USING SOCIALITY TO MANAGE HEALTH AMONGST WOMEN EXPERIENCING HOMELESSNESS

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ABSTRACT

This research combines non-participant observation, a focus group, and semi-structured interviews with both residents and staff at a shelter open to cisgender women, families, and trans and non-binary individuals. The shelter, Valdridge House, is in a medium-sized city in Southern Ontario. This research explores how women experiencing homelessness manage their health through sociality within the shelter space. Adapting to the perceived inaccessibility of the healthcare system, residents use sociality to narrate their mental health and trauma, placing blame on their environment rather than themselves for their situation. Here, they create support amongst residents without any perceived judgement.

INTRODUCTION

Despite Canada's advancing movement of women's rights and intersectionality both in public discourse and academics, women experiencing homelessness often remain on the outskirts of this progression. To address a portion of the homeless population that are stigmatized for their gender as well as being homeless, this research examines how women experiencing homelessness locate their health within this experience. To identify the health issues faced by women experiencing homelessness, their causes, and how women manage and narrate them, I conducted research at a shelter called Valdridge House, located in a medium-sized city in Southern Ontario. Here, I used a combination of observation, a focus group, and in-depth interviews with shelter staff and shelter residents to gather data that could account for the experiences of the population.

This research uses anthropological understandings of structural violence and gendered dynamics of homelessness as well as the data collected to identify how women experiencing homelessness understand and describe their health issues in and outside the shelter setting. In the face of a perceived inaccessible healthcare system, gender-based violence, lack of affordable housing, and insufficient state support, these women manage their health through sociality and narration based on complex understandings of different social spaces and different audiences. I conceptualize sociality as intrinsically linked to greater power dynamics that influence human interaction (Herzfeld 2015:24). The idea of power within this research refers to macro ideas of structural violence alongside the power within the shelter through rules and regulations, as well as the interpersonal power dimensions of human interaction that may be differentiated by age and race, etc. Thus, the shelter, which automatically marks residents as being 'homeless' just by its physical boundaries, is a prime site to understand how structural violence influences its victims, manifesting in both friendship and tensions where social interactions cannot escape the contextual power.

A VIEW FROM THE TOP: UNDERSTANDING STRUCTURAL VIOLENCE

To understand how and why individuals who belong to a certain group face unequal hardship, sociologist Johan Galtung (1969) introduced the concept of structural violence. In its inception, it was applied to homelessness by identifying how structural violence can impede people from meeting their basic needs and leave them in vulnerable economic and social positions. Since then, the term has gained traction across disciplines, including anthropology, as a way of shifting blame away from a marginalized individual towards power imbalances hidden within a social hierarchy (Farmer 2004:313). Bourgois and Schonberg (2009) offer a concise definition that shows the application of structural violence to any marginalized group: "Structural violence refers to how the political-economic organization of society wreaks havoc on vulnerable categories of people" (16).

Despite the emphasis on 'structural' within the term itself, it is, in fact, an approach that combines the everyday experiences of an individual within a group with the recognition that these experiences are the embodiment of structural violence. Structural violence can then be understood as a critique of the idea of one's agency within a hierarchy and particularly of neoliberal ideology, thus, shifting blame from the individual to the systemic factors for whatever inequality is at hand. For example, a prominent feature of neoliberalism, which is the social and economic context in Canada and elsewhere (Johnstone et al. 2017:1444), is the discourse of equal opportunity where anyone can achieve their goal and ascend the class ladder through hard work (Harvey 2005). Thus, ability to climb the class ladder implicitly means that those at the bottom are there by their own failings (Kingfisher 2007:101).

In contrast, structural violence disrupts this narrative of equal opportunity (Farmer 2004:313), suggesting that neoliberalism has created both winners and losers by removing forms of social solidarity and social welfare systems such as unions and social housing, thus forcibly removing what many people relied on for support and stability. Following these changes, winners are those with capital, and the poor become losers who, supposedly, through both choice and fault, are unable to partake in the free market (Johnstone et al.

2017:1453). This minimized state intervention and lack of social support targets those of lower socioeconomic status which negatively affects the already homeless but also leads more people into homelessness (Young and Moses 2013:9). Therefore, not only does pre-existing stigma result in marginalization for certain groups (for example, through racism), neoliberalism serves to institutionalize this ideology and place fault onto the individual.

Having shown structural violence as a pivotal term in conceptualizing inequalities, I now turn to gender-based inequalities that constitute a key characteristic of structural violence in the context of employment. Discussions of structural violence are crucial in showing how women are often denied jobs or employed in lower-paying and less secure jobs (Montesanti and Thurston 2015:8). This financial insecurity that women may face is crucial to understanding gendered structural violence. Indeed, research on interpersonal gender-based violence is adamant that women often stay in abusive situations because they do not feel they have another option due to lacking individual financial security (Duff et al. 2011:4). Accordingly, gender-based violence against women is often recognized as a public health issue that results from women having been placed in vulnerable societal positions due to unequal power arrangements that can lead to homelessness (Montesanti and Thurston 2015:10).

METHODS

To collect data, I used general observations of the workings of the shelter and communal areas, combined with a focus group with shelter employees, and face-to-face semi-structured interviews with shelter clients. The final participant group of shelter residents was made up of six cisgender women between the ages of 26 and 40, one of whom was Indigenous, and the other five were white. With only one Indigenous participant, it was not possible to conclude how this feature of her identity may affect her experiences within my research context. Nonetheless, the disproportionate amount of Indigenous people experiencing homelessness is an important feature of Canadian homelessness (Bingham et al. 2019; Kingfisher 2007). As all participants were cisgender women, sex and gender can be understood

as aligning within my research. Other potentially intersecting characteristics were not mentioned.

Interviews were conducted and audio-recorded in a private and discrete room within the shelter. The interviews followed a semi-structured interview guide that allowed the interview to largely be shaped by how participants responded (Bernard 2018:212). A focus group was also conducted with four staff members at Valdridge House following the same process as the interviews. The recordings were then transcribed, and subject to thematic analysis. To maintain the anonymity of participants to the highest level possible, pseudonyms are used in participants' stories. Participants' ages have also been varied within three years to protect the participant but allow consideration of how age may impact their experiences.

ANALYSIS

This analysis will show how women experiencing homelessness find alternative ways to manage their health when not accessing the healthcare system. Residents instead form social relations that empower the women to label themselves by their mental health and trauma despite isolation and strains caused by structural violence. Within this research, sociality is being used with the understanding that it is a way in which surrounding power dynamics are manifested through behaviours (Herzfeld 2015). For instance, despite the shelter not having constant surveillance, residents still face daily rules of leaving the shelter and returning so as to 'not lose' their bed, as well as the threat of expulsion if an altercation were to occur. Thus, interactions within the shelter represent friction between individual autonomy and a regulatory paradigm, making them key to understanding power within a setting. Henceforth I will integrate quotations from participants, allowing their own narration to take precedence.

MENTAL HEALTH AND THE SHELTER ENVIRONMENT

Although there were many health issues present amongst residents, the dominant concern throughout was mental health. The staff expressed how residents were overall "high acuity," meaning that residents are likely to present unexpecting medical conditions that are unpredictable and require more response: "We have many clients that have lots of health issues … whether it's drug use, or lifestyle, or just simply because they've been homeless for a number of different years" (Staff member). Alongside a multitude of physical health issues, mental health issues were also extremely visible and dense amongst the shelter population.

It is not surprising that mental health issues are rife within the shelter. It is already understood that mental health can be both a pathway into homelessness as well as a result of what it means to experience homelessness. Furthermore, those who are experiencing homelessness are likely to have been living in poverty beforehand and, consequently, with high levels of stress that can deteriorate mental health (Bungay 2013:1017). This trend is also the case for what happens at Valdridge House, which residents describe as being a stressful and undesirable environment. Cath, a 35-year-old resident who had been at Valdridge House for roughly three months at the time of the interview, expressed how she felt her existing mental health issues became harder to manage:

> [I have] concerns of my mental health deteriorating while I'm here. I've been put on stronger antidepressants and I still feel lousy every day, worse each day. It's because not only do I have a great deal of stress, but the environment is just absolutely chaotic. There's no structure at all. I wasn't struggling [before Valdridge House]. I've been mentally ill for many years, but I have not been struggling without any medication for the past seven years until I came here. I anticipated taking steps backwards coming here because the environment is chaotic and I have chronic post-traumatic stress disorder. That's because I lived in a very unhealthy environment when I was a kid. So, to be in the loud obnoxiousness constantly is bringing flashbacks to stuff that I

> haven't had to face because my environment is serene when I'm able to build it on my own. (Cath, 35)

Cath's mental health diagnosis went far beyond PTSD, and she was certainly not alone in expressing the difficulties of managing her mental health. Although she stated that she is now taking medicine within the shelter, she still expressed a feeling of "taking steps backwards" (Cath, 35). She blamed this feeling on environmental factors, referring to social conditions at the shelter and how it reminds her of her childhood experiences in its chaos. In this manner, we see how Cath understands her current mental health state as being determined by things outside of her control, rather than taking on blame for her homelessness and consequent struggle.

Each resident that I interviewed expressed a multitude of mental health diagnoses and how, again, they see the shelter environment as worsening their experiences. As Laura, 26, said: "Even if you're not feeling those [mental health] issues yourself, you're around it so much that you're going to adapt to your environment, and you're going to start feeling those things." Once again, Laura is understanding her mental health as being determined by factors external to her, such as the behaviour of others in violence and/or substance abuse. Cath and Laura's narration of their individual experiences being outside of their control shows an objection to internalizing fault for their situation
despite neoliberal ideology.

Participants were not only open about their mental health with me within interviews, but it was also a daily conversation topic in communal areas amongst other residents and myself. Here, residents would talk openly about their medication, how they were feeling that day and the root of their mental health issues. Residents, such as Amanda, 28, expressed that this behaviour was not 'normal':

> Even if there are people that don't have mental health issues, there's enough of us that do that you feel very understood or at the very least not judged. Like I myself have a couple of

> different mental health diagnoses, I have bipolar, borderline personality disorder, histrionic personality disorder, anxiety, insomnia, mild PTSD. So that's actually quite a bit and it sounds like a lot. I don't want to use the word normal because there's no such thing as normal but, for lack of a better term, a normal person walking down the street, if I were to admit all that they're like "What the hell? What is wrong with you?". Whereas here I'm like "Well, I have all these [diagnoses] but when I take my medication it calms me, it keeps me level, and I'm okay", and they're like "Yeah, I got you because I'm on this for this and it makes me the same way". But other people they just hear all that and they're like "You are going to like stab me in the eye with a fork aren't you?", and you're like, "no". (Amanda, 28)

Here, Amanda identifies an apparent uniqueness of the shelter as a space where every day mental health struggles are a normalized and shared experience. Within the shelter, Amanda is comfortable communicating her diagnoses, and thus legitimizing them in this context. However, Amanda expresses discomfort at the idea of discussing her mental health outside of the shelter due to the stigma she believes she would receive. Amanda also constitutes herself and those in the shelter as 'other' to what is considered normal. This distinction could be understood as spatial in how the physical bounds of the shelter allow for these conversations. But it also demonstrates the labelling of 'normality' or 'abnormality' within a category that could be 'homeless', or 'someone with mental health issues', or perhaps both. Instead, this label is used positively to refer to how she bonds and forms friendships within the shelter, as opposed to the negative label that she believes an outsider would assign. With this analysis, we see how residents use the aforementioned negative shelter environment to create an environment of understanding amongst one another. Residents see these conversations as a way to "look out for each other" (Laura, 26), and although "[fellow residents] may not necessarily have answers or be able to tell you, like, guide you to where to go, but just sometimes having that sympathetic ear to listen makes all the difference in the world, you know" (Pauline, 40). In this, the complex nature of shelter sociality is evident in how there is both

an affective manner in which residents feel support, as well as instrumentality that can be inferred from residents exchanging support.

Those experiencing homelessness are often isolated from family and pre-existing friendships, resulting in feelings of exclusion from their life before homelessness and distrust for strangers (Neale and Brown 2016:558). Yet, the shelter is a space that creates implicit trust in certain situations from what residents expressed as a lack of judgement. Jo, 37, explains the significance of this trust to her:

> I don't pass judgment on people. I've been through a lot in my life and I know shit happens, life is not always fair, and people have their own issues from dealing with whatever they've dealt with in life, right. And I've got my own issues and knowing that there are people out there who care and don't judge me for my issues because of what I've been through, it makes a big difference. When you know there are people out there judging you it makes that struggle and what you're going through so much more difficult because they don't understand. Like some people have had great lives. They have money. They have homes. They have family. They have everything. And then there are people like me who, I'm in a situation where I've got nothing. And I'm struggling and it's like, people don't always understand what it's like to be at that rock bottom. (Jo, 37)

Within this discussion of mental health, residents expressed feeling no judgement and see it as an opportunity to find ways to relate to one another. I witnessed various occasions where intense and honest discussions of mental health occurred without residents necessarily knowing each other's names prior. It is not possible to say whether this feature of the population is due to gender, but the linkage between social connections and positive mental health is considered more significant amongst women than men (Buer et al. 2016:71; Kawachi and Berkman 2001:461). The shelter, understandably, is a space that marks these women as experiencing homelessness. Thus, one dynamic of shelter sociality, as demonstrated above, is the support that it creates whereby residents can interact with one another through a discourse of mental health, knowing that by being within the physical bounds of

the shelter they are likely to have similar experiences. Discourses can reflect "continual acceptance, resistance, and negotiation" (Speed 2006:29), and here residents are demonstrating the choice to legitimize their biomedical diagnoses and accept them within the shelter.

Despite the imposition of structural violence, this does not eliminate residents' individual agency. Residents have found ways to adapt to what structural violence has inflicted upon them and have shown agency in reshaping the environment to suit their needs. Certain degrees of agency may seem restricted by a lack of power, but there is not a *lack* of agency. Instead, it is a question of *how* agency is enacted which may be in the form of resistance, and it may be in submission. Here, I am using agency to explain how residents adapt to a distinct lack of power from their multiple marginalities and exhibit a supportive social dynamic that can be seen for both its affective and instrumental capacity.

GENDERING EXPERIENCES AND NARRATING THE SELF INTO STRUCTURE

Thus far, I have identified how the shelter acts as a locale for residents to narrate their mental health and in turn, find and offer support. Beyond mental health, residents also delve into their life history. In doing so, the influence of gender on their lives becomes apparent. It does not seem appropriate to quote explicit stories of trauma that participants had experienced, but these were shared both within interviews and within these communal social interactions that I have mentioned. Women experiencing poverty are more likely to have experienced intimate partner violence, trauma, depression, and other mental health issues than their male counterparts (Benbow et al. 2019:180), and it has been suggested that gender-based violence is a significant pathway into homelessness for women (Schmidt et al. 2015:7).

As my research did not take a comparative approach to gender by also researching the experiences of men, I cannot comment on the accuracy of this suggestion within my research site. However, each shelter resident that I interviewed had experienced gender-based violence and

discussed it at their own volition. For example, Eleanor, 33, felt that her previous experiences of sexual assault were barriers to being able to find housing:

> The one thing I'm struggling with and I'm working on it right now is actually looking for a place because I'm afraid to leave. Once I find a place [to visit], I don't go to the viewing unless my son is with me … I was never ever afraid of the world but (post-trauma) it's been a struggle to leave home because, … it could be anybody that does that. (Eleanor, 33)

Although participants did not identify the gendered dimension to their experiences, structural violence explains this pattern. Indeed, it has been established that women face disproportionate levels of violence than men on the grounds of their subordinate positioning in the social order (Montesanti and Thurston 2015:7). To truly understand the health issues being faced by this population, there must be the recognition that these rates of violence are not coincidental, and gender is a significant determinant of the health issues being experienced within this population. With a structural violence lens, it is possible to see how gender-based violence is a systemic problem that threatens the wellbeing and safety of these women, leading to mental health issues that become the primary talking point within the shelter. Thus, gender-based violence can be understood as a health issue, a cause of *mental* health issues, and as a pathway into homelessness for women.

As I have stated, residents discuss their trauma and their subsequent mental health issues openly within the shelter. As such, mental health becomes a way of communicating trauma and narrating their experiences through diagnoses and medication. Narrative coherence when discussing one's trauma is considered central for empowering the individual, giving them control to tell their story and make sense of it (Borg 2018:449). In this way, these conversations reflect a dimension of shelter sociality whereby the individual asserts their agency in the situation and residents give each other the setting to enact their narrative coherence. The affective dimension seems overt within this finding that emphasizes mutual support via narrative

coherence. Consequently, the idea of mutual support can be seen for its pragmatic tactic, with the understanding that support will then be reciprocated.

In line with the significance of these interactions, when residents discussed their homelessness it took an individualized approach, meaning that there was no mention of systemic causes of poverty such as cuts to social support, unequal distribution of power, or a sense of the patriarchy disadvantaging them because of their gender. Staff, however, explicitly discussed this matter:

> Think about the social determinants of health, our population doesn't even come close [to a good standard of health]. You think about employment or some type of you know reasonable income, housing, health, gender, geography, my goodness, they're just disadvantaged at all of those levels and the system is built to exclude them. (Staff member)

Understandably, homelessness is a lonely and survival-oriented experience. Accordingly, it is unsurprising that residents do not devote time to discussing the political roots of their status. However, the way that residents use their environment to explain the state of their mental health demonstrates opposition to neoliberal ideas of individual fault that are seen within Ontario's policies. In using mental health and trauma to relate to one another, it acknowledges that these issues go beyond individual experience, creating an understanding of marginalisation at a structural level, that their situation is not their fault.

ADAPTING TO SURVIVE

Having identified how shelter sociality acts as a way to support one another in managing their health, it then poses the question of why. Why do residents not use institutional resources made available to them as a way of managing their health? To answer this question, it is necessary to explore both the workings of the shelter and the population's lack of access to institutions like the hospital. Furthermore, it provokes a contention between when and where

women experiencing homelessness are seemingly accepting of being labelled by their mental health, trauma, and homeless status.

The primary answer to why residents do not address health issues, both physical and mental, was the concern of losing a bed in the shelter.

> I don't know if it's because they don't feel like the staff is trained well enough [on mental health], or if it's that they're afraid that if they say the wrong thing they're going to lose their room, like "You're a problem now". I feel like that could very well part of it. (Laura, 26)

This perceived fear of losing a bed was central to the everyday discourse within the shelter with stories of residents not going to the emergency room at night with a health concern because of this fear, as well as residents being discharged for a night and relocated to a different shelter as a repercussion for bad behaviour within the shelter. Losing a bed was perceived as a real threat to the residents and a key reminder that Valdridge House restricts autonomy. Thus, it shows how the sociality of residents managing their health amongst one another is deeply influenced by the shelter's power.

As I have mentioned, group conversations that can be understood as a way of narrating trauma and blaming environmental factors occur amongst shelter residents. Residents also identified how they look out for one another for any health issue. In fact, Maxine discusses how residents shift the organization of the shelter to aid each other:

> There are a couple of people in the shelter that used to be Personal Support Workers or used to even be nurses, and so I do find that it's quite common for people to go to those people instead because there's a fear of going to the hospital and the doctor. There's a fear of being judged, or just losing your room, or being held. But if you're going to [a resident] then they're not going to hold you overnight. They're not going to keep you for observation. They may watch you themselves for a couple of days to make sure you're okay, but you're not losing your room and they might be able to tell you a cheaper alternative than medication or whatever, right? … There's one

> person who shared a room with somebody who was constantly OD-ing in the bathroom. She ended up saying it was too much for her to keep finding her roommate OD'd in the bathroom, and she ended up getting one person that was trained as a nurse and asking them to switch her room so they could keep an eye on her because it was, it was too much. (Maxine, 30)

Again, it is evident how residents see their social relations as an opportunity to look out for one another alongside a sense of reciprocity in forming alliances. This shows an adaptation to the perceived fear of what it would mean to talk about health with anyone other than residents, which may be losing a bed or feeling judged by someone who has not been in the same position as them. Here, we see how sociality, with both affective and instrumental components, has developed in accordance with what residents are able to manoeuvre and becomes a method of survival, whereby looking out for other residents, you are also forming bonds with people who could in turn look out for you.

Beyond what happens within the shelter, the question extends to why the homeless population refrains from using the healthcare system despite being high acuity and facing more health issues than the general population (Buccieri 2016:3). The data presented thus far shows that residents do have access to healthcare with their discussion of diagnoses and medication, however, this access seems limited and is via resources targeted towards homelessness rather than the conventional healthcare system. The staff regularly spoke of how women experiencing homelessness are stigmatized within healthcare, calling it a "red tape system" (Staff member) which means residents rebuff accessing healthcare, or are treated unfairly when they do. This understanding was communicated through various anecdotes of residents who would resist going to the hospital because of previous experiences they had had, for example:

> There's a client who doesn't go to the hospital because she has a history of mental health and addictions and when she goes they're assuming that [a physical health issue is] one of those things. I mean she only goes when it's so bad that they can actually see what the problem is because otherwise they just

> think it's her mental health or addiction. I think there's a lot of clients who experience that. (Staff member)

Indeed, staff identified this experience as a major problem that they heard from residents and in what they had witnessed themselves. Staff see it as a deterrent from using the healthcare system, as residents are uncomfortable with being labelled by their mental health or drug use for any health issue. This trend is likely to occur with both men and women experiencing homelessness when they try and access institutions that their appearance suggests they are not suited for. This reflects a deep-rooted problem in the stereotypes that are formed around those experiencing homelessness as all being dangerous and addicts (Martins 2008:425) as if it means they are not deserving of the same healthcare treatment.

However, there is also a gendered dimension to this issue. Women, whether visibly homeless or not, are recognized as facing unfair treatment in the healthcare system on the grounds of their gender (Bungay 2013:1023). Staff drew attention to this discrimination, talking about the typical encounter that they see their residents having when going to the emergency room in pain: "Yeah and then you're visibly female-identified and you're just being hysterical" (Staff member). So, with my research pointing to how women experiencing homelessness choose to *not* manage their health through healthcare systems where possible as a way of avoiding the external labelling, the context in which sociality occurs is logical. Just as it is understood within the shelter that fellow residents are likely to have experienced similar trauma and mental health issues, it is known that the healthcare system does not suit the population and, thus, they create a dynamic within the shelter of caring for one another particularly with substance use.

Furthermore, participants discussed a general dislike for using local resources that both men and women had access to, as they feared the large groups of men that congregate outside the buildings. Casey et al. (2008), whilst researching homelessness in the UK, explain a similar behavioural pattern as 'strategies of resistance,' showing how women experiencing homelessness navigate space differently to men based on their gender dynamics and heightened vulnerability. Valdridge House

is in a city with other shelters targeting those who have experienced domestic abuse. Thus, that each participant of mine had experienced abuse yet was at Valdridge House suggests a resistance to the label of 'victim.' Rather than access another shelter and receive catered support, it shows the participants' unwillingness to be labelled by an institution yet a readiness to label themselves within the shelter's sociality with other shelter residents and with myself as a trusted researcher.

CONCLUSION

This research has considered both the macro and micro levels of what this population is experiencing to provoke an understanding of how the women at Valdridge House embody structural violence. My research has shown how women at Valdridge House respond to a healthcare system that they feel is inaccessible by forming spaces to narrate their mental health and trauma within the shelter, as well as be candid with such labels having felt excluded from doing so in institutional 'public' spaces like hospitals. This demonstrates a dualistic sociality in its capacity to be both affective and instrumental for residents.

By recognizing how residents use the communal spaces within the shelter to manage their health, it becomes possible to examine the power dynamics within the site. Women experiencing homelessness have their opportunities unfairly limited by their socio-economic status, gender, health, as well as other potential intersections. Despite a neoliberal context that encases the shelter in policy and marginalization, the site reveals the impact of structure in unfamiliar ways. Residents embody structural violence through their life histories of living in extreme poverty and countless disadvantages including healthcare access. Yet, simultaneously, residents embody their resistance by using the shelter as a space to narrate their experiences in a way that acknowledges the external power impacting them. This finding reveals a new way to see how the homeless understand their situation and is crucial to showing how, together, the population embodies their marginalization as well as their resistance to it.

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