if post-traumatic stress disorder among homeless youth. *Journal of Adolescence*, 30, 117 – 129.

Hacker Hughes, J.G.H., Earnshaw, M.N., Greenberg, N., Eldridge, R., Fear, N.T., Deahl, C. & Wessely, S. (2008). The use of psychological decompression in military operational environments. *Military Medicine*, 173(6), 534 – 538.

Halligan, S.L., Michael, T., Clark, D.M. & Ehlers, A. (2003). Posttraumatic stress disorder following assault: The role of cognitive processing, trauma memory, and appraisals. *Journal of Consulting and Clinical Psychology*, 71, 419 – 431.

Harvey, S.B., Hatch, S.L., Jones, M., Hull, L., Jones, N., Greenberg, N., Dandeker, C., Fear, N.T. & Wessely, S. (2011) Coming home: Social functioning and the mental health of UK reservists on return from deployment to Iraq or Afghanistan. *Annals of Epidemiology*, 21(9), 666 – 672.

Herman, D., Susser, E. & Struening, E. (1994). Childhood out-of-home care and current depressive symptoms among homeless adults. *American Journal of Public Health*, 84(11), 1849 – 1851.

Herman, D., Susser, E., Stuening, E. & Link, B. (1997). Adverse childhood experiences: Are they risk factors for homelessness? *American Journal of Public Health*, 87(2), 249 – 255.

Herman, J.L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5, 377 – 391.

Herman, J.L. & van der Kolk, B.A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, 490 – 495.

Hoge, C.W., Auchterlonie, J.L. & Milliken, C.S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295(9), 1023 – 1032.

Homeless Link (2011). *Survey of Needs and Provision (SNAP)*. Accessed via http://www.crisis.org.uk/pages/homeless-diff-groups.html#1

Hopper, E.K., Bassuk, E.L. & Oliver, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3, 80 – 100.

Horowitz, K., Weine, S. & Jekel, J. (1995). PTSD symptoms in urban adolescent girls: Compounded community trauma. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(10), 1353–1361.

Hotopf, M., Hull, L., Fear, N.T., Browne, T., Horn, O., Iversen, A., Jones, M., Murphy, D., Bland, D., Earnshaw, M., Greenberg, N., Hacker Huges, J., Tate, A.R., Dandeker, C., Rona, R. & Wessely, S. (2006). The health of UK military personnel who deployed to the 2003 Iraq war: A cohort study. *The Lancet*, 367, 1731 – 1741.

Hyun, J.K., Paveo, J. & Kimerling, J. (2009). Military sexual trauma. *PTSD Research Quarterly*, 20(2), 2 – 7.

Iversen, A.C., Fear, N.T., Ehlers, A., Hacker Hughes, J., Hull, L., Earnshaw, M., Greenberg, N., Rona, R., Wessely, S. & Hotopf, M. (2008). Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychological Medicine*, 38, 511 – 522.

Iversen, A., Fear, N.T., Hull, L., Greenberg, N., Jones, M., Browne, T., Murphy, D., Hotopf, M., Rona, R. & Wessely, S. (2007). Pre-enlistment vulnerability factors and their influence on health outcomes amongst UK Military Personnel. *British Journal of Psychiatry*, 191, 506 – 511.

Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J. & Wessely, S. (2005). What happens to British veterans when they leave the armed forces? *European Journal of Public Health*, 15(2), 175 – 184.

Iversen, A.C., van Staden, L., Hacker Hughes, J., Browne, T., Hull, L., Hall, J., Greenberg, N., Rona, R.J., Hotopf, M., Wessely, S. & Fear, N.T. (2009). The prevalence of common mental disorders and PTSD in the UK military: Using data from a clinical interview-based study. *BMC Psychiatry*, 9, 68.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Johnsen, S., Jones, A. & Rugg, J. (2008). *The experiences of homeless ex-service personnel in London*. Centre for Housing Policy: University of York.

Jones, E. (2011). The military and its psychiatric challenges. *International Review of Psychiatry*, 23(2), 125 – 126.

Jones, N., Burdett, H., Wessely, S. & Greenberg, N. (2011). The subjective utility of early psychosocial interventions following combat deployment. *Occupational Medicine*, 61(2), 102 107.

Jones, E. & Fear, N.T. (2011) Alcohol use and misuse within the military: A review. *International Review of Psychiatry*, 23(2), 166 – 172.

Jones, M., Fear, N.T., Greenberg, N., Jones, N., Hull, L., Hotopf, M., Wessely, S. & Rona, R.J. (2008). Do medical services personnel who deployed to the Iraq war have worse mental health than other deployed personnel? *European Journal of Public Health*, 18(4), 422 – 427.

Jones, N., Wink, P., Brown, R.A., Berrecloth, D., Abson, E., Doyle, J., Fear, N.T., Wessely, S. & Greenberg, N. (2011). A clinical follow-up study of reserve forces personnel treated for mental health problems following demobilisation. *Journal of Mental Health*, 20(2), 136 – 145.

Kamieniecki, G. W. (2001) Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review. *Australian and New Zealand Journal of Psychiatry*, 35(3), 352 – 358.

Keane, T.M. & Wolfe, J. (1990). Comorbidity in post-traumatic stress disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology*, 20, 1776 – 1788.

Kessler, R.C., Berglund, P., Delmer, O., Jin, R., Merikangas, K.R. & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62(6):* 593-602.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048 – 1060.

Kilpatrick, D.G., Acierno, R., Saunders, B.E., Resnick, H.S., Best, C.L. & Schnurr, P.P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology*, 68(1), 19 – 30.

Kilpatrick, D. G., & Saunders, B. E. (1999). *Prevalence and consequences of child victimization: Results from the National Survey of Adolescents. Final Report to the US Department of Justice*. Medical University of South Carolina, Department of Psychiatry and Behavioral Sciences. National Crime Victims Research and Treatment Center.

Kim, M.M., Ford, J.D., Howard, D.L. & Bradford, D.W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health & Social Work*, 35(1), 39 – 48.

Kimerling, R., Gima, K., Smith, M.W., Street, A. & Frayne, S. (2007). The veterans health administration and military sexual trauma. *American Journal of Public Health*, 97(12), 2160 – 2166.

Kimerling, R., Street, A., Paveo, J., Smith, M.W., Cronkite, R.C., Holmes, T.H. et al. (2010). Military-related sexual trauma among veterans health administration patients returning from Iraq and Afghanistan. *American Journal of Public Health*, 100(8), 1409 – 1412.

Koegel, P., Melamid, E. & Burnam, M.A. (1995). Childhood risk factors for homelessness amongst homeless adults. *American Journal of Public Health*, 85(12), 1642 – 1649.

Krupnick, J.L. & Green, B.L. (2008). Psychoeducation to prevent PTSD: A paucity of evidence. *Psychiatry: Interpersonal and Biological Processes*, 71, 329 – 331.

Kulka, R. A., Schlenger, W. E., Fairbank, J. A., Hough, R. L., Jordan, B. K., Marmar, C. R. et al. (1990). *Trauma and the Vietnam war generation: Report of findings from the National Vietnam Veterans Readjustment Study.* New York: Brunner/Mazel.

Lazarus, R.S & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Levin, C. Ilgen, M. & Moos, R. (2007). Avoidance coping strategies moderate the relationship between self-efficacy and 5-year alcohol treatment outcomes. *Psychology of Addictive Behaviour,* 21(1), 108-113.

Lister, R. (1998) From equality to social inclusion: New Labour and the welfare state. *Critical Social Policy*, 18(2), 215 – 226.

Luxenberg, T., Spinazzola, J. & van der Kolk, B.A. (2001). Complex trauma and disorders of extreme stress (DESNOS) diagnosis: Part 1. Assessment. *Direct Psychiatry, 21*, 373–394.

Macklin, M.L., Mertzger, L.J., Litz, B.T., McNally, R.J., Lasko, N.B., Orr, S.P et al.(1998) Lower pre-combat intelligence is a risk factor for post-traumatic stress disorder. *Journal of Consulting Psychology*, 66(2), 323 – 326.

MacLean, M.G., Embry, L.E. & Cauce, A.M. (1999). Homeless adolescents' paths to separation from family: Comparison of family characteristics, psychological adjustment, and victimisation. *Journal of Community Psychology*, 27(2), 179 – 187.

MacManus, D., Dean, K., Al Bakir, M., Iversen, A.C., Hull, L., Fahy, T., Wessely, S. & Fear, N.T. (2011). Violent behaviour in UK military personnel returning home after deployment. *Psychological Medicine,* 25, 1 – 11.

Magruder, K.M., Frueh, B.C., Knapp, R.G., Johnson, M.R., Vaughan, J.A., Carson, T.C., Powell, D.A. & Herbert, R. (2004). PTSD symptoms, demographic characteristics, and functional status among veterans treated in VA primary care clinics. *Journal of Traumatic Stress*, 17(4), 293 – 301.

Mares, A.S. & Rosenheck, R.A. (2004). Perceived relationship between military service and homelessness among homeless veterans with mental illness. *Journal of Nervous & Mental Disease*. 192(10), 715 – 719.

Margolin, G. & Gordis, E.B. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, 51, 445 – 479.

Martijn, C., & Sharpe, L. (2006). Pathways to youth homelessness. *Social Science and Medicine, 62,* 1-12.

Marx, B. P. & Sloan, D. M. (2005). Peritraumatic dissociation and experiential avoidance as predictors of post-traumatic stress symptomatology. *Behaviour Research and Therapy, 43*(5), 569–583.

McCarty, D., Argeriou, M., Hueber, R. & Lubran, B. (1991) Alcoholism, drug abuse and the homeless. *American Psychologist*, 46(11), 1139 – 1148.

McGeorge, T., Hacker Hughes, J. & Wessely, S. (2006). The MOD PTSD decision: A psychiatric perspective. *Occupational Health Review*, 122, 21 – 28.

McLean, L.M. & Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality and complex post-traumatic stress disorder. *American Journal of Psychiatry,* 160(2), 369–371.

McKenzie-Mohr, S., Coates, J. & McLeod, H. (2012). Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention. *Children and Youth Services Review*, 34, 136 – 143.

Monson, C.M., Taft, C.T. & Fredman, S.J. (2009). Military-related PTSD and intimate relationships: From description to theory-driven research and intervention development. *Clinical Psychology Review*, 29, 707 – 714.

Moos, R.H. & Schaefer, J.A. (1993). Coping resources and processes: Current concepts and measures. In L. Goldberger & S. Brezntz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (2nd Ed, pp.234-257). New York: Free Press.

Mounier, C. & Andujo, E. (2003). Defensive functioning of homeless youth in relation to experiences of child maltreatment and cumulative victimization. *Child Abuse & Neglect*, 27, 1187 – 1204.

Mulligan, K., Fear, N.T., Wessely, S. & Greenberg, N. (2011). Psycho-educational interventions designed to prevent deployment-related psychological ill-health in Armed Forces personnel: A review. *Psychological Medicine*, 41(4), 673 – 686.

Mulligan, K., Fear, N.T., Jones, N., Alvarez, H., Hull, L., Naumann, U., Wessely, S. & Greenberg, N. (2012). Postdeployment Battlemind training for the UK armed forces: A cluster randomised controlled trial. *Journal of Consulting and Clinical Psychology*, 80(3), 331 – 341.

North, C.S. & Smith, E.M. (1992). Posttraumatic stress disorder among homeless men and women. *Hospital and Community Psychiatry*, 43, 1010 – 1016.

O'Connell, M.J., Kasprow, W. & Rosenheck, R.A. (2008). Rates and risk factors for homelessness after successful housing in a sample of formerly homeless veterans. *Psychiatric Services*, 59, 268 – 275.

Ozer, E.J., Best, S.R., Lipsey, T.L. & Weiss, D.S. (2003). Predictors of post-traumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin*, 129(1), 52 – 73.

Pearlman, L.A. & Courtois, C.A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, 18, 449 – 459.

Pelcovitz, D., van der Kolk, B., Roth, S., Mandel, F., Kaplan, S. & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress*, 10(1), 3 – 16.

Pietrzak, R.H., Johnson, D.C., Goldstein, M.B., Malley, J.C. & Southwick, S.M. (2009). Psychological resilience and postdeployment social support protect against traumatic stress and depressive symptoms in soldiers returning from Operations Enduring Freedom and Iraqi Freedom. *Depression and Anxiety*, 26, 745 – 751.

Piliavin, I., Sosin, M., Westerfelt, A. & Matsueda, R. (1993). The duration of homeless careers: an exploratory study. *Social Services Review,* 67(4), 576-598.

Powell, M. (2000) New Labour and the third way in the British welfare state: A new and distinctive approach? *Critical Social Policy*, 20(1), 39 – 60.

Randall, G., Britten, J. & Craig, T. (2007) *Getting through. Access to mental health services for people who are homeless or living in temporary or insecure accommodation. A good practice guide*. Department of Health: HMSO. Accessed 09/07/11 from http://www.nacro.org.uk/data/files/nacro-2007051102-534.pdf

Rees, S. (2009) *Mental Ill Health in the Adult Single Homeless Population*. London: CRISIS/PHRU.

Rhoades, H., Wenzela, S.L., Golinelli, D., Tucker, J.S., Kennedy, D.P., Green, H.D. & Zhoub, A. (2011). The social context of homeless men's substance use. *Drug and Alcohol Dependence*, 118, 320 – 325.

Rosen, G.M., Spitzer, R.L. & McHugh, P.R. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in DSM-V. *British Journal of Psychiatry*, 192, 3 – 4.

Rosenheck, R., Frisman, I. & Chung, A.M. (1994). The proportion of veterans among homeless men. *American Journal of Public Health*, 84, 466 – 469.

Roszell, D.K., McFall, M.E. & Malas, K.L. (1991). Frequency of symptoms and concurrent psychiatric disorder in Vietnam veterans with chronic PTSD. *Hospital and Community Psychiatry*, 42, 293 – 296.

Ryan, K.D., Kilmer, R.P., Cauce, A.M., Watanabe, H. & Hoyt, D.R. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse and Neglect,* 24(3), 333-352.

Sacks, J. Y., McKendrick, K. & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment,* 34, 90–100.

Saxe, G., Berkowitz, R., Chinman, G., Hall, K., Leiberg, G., Schwartz, J. & van der Kolk, B.A. (1993). Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry*, 150(7), 1037 – 1042.

Schnurr, P.P., Lunney, C.A., Bovin, M.J. & Marx, B.P. (2009). Posttraumatic stress disorder and quality of life: Extension of findings to veterans of the wars in Iraq and Afghanistan. *Clinical Psychology Review*, 29, 727 – 735.

Scoboria, A., Ford, J., Lin, H. J. & Frisman, L. (2008). Exploratory and confirmatory factor analyses of the Structured Interview for Disorders of Extreme Stress. *Assessment,* 15(4), 404–425.

Scott, J. (1993) Homelessness and mental illness. *The British Journal of Psychiatry*, 162, 314 – 324.

Sharpley, J.G., Fear, N.T., Greenberg, N., Jones, M. & Wessely, S. (2008). Pre-deployment stress briefing: does it have an effect? *Occupational Medicine*, 58, 30 – 34.

Sierles, F.S., Chen, J.J., McFarland, R.E. & Taylor, M.A. (1983). Posttraumatic stress disorder and concurrent psychiatric illness: A preliminary report. *American Journal of Psychiatry*, 140, 1177 – 1179.

Smart, R.G. & Ogborne, A.C. (1994). Street youth in substance abuse treatment: Characteristics and treatment compliance. *Adolescence*, 29, 733-745.

Solomon, Z., Weisenberg, M., Schwarnvald, J. & Mikulincer, M. (1988). Combat stress reaction and posttraumatic stress disorder as determinants of perceived self-efficacy in battle. *Journal of Social and Clinical Psychology*, 6, 356 – 370.

Spinnazzola, J., Blaustein, M., Kisiel, C & van der Kolk, B. (2001). *Beyond PTSD: Further evidence for a complex adaptational response to traumatic life events*. Paper presented at the American Psychiatric Association Annual Meeting, New Orleans.

Spinnazzola, J., Blaustein, M. & van der Kolk, B.A. (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? *Journal of Traumatic Stress*, 18, 425 – 436.

Stein, J. A., Leslie, M. B. & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: Mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26,* 1011–1027.

St Mungo's (2009a). *Down and out? The final report of St Mungo's Call 4 Evidence: Mental health and street homelessness*. London.

St Mungo's (2009b). *Happiness matters. Homeless peoples' views about breaking the link between homelessness and mental ill health*. London.

Sumerlin, J.R. (1999). Cognitive-affective preparation for homelessness: Quantitative and qualitative analyses of childhood out-of-home placement and child abuse in a sample of homeless men. *Psychological Reports*, 85, 553 – 573.

Sundin, J., Forbes, H., Fear, N.T., Dandeker, C., Wessely, S. (2011). The impact of the conflicts of Iraq and Afghanistan: A UK perspective. *International Review of Psychiatry*, 23(2), 153 – 159.

Suris, A. & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, and Abuse*, 9, 250 – 269.

Taylor, K.M. & Sharpe, L. (2008). Trauma and post-traumatic stress disorder among homeless adults in Sydney. *Australian and New Zealand Journal of Psychiatry*, 42(3), 206 – 213.

The Howard League for Penal Reform (2010). *Leave no veteran behind*. www.howardleague.org/leave-no-veteran-behind/

The Howard League for Penal Reform (2011). *Leaving forces life: The issue of transition*. www.howardleague.org.uk/leaving-forces-life/

Tyler, K.A. & Cauce, A.M. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. Child Abuse & Neglect, 26, 1261 – 1274.

Ursano, R.J., Benedek, D.M. & Engel, C.C. (2007). Mental illness in deployed soldiers. British Medical Journal, 335, 571 – 572.

Van der Kolk, B.A., Roth, S., Pelcovitz, D. & Mandel, F. (1993). *Complex PTSD: Results of the PTSD Field Trial for DSM-IV*. Washington, DC: American Psychiatric Association.

Van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S. & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389 – 399.

Van Emmerik, A.A., Kamphuis, J.H., Hulsbosch, A.M. & Emmelkamp, P.M. (2002). Single session debriefing after psychological trauma: A meta-analysis. *The Lancet*, 360(9335), 766 – 771.

Votta, E. & Manion, I.G. (2003). Factors in the psychological adjustment of homeless adolescent males: The role of coping style. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 778 – 785.

Walker, S. (2010). Assessing the mental health consequences of military combat in Iraq and Afghanistan: A literature review. *Journal of Psychiatric and Mental Health Nursing*, 17, 790 – 796.

Whitbeck, L.B., Hoyt, D.R. & Ackley, K.A. (1997a). Abusive family backgrounds and later victimisation among runaway and homeless adolescents. *Journal of Research on Adolescence*, 7(4), 375 – 392.

Whitbeck, L.B., Hoyt, D.R. & Ackley, K.A. (1997b). Families of homeless and runaway adolescents: A comparison of parent/caretaker and adolescent perspectives on parenting, family violence and adolescent conduct. *Child Abuse & Neglect*, 21(6), 517 – 528.

Whitbeck, L.B., Hoyt, D.R. & Yoder, K.A. (1999). A risk-amplification model of victimisation and depressive symptoms among runaway and homeless adolescents. *American Journal of Community Psychology*, 27(2), 273 – 296.

Wolfe, S.M., Toro, P.A. & McCaskill, P.A. (1999). A comparison of homeless and matched adolescents on family environment variables. *Journal of Research on Adolescence*, 9(1), 53 – 66.

Zorza, J. (1991). Women battering: A major cause of homelessness. *Clearinghouse Review*, 25(4), 412 – 129.

Empirical paper

A QUALITATIVE EXPLORATION OF THE LIVED EXPERIENCE OF BEING HOMELESS

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Abstract

Homelessness is a complex problem which has significant implications on an individual and societal level. Resources were for many years directed at examining the social, economic and housing trends which contribute to the homelessness problem. However, increasingly more recent research is now examining the individual personal factors implicated in homelessness. There is strong evidence to suggest that amongst the contributory factors to becoming homeless, mental health problems and an increased vulnerability to substance misuse and addiction feature highly. Furthermore, traumatic events are often seen as contributory factors to mental health difficulties and substance misuse, whilst trauma experience has been identified as a risk factor for homelessness. The aim of this qualitative study was to explore the subjective experience of homelessness from the perspective of ten individuals, (seven men and three women), who were living in a homeless hostel. Participants were asked to give their accounts during semi-structured interviews and the subsequent transcripts were analysed using Interpretative Phenomenological Analysis in an effort to gain insight into the meaning of trauma within the lived experience of homelessness. Three super-ordinate themes were identified; construal of the homelessness pathway, impact of homelessness, and coping, with additional overarching themes of trauma and responsibility. Overall, the findings illustrate that the factors that influence the onset and maintenance of homelessness are complex and multifaceted and reflect the uniqueness of individual participant's accounts whilst recognising the commonalities of their experiences. The clinical implications of the research findings are discussed including directions for future research.

Introduction

"*Homelessness is about more than rooflessness. A home is not just a physical space, it also has a legal and social dimension. A home provides roots, identity, a sense of belonging and a place of emotional wellbeing. Homelessness is about the loss of all of these. It is an isolating and destructive experience and homeless people are some of the most vulnerable and socially excluded in our society*" (Crisis, 2012)

Whilst homelessness may be associated with people 'sleeping rough' on the streets with no accommodation, these individuals represent a relative minority of the homeless population. The vast majority of homeless people rely on temporary accommodation including hostels or shelters or reside in unsuitable and insecure short-term accommodation, in squats, for example, or 'sofa-surfing' with friends and family (Rees, 2009). When attempting to define and describe the prevalence and social characteristics of homelessness and homeless people difficulties are encountered due to disparities in sample selection, diagnostic criteria and screening methods, producing wide variations in estimated figures (Fischer, Shapiro, Breakey, Anthony & Kramer, 1986), whilst the transient nature of homeless life adds to the problem of assessing the scale and extent of the problem (Warnes, Crane, Whitehead, & Fu, 2003). There are, however, over 43,600 bed spaces for single homeless people in emergency hostels and supported accommodation in England (St Mungo's, 2009a) and the Department for Communities and Local Government estimate that 2,181 people are sleeping out on any given night in England (CLG, 2012). The number of people living in temporary or insecure conditions is estimated at approximately 400,000 in the UK at any given point in time (Crisis & New Policy Institute, 2003).

The notion that homelessness should be viewed conceptually as a *process* rather than a *situation* (Hodgetts, Chamberlain, Hodgetts & Radley, 2007; Martijn & Sharpe, 2006) has assisted a theoretical understanding of the

multidimensional nature of routes into homelessness influenced by the interaction of macro and micro precipitating factors (Clapham, 2003; Hodgetts et al., 2007; Morrell-Bellai, Goering & Boydell, 2000). Such macro factors include vulnerability to poverty, unemployment, and lack of affordable housing whilst individual micro factors include traumatic life events, loss of employment, relationship breakdown, mental illness, leaving institutional settings (prison, military service, psychiatric facilities), and substance and alcohol misuse (Herman, Susser, Struening, & Link, 1997; Koegel, Melamid, & Burnam, 1995). These factors engender a vulnerability to homelessness (Koegel et al., 1995) and may accumulate over time, coming into particular focus during negative life events in combination with a perceived inability to cope or a lack of supportive resources (Rossi, 1989; Sosin, 2003; Sullivan, Burnam, & Koegel, 2000). Homelessness may occur repeatedly over a period of time (Rees, 2009), often as a result of the same causal factors colluding to make a cyclical process, characterised by individuals entering into and exiting out of homelessness according to circumstance (Susser, Moore, & Link, 1993).

When considering the individual factors implicated in homelessness, mental health problems feature highly (Buhrich et al., 2000, 2003; Fischer & Breakey, 1991; Kamieniecki, 2001; Randall, Britten & Craig, 2007; Rees, 2009; Scott, 1993) as does an increased vulnerability to substance misuse and addiction (Goering et al., 2002; Fischer & Breakey, 1991; McCarty, Argeriou, Hueber & Lubran, 1991). Mental health problems can include personality disorders, anxiety, depression and post-traumatic stress disorder, as well as psychoses (Fischer & Breakey, 1991; Folstom & Jeste, 2002; Rees, 2009; Scott, 1993; St Mungo's, 2009a). Such problems may precede homelessness and be viewed as contributory factors in becoming homeless or may arise or be exacerbated by the homeless situation and accompanying stressors and are often comorbid with substance misuse (Martijn & Sharp, 2006). Those identified as experiencing the greatest mental health difficulties are young homeless people, whilst mental health difficulties and substance misuse problems have been identified in up to two thirds of people sleeping on the streets, regardless of age (Goering, Tomericzenko, Sheldon,

Boydell, & Wasylenki, 2002; Fischer & Breakey, 1991; McCarty, Argeriou, Hueber, & Lubran, 1991; Rees, 2009; St Mungos, 2009a).

Homeless individuals have been found to have a higher than average exposure to physical and sexual violence, both preceding homelessness and occurring during their time spent homeless (Kipke, Simon, Montgomery, Unger, & Iversen, 1997; Martijn & Sharpe, 2006; Smart & Ogborne, 1994), with homelessness viewed as a potential source of trauma in itself (Fitzpatrick, Gory, & Richey, 1993). Exposure to violence that began prior to becoming homeless may be viewed as contributing to the onset of the situation, following the supposition that those who come from abusive backgrounds are more likely to use deviant survival strategies, and face higher levels of victimisation (Kipke et al., 1997; Smart & Ogborne, 1994). Experiences gained whilst homeless such as affiliation with deviant peers, risky sexual behaviours, and substance misuse are seen to amplify the effects of earlier trauma on victimization and depressive symptoms for young women (Whitbeck, Hoyt & Yoder, 1999), and are found to significantly increase the likelihood of serious victimization (Whitbeck et al., 1997a; Whitbeck et al., 1999).

Exposure to adverse experiences during childhood is commonly reported by homeless people, including physical and sexual abuse, neglect, family dysfunction, poverty, violence, and the death of a parent or primary caregiver (Herman, Susser, & Struening, 1994; Herman, Susser, Struening, & Link, 1997; Koegel, Melamid, & Burnam, 1995; Piliavin, Sosin, Westerfelt, & Matsueda, 1993; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Smart & Ogborne, 1994). Reported early adverse experiences and prolonged exposure to trauma are commonly comorbid with substance and alcohol abuse in homeless populations (Herman et al., 1997; Susser et al., 1993), and thought to account for the higher than average suicide rates in homeless people, compared with the general population (Molnar, Shade, Kral, Booth, & Watters, 1998). Mental health and substance misuse problems are often comorbid (Goering et al., 2002; Fischer & Breakey, 1991; McCarty et al.,

1991; Rees, 2009; St Mungos, 2009a) and whilst comorbid symptoms may develop independently to trauma reactions, they can also be viewed as maladaptive coping strategies in reaction to traumatic events. Avoidant coping is most closely linked to substance misuse with the associated tendency to avoid thinking about the consequences of high-risk situations, and to utilise substances to numb and avoid emotions (Levin, Ilgen & Moos, 2007). Avoidant coping is an important predictor of re-victimisation (Foster, 2009), although the causal relationship between trauma symptoms and avoidant coping is unclear. The high rates of exposure to traumatic events that have been reported amongst homeless people (Sacks, McKendrick & Banks, 2008), the number of homeless people that have experienced adverse early childhood experiences, and dysfunctional methods of coping, all contribute to such trauma experiences being conceptualised as risk factors for homelessness (Herman, Susser, & Struening, 1994; Herman, Susser, Struening, & Link, 1997; Koegel, Melamid, & Burnam, 1995; Piliavin, Sosin, Westerfelt, & Matsueda, 1993; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Smart & Ogborne, 1994).

Poor physical and mental health is a common issue for homeless people, accompanied by high mortality rates (Griffiths, 2002) with death from unnatural causes (accidents, suicide, murder, drug or alcohol poisoning) higher than the British average (Griffiths, 2003; Molnar et al., 1998) along with higher rates of premature death, with average life expectancy of 42 years as opposed to 74 years for males (Griffiths, 2003). Homeless people are less likely to access health care services provided by the NHS and non-statutory agencies, however, because of a desire not to be labelled as homeless (Shiner, 1995; Reid & Klee, 1999); giving a low priority to their own mental and physical health requirements when faced with other basic survival needs, such as food and shelter (Rees, 2009); and because accessing mainstream health services is more difficult for those who do not have a permanent address (Wood, Wilkinson & Kumar, 1997). In addition, poor collaboration between services may be present with gaps in service provision where individuals do not fulfil recognised diagnostic criteria, despite

their complex mental health problems, with subsequent issues of potential financial and clinical responsibility for the services involved. Furthermore, there may be a lack of awareness and recognition by services that the behavioural and conduct problems they encounter when working with homeless people may be manifestations of possibly misdiagnosed mental health conditions. Riggs and Coyle (2002) highlight that all of these factors need to be taken into account when planning services for this population of people, and for service provisions and interventions to be effective professionals need to increase their awareness of both the practical and psychological challenges faced by homeless people.

Research rationale

The majority of research into homelessness has utilised quantitative methods which have proved invaluable in identifying the factors that contribute to the onset and maintenance of homelessness. However, such methods cannot give an insight into the personal experience of homelessness or achieve an in-depth understanding, from an individual perspective, of the routes into homelessness or factors that may contribute to the maintenance of the problem. There is consequently a need for a phenomenological focus examining how, from the homeless person's perspective, their personal and social circumstances and experiences are construed and represented. This fresh idiographic emphasis is crucial for developing a more attuned awareness of the cognitive, behavioural and affective meanings given to the experience of being homeless. Given the influence that trauma is seen to have on the onset and maintenance of homelessness for many people, such insight and awareness into the meanings that homeless people give to such events may facilitate professionals to respond not only to the immediate crisis of homelessness, but to also develop interventions that have longer-term benefit.

Research aims

The small amount of qualitative studies undertaken with homeless people that precede the current research have largely focused on issues of identity, mental health and coping strategies (for example, Boydell et al., 2000; Riggs & Coyle, 2002; Williams & Stickley, 2010). There is little phenomenological information recounting the lived experience of homeless individuals that offers insight into how they construe their situation and their consideration of the factors involved in the onset and maintenance of their position. Whilst the presence of trauma has been implicated in prior research as a contributory factor to homelessness, and connected to problems of substance misuse and mental health difficulties, little information is known about homeless individuals' perceptions of this. The proposed research does not seek objective clarification of individuals' perceptions but is focused on gaining a phenomenological understanding by pursuing a narrative account of their life as a homeless person, together with an insight into their perceptions of their trauma history as part of that lived experience. The aim of the research is to increase the depth and quality of knowledge in this area and the research question is therefore:

"*What is the meaning of trauma within the lived experience of homelessness*?"

Method

Design

The design chosen for this research was qualitative as it was felt the most appropriate approach to explore in detail the experiences of homeless people. The suitability of the methodological approach should be regarded as the "primary criterion for judging methodological quality" allowing for a "situational responsiveness" (Patton, 1990, p.39) that permits the research question to influence how the research should be carried out. Therefore,

qualitative data collection and analysis such as this is guided by the purpose of the research. The research question required that a qualitative approach be assumed in order to provide a rich and detailed understanding of homeless individuals' experiences and is concerned with the context of that meaning (Willig, 2008) from the individual's perspective. Farrington and Robinson (1999) report that the majority of research regarding homelessness has employed quantitative methods which lack insight into personal experiences of homelessness and therefore the depth of meaning that may be obtained by examining individual perspectives. However, the precedent set by qualitative research that has been carried out in this area (for example, Hodgetts, Hodgetts & Radley, 2006; Lee & Farrell, 2003; Riggs & Coyle, 2002; Boydell, Goering & Morrell-Bellai, 2000; Snow & Anderson, 1987) strengthens its applicability for use in the present study.

The analytical method chosen to complement the qualitative design and to fulfil the research aims was Interpretative Phenomenological Analysis (IPA), following Smith (1996), with the recommended means of data collection for this analytic strategy being semi-structured interviews (Smith & Osborn, 2008). IPA utilises an inductive approach, identifying themes and concepts that emerge from the data, as opposed to restricting the analysis according to prior theory and knowledge. The aim of the analysis was to channel the complexity of the experiential data into themes to reflect both the diversity of individuals' experiences as well as commonalities amongst the group, revealing collective patterns of experience. The resulting themes are concerned with subjective meaning rather than positivist issues of objectivity and causation relating to participants' experience, with the rationale for theme construction provided by using examples from the data along with an explanation of how this interpretation was made.

IPA has its theoretical foundations in phenomenology and hermeneutics, building on the literature of 19th and 20th century philosophers Husserl, Heidegger, Merleau-Ponty, and Sartre (Smith, 2007). In the context of the present research, a phenomenological approach was taken in order to focus on homeless individuals' perspectives of their lived experiences and how

they seek to understand and attribute meaning to their situation and to the things that have happened to them. The way in which sense is made of how the experiences of the individual are re-created in their narrative relies upon the interpretation of the researcher. As such, the researcher's role in facilitating this interpretation is two-fold, seeking to first try to understand the participant's experience from their perspective, whilst simultaneously evaluating the underlying intent and meaning. Smith, Flowers and Larkin (2009) advise that this involves the researcher being engaged in a "double hermeneutic" where they try "to make sense of the participants trying to make sense of what is happening to them" (p.3). The aim of IPA is therefore to achieve a detailed examination of participants' stories in their own words by exploring experience in its own terms (Smith, 2004; Smith et al., 2009).

Participants

Sample size and criteria

In a review of PhD research utilising qualitative interviews Mason (2010) reports that the concept of 'saturation' should be held as an ideal when choosing the sample size of interview respondents. The point of saturation is considered to be when a further number of interviews will result in the production of repetitive information or will not contain any new concepts or themes. However, Green and Thorogood (2009) suggest that sample size alone is not the only contributory factor when considering saturation. The aims and nature of the study and the homogeneity and expertise of the study participants should also be taken into account (Charmaz, 2006; Morse, 2000; Ritchie, Lewis & Elam, 2003), with the participants in the present research viewed as "experiential experts" on the subject matter discussed (Smith, Flowers & Larkin, 2009, p.58). Proponents of IPA welcome the challenges made to the convention that a larger sample size corresponds with an increase in the value of research (Reid, Flowers & Larkin, 2005). IPA retains an idiographic focus, with ten participants at the higher end of most recommendations for sample sizes (Smith, Jarman & Osborn, 1999). A homeless hostel with links to the University was chosen as the site for the

study, as part of a larger charitable organisation that is keen to develop their research interest in this area. For the reasons outlined, it was decided that a sample size of no more than ten participants would be required and this was the number of participants that volunteered over the two days on which the research took place. For inclusion in the study it was required that the participants were currently resident at the hostel, with no restrictions placed on the length of stay, the number of times the participant had been homeless, or the circumstances of any prior homeless experience (i.e. street or hostel dwelling). It was considered that placing fewer restrictions on the inclusion criteria would allow access to a greater diversity of experience, making any commonalities found across the group all the more pertinent, whilst acknowledging that the sample was not homogenous in terms of the length of time they had been homeless.

Sample demographics

The sample of ten participants was comprised of seven males and three females. All the participants were white British with their age range spanning 19 to 56 years and they were all resident at the same homeless hostel in the city of Southampton. All relevant demographics are listed in Table 1, utilising the pseudonyms given to them.

Table 1 Demographics of participants

Participant Pseudonyms	**Age**	**Education level**	**Length of time spent homeless**
Bill	52	Secondary	9 weeks
Simon	23	Secondary	5 years*
Graham	55	University	2 years
Andrew	21	Secondary	3 years*
Melanie	19	Secondary	3 years*
Gareth	26	Secondary	14 months
Martin	56	Secondary	29 years*
Jessica	22	Secondary	6 weeks
Ben	38	Secondary	3 years
Anna	29	University	5 years*

Whilst all the participants were currently living in the homeless hostel, (*) indicates intermittent periods of homelessness (street, hostel, or squat) and living in accommodation with a formal tenancy.

Procedure

As described above, the recommended data collection method when conducting IPA is semi-structured interviews. Semi-structured interviews start with a set of questions and have the inherent flexibility of further questions being asked, unlike more structured methods where the course of

the interview is predetermined according to what data is required. An interview guide was used, using questions prepared beforehand, with any further questions based on the interviewee's responses. These additional questions were used to guide the participant to give greater elucidation to their accounts and to pursue important or interesting areas that arose during the interview. Smith et al. (2009) suggest that between six and ten open questions will provide enough information on which to base a comprehensive analysis. The questions created for use in the interviews were selected in order to gain an 'insider perspective' of the subjective experience of homelessness, related to the research aims (see Appendix C for the interview schedule). The questions asked were open-ended in nature, avoiding prescriptive or prohibitive statements (Burman, 1994), to engage the participant and to encourage them to speak freely and to talk about their own thoughts and perceptions of their personal experiences, in their own words. The interviews were digitally recorded in order for a permanent record to be made regarding how meaning was "communicatively assembled in the interview encounter" (Holstein & Gubrium, 1995, p.4).

The participants were interviewed individually in a private room in the homeless hostel. Prior to the interview, the researcher had met with staff at the hostel and explained the purpose of the research and what participation entailed and the staff then approached residents to see if they would like to take part and ten people expressed an interest. An information sheet (see Appendix A) was given to the residents by the hostel staff and when the researcher visited the hostel they were able to speak with potential participants to answer any questions or clarify any issues. The participants were asked to sign a consent form (see Appendix B) before the interview commenced. During the interview the researcher endeavoured to maintain a neutral stance in order to facilitate the participants' open expression of their views, reformulating what was said in an impartial manner to check for accurate comprehension of the participant's meaning, whilst remaining empathic to the emotive content of their recollections and perceptions. The interview process, described by Smith and Osborn (2008) as a "one-sided

conversation with a purpose" (p. 58), did not adhere to the usual conversational dynamics in that when silences occurred they were deliberately used to allow the participant time to reflect upon the questions asked or to collect their thoughts. Upon completing the interview the researcher carried out a 'mood repair' exercise with participants (see Appendix D) and the participant was given a debriefing statement (see Appendix E) with information and contact details about the study and sources of further support. Interviews lasted between 30 minutes and one hour and participants received a supermarket voucher as a means of thanking them for taking part.

Ethical Considerations

Ethical approval was sought and obtained from the University of Southampton ethics committee (see Appendix F) and what follows is a synopsis of the ethical considerations that were applied during the planning, data collection, and analysis of the research project.

Informed consent should be viewed as an on-going process (Richards & Schwartz, 2002) and participants were therefore advised that they may withdraw their consent at any point either during or after the interview, without detriment. In addition they were informed of their right not to answer any questions if they did not feel comfortable doing so. As part of consent being viewed as a process, rather than as a one-off event, Richards and Schwartz (2002) recommend that, where possible, participants should be involved in decisions made during the course of the research that may influence the direction and progression of the research. Whilst it was not possible, at the time of the interviews taking place, to predict what themes would emerge from the data collaboration was achieved during the interviews by the researcher checking they had an accurate comprehension of participant's perceptions by reframing their words and probing for extra information. In this way, and by giving as much information as they felt able or willing to, the participants were able to give their consent, in the broader sense of the word, to the content of the account created.

As part of the consent process, participants were advised that no identifiable information would be included in the transcription of the digital recordings of the interviews and pseudonyms would be used to preserve their anonymity. However, there is the likelihood that participants, and others, may be recognisable in the written account of the research. As Jones, Murphy and Crosland (1995) emphasise, when qualitative research findings contain verbatim material and quotations, as within the present research, "anonymity may be preserved but confidentiality is necessarily abandoned" (p.625). All participants were therefore explicitly advised of how it was intended that the research would be presented, utilising excerpts of their speech from the interview data, with this point being reiterated on the consent form that they were requested to sign before the interview commenced.

Consideration was given to issues of the emotional risk to the participants when talking about potentially distressing subjects. The staff group at the hostel were informed of the nature of the study and were on hand to provide direct support to participants following the interviews, as well as providing additional information and contact details of outside support. Furthermore, the study was supervised by a qualified Clinical Psychologist who was available to provide support should all other provisions not be sufficient. A mood repair task consisting of a distraction exercise (see Appendix D) was also utilised at the end of the interview to act as a buffer to any adverse emotional reactions that may have been evoked by what had been discussed as well as the participants receiving verbal and written debriefing (Appendix E). Although these measures were prepared in advance of data collection commencing, Read, Hammersley and Rudegeair (2007) report no serious damage caused by asking people about their experiences of childhood abuse, with a similar outcome thought to occur when talking about other traumatic experiences. No participants reported any adverse effect from discussing their experience, either during the interview or after, with some talking about perceiving the chance to express their views and "tell their story" as beneficial.

Data Management

The digital recordings of the individual interviews were stored securely according to the requirements of data protection legislation. The interviews were transcribed using pseudonyms to protect the participants' identity and to maintain confidentiality. The process of transcription followed the recommendations of Smith et al. (2009), with all speech from both the researcher and the interviewee being transcribed. Non-verbal utterances, such as laughter, and significant pauses and hesitations were noted, whilst the inclusion of finer prosodic details, such as that favoured by conversation analysis, was not required. Following transcription the audio recordings of the interviews were destroyed.

Data analysis

Smith et al. (2009) advocate that an innovative approach should be taken when carrying out the analysis of transcribed data, whilst utilising a heuristic framework in order to focus and structure the analytical process, which should be seen as an "iterative and inductive cycle" (Smith, 2007). The process of interpretation was carried out through sustained engagement with the text, with the resulting analysis seen as a joint product of both the participant and the researcher, in the development of a 'dialogue' between the researcher and the accounts of the participants. Whilst the primary aim of IPA is to gain an understanding of the lived experience of the participant and the meanings they attribute to their experiences, the ways in which sense is made of their perceptions and attributions involves understanding this from a subjective, third-person position. Smith et al., (2009) state that the subjective content of the analysis should not be dismissed as holding less value as long as such subjectivity is acknowledged and is systematically and transparently applied.

The interview transcripts were analysed according to guidelines set out by Smith et al. (2009). The transcription of the interviews by the researcher afforded a familiarity and engagement with the content which was developed

further by additional scrutiny during subsequent re-reading. During the descriptive or phenomenological coding process (Smith et al., 2009) notes were made in the left hand margin, if the material was found to be significant or interesting. The continual reviewing and re-reading of the transcripts during this process allowed insights to be continuously developed and refined and ensured that the subsequent themes that were constructed accurately represented what the participants had said during their interviews. The next stage involved interpretative coding whereby the researcher documented emerging themes in the right hand margin of the transcripts. This involved a higher level of abstraction and interpretation than the descriptive coding with the identification of apparent themes for each transcript. The themes for each transcript were then reviewed and compared with any resulting connections identified, and organised into clusters which reflected the most salient and important aspects of the participants' accounts. The themes were labelled or named using a participant's phrase pertaining to the content, with the choice of expression containing "enough particularity to be grounded and enough abstraction to be conceptual" (Smith et al., 2009, p.92).

Validity and reliability

Validity is not a fixed or universal concept, but should be viewed as a construct grounded in the processes and intentions of the research methodology (Winter, 2000). Rather than adhering to principles of validity in terms of accuracy of measurement it should therefore be acknowledged that, in the present research, validity relates to the transparency of the manner in which the interpretive accounts were created and constructed and the quality and appropriateness of the methodological approach to both data collection and analysis. Yardley (2000) recommends four broad principles for assessing the quality and appropriateness of qualitative research, designed to be used flexibly as guidelines during data collection and analysis. The first of these guidelines is that the research should be sensitive to the context in which it is taking place in terms of the socio-cultural setting, the material obtained, and its position beside existing literature. This sensitivity also relates to the interactional process of the interview and the relationship between the researcher and participant that facilitates the production of quality data from which analytic claims may be grounded. Smith et al. (2009) highlight that the sensitivity to context should be extended to the analysis of the data, when "making sense of how the participant is making sense of their experience requires immersive and disciplined attention to the unfolding account of the participant" (p.180). The responsiveness of the researcher to the participant during the interview and their close attentiveness to the analysis also encompasses Yardley's second principle; namely that of commitment and rigour. It is argued that this should be applied to all areas of the research process, including both data collection and the interpretation and analysis of the data, and is synonymous with the sensitivity to context whilst being reflected in the quality of the outcome of the analysis, where thorough and systematic interpretation is apparent in the credibility of the account. The third principle suggested by Yardley is that of transparency and coherence. This refers to the manner in which the data collection process is described and the explanation of how the interpretations of the experiential data were reached. In the present research advice was sought with reference to the analysis of the data and construction of themes, from a

member of the supervisory team, in order to check the credibility of the data and that there was a progressive, systematic path through the 'chain of evidence', as recommended by Smith et al. (2009). Transparency and coherence can also be assessed by the quality of the written account presenting the research findings and the coherence and plausibility of these findings in light of underlying theoretical assumptions. The last principle proposed by Yardley is again connected with the manner in which the research findings are described and presented, with the assertion that they should have demonstrable impact and importance.

Reliability, in research terms, refers to the ability or capacity for the research to be replicated and consistently yield the same results. When research is qualitative in design, however, its aims are to explore the researched phenomenon in detail (Willig, 2008) and the concern is with describing individuals' personal experiences rather than producing results that are replicable. In addition, inherent within the concept of reliability is the suggestion that research should uncover or represent an absolute 'truth'. This is inconsistent with the tenets of qualitative research concerned with meaning-making where the knowledge produced should be accepted "as constructed, as one version of reality, a representation rather than a reproduction" (Tindall, 1994, p.143). The acknowledgement is made when carrying out IPA that the researcher relies upon a process of inter-subjective meaning-making in making sense of the participant's accounts of their experiences with the product of analysis being a third-person interpretation of a participant's first-person reflections. Those reflections reveal details about an individual's relationship to a given phenomenon in a given context (Smith et al, 2009) with the researcher's own subjective judgements, regarding how the experiential evidence may be sorted into themes, being part of the interpretative meaning-making process. The clarity with which the research aims are described, together with an explicitness of the methodological approach and a transparency in the construction of themes, facilitates an understanding of the contextual basis for the knowledge produced. The epistemological stance that supports the methodological approach and analytical strategy maintains that the knowledge that will be presented

following analysis should be viewed as not objectively reflecting an external reality or 'truth', but as an interpretation of the meaning of experiences for the individuals involved, and thus should be regarded as one version of an interpretive and negotiated creation of meaning.

Results and discussion

The interviews were undertaken with the participants in order to gain insight into their understanding of their experiences of homelessness. The accounts produced were rich in detail, affording an awareness of the meanings they attributed to their lived experiences. Whilst the participants were articulate when describing their experiences often their accounts were typified by inconsistencies that contributed to a picture of chaos and incoherence. This does not result in the plausibility of their accounts being questioned but instead strongly highlights the uncertain, insecure, and unpredictable nature of their situation that is interpreted as being an inherent component of their lived experience as a homeless person.

Hansen (2006) advises that, when writing up qualitative research, there are various unique and valuable characteristics that make the standard reporting format for quantitative research untenable. Rather than presenting the results of the data collection in isolation from a separate discussion chapter, the decision was made by the researcher to include a concurrent presentation and discussion of the research findings, and their relation to prior literature and alternative studies (Hansen, 2006). Such a concomitant approach provides a more fluid narrative of how themes that were identified from the participants' phenomenological accounts are situated in a wider context. Smith et al. (2009) propose this method as one way in which to present the results of the analysis and precedents have been set in the literature for adopting this approach (for example, Knight, Wykes & Hayward, 2003; Riggs & Coyle, 2002).

Description of themes

The process of analysis resulted in the development of three super-ordinate themes: *construal of homelessness pathway, impact of homelessness,* and *coping*. Each super-ordinate theme is comprised of component themes as outlined in Table 2. The participants' own words have been used within the component theme title to ensure the themes remain grounded in the data. The three super-ordinate themes are situated within an overarching thematic framework of *trauma* and *responsibility*. These overarching themes permeate all the super-ordinate and component themes.

Analysis of the participants' accounts revealed the uniqueness of individual's experiences, whilst commonalities were found in the meanings attributed to their experience. Evidence from participants' accounts will be provided for each theme in order to illustrate their understanding and the contextual basis for the way in which the participants' accounts were interpreted and how this contributed to the theme construction. All themes were represented by extracts from the original text, but were not chosen purely for their prevalence, following the recommendation made by Smith (1999) to take into account "other factors, including the richness of the particular passages which highlight the themes, and how the theme helps illuminate other aspects of the account" (p. 226). The participants' quotes utilised to illustrate the themes were chosen as the most appropriate to exemplify how the theme was constructed. These excerpts of speech may be seen to also relate to other themes that share similar features, however, to reduce repetition and to assist the narrative the quotes used were chosen by the researcher to best reflect the theme under discussion. In the selected quotations empty square brackets indicate where material has been omitted; ellipsis points (…) indicate a pause in participants' speech; and information within square brackets has been added for clarification. All potentially identifying information has been changed to protect confidentiality, with unrelated pseudonyms used.

Table 2: Overview of Themes

Overarching themes
Trauma, Responsibility

Super-ordinate Theme	Component Themes
1. Construal of homelessness pathway	▪ Choice: "I never really wanted to be tied down" ▪ Escape: "It was whole relief, I was myself again, I was happy" ▪ Being in the system: "I was released with nothing
2. Impact of homelessness	▪ Identity: "I became who I didn't want to be, have done things I would never have done" ▪ Psychological wellbeing: "Your life's just kind of uprooted and destroyed" ▪ Relationships: "I've seen people rob their own friends in here"
3. Coping	▪ Substance misuse: "It blocks, you don't have to worry about the things you should be worrying about" ▪ Denial & avoidance: "I didn't tell anyone for a while…carried on as normal with me mates" ▪ Planning for the future: "I don't want my life to be shit, I want my life to actually take a different path"

Overarching themes

Trauma

All the participants recounted a history of trauma, describing events experienced during childhood and adulthood. Childhood trauma consisted of parental abandonment; death of a parent; physical and sexual abuse; sexual assault; and witnessing parental self-harm. Trauma that was experienced as an adult included domestic violence, physical assault, robbery, and witnessing violence perpetrated against others. Some participants had extensive and varied histories of traumatic exposure whilst for others they had encountered a single identifiable traumatic event. Whilst for some participants the trauma was in their past, for others it appeared as an on-going feature in their lives, and was perceived by the researcher as connected with their homeless situation, and often related to substance misuse, when considering the physical assaults experienced by some were whilst in a vulnerable condition or situation.

Trauma experience was talked about spontaneously by all participants and was largely in the context of being presented as a component of their life history, whilst for two participants it was described as an immediate precursor to becoming homeless, in that they left the environment where the trauma was taking place, becoming homeless as a result. The degree to which their trauma history constitutes an on-going influence, contributing to the maintenance of their homeless situation, was not something that was explicitly referred to by participants in their phenomenological accounts of life as a homeless person. However, the fact that the participants talked about their trauma histories without prompting indicates that they consider that these experiences feature prominently in their perceptions of *who* they are and that they wished this information to be known as part of the 'back story' to their present situation. This led to the identification of trauma as an overarching theme for all other super-ordinate and component themes with the knowledge that the trauma histories of participants provide a contextual background against which their lived experiences are set.

Responsibility

The concept of responsibility has been identified as an overarching theme that permeates the majority of the super-ordinate and component themes. It reflects the emotional, behavioural, and cognitive features of participants' understanding of both extrinsic and intrinsic issues of responsibility and accountability relating to their homeless situation. Responsibility is a pervasive element in the ways in which participants make sense of their situation and attribute meaning to the things that have happened to them and the ways in which they have then reacted. Responsibility, in these instances, is closely aligned with issues of power and control. Connected to the super-ordinate theme '*construal of homelessness pathway'* issues of responsibility are found in the participants' understanding of the reasons for becoming homeless; whether these were related to attributing the responsibility for their situation to external factors (the prison/homeless system, escaping an abusive situation), or to their individual choice to become homeless to avoid the responsibility they perceived as connected to a settled life. The super-ordinate theme '*impact of homelessness*' contains elements of responsibility in participants' reflections on the causes for changes to perceptions of identity, in terms of their responses to the reactions of others and the behaviour that they have been obliged to adopt in order to survive. Such attributions of responsibility and blame are also contained within participants' descriptions of their relationships with their family and others, whilst the super-ordinate theme '*coping*' is seen to reflect an externalisation of responsibility as a means of managing the impact of their homeless situation. Explicit reference to the overarching theme of responsibility will be made, where applicable, during the discussions that follow of each super-ordinate and component theme.

Super-ordinate and component themes

1. Construal of homelessness pathway

This super-ordinate theme represents aspects of the participants' experience that they identified and defined either as a reason for initially becoming homeless or as involved in their on-going homelessness. The component themes that relate to this super-ordinate concept are connected to either external events that have happened to them: *Being in the system: "I was released with nothing"*; homelessness as an outcome or reaction to events: *Escape: "It was whole relief, I was myself again, I was happy"*; or as a part of their perceived identity and elected lifestyle: *Choice: "I never really wanted to be tied down"*. This theme reflects both commonalities and contrasts in participants' construal of their situation, reflecting differing perceptions of both positive and negative aspects to becoming and remaining homeless.

Choice: "I never really wanted to be tied down"

This component theme was developed from participants' references to decisions they have made in the past connected to how they first became homeless and their perceptions of self and the life they have chosen to live. Whilst other paths into homelessness and the maintenance of this status may be construed as reactive to events, the way in which it was referred to as a choice was interpreted as contributing to their understanding of themselves as exerting a degree of control over their situation.

Martin's account provides an example of how the decision to become homeless was construed as somewhat positive when he described that making the choice to become homeless enabled him to do what he wanted to do and gave him freedom from responsibility:

"*The first time, I decided to make myself homeless. I moved up to London, I wanted to be in the bright lights and earning money and all the rest of it. I've never really wanted to be tied down*. [ ] *Quite a few times I had the opportunity to have a good life, but I chose not to, because I enjoyed having the freedom, the lack of responsibility. I didn't have to answer to anyone*"
Martin, 114 – 116; 433 - 438

For Martin, his first experience of homelessness at the age of 17 preceded a lifetime of itinerancy, intersected by spells of being settled for short periods and having a family, or serving multiple prison sentences. Martin described being a heroin addict for 38 years and identified his drug use as a reason for leaving his family and resuming a homeless lifestyle following a period of being settled:

"I didn't want them around it to be honest with you. I don't want to sound selfish but I chose the drugs. It's only at the time I thought I was doing the right things and I probably was, getting out the way. You don't want your kids growing up around someone injecting drugs in the room and the mothers don't want to see it, obviously"
Martin, 254 – 261

Relating to this period of his life where he had become a father he describes thinking that he was "*doing the right things*" for his family by leaving them and becoming homeless once more, with his choices also fulfilling his original wish for freedom from responsibility. Martin's awareness of how others may construe his decisions and his wish not to be judged by this ("*I don't want to sound selfish*") contextualises his justification for the decisions he made. His explanation of not wanting his children around *"it"* (the drug use) may be seen as an attempt at distancing himself from the possible implication that he didn't want them around *him*. The change in the tense used and his point of reference from first person to third person ("*I didn't"* to

"*you don't*") may serve a similar purpose, or may be viewed as a rhetorical strategy for eliciting understanding and acceptance of the choices he made.

The meaning of homelessness for participants also influenced the way in which they understood their situation and viewed their decisions, with residing in a hostel not defined as being homeless, for some, exemplified in the following statement:

> *"I don't feel myself as homeless 'cause I've got a home. I've got a roof over my head, food, facilities to wash. This is kind of like a break to me really. I could ask my mum to have me back but I don't really want to rent a room off her"*
> Simon, 294 – 297

Simon, who had spent time living on the streets, saw living in the hostel as a positive choice, "*like a break to me really*". On an individual, discursive level, the use of the word "*feel*" in Simon's speech, as opposed to choosing the word "think", may be a feature of the way in which he views himself and the world and suggests a subjective judgement of his position influencing how he defines his situation and his role within this. The above extract may be interpreted as exemplifying an awareness of ways in which Simon could exit the situation but makes an active choice not to do so or the lack of choice he has in terms of the options that are available to him. For others, issues of choice were not so positively construed and understood, with the decision to become homeless seen as a last resort or as a result of having personal free will and the ability to make decisions and choose where they would live withdrawn from them by circumstances.

Escape: "It was whole relief, I was myself again, I was happy"

Similar to the previous component theme, this theme also contained reference to a positive aspect of the experience of first becoming homeless, if only because it was perceived as providing a way of escaping an untenable

situation. It is connected with the previous theme of 'choice' but holds differences in connotation in that, at one extreme, there was felt to be no choice or option other than to escape and become homeless, as the alternative was to remain in a situation that was causing harm and suffering, as in the cases of Anna and Melanie. Anna had experienced domestic violence from the partner she was living with and chose to leave and stay in a women's refuge. Melanie had been sexually abused by her mother's husband and left the situation, becoming homeless as a result. Both of these participant's experiences relate to factors that have occurred in their childhood and as an adult that have been found to precipitate homelessness (Bassuk, Perloff & Dawson, 2001; Zorza, 1991). Anna had endured the domestic violence to the point where she felt she could no longer, whilst Melanie had made previous unsuccessful attempts to stop the abuse:

> "*I went through the whole thing for 6 years, from age 9 to 15 when then I actually got up and left. I did speak to my counsellor at school about it and she phoned the police because I said I didn't want to do that. Then I dropped all the charges because my mum said to me "Is it true?" and then took an overdose in front of me. And I was only 12. So I said it wasn't true and then he didn't get charged for it or anything. And it carried on*"
> Melanie, 64 – 77

For both Anna and Melanie, they felt they had no choice but to escape the situation and become homeless, taking control of their circumstances. Anna and Melanie's accounts describe their pathway into homelessness as an 'ultimate' escape, whilst at the other extreme when Graham found himself homeless, albeit not through the same degree of interpersonal trauma, he actually came to view it as a positive 'escape' route out of the life he had been living previously and with which he had been dissatisfied:

> *"It was quite a shock, to be honest. To begin with homeless meant to me, you know, the source of constant panic, trying to find my way. But*

then it was nice to be part of a community that actually stuck together and tried to support each other. It was different…better…than before"
Graham, 12 – 19

It appears that Graham was able to adapt the meaning of his situation, after his initial reaction to it, leading to greater life satisfaction and a reduction in some of the harmful psychological effects of homelessness (Thoits, 1991). Whilst coming from divergent positions regarding the ways in which the decision to become homeless was made, or viewed as the only option available to them, inherent within both were positive perceptions about the resultant change in circumstances, as can be seen in Graham's extract above and the following statement from Anna relating to leaving the violent situation:

"It was whole relief, the next day. I was myself again, I was bubbly, I was happy"
Anna, 267 – 269

Anna talks here of the "*whole relief*" of leaving the situation and being in a safer place, and that she felt her true identity had returned: "*I was myself again*", speaking of her renewed view of self ("*bubbly*") and the corresponding emotion ("*happy*"). It would appear from their accounts that the escape described in the different circumstances involved retaining or *regaining* control or responsibility, in the case of Anna and Melanie, whereas Graham described an element of *relinquishing* control and responsibility when he reports that he stopped "*trying to find my way*" and reached acceptance of his situation and the positive benefits it brought him. The excerpts of speech used to support the component theme 'escape', and the interpretations discussed above, may be seen to relate to the overarching theme of 'responsibility', with choice or voluntary control seen as a precondition of such responsibility (Smith, 2008). In this way, although they were escaping situations over which they perceived they had little control, their actions in getting away may be construed as taking some responsibility for their own safety and wellbeing as a consequence of assuming control.

As discussed previously, when outlining the description of themes (p.80), to reduce repetition and to assist the narrative, the quotes used were chosen by the researcher to best reflect the theme under discussion, and in this instance the interview extracts were seen to best support the component theme of 'escape'. The following extract is a further example of the close association of the component themes 'choice' and 'escape' that contribute to the superordinate theme 'construal of homelessness pathway':

> "*I was in a tent for about two months, November, December time it was really cold. I could hardly sleep in the night, shivering and really cold. I'd try and wrap myself up in the covers as much as I could but still…it was awful. And from there, yeah, I moved into this place from there. Went down the day centre and managed to find a room here. There's all sorts of rules and stuff…guests, music… but it's warm and dry. Lesser of two evils I suppose….*"
> Andrew, 368 - 375

From the participants' accounts of their experiences it was evident that the homelessness pathway cannot be construed as following a linear progression, with many entering and exiting the situation at different points and for diverse reasons and circumstances. For some, such as Andrew, the circumstances they found themselves currently living in were viewed as a more appealing alternative, relatively speaking, than sleeping rough. Although he regarded he had little choice or control when he first became homeless, his current situation living in the hostel was perceived by him as being a positive escape from sleeping rough and the physical and mental demands this entailed, and he thus viewed his decision to 'escape' and enter the hostel as a "*lesser of two evils*". This may be contrasted with others' accounts of their homelessness pathway that suggest a perception of having been 'captured' within the homelessness system, with their identity detrimentally affected as a result, as exemplified within the next two component themes. This is particularly pertinent when considering participants' opinions of the role of the system and how it is perceived to actively prevent their progression, or escape from the homeless situation.

Being in the system: "I was released with nothing"

This theme corresponds to how some of the participants experienced the 'system' as a causal factor to them first becoming homeless or as a reason for remaining homeless, or both. Participants expressed anger and resentment when talking about this, both in terms of the perceived inadequacies of service provision and their own lack of power and inability to therefore change their situation and exert any control over their circumstances. The following excerpt illustrates Gareth recollections of being released from prison:

> *"I was released with nothing, know what I mean? The clothes I had on me and that was it, and a dead phone. Didn't even have the charger, you know what I mean?"*
> Gareth, 409 – 414

Gareth perceived that being released from prison with nothing, and with nowhere to go, resulted in him first becoming homeless. His repeated use of the phrase "*know what I mean?*" can be construed as a habitual expression but also may be interpreted as a means of checking that his message was being comprehended accurately, with the enormity of having nothing adequately conveyed. He considered that if he had been provided with accommodation upon his release from prison the situation would have been much different:

> "*If I'd be given somewhere to live I probably would have had a job by now and a car by now and a driving licence."*
> Gareth, 420 – 423

Gareth compares the life he feels he could be living, had it not been for the circumstances he encountered when released from prison, and his situation now. The fact that he wasn't given any accommodation he describes as the sole reason for his subsequent homelessness as the following extract illustrates:

(Researcher asks "Is there anything else that you think has gone towards making you homeless, your personality…your experiences that make you the person you are?)

"No. If they'd released me from jail with somewhere to live I'd still be living there now wouldn't I?"
Gareth, 469 – 471

Gareth appeared not to make any connections to any concept of personal responsibility with his appraisal of the situation contributing to feelings of anger and frustration regarding the opportunities he felt had been denied him. Gareth was not the only participant who had been released from prison with nowhere to live although he had then experienced difficulty getting a place in a hostel because his conviction had been for a violent offence, which resulted in him living on the street for 7 months:

"*I was trying every fucking day whilst I was on the street but I got refused because of my criminal record. [ ] I'm not a paedophile or rapist, or nothing like that. I just beat someone up"*
Gareth, 71 - 80

Again, Gareth offered the difficulty he had getting off the street and into a hostel as further evidence of his perception of major flaws in the system and, whilst acknowledging that it was his own criminal record that prevented entry into some hostels, downplayed his responsibility and the influence that his previous actions had to bear on the situation: "*I just beat someone up*".

Whilst others experienced similar difficulties when leaving prison the homelessness system itself was seen by some as contributing to the maintenance of their situation. Martin experienced a different situation following his last release from prison in that he had been provided with somewhere to live but did not perceive this in a positive light, having had no influence or control over where he would be placed:

> "*I don't want to be stuck in bedsits here, there, and everywhere…The last bedsit, I'd stopped using* [heroin]*, but they moved me in down the Derby Road. Within two weeks of being there I was using again, 'cause everyone in the house, every room, they were all heroin addicts. I just couldn't take it no more"*
> Martin, 375 - 383

Martin thus attributes the responsibility for him resuming a previous drug habit to being placed into a situation, without discussion, where he considered himself vulnerable to this happening, with the implication that if the authorities had housed him elsewhere this would not have occurred. Substance abuse is considered one of the biggest risk factors associated with repeat homelessness (Drake et al., 1998; Folsom et al., 2002; Koegel et al., 1995) whilst release from prison with no accommodation or inadequate housing has a close association with reoffending (Department for Communities and Local Government, 2006), contributing to the risk of future homelessness. It is interesting to note that both Gareth and Martin's experiences of release from prison, and homelessness outcome, highlight the need for close collaboration between prison-based housing advice staff and external agencies, if a cycle of homelessness, substance misuse, and re-offending is to be prevented.

For other participants, the ways they perceived that the homeless system was responsible for the maintenance of their situation related to the temporary nature of the hostels they stay in, meaning that these are not long-term places of residence and they were required to move on, often to other hostel accommodation or to tenancies that were only available to them on a short-term basis. Being homeless also prevented participants from gaining employment in order to obtain enough money to enable them to exit the situation. When staying at the hostel there is a financial requirement for residents to contribute towards costs which many felt exacerbated their poverty and prevented them from saving money for a deposit for accommodation elsewhere, as the following interview extract typifies:

> "*I need money for a start and that ain't happening while I'm in here 'cause they're taking, what is it, £36 a week off me. So, I'm left with about £12 after they've done. I can't live on £12 as it is*"
> Andrew, 185 – 188

The circle of poverty, material deprivation, and reduced opportunity that participants described engendered feelings of impotency and helplessness regarding their own ability to change their situation. The effect that this had on individuals' sense of self and associated psychological wellbeing will be discussed in more detail shortly when considering the impact of homelessness within the next component theme.

2. Impact of homelessness

This super-ordinate theme describes the impact of homelessness on participants' lives affecting their identity: "*I became who I didn't want to be, have done things I would never have done*"; their psychological wellbeing "*your life's just kind of uprooted and destroyed*"; and their relationships: *"I've seen people rob their own friends in here".* Collectively these component themes illustrate the pervasive influence that homelessness has on all areas of their lived experience, connected to issues of loss, rejection, and isolation which in turn contribute to the overarching theme of trauma, when the impact of their homelessness is construed as distressing and traumatic in its own right.

Identity: "I became who I didn't want to be, have done things I would never have done"

The concept of identity was apparent throughout the participants' narrative accounts relating both to how they viewed themselves and how they perceived they were regarded by others. There was a collective feeling of being cast under a negative homeless stereotype by people that did not know them and had no knowledge of who they were and their own individual circumstances, as exemplified in the following comment:

> *"I was walking through town with my rucksack and that and some man spat on me before. [ ] They think 'cause you're homeless you're scum of the earth"*
> Gareth, 449 – 452

The fact that being homeless was perceived to change the way they are viewed by others was, for some participants, connected to a loss of their former identity and an adoption of a negative homeless identity, corresponding to how they may have previously viewed homeless people themselves:

"*I became who I didn't want to be, have done things that I would never have done…like, that I wish I'd never done. I've been driven, been on the last of it like. Had no choice but to punch somebody to take their money off them or do something 'cause I've been that hungry, that cold, that wet, that alone*"
Simon, 606 - 611

"I used to think "dirty little smack heads" and six months later I'm fucking one myself. Not fucking good"
Gareth, 438 – 441

That participants' identities are inextricably connected to the way they are perceived and treated by others is also a concept described by Boydell et al. (2000) by which interactions and relationships with others construct and sustain definitions of selfhood. There was the perception, for some participants, that the things they had witnessed and the action they felt they had been forced to take because of their situation, had invoked an irreparable change in their identity, with the on-going situation forcing them to repeat behaviours that reinforced this notion. The participants' own sense of worthlessness and shame regarding this was strengthened by the rejection of society, when they were seen to act in ways that corroborated the views and expectations of the majority of domiciled people with fixed abodes. How such issues of threats to identity were seen to affect participants in terms of their psychological wellbeing and mental health will be discussed within the next component theme.

Psychological wellbeing: "Your life's just kind of uprooted and destroyed"

How the impact of being homeless affected participants psychologically was connected to the meaning they attributed to their situation, as encompassed within the following comments in response to being asked to describe this:

> "*Your life's just, kind of, uprooted and destroyed, I suppose, in a way*"
> Bill, 8 – 9

> "*Struggling to live, basically*"
> Melanie, 10

This feeling of displacement was echoed by many of the participants and was seen to be related to a feeling of being emotionally 'adrift' and disconnected, both from their former selves and the people around them. For some participants this was expressed as their initial reaction to first becoming homeless whilst for others these feelings remained. Baldwin, Conolly, Dimitropolou, Harper and Lilley (1997) suggest that such psychological isolation is considered a natural response to the transition between having somewhere to live and being homeless before the acceptance of the situation leads to it being assimilated into part of their identity (Riggs & Coyle, 2002). From this is may be presumed that for those who experience on-going feelings affecting their self-esteem and psychological wellbeing the process of acceptance and assimilation may not be complete and it is harder for individuals to accept the transition, especially when such changes to their identity are negatively appraised (Jetten, Iyer & Tsivrikos, 2006), as discussed within the previous component theme.

Some participants talked about difficulties they had with their mental health prior to becoming homeless and whilst they did not attribute these problems as a direct reason for becoming homeless, they were seen to impact on their previous intimate and family relationships, contributing to their breakdown

and subsequent homelessness. However, Jessica spoke of a history of self-harm (cutting and ligatures) and bulimia since adolescence, and prior to becoming homeless, that ceased when she entered into an intimate relationship with a supportive partner. She reported not having experienced any thoughts of harming herself, even though she found the experience of being homeless hard, which she attributed to being in a loving relationship and having someone to care for her. Jessica's perception of her ability to cope with her homeless situation, away from her parents, in combination with the positive relationship she had developed with her partner, can be seen as having a positive effect on her self-esteem, which has been highlighted as conducive to a lessening in self-harm attempts (McDonald, 2006).

Whilst not all of the participants had spent time sleeping rough, those that had reported it was during such times that they had felt the most desperate and alone, resulting in thoughts of suicide:

> *"I've wanted to kill myself, being on the street, this last year. Even the whole time in prison, I never wanted to kill myself"*
> Gareth, 433 – 435

This connects with existing literature regarding substance and alcohol abuse in homeless populations contributing to higher than average suicide rates (Herman et al., 1997; Susser et al., 1983; Molnar, Shade, Kral, Booth, & Watters, 1998) when considering that Gareth reported being on the streets when he first tried heroin and recalled that he had first tried taking it in the hope that it would end his life. Kidd and Kral (2003) report that a history of attempted suicide was reported by 76% of their young homeless participants, with themes of isolation, rejection and betrayal, lack of control, and low self-worth forming the basis of their thoughts and experiences concerning suicide.

Relationships: "I've seen people rob their own friends in here"

This component theme was constructed from participants' descriptions of the impact that their homelessness had on their relationships and sources of social support, relating to previous relationships with family and friends outside of the homeless situation and their relationships with others that are homeless. In the first extract, Jessica explains that although she still has a good relationship with her family, contrary to a lot of the other participants, she is aware of a qualitative difference to the support they show her, compared to when she was younger and still lived at home:

> "*I think they just want me to stand on my own two feet, to be honest, so they could help me get a flat but in their eyes it's "no, you've got to do it on your own*"
> Jessica, 493 - 498

Jessica had only recently become homeless for the first time and had chosen to leave her parents' house and become homeless in order to be with her partner. Although she described her parents withholding their support "*you've got to do it on your own*", she did not relate this in a critical way and seemed to accept that she was expected to cope without them. Even when not totally estranged from their family many participants described feelings of alienation and isolation from them, with an implied sense that their homelessness meant that they felt very much alone, albeit living with many other people within the hostel. The following extract illustrates how Andrew considered himself alone and somewhat abandoned by his family, although he was still in contact with them and they lived locally:

> "*My family are…they are quite distant, they just live their own lives. I think they should really think about me and just talk to me and stuff like try and help me out and make me feel better but it just seems like they don't even wanna help me out, it just seems like they're trying to make me feel worse all the time…they just don't want any time with me*"
> Andrew, 601 – 609

The sense Andrew made of being homeless was related to his perception of being rejected by his parents as he had been asked to move out when they divorced and his mother could no longer afford to keep the house where they had been living together. Andrew's feelings of rejection were compounded by how he felt that his family did not give him enough support or want to be part of his life, "*they just don't want any time with me*", with a perception that they were doing this on purpose, "*like they're trying to make me feel worse all the time*", referring to their emotional "distance" from him, even though they live nearby. Andrew spoke of having few friends to talk to from whom he could gain support and when he was asked by the researcher about his relationship with his keyworker at the hostel he spoke about this in terms of her obligation to him, rather than her being a source of support because she wanted to be:

> "*She's all right you know, she does understand but it's just her job innit, it's just her job to do that*"
> Andrew, 666 – 668

Most participants spoke of their homeless as being an isolating experience, although there were varying degrees to which they received support from family and friends away from the homeless situation. Two of the participants, Melanie and Jessica, were in a relationship together that preceded their homelessness and they spoke of the support and security that being together in the situation brought them. Some participants talked of having friends that were also homeless and the benefit of being able to empathise with and understand each other, in ways that people who do not share the same

experience cannot. There was a degree of superficiality to the descriptions of some these relationships, however, and a lack of trust, considered to have arisen as a result of people having learnt to be self-reliant in order to survive:

> "*I've seen people rob friends in here, climb through each other's windows when they're not in and stuff and they lie to them, straight to their face, they're like "I know you've done that and he knows you've done that 'cause he told me*"
> Simon, 89 - 93

3. Coping

This super-ordinate theme relates to the ways in which the participants described the behavioural, cognitive and emotional strategies that they had developed in order to cope with their situation, although these were not explicitly labelled as such by them. The participants who utilised the coping strategy of *substance misuse,* explicitly acknowledged that it was a maladaptive and harmful approach in the longer term, whilst other coping methods adopted such as *denial and avoidance* were viewed in a more positive light, in that it assisted them to manage the stress of their situation in the times they identified that they used it. The coping strategy of *planning for the future* was viewed as an optimistic approach by those that used it in an empowering way to think of ways in which they may change their situation for the better.

Substance misuse: "It blocks, you don't have to worry about the things you should be worrying about"

The following extracts illustrate how drugs were used by some participants as a means of coping with their situation:

> *"When I first took it, I think I tried to take it to kill myself, I think. And that never worked and then I was like, right, that actually kills*

everything, know what I mean? I don't think about nothing, not about shit, feel nice again. I feel like I ain't got no problems, all my problems have gone away. So I wanna feel like that again and so I've used again and then used again and then, before I knew it, I had a raging habit. Was waking up ill every morning, having to go and do something to go and get that. It's not a life"
Gareth, 414 – 421

"*I do enjoy using. I love the buzz, I love the feeling of being high…it's just seeing that bit of blood come back in the syringe and bang! I know I'm gonna be high as a kite within seconds. It blocks, you don't have to worry about the things you should be worrying about. It's a good blocker for all that sort of thing. You're off your head, so you're not thinking about the real issues going on, you're just enjoying yourself. It's an escape"*
Martin, 389 – 401

Gareth and Martin both talk about the use of heroin being linked to "*blocking*" their thoughts to avoid thinking about the "*things you should be worried about*", welcoming the feeling that "*all my problems have gone away*", induced by the drug. It was interesting to note the perspectives of both men were different in that Martin was no longer using heroin whilst Gareth was, as he described, "*a smack head*". As a current user Gareth stated that it overruled his existence, "*it's not a life*", whilst Martin talked about his previous drug use evocatively, describing how he "*loved the buzz*" and recalling in detail the process of how it felt.

Denial and avoidance: "I didn't tell anyone for a while…carried on as normal with me mates"

Bill became homeless after he lost his job, his alcohol use became problematic, and his partner asked him to leave. The following extract is Bill's description of his reactions when he first became homeless:

> *"I couldn't believe it when it happened, I mean she'd threatened it often enough. How many chances can you get given I suppose? And I didn't tell anyone for a while…carried on as normal with me mates, drinking, having a laugh"*
> Bill, 36 - 40

Bill described both a denial to himself that he had become homeless ("*I couldn't believe it"*) whilst continuing with his pre-homeless behaviour of going to the pub and seeing his friends. It is unclear whether this strategy of pretence made the situation less 'real' to himself or whether he was concerned at what people might think of his situation, or a combination of both. Bill stated that the realisation of his situation hit him after a week or so spent in the hostel and that when this happened, and he realised that his partner would not take him back, the perception of the permanency of the changes to his life left him feeling very emotional.

Other participants spoke of further means of denial and avoidance that were connected to emotionally and physically withdrawing from other homeless people within the hostel, by staying in their rooms and not engaging in any contact or conversation with others. It appears that the reasons for this were understood to be a way of distancing themselves from the situation and any sense that they were the same as the other homeless residents and, as with Bill, this was seen as a temporary state. For others, there was a denial of responsibility for their situation, or the rejection of the extent to which their own actions may have contributed to their situation. This was discussed previously as part of the superordinate theme of the construal of homelessness pathway; with a particular focus of the component theme

'being in the system'. In the context of this component theme, however, the denial of responsibility is interpreted as a means of coping and preserving a sense of identity and self-esteem in the avoidance of acknowledging any culpability or blame as the following extract illustrates:

> "*Cause I can handle my own tenancy it's just things have made me not be able to handle it, it's not my fault*"
> Simon, 230 - 231

Planning for the future: "I don't want my life to be shit, I want my life to actually take a different path"

This component theme involves participants descriptions of reaching the stage where they have assimilated the experience of being homeless into their identity and want to use the knowledge that they have gained from the experience of being homeless in order to change their future. Inherent within these descriptions were expressions of feelings of control and a sense of purpose that were seen to combat the sense of disempowerment created by the situation. It appeared that not all participants were at this stage of acceptance, with some not seeing much of a future ahead of them, whilst others positively embraced making plans for what they wanted to happen as a way of coping with the day-to-day reality. The following extract illustrates this:

> *"My view is that life's shit but I don't want my life to be shit, I want my life to actually take a different path, if you know what I mean. You can do the opposite to the influence you've had when you were a child which can make you a better person"*
> Simon, 556 - 558

For Simon, planning for his future involved practical measures that he needed to take in order to stop being homeless, such as attending courses on tenancy management and searching for work, whilst he demonstrated the desire to change his life and become a different, "*better person*". For Simon and other participants, they envisaged that changing their future involved using their past experiences in a positive way to improve things for their own future. Several participants talked about wanting to be a better parent and having the opportunity to give their child, or future children, better experiences and more security than they had in their formative years. There was the acknowledgement that the process of change may be difficult, not just because of the practical difficulties involved with their homeless situation but because of the individual changes they felt they would personally have to make as the subsequent extract, using a film analogy, illustrates:

> "*It's like the Saw film…you know you will cut yourself if you climb through all this barbed wire or you can stay there and you'll die cause something will happen if you don't get out, so it's like you can cut yourself but you'll survive*"
> Melanie, 556 - 559

Lazarus and Folkman (1984) describe coping as the ways in which cognitive and behavioural efforts are made to manage psychological distress. The coping strategies discussed within this component theme and described by participants refer to specific behavioural or psychological techniques employed to manage the impact of their homeless situation (Davidson, Neale, & Kring, 2004; Lazarus & Folkman, 1984; Moos & Schaefer, 1993). The strategy identified as approach coping (also known as problem-focused) can be seen where Simon has taken direct action to resolve the stress of their situation, by making plans to procure accommodation and by utilising available resources to enable these aims to be achieved. Avoidant coping in which the individual avoids the issue were used by Gareth and Martin in describing their drug use whilst Bill described emotion-focused coping (also known as cognitive) to temporarily manage his feelings of shame and sadness at the situation he found himself in (Gurung, 2010). Problem-focused strategies are most effective when the user has the realistic potential to be able to change the situation with the actions they take, whereas an emotion-focused approach is most successful as a short-term strategy aimed at reducing arousal in the moment and therefore, as a consequence, may not address the factors that may cause the stress or negative emotion in the first place.

The preceding discussions of the themes constructed following analysis of participants' accounts shows how the themes were derived from the collective experiences of the participants. What follows is a closer consideration of the accounts of two individual participants, in order to demonstrate a commitment to the hermeneutic process inherent within IPA.

Contradiction and complexity

The idiographic approach used in IPA, where the focus on individual accounts is balanced with making claims for the group, involves iteratively moving between the particular to the general. This results in the construction of super-ordinate themes that offer a summary of key themes reflecting commonalities and divergence across the collective accounts. Whilst these highlight common issues the ways in which the individual data may be reduced in this respect neglects the complexity of individuals and the inherent inconsistencies and contradictions that make them and their accounts unique. As Smith et al. (2009) highlight, "the detail of the individual also brings us closer to significant aspects of the general" (p.32) and for these reasons two cases have been selected to examine in greater detail. The first case, 'Ben' (Box 1), was chosen as *within* his account much complexity and inconsistency was encountered, whilst the second case, 'Graham' (Box 2) was chosen to reflect an account that was considered atypical, in order to illustrate contradiction and complexity *between* cases.

Box 1 Summary of Ben's story

Ben is 38 years old and, at the time of interview, had been living at the homeless hostel for two months. He first became homeless approximately two years ago after being released from prison where he had been held on remand for shoplifting. His partner ended the relationship while he was in prison and he had nowhere else to go. He stayed in a number of hostels locally before obtaining a short term tenancy with a housing association and when this ran out Ben returned to the homeless hostel. Ben stated that he was an alcoholic and a drug user, having been a regular heroin user for a period of time although he maintained that he now only used this occasionally.

Ben was physically abused by his father during his childhood, stating that his father had been very violent towards himself and his mother and they had received regular beatings. He has two older sisters and a younger brother who Ben says his father was never violent towards. During his adult life two

of Ben's relationships with women have been characterised by domestic violence perpetrated against him, with the brother of one of his ex-partners regularly beating him up when Ben was incapable of defending himself because he was incapacitated through excess alcohol or drug use. Ben has also been assaulted on numerous occasions by unknown assailants and, at the time of the interview, had recently been beaten up and robbed of his possessions whilst drunk in the local park, sustaining significant injuries that required hospital treatment.

Relating Ben's story to the super-ordinate and component themes

Inconsistencies were apparent in Ben's descriptions of his drug and alcohol use (*substance misuse*), when he talked about it as "*my demon, my downfall*", and that he needed to "*get straight*" before later saying that he did not want to stop and it was the only thing that "*keeps me sane*" (*coping, psychological wellbeing*). Ben said that he "*could have had it all*" then said "*I was always on a hiding to nothing*", when talking about his path into homelessness, implicating a sense of uncertainty, doubt, and confusion about his *identity* and how this had been affected by his situation. Ben's drug and alcohol use were related to the overarching theme of *responsibility* around his perceptions for why he started: "*I only tried smack when I got in the hostel system*", blaming the *system* for becoming homeless on release from prison. Conversely, Ben also said that he was the one responsible ("*I pushed the boat out too far and lost the rope to pull it in*" and "*I made myself, I've made me own choices, I make my own mistakes*", relating to the theme of *choice* and *responsibility* once more. Another inconsistency, indicative of the explicit confusion and unpredictability that Ben felt, was related to his *relationships* with others, which were often characterised by violence perpetrated against him (*trauma)*. Ben spoke of his own bewilderment regarding this ("*I can't understand how can they do this when they love me*?") and spoke of his misplaced perception of his *responsibility* (*"I wind them up"*) whilst acknowledging that "*I don't deserve this*".

Box 2 Summary of Graham's story

Graham is 55 years old and, at the time of interview had been staying at the hostel for approximately 6 weeks. He had become homeless 2 years previously after arriving in Spain where he had intended to travel for a couple of months. On arrival his money and passport was stolen and Graham said that he began living rough and was drinking heavily. After a period of time on the streets he lived in a hostel in Spain, started teaching to earn some money, and saved enough to get a ticket to return to the UK. Upon returning to the UK he lived in a homeless hostel for a few weeks in London before moving to his present hostel accommodation.

Graham said that he had been to university and drama school. He worked in the theatre and film industry and management training before setting up a global recruitment company. When this venture failed he became unemployed and had not worked for the 3 years prior to travelling to Spain. Graham said that he had been adopted as a baby, his parents were both dead and he had no other family, having never married.

Relating Graham's story to the super-ordinate and component themes

Whilst idiographic extracts of Graham's account have been used previously to offer supporting evidence for themes at the group level of analysis his account was largely inconsistent to that of the other participants. These inconsistencies were apparent in his descriptions of the positive *impact of homelessness* on his life ("*for me it's been all positive, it's all worked out well*") which he felt enhanced his *identity* ("*I'm quite interested in culture and finding out about different societies*"). Whilst he had been drinking heavily when he was initially homeless and described feeling "*anxious and worried*" (*psychological wellbeing*) he described feeling more stable ("*my attitude and perception has changed*") and no longer feels the urge to drink to excess (relating conversely to *substance misuse*). Graham said he drew upon Buddhist philosophy as a *coping* strategy ("*it's about the way you attend to the situation, you can think "shit" or you can try and turn it around which I managed to do quite early on…thinking "what can you learn from this, this*

experience?"") and has enjoyed largely positive *relationships* since becoming homeless ("*it was nice to be part of a community that stuck together and tried to help each other…I've met a few good friends along the way*")

Conclusion

There is little phenomenological information recounting the lived experience of homeless individuals that offers insight into how they construe their situation and their consideration of the factors involved in the onset and maintenance of their position. The presence of trauma has been implicated in prior research as a contributory factor to homelessness, and connected to problems of substance misuse and mental health difficulties. The proposed research was therefore undertaken in order to explore the meaning of trauma within the participants' lived experience of being homeless. Trauma was present in the majority of the participants' accounts although the degree to which their trauma history is understood to constitute an on-going influence, contributing to the maintenance of their homeless situation, was not something that was explicitly referred to by participants in their phenomenological accounts of life as a homeless person. Nonetheless, the fact that the participants talked about their trauma histories without prompting indicates that they consider that these experiences feature prominently in their perceptions of *who* they are. The manner with which the participants talked about their experiences so readily and were willing to divulge personal information is seen as a particular strength of this research.

During the interviews, the researcher became aware of a degree of reticence when prompting the participants to expand upon the trauma experiences they recounted, and gave consideration to this in their reflective account of the research process (see Appendix G). The researcher utilised their clinical psychology skills in developing rapport and eliciting information with careful questioning but there was a reluctance to probe too deeply, for fear of re-traumatising the participant. Despite the precautions taken in the form of preparing a mood repair exercise for the end of the interview and briefing the hostel staff, the researcher felt concerned that, as the relationship with the participant was not a therapeutic one, they would be unable to intervene adequately if the participant became distressed during the interview. In addition, although the participants were given details of sources of on-going

support, the brief relationship constructed between the researcher and participant for the duration of the interview meant that, unlike a clinical encounter, the researcher would have no opportunity to facilitate any therapeutic input for any potential enduring distress. The interviews also took place in a short space of time, occurring over two days at a weekend, meaning the opportunity to reflect upon the process between the interviews was reduced. In addition, the researcher was unable to seek any supervisory guidance in order to reflect upon and share concerns. It is possible that if this opportunity had been available, made possible by the interviews taking place over a greater time period, both the content of the questions and the approach assumed by the researcher could have been refined or modified. It is therefore thought that the inexperience of the researcher possibly contributed to the research aims of exploring the relationship between homelessness and trauma not being adequately met.

Several key themes associated with the experience of homelessness were identified in this study, the clinical and service delivery implications of which will be discussed shortly. Overarching themes of *trauma* and *responsibility* were present throughout the participants' accounts and three super-ordinate themes were identified. These three themes: *construal of homelessness pathway*, *impact of homelessness*, and *coping,* are interconnected and are comprised of numerous component themes. The accounts that contributed to the construction of the themes reflected the uniqueness of individuals' experiences, whilst commonalities across the group of participants were found, although the diversity in the age of participants and experience of being homeless will be discussed shortly. Whilst the component themes are presented as contributing to super-ordinate themes in order to produce a coherent account of individuals' experiences, the divisions between the themes were not precise and there were interactions across the themes, as reflected in the narrative used to support them. In order to assist the analytic process the researcher discussed initial themes and their relationships with one another with a member of the supervisory team, as a means of checking the credibility and plausibility of the theme construction. Initially

'responsibility' was considered by the researcher to be a valid super-ordinate theme however, the presence of responsibility as a central construct to most of the other themes, over and above the intersections found between themes, meant that this was re-framed as an overarching theme instead.

The themes emerged through the participants' accounts and reflect the richness of the material obtained, aided by use of semi-structured interviews which allowed participants to direct their recollections and perceptions to include personally salient information. The acknowledgement is made when carrying out IPA that the researcher relies upon a process of inter-subjective meaning-making in making sense of the participant's accounts of their experiences with the product of analysis being a third-person interpretation of a participant's first-person reflections. Those reflections reveal details about an individual's relationship to a given phenomenon in a given context (Smith et al, 2009) with the researcher's own subjective judgements, regarding how the experiential evidence may be sorted into themes, being part of the interpretative meaning-making process. The researcher chose the themes which resonated most in terms of making sense of the meaning of the participants' accounts. By the subjective nature of interpretation, the assumptions the researcher brought to the research environment and the analysis undoubtedly influenced the way in which the data were collected (i.e. the questions that were asked) and the meaning that was attributed to participants' accounts during analysis. Some of the assumptions that the researcher acknowledged were challenged as a result of the interview process and the information that was obtained. These included the clarity and coherence with which individual participants were able to talk about their experiences, despite the obvious chaos and disruption that typified many of their histories. There was an expectation that participants would give more credence to their traumatic pasts as a reason for their homeless situation and this was not apparent, in terms of assigning blame to specific individuals or events they had experienced, despite frequent open acknowledgements that trauma had been experienced. In addition, the ability for some participants to utilise humour was unexpected, as was the absence of self-pity to a large extent, whilst there appeared a genuine interest in the majority

of the participants for their contribution to the research process to be of positive benefit for people in the future. As recommended when undertaking IPA, a reflective diary was written during the research period in order to contribute to a transparency of the researcher's assumptions when commencing the research process and reactions to the experience (see Appendix G).

Limitations

This study was inconclusive about the impact of trauma on participants' lives as this did not contribute to a super-ordinate theme and was not widely discussed by participants although they all presented their trauma histories spontaneously as a means of presenting themselves and giving contextual background information to their lives. When reflecting upon the interview process the researcher acknowledges experiencing a tension between wanting to explore the traumatic experiences that participants were recounting as part of their history more fully against the knowledge that, in their position as interviewer, not clinician, they would be unable to help the participant therapeutically in this context. It would therefore appear that this reluctance and cautiousness on the part of the researcher may have contributed to this important area not being explored in greater detail, leading to the research aims not being fully achieved. Additionally, as reflected upon previously, the research was conducted over a very short time period which afforded little opportunity for the researcher to reflect upon the process and content of the interviews in order to refine their technique.

Smith et al. (2009) recommend, when choosing a sample of participants, that they are chosen purposively in order to offer insight into a particular experience; granting access to a particular perspective on the phenomena under study, representing a "perspective, rather than a population" (Smith et al., 2009, p.49). For this insight to be meaningful there is the recommendation that the sample should be homogenous and in the present study, homogeneity can be seen in their experience of being resident at the same homeless hostel. There was variation in other aspects of their lived experience, however, including the length of time spent homeless, whether they had ever slept on the street, and time spent in prison. For instance, one participant had spent approximately 29 years as a homeless person, albeit with some settled periods during this time, whilst another had only been homeless for 9 weeks. In retrospect, as these variability issues could have significant impact of the individual's route into homelessness and factors

which may maintain their situation, it may have been useful to divide the sample so that the phenomenon (i.e. homelessness) could be viewed according to their degree of experience. Alternatively, if more consideration had been given to this during the selection process in order to make the sample as uniform as possible, according to social and theoretical factors pertinent to the research, it would have been possible to be more effective when examining the psychological variability within the group during the analysis of patterns of convergence and divergence.

Clinical implications and future work

The sample consisted of people who were residing in a homeless hostel and the experiences of homeless individuals in other circumstances, such as living on the streets, might be quite different with alternative perspectives taken, producing different themes and salient points of interest. An exploration of the same issues with different groups of homeless individuals will aid understanding of the complex challenges they may face. Taking a more focused, bolder approach in the discussion of potentially emotive topics such as trauma experience would also be recommended in order to complement the more quantitative work in this area that has established links between this and homelessness in order to more fully understand the relationship between the two. The issue of loss was a feature related to the trauma experienced by participants in the present study, in terms of parental abandonment and the breakdown of relationships for example, or in more psychological terms such as the loss of identity and feelings of safety and security. Whilst loss was a feature of the trauma experienced by some participants prior to becoming homeless it could also be attributable as a consequence of their homeless situation, connected with what previous authors have said about homelessness itself being a trauma in itself. In order to contribute to a greater understanding of responses to trauma, the potential for future revictimisation, and how trauma history may influence more severe and complex symptoms, future research examining this important component of trauma is warranted.

The themes identified in this study have important clinical implications and hold recommendations for future research and service development. The insight afforded into the ways in which homeless people attempt to cope with their circumstances is crucial for practitioners working in this area in terms of developing therapeutic interventions and the planning of effective service provision. These include the utilisation of a consistent theory-based framework to inform the practices of those that work with homeless people, drawing on the empirical foundations linking trauma with homelessness; to utilise systematic screening processes for trauma histories using

standardised measures in order to avoid practices that may be considered as re-traumatising; and an integration of services related to substance misuse, mental health and trauma to improve outcome. The key to this development appears to lie in the more thorough and systematic assessment of people that use homelessness services, to include both general psychologically symptomology and specific trauma-related disturbance. By such attention being placed on achieving a greater understanding of homeless individual's early onset, multiple, or extended trauma histories there is a potential for phenomena to be identified that have the potential to interfere with effective treatment. This will then lead to alternative treatment approaches being adopted that may have more benefit in targeting cognitive phenomena or increasing self-capacity which, in turn, may have more of a positive effect at reducing symptoms that may contribute to the maintenance of their homeless situation.

List of Appendices

Appendix A: Participant information sheet

Study Title: A qualitative exploration of the lived experience of being homeless

Researcher: Melissa Watts **Ethics number**: [redacted]

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

My name is Melissa Watts and I am a Trainee Clinical Psychologist at the University of Southampton. As part of my qualifications to become a Clinical Psychologist, I have to do a piece of research. This is my research project.

This study is looking at the experiences of people who are homeless, and whether any traumatic things happened in the past which might still affect them.

Why have I been chosen?

Individuals who are in contact with some hostels or a street outreach teams in Southampton are being asked if they would like to take part in the study.

What will happen to me if I take part?

If you decide to take part, we will meet just once and I will explain the study in more detail. If you agree to take part, I would ask you to sign a consent form so that I know you have understood what I am asking you to do. I will then conduct a digitally recorded interview with you, asking you questions about what being homeless is like for you and things that may have happened in the past that you think have contributed to your situation. The interview will take approximately one hour. I will keep the recording of the interview and the transcription of this, entirely confidential.

After we have finished the interview I will explain again what the study is about, and ask if you have any questions. I will also ask if any of the questions upset you, or if you wanted to talk about any of them. If you agree to take part in the study, you will receive a £10 food voucher to thank you for your time and effort.

Are there any benefits in my taking part?

We don't know much about what causes people to become homeless. The more we do know, the more we might be able to stop it happening in the future, as well as help people who do find themselves with nowhere to live. Your taking part is an important part of this knowledge.

Are there any risks involved?

Sometimes, when talking about things that happened in the past, people can become upset. If you found yourself getting upset, you would be able to stop the

study and either take a break or we can stop all together. You can also refuse to answer questions without giving me a reason. In the same way, if I felt you were becoming upset, I would suggest that we stop.

Will my participation be confidential?

All the information you give me will be kept entirely confidential: there will be no way of identifying you from the transcriptions of the interview material and the recordings will be erased once they have been transcribed. The initial interview recording and later transcriptions will be kept locked away, and only I have the key. This is in accordance with the Data Protection Act, British Psychological Society Code of Ethics and Conduct, and the University of Southampton's Code of Practice.

What happens if I change my mind?

You can change your mind at any time, and stop the study without giving me any reason. This would not affect any care or help you are receiving from the hostel or outreach team.

What happens if something goes wrong?

It is highly unlikely that anything would go wrong. If you were not happy with the way things had gone, you could speak to either me or my supervisor. Alternatively, you could speak to the Chair of the Ethics Committee at Southampton University: [redacted] Phone: [redacted] email [redacted]

Where can I get more information?

If you had any more questions, I would encourage you to contact me first [redacted]). You could also speak to my supervisor, [redacted] ([redacted]).

Thank you very much for taking the time to read this.

Appendix B: Consent form

CONSENT FORM (*Version 2.0***)**

Study title: A qualitative exploration of the lived experience of being homeless

Researcher name: Melissa Watts

Study reference: [redacted]

Ethics reference: [redacted]

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (30.01.12; version 2.0) and have had the opportunity to ask questions about the study.	☐
I agree to take part in this research project and agree for my data to be used for the purpose of this study	☐
I consent to the use of direct quotes from my interview in the write up of this project so long as my identity cannot be identified	☐
I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected	☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name)……

Signature of participant……..

Date……

Appendix C: Draft semi-structured interview schedule

1) The term ‘homeless’ means different things to different people. Can you tell me what being homeless means to you?

Prompt: Preferable term?

2) Can you tell me how you became homeless?

*Probe: Can you tell me what life was like before you became homeless? If trauma mentioned use prompts as listed below for additional information, if required**

3) Can you tell me the worst thing about being homeless?

4) Are there any positive things about being homeless?

5) What or who has been helpful/unhelpful to you in the past whilst you have been homeless?

6) What do you hope will happen to you in the future?

*Types of prompts/probes to be used (following Kvale, 1996, p. 133 - 135)

- “Do you remember an occasion when…?”
- “What happened in the episode mentioned…?”
- “Could you say something more about that?”
- “Can you give a more detailed description of what happened?”
- “Do you have further examples of this…?”

NB: Six questions were prepared based on recommendations made by Smith, Flowers and Larkin (2009) who suggest that between six and ten open questions will provide approximately 45 to 90 minutes of conversation, with the intention that additional questions and topical trajectories would be followed, as appropriate.

Appendix D: Mood repair exercise

With each of the following words, think of an associated memory:

- **Your happiest memory**

- **Your greatest achievement**

- **An experience or event that made you laugh**

Appendix E: Participant debriefing sheet

Study Title: A qualitative exploration of the lived experience of being homeless

Researcher: Melissa Watts

Thank you for taking part in my study, during which you talked about things that might have happened to you in your life which were frightening or upsetting. What we have talked about will be used to understand more about how these things affect people who are homeless. This might also be used in the future to help other people who are homeless, or help people avoid becoming homeless in the first place.

Because some of the questions have asked about difficult things that might have happened in the past, you might feel upset. If so, you might find it useful to talk to someone about this. You could talk to me, staff at the hostel/outreach service, your doctor, or maybe a friend. Here are two groups that can also give you advice.

- Samaritans: Samaritans gives confidential non-judgemental emotional support, 24 hours a day for people who are feeling upset. 08457 90 90 90.

- Shelter: Shelter is a charity that gives advice, information and advocacy to people in housing need. Their free housing advice helpline is 0808 800 4444.

Finally, I would just like to say thank you very much for taking part in this study.

Melissa Watts

Appendix F: University of Southampton ethical approval

UNIVERSITY OF Southampton

Ms Melissa Watts
School of Psychology
University of Southampton
University Road
Highfield
Southampton
SO17 1BJ

RGO Ref: 8473

17 February 2012

Dear Ms Watts

Project Title A Qualitative Exploration of How the Presence of Trauma Influences the Lived Experience of Being Homeless

This is to confirm the University of Southampton is prepared to act as Research Sponsor for this study, and the work detailed in the protocol/study outline will be covered by the University of Southampton insurance programme.

As the sponsor's representative for the University this office is tasked with:

1. Ensuring the researcher has obtained the necessary approvals for the study
2. Monitoring the conduct of the study
3. Registering and resolving any complaints arising from the study

As the researcher you are responsible for the conduct of the study and you are expected to:

1. Ensure the study is conducted as described in the protocol/study outline approved by this office
2. Advise this office of any change to the protocol, methodology, study documents, research team, participant numbers or start/end date of the study
3. Report to this office as soon as possible any concern, complaint or adverse event arising from the study

Failure to do any of the above may invalidate the insurance agreement and/or affect sponsorship of your study i.e. suspension or even withdrawal.

On receipt of this letter you may commence your research but please be aware other approvals may be required by the host organisation if your research takes place outside the University. It is your responsibility to check with the host organisation and obtain the appropriate approvals before recruitment is underway in that location.

May I take this opportunity to wish you every success for your research.

Yours sincerely

Dr Martina Prude
Head of Research Governance

Tel: 023 8059 5058
email: rgoinfo@soton.ac.uk

Appendix G: Reflective research diary

The location of the homeless hostel is just off a busy duel carriageway amongst some business and industrial units and I have driven past lots of times without knowing it was there. Were it not for the people outside you wouldn't know the purpose of the building but the man sat in his sleeping bag outside and the others stood around smoking indicate that I've come to the right place (although this may be a judgement on my part regarding stereotypes of homeless people). I feel a bit daunted going inside but a couple of the residents are helpful and show me where the staff are and the staff are all very friendly and helpful. I wonder what they think of me and suspect that they can sense my nervousness and probably think that I'm out of my depth. The building is a lot bigger than I imagined, housing around about 60 residents. It reminds me a little of a psychiatric hospital I have worked in with its communal 'recreation' rooms and the somewhat tired décor. After some initial confusion about who I will see to start off with the interviews flow one after another to the point where people are eager to see me. I think word went round that the interviews were perhaps not particularly taxing and a relatively easy way to get the food voucher and I don't think I'm necessarily being cynical in assuming this.

Overall I am struck by the ease with which most participants talk about their experiences and the matter-of-fact way in which they discuss some pretty horrific things that they have experienced, and in some cases, continue to experience. It is quite emotionally draining listening to their stories as, although there are some positive aspects to their reflections there is an awful lot of sadness too – not necessarily always directly articulated by them but these feelings are evoked in me. I wonder how ideas of transference and counter-transference work in these situations. As time goes on I am beginning to wish that I had arranged to carry out the interviews with some space in between (both between the interviews and perhaps having a period of time to reflect and discuss in supervision). I feel a little overwhelmed by all the stories that people have told me and know that, with some participants I haven't asked further questions about their experiences because I am afraid that they will become upset and I know that my ability to help them is limited to the time I have with them today. When I reflect upon the expectations that I had of what the interview process would be like and what I hoped to gain from the participants, in terms of the research, I suppose my personal experience of homeless people is minimal, the same as anyone from the general public I suppose. From the preparatory literature searches I had made linking homelessness with trauma I think I was expecting everyone to blame their trauma experience and deny any responsibility for their situation. Whilst some people did seem to not have insight into how their own actions

may have contributed to their situation there was never any real attribution of fault linked to the trauma (or their own emotional and psychologically responses to this), rather when blame was levelled it was done so to an external agency, i.e. the 'system' rather than an individual, and still not connected to people's own reactions to this.

I don't think I expected to see so much resilience in people regarding their situation, although some people seemed to have adjusted to their situation better than others, whilst some see it as a positive experience and, if not necessarily a life choice (in terms of an ambition or aspiration to be homeless), as a positive alternative to a life they did not want. As a parent I am thinking of how some of these people, the majority having experienced parental abandonment or abuse at the hand of a carer, may have made different choices and their lives may have been far different, were it not for the actions of their parents, or their inactions when reflecting on those who were apparently less than supportive when children had experienced trauma. Despite their experiences there is also a great deal of humour contained in many of their reflections and, whilst this may have been used as a defence I am struck by some of their ability to see humour in such adversity.

Bill

Bill is the first person that I interviewed and reminded me of someone you might see in the pub with his wife at the weekends or with his mates playing pool, casually dressed in a football shirt and jeans. Doesn't fit with the stereotype of a homeless person that I, and I'm sure lots of others, have. He appeared quite confident and I got the impression that he did not identify with many of the other residents of the hostel. Whilst he gave the impression that he was taking the situation in his stride and was self-assured and jovial in his interactions with myself, staff, and other hostel residents I think this was part of a front that he portrayed and it was clear from his interview responses that the loss of the relationship that led to him becoming homeless continued to trouble him and there were glimpses of a more vulnerable side to him at times during the interview. He was very courteous and concerned for my safety, waiting with me until a member of staff could be found following his interview, for example.

Simon

Simon was a bit of an enigma really. Again, he didn't really fit with my image of how a homeless person would present themselves. He was very friendly and helpful but I felt he wanted to be seen to be like this rather than feeling it. I felt that he was quite controlled in the way that he spoke about things, somewhat disengaged with his emotions, for example, perhaps talking about

unjust or unfair things and using the words to describe them in this way but with no real emotion behind them. He seemed to be very bright with lots of plans and dreams that were eminently achievable yet he has been homeless for 5 years, on and off, since he was 18. He presented himself as 'playing the system', however, and gave the impression that his situation suited him for the moment until his plans came to fruition although beneath this was an undercurrent of shame or embarrassment at his situation, when talking about his girlfriend who came from a 'proper' stable background.

Andrew

Andrew was quite flat in affect and had what you might call an air of helplessness (learned helplessness?) about him. He had definite ideas about the fact that his family didn't help him enough and saw himself as a victim. This extended to his thoughts on the housing system and how he felt about people from outside of the UK getting house whilst he remained with no fixed abode. He said that he had been bullied throughout his life and I could see how this could happen as he appeared quite passive and with no clear idea of what he had done, or could do, to change or prevent his situation, with a philosophy that things 'happen' to him, regardless of whatever action he may take. I suppose he embodies what disempowerment is.

Melanie

Melanie was a tough little cookie who has had an awful amount of horrible things happen to her. She looks like she could take on the world though and that she wouldn't be scared of anything. I would imagine her to be a fierce and loyal friend. She told her story in a very matter-of-fact way and whilst it didn't feel rehearsed I imagined that she's told it many times before. I got the feeling that no matter how many times she got knocked down she would get right back up again although got glimpses of the little girl that had been rejected by her parents – while she didn't really express any sadness about this I felt very sad for her and wondered, as I did with many of the other people I interviewed, what life would be like for her now if her experiences as a child had been different.

Simone

Simone was a lovely girl, quite shy. She was in a relationship with Melanie. Her experiences had a different quality to many of the other people and I believe she came from a reasonably privileged background. She said that her parents could help her out with somewhere to live if she wanted them to but she wanted to be independent from them, which made me think of the Pulp song "Common People" – "If you call your Dad he could stop it all". Simone had been homeless for a matter of weeks, moving into the hostel with Melanie, and you got the impression that she wouldn't survive nearly as

well without Melanie with her as she seemed quite vulnerable and not so 'streetwise' as the other participants. Her history of trauma was different to the others in that there had been a single catastrophic event (gang rape) which she felt contributed to subsequent difficulties with drug abuse, self-harm and an eating disorder, although she did not incorporate these difficulties into her description and understanding of her present situation (quite the reverse, seeing her relationship with Melanie being the most positive thing that had happened to her, with their homeless situation being almost incidental).

Gareth

Out of the people that I interviewed, Gareth was the one I felt the most intimidated by but also the one that I could see as a little boy the most easily. Initially he was quite prickly at the start of the interview and gave quite terse responses to my questions but he did mellow although quickly became somewhat irritable if he thought he wasn't being understood. Of all the participants, he was the most angry at his situation and failed to take any responsibility for the events that led to him being homeless. We were interrupted several times during my interview with him by people looking for him and I did wonder if he may have been dealing within the hostel (he also spoke of having to use heroin numerous times a day with no means of financially supporting this habit with the benefits he received). He attributed his homelessness to being released from prison with nowhere to go and seemed unable to make accept any responsibility for the crime that meant that he was sent to prison in the first place. I could see that now he had been in this situation and because he had committed more crime as a result of his situation (he said) this could easily become a circular process as I think he was impulsive, and did not seem to learn from prior experiences. There is also the possibility of longer prison sentences if his crimes escalate with his rising frustration and anger at the situation. He was probably the most eloquent in talking about the sheer horribleness of being on the street and drug use (reasons for it) but had received relatively little education and could not read which I felt quite disturbed by, given his young age. Whilst I felt intimidated by Gareth I also felt a deep empathy for him and the things that he described.

Martin

Martin was the archetypal 'wanderer', really charming. He was quite reflective about the effect his actions have had on his family and had a different perspective than the majority of the other participants, having been homeless, off and on for a great number of years. It sounded like he had enjoyed himself and he made light of the many times that he had been in prison. He had fantastic insight into his drug use and gave a really evocative

description of what it was like to use heroin and the things that had drawn him back to using after getting clean. Although he gave quite a positive account of a colourful and varied past there was also a tinge of sadness but I felt that this may be because this was all behind him now - he considered himself an old man and although he was only in his late 50s for a homeless man of such long periods I suppose he has exceeded the average life expectancy and he reflected sadly on that fact that many of his peers are now dead

Ben

I couldn't help but like Ben, he was of short stature and has a playful way with a great sense of humour which made him very likeable although he looked lots older than his years as he was very scarred from various assaults and could also see the physical ravages of alcohol on his body. He had been beaten up very badly and robbed the day prior to the interview and half of his face was very swollen and his eye badly damaged. As the result of an earlier assault part of his ear was hanging off and although he had had operations he has been involved in further violence shortly after which had re-opened the wound and he had not bothered to return to hospital. It made me sad that people would want to hurt him and showed how vulnerable people can be when their drink or substance misuse reached these proportions; both with errors in their judgement about who they spend time with or can trust and their tendency to not prioritise their own self-care. Ben had no intentions of quitting alcohol, unlike the drink and substance misuse of others, and had no real insight into the role this played in his problems and situation. I feel the future isn't that bright for him, sadly.

Anna

Anna was a hard person to fathom out – she appeared very keen to give me the answers that she thought I wanted, to the point of asking me at the end of the interview whether the answers she had given would be able to help me with my research. She had stayed at the hostel on various occasions after she has fallen out with her boyfriend and did not really consider herself as homeless and returns when they have both had the chance to cool down. Her first experience of homeless, however, had been following a serious domestically violent assault with a previous partner and I think that she really considered it as a safe haven (although there was violence in her current on-off relationship). Anna said that she had been diagnosed with clinical depression but that she did not wish to receive any treatment for it and I did wonder about her mental health history as she described attending university and training to become a teacher which seems at great variance to how she presented.

Appendix H Example of transcript coding

Interview 2 Simon

1		**R:** Maybe you can tell me a bit about how you	Is this different from After?
2		became homeless?	
3		**I:** How I became homeless? Well I've been	
4	Experience	homeless twice, I can tell you about one or both of	
5		them if you wanna know?	
6		**R:** Yeah, all of them…	wants to tell the story, not simple - emphasis
7		**I:** Could be a long story →	
8		**R:** I'm interested…	
9		**I:** First time, just before I turned 18 really, before I	
10		moved up to Bedford, cause I had a friend who lived	
11	Contributory factors:	up there and I was staying in a camper van for a	
12		month or so and I got a credit card while I was up	
13		there and I put money towards rent deposit and got	two jobs - trying to make go of it - seen reflexive diary (impression trying to present himself in actual way)
14	↓	myself a place, had two jobs but I couldn't afford the	
15	financial	rent there, so with my last pay I was like shall I pay	
16		as much as I can and hopefully he'll let me off cause	
17		I've got no money for food for the next couple of	
18		weeks or shall I just spend it and do whatever. I was	
19		only 19…no, just 18. So I was like I'll go down to my	
20		mates that I've never met before that used to play	
21		internet games with and I went down to his for a	
22		couple of days, come back home and got kicked out.	
23		And because my sister found out that she was	distancing from responsibility?
24		pregnant at that point, while I was away for the four	
25		months, my mum said I couldn't move back because	
26	family issues	the room that used to be mine was gonna be the	
27		baby's room. So I came back and that started off my	
28		life as being homeless for a couple of years, I've	
29	Responsibility	been through various, well I think every hostel apart	
30		from new ones that have been built recently over the	
31		past year or two. I was in all the hostels when I was	Positive image of himself a situation?
32	Positive experience	about 18. I've got some good experiences out of it –	
33		I had my own place, I cooked for myself, cleaned for	
34		myself…	
35		**R:** So how old are you now?	
36		**I:** 23.	
37		**R:** Going back a bit, what was life like growing up?	
38		What was life like before you became homeless?	
39		**I:** Good and bad. Sister was always the favourite,	
40	Background Context	pretty much. I can even say that now arguing with	
41		my mum, you help out, you've given her your three	Doesn't verbalise "its not fair". Implicative.
42		bedroom house, you've moved into a two bedroom	
43		flat. You complain about the people living below you	
44		all the time, you chuck her money for her car and	
45		stuff like that. I don't really get that kind of support	

46		level, not with regards to money.	
47		**R:** Is your sister older or younger than you?	
48		**I:** Younger. But she's got two kids now. She has one	Mediating comments - tries to understand?
49		then she's pregnant again, I can see why she gets a	
50		bit of support.	
51	Trauma-abandonment	**R:** And what about your dad…	
52		**I:** No, gone.	
53		**R:** Never been around?	
54		**I:** I saw him for about two weeks when I was about	
55		16, 17, did a bit of work with him cause my auntie	
56		found out that he lived round in the area.	
57		**R:** Previously to that you hadn't seen him?	
58	Trauma-bullying	**I:** No, not that I can remember. Got bullied at school	→ abrupt change ?? linking two 'bad' experiences
59		**R:** What kind of bullying?	
60		**I:** Well for ages, from primary school, even before	
61		then really, until year nine, ten. I was bullied, hit	↓
62		most days, sat on school buses, sat at the back of	
63		the bus and that was the cool kid's seat and if I	making connection to things he feels bad/sad about?
64		wouldn't move I got my head smashed against the	
65		window by a girl, so…	
66		**R:** Was it all physical bullying?	
67		**I:** Pretty much, yeah. Cause I was at least the	self esteem- not the cool kid, hit by a girl.
68		smallest in the year but I was the oldest in the year	
69		**R:** Has this continued as an adult? What influence	
70		do you think this has had on your situation now?	
71	Resilience Responsibility	**I:** None really, I can look after myself. No, I'm here	No link to remote past?
72		because I moved in with a girl that I met at the	
73		YMCA and it was that breaking down that put me	
74		back to the hostels. She obviously came from a kind	implication that he considers his own background as 'broken' too
75		of broken background as such to be in a hostel. My	
76	Relationships in & out of Situation	girlfriend now, she's stable, she lives with her	
77		parents, her parents own their own home and that.	
78		She works in Argos; that's where I met her at	
79		Christmas, when I had a job at Christmas which is	
80		where I met her. She's worked at pre-school, she	
81		goes to college, she's learning to drive, so she's on	
82	Real impact of homelessness	the up. And to be honest with you I'm lucky she saw	Embarrassed by Situation
83		me before I moved in here, when I was living with	
84	↓	my mum before I got kicked out. To be honest that's	
85		the worse thing about being homeless, what people	
86	Support, what people think of you	think of you. And no support, no money. When	opposite to own situation / what he aspires too
87		you're homeless life revolves around money; if you	
88		haven't got no money you've got to go out and	↓
89		steal. I've seen people rob friends in here, climb	his way out
90		through each other's windows when they're not in	
91		and stuff and they lie to them, straight to their face,	
92		they're like I know you've done that and he knows	
93		you've done that cause he told me.	

Contrasts to his judgement of what friendship/support should be / against necessity "you've got to go out and steal".

References

Baldwin, S., Conolly, J., Dimitropolou, F., Harper, E. & Lilley, D. (1997*). A transitional space in action: A report on counselling services in cold weather shelters*. London: Just Ask Counselling and Advisory Service.

Bassuk, E.L., Buckner, J.C., Perloff, J.N. & Bassuk, S.S. (1998). Prevalence of mental health and substance abuse disorders among homeless and low income housed mothers. *American Journal of Psychiatry*, 155(11), 1561 – 1564.

Boydell, K.M., Goering, P. & Morrell-Bellai, T.L. (2000). Narratives of identity: Representation of self in people who are homeless. *Qualitative Health Research*, 10, 26 – 38.

Boyle, T.J. (2009). The experience of homeless lesbian, gay, bisexual, and transgender youth and the meanings attached to these experiences. Ph.D Thesis, Yeshiva University. http://gradworks.umi.com/34/01/3401429.html accessed 2/10/11

Buhrich, N., Hodder, R., & Teesson, M. (2000). Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry*, 34, 963 – 966.

Buhrich, N., Hodder, R., & Teesson, M. (2003). Schizophrenia among homeless people in inner-Sydney: current prevalence and historical trends. *Journal of Mental Health*, 12(1), 51 – 57.

Burman, E. (1994). 'Interviewing'. In P.Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide,* pp. 49-71. Buckingham: Open University Press.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Clapham, D. (2003). Pathways approaches to homelessness research. *Journal of Community and Applied Social Psychology*, 13, 119 – 127.

Crisis (2009). No one's priority: the treatment of single homeless people by local authority homelessness services. Accessed 09/07/11 from http://www.crisis.org.uk/data/files/publications/090929%20Mystery%20Shopping.pdf

Crisis (2012). What is homelessness and how many people are homeless? Accessed 03/06/12 http://www.crisis.org.uk/pages/-about-homelessness-61900.html

Crisis & New Policy Institute (2003). *How many? How much? Single homelessness and the questions of numbers and cost*. London: Crisis UK.

Department for Communities and Local Government (CLG) (2006). *Evaluating homelessness prevention*. Accessed 06/06/12 from http://www.communities.gov.uk/documents/housing/pdf/150970.pdf

Department for Communities and Local Government (CLG) (2012). *Homelessness and rough sleeping*. Accessed 09/07/11 from http://www.communities.gov.uk/housing/homelessness/

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K. & Ackerson, T.H. (1998). Assertive community treatments for patients with co-occurring severe mental illness and substance use disorder. *American Journal of Orthopsychiatry*, 68(2), 201 – 215.

Fischer, P.J. & Breakey, W.R. (1991). The epidemiology of alcohol, drug and mental disorders among homeless persons. *American Psychologist*, 46(11), 1115 – 1128.

Fischer, P.J., Hodgetts, S., Breakey, W. R., Anthony, J. C. & Kramer, M. (1986). Mental health and social characteristics of the homeless: A survey of mission users. *American Journal of Public Health*, 76, 5, 519-524.

Fischer, P.J., Shapiro, S., Breakey, W.R., Anthony, J.C. & Kramer, M. (1986). Mental health and social characteristics of the homeless: A survey of mission users. *American Journal of Public Health*, 76(5), 519 – 524.

Fitzpatrick, K. M., Gory, M. E., & Ritchey, F. J. (1993). Criminal victimization among the homeless. *Justice Quarterly,* 10, 353–368.

Folsom, D. & Jeste, D. (2002). Schizophrenia in homeless persons: A systematic review of the literature, *Acta Psychiatrica Scandinavica*, 162(6), 404- 413.

Goering, P., Tolomiczenko, G., Sheldon, T., Boydell, K. & Wasylenki, D. (2002). Characteristics of persons who are homeless for the first time. *Psychiatric Services*, 53(11), 1472 – 1475.

Goodman, L., Corcoran, C., Turner, K., Yuan, N. & Green, B. (1998). Assessing traumatic event exposure: General issues and preliminary findings for the Stressful Life Events Screening Questionnaire. *Journal of Traumatic Stress*, 11(3), 521 – 542.

Goodman, L.A, Saxe, L. & Harvey, M. (1991). Homelessness as psychological trauma. *American Psychologist*, 46, 1219 – 1225.

Green, B. (1996). Trauma History Questionnaire. In B.H. Stamm (Ed.) *Measurement of stress, trauma, and adaptation* (pp. 366 – 369). Lutherville, MD: Sidran Press.

Green, J. & Thorogood, N. (2009). *Qualitative methods for health research* (2nd Ed.). Thousand Oaks, CA: Sage.

Hansen, E. (2006). *Successful qualitative health research: A practical introduction*. Maidenhead: Open University Press.

Herman, D., Susser, E. & Struening, E. (1994). Childhood out-of-home care and current depressive symptoms among homeless adults. *American Journal of Public Health,* 84(11)*,* 1849- 1851.

Herman, D., Susser, E., Struening, E. & Link, B. (1997). Adverse childhood experiences: Are they risk factors for homelessness? *American Journal of Public Health*, 87(2), 249 – 255.

Hodgetts, A., Chamberlain, K., Hodgetts, D. & Radley, A. (2007). Health inequalities and homelessness: Considering material, spatial and relational dimensions. *Journal of Health Psychology*, 12, 709 – 725.

Hodgetts, D., Hodgetts, A. & Radley, A. (2006). Life in the shadow of the media: Imaging street homelessness in London. *European Journal of Cultural Studies*, 9, 497 – 516.

Holstein, J. A. & Gubrium, J.F. (1995).*The active interview*. London: Sage.

Jetten, J., Iyer, A. & Tsivrikos, D. (2006). *Torn between identities: predictors of adjustment to identity change*. In F. Sani (Ed.), Individual and collective self-continuity. New York: Lawrence Erlbaum.

Kamieniecki, G. W. (2001). Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: A comparative review. *Australian and New Zealand Journal of Psychiatry*, 35(3), 352 – 358.

Kidd, S. A. & Kral, M. J. (2002). Suicide and prostitution among street youth: A qualitative analysis. *Adolescence*, 37(146), 411-430.

Kipke, M.D., Simon, T.R., Montgomery, S.B., Unger, J.B. & Iversen, E.F. (1997). Homeless youth and their exposure to and involvement in violence whilst living on the streets. *Journal of Adolescent Health*, *20*, 360-367.

Knight, M.T.D., Wykes, T. & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health*, 12(3), 209 – 222.

Koegel, P., Melamid, E., & Burnam, M.A., (1995). Childhood risk factors for homelessness amongst homeless adults. *American Journal of Public Health*, 85(12), 1642-1649.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. London: Sage.

Lazarus, R.S. & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

Lee, B.A. & Farrell, C.R. (2003). 'Buddy, can you spare a dime?' Homelessness, panhandling, and the public. *Urban Affairs Review*, 38, 299 – 324.

Lister, R. (1998). From equality to social inclusion: New Labour and the welfare state. *Critical Social Policy*, 18(2), 215 – 226.

Martijn, C. & Sharpe, L. (2006). Pathways to youth homelessness. *Social Science and Medicine*, 62, 1 – 12.

Martins, D.C. (2008). Experiences of homeless people in the health care delivery system: A descriptive phenomenological study. *Public Health Nursing*, 25(5): 420 – 430.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, 11(3), Art. 8.

McCarty, D., Argeriou, M., Hueber, R. & Lubran, B. (1991). Alcoholism, drug abuse and the homeless. *American Psychologist*, 46(11), 1139 – 1148.

McDonald, C. (2006). Self-mutilation in adolescents. *The Journal of School Nursing*, 22(4), 193 – 200.

Molnar, B.E., Shade, S.B., Kral, A.H., Booth, R.E., & Watters, J.K. (1998). Suicidal behaviour and sexual/physical abuse among street youth. *Child Abuse and Neglect*, *22*(3), 213-222.

Moos, R.H., & Schaefer, J.A. (1993). Coping resources and processes: current concepts and measures. In L.Goldberger & S.Brezntz (Eds.). *Handbook of stress: Theoretical and clinical aspects* (2nd ed, pp 234-257). New York: Free Press.

Morrell-Bellai, T., Goering, P. & Boydell, K. (2000). Becoming and remaining homeless: A qualitative investigation. *Issues in Mental Health Nursing*, 21, 581 – 604.

Morse, J.M (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3 – 5.

Partis, M. (2003). Hope in homeless people: A phenomenological study. *Primary Health Care Research and Development*, 4: 9 – 19.

Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). California: Sage.

Piliavin, I., Sosin, M., Westerfelt, A. & Matsueda, R. (1993). The duration of homeless careers: an exploratory study. *Social Services Review,* 67(4), 576-598.

Powell, M. (2000). New Labour and the third way in the British welfare state: A new and distinctive approach? *Critical Social Policy*, 20(1), 39 – 60.

Randall, G., Britten, J. & Craig, T. (2007). *Getting through. Access to mental health services for people who are homeless or living in temporary or insecure accommodation. A good practice guide.* Department of Health: HMSO. Accessed 09/07/11 from http://www.nacro.org.uk/data/files/nacro-2007051102-534.pdf

Read, J., Hammersley, P. & Rudegeair, T. (2007). Why, when and how to ask about childhood abuse*. Advances in Psychiatric Treatment*, 13: 101 – 110.

Rees, S. (2009). *Mental Ill Health in the Adult Single Homeless Population*. London: CRISIS/PHRU.

Reid, P. & Klee, H. (1999). Young homeless people and service provision. *Health & Social Care in the Community,* 7, 17-24.

Resnick, H.S., Falsetti, S.A., Kilpatrick, D.G. & Freedy, J.R. (1996). Assessment of rape and other civilian trauma-related post-traumatic stress disorder: Emphasis on assessment of potentially traumatic events. In T.W. Miller (Ed.) *Stressful life events*, pp. 231 – 266. Madison: International Universities Press.

Riggs, E.H. & Coyle, A. (2002). Young peoples' accounts of homelessness: A case study analysis of psychological well-being and identity. *Counselling Psychology Review*, 17(3), 5 – 15.

Ritchie, J. & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R.G. Burgess (Eds.), *Analysing qualitative data* (pp. 172-194). London and New York: Routledge.

Rossi, P.H (1989). *Down and Out America: Origins of homelessness.* Chicago, University of Chicago Press.

Ryan, K.D., Kilmer, R.P., Cauce, A.M., Watanabe, H. & Hoyt, D.R. (2000). Psychological consequences of child maltreatment in homeless adolescents: Untangling the unique effects of maltreatment and family environment. *Child Abuse and Neglect,* 24(3), 333-352.

Sacks, J. Y., McKendrick, K. & Banks, S. (2008). The impact of early trauma and abuse on residential substance abuse treatment outcomes for women. *Journal of Substance Abuse Treatment,* 34, 90–100.

Scott, J. (1993). Homelessness and mental illness. *The British Journal of Psychiatry*, 162, 314 – 324.

Shiner, N. (1995). Adding insult to injury: Homelessness and health service use. *Sociology of Health and Illness,* 17, 525-549.

Smart, R.G. & Ogborne, A.C. (1994). Street youth in substance abuse treatment: Characteristics and treatment compliance. *Adolescence,* 29(115), 733 – 745.

Smith, A.M. (2008). Control, responsibility, and moral assessment. *Philosophical Studies*, 138(3), 367 – 392.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261 – 271.

Smith, J.A. (1999). Towards a relational self: Social engagement during pregnancy and psychological preparation for motherhood. *British Journal of Social Psychology*, 38, 409 – 426.

Smith, J.A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, 2, 3-11

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage.

Smith, J.A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.) *Qualitative health psychology: Theories and methods*, pp.218–241. London: Sage.

Smith, J.A. & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp.53-80). London: Sage.

Snow, D.A. & Anderson, L. (1993). *Down on their luck: A study of homeless street people*. Berkeley: University of California.

Sosin, M.R. (2003). Explaining adult homelessness in the US by stratification or situation. *Journal of Community and Applied Social Psychology,* 13(2), 91–104.

Sullivan, G., Burnam, A., & Koegel, P. (2000). Pathways to homelessness among the mentally ill. *Social Psychiatry and Psychiatric Epidemiology,* 35(10), 444–450.

Thoits, P.A. (1991). On merging identity theory and stress research. *Social Psychology Quarterly*, 54(2), 101 - 112

Tindall, C. (1994). Issues of evaluation. In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide* (pp. 142-159). Buckingham: Open University Press.

Votta, E. & Manion, I. G. (2003). Factors in the psychological adjustment of homeless adolescent males: The role of coping style. *Journal of the American Academy of Child and Adolescent Psychiatry,* 42, 778–785.

Warnes, A., Crane, M., Whitehead, N. & Fu, R. (2003). *Homelessness factfile*. London: Crisis.

Williams, S. & Stickley, T. (2010). Stories from the streets: People's experiences of homelessness. *Journal of Psychiatric and Mental Health Nursing*, 18(5), 432 – 439.

Willig, C. (2008). *Introducing qualitative research in psychology.* Maidenhead. Open University Press.

Winter, G. (2000). A comparative discussion of the notion of ‘validity’ in qualitative and quantitative research. The Qualitative Report, 4. Accessed from http://www.nova.edu/ssss/QR/QR4-3/winter.html

Wolfe, J. & Kimerling, R. (1997). Gender issues in the assessment of Posttraumatic Stress Disorder. In J.Wilson & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD*, pp.192 – 238. New York: Guilford.

Wood, N., Wilkinson, C. & Kumar, A. (1997). Do the homeless get a fair deal from general practitioners? *Royal Journal of Social Health,* 117, 292-297.