

African American Men Facing Homelessness and Co-occurring Disorders: A Qualitative Investigation of Multiple Stigmas

Rebecca C. Mayor
Marquette University

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AFRICAN AMERICAN MEN FACING HOMELESSNESS AND CO-OCCURRING
DISORDERS: A QUALITATIVE INVESTIGATION OF MULTIPLE STIGMAS

by

Rebecca C. Mayor, M.A.

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ABSTRACT
AFRICAN AMERICAN MEN FACING HOMELESSNESS AND CO-OCCURRING
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Rebecca C. Mayor, M.A.

Marquette University, 2011

Homelessness is a pervasive and problematic phenomenon, and programs designed to assist individuals experiencing homelessness and reduce homelessness face a number of challenges. One such challenge involves difficulty engaging and retaining clientele experiencing homelessness in supportive services (Bhui et al., 2006; Ng & McQuiston, 2004; Padgett et al., 2008). The literature suggests that one explanation for this difficulty may involve the stigmatization experiences that individuals facing homelessness accumulate over time; previous studies have indicated that holding a marginalized position in society may make individuals experiencing homelessness more reluctant to engage in services (because of social rejection fears) and/or more sensitive to injustices that sometimes occur within homeless assistance programs (Bhui et al., 2006; Kim et al., 2007; Leipersberger, 2007; Padgett et al., 2008). However, the overall relationship between stigmatization and the psychosocial functioning of individuals facing homelessness has rarely been investigated empirically.

The purpose of the current study, therefore, was to explore how a specific subgroup of the homeless population experiences and responds to multiple sources of stigmatization: African American men facing chronic homelessness and co-occurring mental illness and substance use disorders. Grounded theory research methodology (Corbin & Strauss, 2008) was used to examine this topic from the perspective of men participating in mental health/substance-related counseling at a homeless shelter and maintaining abstinence from alcohol and drugs. Twelve men participated in individual interviews during which they were asked to discuss their experiences being stigmatized, the perceived impact of stigmatization on their psychosocial functioning, coping strategies they employ in response to stigmatization, and treatment-seeking behaviors.

Results revealed that (a) the participants have been multiply stigmatized, (b) they perceive the stigma of homelessness as the most difficult stigma with which to contend, and (c) they believe it is more difficult to be stigmatized for multiple reasons than for a single reason alone. Results also indicated that the impact of stigmatization on the participants' lives has changed over time (from disempowerment to empowerment) and that the participants have altered their stigmatization coping strategies (from unhelpful and destructive to helpful and constructive). Findings, implications, and limitations of the current study are discussed. Directions for future research are recommended.

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African American Men Facing Homelessness and Co-occurring Disorders:

A Qualitative Investigation of Multiple Stigmas

Chapter I: Introduction

Statement of the Problem and Purpose of the Study

Although difficult to measure with accuracy due to debates of definition and constraints of methodology, homelessness is a pervasive and long-standing societal problem (National Coalition for the Homeless, 2007; Kusmer, 2002; Toro et al., 2007). National prevalence estimates indicate that 3.5 to 7 million individuals will experience homelessness in any given year (Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005; National Coalition for the Homeless, 2007). The National Alliance to End Homelessness (n.d.a.) has estimated that around 744,000 people will be homeless on any given night.

The phenomenon of homelessness is very costly to both those experiencing homelessness and society as a whole. Individuals who are homeless face increased vulnerabilities to acute and chronic health complications (Lee & Schreck, 2005), substance abuse and dependence (Green, 2005; LePage et al., 2006), mental illness and emotional maladjustment (Littrell & Beck, 2001; Green, 2005), unemployment (Green, 2005), discrimination (Crocker, Major, & Steele, 1998), victimization (Lee & Schreck, 2005), and premature mortality (Hwang et al., 2005). Homelessness threatens both quality of life and life itself for those experiencing it.

Homelessness is also extremely costly for society (Burt et al., 2001). Because individuals facing homelessness often contend with the aforementioned difficulties, they utilize a variety of public systems and services (National Alliance to End Homelessness, n.d.b.). According to the National Alliance to End Homelessness (2006), the federal

government spent over \$1.9 billion dollars on dedicated homelessness programs in 2006 alone. Mitka (2006) suggested that the chronically homeless population in particular “cost[s] society millions of dollars for emergency medical services, psychiatric treatment, detoxification, shelter use, and law enforcement” (p. 2344).

A variety of programs exist to prevent long-term homelessness and to help individuals who are homeless find respite, secure housing, obtain employment, reduce psychiatric symptoms, decrease or eliminate substance abuse, and ultimately become reintegrated into mainstream society (Crook, Mullis, Cornille, & Mullis, 2005; Glasser & Bridgman, 1999). These programs typically involve outreach, case management, job training, educational programming, provision of transitional housing/housing, substance abuse treatment, and/or mental health services (Glasser & Bridgman, 1999; Hwang et al., 2005). Unfortunately, although billions of dollars have been allocated to the homeless cause and there are now thousands of programs in the United States offering assistance to the homeless, many of them have been ineffective in leading to the permanent re-housing of those who are homeless (Dennis, Buckner, Lipton, & Levine, 1991; Glasser & Bridgman, 1999; Leipersberger, 2007; Mitka, 2006). This is a particularly unfortunate problem considering the positive relationship that exists between engagement in services and re-housing or housing stability (Thompson, Pollio, Eyrich, Bradbury, & North, 2004).

One possible reason for the relative ineffectiveness of these homeless assistance programs may relate to their difficulty engaging and maintaining clientele (Bhui, Shanahan, & Harding, 2006; Ng & McQuiston, 2004; Padgett, Henwood, Abrams, & Davis, 2008). Some researchers have examined why individuals facing homelessness

seem to underutilize the services that are available to them. Themes emerging from their studies appear to involve perceived stigmatization (related to mental illness, substance use, and/or homelessness itself; Bhui et al., 2006; Kim et al., 2007; Leipersberger, 2007; Padgett et al., 2008), negative perceptions of service staff (often due to power differentials; Bhui et al., 2006; Leipersberger, 2007; Padgett et al., 2008), and the often rigid and disempowering nature of shelterization (Bhui et al., 2006; Leipersberger, 2007; Padgett et al., 2008). Given the powerful link between service engagement and positive outcomes (Padgett et al., 2008; Thompson et al., 2004), there is a need to give more empirical attention to these variables that appear to hinder individuals who are homeless from seeking supportive services.

One of these variables, stigmatization, has received a considerable amount of attention in the empirical literature. For instance, several definitions of stigma have been proposed (e.g., Crocker et al., 1998; Goffman, 1963; Jones et al., 1984; Link & Phelan, 2001), and stigmas have been organized into different categories and dimensions (e.g., Goffman, 1963; Jones et al., 1984). Additionally, we know that stigmatized persons are vulnerable to experiences of prejudice and discrimination, attributional ambiguity, expectancy confirmation processes, stereotype threat, heightened awareness of their devalued social identity, and identity threat (Crocker et al., 1998; Major & O'Brien, 2005). All of these experiences can lead to additional forms of psychological, social, and physical stress (Dovidio, Major, & Crocker, 2000; Major & O'Brien, 2005). Indeed, stigma has been linked to a variety of negative outcomes, including poor mental health, physical illness, academic underachievement, infant mortality, low social status and

social rejection, poverty, and reduced access to housing, education, health care, and jobs (Major & O'Brien, 2005).

Stigmatized individuals do not respond to stigmatization with complete passivity or helplessness, however, despite the fact that stigma research has focused largely on the negative consequences that result from stigmatization (Dovidio et al., 2000). In fact, stigmatized individuals have been found to employ a variety of strategies to cope with and manage the predicaments associated with their devalued social status (Dovidio et al., 2000). These strategies have been reported to include attributing events to prejudice and discrimination, making social comparisons, psychologically disengaging and disidentifying, and negotiating one's identity (Crocker et al., 1998; Deaux & Ethier, 1998). Additionally, these strategies and others have been organized into theoretical frameworks by some stigma researchers (e.g., Major & O'Brien, 2005; Miller & Kaiser, 2001; Shih, 2004). Other researchers have begun to explore individual differences among the stigmatized that may influence how they experience and respond to stigmatization (e.g., stigma-consciousness, level of stigma internalization; Brown & Pinel, 2003; Ritsher, Otilingam, & Grajales, 2003; Pinel, 1999).

Although researchers have explored individual differences related to stigmatization, the possibility that some stigmatized groups may experience stigmatization differently from others needs further examination. Individuals facing homelessness, for instance, comprise a population that has been surprisingly underexamined as a unique stigmatized group (Kidd, 2007; Lee et al., 2004; Thompson et al., 2004). The studies that have examined stigmatization of those who are homeless, either directly or indirectly (Bentley, 1997; Boydell, Goering, & Morrell-Bellai, 2000;

Kidd, 2007; Lankenau, 1999; Miller & Keys, 2001; Osborne, 2002), point to the idea that at least some individuals are well aware of their devalued social status, experience identity transformations and negative outcomes as a result of homeless stigmatization, and attempt to manage both stigmatization and its undesirable outcomes. None of these studies, however, have offered a specific, comprehensive theory as to how individuals facing homelessness experience and respond to stigmatization. Furthermore, none of these studies have related their findings to the preexisting literature on stigma.

As such, the purpose of the present study was to address these limitations by building a theory of stigmatization of the homeless population in light of the preexisting research on stigma and on homelessness. Specific research questions related to this study are outlined below.

Research Questions

The general research question associated with the current study was, “How do individuals facing homelessness experience and respond to social stigmatization?” More specific research questions subsumed under this general research question included the following: (a) “How are individuals facing homelessness impacted by stigmatization, if at all?” (b) “How does stigmatization influence the way individuals who are homeless perceive themselves, other individuals who are homeless, non-homeless individuals, and treatment services?” (c) “How do individuals experiencing homelessness manage or cope with their devalued social identity?” and (d) “How does stigmatization influence the decisions of individuals who are homeless to enter and remain engaged in mental health/substance-related treatment?”

To answer these research questions, two noteworthy decisions were made related to (a) methodology and (b) sampling. Given the paucity of research on stigma's impact on the nation's homeless population, an exploratory qualitative approach was selected for this study (i.e., grounded theory, for reasons explained further in Chapter III). Qualitative methodology was also chosen in response to stigma researchers' suggestion that within-group variability of stigmatization experiences should be examined from the perspective of the stigmatized themselves (Link & Phelan, 2001; Major & O'Brien, 2005). To control for some of the heterogeneity of the homeless population, this study focused on a specific subgroup of the homeless: African American men with co-occurring mental illness and substance use disorders experiencing chronic homelessness. Focusing on this particular subgroup allows for the development of increased understanding of what it means to be multiply stigmatized as an individual who is homeless.

Conclusion and Perceived Importance of the Study

In summary, I proposed and completed a grounded theory study of how a specific subgroup of the homeless population experiences and responds to social stigmatization. The following chapters in this manuscript provide an extensive review of the literature demonstrating how I arrived at my decisions for focusing the current study, a detailed outline of the procedures used for data collection and analysis, a presentation of the study results, and an overall discussion of the study. It is my hope that the results from this study can eventually be used to inform practices employed with individuals facing both homelessness and multiple stigmatization processes.

Author's Note: People-first Language

Especially considering that the focus of this study is on stigmatization, people-first language is used whenever possible throughout this manuscript (e.g., “individuals who are homeless” or “individuals facing homelessness” vs. “homeless individuals”). However, there are occasions where non-people-first language is utilized simply for stylistic purposes (e.g., more parsimonious presentation).

Chapter II: Literature Review

The right to housing has been recognized formally at both the national and international levels for the past several decades. In 1948, for instance, the General Assembly of the United Nations proclaimed housing as an individual right in the Universal Declaration of Human Rights. Article 25(1) of this document declared, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, *housing*¹ and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (United Nations, 2008). When Congress passed the Housing Act of 1949, “the goal of a decent home and suitable living environment for every American family” was established (Martinez, 2000, p. 467). The Fair Housing Act of 1968 prohibited discrimination in the sale, rental, and financing of dwellings based on race, color, religion, sex, and national origin (U. S. Department of Housing and Urban Development, 2007b).

Unfortunately, despite these global ambitions and legislative strivings, homelessness remains a pervasive problem worldwide and within the United States (Toro et al., 2007). Many factors have contributed to the persistence of homelessness. The purpose of this chapter is to review the literature on homelessness (e.g., causes, prevalence rates, correlates, attempts at eradication) and to consider one variable that may relate to its continuation in American society, namely, the stigmatization of individuals who are homeless.

¹ Emphasis mine.

History of Homelessness in the United States

The phenomenon of homelessness is not new to the United States (Abelson, 1999). In fact, according to Kusmer (2002), homelessness has been a part of American culture since the founding of the colonies. As early as the 1640s, laws were in place to discourage “undesirable people” from settling in certain areas; included in this group were the “vagrant,” the “insane,” and the “wandering poor” (Kusmer, 2002; Marvasti, 2003). Peace officers were responsible for “warning-out” or managing the “undesired” (Abelson, 1999; Bloom, 2005). Management typically involved sending these individuals back to where they came from, similar to some modern communities’ use of Greyhound bus tickets to do the same (Kusmer, 2002). Some people were detained in workhouses, and still others were auctioned off as laborers to more privileged colonists (Marvasti, 2003).

At the end of the eighteenth century, homelessness became more noticeable as indentured servants were replaced by slave labor but maintained a relatively marginal existence, as many of them had difficulty establishing themselves after they were granted freedom (Kusmer, 2002). Homelessness grew even more widespread in the early 1800s as urbanization and industrial development took hold in the United States and job insecurity became commonplace (Kusmer, 2002). By the 1840s, rooms in police stations were set aside for overnight lodging of people without homes, and charities started to approach the problems of unemployment, sporadic employment, and homelessness (Kusmer, 2002). A distinction was also made between the “insane” poor and the rest of the poor in the early decades of the 1800s, and individuals with mental illness ended up being declared wards of the nation (Marvasti, 2003). As a result, state hospitals were built

to house and treat individuals with mental illness, and the profession of psychiatry was established (Marvasti, 2003). Institutionalization of those with mental illness began.

In the later 1800s, homelessness became a nationally recognized concern when a more “threatening” or “deviant” type of un-housed person emerged: the “tramp” (Kusmer, 2002). The so-called tramp typically rode the rails without pay, banded with other tramps, and intimidated farm workers and urban dwellers (Bloom, 2005; Kusmer, 2002). Tramps differed from their “hobo” counterparts in that they did not seek work (e.g., as seasonal laborers) and were consequently seen as less socially acceptable (Bloom, 2005; Kusmer, 2002). Following the Civil War, many individuals facing homelessness began to gravitate toward cities where rescue missions tended to be located (e.g., the Salvation Army); it was the younger subgroup of the homeless who continued to ride the rails, often in search of adventure but also as mobile workers (Bloom, 2005; Kusmer, 2002).

This trend continued largely until the Great Depression and World War II when economic destitution became more widespread and men enlisted in the military in great numbers (Kusmer, 2002). Following World War II, those who remained homeless or unaffiliated became largely confined to the skid rows of large cities (i.e., neighborhoods with inexpensive lodging for the transient or marginally employed, who were usually male; Glasser & Bridgman, 1999; Kusmer, 2002). Individuals with mental illness generally remained institutionalized. Because of this confinement and decreased visibility of society’s marginalized, homelessness was not considered a major societal problem again until the 1970s (Kusmer, 2002).

By the late 1970s, mass homelessness emerged. Americans began to encounter people living on the streets with great frequency, especially in the downtown areas of large cities (Glasser & Bridgman, 1999). The emergence of “street people” was attributed to two main factors: deinstitutionalization of individuals with mental illness and the reduction of inexpensive housing in inner cities via urban renewal projects (Glasser & Bridgman, 1999; Marvasti, 2003).

The first factor that contributed to mass homelessness in the 1970s was deinstitutionalization of individuals with mental illness. Deinstitutionalization was at least in part the result of the Community Mental Health Act (CMHA) of 1963 (Marvasti, 2003). The CMHA was designed to provide federal funding to community mental health centers so that community-based care could be considered as an alternative to institutionalization for those with considerable mental illness (Marvasti, 2003). Life in the community was considered more humane than life in a psychiatric hospital, and many psychiatric patients were consequently released into the community (Glasser & Bridgman, 1999). Additionally, many state institutions were closed (Glasser & Bridgman, 1999). Unfortunately, about ten years after community placements began, individuals who had been released from hospitals became highly visible on the streets and seemingly uncared for by the community. Community placements had been unsuccessful for many individuals, leaving them with great needs roaming the streets disheveled, psychiatrically disturbed, and without treatment (Glasser & Bridgman, 1999).

The reduction of inexpensive housing options also contributed to the emergence of mass homelessness in the 1970s (Abelson, 1999; Kusmer, 2002). Social policies following World War II favored home ownership and the building of communities, which

resulted in several urban renewal projects that demolished single-room occupancy units and other forms of inexpensive housing (Glasser & Bridgman, 1999). Renewal projects of the 1960s and 1970s took over skid row districts and failed to provide replacement housing options for the people who had lived in them (Kusmer, 2002). For instance, according to Glasser and Bridgman (1999), between 1970 and 1980, over one million single-room occupancy units were destroyed with no replacement units built.

Gentrification processes during the 1980s and 1990s contributed further to the displacement of low-income individuals and individuals without homes (Glasser & Bridgman, 1999).

The increased dislocation of individuals from state institutions, community placements, single-room occupancy units, skid row districts, and neighborhoods with inexpensive housing enabled public awareness of the homeless plight to grow considerably during the 1970s and 1980s (Kusmer, 2002). Link and colleagues (1996) suggested that the 1980s comprised the first era since the Great Depression that homelessness was part of the daily experience of millions of Americans, thanks in part to extensive media coverage of homelessness (i.e., if people did not have firsthand exposure to homelessness, they heard about it through the media). There was increased recognition among American citizens that something needed to be done to protect individuals without housing and help them leave the streets, especially considering the widespread dismantling of government-based social welfare programs during the 1980s that left marginalized persons with little or no resources of their own (Green, 2005). Americans rallied in massive numbers during events like “Hands Across America” in 1986 to raise

awareness of and relief for national hunger and homelessness epidemics (U. S. A. for Africa, 2007).

Individuals facing homelessness acted on their own behalf as well. For instance, in 1979, some men who were homeless filed a class action suit against the state of New York. Callahan versus Carey, as the suit is referred to today, mandated New York to provide a minimum of social services to men facing homelessness, including clean and safe shelter (Glasser & Bridgman, 1999; Kusmer, 2002). The momentum of this suit eventually inspired the first (and only) major federal legislative response to homelessness, the Stewart B. McKinney Homeless Assistance Act of 1987. This act authorized millions of federal dollars for hunger and housing relief (Foscarinis, 1996; National Coalition for the Homeless, 2008).

The McKinney Act has been critical in helping organizations for the homeless population to meet the urgent needs of their clientele and has saved many lives (National Coalition for the Homeless, 2008). However, eradication of homelessness remains to be seen. The statements of the Interagency Council on Homelessness, established by Congress in 1987 to oversee homelessness policy associated with the McKinney Act, emphasize the importance of shifting the national response to homelessness from management to eradication. Philip Mangano, executive director of the Council, has stated: "We can no longer tolerate the homelessness of so many of our neighbors. Our commitment is to fulfill the promise of a home for every American... We are not content to manage the crisis, or to maintain the effort, or to accommodate the response. We were called to one goal, one objective, one mission - to abolish homelessness. Now is the time to forward the advocacy, fashion the strategy, and to fulfill that mission" (United States

Interagency Council on Homelessness, 2003). As Glasser and Bridgman (1999) have pointed out, "...homelessness confronts us with our inability to offer everyone the most basic conditions for a healthy and productive life" (p. 2). The prevalence of homelessness challenges the notion of the American dream and leaves the strivings of the Housing Act of 1949 unrealized.

In 2010, "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness," the nation's first comprehensive federal plan to end homelessness, was presented to the Office of the President and Congress (U. S. Interagency Council on Homelessness, 2011). This ambitious plan involves interagency collaboration that aligns mainstream housing, health, education, and human services. The goals of this plan are to: end chronic homelessness in 5 years, prevent and end homelessness among veterans in 5 years, prevent and end homelessness for youth and families in 10 years, and establish a plan for ending all other types of homelessness. It emphasizes rapid re-housing and permanent supportive housing strategies and is built on the idea that homelessness in this country is unacceptable, preventable, and solvable.

Prevalence of Homelessness

Although homelessness is considered a pervasive problem in the United States, it is difficult to determine the exact number of people who are homeless. One reason for this difficulty is obvious and involves the fact that individuals who are homeless are hard to locate given that they do not have their own residences (National Coalition for the Homeless, 2007). Epidemiological researchers are unable to search all of the places where individuals without housing may seek shelter (e.g., vehicles, boxcars, caves; National Coalition for the Homeless, 2007). Consequently, prevalence counts are likely

underestimates of the homeless population (Glasser & Bridgman, 1999; Toro et al., 2007).

Another reason it is difficult to calculate the number of individuals in the United States without homes is because homelessness can be difficult to define (National Coalition for the Homeless, 2007). There are a variety of nuances associated with defining homelessness. Burt and colleagues (2001), for instance, pointed out that individuals' experiences of homelessness may vary considerably. Some people may be homeless once or twice in their lives for a short amount of time while others may cycle in and out of homelessness for an extended period of time. Still others may experience a single episode of homelessness that lasts for many years. Distinctions can therefore be made among individuals who are homeless on the basis of length of homelessness (e.g., short-term versus chronic) and/or number of episodes of homelessness (e.g., single versus multiple).

Distinctions can also be made on the basis of where people without homes seek shelter (e.g., on the streets, in shelters, with relatives or friends). Glasser and Bridgman (1999) suggested that there may be a difference between the "literally homeless" and the "precariously housed." According to these researchers, the literally homeless are those who have no access to conventional housing and live on the streets, in homeless shelters, in abandoned buildings, etc. The precariously housed, on the other hand, are those who have tenuous or temporary claims to conventional housing. They may live in the homes of others or pay for housing in hostels or hotels by the day or week, for example. The National Coalition for the Homeless (2007) noted that it can be difficult to track both the literally homeless and the precariously housed.

All in all, regardless of the way homelessness is defined, it is important to remember that the definition of homelessness used in epidemiological studies can influence the resulting estimates of homelessness (Glasser & Bridgman, 1999). For example, a recent telephone survey of 435 randomly selected households in the United States revealed a lifetime prevalence of literal homelessness (i.e., residence in shelters, abandoned buildings, public spaces, etc.) of 6.2% (Toro et al., 2007). This figure increased to 12.9% when the definition of homelessness was expanded to include being precariously housed, or doubling-up with relatives or friends. In addition, given that only households (and households with telephones, for that matter) were sampled in this study, lifetime prevalence rates of 6.2-12.9% were likely underestimates, as individuals who were currently homeless and people with an increased likelihood of having a past experience with homelessness (e.g., the incarcerated) were systematically excluded from the study (Shinn, 2007; Toro et al., 2007).

The most cited national prevalence estimates of homelessness indicate that 3.5 to 7 million individuals will experience homelessness in a given year (Hwang et al., 2005; National Coalition for the Homeless, 2007; Toro et al., 2007). The National Alliance to End Homelessness (n. d. a.) has estimated that around 744,000 people will be homeless on any given night in the United States. The National Alliance to End Homelessness has also suggested that 10-20% of single homeless adults are chronically homeless.

Definitions of Homelessness

As aforementioned, there are a variety of ways that homelessness can be defined, and the way in which homelessness is defined can influence the estimated prevalence rates obtained via epidemiological studies (Glasser & Bridgman, 1999). The definition of

homelessness used in other types of studies can also influence the interpretation and application of those studies' findings (e.g., a study on the literally homeless may not yield results that are as applicable to the precariously housed and vice versa). At least two definitions of homelessness are commonly used for research purposes; these include the federal definition of homelessness and the U. S. Department of Housing and Urban Development's (HUD) definition.

The official federal definition of homeless can be found in the United States Code, Title 42, Chapter 119, Subchapter I (U. S. Department of Housing and Urban Development, 2007a). This definition states: "The term 'homeless' or 'homeless individual or homeless person' includes (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings" (U. S. Department of Housing and Urban Development, 2007a). Additionally, this definition states that "the term 'homeless' or 'homeless individual' does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law" (U. S. Department of Housing and Urban Development, 2007a).

According to the National Alliance to End Homelessness (n. d. a.), HUD defines a person who is homeless as someone who is "sleeping in an emergency shelter; sleeping in places not meant for human habitation, such as cars, parks, sidewalks, or abandoned or

condemned buildings; spending a short time (30 consecutive days or less) in a hospital or other institution, but ordinarily sleeping in the types of places mentioned above; living in transitional/supportive housing but having come from streets or emergency shelters; being evicted within a week from a private dwelling unit and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing; or being discharged from an institution and having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing.” Furthermore, HUD goes on to define a person who is chronically homeless as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, or developmental disability including the co-occurrence of two or more of these conditions” (National Alliance to End Homelessness, 2007, p. 2).

Causes of Homelessness

The reasons for homelessness are diverse and plentiful (Koegel, Burnam, & Baumohl, 1996; Stein & Gelber, 1995; The United States Conference of Mayors – Sodexo, Inc., 2006). Researchers have suggested numerous probable causes of and contributors to homelessness. These causes and contributors have been purported to include poverty, lack of affordable housing, failure of the CMHA, mental illness, substance addiction, chronic health conditions, criminal behavior, employment problems,

family dysfunction or violence, economic conditions, changes in the labor force, tightening of welfare programs, inadequate social policies, limited social support, societal attitudes toward homelessness, and natural disasters (Abelson, 1999; Banyard & Graham-Bermann, 1995; Koegel et al., 1996; Mojtabai, 2005; National Alliance to End Homelessness, n.d.a.; Stein & Gelberg, 1995; The United States Conference of Mayors – Sodexo, Inc., 2006).

There have been attempts in the past to organize the various contributors to homelessness. According to Glasser and Bridgman (1999), for instance, historically there have been two separate schools of thought on why homelessness exists in our society. The first school emphasizes personal pathology factors as the root of homelessness. Individuals who ascribe to this school focus on the immediate and individual reasons people become homeless, such as addiction, mental illness, or experiences of domestic violence. They suggest that internal deficiencies or personal experiences make certain individuals more vulnerable to homelessness.

The second school described by Glasser and Bridgman (1999) focuses on structural, or societal, contributors to homelessness. People who identify with this framework focus on broad, external social conditions that influence whether an individual can maintain stable housing. They look at environmental conditions like the availability of housing, opportunities to obtain financial assistance, and racial/ethnic discrimination.

Relatively recently, these two schools of thought have been reconciled in more holistic (i.e., ecological) models of homelessness that examine the individual-in-society as opposed to just the individual or just the social context in which an individual lives (Glasser & Bridgman, 1999; Toro, Trickett, Wall, & Salem, 1991). The ecological

perspective extends the work of the previous schools of thought by allowing researchers to examine the interplay between individual characteristics and contextual variables as another contributor to and maintainer of homelessness (Glasser & Bridgman, 1999). As Toro and colleagues (1991) noted, “Homelessness is now recognized as a complex and multifaceted phenomenon involving broad social policies, economic shifts, service system deficiencies, disruptions in social support, and individual and family differences in access to resources and coping styles” (p. 1208). Using an ecological perspective to examine homelessness should allow for a greater understanding of the complex and multifaceted nature of this phenomenon, as this perspective emphasizes the importance of looking at multiple levels of the person, multiple levels of the environment, and multiple levels of person-environment transactions that take place between homeless persons and their communities (Toro et al., 1991).

While a general ecological perspective on homelessness has unified the two historical schools of thought, different types of ecological models have been proposed to conceptualize the phenomenon of homelessness further (Glasser & Bridgman, 1999). For example, the Morse Model developed by Gary Morse in 1992 suggests that homelessness should be examined from five levels: the individual level, the organizational level, the community level, the institutional level, and the cultural level (Glasser & Bridgman, 1999). The individual level involves examining the characteristics of individuals who are homeless and their adaptations to homelessness. The organizational level involves looking at services that are offered to the homeless population, specifically eligibility requirements and other potential sources of limitation. The community level involves municipal policies and neighborhood activism, while the institutional level includes

housing and social assistance programs as well as the criminal justice system. Finally, the cultural level includes cultural attitudes toward homelessness and its correlates (e.g., race/ethnicity, mental illness, and substance addictions).

The Toro Model developed by Toro and colleagues in 1991 is another example of an ecological approach to understanding homelessness (Glasser & Bridgman, 1999). This model identifies four ecological principles that are considered when investigating homelessness: adaptation, cycling of resources, interdependence, and succession (Glasser and Bridgman, 1999; Toro et al., 1991). The adaptation principle highlights the broad contextual view of homelessness, identifying environmental characteristics/restrictions and assessing the homeless response to them. The cycling of resources principle focuses on how resources within individuals and their social systems are defined, distributed, and enhanced. The interdependence principle suggests that any system can be viewed as a series of interdependent components. It consequently emphasizes the importance of thinking about the impact that one person's or one organization's actions can have on the greater systems to which they belong. Finally, the succession principle stresses the time dimension of ecosystems by asserting that they are in a constant state of flux. This principle suggests that present-day homelessness should be examined in relation to historical homelessness as well as anticipated future homelessness. In other words, one should look back and forward when considering contemporary homelessness.

Shinn's (2007) work highlights how the ecological framework encourages multi-level examination of individuals (in addition to multi-level examination of contexts and person-context transactions). Just as environments can be examined from multiple levels (e.g., by separating organizational-, institutional-, and cultural-level characteristics), so,

too, can individuals. Shinn recommended organizing the characteristics of individuals who are homeless into three interrelated types of capital: economic, social, and human. Economic capital refers to income and wealth, both of the individual who is homeless and his/her family of origin. Social capital refers to social relationships and networks at both the informal and formal levels. Human capital refers to all of the factors that help people to secure incomes and housing; it includes education, work experience, physical health, and mental health, to name a few.

In sum, multiple reasons for homelessness have been identified and perceived as increasingly interrelated, due in part to the emergence of the theoretical ecological models on homelessness. The identification of the wide variety of contributors to homelessness and their interplay has been very important in informing intervention and policy for homeless persons as a whole (Toro et al., 1991). At the same time, care should be taken to continually include the homeless perspective on reasons for homelessness so that premature or inaccurate assumptions are not applied inappropriately to individual cases.

A study by Mojtabai (2005) underscores this point. Mojtabai examined reasons for loss of housing and continued homelessness from the perspective of two groups: homeless individuals with mental illness and homeless individuals without mental illness. Perhaps contrary to expectations, few differences in reasoning were observed, and only a small fraction of the group with mental illness reported mental illness as a reason for continued homelessness. This finding suggests that individuals facing homelessness and the people who study them may assign different levels of importance to this potential contributor. Even though mental illness is commonly cited as a contributor to

homelessness in the literature, the individuals who are homeless may not perceive it to be as significant a contributor as other factors (e.g., insufficient income, unemployment, lack of affordable housing).

Characteristics and Correlates of Homelessness

Much of the research on homelessness to date has focused on the characteristics of individuals who are homeless and the problems they face (Cohen & Wagner, 1992; Shinn, 2007). Data on the characteristics and correlates of homelessness have been obtained via a wide variety of samples (e.g., single gender, mixed gender, sheltered, unsheltered) and methodologies (e.g., qualitative investigations, large-scale quantitative surveys). The National Survey of Homeless Assistance Providers and Clients (NSHAPC) from 1999, which sampled over 6,400 homeless program representatives, 6,500 homeless programs, and 4,200 program consumers, has frequently been referenced as a source of information about the homeless population (Green, 2005). The purpose of this section is to review the correlates of homelessness and to emphasize that “the belief that the homeless are just lacking permanent shelter is a horrible simplification of the issues surrounding homelessness” (Green, 2005, p. 9). I chose the term “correlates” to emphasize that the directionality between homelessness and the characteristics associated with it is often unclear. Certain characteristics may increase individuals’ vulnerability to becoming homeless, and being homeless may increase individuals’ likelihood of manifesting certain characteristics (Glasser & Bridgman, 1999; Shinn, 2007).

Gender, Age, and Parent Status. Although there have been growing numbers of single women, women with children, unaccompanied youth, and families joining the homeless population, homelessness appears to affect single men most of all (Abelson,

1999; Bloom, 2005; Molina, 2000; Roll, Toro, & Ortola, 1999; The United States Conference of Mayors – Sodexo, Inc., 2006). As Hurley (2002) noted, “Men make up the vast majority of groups that commonly experience homelessness, including the unemployed, former prisoners, veterans of the armed forces, and members of the foster care system” (p. 45). Approximately 51% of the homeless population is comprised of single men (National Coalition for the Homeless, 2007). Single women comprise about 17% (National Coalition for the Homeless, 2007). Men are also more likely to be chronically homeless than women (Green, 2005).

Homeless families represent 30% of the homeless population, and the vast majority of them are headed by women (Green, 2005; National Coalition for the Homeless, 2007). Because women are more likely than men to have children with them, they consequently may have better access to more desirable types of shelters (Stein & Gelberg, 1995). They also have more access to federal support (e.g., via welfare programs; Stein & Gelberg, 1995).

Another subgroup of the homeless population is comprised of unaccompanied youth. These individuals make up 2% of the homeless; they are generally runaways or former foster care children (Green, 2005; National Coalition for the Homeless, 2007). Although the number of children who are homeless is growing with the rise of homeless families, the vast majority of the homeless population is still between the ages of 25 and 54 (Green, 2005). Interestingly, in a study on the risk factors for long-term homelessness, Caton et al. (2005) found that age was a significant predictor of duration of homelessness with younger individuals experiencing significantly shorter durations.

Race/Ethnicity. In terms of race/ethnicity, 41% of individuals who are homeless are Caucasian, 40% are African American, 11% are Hispanic, and 8% are Native American (Green, 2005; Kusmer, 2002). Racial/ethnic minorities (especially African Americans and Native Americans) are greatly overrepresented in the homeless population when census data are considered (Gamst et al., 2006; Green, 2005). This is consistent with cross-cultural studies on homelessness. As Shinn (2007) noted, "...everywhere [i.e., not just in the United States]², stigmatized and excluded groups [e.g., racial/ethnic minorities]³ are more likely to become homeless" (p. 666). Shinn described four types of social disparities that serve as important mechanisms linking race to homelessness; these lie in the realms of employment, distribution of wealth, access to housing/real estate, and imprisonment rates. Unfortunately, despite the disproportionate representation of minorities in the homeless population, most research studies have neglected to include an incorporation of cultural factors (e.g., ethnic identity, acculturation, provider-consumer racial matching) in their designs (Gamst et al., 2006)

Mental Illness. Individuals who are homeless have been found to exhibit higher rates of psychiatric disorders than the general population (Littrell & Beck, 2001). Empirical studies have generally found that between one-fourth and one-third of individuals facing homelessness have severe mental illness (Green, 2005). Fifty-seven percent of individuals surveyed for the NSHAPC reported at least one lifetime problem that was related to mental health (Burt et al., 2001; Green, 2005). This finding has been replicated in other studies (e.g., Caton et al., 2005) but may be an underestimate given sampling difficulties associated with obtaining participants who are homeless (Stein &

² Bracketed portion mine.

³ Bracketed portion mine.

Gelberg, 1995). Mood, anxiety, and thought disorders appear to occur with frequency within the homeless population. For instance, rates of depression, posttraumatic stress disorder, and schizophrenia have been found to be at 20%, 27%, and 11%, respectively (LePage et al., 2006).

Differences have been found between individuals who are homeless with mental illness and their non-mentally ill counterparts. For instance, the subgroup with mental illness has been noted to be more isolated, to face homelessness longer, and to have more contacts with the legal system (Stein & Gelberg, 1995). This observation suggests that those with mental illness may comprise their own subgroup of the homeless population.

Substance Abuse and Dependence. Individuals without homes have higher rates of substance abuse than their domiciled counterparts (Green, 2005). According to the NSHAPC, 62% of those surveyed reported an alcohol-related lifetime problem, and 58% reported a drug-related lifetime problem (Green, 2005). Other studies have yielded similar figures (e.g., Caton et al., 2005). According to Glasser and Bridgman (1999), “There is substantial evidence that alcoholism is the most pervasive health problem of the homeless in the United States” (p. 26). Rates of alcoholism among the homeless have ranged from 58-68% in men and are at about 30% for women; these rates are higher than those found in the general population and may even be underestimates (Glasser & Bridgman, 1999; LePage et al., 2006). Drug use rates are also higher in the homeless than in the general population (Glasser & Bridgman, 1999). Finally, men appear to be more likely than women to have problems with alcohol and/or drugs (Stein & Gelberg, 1995)

Co-occurring Mental Illness and Substance Use Disorders. A large proportion (up to 46%) of the homeless population with mental illness also has co-occurring

substance use disorders (Dennis et al., 1991; Stein & Gelberg, 1995). Individuals with co-occurring disorders have been found to experience more severe symptoms of psychiatric illness, deny their psychiatric and substance use problems, experience suicidal ideation and behavior, and refuse treatment (Green, 2005). They also tend to have more severe physical problems and poorer treatment outcomes than individuals with mental illness or substance use problems alone (Green, 2005). Finally, they tend to remain homeless longer than other subgroups of the homeless population (Green, 2005). Unfortunately, as Stein and Gelberg (1995) noted, “Homeless persons with concurrent alcohol, drug, and mental disorders are considered the most disadvantaged and underserved segment of the population” (p. 76).

Physical Health. As with mental illness and substance use disorders, individuals who are homeless are more likely to have serious physical health problems than the general population. Lee and Schrek (2005) pointed out that “numerous investigations have documented the substantially higher rates of infectious and degenerative disease...found among the homeless than in the domiciled population” (p. 1061). These health problems often stem from the lack of healthcare, poor nutrition, unsanitary living conditions, exposure to inclement weather, and risky lifestyles (e.g., drug use, unprotected sexual activity) associated with homelessness (Green, 2005; Hwang et al., 2005). According to Green (2005), the NSHAPC found that 55% of the homeless population has no medical insurance; the homeless population also faces major barriers to obtaining healthcare (Hwang et al., 2005). Forty-six percent of those surveyed endorsed having at least one chronic health condition (e.g., arthritis, hypertension, diabetes, cancer; Green, 2005). Twenty-six percent said they had an infectious condition (e.g., bronchitis,

pneumonia, tuberculosis, sexually transmitted disease; Green, 2005). Finally, individuals who are homeless are at increased risk for mortality (Hwang et al., 2005; Solliday-McRoy, Campbell, Melchert, Young, & Cisler, 2004).

Neuropsychological Functioning. There has been support for the idea that neuropsychological problems are common within the homeless population (Solliday-McRoy et al., 2004). Studies on the neuropsychological functioning of individuals who are homeless have suggested that up to 80% of them may display signs of cognitive impairment (Solliday-McRoy et al., 2004). A study of 90 men in shelters by Solliday-McRoy and colleagues (2004), for instance, found that a vast majority of participants screened positive for impairment in at least one area of cognitive functioning (usually memory). More than half of the sample displayed impairment in verbal learning and verbal memory ability. Nearly three-quarters displayed deficits in cognitive processing speed, visual-perceptual integration, and/or visuospatial memory. Twenty-eight percent obtained scores suggestive of attentional problems. On average, the sample demonstrated below average intellectual abilities, another possible indicator of impaired neuropsychological functioning. Interestingly, none of the test scores were significantly associated with histories of traumatic brain injury, mental illness, substance use disorders, or length of time in the shelter. This finding suggests that the neuropsychological deficits found in the sample may have been independent of factors that frequently influence performance on cognitive tasks.

Early Childhood/Familial History. According to Shinn (2007), early childhood/familial history may contribute to homelessness. For instance, many adults who are homeless have come from impoverished or low socioeconomic status families.

Shinn offered three explanations for why coming from such a background may predispose individuals to homelessness later in life: (a) people who are raised in a culture of poverty may be less energized to remove themselves from poverty later on; (b) people from poorer backgrounds may have less familial resources/wealth to draw from in dire financial situations; and (c) growing up in poverty may relate to poorer physical and mental health outcomes that make it difficult to obtain and sustain employment.

Besides growing up in poverty, many adults who are homeless have also come from backgrounds that involved out-of-home placements during childhood. In a study on risk factors for long-term homelessness, for instance, Caton et al. (2005) found that 21% of their sample of 445 adults had experienced an out-of-home placement during childhood. Twenty-four percent of the sample also obtained scores indicative of early family dysfunction on one of the measures that Caton et al. utilized.

Trauma and Victimization. Trauma and victimization appear to be common among individuals who are homeless (Stein & Gelberg, 1995). For instance, Christensen and colleagues (2005) found that nearly 80% of the participants from their study on trauma among individuals who are homeless and have co-occurring disorders had experienced physical or sexual abuse at some point in their lives (100% of their female participants and 69% of their male participants, total $n = 78$). Most of the trauma had occurred during the participants' childhood or adolescent years. Early trauma, especially unresolved or untreated, is a potential risk factor for homelessness, as it is associated with psychological distress that is often disturbing enough to encourage self-medicating behaviors (e.g., substance misuse; Christensen et al., 2005).

Victimization during homelessness also appears to be quite prevalent. Lee and Schreck (2005), for example, used data from the NSHAPC to examine the extent to which participants (n = 2,401) had been the victims of theft, physical assault, and/or sexual assault. Fifty-four percent of respondents reported at least one experience of victimization during their time on the streets; 21% of the sample said they had been physically attacked, and 11% of female participants said they had been raped. About half said they had been victims of theft, and theft was frequently accompanied by a physical attack. When results of the study were compared with results of studies involving the domiciled population, Lee and Schreck found that individuals who were homeless were disproportionately victimized. Victimization was attributed to the marginality and vulnerability of the homeless population (e.g., the participants spent a sizable proportion of their time on the streets, often in dangerous neighborhoods).

Unfortunately, victimization during homelessness has been associated with a number of negative outcomes, including fear, psychological distress, substance abuse, physical injury, decreased employment, poor self-efficacy, and decreased quality of life (Lee & Schreck, 2005). Lee and Schreck (2005) noted, "...experiencing a crime against one's person or property while on the social, economic, health, and spatial margins of society may compound or intensify the outcomes that normally follow victimization. These outcomes could make it harder to escape the streets, just as the costs associated with victimization in the domiciled population increase the chances of long-term disadvantage" (p. 1076). Furthermore, trauma and accidents are the leading causes of illness, disability, and death among individuals who are homeless (Stein & Gelberg, 1995).

Criminality. Studies have shown that there is more incarceration and criminal activity among the homeless than domiciled populations (Stein & Gelberg, 1995). In a study on risk factors for long-term homelessness, Caton et al. (2005) found that a large proportion of their sample (total n = 445) had a history of arrests (58%) or had served jail or prison time (14%). Arrest history was found to be one of the strongest predictors of duration of homelessness; participants with an arrest history were more likely to experience a longer episode of homelessness. Shinn (2007) suggested that there is a strong causal link between imprisonment and homelessness as well. People lose income when they are in prison, and their employment opportunities are significantly diminished after release from prison (Shinn, 2007). A felony conviction can result in civil disabilities like denial of welfare benefits, food stamps, and financial aid for higher education (Shinn, 2007). Furthermore, a history of criminal conviction often restricts housing options, despite lack of empirical support for a link between criminal history and housing failure (Malone, 2009).

Researchers have noted that individuals who are homeless tend to be charged with minor offenses, such as petty theft, trespassing in vacant buildings, loitering, public drunkenness, and disorderly conduct (Lee & Schreck, 2005; Stein & Gelberg, 1995). Men are significantly more likely than women to have involvement in the criminal system (Stein & Gelberg, 1995). This may stem in part from the fact that they are also more likely to have alcohol and drug disorders (Stein & Gelberg, 1995). One study found that 41% of men reported committing a crime in the past year (LePage et al., 2006).

Military History. Large numbers of veterans have been observed in the homeless population since the increase of homelessness in the 1970s (Tessler, Rosenheck, &

Gamache, 2002). Veterans are estimated to comprise 23% of the homeless population, and 98% of veterans who are homeless are male (Green, 2005). Many influences may predispose veterans to homelessness, including military-related trauma and inadequate care post-discharge (Tessler et al., 2002). Studies comparing homeless veterans to their non-veteran counterparts have suggested that homeless veterans have higher rates of alcohol use problems (Tessler et al., 2002). At the same time, they may also harbor personal resources that other homeless subgroups do not possess (e.g., membership in a street subculture related to military history, more extensive education histories, opportunities to receive additional services via Veterans Affairs; Applewhite, 1998; Tessler et al., 2002).

Income and Education. According to Green (2005), “The most consistent characteristic of all homeless persons regardless of race, gender, or family status, is their lack of income and pervasive poverty” (p. 7). Single adults who are homeless have incomes 51% below the federal poverty level; families facing homelessness have incomes 46% below (Green, 2005). Lack of education and limited job skills are serious issues that frequently contribute to difficulty securing employment. The high school dropout rate of the homeless population is higher than the national average at 38%, suggesting that individuals who are homeless may have educational deficits that hinder their ability to get higher paying jobs once they exit school (Green, 2005).

Costs of Homelessness

The phenomenon of homelessness is very costly both to those who are facing homelessness and society as a whole. It is costly to individuals who are homeless in that they face increased vulnerabilities to acute and chronic health complications, substance

abuse and dependence, mental illness and emotional maladjustment, unemployment, discrimination, victimization, and premature mortality (e.g., Green, 2005; Rew & Horner, 2003; Wilson, 2005). Homelessness threatens quality of life and life itself for these individuals.

Homelessness is also extremely costly for society (Burt et al., 2001). Because individuals facing homelessness have no residence of their own, they utilize a variety of public systems and services (National Alliance to End Homelessness, n.d.b.). According to the National Alliance to End Homelessness (2006), the federal government spent over \$1.9 billion dollars on dedicated homelessness programs in 2006 alone. Mitka (2006) reported that the chronically homeless population in particular “cost[s] society millions of dollars for emergency medical services, psychiatric treatment, detoxification, shelter use, and law enforcement” (p. 2344). The use of emergency shelters, hospitals, and prisons as alternatives to long-term housing by persons facing homelessness is an inefficient use of financial resources. For instance, the National Alliance to End Homelessness (n.d.b.) pointed out that “the cost of an emergency shelter bed funded by HUD’s Emergency Shelter Grants program is approximately \$8,067 more than the average annual cost of a federal housing subsidy.” It has consequently been suggested that preventing future homeless episodes and ensuring timely re-housing of the currently un-housed can result in significant cost savings (National Alliance to End Homelessness, n.d.b.).

Supporting Individuals Who Are Homeless and Ending Homelessness: Programs and Interventions

A variety of programs exist to prevent long-term homelessness and to help individuals who are homeless find respite (i.e., immediate food and shelter), secure

permanent housing, obtain employment, reduce psychiatric symptoms, decrease or eliminate substance abuse, and ultimately become reintegrated into mainstream society (Crook et al., 2005; Glasser & Bridgman, 1999; Green, 2005). These programs typically involve outreach, case management, job training, educational programming, provision of housing/transitional housing, substance abuse treatment, and/or mental health services (Glasser & Bridgman, 1999; Hwang et al., 2005). The majority of these programs have received funding from the McKinney Act (National Alliance to End Homelessness, n.d.b.).

Unfortunately, although billions of dollars have been allocated to the homeless cause and there are now thousands of programs in the United States offering assistance to the homeless population, many of them have been ineffective in leading to the permanent re-housing of those without housing (Dennis et al., 1991; Glasser & Bridgman, 1999). Homelessness has remained relatively stable in its prevalence over the years (Leipersberger, 2007; Mitka, 2006). Additionally, Shinn (2007) pointed out that while “making housing affordable, by either boosting incomes or subsidizing housing, seems a key component in any solution to homelessness, and may have benefits for other outcomes ... in many cases housing alone will be inadequate to the multifaceted nature of homelessness” (p. 679). The purpose of this section is to briefly review the literature on programs that serve the homeless population, pointing out the characteristics of those that seem to be more effective and discussing some of the problems that plague homeless assistance endeavors (with a particular emphasis on engagement and retention difficulties).

Characteristics of Effective Programs for the Homeless. While I did not locate any large-scale, meta-analytic studies related to the effectiveness of programs and interventions for the homeless population (at least in terms of reducing the prevalence of homelessness), I found a few articles that reviewed some of the programs that exist and pointed to their effectiveness. For example, Green (2005) noted that studies conducted by HUD suggest that the most effective programs for individuals who are homeless involve multi-agency collaboration and long-term planning. According to her, “The most successful homeless assistance programs act as a single system, providing all of the following services: prevention, outreach and assessment, emergency shelter, transitional housing, appropriate supportive services (mental health, substance abuse, domestic violence and job readiness), permanent supportive housing, and permanent housing” (p. 10). Green indicated that the best practice service model of delivery marries supportive housing and integrated supportive services in a seamless manner. This indication is consistent with Dennis et al.’s (1991) suggestion that (a) the availability of on-site and off-site supportive services and (b) intensive, extended follow-up of homeless service consumers have been noted as two factors significantly associated with ability to remain re-housed.

Tsemberis, Gulcur, and Nakae (2004) noted the benefits of utilizing the Housing First approach to reducing homelessness among chronically homeless individuals with co-occurring mental illness and substance use disorders. The Housing First approach allows individuals to obtain stable supportive housing prior to satisfying treatment prerequisites (e.g., psychiatric treatment engagement/completion, sobriety/abstinence from substances), in contrast to the Continuum of Care approach (Tsemberis et al., 2004).

These researchers examined the longitudinal effects of a Housing First program in New York City and reported an 80% housing retention rate among their study participants. Furthermore, these researchers' participants were found to maintain their housing without experiencing an increase in psychiatric or substance disorder-related symptoms relative to other participants receiving a Continuum of Care approach. Tsemberis and colleagues suggested that interdisciplinary team-based Housing First programming, which combines a consumer-driven philosophy with harm reduction-focused integrated dual diagnosis treatment, positively affects housing stability. The U. S. Interagency Council on Homelessness (2011) noted that evaluations of Housing First permanent supportive housing programs have shown significant improvements in housing stability, reductions in durations of homelessness, and decreases in utilization of costly public services (e.g., emergency rooms, jails, shelters).

Glasser and Bridgman (1999) found that services and programs involving outreach, centralized hub stations, indigenous leadership, case management, transitional and supportive housing, homesteading, and self-help housing plans have been particularly effective in ameliorating homelessness. However, these researchers did not provide statistical evidence for their assertions. As such, the effectiveness of services and programs not referenced in other studies (e.g., homesteading, self-help housing) remains questionable.

Hwang and colleagues (2005) conducted a systematic review of interventions designed to improve the health of the homeless population, as eliminating homelessness involves more than just providing housing. A variety of health-related outcomes were assessed, including physical health, mental health, substance use, HIV risk behavior,

healthcare utilization, adherence to healthcare plans, and quality of life. Hwang et al.'s main finding (based on 73 studies) was that interventions providing coordinated treatment/support that was specifically adapted to the needs of their consumers resulted in greater improvements in health-related outcomes than usual care. It was consequently recommended that such interventions be considered in conjunction with housing programs to expedite the greater goal of ending homelessness. Indeed, the National Health Care for the Homeless Council (NHCHC) has asserted that ending homelessness and alleviating its associated consequences will involve ensuring adequate healthcare in addition to housing stability and access to employment (National Health Care for the Homeless Council, 2011).

In introducing their research study, LePage and colleagues (2006) emphasized the importance of treatment environment on program outcomes. These researchers suggested that programs with more support, practical skills training, and outlets for personal expression resulted in better social functioning of their consumers. Additionally, program consumers were noted to report higher satisfaction when policies were clear, they felt involved and supported, programs were well-organized, and practical skill development was emphasized.

In a qualitative investigation, MacKnee and Mervyn (2002) asked formerly homeless individuals (n = 17) what helped them to make a more permanent transition back to mainstream society. Nineteen incidents were cited as facilitative in getting them off the streets, and many of them speak to the services that are provided via homeless programming. The nineteen incidents involved recognizing one's personal destitution; revolting against death, violence, and devaluation of life; having someone reach out;

relocating and separating from the street lifestyle; experiencing a spiritual event; going through detoxification or drug rehabilitation; realizing one's self-worth; realizing one's confidence and abilities; establishing a stable and legitimate job; achieving educational success; creating relationships with mainstream people; reestablishing family relationships; experiencing accountability; establishing a stable residence; emulating mainstream role models; formal or informal counseling; facing the responsibilities of parenting; dealing with issues they had prior to living on the streets; and bottoming out. Only four incidents were seen as hindering one's transition off the streets: being loyal to the "street family;" receiving free services and welfare; having bad experiences with support providers; and learning in alternative schools.

Thompson and colleagues (2004) were also interested in the perspectives of formerly homeless individuals on contributors to their successful exits from homelessness. They interviewed twelve individuals to identify the processes that enabled them to leave homelessness and achieve housing stability. The study participants indicated that improving relationships with significant others (e.g., family, service providers), changing internal motivation and accepting personal responsibility for improving their lives, and utilizing needed services (e.g., substance abuse treatment, employment training) all empowered them to leave homelessness. Relationships with family and service providers were cited most frequently as important to gaining housing stability; interpersonal relationships were described as fueling their sense of self-worth.

Problems Associated with Homeless Assistance Programs. A number of problems associated with homeless assistance programs have been examined and/or discussed in the literature on homelessness. These problems have been reported to

include difficulties with administrative and bureaucratic procedures, unreliable and/or inadequate funding, trouble accommodating the vast number of individuals facing homelessness and their variety of special needs, and lack of affordable housing in which the homeless population can be placed (Green, 2005). Difficulty engaging and retaining clientele in services (particularly those with co-occurring mental illness and substance use disorders) has also been cited with frequency as a problem reported by homeless assistance programs (Bhui et al., 2006; Ng & McQuiston, 2004; Padgett et al., 2008; Thompson et al., 2004). This is a particularly unfortunate problem considering the positive relationship that exists between engagement in services and re-housing/housing stability (Thompson et al., 2004). Given that engagement problems are less structurally-based and more within the arena of psychology in that they are often relationally-based (i.e., relationships/alliances between service providers and their clientele can predict engagement, retention, and outcomes; Thompson et al., 2004), focus of this section will now turn to reasons for engagement and retention difficulties.

Engaging and Retaining Clientele Who Are Homeless. According to researchers (e.g., Padgett et al., 2008; Thompson et al., 2004), engagement and retention are regarded as key factors in recovery from mental illness, substance use disorders, and difficulties related to life on the streets. At the same time, they remain among the greatest challenges confronting service providers seeking to help individuals who are homeless, especially those with severe mental illness and/or alcohol and drug addiction, a population within which trust-building is considered “essential to successful engagement” (Padgett et al., 2008, p. 226). Kim et al. (2007) observed, “Despite the abundance of physical and mental healthcare needs in the homeless population, mentally

ill homeless adults consistently underutilize regular or preventative physical and mental health services” (p 364). Given that intensity and duration of treatment are strong predictors of treatment success (in general and especially among the homeless), it is worthwhile to consider the contributors to problems reaching and retaining clientele who are homeless (Padgett et al., 2008). Several researchers have recognized the importance of obtaining the perspective of individuals facing homelessness on why they may not utilize services with more regularity. Below is a review of studies that have surveyed individuals who are/were homeless followed by a summary of their findings examined in aggregate.

First, Kim and colleagues (2007) conducted a study examining the barriers to physical and mental healthcare from the perspective of individuals who were homeless and had mental illness (n = 154). Barriers to physical healthcare related primarily to an underlying dimension involving practical access issues, while barriers to mental healthcare related primarily to an underlying dimension involving stigma of mental illness and fear of social rejection resulting from having a mental illness. Overall, results of the study implied that physical healthcare should be made more accessible to the homeless population, while the stigma associated with seeking mental healthcare should be systematically reduced to encourage more help-seeking.

Leipersberger (2007) conducted interviews with 25 participants who had severe mental illness and had experienced at least one episode of homelessness in the past year. Three types of barriers were described as hindering service utilization: barriers stemming from the self, barriers stemming from organizational characteristics, and barriers stemming from society. Barriers stemming from the self included negative self-image,

pride (i.e., wanting to maintain what little pride they had), distrust toward mental health professionals, fear of medications, substance use, poverty, lack of understanding of mental illness, lack of knowledge about resources, and physical health problems. Barriers stemming from organizations involved perceived inexperience of staff, perceived uncaring attitude of service professionals, high staff turnover, lack of similarity in life experience between staff and clients (e.g., on the basis of racial background or housing status), inequitable power distributions within homeless programs, imposition of strict rules, inappropriate services, inadequate services, unsafe settings, and lack of privacy in shelters. Finally, barriers stemming from society were reported to include the political climate, policies making criminal history a barrier to finding employment/housing, societal stigma toward mental illness, and societal stigma toward homelessness. Respondents frequently reported feeling looked down upon by healthy and housed individuals, which caused them to experience sadness, frustration, helplessness, and hopelessness.

Another study was conducted by Padgett and colleagues (2008). These researchers asked their participants what enhanced or impeded their entry and retention in treatment for mental health and/or substance abuse problems; responses were analyzed via grounded theory methodology. The interviewees indicated the following as facilitative of their entry into and retention in treatment: symptoms of mental illness becoming overwhelming; programs that provided quick access to housing; safe, clean, and quiet facilities; staff kindness toward them; and individualized attention from staff (versus routinized or dehumanizing attention). Factors that hindered their entry into and willingness to remain in treatment included lack of treatment options (i.e., the dominance

of group modalities), substance use (e.g., sometimes treatment was denied on the basis of their non-abstinence), program rules and practices that infringed on their sense of autonomy (e.g., curfews, signing over of disability checks for others to manage, close supervision of their behavior), and lack of equality with staff. One participant described this inequality as “a totem pole, you know, and clients are at the bottom, and the staff, they’ve got the top and they have their laws or this rule or that rule...and they’re very, very controlling, these people” (p. 230). Padgett et al. suggested the following as implications of their findings: (a) homeless assistance programs should demonstrate sensitivity and flexibility in dealing with clientele; (b) housing first projects should be considered, as they may attract persons who do not want to conform to shelter rules or live in the restrictive environments of shelters; (c) stronger emphasis should be placed on self-determination of clientele; and (d) more treatment options should be provided (e.g., individual therapy in addition to group).

Finally, Bhui et al. (2006), noting that service providers’ views on the services persons who are homeless need often diverge from views of those who are experiencing homelessness, interviewed 10 individuals who were homeless on their perceptions of the adequacy of the care that is offered to them. One theme that emerged from the interviews was that the participants felt stigmatized by service providers, the public, and other members of the homeless population. Participants suggested that staff members of homeless assistance programs treated them in dehumanizing ways, particularly by expressing prejudicial attitudes, enforcing excessive shelter rules, and imposing religious practices (when the shelters were faith-based). Furthermore, they felt dehumanized when they had to enter long waiting lists for housing or when their goals were unrecognized or

invalidated by their providers. Finally, individuals with mental illness suggested that they were considered to be of lesser status than individuals without mental illness, which discouraged them from seeking help for their problems.

In sum, participants from the studies above suggested a variety of reasons as to why individuals who are homeless may not utilize the supportive services that are often available to them. Some themes appeared to emerge across studies as to why individuals experiencing homelessness may be difficult to engage and/or retain in treatment. One such theme involved their experiences of stigmatization related to mental illness (Bhui et al., 2006; Kim et al., 2007; Leipersberger, 2007), substance use (Leipersberger, 2007; Padgett et al., 2008), and/or homeless status (Bhui et al., 2006; Leipersberger, 2007). Another theme involved negative staff-consumer interactions, as staff members were often perceived as uncaring, prejudicial, or unfairly placed in superior positions of power (Bhui et al., 2006; Leipersberger, 2007; Padgett et al., 2008). Finally, the imposition and enforcement of strict, controlling, and dehumanizing rules in shelters was also mentioned as non-facilitative of motivation to utilize support services. This last theme was consistent with other researchers' discussions of shelters as institutions that foster dependency, passivity, and lack of self-initiative/self-regulation among the individuals who use them (e.g., Glasser & Bridgman, 1999). Even though shelters were generally developed with good intentions and shelter policies are used to ensure the safety of shelter-goers, unintended but negative consequences have been associated with them. Molina (2000), for instance, asserted, "The politics of compassion...have erroneously led to policies of sheltering and the segregation of homeless people. Advocates for homeless individuals pushing for their 'right to shelter' have managed to institute policies that seek

to treat their maladies and confine them to designated areas. Shelters, as ‘total institutions,’ exercise complete control over their clients and create dependence...” (p. 682).

To conclude this section, when one examines the themes that emerged from the studies on individuals experiencing homelessness and their underutilization of services (i.e., perceived stigmatization, negative perceptions of service staff – often due to power differentials, and the commonly rigid and disempowering nature of shelterization), one can see that they are interrelated. For instance, it is likely that having inequitable power in settings that limit personal autonomy reminds individuals who are homeless of their marginalized, stigmatized status in society. It is also possible that holding a marginalized position in society makes individuals experiencing homelessness more sensitive to injustices that may take place within homeless assistance programs. Either way, these are just hypotheses; even though barriers to treatment-seeking have been identified, relatively little is known about the underlying mechanisms that cause them to have their influence on the decisions of individuals who are homeless to engage in treatment. In other words, reasons for difficulties engaging and retaining clientele who are homeless have been identified, but they have not been explained in great detail. As such, and given the powerful link between service engagement and positive outcomes (Padgett et al., 2008; Thompson et al., 2004), there is a need to give more empirical attention to the aforementioned variables that appear to hinder individuals who are homeless from seeking supportive services.

For the purposes of this research project, I decided to focus on the theme of stigmatization. Although considerable research has been done on stigma and its

consequences for the stigmatized, the relationship between stigmatization and the psychosocial functioning of individuals who are homeless is not well understood from an empirical perspective. Little is known about this particular population's experiences of and responses to stigmatization despite the fact that persons facing homelessness (especially those with co-occurring mental illness and substance use disorders) comprise one of society's most stigmatized groups. A review of the existing literature on stigma (e.g., definitions, correlates, responses to stigma, etc.) is presented below followed by a review of its application to the homeless population.

Overview of the General Concept of Stigma

Stigma is not a new construct. The concept of stigma dates back at least as far as ancient Greece (Crocker et al., 1998). During this time period, the term "stigma" was used to refer to "a sign, or mark, cut or burned into the body, that designated the bearer as a person who was morally defective and to be avoided - a slave, a criminal, or a traitor, for example" (Crocker et al., 1998, p. 504).

A more contemporary perspective on stigma can be traced to 1963 and Erving Goffman's classic monograph on stigma, entitled *Stigma: Notes on the Management of a Spoiled Identity* (Major & O'Brien, 2005). Within this text, Goffman (1963) referred to stigma as a deeply discrediting attribute, characteristic, or mark that reduces someone "from a whole and usual person to a tainted, discounted one" (p. 3). Goffman suggested that people who are stigmatized are perceived as having a "spoiled" identity that renders them susceptible to social devaluation.

Goffman's landmark work triggered a slew of research on the topic of stigma and extensions of his conceptualization. This research has been conducted predominantly

through social psychologists and other individuals interested in the social cognitive approach to understanding human nature (Deaux & Ethier, 1998; Link & Phelan, 2001). Social cognitive theorists believe that people construct categories and link categories to stereotyped beliefs and expectations to make sense of their worlds (Link & Phelan 2001).

The beliefs of social cognitive theorists are reflected in Jones and colleagues' (1984) suggestion that a stigma is a mark (i.e., attribute) that links a person to undesirable characteristics (i.e., via categorization and stereotyping). Crocker and colleagues (1998) emphasized the social construction and contextual piece of stigmatization via their definition of a stigmatized person as “a person whose social identity, or membership in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others...stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context” (p. 504-505). Deaux and Ethier (1998) explained that what is stigmatized in one social context may not be stigmatized in another, as contexts determine which attributes are devalued. At the same time, Major and O'Brien (2005) pointed out that while there may be cross-cultural variance in what is stigmatized, “...stigmatized groups tend to be negatively stereotyped on the dimensions of competence and/or warmth in most cultures” (p. 396).

Link and Phelan's (2001) conceptualization of stigma expanded Jones et al.'s (1984) definition to include more than stereotypes. In fact, these researchers proposed that stigma occurs as a result of several interrelated components that co-occur in a power situation: labeling, stereotyping, separation, status loss, and discrimination. They explained, “In the first component, people distinguish and label human differences. In the

second, dominant cultural beliefs link labeled persons to undesirable characteristics – to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of ‘us’ from ‘them.’ In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination” (p. 367).

Finally, Corrigan and Watson (2002) offered a distinction between public stigma and self stigma. Public stigma refers to the negative stereotypes and judgments that are placed on stigmatized individuals by society and are used to devalue and exclude them. Self stigma, on the other hand, refers to the degree to which stigmatized individuals internalize these stereotypes and judgments and use them to devalue and exclude themselves.

Regardless of which conceptualization of stigma that one identifies with (e.g., Corrigan & Watson, 2002; Crocker et al., 1998; Goffman, 1963; Jones et al., 1984; or Link & Phelan, 2001), two fundamental components are present: “(1) the recognition of difference based on some distinguishing characteristic, or ‘mark;’ and (2) a consequent devaluation of the person” (Dovidio et al., 2000, p. 3). According to Deaux and Ethier (1998), stigmatization processes are of particular concern because they are often manifested in discriminatory behaviors toward the stigmatized. Stigmatization involves dehumanization, threat, aversion, and depersonalization (Dovidio et al., 2000). As Dovidio and colleagues (2000) noted, “Stigmatization, at its essence, is a challenge to

one's humanity" (p. 1). Consequently, stigmatization is a very costly phenomenon; the specific costs of stigmatization are reviewed in detail later in this manuscript.

Categorization of Stigmas

Although all stigmas are similar in that they typically reflect some quality that is undesirable by the standards of the social context in which they are evaluated (Deaux & Ethier, 1998), researchers have attempted to organize stigmas into different types of categories and dimensions so that they can be compared and differentiated in meaningful ways (Crocker et al., 1998). Goffman (1963) and Jones et al. (1984) in particular are frequently referenced for their efforts to organize stigmas.

First, Goffman (1963) created a stigma typology. He recognized three types of stigmatizing conditions: (a) "tribal stigmas," (b) "abominations of the body," and (c) "blemishes of individual character." Tribal stigmas are "familial, or passed from generation to generation, and include membership in devalued racial, ethnic or religious groups" (Crocker et al., 1998, p. 506-507). Race, sex, religion, and nation are examples of tribal stigmas (Dovidio et al., 2000). Abominations of the body comprise "physical characteristics that convey a devalued social identity, such as physical handicaps of varying sorts, disfiguring conditions, and obesity" (Crocker et al., 1998, p. 507). Finally, character blemishes involve "devalued social identities related to one's personality or behavior" (Crocker et al., 1998, p. 507). Examples of character blemishes include mental disorders, addictions, and unemployment (Dovidio et al., 2000).

Jones and colleagues (1984) furthered Goffman's work by specifying six dimensions along which stigmatizing conditions can fall (Crocker et al., 1998). These include (a) "concealability," (b) "course," (c) "disruptiveness," (d) "aesthetic quality," (e)

“origin,” and (f) “peril.” Concealability refers to the degree to which the stigmatizing condition can be hidden from others (e.g., facial disfigurement vs. homosexuality), course refers to how the condition changes over time (i.e., does it become more salient or debilitating; an example would be multiple sclerosis vs. blindness), and disruptiveness refers to the extent to which the condition impacts the flow of social and interpersonal functioning (e.g., a stuttering condition; Crocker et al., 1998; Dovidio et al., 2000).

Aesthetic quality refers to how upsetting the condition is to others, origin refers to how the condition was acquired and who is responsible for it (e.g., was it congenital, acquired, accidental, or intentional), and peril refers to the amount of danger the condition may hold or is perceived to hold for others (e.g., someone’s highly contagious disease vs. their obesity; Crocker et al., 1998; Dovidio et al., 2000). Jones and colleagues (1984) suggested that peril, concealability, and origin are the most central dimensions of stigma.

Crocker and colleagues (1998), conversely, suggested that just two of Jones et al.’s (1984) dimensions are particularly important in understanding stigmatized individuals’ experiences of stigmatization. These dimensions are visibility/concealability and controllability/origin. First, Crocker et al. (1998) suggested that individuals with visible stigmas may have different concerns than individuals with concealable stigmas. Individuals with visible stigmas are more aware of the possibility that people’s reactions to them may be due to their stigmas. They may even expect that others will use their stigmas as a central basis for judging them, making it difficult to distinguish their stigma- and non-stigma-based reactions. Individuals with concealable stigmas, on the other hand, face dilemmas in regard to hiding their stigmas and may worry about the consequences of their stigmas becoming public knowledge.

The controllability dimension is also purported to be of utmost importance (Crocker et al., 1998). This dimension refers to the stigmatized person's level of responsibility for having the stigmatizing mark, maintaining it, and/or eliminating it (Dovidio et al., 2000). The controllability dimension is important because research has shown that individuals considered to have controllable stigmas are more stigmatized than individuals believed to have little or no control over their stigmatizing condition. They are more disliked, rejected, and harshly treated (Crocker et al., 1998). Additionally, they are less pitied and offered less support (Crocker et al., 1998).

Correlates/Manifestations of Stigmatization Processes

Stigmatization processes manifest themselves in a variety of ways that culminate in a threat to stigmatized individuals' sense of self and self-worth (Crocker et al., 1998). Targets of stigmatization are likely to face the following correlates of stigmatization processes: experiences with prejudice and discrimination, attributional ambiguity, expectancy confirmation processes, stereotype threat, and heightened awareness of their devalued social identity/identity threat (Crocker et al., 1998; Major & O'Brien, 2005). The purpose of this section is to review these correlates.

Experiences with Prejudice and Discrimination. As stereotyping and prejudice are central to stigmatization (Dovidio et al., 2000), the possibility of becoming a target of prejudice and discrimination, be it subtle or blatant, is ever-present among the stigmatized (Crocker et al., 1998). As such, stigmatized persons may feel heightened vulnerability to these threats. They may respond to this sense of vulnerability with hypervigilance (i.e., a sense of being constantly "on-guard" for the threats), enhanced sensitivity to others' attitudes, and/or extreme mistrust of others' intentions (Crocker et

al., 1998). Deaux and Ethier (1998) pointed out that stigmatized individuals' responses to the idea of being discriminated against vary; one person may see an act as highly discriminatory while the same act may go unnoticed by another individual.

Unfortunately, whether or not acts of prejudice and discrimination are perceived as such, they have a number of negative outcomes. For instance, Major and O'Brien (2005) noted that discrimination limits access to important life domains (e.g., housing, work, education, health care) and consequently impacts the social status, psychological well-being, and physical health of the stigmatized. Additionally, the negative outcomes associated with discrimination of the stigmatized (e.g., lowering of social status) may result in even more opportunities for further discrimination to take place (Major & O'Brien, 2005).

Attributional Ambiguity. Attributional ambiguity has been cited as another correlate of stigmatization processes (Crocker et al., 1998). This term refers to the uncertainty that stigmatization targets face when deciding whether treatment from others is due to their prejudice and discrimination or due to other factors. Stigmatized individuals are generally aware of their devalued social identity and consequently have a difficult time distinguishing if others' reactions to them are due to their social identity or to their personal identity. Crocker and colleagues (1998) suggested that this ambiguity can be protective in the sense that a stigmatized individual can choose to attribute another's negative evaluation of them to prejudice. The ambiguity can be damaging in that stigmatized individuals may have difficulty accepting personal credit for positive outcomes that are determined by others (e.g., they might question whether a scholarship has been awarded on the basis of their merit or the basis of their stigmatized status).

Expectancy Confirmation Processes. Stigmatization processes are often accompanied by expectancy confirmation processes. Expectancy confirmation processes are also known as self-fulfilling prophecies. According to Major and O'Brien (2005), negative stereotypes and expectations about society's stigmatized influence people to behave toward stigmatized individuals in certain ways. This behavior can directly affect stigmatized persons' thoughts, feelings, and behaviors, which may then confirm the initial stereotypes and expectations. Self-perceptions of stigmatized individuals may also be modified (albeit subconsciously) to be consistent with society's expectancies. Of particular note is the fact that expectancy confirmation processes can occur when stigmatized individuals are unaware of others' expectations, stereotypes, and prejudicial attitudes (Major & O'Brien, 2005).

Stereotype Threat. Stereotype threat, as conceptualized by Steele and Aronson (1995), is another phenomenon that is related to stigmatization (Crocker et al., 1998; Major & O'Brien, 1995). It involves having awareness of the specific stereotypes that are held for one's group and being concerned about behaving in such a way that the stereotypes will be confirmed. This concern can cause self-doubt and undermine performance, thereby resulting in the confirmation of the stereotype. Concern is usually precipitated by the activation of stereotypes via situational cues. Ideomotor processes (i.e., associative links in memory between stereotypes and the behaviors they imply) then trigger the behaviors that stigmatized individuals try to avoid. According to Major and O'Brien (2005), activation of stereotypes among stigmatized individuals is more likely to result in stereotype-consistent behavior than activation of stereotypes among non-

stigmatized individuals. This is likely due to the fact that stereotypes are more accessible in the minds of stigmatized individuals (Major & O'Brien, 2005).

Awareness of Devalued Social Identity and Identity Threat. According to Deaux and Ethier (1998), "Although many circumstances can threaten an identity, stigmatization is one of the most pernicious and may indeed be one of the most common" (p. 313). Stigmatized individuals face great threats to their identity. In general, stigmatized individuals are aware of their devalued social status, and this devaluation poses a threat to their personal self-esteem as well as their collective self-esteem (Crocker et al., 1998). An overall identity threat (i.e., "a threat to the aspect of self that is derived from membership in a devalued social group or category;" Major & O'Brien, 2005, p. 398) exists because stigmatized individuals may eventually start to wonder if others' perceptions of them are valid; if so, then they may start to believe that they deserve their devalued status. This explanation is consistent with theories on self-concept that suggest self-concept develops as a result of interactions with others and internalization of their appraisals (Crocker et al., 1998). These theories suggest that self-concept is diminished when others are perceived as emitting negative appraisals. Similarly, one's identity becomes especially threatened when others are perceived as judging it negatively.

Major and O'Brien (2005) emphasized the distinction between others' emissions of negative appraisals and stigmatized individuals' perceptions of these emissions. They suggested that stigma's effects are mediated through stigmatized individuals' understanding of how others view them, their interpretation of social contexts, and their motives. Of course, stigmatized individuals' understandings, interpretations, and motives are determined, at least in part, by their experiences as stigmatized individuals (Major &

O'Brien, 2005). Consequently, there appears to be a feedback cycle involving all of these factors.

Consequences of Stigmatization for the Stigmatized

According to Crocker et al. (1998), some stigma researchers have suggested that being stigmatized involves the internalization of negative images and stereotypes, which can alter or harm the stigmatized's personality and sense of well-being. Other stigma researchers, conversely, have argued that no internalization is necessary for stigmatizing messages to impact the stigmatized negatively (Crocker et al., 1998). Whichever the case may be, stigmatization has far-ranging effects on its targets, as it has been associated with a variety of physical, psychology, and social stressors (Dovidio et al., 2000; Major & O'Brien, 2005). In their review of the literature on stigma, for instance, Major and O'Brien (2005) found that stigma has been linked to a variety of negative outcomes, including poor mental health, physical illness, academic underachievement, infant mortality, low social status/social rejection, poverty, and reduced access to housing, education, health care, and jobs. Two of these outcomes are reviewed in greater detail here: psychological well-being and physical health.

Psychological Well-being. According to Major and O'Brien (2005), a sizable number of empirical investigations have taken place in the past two decades on the relationship between stigmatization processes and self-esteem as a measure of psychological well-being. Both personal and collective esteem have been examined, and esteem has been measured both directly (e.g., self-report measures) and indirectly (e.g., implicit association tests). The idea that there is a strong negative correlation between stigmatization and esteem has received mixed support from the literature with studies

measuring esteem indirectly providing more support (Major & O'Brien, 2005). A literature review on twenty years of studies involving direct measures, on the other hand, concluded that prejudice against stigmatized groups does not generally result in lowered personal or collective esteem for members of those groups (Crocker & Major, 1989). Because of these mixed results, which have frequently been based on comparisons of stigmatized groups to non-stigmatized groups and have tended to focus on trait esteem instead of state esteem, it has been suggested that within-group and within-person variability be assessed further, especially since stigmatization is often dependent on social contexts and situations (Crocker et al., 1998; Major & O'Brien, 2005). It is also possible that state esteem is more vulnerable to stigmatization processes than trait esteem and should consequently be assessed with greater frequency.

Other measures of psychological well-being have also been used in the research literature on stigma. Studies of depression and stigmatization, for example, have revealed that depression is more prevalent among members of stigmatized groups (Crocker et al., 1998). Some other measures of psychological distress have also shown positive correlations with stigmatization (Major & O'Brien, 2005). Studies of life satisfaction and stigmatization, conversely, have suggested that stigmatized individuals, on average, are not particularly dissatisfied with their lives in comparison to non-stigmatized individuals (Crocker et al., 1998). This finding raises the possibility that certain variables may be moderating the relationship between stigmatization and general life satisfaction and are consequently worthy of investigation.

Overall, the research seems to indicate that while some stigmatized individuals may be vulnerable to lowered self-esteem, diminished life satisfaction, and depression in

particular, most are able to maintain positive general views of themselves and their groups (Crocker et al., 1998). This observation indicates that more research is needed on individual differences in responses to stigmatization (e.g., research on why some stigmatized individuals are vulnerable to negative outcomes while others thrive psychologically despite stigmatization). It also suggests that something may be helping stigmatized individuals to preserve their general sense of esteem and life satisfaction while not fully protecting them from depressive symptomatology and other manifestations of psychological distress.

Physical Health. Physical health has also been examined with frequency as a potential outcome of stigmatization processes (Major & O'Brien, 2005). Experiences of discrimination in particular have been used as a measure of stigmatization (Major & O'Brien, 2005). Studies have found that members of stigmatized groups (as compared to their non-stigmatized counterparts) are at greater risk for physical health problems, such as hypertension, coronary heart disease, chronic pain, and stroke (Major & O'Brien, 2005). Discrimination has been said to affect health directly by “exposing [the discriminated]⁴ to physical and social environments that are more toxic and by limiting their access to quality medical care and nutrition” (Major & O'Brien, 2005, p. 409). Discrimination has been noted to affect health indirectly via identity threat mechanisms, which can result in a variety of physiological responses that can be troublesome when they occur with frequency (e.g., increased blood pressure, increased cortisol levels; Major & O'Brien, 2005). For example, some stigmatized groups (e.g., ethnic minority men) have shown elevated resting blood pressure in comparison to non-stigmatized groups (Major & O'Brien, 2005).

⁴ Brackets mine.

Responses to Stigmatization

The research on stigma to date has largely focused on how stigmatized individuals experience negative consequences as a result of their stigmatized status (Dovidio et al., 2000). More recently, researchers have been examining the strategies that stigmatized individuals use to cope with and manage the predicaments of stigmatization (Dovidio et al., 2000). The latter approach to stigma research is more empowering to the stigmatized in that it conceptualizes them as much more than passive, helpless recipients of stigmatizing processes (Link & Phelan, 2001; Major & O'Brien, 2005). Additionally, the stigmatized have been conceptualized as utilizing the same or similar coping strategies as their non-stigmatized counterparts, an approach that further helps to de-pathologize them (Crocker et al., 1998; Dovidio et al., 2000). The objectives of this section are to review the coping strategies used by stigmatized individuals, discuss some models of responding to stigma, explain how coping with stigma may have an unintended consequence, and examine a source of individual differences in responses to stigmatization.

Coping Strategies of the Stigmatized. A number of general coping responses have been identified among stigmatized populations. These include the following: attributing events to prejudice and discrimination, making social comparisons, psychologically disengaging and disidentifying, and negotiating one's identity (Crocker et al., 1998; Deaux & Ethier, 1998). As aforementioned, these coping responses are not limited to stigmatized populations but rather appear to be used regularly among them.

The first coping response involves attributing negative life events to external causes (e.g., prejudice, discrimination) versus internal causes (e.g., personal deficits; Crocker et al., 1998). The purpose of this strategy is to protect one's self-esteem (or

group-esteem) by designating responsibility for negative events to external, uncontrollable sources. Some research suggests that stigmatized individuals may over-attribute negative outcomes to prejudice and discrimination as a result of their heightened awareness of others' reactions to their stigmatizing conditions (i.e., they may assume that their stigmas are the main cause of others' reactions to them when they may not be; Crocker et al., 1998). Other stigmatized persons may be reluctant to attribute negative outcomes to prejudice and discrimination, even when there is evidence of prejudice and discrimination (Crocker et al., 1998). This reluctance may be due to several factors, including high costs associated with making this type of attribution (e.g., negative judgment from others), the fact that this attribution undermines personal control (i.e., if the cause is external, it is out of one's control), and the potential for damaging interpersonal relationships (e.g., if one accuses a service provider of being prejudiced when that person perceives himself as being non-prejudiced, conflict may result; Crocker et al., 1998).

A few factors may explain the variability in stigmatized individuals' willingness to attribute undesirable outcomes to external causes. For instance, studies have shown that stigmatized individuals are less likely to make attributions to prejudice and discrimination when they feel their stigma is controllable; perhaps this is because they feel they deserve the negative outcomes (Crocker et al., 1998). Research has also indicated that the more one identifies with his or her stigmatized group, the more likely s/he is to make attributions to prejudice and discrimination (Crocker et al., 1998). This may be due to the fact that groups experience larger discrimination than individuals, and,

as such, it is easier for discriminated individuals to recognize greater amounts of discrimination against their group than their individual personhood (Crocker et al., 1998).

A second coping response involves making selective social comparisons. According to Crocker and colleagues (1998), social comparisons provide a useful source of self- and/or group-relevant information. There are benefits and drawbacks to using certain kinds of social comparison methods. For instance, making upward comparisons has been linked to poor affect, reduced self-esteem, and negative group identity but may help disparities between individuals and groups become well-known (Crocker et al., 1998). Making downward comparisons, conversely, has been linked to improved affect, increased self-esteem, and positive group identity (Crocker et al., 1998). Because stigmatized groups tend to be disadvantaged, members of them may limit their social comparisons to other individuals who share the same stigmatized status (Crocker et al., 1998). This prevents the negative consequences associated with upward comparisons and protects the self from the pain of realizing the multiple disparities one experiences (Crocker et al., 1998).

A third coping response involves psychological disengagement and/or disidentification (Crocker et al., 1998; Major & Schmader, 1998). The disengagement response involves detaching one's sense of self-esteem from the external feedback or outcomes one may attain in a particular domain (e.g., school, athletics) so that the feedback and outcomes cannot impact one's self-esteem (Crocker et al., 1998; Major & Schmader, 1998). One's feelings of self-worth are consequently made independent of one's success or failure in that domain (Major & Schmader, 1998). Disidentification involves the more chronic adaptation of separating a domain from one's sense of identity

completely (Crocker et al., 1998). Crocker and colleagues (1998) suggested that both of these processes are often elicited by previous poor performance in certain domains and/or the anticipation of poor performance.

These two psychological processes are adaptive in the sense that they protect self-esteem and self-worth, but they can also be costly to the individuals who employ them. Major and Schmader (1998) pointed out, for instance, that disengagement and disidentification from a domain undermine an individual's motivation to achieve in that domain and consequently their actual achievement. Additionally, when underachievement results, it may feed into the stereotypes society holds about the stigmatized individual's group (Crocker et al., 1998).

A fourth coping strategy in response to stigmatization involves identity negotiation (Deaux & Ethier, 1998). According to Deaux and Ethier (1998), identity negotiation occurs when "there is a perceived need to adjust or in some way redefine a particular identity, as a consequence of some social, psychological or contextual demand" (p. 306). There are two forms of negotiation: identity negation and identity enhancement (Deaux & Ethier, 1998). Negation involves dissociating oneself from a social identity (e.g., by eliminating an identity, distancing oneself from the stigmatized group, or engaging in denial) or reinterpreting that identity (e.g., by seeing it as less important to oneself or perceiving oneself as an "ex" to that identity – such as an ex-addict; Deaux & Ethier, 1998). Enhancement, on the other hand, involves asserting or extending an existing identity by proclaiming that identity cognitively, verbally, or behaviorally; intensifying one's level of contact with others who share the same identity; or working to promote social change to enhance the identity's status (Deaux & Ethier, 1998). Increasing

one's identification with the stigmatized group to which one belongs allows an individual to obtain emotional, informational, and instrumental support from the group (Major & O'Brien, 2005). Stronger group membership may also validate one's social perceptions and enhance one's sense of belonging (Major & O'Brien, 2005). Furthermore, group identification has been shown to correlate positively with group esteem among stigmatized groups, which helps to offset the negative impact of societal stereotypes (Major & O'Brien, 2005).

Models of Responding to Stigma. Researchers have worked to develop models and conceptualizations of how and when certain coping mechanisms are utilized. Within this section, I will review them (i.e., Major & O'Brien, 2005; Miller & Kaiser, 2001; Shih, 2004). The first provides an explanation for how stigmatized individuals experience and respond to identity threat, the second is a theoretical perspective on coping with stigma in general, and the third is a conceptualization of stigma response that differentiates coping and empowerment.

Major and O'Brien's (2005) Model of Stigma-induced Identity Threat. Major and O'Brien (2005) devised a model to explain how stigmatized individuals respond to threats to their identities that are caused by their devalued societal status. This model integrates identity threat models of stigma with transactional models of stress and coping and operates under the assumption that having a stigma increases one's exposure to stressful and identity-threatening situations. Major and O'Brien defined identity threat as being the result of an individual's appraisal of a stigma-related stressor as harmful to their identity and in excess of their resources to cope with it.

According to Major and O'Brien (2005), three factors influence an individual's appraisal of the significance of stigma-related stressors for their well-being: collective representations, situational cues, and personal characteristics. Collective representations reflect an individual's understanding of the dominant group's views of his/her stigma and include awareness of his/her devalued status, knowledge of cultural stereotypes, and acknowledgement that s/he is a likely victim of discriminatory acts. Situational cues represent the extent to which a stigmatized individual is likely to be devalued, stereotyped, or discriminated against. Personal characteristics include such factors as stigma sensitivity (i.e., sensitivity to being stigmatized), level of group identification, level of domain identification, goals, and motives. In general, individuals who are highly stigma sensitive, who identify strongly with the stigmatized group, and who identify strongly with the domain within which their group is negatively stereotyped are more likely to see themselves as potential targets of discrimination and consequently perceive greater identity threats (Major & O'Brien, 2005). Individuals who have motives to believe in a just societal system are less likely to blame discrimination for negative outcomes but also experience more identity threat when confronted directly with prejudice aimed at them or the stigmatized group to which they belong (Major & O'Brien, 2005).

Major and O'Brien (2005) suggested that all stigma-related events are appraised for the potential impact they may have on an individual's well-being. Two types of appraisals are made. The first is considered primary and involves evaluation of the demands associated with a stigma-related stressor (e.g., how self-relevant it is, how threatening it is, how much effort it involves, and how uncertain it is). The second is

considered secondary and refers to assessment of the resources an individual has in their possession to cope with the demands of the stressor. If demands exceed resources, identity threat emerges; if resources exceed demands, identity challenge emerges. Whichever the case may be, the appraisal outcome will direct an individual's affective, cognitive, behavioral, and physiological responses to the stigma-related event.

Two types of responses can emerge following an appraisal: involuntary and voluntary (Major & O'Brien, 2005). Involuntary responses are responses that do not serve to modify or regulate the stressful experience; contrarily, voluntary responses are conscious volitional efforts to regulate emotions, cognitions, behaviors, physiological reactions, and environments. Examples of involuntary responses include anxiety, arousal, increased blood pressure, decreased working memory capacity, and vigilance to threat-related stimuli. Voluntary responses include coping strategies. These coping strategies can be categorized in a variety of ways (e.g., problem-focused vs. emotion-focused, engagement-focused vs. disengagement-focused). Depending on one's response to identity threat, various stigma-related outcomes will be produced (e.g., in the realms of health, self-esteem, and academic achievement; Major & O'Brien, 2005).

Miller and Kaiser's (2001) Theoretical Perspective on Coping with Stigma.

Miller and Kaiser (2001) proposed a useful theoretical model for how individuals cope with stigma. They suggested that an increasing interest in conceptualizing prejudice and discrimination as stressors in the lives of stigmatized individuals is beneficial in that it puts stigma in the domain of stress and coping. This placement is important to consider because individual differences in stress appraisal and coping may allow researchers to determine why some stigmatized individuals function just as well as the less stigmatized

while others are more negatively impacted by their stigmatized status. For instance, according to stress and coping models, a stigma-related event will only be experienced as stressful if it is appraised as exceeding one's resources for coping. Furthermore, stigma-related stress should only be detrimental to an individual if s/he cannot cope with it effectively.

Miller and Kaiser (2001) used Compas, Connor-Smith, Saltzman, Thomsen, and Wadsworth's (2001) hierarchical theory of stress and coping as a framework for their own model. As such, the first portion of their model begins by distinguishing voluntary (i.e., coping) and involuntary (i.e., non-coping) responses to stigma-related stressors to emphasize that not every response a person has to stress constitutes coping. They then assert that individuals may either engage (i.e., approach or fight) or disengage (i.e., avoid or flee) with the stressful event. Finally, voluntary engagement coping is divided into two categories: primary and secondary control. Primary control includes coping efforts that are "directed toward influencing objective events or conditions to enhance a sense of personal control over the environment or one's reactions" (p. 78). Secondary control coping involves "efforts to adapt to the situation" and includes "efforts to change the way one feels about the fact that a bad situation has occurred" (p.78). Below is a review of the stress responses that stigmatized individuals may experience per Miller and Kaiser. Most of these have been discussed in detail elsewhere in this document; the purpose of reviewing them here is to pinpoint in which coping categories they fall.

Voluntary Engagement Coping: Primary Control. According to Miller and Kaiser (2001), stigmatized individuals may engage with stigma-related stress to change it by either controlling the situation or the self in the situation. Compensation, emotional

expression/regulation, and problem-solving are all examples of primary control coping strategies that stigmatized individuals utilize. Compensation involves adapting one's social interaction strategies by behaving in a socially skillful or stereotype-disconfirming manner. Regulation of emotional expression (particularly that of anger or anxiety) allows stigmatized individuals to concentrate more on the behaviors they can use to reduce the impact of stigmatization on the situation they are in. In some situations, freedom of emotional expression is helpful in organizing collective action (e.g., open sharing of dissatisfied feelings may energize stigmatized groups to rally for their well-being). Finally, stigmatized individuals employ problem-solving skills to find strategies for attaining their goals, which may involve improving their devalued status.

Voluntary Engagement Coping: Secondary Control. Miller and Kaiser (2001) suggested that stigmatized individuals may engage with stigma-related stress to learn how to adapt to it. Distraction, cognitive restructuring, and acceptance are all secondary control coping strategies. When an individual is employing distraction, s/he is engaging in thoughts or activities that draw attention away from the stigma-based stressor. Distraction is used to prevent ruminative thinking or intrusive thoughts about the stress induced from stigmatization processes; these would otherwise result in psychological distress. Cognitive restructuring is used to redefine the meaning of threatening and stressful stigma-related events. It may manifest itself in selective attribution-making and/or psychological disengagement/disidentification. Finally, accepting one's life situation can help a stigmatized individual adapt to stigma-related stress. While it may prevent subjective experiences of stress, acceptance may also prevent collective action

and eventual social changes. All three of these strategies have been supported in the literature as adaptive when stressors are uncontrollable.

Voluntary Disengagement Coping. According to Miller and Kaiser (2001), stigmatized individuals may disengage from stigma-related stress by actively and consciously avoiding situations in which stigma may be a problem, denying or minimizing prejudice and discrimination, or engaging in wishful thinking. First, stigmatized individuals may avoid situations in which stigma is expected to be problematic. They may avoid social interactions with stigmatizing individuals and affiliate instead with other stigmatized persons. They may also avoid making social comparisons with non-stigmatized groups so they do not experience the stress that accompanies knowledge about how others are doing better. This strategy may backfire, however, because avoiding knowledge about others' superior life conditions may prevent stigmatized individuals from trying to challenge their devalued status. Second, stigmatized individuals may deny or minimize prejudice and discrimination, even when prejudice and discrimination are evident. This strategy denies the overall existence of a problem related to prejudice or discrimination. It also protects one's sense of control and one's sense of their ability to be socially accepted by others. Finally, stigmatized individuals may engage in wishful thinking. They may believe, for instance, that non-stigmatized persons or persons of higher status are not prejudicial or discriminating. They may believe that these individuals are even supportive of their plight.

Involuntary Engagement. Miller and Kaiser (2001) stated that involuntary engagement responses involve physiological arousal (e.g., cardiovascular activation), emotional arousal, rumination, intrusive thinking, and impulsive acting. These responses

are often seen during stereotype threat processes. Some involuntary engagement responses are consequently maladaptive and have been linked to depression and psychological distress. Other involuntary engagement responses may be adaptive in that they orient the stigmatized individual to threats to the self and trigger coping responses.

Involuntary Disengagement. A final category of stress response is referred to as involuntary disengagement. According to Miller and Kaiser (2001), involuntary (i.e., preconscious) avoidance of stigma-related stress is the primary involuntary disengagement response seen among stigmatized individuals. It involves tuning out stigma-based stressors at the preattentional level. It is adaptive in the sense that it reduces psychological distress associated with being aware of stigmatization processes and consequently reserves coping resources for more problematic stressors.

Shih's (2004) Distinction between Coping and Empowerment as Responses to Stigma. In her article on responses to stigma, Shih (2004) noted that stigma research has largely focused on the detrimental effects of stigmatization as a chronic environmental stressor. She pointed out that despite these detrimental effects, many stigmatized individuals function just as well as and are just as satisfied as non-stigmatized individuals. Citing Corrigan and Watson's (2002) distinction between public stigma and self stigma, Shih observed that public stigma does not always lead to self stigma. She suggested that there are two separate models to account for how people can react to stigma in adaptive and resilient ways: a coping model and an empowerment model.

According to Shih (2004), the coping model entails stigmatized individuals' adoption of strategies they use to avoid negative consequences associated with stigmatization. As such, coping is seen as preventative and reactive. Coping consequently

involves the depletion of an individual's resources. The empowerment model, however, suggests that stigmatized individuals are active agents who seek to understand the social world they live in and create positive outcomes for themselves in spite of the stigma-related barriers they face. For individuals who respond to stigma with a sense of empowerment, overcoming adversity is enriching and energizing in that a sense of mastery and self-efficacy is achieved when accomplishments are made. Empowerment is seen as a proactive process versus a reactive or preventative process.

Shih (2004) suggested that there are a number of variables that may influence whether an individual copes with stigmatization or is empowered by their stigmatized position in society. These include individual differences (e.g., intelligence), the implicit theories one holds (e.g., toward achievement), the type of stigmatizing condition one has, and external variables (e.g., one's family life, level of community acceptance).

Additionally, Shih proposed that individuals who identify more strongly with the stigmatized group to which they belong are more empowered. This is because they are more likely to interact with that group and see its positive characteristics, making them less likely to buy into negative stereotypes of the group. Finally, Shih indicated that an individual's perceived legitimacy of a stigma may influence how empowered they feel. For instance, if they feel an ascribed stigma is illegitimate, they may become angered, empowered, and motivated to take action to remove the stigma.

Finally, Shih (2004) reviewed three psychological processes that targets of stigma use to avoid the negative effects of stigmatization: strategic interpretations of the social environment, compensation, and carrying multiple identities. Strategic interpretations of the social environment involve the selective social comparison and attribution-making

that was discussed previously, so it will not be reviewed here. Compensation involves developing skills to compensate for one's stigma, which allow individuals to achieve their goals in spite of the disadvantages associated with their stigmas. Compensation strategies may involve, for example, paying attention to how one presents oneself to stigmatizing individuals, refining one's social interaction skills for the situation one is in, and working to disprove stereotypes. Carrying multiple identities allows a stigmatized individual to draw from alternate identities in potentially stigmatizing situations. For instance, someone may "switch" identities depending on the context s/he is in, emphasizing identities or roles that are valued in that particular context and deemphasizing stigmatized identities. According to Shih, greater self-complexity has been associated with resilience to stress-related illness and depression as well as to higher levels of social support and life satisfaction.

Ego Depletion: An Unexpected Consequence to Coping with Stigma. The three models discussed in the previous section highlight a variety of strategies that stigmatized individuals employ to manage the stress that their stigmatized status produces. While these strategies are beneficial in that they serve to protect stigmatized individuals, some researchers (e.g., Inzlicht, McKay, & Aronson, 2006) have suggested that their usage may be accompanied by an unintended cost: depletion of self-regulatory abilities. Self-regulation refers to the process of controlling or overriding one's thoughts, feelings, urges, impulses, and behaviors (Baumeister, Gailliot, DeWall, & Oaten, 2006). Put more simply, it refers to the process by which individuals seek to control themselves. Self-regulation is adaptive in the sense that it allows individuals to make the changes necessary to attain their goals and facilitates adherence to societal norms, rules, and

standards (Baumeister et al., 2006; Gailliot et al., 2007). Good self-regulation has been associated with a number of desirable outcomes, including mental health, effective coping, healthy interpersonal functioning, decreased aggression, and less susceptibility to criminality and substance use (Gailliot et al., 2007). At the same time, failures of self-regulation have been linked to many personal and societal problems, such as crime, substance abuse/dependence, overeating, cognitive difficulties (e.g., with reasoning and decision-making), excessive spending, and so on (Baumeister et al., 2006).

Given the strong associations between self-regulatory ability and a wide variety of outcomes, researchers have developed conceptual models to better understand the processes of self-regulation. The strength model of self-regulation, for instance, asserts that self-regulation relies on a limited resource (similar to energy or strength), which is used to interrupt and alter behavior as needed (Baumeister et al., 2006). According to this model, each incident of self-regulation temporarily depletes this limited resource, which makes subsequent self-regulation more difficult (Baumeister et al., 2006). The reduction of the resource and the consequent weakened state of self-regulating ability has been referred to as “ego depletion” (Baumeister et al., 2006). Ego depletion has been compared to the tiring of muscles upon physical exertion in that there is a temporary reduction in capacity or power. Capacity or power can be renewed with rest or time. Additionally, there is the opportunity to increase one’s self-regulatory strength via exercise.

A plethora of studies have been conducted on self-regulation, especially in relation to undesirable or maladaptive behaviors (e.g., overeating, substance abuse, acts of aggression). Recently, Inzlicht and colleagues (2006) decided to examine self-regulation in relation to stigma; specifically, they sought to explore stigma’s impact on

self-control. Their study was based on the premise that failure of self-control has been viewed as “an outcome that some people have called *the* defining problem of modern society, responsible for problems as diverse as depression, violent crime, and drug abuse” (p. 263). Inzlicht et al. hypothesized that stigmatized individuals use self-control to manage their devalued social identity and the stressors that accompany it. This use of self-control consequently leaves the stigmatized with less regulatory resources to use for other things (e.g., regulating an addiction).

To test their hypothesis, Inzlicht et al. (2006) conducted a series of three studies. The first study explored whether individuals who were sensitive to stigmatization would report more impaired self-regulatory capacity than individuals who were less sensitive. Results showed that greater levels of feeling stigmatized predicted lower levels of academic self-regulation. The second study examined how situationally-activated stigma could influence performance on an attention-related task. Participants in a high stereotype threat condition (i.e., high stigma condition) took significantly longer to complete the attention-related task. Finally, the third study looked at how situationally-activated stigma could influence performance on a task requiring physical stamina. Inzlicht et al. found that individuals in the high threat (i.e., high stigma) condition were less able to persist in the physical task than their non-threat counterparts. The authors of the study suggested that the high threat participants (from the second and third studies) risked confirming negative group stereotypes, needed to manage this threat, had fewer resources to apply to the attention-related and physical stamina tasks, and consequently exhibited decreased performance on them.

Overall, the results of Inzlicht and colleagues' (2006) work provide support for the idea that stigma and stigma management can weaken stigmatized individuals' ability to utilize self-regulatory processes during subsequent activities. It is possible that this observation may leave stigmatized individuals more prone to developing maladaptive coping responses (e.g., substance use). Stigmatized individuals may also struggle more with resolving non-stigma-related problems. Finally, stigmatized individuals may be good targets for interventions involving increasing self-regulatory strength.

Individual Differences in Responses to Stigmatization: Stigma-Consciousness. Given that stigmatized individuals respond differently to their stigmatized status and acts of stigmatization, some researchers have sought to identify characteristics that may explain these individual differences (e.g., Brown & Pinel, 2003; Pinel, 1999). Stigma-consciousness has been identified as one such variable and refers to how chronically conscious stereotyped individuals are of their stigmatized status and the extent to which they expect to be stereotyped or discriminated against because of it (Brown & Pinel, 2003; Pinel, 1999). Studies have shown level of stigma-consciousness influences stigmatized individuals' experiences of stigmatization (Brown & Pinel, 2003; Pinel, 1999).

For instance, in a study validating the Stigma-Consciousness Questionnaire, Pinel (1999) compared people high in stigma-consciousness with people low in stigma-consciousness. This researcher found that participants high in stigma-consciousness were significantly more likely to (a) perceive discrimination aimed at themselves, (b) perceive discrimination aimed at their stigmatized group, (c) provide sound evidence for these perceptions (e.g., concrete examples of being stereotyped), and (d) avoid stereotype-

relevant situations and consequently miss the opportunity to disprove stereotypes. Brown and Pinel (2003) also found differences between high and low stigma-conscious individuals. These investigators studied whether level of stigma-consciousness would moderate the impact of stereotype threat on the math performance of women. In the low threat condition, stigma-consciousness showed no relationship to performance, but in the high threat condition, women high in stigma-consciousness performed significantly more poorly on the math task than women low in stigma-consciousness ($d = .88$). Finally, Inzlicht et al. (2006) suggested that “People who expect to be stereotyped by others and who are sensitive to rejection based on their group anticipate being the target of prejudice, are extra vigilant for stigma-related threats, and are more likely than other people to perceive ambiguous situations as identity threatening” (p. 263).

In sum, the research to date appears to suggest that level of stigma-consciousness impacts stigmatized individuals’ experiences of stigmatization and may explain why individuals respond differently to similar acts of stigmatization. Other explanations for individual differences are still needed. One such explanation may be found in the level of internalization of stigma, which may also be related to level of stigma-consciousness. According to Ritsher and colleagues (2003), internalized stigma is the “devaluation, shame, secrecy, and withdrawal triggered by applying negative stereotypes to oneself” (p. 32). These researchers suggested that individuals high in internalized stigma may benefit from interventions designed to reduce or challenge internalization processes; perhaps interventions aimed at managing level of stigma-consciousness would also be beneficial.

Summary and Critique of the Stigma Literature

In sum, although stigmatizing processes have undoubtedly existed since the beginning of humankind, it was not until the early 1960s that the construct of stigma really began to be examined empirically in the social sciences. Over the past half-century, a number of definitions and categorizations of stigma have been proposed. The reasons for stigmatizing have been examined, and targets of stigmatization have been evaluated for their experiences of and responses to stigmatization. Research has provided evidence for the idea that being stigmatized relates to undesirable and personally damaging outcomes. Responses to being stigmatized can be both protective and empowering, but they may come with a high price. Stigmatized individuals often respond differently to experiences of being stigmatized, and these differences may be due to personal characteristics like level of stigma-consciousness and stigma internalization. As Crocker et al. (1998) pointed out, however, across individuals, stigma is about a valuing of the self:

“...at its heart, social stigma is about maintaining the integrity of the self, about construals of the world and one’s place in it, and about the power of situations that shape experiences. The need to maintain a sense of self as morally adequate, in control, and competent underlies both the desire to stigmatize and the responses of those who are stigmatized...For those who are stigmatized, stigma is about the threat to one’s sense that one has a safe, valued, and valuable self. Coping strategies...despite their costs, enable many stigmatized individuals to maintain a sense of their worth in the face of devaluation” (p. 543).

While the literature on stigma has grown considerably over the past few decades and the topic of stigma continues to attract empirical attention, much more research is needed on the construct. Several criticisms of the literature to date have been raised. These include the wide variety of stigma definitions used in studies (making it difficult to compare studies' results), the focus on individual contributors to and costs of stigma (vs. structural contributors and costs), the fact that most studies on stigma and outcomes have been correlational, and the lack of controlling for third variables (Link & Phelan, 2001; Major & O'Brien, 2005). Major and O'Brien (2005) have also commented that much of the stigma literature has focused on comparing stigmatized and non-stigmatized individuals instead of exploring within-group variability. Finally, Link and Phelan (2001) noted that many stigma researchers have examined stigma from the perspective of theories that are relatively "uninformed by the lived experiences of the people they study" (p. 365) or that do not attend closely enough to the words and perceptions of the individuals under study.

Particularly in regard to these last two limitations, one group that has been surprisingly understudied as a stigmatized population is comprised of individuals who are homeless (Kidd, 2007). Underexamination of individuals experiencing homelessness as targets of stigmatization is surprising given that they often carry multiple stigmas (e.g., related to mental illness, addiction, criminal history, racial/ethnic minority status, poverty, physical appearance) and the homeless population is rather heterogeneous (Lee, Farrell, & Link, 2004). When reviewing the literature on stigma, I observed that many of the articles opened with a listing of stigmatized groups. Interestingly, individuals facing homelessness were not included in these lists. Additionally, in the majority of studies and

even large studies (e.g., the literature review on self-esteem and stigma by Crocker and Major, 1989), there was little indication that individuals experiencing homelessness were included as study participants, let alone adequately represented. Finally, I did not locate any studies that involved the direct application of stigma literature to interventions with individuals who are homeless. The purpose of the following section is to review the small amount of literature that does pertain to stigmatization of the homeless population.

Literature Relevant to Stigma and Homelessness. Although the empirical literature on stigmatization of the homeless population is relatively sparse, many homeless researchers are quick to point out that individuals who are homeless experience widespread stigmatization. Thompson and colleagues (2004), for instance, explained:

“It is clear that homeless individuals suffer from stigmatization and social isolation. They are a population largely marginalized from society, with limited power over their environment as they reside in hostile environments where personal safety is at risk. Living on the street leads to disaffiliation from society and adoption of survival strategies that further alienate the individual from societal norms. Homeless individuals...often must employ unconventional means to meet their basic needs” (p 423).

Wright (2005) suggested that stigmatization even contributes to the presence of homelessness: “Whatever the proximal causes of this or that person’s housing status, homelessness exists as a social condition through processes of stigmatization and social exclusion...People ‘become’ homeless because they are socially constructed as unworthy of the rights of citizenship that others enjoy, because their very being is defined as an existence at the economic, social, cultural, or political fringe” (p. 926). Furthermore,

research has pointed out the ways in which some people stigmatize individuals who are homeless, both attitudinally and behaviorally:

“Ethnographic investigations document the degradation rituals endured by [the homeless]⁵, who are routinely avoided or treated as non-persons by passersby...The substantial percentages of survey respondents blaming homeless people for being homeless and attributing deviant properties (substance abuse, mental illness, dangerousness, etc.) to them would seem to confirm the public’s negative view of the homeless” (Lee et al., 2004, p. 42).

Unfortunately, relatively little research has been done on stigma and homelessness from the perspective of the stigmatized. The few studies (n = 6) that have involved obtaining the perspective of individuals who are/were homeless on their stigmatized status and identities (either directly or indirectly) will now be reviewed and followed by a summary and critique.

First, Lankenau (1999) completed an ethnography of panhandlers who were homeless to determine how they endure stigmatization in the form of frequent public humiliation and degradation as they ask passersby for financial assistance. His participants reported that they often had contact with individuals who made them feel poorly about themselves by ignoring them, harassing them, or making critical comments. As one participant explained, “...sometimes people just walk past you like you’re nobody, like you’re a piece of garbage. And they don’t look at you. Or if you try to ask them for a job, they look at you like, ‘You’ve been on the street. I’m not going to hire you.’ And they make us feel really bad. They call us all kinds of things” (p. 296).

⁵ Bracketed information added.

To handle others' reactions to them, participants reported using two of the coping mechanisms described previously: management of emotions and management of identity (Lankenau, 1999). Participants discussed learning how to manage their emotions to prevent feeling poorly about themselves and to ensure that they would not behave in ways that would deter observers from making contributions to them. They talked about becoming hardened to maltreatment from others and learning not to take others' comments personally. Additionally, they explained how they suppressed angry or aggressive reactions to others' degrading comments because they believed emotional outbursts may result in fewer contributions from others. Identity management was also discussed; for instance, some participants suggested that they altered their physical appearance to look needier. Others talked about how they worked to conform to certain social norms (e.g., norms for social interaction) to compensate for the social norms they could not conform to (e.g., having regular work, being housed).

Finally, some of the participants talked about associating with higher status, mainstream individuals to reduce the impact of their stigmatized status (Lankenau, 1999). They suggested that affiliating with generous individuals who were not homeless helped them to enhance their social status. Affiliation was also said to improve their sense of self.

The next study to obtain the perspective of the homeless population on its lowered social status (at least indirectly) was done by Boydell et al. (2000). These researchers looked at 29 un-housed participants' narratives of identity, recognizing that persons experiencing homelessness often lose their sense of identity, self-worth, and self-efficacy as they lose a place to live. Boydell and colleagues' qualitative study was based on (a) the

premise that implicit and explicit social messages about the value of individuals who are homeless impact their self-concepts and (b) the observation that individuals who are homeless longer are more likely to embrace unconventional self-concepts (e.g., an identity of “tramp” or “bum”) than individuals who are homeless for shorter periods of time.

Results of Boydell et al.’s (2000) interviews indicated that at least some individuals who are homeless strive to preserve their self-worth by holding on to positive former identities, devaluing current homeless identities, and envisioning more favorable future identities. Participants talked about former identities in terms of loss, including loss of former roles, entitlements, and rights as well as loss of others’ recognition of those former identities. In regard to present homeless identities, participants often described experiencing a devalued self, mainly because of their marginalized status. The participants were observed to make in-group social comparisons to cope with homelessness (a response described earlier in the general stigma section of this chapter), placing themselves at the top of a homeless hierarchy as a means to preserve their sense of self. Newly homeless individuals described their present selves more positively than chronic homeless individuals, who often described themselves in negative terms and/or with self-disappointment. Finally, the participants described their visions for their future identities; these identities usually involved non-homelessness, increased health and well-being, having a deeper understanding of life’s purpose because of facing homelessness, and pursuing work to help other individuals facing homelessness to exit it.

A third study involving stigma among the homeless population was done in Britain by Bentley (1997), who examined the psychological effects of experiencing

homelessness. Bentley interviewed 12 participants about their experiences of homelessness and used grounded theory to interpret the interview content. Some themes that emerged from the participants included being viewed negatively as unacceptable outsiders by non-homeless individuals, losing one's sense of uniqueness/personhood because of being ignored by mainstream society, finding ways to connect with others (i.e., turning especially to other individuals facing homelessness and withdrawing from services because of dissatisfaction), working hard to maintain one's existence, feeling life affirmation when others recognized them as distinct individuals, feeling helpless to control one's situation, and withdrawing from others both physically and psychologically. These themes were classified into three overarching categories: relationships with others, need for acknowledgement, and inability to reach out for help. Overall, the participants felt detached from and unacknowledged by mainstream society, which resulted in feelings of helplessness and withdrawal behaviors aimed at self-preservation. Because of withdrawing and becoming more marginalized, participants were treated as distinct individuals less and less, which led to dissatisfaction with those who did try to reach out. After a certain point, however, some of the participants indicated that they were able to establish positive relationships with mainstream individuals and consequently began to reestablish a sense of self-worth.

Miller and Keys (2001) conducted a study on dignity among individuals facing homelessness, which stemmed from their assumption that the “social stigma of homelessness and the degrading and dehumanizing conditions [homeless]⁶ individuals encounter may compromise their dignity” (p. 332). Dignity was defined as self-worth that originates from both internal and external forces, though Miller and Keys focused their

⁶ Information in brackets was added.

study on external factors that may enhance or undermine one's sense of dignity. They asked guests and alumni from a shelter program to provide examples of events that they felt validated or invalidated their sense of dignity. Qualitative analyses were used to interpret data.

Eight dignity-validating events and eight dignity-invalidating events were reported (Miller & Keys, 2001). The events were further categorized as interpersonal events or person-setting events. The dignity-validating events included having basic needs met (cited by 71% of the participants); receiving care, support, and encouragement from others (67%); having individual identities acknowledged by others (50%); receiving personalized services by providers (46%); feeling as though one was part of a family or group (46%); accessing resources aimed at increasing self-sufficiency (46%); having opportunities to participate in the greater community (21%); and having roles (e.g., as volunteers or employees; 21%). The dignity-invalidating events, on the other hand, included being treated as though one lacked an individual identity (e.g., being treated like a number, being treated like an animal, being insulted and stereotyped, being ignored; 88%); poor services (e.g., impersonal services, long waiting lines, being given orders by staff; 71%); excessive and arbitrary shelter rules (54%); lack of basic needs resources (50%); being treated unjustly because of homeless status (41%); being wrongly associated with other homeless individuals' negative behaviors (33%); feeling as though others do not care about them (21%); and dirty or inadequate living environments (17%).

Miller and Keys (2001) also examined the consequences of dignity-validation and dignity-invalidation. When participants felt as though their dignity was validated, they experienced increased self-worth, self-confidence, and motivation to improve their life

conditions, become self-sufficient, exit homelessness, and help others. Conversely, when dignity was invalidated, they experienced decreased self-worth, feelings of anger and depression, and even suicidal ideation. The major finding of this study, as pointed out by the authors, was that being treated with dignity related to motivation to improve life circumstances. Although it is frequently assumed that survival needs are of utmost importance when working with individuals who are homeless, Miller and Keys noted that their study results indicate that dignity needs seem to be just as worthy of attention.

Osborne (2002) conducted a study with 97 participants to determine how individuals experiencing homelessness maintain a sense of self-worth. This researcher suggested that “Homeless individuals face a very profound identity dilemma. Like most persons, homeless individuals are highly motivated to maintain a stable and positive self-view...It seems there are two possibilities for maintaining a stable identity...One would be to maintain one’s domiciled identity and do whatever is possible to ‘get off the street.’ The other would be to incorporate being ‘homeless’ into one’s identity” (p. 43). Results of this study revealed that identifying strongly with being homeless had a positive correlation with self-esteem ($r = .82$), a negative correlation with service usage ($r = -.82$), and a negative correlation with attempts to exit homelessness ($r = -.59$). Additionally, amount of time spent homeless correlated positively with identification with homelessness ($r = .60$). Osborne concluded that identifying with homelessness is like a double-edged sword in that it appears to protect self-esteem but may keep individuals who are homeless entrenched in homelessness.

Another interesting finding from Osborne’s (2002) work was that participants who expressed having strong internal needs (e.g., respect, integrity) were significantly

less likely to seek supportive services than participants high in external needs (e.g., food, clothing). Given the complaints about homeless programs that have been raised in previous studies (see section about difficulty engaging homeless clientele), this finding may not be surprising. A major implication of this finding is that, as Miller and Keys (2001) pointed out, services need to focus on more on than just the basic needs of their clientele. Osborne (2002) suggested that failure of individuals high in internal needs to seek services may in fact be viewed as their attempt to maintain a sense of self-respect.

Finally, Kidd (2007) conducted a sixth study related to stigmatization of individuals experiencing homelessness. He examined the impact that social stigmatization has on the mental health functioning of youth who are homeless, as his previous exploratory work indicated that this population faces intense stigmatization that leads to feelings of worthlessness, loneliness, social alienation, and suicidality. Kidd developed a stigma questionnaire ($\alpha = .87$) to test his hypothesis that greater perceived levels of stigma would be associated with decreased self-esteem, increased sense of loneliness, presence of suicidal ideation, and feelings of being trapped in homelessness. Kidd's expectations were confirmed, and perceived stigma was most strongly associated with loneliness and feelings of being trapped in homelessness. Additionally, the more time youth had spent on the streets, the more experiences of stigmatization they reported. Kidd concluded his study by suggesting that interventions are needed to address the stigma that individuals who are homeless experience (e.g., interventions to help them cope with stigma rather internalize it) given stigma's relationship with mental health outcomes in this population.

Summary, Limitations, and Implications for the Present Study. The six studies reviewed above were unique in that they examined (at least indirectly) the experiences of stigmatization from the perspective of individuals who are/were homeless. Although these studies were not intended to be examined in aggregate, several informal themes emerged from considering them together. First, all of the studies indicated that their participants experienced feelings of being devalued by the majority of mainstream society. Devaluation was manifested in non-homeless persons' responses to the participants (e.g., ignoring, avoiding, harassing, criticizing, and patronizing the participants). Furthermore, being devalued and stigmatized by others often triggered a number of negative psychological outcomes (e.g., feelings of worthlessness, helplessness, depression, anger, and even suicidality).

A second theme that emerged from the six studies involves the fact that the participants attempted to manage the negative psychological outcomes associated with being treated poorly by mainstream society members. Several of the coping mechanisms they described were the same as those reviewed in the general stigma section above. These coping mechanisms included emotional management, identity negotiation, making in-group social comparisons, and compensation, to name a few.

A third theme that appeared across several of the studies involved the idea of a homeless identity replacing former social identities. Several study participants described how living on the streets and lacking a sense of belonging to mainstream society resulted in them losing their former identities and being treated in non-individualized manners by others. To cope with this frustrating experience, some participants described hanging on to their domiciled identities and devaluing homelessness, while others began to

internalize a homeless self-concept. One study (i.e., Osborne, 2002) found that individuals who began to incorporate homelessness into their self-concept were less likely to attempt to exit homelessness. However, when homeless participants' individual self-worth began to be validated, their self-esteem improved, and they became motivated to leave homelessness behind (Miller & Keys, 2001).

This idea of self-worth validation ties in with a fourth and final theme that seemed to emerge from the studies: reintegration into mainstream society via affiliation with mainstream individuals and/or organizations. Some of the studies indicated that forming relationships with trustworthy, non-homeless individuals (e.g., service providers, regular passersby who contributed to panhandling without judgment) helped participants to enhance their self-worth and seek services to improve their lives. This theme was also raised in the studies by MacKnee and Mervyn (2002) and Thompson et al. (2004), which were described previously in the section on characteristics of effective programs for the homeless population. Interestingly, individuals facing homelessness with high internal needs (e.g., to be respected, treated with integrity) were the least likely to seek services according to Osborne's (2002) work, an observation that is perhaps attributable to the fact that many supportive services for the homeless population are perceived as dehumanizing or non-individualized by their patrons. It is also possible that individuals high in internal needs are more sensitive to the stigmatizing and degrading actions of others (Major & O'Brien, 2005). Whatever the explanation may be, it seems as though individuals facing homelessness with high internal needs – those who want to be validated most of all – are least likely to place themselves in positions to interact with mainstream, higher status

individuals who may help them to get the self-affirmation they crave and, consequently, the motivation and resources they need to exit homelessness.

In summary, examining the previous six studies together yielded several themes related to the experiences of stigmatization among individuals who are homeless (i.e., awareness of devalued status accompanied by negative psychological reactions, attempts to cope with holding a stigmatized identity, identity transformations as a result of becoming homeless, and usefulness of validating and supportive relationships with mainstream individuals). While these observations are helpful in expanding our understanding of stigma and homelessness, they are incomplete and may even be inaccurate given that the studies above did not set out to specifically explore stigma [with the exception of Kidd (2007), who strove to understand some of the psychological outcomes associated with perceived stigmatization]. Lankenau (1999) wanted to understand how panhandlers cope with public degradation, Boydell et al. (2000) attempted to gain an understanding of the identities homeless persons hold, Bentley (1997) was interested in the psychological effects of homelessness, Miller and Keys (2001) looked specifically at the role of dignity validation and invalidation, and Osborne (2002) focused on homeless identity formation and correlates of holding a homeless self-concept. In addition to the aforementioned studies not focusing directly or comprehensively on stigma, several other limitations can be found in the literature to date.

First, none of the studies reviewed here were discussed in light of the extensive literature base on stigma that was reviewed earlier in this document. Results of the studies, for instance, were not compared to what is already known about stigmatized

groups' experiences of and responses to the manifestations of stigma. Additionally, none of the studies appeared to be based on preexisting theoretical models (e.g., Major & O'Brien, 2005, Miller & Kaiser, 2001), which is unfortunate given that these models could be strengthened by empirical support in the form of their application to specific stigmatized groups. Finally, with the exception of Kidd (2007), who looked at differences based on level of perceived stigma, none of the studies appeared to explain the individual differences that were found among response styles, psychological outcomes, identity affiliations, treatment-seeking behaviors, and so on. At the same time, it appears that variables like stigma-consciousness and level of stigma internalization may be explanatory for this group; they just have not been assessed.

A second limitation of the literature to date involves the great deal of within-group heterogeneity associated with the homeless population. While certain studies (e.g., Miller & Keys, 2001) pointed out that their findings may not be applicable to the entire homeless population given the specific homeless subgroups they examined, no studies were found that compared different homeless subgroups with each other. This was surprising given that different homeless subgroups may have different experiences from each other, which would necessitate the formulation of different types of interventions. For instance, it was suggested by the studies that individuals who are chronically homeless have different experiences and worldviews than individuals who have been homeless very short-term. There may also be differences based on how many stigmas that persons who are homeless possess; for instance, it is possible that African American men with comorbid mental illness and alcohol addiction would experience stigma differently

from women with children who became homeless as the result of fleeing from domestic violence.

Another limitation associated with the present literature involves the lack of application of study findings to homeless policies and interventions. While some of the researchers suggested that interventions are needed to help individuals who are homeless manage the stigma they face (e.g., Kidd, 2007) and others suggested that homeless programs should involve more than the provision of basic needs services (e.g., Miller & Keys, 2001), no studies were located that responded to these suggestions. Additionally, the homeless perspective on what changes they would like to see in regard to being targets of stigmatization was not directly obtained.

Given these limitations and the overall lack of literature on the stigmatization experiences of homeless populations, more research is clearly needed in this area. The four aforementioned themes, for instance, need further investigation to determine how exactly they play out as well as their interrelations. The purpose of the present study was to build a comprehensive, grounded theory of how individuals who are homeless experience and respond to social stigmatization while accounting for some of the limitations in the literature to date. For example, unlike much of the previous literature, the present study focused directly on building upon the stigma research that has been conducted thus far and reviewed earlier in this paper; homeless stigmatization was therefore studied from a more comprehensive and intentional perspective than usual via this research project. Additionally, the theory discovered via this study was compared with the preexisting stigma literature in Chapter V of this document to initiate conversation about the degree to which current conceptualizations of stigmatization (e.g.,

Major & O'Brien, 2005; Miller & Kaiser, 2001; Shih, 2004) apply to the homeless population of interest. Although the purpose of the current study was not to formally test any of the current models of stigmatization, the theory it yielded may help to inform them.

The present study expanded the literature on stigmatization in other ways as well. First, as stigma researchers suggest that the within-group variability of stigmatization should be examined from the perspective of the stigmatized themselves, an exploratory qualitative approach was taken to obtain this perspective. A specific subgroup of the homeless population was targeted to rule out the influence of confounding variables and to acknowledge the vast heterogeneity that characterizes homelessness: African American men with co-occurring mental illness and substance use disorders who are experiencing chronic homelessness.

Second, the current study addressed limitations of previous research on homeless stigmatization in that it was specifically designed to inform application of the theory it yielded. For instance, in the current study, individuals experiencing homelessness were asked how stigmatization influences their perceptions of the supportive services that are available to them and their willingness to use programs offered by mainstream society. They were asked for their perspective on what they believe will help them cope more effectively with stigma in the future. Overall, a more expansive discussion of the applicability of the current study's results to real-world policy and intervention was offered.

Finally, the impact of multiple stigmatization was examined via the current study. The literature on homeless stigmatization to date has not emphasized or explored the fact

that many individuals who are homeless are multiply stigmatized despite the probability that carrying multiple stigmas may influence the way one experiences and responds to stigmatization. As such, the targeted population for the study was one that faces multiple sources of stigma: stigma due to homelessness, stigma due to racial/ethnic minority status, stigma due to mental illness, and stigma due to substance misuse/addiction. Below I briefly discuss the literature on stigmas due to racial/ethnic minority status, mental illness, and substance use disorder/addiction, followed by a brief summary of the current literature on multiple stigmas. I chose to focus on these particular stigmas because they are prevalent among individuals who are homeless, relate strongly to treatment utilization, and have support from the literature as particularly debilitating.

Stigma due to racial/ethnic minority status. As members of a racial/ethnic minority group, African Americans comprise one of this nation's stigmatized populations. They have faced a long history of discrimination and maltreatment in this country (Gary, 2005b), and exposure to the manifestations of stigmatization processes continues to occur on a regular basis. The stress of racism is particularly salient for this group (Lewis-Coles & Constantine, 2006). According to Lewis-Coles and Constantine (2006), African Americans report greater amounts of racism-related stress than White Americans and other racial/ethnic minorities. Furthermore, this stress has a significant impact on their psychological and physical well-being (Harrell, 2000; Williams, Neighbors, & Jackson, 2003). Harrell (2000) noted, "Racism can traumatize, hurt, humiliate, enrage, confuse, and ultimately prevent optimal growth and functioning of individuals and communities" (p. 42). Williams and colleagues (2003) have found that perception of discrimination alone is associated with multiple indicators of poorer

physical and mental health among racial/ethnic minorities. Unfortunately, African Americans are also less likely to seek and receive health care, which may be due to structural/economic barriers, mistrust of service providers, and lack of culturally-sensitive services (Gary, 2005b).

Stigma due to mental illness. According to Overton and Medina (2008), individuals with mental illness and other mental health problems are some of society's most stigmatized. The label of "mentally ill" often results in stereotypes, discrimination, and prejudice (Corrigan, 2004). Indeed, individuals with mental illness face negative stereotypes/expectations of others as well as barriers to obtaining employment, housing, and treatment (Overton & Medina, 2008).

It has been suggested that the stigma of mental illness can be as debilitating as the mental illness itself (Overton & Medina, 2008). Stigmatization can contribute to diminished self-esteem, self efficacy, and confidence in one's future as others' negative attitudes and behaviors become internalized (Corrigan, 2004). Furthermore, the research strongly suggests that the stigma of mental illness is one of the reasons why individuals who would benefit from treatment services often do not seek them or participate in them fully (Corrigan, 2004; Gary, 2005a). Additionally, according to Overton and Medina (2008), "If a person with mental illness is able to reach out and seek services, the effects of stigma have been shown to influence the efficacy of his or her treatment. People who are using services and perceive their own devaluation or rejection from society have been shown to have poor treatment outcomes" (p. 146).

Stigma due to substance use disorder/addiction. There is significant social disapproval and stigma associated with substance addiction (Lavack, 2007; Room, 2005).

Individuals in treatment for alcohol and/or drug problems are frequently and disproportionately marginalized (Room, 2005). In addition, persons in recovery from alcohol or drug addiction continue to face the manifestations of stigmatization processes. For example, they are less likely to be hired for a position when their status is known (Lavack, 2007). As such, the stigma of addiction is considered a contributor to treatment underutilization among individuals with substance use disorders (Lavack, 2007).

One of the major contributors to this stigma is public misunderstanding of addiction processes. It is often believed that addiction results from a lack of self-control or willpower and represents a personal weakness. The public is not well-informed about the notion of addiction as a brain disease (Lavack, 2007). Furthermore, policy decisions at the local and national level may also contribute to the marginalization of individuals with substance use disorders (e.g., laws requiring eviction from public housing for drug dealing or sending people to prison for selling drugs; Room, 2005).

Multiple stigmas. According to Conner and Rosen (2008), “Whereas research has addressed the impact of mental illness stigma on treatment-seeking attitudes and behaviors, the effects of other stigmas such as age, race, drug addiction, and poverty have received far less attention. In addition, research has not sufficiently addressed the potential additive effect of stigma on individuals who are experiencing multiple stigmas simultaneously” (p. 244). This lack of research is somewhat surprising given that the literature informally appears to support the idea of an additive effect of multiple stigmatization. For instance, according to Gary (2005a), there is profound evidence in the literature that ethnic minority populations with mental illness are less likely to utilize treatment services than non-ethnic minority populations with mental illness; European

Americans with mental illness, for instance, are more likely to seek treatment than African Americans and Latinos (Corrigan, 2004). Gary (2005b) suggested that the presence of “double stigma” explains this phenomenon (p. 981).

The interest in examining the impact of multiple stigmas appears to be growing. Conner and Rosen (2008), for example, conducted a qualitative study with older adult methadone maintenance clients to explore the effect of experiencing multiple stigmas on treatment seeking attitudes. Results from this study revealed that the population of interest may carry eight distinct stigmas. Of the 23 participants who reported feeling stigmatized (total n = 24), nearly half described carrying three or more stigmas. Most notably, participants who reported having more stigmas were more likely to identify stigma as a barrier to substance abuse and mental health treatment. All in all, studies like Conner and Rosen’s (2008) provide strong rationale for continuing to investigate the impact of multiple stigmatization.

Chapter III: Methods

The purpose of the present study was to extend our knowledge of how individuals who are homeless experience and respond to social stigmatization. Although the construct of stigma has been receiving increasing empirical attention over the past few decades, only a handful of studies have addressed how stigmatization affects individuals who are homeless. It is currently unclear how well various theories of stigma apply to this unique population. Furthermore, the impact of stigmatization on this population's treatment-seeking and treatment-engagement behaviors remains unknown. Research is also needed to determine whether individuals experiencing homelessness have treatment needs related to their devalued status in society.

To answer the study's research questions, two noteworthy decisions were made related to (a) sampling and (b) methodology. First, in terms of sampling, I decided to focus on a specific subpopulation of the homeless: African American men with co-occurring mental illness and substance use disorders experiencing chronic homelessness. I chose to focus on this subgroup for a variety of reasons. First, the homeless population is very heterogeneous (Banyard & Graham-Bermann, 1995) and, as such, "single theories of homelessness are inadequate" (Stein & Gelberg, 1995, p. 75). Stein and Gelberg (1995) noted that "...the heterogeneity of the homeless population...implies that they require a diversity of services...Identification of and more knowledge about characteristics of subgroups in the homeless population are necessary to define their needs more precisely and to develop appropriate policy approaches and services to address their needs" (p. 75). Focusing on such a specific subgroup allows for more individualized recommendations to be made in congruence with study results. As Padgett

and colleagues (2008) suggested, “Persons suffering from severe mental illness, substance abuse and homelessness are among the most vulnerable and hardest-to-reach...and much can be learned from their personal narratives. The success of the delicate negotiation beginning with outreach and engagement depends upon the fit between consumers’ needs and the service system’s ‘offer.’ Policies and practices that integrate consumers’ opinions are more likely to make an offer that is not refused” (p. 231-232).

The second reason I decided to focus on the aforementioned subgroup involves the fact that I expected its members to face multiple sources of stigma. Members of this subgroup carry a number of stigmatized conditions (e.g., related to homelessness, racial/ethnic minority status, mental illness, and substance addiction; Harrell, 2000; Lavack, 2007; Overton & Medina, 2008). As such, I expected that participants drawn from this subgroup would be able to speak more extensively about stigmatization than participants drawn from less stigmatized subgroups. I also expected that they would be able to speak to the impact of multiple stigmatization, an area of inquiry that has yet to be addressed fully by the literature. According to Conner and Rosen (2008), “Whereas research has addressed the impact of mental illness stigma on treatment-seeking attitudes and behaviors, the effects of other stigmas such as age, race, drug addiction, and poverty have received far less attention. In addition, research has not sufficiently addressed the potential additive effect of stigma on individuals who are experiencing multiple stigmas simultaneously” (p. 244).

The third reason I decided to focus on this subgroup is because its members have great needs but are often the most difficult to engage in supportive services. For instance,

Stein and Gelberg (1995) suggested that the homeless subgroup with mental illness has been noted to be more isolated, to be homeless longer, and to have more contacts with the legal system than non-mentally ill subgroups. Green (2005) noted that individuals with co-occurring mental illness and substance use disorders are the most likely to refuse treatment and tend to remain homeless longer than other homeless subgroups. Furthermore, Mitka (2006) indicated that individuals who are chronically homeless are particularly costly for society.

Finally, I selected the aforementioned subgroup for practical reasons. Given that men comprise the largest subgroup of the homeless population (National Coalition for the Homeless, 2007), African Americans are overrepresented among them (Gamst et al., 2006), and men are more likely than women to be chronically homeless (Green, 2005), I assumed it would be easier to obtain participants from this subgroup than from others. Furthermore, given my university's affiliation with a shelter for men with co-occurring mental illness and substance use disorders, I had additional incentive to focus on this particular subgroup.

The second important decision I made in order to answer my research questions involved my selection of a research methodology. I decided to utilize qualitative methodology in this study for the following reasons: (a) it allows research participants to express their perspectives and experiences in their own words and in rich detail; (b) it allows for discovery, description, and the emergence of unexpected results; (c) it allows for contextual analysis (in this case the context of homelessness); (d) it allows for a personal interaction between researchers and participants (which can help participants feel more valued and as though their voices are truly being heard, a potentially

uncommon experience for individuals who are homeless); and (e) it may be more feasible to implement with individuals who are homeless than a quantitative study, as they may be uncomfortable with quantitative measures/testing situations or unable to read and write (Hill, 2006; Miller & Keys, 2001; Morrow & Smith, 2000). Furthermore, some individuals have suggested that a qualitative approach to research may be the most appropriate for investigations of understudied populations (e.g., Morrow & Smith, 2000).

Given that individuals who are homeless are understudied in the realm of psychology and that “the general focus of research on homelessness has ignored the inner lives of homeless persons and how they experience their world” (Miller & Keys, 2001, p. 332), I wanted to find a research methodology that could “illuminate the rich experiences and varied perspectives of homeless individuals” (Cohen & Wagner, 1992, p. 38). It has been proposed that “the key to understanding homelessness has been to comprehend what homeless people experience” (Christian, 2003, p. 88). Including the homeless voice in empirical research on homelessness allows for this comprehension and can inform efforts to eliminate or better manage this societal problem (Blasi, 1994).

All in all, I elected to use qualitative methodology for this project because of its ability to incorporate and highlight the homeless voice into empirical research. I further decided to use grounded theory (originally developed by Glaser and Strauss, 1967) as my qualitative methodology of choice. There were a number of reasons for this selection. First, the aim of grounded theory is “to produce innovative theory that is ‘grounded’ in data collected from participants on the basis of the complexities of their lived experiences in a social context” (Fassinger, 2005, p. 157). Grounded theory allows for the creation of

a theory that can explain homeless individuals' experiences and responses to stigmatization as opposed to simply describing them.

Second, grounded theory is comprised of a set of relatively structured and systematic procedures [particularly the Strauss and Corbin (1998) version of grounded theory; Fassinger (2005)], which lends to the empirical rigor that qualitative research is often accused of lacking. The procedures associated with grounded theory also make the methodology more learner-friendly than other qualitative approaches, which was advantageous for the study given that the research team was comprised primarily of graduate students fairly new to qualitative research. In addition, I believe that the systematic nature of grounded theory fits with my paradigmatic orientation, which lies between postpositivism and constructivism. Finally, I expected that utilizing a systematic methodology would complement the current literature in that many of the studies on homelessness reviewed either did not appear to follow an established qualitative methodology or did not clearly describe their procedures for data analysis and interpretation. If a study utilizing a clear, replicable set of procedures yields findings similar to those of previous studies, the trustworthiness and transferability of all of the studies' results can be supported.

A third reason I chose grounded theory for the proposed study is because it lends itself well to the use of research teams (Fassinger, 2005). Using a research team can be particularly useful for monitoring and accounting for researcher biases. Members of a research team can also provide multiple perspectives on the data, allowing for better understanding of data complexity.

A final reason grounded theory was chosen involves its feasibility; it requires less time and yields less data than a thorough case study or ethnography would. At the same time, increased feasibility has not compromised grounded theory's reputation in the research world. In fact, grounded theory has been described as the most influential methodology in qualitative research today (Fassinger, 2005).

The purpose of this chapter is to review the specific procedures that were used to accomplish the goals of this study (e.g., participant selection and recruitment, research team composition, data collection, data analysis, quality assurance measures).

Target Population

This study's target population was defined as adult (ages 25-60) African American men who fulfill HUD's criteria for chronic homeless status (i.e., "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years;" National Alliance to End Homelessness, n. d. a.), have co-occurring mental illness and substance use disorders, are residing currently in a local homeless shelter where they are participating in mental health/substance-related counseling services, and who fulfill additional inclusion criteria. These additional inclusion criteria were evaluated informally (i.e., via professional judgment) both at the time of recruitment and at the time of data collection and included: (a) fluent in English, (b) no apparent substance intoxication, (c) no apparent thought disturbance that would otherwise impede data collection, and (d) no apparent cognitive impairment that would otherwise impede data collection. All of the aforementioned inclusion criteria were selected to increase the sample homogeneity and to obtain the perspective of individuals

facing multiple stigmas. The age range of 25-60 was selected to increase sample homogeneity and to obtain the more “middle” adulthood vs. “young” adulthood perspective; experiences of homelessness among younger adults may be quite different (e.g., potentially different types or degrees of stigmatizing experiences, different access to resources, different durations of homeless episodes; Caton et al., 2005).

Given the sampling approach used, the generalizability of the theory emerging from this study is unknown. Furthermore, recruiting only from a local shelter results in a sample of convenience accompanied by both predictable and unanticipated characteristics and biases that further limit generalizability.

Participant Pool

The participant pool was limited to individuals residing at a publicly-funded emergency shelter and comprehensive social services agency for adult men between May and November 2010. This homeless shelter/agency (referred to as “HSA” in this document) provides shelter, case management services, and mental health/AODA counseling for adult men experiencing homelessness in the Milwaukee, Wisconsin, urban area. HSA provides shelter to 70-80 men on any given day, and length of stay and involvement in HSA services varies widely from individual to individual (means and standard deviations currently unavailable). Mental health/AODA counseling at HSA is primarily based on motivational interviewing, stages of change, and relapse prevention principles, and men utilizing counseling typically receive 1 hour of individual counseling and 4-12 hours of group counseling per week. All individuals residing at HSA during the aforementioned time period who fulfilled inclusion criteria for the study were eligible to express interest in or be referred by HSA staff (with their consent) for study participation.

Participants

Twelve participants were recruited from HSA, and all 12 completed the study. All of the participants fulfilled the aforementioned inclusion criteria (i.e., adult African American men with co-occurring mental illness and substance use disorders experiencing chronic homelessness). The participants ranged in age from 25 to 59, and they presented with a variety of psychiatric and substance use disorders. Their number of homeless episodes ranged from 1 to 6, their total duration of homelessness ranged from 2 to 15 years, and the duration of their most recent episode of homelessness ranged from 2 months to 4 years. Their overall affiliation with HSA ranged from 1.5 months to 10 years, and the duration of their current affiliation with HSA ranged from 1 to 6 months; some participants had reported utilizing HSA services off and on throughout their experiences of homelessness. It should be noted that the participants were successfully satisfying requirements for residing at HSA (e.g., being perceived by staff as “ready” to participate in HSA programming and/or progressing satisfactorily in programming, not breaking rules excessively, not having an excessive number of positive drug screens, not being violent).

Participants’ education levels ranged from 6th grade to 1 year of vocational/technical schooling or college coursework. Eleven out of 12 participants reported unemployment. Two out of 12 reported a history military of service, though only one reported combat experience. Five participants reported being single, 4 reported being divorced, 2 reported being separated, and 1 reported being widowed. The reported number of children ranged from 0 to 6. A description of the participants’ demographics and brief personal details can be found in Table 1.

Table 1

Research Participants' Demographic Information and Brief Personal Details

Pseudonym Selected by Participant	Demographic Information	Information Related to Homeless Status	Diagnoses and Treatment
Brook	Age: 53 Marital status: Divorced Number of children: 1 Education: 1 year of vocational school Employment status: Unemployed Military: No history	Total duration of homelessness: 4 years Number of homeless episodes: 4 Duration of most recent episode: 8 months Length of total affiliation with HSA: 3 years Reason for homelessness: Addiction	Mental health: Depression Substance-related: Alcohol dependence Amount of time in treatment at HSA: 1 month
Willy	Age: 46 Marital status: Divorced Number of children: 2 Education: 9 th grade Employment status: Unemployed Military: No history	Total duration of homelessness: 10 years Number of homeless episodes: 5-6 Duration of most recent episode: 14 months Length of total affiliation with HSA: 10 years Reason for homelessness: Addiction	Mental health: Depression Substance-related: Alcohol and cocaine dependence Amount of time in treatment at HSA: 3 months

Smith	<p>Age: 50</p> <p>Marital status: Separated</p> <p>Number of children: 3</p> <p>Education: 11th grade</p> <p>Employment status: Unemployed</p> <p>Military: No history</p>	<p>Total duration of homelessness: 15 years</p> <p>Number of homeless episodes: 5</p> <p>Duration of most recent episode: 1 year</p> <p>Length of total affiliation with HSA: 2 months</p> <p>Reason for homelessness: Addiction</p>	<p>Mental health: Depression</p> <p>Substance-related: Alcohol and cocaine dependence</p> <p>Amount of time in treatment at HSA: 2 months</p>
Icy	<p>Age: 51</p> <p>Marital status: Single</p> <p>Number of children: 6</p> <p>Education: 8th grade</p> <p>Employment status: Unemployed</p> <p>Military: National Guard, no combat</p>	<p>Total duration of homelessness: 2 years</p> <p>Number of homeless episodes: 4</p> <p>Duration of most recent episode: 1 year</p> <p>Length of total affiliation with HSA: 4 months</p> <p>Reason for homelessness: Mental illness</p>	<p>Mental health: Bipolar disorder and paranoid schizophrenia</p> <p>Substance-related: Cocaine and alcohol dependence</p> <p>Amount of time in treatment at HSA: 4 months</p>
Jordan	<p>Age: 50</p> <p>Marital status: Divorced</p> <p>Number of children: 1</p>	<p>Total duration of homelessness: 8 years</p> <p>Number of homeless episodes: 4-5</p>	<p>Mental health: Depression</p> <p>Substance-related: Alcohol and cocaine dependence</p>

	<p>Education: GED</p> <p>Employment status: Unemployed</p> <p>Military: No history</p>	<p>Duration of most recent episode: 3 years</p> <p>Length of total affiliation with HSA: 3 years</p> <p>Reason for homelessness: Addiction and unemployment</p>	<p>Amount of time in treatment at HSA: 1 month</p>
Wayne	<p>Age: 56</p> <p>Marital status: Widowed</p> <p>Number of children: 3</p> <p>Education: 11th grade</p> <p>Employment status: Unemployed</p> <p>Military: No history</p>	<p>Total duration of homelessness: 6 years</p> <p>Number of homeless episodes: 4-5</p> <p>Duration of most recent episode: 2 months</p> <p>Length of total affiliation with HSA: 2 months</p> <p>Reason for homelessness: Disconnecting from support group</p>	<p>Mental health: Depression</p> <p>Substance-related: Alcohol and cocaine dependence</p> <p>Amount of time in treatment at HSA: 2 months</p>
Mike	<p>Age: 41</p> <p>Marital status: Separated</p> <p>Number of children: 1</p> <p>Education: 11th grade</p>	<p>Total duration of homelessness: 2 years</p> <p>Number of homeless episodes: 1</p> <p>Duration of most recent episode: 2 years</p>	<p>Mental health: Depression</p> <p>Substance-related: Alcohol and cocaine dependence</p> <p>Amount of time in treatment at HSA: 1.5 months</p>

	<p>Employment status: Unemployed</p> <p>Military: No history</p>	<p>Length of total affiliation with HSA: 1.5 months</p> <p>Reason for homelessness: Unemployment</p>	
Shake	<p>Age: 33</p> <p>Marital status: Single</p> <p>Number of children: 1</p> <p>Education: Technical classes</p> <p>Employment status: Unemployed</p> <p>Military: No history</p>	<p>Total duration of homelessness: 3 years</p> <p>Number of homeless episodes: 2</p> <p>Duration of most recent episode: 6 months</p> <p>Length of total affiliation with HSA: 3 months</p> <p>Reason for homelessness: Addiction</p>	<p>Mental health: Depression</p> <p>Substance-related: Alcohol dependence</p> <p>Amount of time in treatment at HSA: 1 month</p>
Malik	<p>Age: 25</p> <p>Marital status: Single</p> <p>Number of children: 0</p> <p>Education: 12th grade and 2 months of college</p> <p>Employment status: Employed at a restaurant</p>	<p>Total duration of homelessness: 2.5 years</p> <p>Number of homeless episodes: 5</p> <p>Duration of most recent episode: 5 months</p> <p>Length of total affiliation with HSA: 5 months</p>	<p>Mental health: Schizophrenia</p> <p>Substance-related: Alcohol dependence</p> <p>Amount of time in treatment at HSA: 4 months</p>

	Military: No history	Reason for homelessness: Terminated from college for vandalism	
Tony	Age: 45 Marital status: Divorced Number of children: 4 stepchildren Education: 11 th grade Employment status: Unemployed Military: No history	Total duration of homelessness: 9 years Number of homeless episodes: 4 Duration of most recent episode: 4 years Length of total affiliation with HSA: 5.5 months Reason for homelessness: Addiction, unemployment, financial problems, conflict with landlord	Mental health: Schizoaffective disorder, bipolar type Substance-related: Alcohol and cocaine dependence Amount of time in treatment at HSA: 5.5 months
John	Age: 59 Marital status: Single Number of children: 3 Education: 1 year of college Employment status: Unemployed	Total duration of homelessness: 15 years Number of homeless episodes: 5 Duration of most recent episode: 3 years Length of total affiliation with HSA: 3 years	Mental health: Depression and PTSD Substance-related: Alcohol dependence and marijuana abuse Amount of time in treatment at HSA: 4 months

	Military: Army with combat experience	Reason for homelessness: Mental health problems	
Jack	Age: 55 Marital status: Single Number of children: 0 Education: 6 th grade Employment status: Unemployed Military: No history	Total duration of homelessness: 25 months Number of homeless episodes: 2 Duration of most recent episode: 6 months Length of total affiliation with HSA: 3 months Reason for homelessness: Released from prison without resources	Mental health: Depression and schizophrenia Substance-related: Cocaine, heroin, and alcohol dependence Amount of time in treatment at HSA: 1 month

The Research Team

This study used a research team to carry out data collection and analysis. A team approach was chosen for two reasons. First, utilizing a team approach is practical given the vast amount of data that qualitative work is known for yielding. Second, it can help to manage the subjectivity associated with qualitative data analysis (Morrow, 2005), as team members provide multiple perspectives and can challenge each other's biases, assumptions, and expectations.

The team was comprised of the following: a principal investigator, a "primary team," an external auditor, three external consultants, and two interview transcribers. I was the principal investigator and one of the primary team members. The primary team

was comprised of five members who were responsible for collecting (4/5 members) and analyzing (5/5 members) study data. The primary team members were comprised of doctoral-level graduate students in a counseling psychology department (4/5 members) and a Department of Veterans Affairs (DVA) employee with a bachelor's degree in psychology and psychology research experience at DVA. The primary team members included: a 29-year-old European American woman, a 27-year-old African American woman, a 27-year-old European American woman, a 29-year-old African American man, and a 30-year-old biethnic (Pacific Islander and Latino) man. Three of the primary team members had prior experience with grounded theory research, one had prior experience with general qualitative research, and one had no prior experience with qualitative research. The primary team members without experience in grounded theory research were trained in this specific methodology prior to and as they participated in data collection and/or analysis. Three of the primary team members had prior clinical experience working with individuals facing homelessness.

The primary team was involved throughout most of the research process, from protocol development through grounded theory development. Essentially, the primary team (with the exception of the single member who only participated in data analysis – the 30-year-old biethnic man) shared responsibility for research protocol development, data collection, data analysis (all three levels of coding), and theory development. As such, the primary team shares credit for the study findings. As the principal investigator, however, I carried the most responsibility for the study and facilitated all research team training, data collection, and data analysis.

Although the primary team carried the most responsibility for data collection and analysis, other research team members were also involved. An external auditor, for instance, was consulted to “provide a perspective on the data that is not as influenced by groupthink” (Hill et al., 2005, p. 201). This auditor was a graduate of a master’s program in community counseling with experience in grounded theory methodology; she was a 26-year-old European American woman. Three external consultants were also utilized in a consultative manner as needed (e.g., when methodological questions arose or study-related difficulties occurred); these individuals were my dissertation committee members. Finally, two primary team members served as transcribers, namely, myself and the primary team member who did not participate in data collection. This particular member participated in transcription-related activities primarily for training purposes (e.g., to increase his familiarity with the interview protocol since he did not complete interviews).

With the exception of the external auditor, all members of the research team were familiar with the aims of the proposed study (i.e., they read and/or discussed the dissertation proposal). Additionally, the primary team and the external auditor had at some point received training in grounded theory methodology (i.e., read about grounded theory procedures, reviewed several grounded theory studies, practiced grounded theory techniques with someone familiar with grounded theory methodology, and/or participated previously in grounded theory research). Furthermore, consistent with Fassinger’s (2005) recommendations for preparing interviewers, the primary team members involved in data collection practiced interviewing each other and conducted either a mock interview or a pilot interview prior to conducting any interviews that were analyzed for the study. Finally, the primary team members involved in data collection participated in a HSA

orientation for visiting researchers that was facilitated by one of the HSA counselors; this orientation involved familiarizing the primary team members with HSA policies, procedures, and suggestions for working with HSA clientele.

To enhance the study's trustworthiness, the primary team reflected upon and reported their perceived expectations, assumptions, and biases that would potentially impact the study prior to data collection (Morrow, 2005). Biases have been defined as "personal issues that make it difficult for researchers to respond objectively to the data" (Hill, Thompson, & Williams, 1997, p. 539). They can arise from demographic characteristics as well as values and beliefs about the study topic and were discussed prior to, during, and following the research process (Hill et al., 2005). Expectations, assumptions, and biases reported and discussed by the primary team included the following: (a) participants will be aware of their stigmatized/devalued social status, (b) participants will report being stigmatized for a variety of reasons (e.g., for housing status in addition to ethnic minority status), (c) participants will report being stigmatized in a variety of ways (overt discrimination, negative stereotypes), (d) participants will report negative consequences associated with stigmatization (e.g., depression), (e) participants will report a variety of strategies for coping with stigmatization (e.g., substance misuse, disidentification), (f) participants will report that their stigmatization has impacted their treatment-seeking in a negative way, and (g) participants may have difficulty communicating stigmatization experiences (e.g., due to interviewer-participant demographic-based mismatches). The primary team also discussed biases they bring to the study simply because of their unique demographic backgrounds (e.g., race/ethnicity, gender, socioeconomic status, age, educational history, housing status, etc.) and/or their

level of comfort interacting with the homeless population. Furthermore, primary team members acknowledged that they may be biased by the knowledge they obtained from reading Chapter II of this manuscript and/or by previous experiences they had doing grounded theory research. For example, they acknowledged that they expected participants to report using certain coping strategies they had learned about stigmatized groups using when they reviewed Chapter II of this manuscript.

Instruments

Background Information Form. Prior to conducting the interview, participants were asked to complete a Background Information Form (BIF; see Appendix A). This form requested various types of background information from the participants, including their age, duration of homelessness (total and/or current episode), number of homeless episodes, duration of affiliation with HSA (total and/or current), duration of mental health and AODA treatment at HSA, psychiatric and substance-related diagnoses, physical health status, employment status, marital/parental status, educational background, and military history. These forms were administered orally by the interviewer for the sake of time.

Interview Protocol. As grounded theory researchers tend to use interviewing as their primary method of data collection (Fassinger, 2005), interviews comprised this study's primary source of data. According to Fassinger (2005), grounded theory researchers also tend to provide some degree of structure (albeit flexible) in presenting their interview questions to participants. As such, a semistructured protocol was used to guide the interview (see Appendix B). This protocol prompted participants to discuss their beliefs about stigmatization (e.g., "Some people might say that individuals who are

homeless are stigmatized while others may not. What do you think?” and “How and why might individuals who are homeless be stigmatized?”), personal experiences being stigmatized (e.g., “How have you been stigmatized?”), perceived impact of being stigmatized (e.g., “How does being stigmatized impact you?”), coping strategies for managing stigmatization (e.g., “How do you deal with being stigmatized in general?”), and treatment-seeking/engagement behaviors (e.g., “Why do you stay at the HSA and in HSA programming?”).

Consistent with grounded theory research, a modified interview protocol was introduced after the first couple interviews given that grounded theory data analyses occur simultaneously with data collection and can inform future data collection endeavors (Corbin & Strauss, 2008; see Appendix C for the modified version). The original protocol was modified such that (a) the second version included presentation of a visual cue containing the definition of stigmatized, (b) one of the questions was removed (i.e., “What would you want done about stigmatization?”), and (c) one of the questions was relocated to a later section (i.e., “How did you become an individual facing homelessness?” was moved to the “Closing Questions” section). The visual cue (see Appendix C) was added to aid participants’ understanding of the definition and to offer a reminder to be referenced throughout the interview. The deleted question was removed because the first participants consistently reported that they “[had] no idea.” The relocated question was moved to enhance interview flow.

Data Collection Procedures

Participant Recruitment. Participants were recruited directly from HSA with formal permission from HSA staff. HSA counseling staff (n = 3) were informed about the

nature of the study and agreed to make referrals. HSA counseling staff adhered to the following procedures for making referrals: (a) familiarizing themselves with study inclusion criteria; (b) identifying individuals in their caseloads who fulfilled inclusion criteria and verbally informing them about the study; and (c) facilitating a formal referral to the principal investigator when individuals expressed interest in study participation by (i) completing a Release of Information Form (see Appendix D), (ii) completing a Checklist for Participant Inclusion Form (see Appendix E), and (iii) informing the principal investigator that these forms were completed. These referral procedures and scripted instructions for carrying them out can be viewed in Appendix F.

When the principal investigator learned of an individual potentially interested in participating in the study, efforts were made to meet that individual as soon as possible at HSA, especially given the high turnover rate at homeless shelters. One to two of the primary team members retrieved and reviewed their paperwork (i.e., Release of Information Form and Checklist for Participant Inclusion Form) for completeness and then met them in person at HSA. During this meeting, prospective participants were provided with information about the study and scheduled for a data collection appointment if they stated they wanted to participate and fulfilled inclusion criteria. They were given a written reminder of their upcoming appointment and its location (HSA or Marquette University campus). An outline of participant scheduling procedures can be viewed in Appendix G.

Incentive/compensation for participation was provided in the form of a \$10 gift card to the participant's choice of McDonald's, Cousin's Subs, or Subway restaurants. Participants were informed of the incentive/compensation both by their referral source

and the primary team member who scheduled them for their data collection appointment, and participants were given the gift cards upon completion of their interviews.

Pilot Data Collection. The recruitment procedures outlined above and the data collection procedures outlined below were piloted with an individual who fulfilled inclusion criteria for the study. The main purpose of piloting the protocol was to ensure the understandability of the interview protocol questions and to allow for revisions and additions prior to beginning the study (Fassinger, 2005). It was also used to help determine an approximate amount of time needed to complete the interviews. The principal investigator completed the pilot, and revisions did not end up being made to the data collection procedures immediately after the pilot because the pilot went smoothly.

Obtaining Consent and Completing the Background Information Form.

Consent for participation in the study was obtained just prior to the interview (see Appendix H for a copy of the Informed Consent Form). Before entering the study, prospective participants were given a written description of the study's goals and procedures. The voluntary nature of participation, potential risks and benefits, confidentiality, the possibility that responses would be used verbatim, reimbursement, etc., were explained to the prospective participants. All prospective participants ended up consenting to participating in the study. They were then given a copy of the Informed Consent Form for their personal records.

The participants were then asked to select a pseudonym to be used on their Checklist for Participant Inclusion Forms, Background Information Forms, and interview protocols. Pseudonyms were used to protect participant privacy. The Background

Information Forms were then completed, and participants were prepared for the interviews.

Interviewing. Individual, face-to-face interviews were completed with the participants utilizing the original or modified interview protocol (see Appendices B and C), and all interviews were audiorecorded. Face-to-face interviews were chosen for logistical reasons (i.e., the population of interest may not have access to a phone), their potential to maximize rapport, and the opportunity they provide for collecting nonverbal sources of information. One to two members of the primary team were present for each interview. When two members were present (7/12 interviews), one conducted the interview while the other handled the recording equipment, took notes, and asked follow-up questions as needed. Interview duration ranged from 45 to 145 minutes. Upon completion of the interviews, the participants were thanked for their involvement in the study and compensated for their time with a gift card of their choice. Participants signed a Receipt of Confirmation Form indicating that they received compensation (see Appendix I). When participants left the data collection session, the interviewer(s) took a few moments to record their reactions to the interview as well as interview completion time using the Interviewer/Assistant Interviewer Debriefing Form (see Appendix J). Responses on this form were used as a memoing tool (as recommended by Corbin and Strauss, 2008), discussed during research team meetings, and used to inform future data collection sessions. Participants' pseudonyms were used on these forms to protect their privacy.

Participants were recruited and interviewed until saturation (Corbin & Strauss, 2008) was achieved ($n = 12$). Saturation was determined by primary team discussion of

when no new themes or unanticipated information appeared to be emerging during interviews; the primary team used Interviewer/Assistant Interviewer Debriefing Forms to help keep track of this (see Appendix J). The number of participants in a grounded theory study is difficult to determine in advance given the end goal of data saturation following theoretical sampling (Corbin & Strauss, 2008).

Transcribing. Each interview was transcribed verbatim, with the exception of minimal encouragers and filler words. Confidentiality was maintained by deleting any identifying information from the transcripts and using pseudonyms. All transcripts were checked for accuracy by a second transcriber.

Data Analysis Procedures

Data were analyzed following the grounded theory procedures outlined by Strauss and Corbin (1998) and Corbin and Strauss (2008). Inherent in this methodology is the constant comparative method, an analytic process that involves comparing each new piece of data to existing data until an overarching, explanatory theory is developed (Fassinger, 2005; Strauss & Corbin, 1998). Essentially, every piece of data is compared with every piece of data; you compare data with data, data with categories, categories with categories, and categories with concepts until an abstract theory is formulated (Charmaz, 2006). The end result of grounded theory methodology is a grounded theory characterized by the presence of a central, core concept and an interconnected storyline (Strauss & Corbin, 1998).

To attain this end result, data are examined, compared, and reduced through coding procedures. Coding refers to the process of extracting concepts and categories from raw data (Corbin & Strauss, 2008). In grounded theory, there are three types of

coding processes: open coding, axial coding, and selective coding (Strauss & Corbin, 1998). These three types of coding occur recursively rather than sequentially due to the constant comparative method (Fassinger, 2005). However, data analyses begin with open coding and end when saturation occurs (i.e., when no new information emerges during coding processes; Strauss & Corbin, 1998). The different types of data analyses are described in more detail below.

Open Coding. Open coding is defined as “the analytic process through which concepts are identified and their properties and dimensions are discovered in data” (Strauss & Corbin, 1998, p. 101). Concepts are “words that stand for ideas contained in the data,” properties are “characteristics that define and describe concepts,” and dimensions are “variations within properties that give specificity and range to concepts” (Corbin & Strauss, 2008, p. 159). Open coding involves close examination of study data, which are usually in the form of interview transcripts. Transcripts can be examined in many ways (e.g., word-by-word, phrase-by-phrase, line-by-line, paragraph-by-paragraph, etc.; Strauss & Corbin, 1998). Researchers choose how to read the transcripts (e.g., line-by-line) and then record all of the ideas that emerge as the transcripts are read in that fashion (Strauss & Corbin, 1998). These ideas are then abstracted and labeled (i.e., named as a particular concept; Strauss & Corbin, 1998). Conceptualization then allows tentative categorization to occur, as concepts have properties that lie along dimensions that can be organized under higher-order concepts (Strauss & Corbin, 1998). The properties and dimensions of categories can then be analyzed (Strauss & Corbin, 1998).

For this project, each transcript was open coded by 1-2 members of the primary team. The primary team began with line-by-line open coding, as Strauss and Corbin

(1998) suggested that line-by-line analyses generate the most concepts and categories. Each separate idea in the data was labeled in the transcript margin (i.e., assigned a conceptual name) and examined for its properties and dimensions. These concepts were then organized into tentative categories, which were also named and examined for their properties and dimensions. Later transcripts were examined response-by-response or paragraph-by-paragraph, as conceptual labels and tentative categories were already discovered (Strauss & Corbin, 1998).

As concepts and categories were discovered, they were entered into a listing of all of the concepts and categories. Their properties and dimensions were discussed and noted. Concepts, categories, properties, and dimensions were discussed amongst the primary team until consensus was achieved (similar to internal auditing). The external auditor was then provided with a couple of open coded transcripts for auditing purposes. If/when the auditor's review of the transcripts and open codes was in contention with the primary team's conclusions, the discrepancy was examined and the data reevaluated by primary team members.

Overall, 1,350 open codes emerged from this level of coding. Examples of open codes include: "participant believes he is stigmatized by his family," "participant responded to stigmatization in the past by getting high," and "substance misuse decreased participant's treatment-seeking behaviors because participant did not want to stop using."

Axial Coding. According to Strauss and Corbin (1998), axial coding is "the process of relating categories to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions" (p. 123). Although open coding results in the generation of some categories,

these categories can be described as tentative and/or fractured. The purpose of axial coding is to organize the fractured information that results from open coding so that this information can be understood in a more precise way (Strauss & Corbin, 1998).

Categories are related to subcategories in an explanatory fashion during axial coding (Strauss & Corbin, 1998). The questions of who, what, where, when, why, how, and with what consequences are considered for each category (Strauss & Corbin, 1998). Depth and structure is consequently added to each category, and the relations among categories begin to be conceptualized and organized.

For this project, axial coding was initiated by the primary team by reviewing the tentative categories, properties, and dimensions that were identified during open coding. Tentative categories were collapsed into categories/themes and subcategories/subthemes. The title of 'theme' or 'subtheme' was designated when a category or subcategory was endorsed by at least 5 of the 12 participants because this appeared to be a sizable proportion of the sample (>40%). Similar standards for theme designation and discussion have been used in other qualitative research studies (e.g., Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003).

During axial coding, sections of transcripts were read and reread as the primary team attempted to arrive at greater understanding of the relationships among emerging categories/themes and subcategories/subthemes. The causes, conditions, and consequences associated with each category/theme were explored as the data that subsumed the categories were reviewed. The relations among categories/themes and subcategories/subthemes were tentatively outlined and submitted to the external auditor

for review. Any disagreement between the auditor and the primary team was examined in depth, and data were reevaluated until consensus was achieved.

At the beginning of axial coding, 696 axial codes were identified. By the end of axial coding, these had been collapsed into 38 categories/themes and 84 subcategories/subthemes. Examples of axial codes that emerged include: “participant’s emotions have been impacted negatively by stigmatization” as a category/theme with “participant has been saddened by stigmatization,” “participant has been frustrated or angered by stigmatization,” “participant has experienced aggressive ideation after stigmatization,” and “participant has been exhausted or fatigued by stigmatization” as subcategories/subthemes.

Selective Coding. Strauss and Corbin (1998) define selective coding as “the process of integrating and refining the theory” (p. 143). Although axial coding involves linking categories with subcategories, selective coding takes this process one step further by linking categories with other categories to form a larger theoretical scheme (Strauss & Corbin, 1998). In other words, the categories are examined in aggregate and integrated to explain the phenomenon under study. Data from the study are thus organized as a set of interrelated concepts and categories that form a theory (Strauss & Corbin, 1998).

The first step in organizing the data involves choosing a central, core category that represents the main theme of the study and can pull all of the other categories or themes together while explaining the variation that exists within categories and themes (Strauss & Corbin, 1998). After the core category has been identified, an overarching theoretical scheme is organized. This scheme is outlined, described, refined, and revised until an explanatory statement of category relationships is found (Strauss & Corbin,

1998). Theory refinement involves reviewing the scheme for internal consistency, checking for gaps in logic, filling in poorly developed categories (which may involve collecting more data until theoretical saturation is reached), trimming excess categories (i.e., dropping extraneous concepts), and accounting for variation/outlying cases (Strauss & Corbin, 1998).

In the current study, selective coding began with the primary team selecting a central, core category or theme that attended to the focus of the research, consistent with Strauss and Corbin's (1998) advice. The categories/themes and subcategories/subthemes that emerged from axial coding were then integrated. All forms of data were consulted for this process, including the ongoing memos that the primary team members maintained since data collection began. To aid the selective coding process, storylines and diagrams were constructed and discussed (Strauss & Corbin, 1998). A theoretical scheme was discovered, refined, and revised. Once the primary team arrived at consensus about the completeness of the scheme, the scheme was sent to the external auditor (in diagram format) for review. The auditor's feedback was taken into consideration as the theoretical scheme underwent further revision and consensus was achieved.

The central, core category identified via selective coding and its interrelations with categories/themes and subcategories/subthemes is presented in Chapter IV and depicted by Figure 1 in Chapter IV. This core category integrated all of the categories/themes and subcategories/themes that emerged naturally from the interviews while maintaining sensitivity to the research question(s) posed by the current study. The primary research question affiliated with this study was, "How do individuals facing homelessness experience and respond to social stigmatization?" The central, core

category that emerged was “participants’ management of multiple stigmatization processes.”

Quality Assurance Processes

Several measures were taken to assure the quality of the research and to enhance the trustworthiness of the obtained results. Several researchers have identified standards for quality qualitative research (e.g., Charmaz, 2006; Lincoln & Guba, 2000; Morrow, 2005). These standards involve such constructs as credibility, transferability, dependability, confirmability, usefulness, and researcher reflexivity, to name a few (Charmaz, 2006; Lincoln & Guba, 2000; Morrow, 2005). In the current study, several strategies were employed to enhance its overall trustworthiness.

First, the subjectivity of the primary team was acknowledged. The primary team members demonstrated reflexivity. They recorded and discussed their personal study-related biases, expectations, and assumptions and challenged each other on them throughout the study. They also acknowledged that their own life experiences likely influenced the way the data were examined and interpreted.

Second, an external auditor was involved in the project. This individual served the purpose of “checking” some of the biases, expectations, and assumptions associated with the primary team. The auditor also helped to evaluate the soundness of decisions made by the primary team and provided feedback about the clarity of the primary team’s arguments. It should be noted that the primary team members also felt comfortable challenging each other and provided internal auditing as well.

Third, detailed information was provided about the researchers, the participants, the research context, and the procedures that were used so that the transferability and

dependability of the study research can be assessed by others. Systematic procedures were followed, and they have been documented for others to see and/or replicate. A detailed audit trail was kept so that all of the research team's decisions, activities, and inklings can be traced and reviewed. Each member of the primary team was also encouraged to keep his or her own personal journal documenting reactions to the data and emerging ideas about the theoretical scheme.

Finally, in the interest of triangulation, study results have been compared to the preexisting theoretical models and studies of stigmatization that were reviewed in Chapter II of this manuscript. These comparisons are discussed in Chapter V.

Chapter IV: Results

The purpose of the present study was to build a theory of stigmatization of the homeless population in light of the preexisting research on stigma and the preexisting research on homelessness. The primary research question affiliated with this study was, “How do individuals facing homelessness experience and respond to social stigmatization?” More specific research questions subsumed under this general research question included the following: (a) “How are individuals facing homelessness impacted by stigmatization, if at all?” (b) “How does stigmatization influence the way individuals who are homeless perceive themselves, other individuals who are homeless, non-homeless individuals, and treatment services?” (c) “How do individuals experiencing homelessness manage or cope with their devalued social identity?” and (d) “How does stigmatization influence the decisions of individuals who are homeless to enter and remain engaged in mental health/substance-related treatment?” This study explored how a specific subgroup of the homeless population experiences and responds to multiple sources of stigmatization: African American men facing chronic homelessness and co-occurring mental illness and substance use disorders. Twelve men participated in individual interviews during which they were asked to discuss their beliefs about stigma, personal experiences being stigmatized, the perceived impact of stigmatization on their psychosocial functioning, coping strategies they employ in response to stigmatization, and treatment-seeking behaviors. The purpose of this chapter is to present the findings that emerged from the interviews.

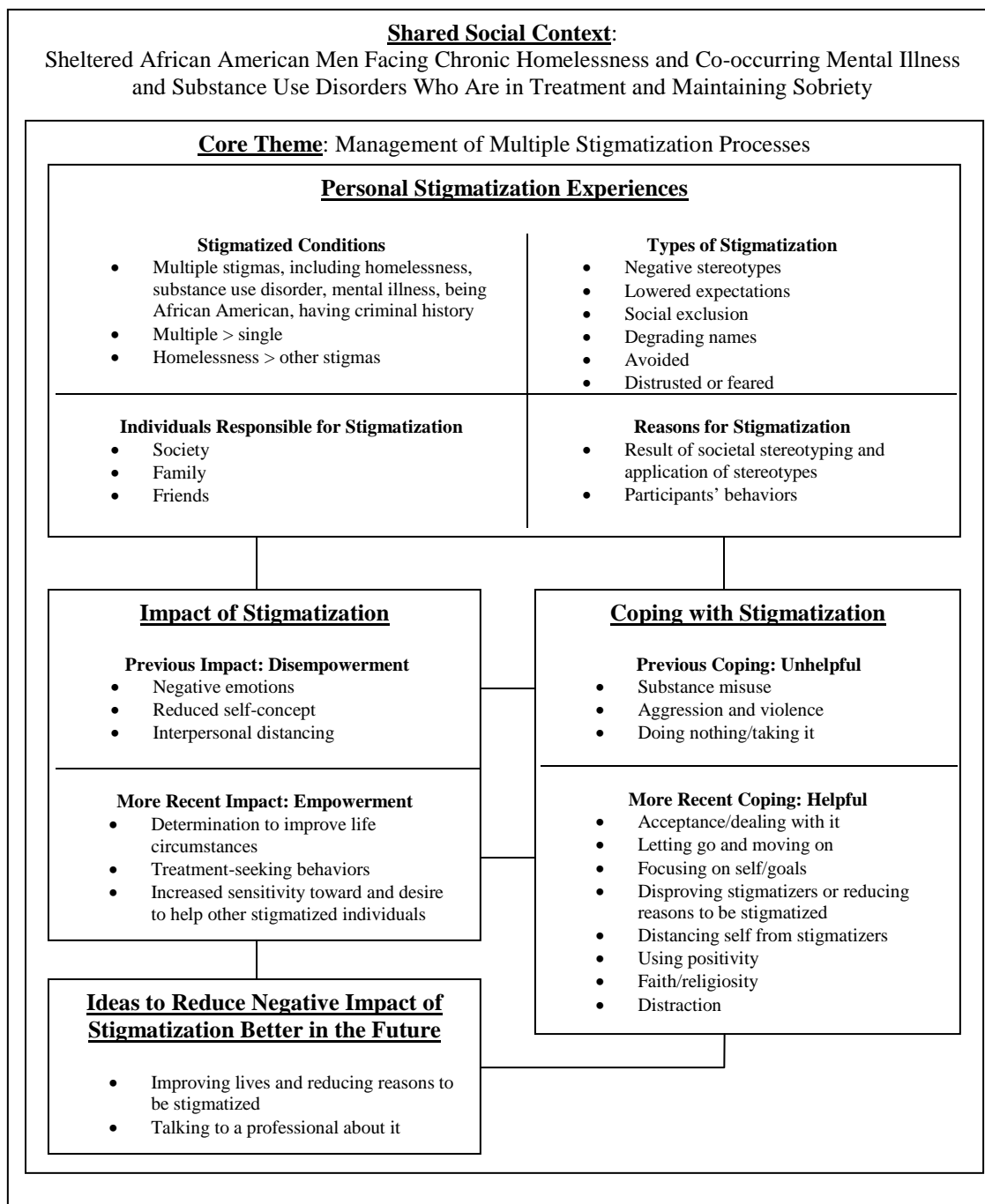
The overarching theoretical scheme (Strauss & Corbin, 2008) that emerged from data analysis and attends to the aforementioned research questions was that these

participants are multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way. The central, core category that emerged from grounded theory coding procedures was “participants’ management of multiple stigmatization processes.” Figure 1 depicts a visual representation, or model, of the theoretical scheme and how the core category/core theme, categories/themes, and subcategories/subthemes are interconnected given these participants’ shared social context.

In the sections that follow, the overarching theoretical scheme and pictorial model that emerged from the study are presented in terms of findings related to the participants’ shared social context, the core category/core theme, the categories/themes, and the subcategories/subthemes. The following words and phrases are used to note the number of participants who endorsed a particular theme or subtheme (recall that at least 5 of the 12 participants had to comprise a category or subcategory in order for it to be considered a theme or subtheme): (a) *the participants, these men, the majority, most, many, almost all, generally, and typically* are used when a participant response emerged in more than half (7 or more) of the interviews; (b) *several, some, a sizable number, half* (when N=6), *nearly half* (when N=5), and *sometimes* are used when a participant response emerged in 5-6 of the interviews; and (c) *a few* and *occasionally* are used when a participant response emerged in 3-4 of the interviews. More specific wording (e.g., *all, one*) is sometimes used as well. This type of wording and phrasing has been used regularly in other grounded theory studies (e.g., Timlin-Scalera et al., 2003). Illustrative participant quotes are also used to present the findings, consistent with grounded theory methodology (Fassinger, 2005).

Figure 1

Participants are multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way



Shared Social Context

The findings that emerged from the current study cannot be separated from the context from which they were derived. The participants in this study shared a similar social context. All of the participants were sheltered African American adult men experiencing chronic homelessness and co-occurring mental illness and substance use disorders who were participating in mental health/substance-related counseling at HSA and had maintained abstinence from alcohol and/or drugs for at least the month preceding their interviews (see Table 1 in Chapter III). Furthermore, they were found to share similar beliefs about stigmatization processes related to various stigmatized groups (i.e., individuals facing homelessness, African Americans, individuals with mental illness, individuals with substance use disorders) as well as to themselves. All twelve participants were able to describe both general and specific experiences during which they personally faced stigmatization. Participants' shared beliefs about stigmatization processes related to various stigmatized groups are presented below (i.e., beliefs about whether they are stigmatized, how they are stigmatized, perceived reasons they are stigmatized, and who stigmatizes them).

Shared beliefs about stigmatization processes related to individuals facing homelessness. Prior to being introduced to stigma-related terminology or definitions, all of the men in the study described ways in which individuals facing homelessness are stigmatized. When asked directly whether they agree that the homeless population is stigmatized, all of the participants responded affirmatively.

The participants described a variety of ways they think the homeless population is stigmatized. For example, the majority of participants suggested that individuals facing

homelessness are stereotyped negatively (e.g., assumed to have substance addiction, mental illness, and criminal backgrounds; judged as lazy, irresponsible, and untrustworthy). As Brook suggested, “They’re looked down upon as druggies or alcoholics and/or mentally handicapped. Thieves, a thief, or just a criminal...They’ve been stereotyped as lazy, good for nothing, want something for free.”

Many participants described how individuals experiencing homelessness are devalued by society. Jack, for instance, stated, “People look down on them...they think they nothing, and got nothing, and don’t want nothing. And they look down on them.” Mike noted, “People are looking at us like pests, bad to society, worthless...a disease. That’s how I see it.”

Most of the participants noted that individuals who are homeless are somehow excluded from mainstream society, either generally or in specific ways. Smith described them as generally being “cast away from society.” Tony stated, “They feel that we shouldn’t even be a part of the society. We should just fall off the side of the earth or something.” A couple of the participants noted that it is more difficult for people who are homeless to obtain employment. A few other participants stated that they believe individuals experiencing homelessness are frequently asked to leave stores or are prohibited from congregating in certain locations (e.g., public parks).

Almost all of the participants described how individuals facing homelessness are generally “treated badly.” Willy suggested, “They treat you bad, they talk to you bad.” Smith said, “They are treated poorly, unfairly...and discriminated against.”

Half of the participants suggested that individuals who are homeless are usually blamed for their housing status. According to Icy, “A lot of people will look at it like,

‘You don’t wanna do no good for yourself. You wanna be this way because you choose to be this way.’ And a lot of times that ain’t the case.”

Several of the men also noted that individuals facing homelessness are called degrading names (e.g., “bum,” “hobo,” “tramp”). A few men stated that individuals facing homelessness are given certain degrading “looks” or are otherwise ignored entirely. Brook, for instance, noted, “A lot of times they look through them.”

All of the participants speculated on why individuals facing homelessness are stigmatized. The majority of participants suggested that people who are homeless are treated differently because they are perceived as being responsible for their housing status, and a sizable number of the men suggested that they are treated differently because of other types of stereotypes about the homeless. For example, Brook stated, “I think a lot of that has to do with the media...If you see a homeless person on television, they’re panhandling, snatching purses, stealing, raping, always looking for the easy way out.” Many of the participants also stated that individuals experiencing homelessness are stigmatized because of their own behaviors and appearances (e.g., engaging in unusual behaviors like sleeping outside, engaging in socially unacceptable behaviors like panhandling, appearing disheveled, being malodorous). As Tony put it, “because, uh, they clothes aren’t as clean, they smell, or, you know, they beg a lot.”

When asked who stigmatizes individuals who are homeless, the participants responded with the “general public.” Nearly half also reported that shelters stigmatize the homeless, and a few noted that law enforcement stigmatizes the homeless as well.

Shared beliefs about stigmatization processes related to African Americans.

All but one of the participants indicated that they believe African Americans represent a

stigmatized group. When asked how African Americans are stigmatized, several participants noted that they are stereotyped (e.g., as dangerous, criminals, lazy, uneducated). John, for example, stated, “Just ‘cause you’re black, they figure something’s gotta be wrong with you. Like you’re a gangbanger.” Smith added, “Laziness...lack of education, not willing to work. They want fast, easy money.” Nearly half of the participants described how African Americans are socially excluded, primarily from the workforce. Shake noted, “It’s hard to get a job, people. It’s hard to get a job, man, for real. For real.” Finally, a few participants suggested that African Americans are simply discriminated against in general.

Nearly all of the participants speculated on why African Americans are stigmatized. Half of the participants attributed stigmatization of African Americans to the behaviors of African Americans. For instance, Willy suggested, “Because of their attitudes...They’re not playing the game right.” Jordan added, “Especially with the younger generation, how wild they are...The younger generation of African Americans is so violent that, uh, yeah, they stigmatize them because of that.” Nearly half of the participants attributed stigmatization of African Americans to racism. Tony pointed out, “Racism still exists, and black people and white people do not want to deal with it.”

When asked who stigmatizes African Americans, the participants responded with “other races.” A few participants stated that African Americans stigmatize each other. A few also mentioned that homeless shelters stigmatize African Americans.

Shared beliefs about stigmatization processes related to individuals with mental illness. All of the men in the study stated that they believe individuals with mental illness are stigmatized. Several of them stated that people with mental health

problems are simply devalued. As Jordan put it, “People look at you like, you know, you ain’t nothing.” Nearly half reported that individuals with mental illness are socially excluded. Tony, for example, stated, “We’re pushed to the side. Don’t nobody, you know, society don’t wanna deal with this. This is not a problem for them. This is more like, uh, a stock.” A few participants noted that individuals with mental illness are called degrading names (e.g., “crazy”), laughed at, or gossiped about. According to Malik, “These people are talked about behind their back.” A few participants also suggested that individuals with mental health problems are treated poorly (e.g., Willy: “They get treated poorly and badly. They don’t get no fair shake.”) or are otherwise avoided (e.g., John: “People are like, ‘Oh, he’s crazy, so I ain’t gonna deal with him.’”).

All of the participants speculated on why individuals with mental illness are stigmatized. The majority of participants attributed the maltreatment to fear of individuals with mental illness. As Smith put it, “I don’t know if I want to associate with a person like that because you never know, you never know.” John added, “Because they afraid you might snap on them, stuff like that.” Several of the participants noted that some individuals with mental illness may have unusual behaviors or appearances that contribute to the fear and/or stigmatization. Tony stated, “Some of them can’t talk too well. I have seen some sitting in their own feces...Just kind of, like, out there, you know what I’m saying? Hearing voices or stuff like that.” Brook suggested, “Would you like to be sitting around your friend or relative with Tourette’s or another kind of mental illness, and they made scenes or drooled or some other unacceptable gesture in public? No.”

When asked who stigmatizes individuals with mental illness, the majority of participants responded with “everyone.” Almost half admitted that they themselves

stigmatize people with mental health problems. A few reported that they believe homeless shelters and law enforcement also stigmatize individuals with mental illness.

Shared beliefs about stigmatization processes related to individuals with substance use disorders. All of the study participants agreed that individuals with substance use disorders are stigmatized. These men suggested that they are called degrading names related to their substance misuse. Jordan stated, “People call you ‘crackhead.’ Say, ‘You ain’t nothing but a drunk.’... Yeah, ‘crackhead,’ ‘dope fiend,’ any name you can think of, they call it.” A sizable number of the participants also stated that individuals with addiction problems are stigmatized in that they are expected to fail in their attempts to recover from addiction. John noted, “Some of them may even go so far as to say that once you’ve been doing that, you’re going to always be like that. Once a junkie, always a junkie.” Smith added, “A lot of individuals think that they’re not going to amount to anything... You never going to overcome your addiction. You just going to be a loser all your life.” Finally, a few of the participants described how individuals with substance use disorders are negatively stereotyped (e.g., as dangerous, criminals, “dirty,” “losers”), verbally shamed, and/or socially excluded.

Nearly all of the participants speculated on why individuals with substance use disorders are stigmatized. Most of the participants attributed maltreatment of these individuals to their behaviors (e.g., prioritizing substances over other responsibilities, being untrustworthy, being unpredictable, committing crimes to support their addictions). Shake noted, “I think because they chose their addictions over everything else. Bills, neglected bills. Neglected they family. Neglected they son. Neglected everything. Everything.” Malik added, “People with addictions lie. They steal to get what they want.”

Willy continued, “It’s hard for somebody to trust you when you got an addiction. Even your own family won’t trust you. You got to build trust.”

Many of the participants also attributed stigmatization of individuals with alcohol and other drug abuse problems to fear of what individuals with substance use disorders will do. Brook noted, “It’s a scary thing when a person is drunk or under the influence. You don’t know what they are going to do. They’re falling down, staggering, slurring, speech is slurred.” Jack added, “You can’t just say anything to a person that you know is high or drunk. ‘Cause he gonna snap back at you. He might even shoot you.”

Half of the participants pointed out that they believe individuals with addictions are stigmatized because addictions are commonly viewed as the result of poor self-control vs. a brain disease. Wayne suggested, “The one that was able to have a drink and then get up the next morning and make it to work couldn’t understand why that person that picked up a drink continued on drinking until it was time to go to work.”

When asked who stigmatizes individuals with substance use disorders, the majority of participants responded with “people who do not have addictions.” A few reported that they themselves stigmatize individuals with substance-related problems.

Shared beliefs about stigmatization processes related to individuals with criminal backgrounds. Nearly half of the men who participated in this study spontaneously discussed how they believe individuals with criminal backgrounds comprise an additional stigmatized group. A couple of them noted that these individuals are stigmatized by potential employers in that it is more difficult for them to get hired.

Core Category: Management of Multiple Stigmatization Processes

Data analysis yielded the identification of a core demand imposed upon and shared by the participants in this research study: management of multiple stigmatization processes. The men who participated in this study reported that they were multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way. All twelve of the research participants reported that they have personally been stigmatized with all but one of them being stigmatized for multiple conditions (e.g., substance use disorder in addition to housing status vs. “just” substance use disorder or “just” housing status). All twelve also reported that they have been impacted negatively, or in a disempowering manner, by stigmatization processes but that they have since learned how to cope with them in a helpful way. All but one of the participants indicated that they had previously coped with being stigmatized in an unhelpful or even destructive manner. Notably, the participants reported that they have most recently been impacted by stigmatization processes in a positive, or empowering, manner. At the same time, the men in this study still identified a few ideas for how they believe they would be able to reduce or cope with the negative impact of stigmatization even more effectively in the future. Overall, and as such, “management of multiple stigmatization processes” emerged as the core theme of this study. Interrelated categories/themes and subcategories/subthemes that are held together by this core category are discussed in detail below.

Personal Stigmatization Experiences

All twelve of the research participants reported that they have personally been stigmatized. Below is a presentation of findings related to the conditions (i.e., stigmas)

for which participants have been stigmatized, the various ways they have been stigmatized, their perceived reasons for being stigmatized, and the individuals who stigmatize them.

Stigmatized Conditions. The participants in this study were African American men experiencing chronic homelessness and co-occurring mental illness and substance use disorders. These men reported being personally stigmatized for a variety of conditions, or stigmas. All but one of the men in this study stated that they have been stigmatized for their housing status, or homelessness. Nearly all of them reported being stigmatized for their substance use disorders. Many suggested they have been stigmatized for their racial/ethnic minority status, or being African American. Several stated that they have been stigmatized for having a mental illness. Nearly half reported stigmatization related to their criminal histories. Notably, all but one participant noted being multiply stigmatized (i.e., stigmatized for multiple conditions vs. a single condition).

Multiple Stigmatization vs. Single Stigmatization. All but one of the men in this study reported that they have been multiply stigmatized. Nearly all of them also suggested that being multiply stigmatized is more difficult than being stigmatized for a single condition. The majority of participants attributed this relatively greater amount of difficulty to the idea that there is “more” stigmatizing and “more” stigmatization-related challenges with which to contend when being multiply stigmatized. Jordan, for instance, suggested, “Because you more stigmatized...More ammunition to use at you.” Tony added, “I think it’s a stronger impact because you already got one strike against you, you’re Black, African American. It makes it even more bad on you if you got a drug problem. It makes it even worse on you if you homeless. It makes it even worser if you

got a mental problem. So all that goes hand in hand.” Shake observed, “I mean, a man can only take so much, man. For real.”

Most Difficult Stigmas. Participants in this study were asked to rank the difficulty levels of the various stigmas they face and were given an opportunity to identify the stigma(s) or combination(s) of stigmas they find most upsetting or challenging. Notably, several discrepancies and contradictions were observed as the men shared their perspectives on this topic during the interviews. For example, a few of the participants did not end up ranking conditions for which they had previously stated they were stigmatized. Others ranked specific conditions as most difficult but later modified their responses when asked which stigma they find most upsetting or challenging. As such, no consistent themes or patterns emerged from this portion of the interviews, with the exception that participants typically identified homelessness as the especially difficult or upsetting stigma they face. Interestingly, half of the participants also noted that they first became aware of being stigmatized by others when they became homeless.

When asked to speculate on why homelessness comprises such a difficult or upsetting stigma, a few of the participants spoke to the idea that being homeless restricts accessibility of resources and contributes negatively to other stigmatizing conditions. As Willy put it, “Because, like I said, when you homeless, you lose a lot of outlets...Like the job, for instance...When you really need help, help pass you over. So homeless has a lot to do with your recovery, and work is part of your recovery. If you can’t, if you ain’t got no financial assistance, you’ll always be homeless. No matter what.” Malik added, “Like me being homeless, it’s more restrictions. It’s more stuff that I can’t do...stuff that’s easier to do is not easy to do compared to if I was not homeless.” Icy continued, “I would

say the homeless. I mean, you tired. You gotta find somewhere to lay down... You gotta figure out how you gonna bathe and what you gonna eat...the little things, you know. That's a lot; take a lot out of you. Take a hell of a lot out of you."

Non-stigmatized or Less Stigmatized Conditions. A few of the men in this study reported that they either did not face stigmatization or "as much" stigmatization for certain conditions, or stigmas. The conditions for which a few of the participants reported being either non-stigmatized or less stigmatized were homelessness and mental illness. A sizable number of the men who participated in this study offered a rationale for why they have not faced stigmatization or "as much" stigmatization for certain conditions, or stigmas. Namely, they stated that the lack of or lesser amount of stigmatization was due to the invisibility or concealability of that condition. As Jack, for example, noted, "People don't really know I'm from the shelter. They don't really know I have a mental problem. So, you see what I'm saying? Only time they really know that is if I tell them that."

Types of Stigmatization. The participants in this study described a variety of ways in which they have personally been stigmatized. Six types of stigmatization emerged as subthemes: negative stereotypes, lowered expectations, social exclusion, being called degrading names, being avoided, and being distrusted or feared. These are presented below.

Negative Stereotypes. Almost all of the men who participated in this study described negative stereotyping as a type of stigmatization they have personally experienced. They reported a number of stereotypes that other individuals have applied to them, including assumptions that they are "crazy," misusing substances, criminals, untrustworthy, and uncaring. Willy, for instance, described how he has been stereotyped

based on his physical appearance and homeless status: “They feel you could be a potential robber.” Icy noted that he has been stereotyped as “crazy” because he uses psychiatric medications. Tony reported an incident during which he was stereotyped as abusing alcohol and drugs because of his African American and homeless statuses and for having a history of substance-related problems: “My probation officer was so ticked off at me, she put me in jail for 5 days. ‘Cause she claimed that I had drugs and alcohol in my system. She never took a drop. She just told me that I’m still doing drugs...Because I was Black and homeless.”

Lowered Expectations. Most of the men described others’ lowered expectations for them as a form of stigmatization they have personally experienced. They reported that these “lowered” expectations primarily relate to (a) the assumption others make that the participants will never overcome their substance use disorders and (b) others’ continual reminders of mistakes or negative choices participants made in the past. As an example, Brook noted, “They ask, ‘When you going to start back [using]? How long is it going to last this time?’ That’s a stigma. They’re saying, ‘Oh, you don’t have the strength or the courage to continue on in a new life era.’” Willy offered, “I mean, they just come straight out and say, ‘You’ll be getting high. It’s just a matter of time.’” Wayne suggested, “They always bring up or remember what problems I did have or what life I did live...I won’t ever be let loose....They love you, but they remind you about, constantly, about your old...the pain that you brought upon them.”

Social Exclusion. Many of the men reported some form of social exclusion as a type of stigmatization they have personally experienced. Several of them noted that they believe they have intentionally been excluded by family and friends. For instance, Jordan

noted that his family no longer allows him to stay with them. Wayne and Shake both stated that they do not get visits from their family or friends. Brook suggested that he was not invited to family gatherings in the past because his family expected him to drink too much alcohol.

A few of the participants discussed how they have been excluded from the workforce. Willy suggested that he has been denied jobs because of his homelessness: “I done went to certain places and put an application in, and they’d tell me they don’t have any openings. Then I go back, and they be hiring somebody.” Malik noted, “Sometimes people will, like, hide positions...Like the lady in the office, not real helpful to you.”

Being Called Degrading Names. Many of the participants reported that they have been called degrading names as a form of stigmatization. Several of them reported being called degrading names related to their substance use disorders (e.g., “crackhead,” “drunk”), and a few reported being called degrading names related to their housing status (e.g., “hobo,” “tramp,” “bum”). Brook suggested, “Most people with chemical dependency and/or mental or homeless issues rarely open up because you’re a ‘hobo,’ ‘bum,’ ‘tramp,’ ‘yahoo’...you’re a ‘drug/crackhead,’ you’re ‘alcoholic,’ you’re ‘crazy.’ At some point or another, we’ve heard these things said to us directly or whispered from afar.” Smith added, “Even the individuals that sell the drug say, ‘Oh, here come that crackhead, that woo-woo.’”

Being Avoided. Half of the participants described how they have intentionally been avoided by others as a form of stigmatization. Jordan suggested, “Some people, they see us coming, they’ll walk across the street. Like, I’ve seen it. It’s happened to me before. They seen me coming, they go across the street.” Mike reported having similar

experiences as Jordan walking down the street: “If they feel I’m homeless or I’m walking down the street and they think I’m homeless, then they move over...Yeah, they walk across the street. Maybe not want to be bothered.”

Being Distrusted or Feared. Some of the participants also described being distrusted or even feared by others as a form of stigmatization they have experienced. Smith noted, “They look at you, they size you up. They wonder.” Icy described a specific incident during which he tried to visit his mother and she displayed distrust by not letting him into her home: “She opened the door. She looking outside, ‘What you want? What you want?’ ‘Mom, I just stop by. Can I come in?’ ‘No, ain’t nobody here to watch you. I ain’t gonna let you in my house for you to take something up out of my house.’”

Perceived Reasons for Stigmatization. All of the men in this study speculated on why they have experienced stigmatization. Two subthemes emerged from these speculations; participants made attributions to (a) societal stereotyping and application of stereotypes to themselves and/or (b) their own socially unacceptable behaviors. These are discussed below.

Result of Societal Stereotyping and Application of Stereotypes. The study participants attributed at least some of the stigmatization processes they have experienced to the existence of societal stereotypes and application of these stereotypes to themselves by others. Brook, for instance, suggested that he is stigmatized for his substance use disorder because of stereotypes that exist about individuals with addictions: “That reflects on me being an alcoholic even though people might not know who and what I am...Football players are expected to be big and strong, and alcoholics are expected to be non-caring, dirty thieves.” Willy provided another example of this process: “Because

there's so much activity on the street, you know, so much killing about drugs and alcohol, and people shooting. So how would it look? I'm on drugs. I drink, you know, so I'm not going to be no different from that guy on the corner that sells drugs and carry a gun."

Jordan added, "Say, for instance, they're watching TV and they see this movie. And they see a bum guy in the street or whatever. And they can pick it up from there, and then when they see a person that, in life, that's like that, they categorize them like [the one on TV]."

Result of Participants' Own Behaviors. The men who participated in this study also attributed at least some of the stigmatization processes they have experienced to their own socially unacceptable behaviors, including presenting an unusual physical appearance (e.g., being disheveled), becoming angry or aggressive, panhandling, committing a crime or putting others in jeopardy, violating others' trust, using substances, and engaging in unusual behaviors (e.g., digging through trash receptacles). Brook stated, "For one, I brought things upon myself. By my alcohol use. I was intoxicated and committed a crime. And I'm a felon...I put society in jeopardy." Willy suggested that some of the stigmatization he has experienced has been due to having an angry attitude: "Could be my attitude. Like I said, my drug and alcohol use. It changes your attitude. You get boisterous, angry about...really get angry at yourself. So you taking your frustrations out on other people, talking unnecessarily. Saying unnecessary things because you can't have your way and you want more drugs. Pointing the blame at others when it's your fault...And...when you behave a certain way, everybody finds out, because it's the word of mouth. 'He ain't to be trusted.'" Icy attributed stigmatization experiences to his appearance: "And just living a certain lifestyle. Living out here on the

streets. It take a wear and tear on you. You not sleeping, you not eating right. You not resting right. And you have this certain demon look to you. People are like, ‘Whoa, wait a minute. Something ain’t right with this cat here.’” John added that he also believes stigmatization occurs depending on self-presentation of the potentially stigmatized: “Well, it’s the way you present yourself to individuals. If you come to them all talking outta your head. Or it’s the way you carry yourself. That’s what it boils down to. Your character and stuff.”

Predominant Individuals Responsible for Stigmatization of Participants.

Participants were asked to identify individuals or groups of individuals who have stigmatized them. The majority of participants reported that they have been stigmatized by society in general. Most of the participants also described being stigmatized by their own families. Several noted that they have been stigmatized by friends. A few reported that they have stigmatized themselves, and a few others suggested they have been stigmatized by homeless shelters.

Impact of Stigmatization

All twelve of the men who participated in this study reported that being stigmatized has somehow impacted their psychosocial functioning. All of the participants stated that they have been impacted negatively, or in a disempowering manner, by stigmatization processes. The majority of the participants noted, however, that the impact of stigma has changed in that they have most recently been impacted by stigmatization processes in a positive, or empowering, manner. The specific types of impact that stigmatization has had on these participants’ lives are presented in detail below.

Previous Impact: Disempowerment. All twelve of the study participants reported that they have been impacted negatively, or in a disempowering manner, by stigmatization processes. Although the majority of these men suggested that the disempowering impact has lessened over time, they also described it as profoundly negative and distressing in nature. As Willy put it, “This stigma, or stigmatizing, is something powerful. That’s something that goes through my mind daily. You think about it everyday. Yeah. Just about.” Tony stated, “It’s very hard to deal with.” Jack noted, “It make me feel like shit.” Jordan added, “It still bothers me, you know. It still bothers me.” Smith shared, “That stuck with me for a long time, man. That really stuck with me for a long time...I still get kind of choked up, you know, because...not only for myself but for other homeless individuals who are still struggling.” Overall, the participants identified three types of negative, disempowering impact that stigma has had on their lives: negative emotions, reduced self-concept, and interpersonal distancing.

Negative Emotions. All twelve of the men who participated in this study reported that being stigmatized has resulted in the emergence of negative, unwanted emotions (e.g., general emotional pain, sadness, frustration, anger, fear, worry, aggression, hatred, shame, guilt, embarrassment, stress, exhaustion). The majority of participants reported that they have experienced anger, frustration, or resentment in response to stigmatization processes. As Willy stated, “Believe me, it’s not good to be stigmatized. It’s not no good feeling. It stirs up a whole lot of things, you know. Anger. Frustration. Just a lot of mixed emotions. A lot of negative emotions.” Icy observed that stigmatization sometimes resulted in anger directed at self, while Mike noted that his anger was directed toward others (i.e., the stigmatizers). Nearly half of the participants described angry feelings

escalating into aggressive ideation after being stigmatized. Jack, for example, shared, “It make me wanna beat somebody and show them different. That I am somebody...It make me wanna just holler out and hit somebody in the neck or slap somebody in the face. They say something crazy, or be fucking with me about being locked up in a place like this [shelter].” Icy added, “It made me crazy, or made me start gangbanging...Just being aggressive and just not caring.”

Most of the participants also reported that feelings of sadness, depression, or generally feeling “down” resulted from stigmatization processes they faced. Tony noted, “It had to make me depressed...to think about it everyday, to have to deal with it everyday. This is something I have to deal with until the day I die...Sometimes I just go to be by myself, and just cry. You know, walk down by the lakefront, and cry. It’s real bad.” Smith suggested, “It saddens me...I think a lot of my depression, you know, I think that’s where it comes from.” Brook also contributed, “That make me feel kind of sad for society.”

Several of the participants indicated that being stigmatized simply “hurts.” Wayne, for instance, described, “There was that old saying that just came to me about it. They say, ‘Sticks and stones may break my bones, but words will never hurt.’ It’s not true. It’s not true. It does hurt. It is [painful]. You become...how can you say it? Emotional.” Jordan acknowledged, “It’s hurtful. It’s hurtful.”

Nearly half of the participants also described stigmatization experiences as emotionally tiresome or exhausting. Malik, for example, stated, “When I’m dwelling on negative stuff like that, it just really make me tired.” Tony added, “It’s making me tired...My mind is tired. It’s stressing me. It’s stressing me out totally.”

Reduced Self-concept. Nearly all of the study participants described stigmatization experiences resulting in a reduced self-concept, or a negatively altered sense of self. As Smith put it, “Just lost total respect for myself...I didn’t ever think I was going to be able to get myself together. ‘Cause it [the idea of being a loser] was just implanted. I mean, I actually thought, ‘Man, that’s what I am.’...I didn’t know what I was...I actually started to believe it. I started to live it...I actually thought I was a loser...For a long time, I actually felt like I’m going to be stuck like this forever.” Wayne added, “It makes you feel...like you’re not really worth much. You’re not really a person. Like you don’t have any feelings...You just think about yourself as hopeless, worthless...It can bring you to thoughts of, ‘What’s the sense of being here?’” Tony noted, “It changes the way you feel about yourself...You feel the way they [stigmatizers] feel when they talk: ‘I ain’t gonna be nothing. I ain’t gonna amount to nothing.’ Or, ‘I ain’t got nothing.’...It drags you into the ground.”

Interpersonal Distancing. Most of the men in the study also indicated that being stigmatized resulted in interpersonal distancing from others, both behaviorally and cognitively. Many of the participants described distancing themselves behaviorally from other people as the result of stigmatization. Behavioral interpersonal distancing was described as intentionally isolating themselves from others or choosing not to “open up” when in the presence of others. Icy, for instance, noted, “I’m a pretty quiet guy now. I don’t really talk too much now.” Brook shared, “It’s difficult to open up to people.” Wayne and Malik described themselves as socially “withdrawn.” Smith added, “I never really reached out for that help until, really, a few years ago.” Jordan reported, “Well, I

tend to travel alone. Be by myself. So I don't have to hear all this [stigma-related] nonsense.”

Several of the men also described themselves as distancing themselves cognitively from others. Cognitive interpersonal distancing was described as thinking about how they do not “belong” in mainstream society and how they are excluded, isolated, and alone. As an example, Jack stated that he has thoughts that “Nobody cares for you but yourself.” Wayne noted, “It makes you feel...like you don't belong.”

More Recent Impact: Empowerment. Most of the men who participated in this study reported that the impact of stigmatization on their psychosocial functioning has changed. These participants indicated that it has changed in that they have most recently been impacted by stigmatization processes in a positive, or empowering, manner. Namely, the participants reported that they have (a) developed determination to improve their life circumstances, (b) decided to seek professional treatment, and (c) experienced increased sensitivity toward and desire to help other stigmatized individuals – all in response to their own personal experiences with stigmatization.

Tony offered an example of this overall change process from disempowerment to empowerment: “I don't feel as bad as I did the last time I was homeless. And the reason why is because I looked at it [homelessness] in a different way [then]. I looked at it as a taboo thing; it was a real bad thing. I mean, it is a taboo thing; it is a bad thing. But I don't have to feel that way. I don't have to judge myself today. I can look in the mirror and be proud of myself today, when last time I was homeless, I couldn't do that. I didn't have the strength to do that. I was beaten and tore down so bad from people talking about me or not giving me a helping hand.” Wayne added, “So I look back on that stigma as a

reminder, and to not use it as a victim, but to use it as a strength today. Wow!” Below is a discussion of the three positive, or empowering, types of impact that stigmatization has had on the participants’ lives.

Determination to Improve One’s Life Circumstances. Several of the participants reported that being stigmatized increased their determination to improve their life circumstances, primarily by “getting [their] lives in order.” Willy, for example, noted, “I think that [stigmatization] really makes me more determined to get it right, get my life in order...It makes me stronger. It makes me feel that I’m gonna reach my goal. I’m gonna get me a job. I’m gonna prove them all wrong. I’m gonna do this, and nothing’s gonna stop me.” Malik suggested, “It makes me that much more determined to get myself in the situations where I can be treated fairly as an adult and a hard-working Black man. Motivation. That’s what I think it is.” Jack added, “It makes me feel more aspiring to prove to them [stigmatizers], as well as myself, that I just made a mistake, and I wasn’t looking for this to happen. But that I got something in mind to do about it and I want to do about it.” Finally, Jordan suggested, “People could say so much to you that it could draw you backwards. But I’m using that as motivation. Because people are looking for me to fail, I’m out to prove them wrong and to prove something to myself.”

Treatment-seeking Behaviors. The majority of the participants also suggested that being stigmatized encouraged them to seek professional treatment (e.g., mental health/substance-related counseling). Several of the participants indicated that they decided to seek treatment because they no longer wanted to be stigmatized and/or wished to “prove [stigmatizers] wrong” about them. A sizable number of the men identified substance addiction as the primary stigmatized condition that encouraged them to seek

services; a few identified homelessness. A couple of the participants also commented that they used their experiences being stigmatized to obtain supportive services (i.e., operated under the assumption that some people actually “reach out” to those who are stigmatized). For example, Shake observed, “I hate to say it, you know, but people are willing to help alcoholics. People are willing to help the disadvantaged...I’m living testimony. I see it happening, man.” Jack added, “Because I’m homeless, ‘cause I don’t have nothing. That’s what helped me go to these people to help me...They got to help me with this ‘cause I don’t have nothing man. I don’t have a pot to piss in.”

A quote from Icy helps to illustrate how being stigmatized encouraged participants to seek treatment: “I got tired of people looking down on me. I get mad, and I tell them, ‘I’m gonna get my shine on one day.’ And meant by ‘shine,’ I’m gonna get myself together.” Brook noted, “I don’t want to be stigmatized as a drunk, period...I just made the decision, and it’s made me urgent in seeking positive help.” Jordan commented, “Just tired of being name-called, the stigma, everything that comes with it. It’s just not cool with me...The name-calling and the stigma, it’s motivation enough [to seek treatment].”

Increased Sensitivity Toward and Desire to Help Other Stigmatized Individuals.

All of the participants indicated that being stigmatized increased their sensitivity toward and/or their desire to help other stigmatized individuals and, more specifically, other individuals experiencing homelessness. Almost all of the participants stated that being stigmatized has increased their desire to demonstrate compassion toward, encourage, or provide resources to other individuals who are homeless. Brook, for example, described his response to seeing other individuals experiencing homelessness: “I have sympathy for

them, and I try to give them the best information I can tell them...I try to help them.” Wayne noted, “I have a deep compassion towards them [other individuals residing at HSA]. Worry when one of them goes out the door because it could be me.” Tony added, “I’ve been learning to talk to people and let them know you gotta be strong, don’t give up, keep going to your drugs and alcohol meeting, try to stay sober...I’m always passing out papers and flyers and things about where you can go to eat, where you can go to sleep tonight, and this, that, or the other thing.”

Many of the participants also noted that they actively try not to stigmatize other individuals who are homeless or carry other stigmatized statuses. Smith, for instance, noted, “I try not to stigmatize anyone...because, like I say, I’ve walked in your shoes. I know what it’s like to be stigmatized.” Jack suggested, “I can’t judge them for what they is, and no way they can judge me. All I know is we in the same boat together, and we are trying to do better for ourselves.”

Coping with Stigmatization

All of the men who participated in the current study described their various strategies for coping with or managing being stigmatized by other individuals. All but one of them noted that their coping responses have changed over time. All eleven participants who stated that their coping has changed indicated that they had previously coped with being stigmatized in an unhelpful or even destructive manner. All of the participants described their current coping strategies as helpful and constructive. Below I present the findings related to the participants’ previous coping strategies (i.e., substance misuse, aggression and violence, doing nothing/taking it) and their more recent coping strategies (i.e., acceptance/dealing with it, letting go and moving on, focusing on

self/goals, disproving stigmatizers or reducing reasons to be stigmatized by them, distancing self from stigmatizers, using positivity, turning to faith/religiosity, using distraction).

Previous Coping: Perceived as Unhelpful. The study participants reported that they coped with stigmatization experiences differently in the past than they have as of late. Namely, they reported abusing substances, using aggression and violence, and doing nothing/taking it [the stigmatization]. Notably, these participants described all three of these approaches as unhelpful in managing stigmatization processes (at least in the long-term; a couple participants described these approaches as having short-lived benefit).

Substance Misuse. The majority of participants reported that they abused alcohol and/or drugs to cope with stigmatization experiences in the past. For example, John mentioned, “I turned to drinking and drugging. That was my escape. That was my crutch.” As Jordan put it, “Well, since they already think I’m an alcoholic, I might as well drink. I can get into that role.” Willy noted, “I thought, ‘Forget them all. I’m gonna get high.’”

The men who used this coping strategy reported that it was ultimately unhelpful, though a couple of them suggested that substance intoxication offered a short-term escape from stigmatization. As Jack put it, “It help me to relieve, to escape...I just wanna get away from it. But when I get out of it, come down, that’s when it scares me. ‘Cause I gotta look at it.”

Aggression and Violence. Nearly half of the study participants described using aggression or violence to cope with stigmatization experiences. Brook stated, “I dealt with it in an aggressive way. If I felt I was being put down, or devalued, and the

opportunity would arise, I would use violence...I used illegal means to get back at people who put me down because of alcoholism, my complexion, my criminal history, my age.” Icy described how he personally used aggression and violence: “Gangbanging and just acting a fool. Wanting to take shit, robbing folks, and all kinds of crazy stuff. Lots of insane stuff, been in the penitentiary. Nearly lost my life twice.” Shake reported, “Once upon a time, I used to fly off the handle. Try to make a motherfucker see me...try to prove them wrong...Oh boy, fought. Cuss you out. Bully you...You ain’t gonna whoop my ass, you know what I mean. I refuse to be whooped.”

With the exception of one participant who stated that being physically intimidating staved off stigmatizers, the individuals who reported using this strategy stated that it was ultimately unhelpful. Brook noted, “It was counterproductive.” Malik reasoned, “I didn’t really accomplish too many goals, so nah, it didn’t really help me.”

Doing Nothing/Taking It. Several men who participated in this study describing “doing nothing” or simply “taking it” in response to stigmatization. Smith mentioned, “I couldn’t do nothing. I was just stuck.” As Tony noted, “I wasn’t doing anything about the situation...I wasn’t trying to put effort in.” Willy suggested, “When I got stigmatized previously, I would just try to run and hide...wondering...would I be able to make it.” The participants who responded to stigmatization in this manner described it as unhelpful. As Tony simply stated, “No, it wasn’t helping me.”

More Recent Coping: Perceived as Helpful. All of the participants described a variety of current coping strategies they use to manage stigmatization processes. The subthematic coping strategies that emerged from data analysis included: acceptance/dealing with it, letting go and moving on, focusing on self/goals, disproving

stigmatizers or reducing reasons to be stigmatized by them, distancing self from stigmatizers, using positivity, turning to faith/religiosity, and using distraction. These were all described as helpful and effective in managing the psychological demands associated with being stigmatized. As Jordan noted, “It done got better over time because I just learned how to deal with it.” Tony added, “I don’t blame no more. I don’t blame this person or that person and sit in pity and cry about it, and don’t do nothing about it. It’s changing because I’m doing something about it...It’s changing because I’m feeling better about myself.” The participants’ current strategies for coping with stigma are described in detail below.

Acceptance/Dealing with It. The participants identified accepting that stigma exists and “just dealing with” its existence as one of their current coping strategies. Brook explained, “I’ve learned to accept that that’s just the way it is. I can’t change other people. There’s nothing I can do about it. I can’t change the way that person feels. A lot of times they can’t change the way they feel because a lot of the time they don’t even know how they feel.” Smith added, “If they’re going to stigmatize me, they’re going to stigmatize me.” Jordan noted, “And people just gonna be people. There’s nothing I can do about that. It’s the way I got to deal with it.” John continued, jokingly, “I just accept the fact I’m Black.” He elaborated, “It’s nothing I can change about it. I just have to accept that that’s life. If an individual wants to be prejudiced or discriminatory towards me, that’s on them.” Malik added, “I just deal with it. Try not to let it get to me. Try not to let it affect my life too much.”

Letting Go and Moving On. Letting go of stigmatizing experiences and simply moving on with one’s life was described as another coping strategy used by the majority

of study participants. As Smith stated, “It’s just an individual’s opinion, you know. You just let it run off of you, man. As long as you know that you stand for something and you’re working on something, it’s okay... You let it go... Keep moving.” Wayne explained, “Not really giving up, but letting go... Work on moving on to things that are best for my life today.” Mike commented, “I just let it go. My thought it is people gonna think what they want to think.” Shake added, “I try not to pay attention to it, man. I try to let it brush off my shoulders and keep on walking. I don’t let it bother me... In one ear, go out the other.”

Focusing on Self/Goals. Most of the participants described how they cope with stigmatizing experiences by focusing on themselves and their goals instead of attending to and focusing on the stigmatizing experience. Smith reported, “All I can basically do is try to work my program right now.” Icy noted, “I’m gonna get up and brush myself off and do what I need to do for me... I need to be selfish and stay selfish and try to do what’s right... If I stay focused on that, then a lot of shit will fall into place.” Malik offered, “I try to stay focused on getting my life together, and I need it.” Brook noted that he responds to others’ stigmatizing expectations that he will relapse by “continuing to do what [he] do[es],” namely, continuing to apply for jobs so he can join the workforce again.

Disproving Stigmatizers or Reducing Reasons to Be Stigmatized by Them.

Almost all of the participants noted that they cope with stigma by either disproving their stigmatizers’ assumptions and expectations or reducing reasons to be stigmatized by potential stigmatizers. Brook stated, “I try to make that person question their own beliefs by doing the opposite of what they expect. A homeless person should be dirty, drunk,

ignorant, a thief, and I'm none of those. I show people I'm not a liar." Wayne continued, "I wasn't gonna let myself be as what they might perceive me to be." Willy noted that he intentionally treats himself the way he wants to be treated by others, including potential stigmatizers: "You got to respect yourself in order to get respect. If you don't respect yourself, you're not going to get any." John added, "[If] people see you trying to make it ahead, they gonna help you." Shake explained how he attends to his hygiene to prevent stigmatization: "Making myself up, taking care of myself, man, for real. I have tried to dress the best that I can, to keep shaved. I don't wanna give nobody no reason to talk about me."

Distancing Self from Stigmatizers. Another coping strategy employed by the majority of the study participants was reported to include distancing themselves from stigmatizers. Distancing was said to take a variety of forms, including avoiding potential stigmatizers, ignoring stigmatizers when being stigmatized, and literally walking away from situations during which participants got stigmatized. As Willy put it, "I don't deal with them. I avoid them." John agreed, suggesting, "I avoid people with prejudices and that kind of stuff." Jordan stated, "I just started ignoring it...I just let people be people." Wayne displayed pride in his ability to walk away from stigmatizers as he aged: "After I got older...I felt more of a man that I was able to walk away." Mike noted, "I know how to get up and move away."

Using Positivity. Several participants discussed using positivity to cope with stigmatization experiences, whether it be reframing a negative event in a positive way, thinking positively in general, surrounding themselves with positive individuals, or doing something positive for someone else to make themselves feel good. As Willy suggested,

“I think about myself positive, that’s the only thing that keeps me motivated. I don’t think nothing negative of myself. I try to turn the negative into positive.” Smith described his use of positivity: “Just trying to be around positive people, trying to go positive places, just trying to live a positive lifestyle. Trying to read something positive. Something that’s going to pick me up.” Tony continued, “I try to do anything positive to help me fix the negative. That way, my day will be complete.”

Turning to Faith/Religiosity. Many of the men who participated in this study described using their faith or religious beliefs to help them cope with being stigmatized members of society. They discussed engaging in spirituality-based activities like attending religious services, reading the Bible, and praying. Smith reported, “I look to a higher power.” Icy noted, “I pray and talk to God a lot...I don’t need nobody’s approval but his.” Jack noted that he reads his bible and prays to God to help him through stigmatizing situations he faces. Shake noted that he now goes to church regularly.

Using Distraction. Half of the participants reported engaging in a cognitively-distracting activity to help them cope with stigmatizing experiences. Such activities were reported to include reading, writing, listening to music, and being physically active (e.g., playing sports). Wayne stated, “What I do now, is some reading and writing.” Jack noted, “Usually I listen to music. I block it out.” John suggested, “I’m into books. Anything that keeps myself away from that.” Tony explained how helpful distraction has been for him: “I was more depressed when I wasn’t reading and listening to music...You gotta have some type of an outlet.”

Ideas for Reducing the Negative Impact of Stigmatization Better in the Future

Although the men in this study suggested that their current (or more recently utilized) coping strategies for managing the negative psychosocial impact of being stigmatized are helpful, effective, and/or constructive, they still identified a few ideas for how they believe they would be able to reduce or cope with stigmatization even better in the future. These ideas included (a) continuing to improve their lives and reduce reasons to be stigmatized altogether and (b) talking to a mental health professional about their experiences being stigmatized. These ideas are described in greater detail below.

Improving Lives and Reducing Reasons to Be Stigmatized. The majority of the men in this study stated that improving their lives and reducing their reasons to be stigmatized altogether would help them to manage stigmatization processes better. They cited several ways they could improve their lives and/or reduce their reasons to be stigmatized, including maintaining abstinence from alcohol and drugs, obtaining employment, living independently in their own homes, and achieving financial stability. Willy, for instance, explained how having a job would help him to manage stigmatization better in the future: “Because then I would have some responsibilities. I would feel that me handling responsibilities and being responsible will have a big effect because people will see, ‘Well, he’s got his own house, he’s doing this, and he’s working.’ Stuff like that. ‘And he still has his own home after a year or so, so it’s good.’” Jordan suggested “changing [his] life” would help him to cope better: “Try to get gainful employment. Stop being homeless. Don’t drink. Don’t use drugs. Try to become a productive member in society. And people will get a different opinion about you... There are always two sides to a story, and the way I look at it is... what do I play in this role? My role is being

homeless and drinking alcohol and stuff like that. So now it's time for me to make a change, so the role will be reversed for me....I play a big role in this.” John described a similar idea: “Stay clean, like I'm doing now. I think once a person, or some individuals see that I'm trying to do the right thing and everything, that they'll help me. So the stigmatizing probably wouldn't bother me that much because I'm getting help for my symptoms.”

Talking to a Mental Health Professional about Being Stigmatized. None of the men in this study suggested that talking to someone about being stigmatized would help them to manage stigmatization processes more effectively when asked what would help them to manage stigma better in the future. However, all but one indicated that they would want to talk to someone about stigmatizing experiences they have faced when asked whether they would want to talk to someone about such experiences. Furthermore, the majority of these eleven participants identified a mental health professional as the type of person they would want to talk to. Interestingly, only two stated that they actually turn to a mental health professional to help them cope with stigmatization at this point in time.

The study participants identified a variety of reasons why they would want to share stigmatizing experiences with a mental health professional. These reasons were reported to include the opportunity to “release feelings,” relapse prevention, obtaining assistance focusing on the positive and “dealing with” stigmatizing experiences, and the perception that mental health providers are compassionate. As Jordan suggested, “That person [substance abuse counselor] is understanding and compassionate. And they really go out of their way to help you deal with whatever's going on with you.” Shake noted, “I

got a lot on my chest, man. I'd like to get it off....Maybe they [counselors] can give me some better ideas about how to handle certain situations.”

General Findings Related to Participants' Help-seeking Behaviors. In addition to the participants' aforementioned ideas for managing stigmatization processes more effectively in the future involving seeking and remaining engaged in supportive services (e.g., mental health/substance-related counseling, temporary housing, job training, case management, etc.), there were other ancillary findings related to their help-seeking behaviors that have not otherwise been discussed in this chapter. First, when asked what helped these men to seek services at HSA, they named a variety of factors. These factors generally included wanting to quit using alcohol and other drugs, realizing they needed professional help to overcome their problems, receiving a positive recommendation from someone else about HSA programming, knowing of HSA's positive reputation and its wide variety of offered resources, and spirituality - in addition to having determination/desire to improve their life circumstances and wanting to reduce stigmatization, both of which were discussed previously in the impact section. As reported previously, the majority of the study participants suggested that being stigmatized actually encouraged them to seek professional treatment (at least after a certain point).

When asked what stopped them or hindered them from seeking services at HSA, the majority of participants referenced difficulties associated with their substance use disorders (e.g., wanting to keep using, having strong cravings/urges, and being around other substance users who discouraged them from seeking help). Only a couple of the participants indicated that previous stigmatization experiences impacted their treatment-

seeking behaviors in a negative way, though a few also acknowledged that they experienced some form of emotional distress (e.g., anxiety, apprehension, fear) associated with asking for help given previous stigmatization they had experienced.

Finally, when asked for their reasons for remaining engaged in treatment, all but one of the participants cited their desire for a better life, and, as noted previously, several of these participants reported that being stigmatized actually increased their determination to improve their life circumstances (at least after a certain point in time). Additionally, many of the participants also reported that having a good experience in treatment (i.e., finding it helpful or effective) was another reason they remained engaged.

Summary

To summarize the major findings, the overarching theoretical scheme (Strauss & Corbin, 2008) that emerged from data analysis was that these participants are multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way. The central, core category that emerged from grounded theory coding procedures was “participants’ management of multiple stigmatization processes.” Results revealed that (a) these participants have been multiply stigmatized, (b) they perceive the stigma of homelessness as the most difficult stigma with which to contend, and (c) they believe it is more difficult to be stigmatized for multiple reasons than for a single reason alone. Results also indicated that the impact of stigmatization on the participants’ lives has changed over time (from disempowerment to empowerment) and that the participants have altered their strategies for coping with stigmatization (from unhelpful and destructive to helpful and constructive).

Chapter V: Discussion

The purpose of the present study was to build a theory of stigmatization of the homeless population in light of the preexisting research on stigma and the preexisting research on homelessness. The primary research question affiliated with this study was, “How do individuals facing homelessness experience and respond to social stigmatization?” More specific research questions subsumed under this general research question included the following: (a) “How are individuals facing homelessness impacted by stigmatization, if at all?” (b) “How does stigmatization influence the way individuals who are homeless perceive themselves, other individuals who are homeless, non-homeless individuals, and treatment services?” (c) “How do individuals experiencing homelessness manage or cope with their devalued social identity?” and (d) “How does stigmatization influence the decisions of individuals who are homeless to enter and remain engaged in mental health/substance-related treatment?”

This study explored how a specific subgroup of the homeless population experiences and responds to multiple sources of stigmatization: African American men facing chronic homelessness and co-occurring mental illness and substance use disorders. Twelve men participated in individual interviews during which they were asked to discuss their beliefs about stigma, personal experiences being stigmatized, the perceived impact of stigmatization on their psychosocial functioning, coping strategies they employ in response to stigmatization, and treatment-seeking behaviors. Grounded theory methodology (Strauss & Corbin, 1998; Corbin & Strauss, 2008) was used to analyze data yielded from the interviews. The purpose of this chapter is to review the study findings and discuss them in relation to the preexisting research on stigma and homelessness.

Summary of study findings: How do individuals facing homelessness experience and respond to social stigmatization?

The men in this study described their beliefs about stigmatization processes both in relation to stigmatized groups in general and their personal experiences as members of stigmatized groups. The overarching theoretical scheme (Strauss & Corbin, 2008) that emerged from data analysis and attends to the aforementioned research questions was that study participants (i.e., sheltered African American men facing chronic homelessness and co-occurring mental illness and substance use disorders in treatment and maintaining sobriety) are multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way. The central, core category that emerged from grounded theory coding procedures was “participants’ management of multiple stigmatization processes.”

The men in this study discussed how they are multiply stigmatized (i.e., stigmatized for their housing status, racial/ethnic minority status, mental illness, substance use disorders, criminal histories) and how homelessness represents their most difficult stigmatized condition. They described various types of stigmatization they personally face (i.e., negative stereotypes, lowered expectations, social exclusion, degrading name-calling, being avoided, being distrusted or feared) and identified their primary stigmatizers (i.e., society, family, friends). They provided two primary hypotheses for the cause of their stigmatization (i.e., societal stereotyping with application of stereotypes to themselves as well as their own behaviors). They also discussed the impact that stigmatization has had on their lives both in the past (i.e.,

disempowerment: negative emotions, reduced self-concept, interpersonal distancing) and more recently (i.e., empowerment: determination to improve life circumstances, treatment-seeking behaviors, increased sensitivity toward and desire to help other stigmatized individuals). They also identified and evaluated the strategies they have used to deal with stigmatization both previously (i.e., substance misuse, aggression and violence, doing nothing/taking it – all described as unhelpful) and currently (i.e., acceptance/dealing with it, letting go and moving on, focusing on self/goals, disproving stigmatizers or reducing reasons to be stigmatized, distancing selves from stigmatizers, using positivity, turning to religion/faith, distracting themselves – all described as helpful). Finally, they shared ideas for how they can manage stigmatization even more effectively in the future (i.e., improving their lives/further reducing reasons to be stigmatized, talking to a mental health provider about stigmatization experiences).

How are individuals facing homelessness impacted by stigmatization, if at all? All twelve of the men who participated in this study reported that being stigmatized has somehow impacted their psychosocial functioning. All of the participants stated that they have been impacted negatively, or in a disempowering manner, by stigmatization processes. They described stigmatization processes as profoundly negative and distressing in nature. They reported experiencing negative emotions, reduced self-concept, and interpersonal distancing as a result of being stigmatized. The majority of the participants noted, however, that the impact of stigma has changed in that they have most recently been impacted by stigmatization processes in a positive, or empowering, manner. More specifically, they noted that they have (a) developed determination to improve their life circumstances, (b) decided to seek professional treatment, and (c) experienced

increased sensitivity toward and desire to help other stigmatized individuals – all in response to their own personal experiences with stigmatization.

How does stigmatization influence the way individuals who are homeless perceive themselves, other individuals who are homeless, non-homeless individuals, and treatment services? Nearly all of the study participants reported that being stigmatized resulted in a reduced self-concept, or a negatively altered sense of self, at least when the impact of stigmatization was described as being disempowering. The participants also described the idea of carrying a stigmatized status as a painful experience with which to empathize. For instance, they all indicated that being stigmatized increased their sensitivity toward and/or their desire to help other stigmatized individuals and, more specifically, other individuals experiencing homelessness. Many of the participants noted that they actively try not to stigmatize individuals who are homeless or carry other stigmatized statuses.

Participants' disclosures about the interpersonal distancing and negative emotions resulting from stigmatization experiences spoke to their perceptions of individuals different from themselves (e.g., individuals who are not homeless). Participants' discussion of interpersonal distancing (often a result of feeling distrustful of others or as though they do not "belong" in others' social circles), for instance, implied that they have perceived other, non-homeless individuals as potential stigmatizers. Additionally, many of the participants described developing angry feelings and aggressive ideation directed toward individuals who stigmatize them. Although participants typically attributed stigmatization to stereotype application processes, their discussion of negative emotions

resulting from stigmatization experiences suggested that they perceive stigmatizers negatively (e.g., as being hurtful or ignorant).

Interestingly, only a couple of the participants indicated that previous stigmatization experiences impacted their treatment-seeking behaviors in a negative way. In fact, the majority of the study participants suggested that being stigmatized actually encouraged them to seek professional treatment (at least after a certain point), and many of them noted that they would want to talk to a mental health professional about their experiences being stigmatized in order to help them manage these experiences more effectively.

How do individuals experiencing homelessness manage or cope with their devalued social identity? All of the men who participated in the current study described various strategies for coping with or managing being stigmatized by other individuals. All but one of them noted that their coping responses have changed over time. All eleven participants who stated that their coping has changed indicated that they had previously coped with being stigmatized in an unhelpful or even destructive manner (i.e., via substance misuse, aggression and violence, and doing nothing/taking it). All of the participants described their current coping strategies (i.e., acceptance/dealing with it, letting go and moving on, focusing on self/goals, disproving stigmatizers or reducing reasons to be stigmatized, distancing selves from stigmatizers, using positivity, turning to religion/faith, and distracting themselves) as helpful and constructive.

How does stigmatization influence the decisions of individuals who are homeless to enter and remain engaged in mental health/substance-related treatment? As aforementioned, only a couple of the participants indicated that previous

stigmatization experiences impacted their treatment-seeking behaviors in a negative way. The majority of the study participants, in fact, suggested that being stigmatized actually encouraged them to seek professional treatment (at least after a certain point). When asked for their reasons for remaining engaged in treatment, all but one of the participants cited their desire for a better life, and several of these participants reported that being stigmatized actually increased their determination to improve their life circumstances (at least after a certain point in time). Additionally, many of the participants also reported that having a good experience in treatment (i.e., finding it helpful or effective) was another reason they remained engaged in treatment. Furthermore, many of the men noted that they would want to talk to a mental health professional in the future about their experiences being stigmatized in order to help them manage these experiences more effectively.

Discussion of Study Findings

In this section, I discuss the major study findings in relation to previous literature on stigma and homelessness. More specifically, I discuss the findings related to participants' personal stigmatization experiences, the impact of stigmatization on these participants' lives, participants' strategies for coping with or managing stigmatization experiences, and participants' ideas for reducing the negative impact of stigma more effectively in the future. A section below is also dedicated to the importance of considering the participants' unique context (e.g., having co-occurring disorders, being sheltered, participating in mental health/substance-related counseling, maintaining sobriety) when interpreting study findings. Following this section, I offer hypotheses on (a) why and when the impact of stigmatization on the participants' lives has changed as

well as (b) why and when participants' strategies for managing stigmatization have changed.

Participants' personal stigmatization experiences. All twelve of the research participants reported that they have personally been stigmatized, and all but one reported being stigmatized for multiple conditions (e.g., homelessness, African American heritage, and substance use disorders vs. "just" homelessness, "just" being African American, or "just" substance use disorders). These findings were not surprising given participants' membership in multiple groups that are stigmatized (Conner & Rosen, 2008; Lee et al., 2004). Additionally, it was not surprising that the men in this study suggested that they find it more difficult to be multiply stigmatized than stigmatized for a single condition given the potential for an additive effect of multiple stigmatization suggested by the preexisting literature on stigmatization processes (e.g., Conner & Rosen, 2008; Corrigan, 2004; Gary, 2005a; Gary, 2005b). Overall, this study supports the idea of an additive effect of multiple stigmatization.

It was interesting that participants typically identified homelessness as the especially difficult or more upsetting stigma they face. A possible explanation for this finding may be the correlates between homelessness and other stigmatized conditions (e.g., racial/ethnic minority status - Shinn, 2007; mental illness - Littrell & Beck, 2001; substance use disorders - Green, 2005; criminality - Stein & Gelberg, 1995) and how homelessness can contribute negatively to these other conditions. As a few of the participants noted themselves, being homeless restricts accessibility of resources and makes it difficult to overcome other stigmatizing conditions (e.g., substance addiction; Thompson et al., 2004). Furthermore, as half of the participants suggested, individuals

who are homeless are often blamed for their housing status (Lee et al., 2004), and research has shown that individuals considered to have controllable stigmas are more stigmatized than individuals believed to have little or no control over their stigmatizing condition (Crocker et al., 1998; Dovidio et al., 2000).

Participants occasionally suggested that they either did not face stigmatization or “as much” stigmatization for their housing status. The rationale offered for why there was a lack of or lesser amount of stigmatization for their housing status involved the invisibility or concealability of that condition. Some stigma researchers (e.g., Jones et al., 1984; Crocker et al., 1998) have noted that stigma concealability plays an important role in stigmatization impact.

The men in this study reported the various types of stigmatization they personally face to include negative stereotypes, lowered expectations, social exclusion, degrading name-calling, being avoided, and being distrusted or feared. All of these are consistent with conceptualizations, correlates, or manifestations of stigma described within the literature on stigma. Link and Phelan’s (2001) conceptualization of stigma, for instance, suggested that stigma occurs as a result of several interrelated components that co-occur: labeling, stereotyping, separation, status loss, and discrimination. As another example, Dovidio et al. (2000) noted that stereotyping and prejudice are central manifestations of stigmatization processes. It should also be noted that the types of stigmatization reported by the current participants have also been reported by participants from other studies examining societal maltreatment of the homeless population reviewed in Chapter II (e.g., Lankenau, 1999; Miller & Keys, 2001).

The two primary hypotheses offered by participants for the cause of their stigmatization (i.e., societal stereotyping with application of stereotypes to themselves as well as their own socially unacceptable behaviors) are consistent with the literature on stigma. Social cognitive theorists (who have made sizable contributions to the research body on stigma), for instance, believe that people construct categories and link categories to stereotyped beliefs and expectations to make sense of their worlds (Deaux & Ethier, 1998; Link & Phelan, 2001). As such, the participants' idea that they are categorized and that stereotypes associated with those categories are then imposed upon them is consistent with explanations proposed by social cognitive theorists. Furthermore, participants' acknowledgement that they display socially unacceptable behaviors is consistent with the conceptualization of stigma that suggests that stigmatized individuals possess some attribute (or display some behavior) that is socially devalued (Crocker et al., 1998; Link & Phelan, 2001). Participants admitted to displaying some socially devalued behaviors that make them easier targets for stigmatization processes.

Disempowering impact of stigmatization on these participants' lives. As noted previously, all of the men who participated in this study reported that they have been impacted negatively, or in a disempowering manner, by stigmatization processes. They described stigmatization processes as profoundly negative and distressing in nature. They reported experiencing negative emotions, reduced self-concept, and interpersonal distancing as a result of being stigmatized. The distressing and disempowering impact of stigma on these participants' lives is not surprising, however, as the negative psychosocial impact of stigma has been well-documented in the stigma literature. In their review of the stigma literature, for instance, Major and O'Brien (2005) found that stigma

has been linked to a variety of negative outcomes, including poor mental health, physical illness, academic underachievement, infant mortality, low social status/social rejection, poverty, and reduced access to housing, education, health care, and jobs.

All twelve of the men who participated in this study reported that being stigmatized has, at some point, resulted in the emergence of negative, unwanted emotions (e.g., general emotional pain, sadness, frustration, anger, fear, worry, aggression, hatred, shame, guilt, embarrassment, stress, exhaustion). The negative emotionality that participants reported as resulting from stigmatization experiences is consistent with (a) studies of depression and stigmatization revealing that depression is more prevalent among members of stigmatized groups (Crocker et al., 1998), (b) studies demonstrating positive correlations between psychological distress and stigmatization (Major & O'Brien, 2005), and (c) the few studies examining the psychological impact of stigmatization on individuals facing homelessness (e.g., Kidd, 2007).

Nearly all of the study participants described stigmatization experiences as resulting in a reduced self-concept, or a negatively altered sense of self. Bentley (2007) and Boydell et al.'s (2000) qualitative studies on the psychological effects of homelessness revealed similar themes. Reduced self-concept was not an unexpected finding given the overall literature on stigmatization processes. As Deaux and Ethier (1998) noted, for instance, "Although many circumstances can threaten an identity, stigmatization is one of the most pernicious and may indeed be one of the most common" (p. 313). Additionally, given that stigmatized individuals are generally aware of their devalued social identity and consequently have a difficult time distinguishing whether others' reactions to them are due to their stigmatized social identity or to their personal

identity (Crocker et al., 1998), it is plausible that attributing stigmatization to one's self (vs. one's stigmatized condition) would result in a reduced self-concept (consistent with the idea of self stigma; Corrigan & Watson, 2002). Interestingly, studies have shown that stigmatized individuals are less likely to make attributions to prejudice and discrimination when they feel their stigma is controllable (Crocker et al., 1998); perhaps this is because they feel they somehow deserve the negative outcomes.

Most of the men in the study indicated that being stigmatized resulted in interpersonal distancing from others, both behaviorally (e.g., intentionally isolating or choosing not to "open up" due to distrust of potential stigmatizers) and cognitively (e.g., thinking about how they do not "belong"). This theme was similar to Bentley's (1997) finding associated with psychological and physical interpersonal withdrawal that emerged via qualitative investigation of the psychological impact of homelessness. Interpersonal distancing may be explained, at least in part, by the idea that the threat of being stereotyped or discriminated against is ever-present among the stigmatized (Dovidio et al., 2000). Stigmatized individuals may respond to this threat (and its associated sense of vulnerability) with hypervigilance (i.e., a sense of being constantly "on-guard" for the threats), enhanced sensitivity to others' attitudes, and/or extreme mistrust of others' intentions (Crocker et al., 1998).

Empowering impact of stigmatization on participants' lives. Interestingly, the majority of the participants noted that the impact of stigmatization on their psychosocial functioning has changed in that they have most recently been impacted by stigmatization processes in a positive, or empowering, manner. More specifically, they noted that they have (a) developed determination to improve their life circumstances, (b) decided to seek

professional treatment, and (c) experienced increased sensitivity toward and desire to help other stigmatized individuals. Again, this finding is not surprising when one considers Shih's (2004) distinction between coping and empowerment as responses to stigmatization. Shih observed that public stigma does not always lead to self stigma and that some stigmatized individuals respond to stigmatization with a sense of empowerment. Her empowerment model suggests that stigmatized individuals are active agents who seek to understand the social world they live in and create positive outcomes for themselves in spite of the stigma-related barriers they face. Studies of life satisfaction and stigmatization support Shih's empowerment model. Such studies have suggested that stigmatized individuals, on average, are not particularly dissatisfied with their lives in comparison to non-stigmatized individuals (Crocker et al., 1998). These studies raise the possibility that certain variables may be moderating the relationship between stigmatization and general life satisfaction.

The possible presence of some form of variable influencing the relationship between stigmatization and life satisfaction may help to explain why the participants in the current study described experiencing an empowering impact of stigmatization while some of the participants from previous studies investigating homelessness did not, especially when considering the theme of treatment-seeking behaviors that emerged as an example. The majority of the current study's participants suggested that being stigmatized actually encouraged them to seek professional treatment (at least after a certain point in time), a finding in contrast to previous studies on homelessness and treatment utilization. Previous studies examining why individuals facing homelessness seem to underutilize the supportive services that are available to them (e.g., Bhui et al.,

2006; Kim et al., 2007; Leipersberger, 2007; Padgett et al., 2008) have conversely identified perceived stigmatization as contributing to treatment avoidance. It is possible that participants from these studies had yet to experience a stigmatization impact transformation from disempowerment to empowerment. Hypotheses related to this idea are discussed further below.

Participants' past strategies for coping with or managing stigmatization experiences. All of the men who participated in the current study described various strategies for coping with or managing being stigmatized by other individuals. All but one of them noted that their coping responses have changed over time. All eleven participants who stated that their coping has changed indicated that they had previously coped with being stigmatized in an unhelpful or even destructive manner. They reported their previous coping strategies to include substance misuse, aggression and violence, and doing nothing/taking it.

None of these strategies for managing stigmatization experiences are accounted for directly by Miller and Kaiser's (2001) theoretical perspective on coping with stigma. The first portion of Miller and Kaiser's model begins by distinguishing voluntary (i.e., coping) and involuntary (i.e., non-coping) responses to stigma-related stressors to emphasize that not every response a person has to stress constitutes coping. They then assert that individuals may either engage (i.e., approach or fight) or disengage (i.e., avoid or flee) with the stressful event. Finally, voluntary engagement coping is divided into two categories: primary and secondary control. Primary control includes coping efforts that are "directed toward influencing objective events or conditions to enhance a sense of personal control over the environment or one's reactions" (p. 78). Secondary control

coping involves “efforts to adapt to the situation” and includes “efforts to change the way one feels about the fact that a bad situation has occurred” (p.78).

Given Miller and Kaiser’s (2001) categorizations, participants’ substance misuse would be conceptualized best as either (a) voluntary engagement/secondary control coping given that they were intentionally trying to change their feelings about the stigmatizing situation (similar to Miller and Kaiser’s distraction strategy) or (b) voluntary disengagement coping given that they were intentionally trying to “escape” from the negative impact of stigmatization experiences. Aggression and violence as defined by the men in this study would comprise voluntary engagement/primary control coping (similar to Miller and Kaiser’s emotional expression/regulation strategy). Finally, doing nothing/taking it would be considered involuntary engagement provided that the stigmatization resulted in unwanted negative emotions and reduced self-concept.

It is interesting to consider how stereotype threat (Steele & Aronson, 1995), a correlate of stigmatization (Crocker et al., 1998; Major & O’Brien, 2005), may have contributed to some of these coping strategies. It is possible that awareness of societal stereotypes of these participants related to them being substance abusers or violent criminals actually resulted in confirmation of these stereotypes. According to Major and O’Brien (2005), activation of stereotypes among stigmatized individuals is more likely to result in stereotype-consistent behavior than activation of stereotypes among non-stigmatized individuals.

Finally, participants’ coping strategies involving substance misuse, aggression and violence, and doing nothing/taking it may represent a manifestation of the negative mental and physical health outcomes associated with discriminatory stigmatization

processes (Dovidio et al., 2000; Major & O'Brien, 2005). For instance, associations between racial discrimination and health outcomes have been reported consistently (Borrell et al., 2007; Major & O'Brien, 2005), and a recent emergence of studies have supported the idea of a relationship between racial discrimination and health risk behaviors like substance misuse (Borrell et al., 2007). Borrell and colleagues (2007) suggested that substance misuse represents an unhealthy coping strategy used for dealing with discriminatory experiences. They also noted that their study participants who reported experiencing any discrimination were also more likely to endorse higher anger, less control over their lives, lower emotional support, and more negative interpersonal interactions.

Participants' current strategies for coping with or managing stigmatization experiences. All of the participants described their current coping strategies (i.e., acceptance/dealing with it, letting go and moving on, focusing on self/goals, disproving stigmatizers or reducing reasons to be stigmatized, distancing selves from stigmatizers, using positivity, turning to religion/faith, and distracting themselves) as helpful and constructive. Many of these are accounted for by Miller and Kaiser's (2001) theoretical perspective on coping with stigma. For instance, acceptance/dealing with it and using distraction as described by the participants are equivalent to Miller and Kaiser's acceptance and distraction strategies, respectively, which are both categorized as voluntary engagement/secondary control coping strategies. Disproving stigmatizers' expectations/reducing reasons to be stigmatized is represented by Miller and Kaiser's compensation strategy, which involves adapting one's social interaction strategies by behaving in a socially skillful or stereotype-disconfirming manner and is considered

voluntary engagement/primary control coping. Participants' description of distancing themselves from stigmatizers is accounted for by Miller and Kaiser's avoidance strategy, which is categorized as voluntary disengagement coping. Letting go/moving on and focusing on self/goals would both likely be considered voluntary engagement/primary control coping by Miller and Kaiser. This is because they either involve emotional regulation (letting go) and/or employment of problem-solving skills for attaining personal goals and improving their devalued status (moving on, focusing on self/goals). Using positivity would likely be categorized as voluntary engagement/secondary control coping because of the cognitive restructuring it involves; Miller and Kaiser categorize cognitive restructuring as voluntary engagement/secondary control coping. Finally, turning to faith/religiosity would also likely be considered voluntary engagement/secondary control coping because it involves learning how to adapt to stigma-related stress, similar to acceptance.

Miller and Kaiser (2001) are not the only stigma researchers that can explain the study participants' use of current coping strategies. The participants' use of acceptance/dealing with it, for instance, may have something to do with attributional ambiguity, cited as a correlate of stigmatization processes (Crocker et al., 1998). This term refers to the uncertainty that stigmatization targets face when deciding whether treatment from others is due to prejudice and discrimination or due to internal factors (e.g., personal deficits). Acceptance/dealing with it may represent a healthy resolution of attributional ambiguity in that participants have realized that stigmatization simply exists (due to external causes) and is not always attributable to their personal identities or deficits (i.e., internal causes).

Furthermore, participants' use of focusing on self/goals may be explained by the selective social comparisons coping strategy identified by Crocker and colleagues (1998). These researchers suggested that making downward comparisons has been linked to improved affect, increased self-esteem, and positive group identity. When the study participants focus on themselves and their goals, they are, in a way, making downward comparisons with their former selves (e.g., their former identities as active substance abusers).

Finally, with regard to these participants' use of disproving stigmatizers/reducing reasons to be stigmatized, it is useful to reference identity negotiation strategies described by Deaux and Ethier (1998). According to Deaux and Ethier, identity negotiation occurs when "there is a perceived need to adjust or in some way redefine a particular identity, as a consequence of some social, psychological or contextual demand" (p. 306). There are two forms of negotiation: identity negation and identity enhancement (Deaux & Ethier, 1998). Negation involves dissociating oneself from a social identity (e.g., by eliminating an identity, distancing oneself from the stigmatized group, or engaging in denial) or reinterpreting that identity (e.g., by seeing it as less important to oneself or perceiving oneself as an "ex" to that identity – such as an ex-addict; Deaux & Ethier, 1998). Enhancement involves asserting or extending an existing identity by proclaiming that identity cognitively, verbally, or behaviorally; intensifying one's level of contact with others who share the same identity; or working to promote social change to enhance the identity's status (Deaux & Ethier, 1998). Participants' efforts to disprove stigmatizers' expectations and reduce reasons to be stigmatized appear to represent both identity negation and enhancement.

It is noteworthy that the participants in the current study reported using similar coping strategies to participants in other studies exploring the stigmatization of individuals facing homelessness. For example, Boydell et al. (2000), in an attempt to gain an understanding of the identities homeless persons hold, found that one of the coping strategies utilized by their participants involved envisioning more favorable future identities (similar to the focus on self/goals reported by the current study's participants). As another example, Lankenau's (1999) participants reported using emotional regulation (similar to the letting go reported by the current study's participants) and identity management (similar to the reduction of reasons to be stigmatized reported by the current study's participants).

Participants' ideas for reducing the negative impact of stigma more effectively in the future. Although the men who participated in this study reported that their current coping strategies have been effective in helping them to manage stigmatization experiences, they also shared ideas for how they believe they would be able to manage stigmatization even more effectively in the future. More specifically, they listed (a) improving their lives/further reducing reasons to be stigmatized and (b) talking to a mental health provider about stigmatization experiences. The idea of continuing to improve their lives/further reduce reasons to be stigmatized is consistent with Miller and Kaiser's (2001) compensation strategy and Deaux and Ethier's (1998) identity negotiation strategies described previously. The idea of talking to a mental health provider best represents a manifestation of Miller and Kaiser's (2001) problem-solving strategy.

Importance of the participants' unique context. The importance of these participants' unique social context on the interpretation of study findings should not be understated. These participants were all sheltered African American men facing chronic homelessness and co-occurring mental illness and substance use disorders in treatment and maintaining sobriety at HSA. It is conceivable that participants' social context influenced study results in two primary ways. First, the fact that these men had psychiatric disorders (e.g., depression, schizophrenia) may have influenced the negative impact of stigmatization on their lives. The negative emotions, reduced self-concept, and interpersonal distancing they reported experiencing may have been impacted by their mental health conditions in addition to stigmatization processes. Psychiatric disorders are commonly associated with negative emotions (e.g., depression, irritability, general distress), a reduced sense of self (e.g., thoughts of worthlessness or helplessness), and interpersonal distancing (e.g., social withdrawal). It is possible that these participants' psychiatric diagnoses made them more susceptible to the disempowering impact of stigmatization as well as to stigmatization itself, especially if/when these diagnoses were inadequately managed.

Second, the fact that the men who participated in this study were residing in a homeless shelter, engaging in mental health/substance-related counseling, and maintaining abstinence from alcohol and drugs may have influenced the change in coping strategies they reported utilizing. It is possible that involvement in supportive services allowed them an opportunity to learn and implement more effective strategies for managing social stigmatization in addition to strategies for managing mental illness and substance use disorders. It is also possible that engaging in supportive services and

utilizing shelter resources decreased their reasons to be stigmatized in the first place. For instance, by maintaining their sobriety and having access to laundry facilities/showers, their substance use disorders and homelessness were less visible to others and consequently less targeted for stigmatization than when the participants were actively using and displaying more visible indicators of their housing status. Furthermore, as one participant noted, “[If] people see you trying to make it ahead, they gonna help you.” Perhaps stigmatization of these individuals was reduced by their efforts to improve their stigmatized conditions and overall life circumstances.

Changes associated with the impact of and coping strategies associated with stigmatization processes: Why and when? As noted previously, the impact of stigmatization on these participants’ lives was reported to change from disempowering to empowering. Furthermore, the participants’ strategies for managing stigmatization experiences were reported to transform from being unhelpful or destructive to helpful and constructive. Unfortunately, no themes emerged from data analysis explaining why or when the impact of and coping strategies associated with stigmatization processes changed. In this section, I offer some overlapping hypotheses related to “why” and “when.”

First, as noted previously, the men who participated in this study were residing in a homeless shelter, engaged in mental health/substance-related counseling, and maintaining abstinence from alcohol and drugs. By doing so, they were theoretically reducing their reasons to be stigmatized (and thereby the potential to experience the negative impact of stigmatization) while expanding their repertoire of adaptive coping strategies (and thereby the potential to experience the negative impact of stigmatization).

Simply maintaining sobriety, for example, may have changed their approach to stigma management from unhealthily avoidant or aggressive/destructive to proactive and constructive. It is probable that there are strong interrelations among degree of stigmatization, stigmatization impact, and coping strategies for managing stigmatization, though these have yet to be elucidated by research.

Second, it is possible that the study participants reported a change in stigmatization impact and their responses to stigmatizing experiences because their appraisals of stigmatization experiences have changed. In their model of stigma-induced identity threat, Major and O'Brien (2005) suggested that all stigma-related events are appraised for the potential impact they may have on an individual's well-being. Two types of appraisals are made. The first is considered primary and involves evaluation of the demands associated with a stigma-related stressor (e.g., how self-relevant it is, how threatening it is, how much effort it involves, and how uncertain it is). The second is considered secondary and refers to assessment of the resources an individual has in their possession to cope with the demands of the stressor. If demands exceed resources, identity threat emerges; if resources exceed demands, identity challenge emerges. Whichever the case may be, the appraisal outcome will direct an individual's affective, cognitive, behavioral, and physiological responses to the stigma-related event. It is possible that the study participants' appraisals of stigma-related stressors have changed in that they find them less demanding and/or that they believe they are better equipped to handle them. Again, the potential interrelations among appraisals, coping strategies, types of stigmatization experiences, and impact of stigmatizing events remains unclear,

though given the model that emerged from data analysis, it appears that these participants are currently facing more of an identity challenge than an identity threat.

Third, it appears that the men who participated in the present study have transitioned from “coping with” stigmatization experiences to being “empowered by” stigmatization experiences, consistent with Shih’s (2004) distinction between coping and empowerment models of stigmatization. Shih pointed out that despite the many detrimental outcomes associated with stigmatization, many stigmatized individuals function just as well as and are just as satisfied as non-stigmatized individuals. In fact, Crocker and colleagues (1998) noted that while some stigmatized individuals may be vulnerable to lowered self-esteem, diminished life satisfaction, and depression in particular, most are able to maintain positive general views of themselves and their groups. This may have something to do with interrupting public stigma from turning into self stigma (Corrigan & Watson, 2002). Citing Corrigan and Watson’s (2002) distinction between public stigma and self stigma, Shih (2004) observed that public stigma does not always lead to self stigma and suggested that this may have something to do with responding to stigmatization with a proactive vs. reactive process. It is possible that the participants in this study have learned how to cope with the effects of stigmatization “enough” that the negative impact has lessened (or vice versa) and they are now better equipped to make constructive life changes while helping other stigmatized individuals to do the same (i.e., a more proactive response process).

Fourth, it is possible that the participants in this study have resolved attributional ambiguity associated with the stigmatization experiences they have accumulated, which may have helped them to decide to seek treatment. It is noteworthy that the participants in

this study attributed the presence of stigmatization in their lives to both external causes (i.e., societal stereotyping) and internal causes (i.e., their own socially unacceptable behaviors). By striking a balance in attributions made between external and internal factors, these participants may have learned how to take a “just right” level of responsibility for their current life circumstances and unwanted stigmatization experiences. Instead of feeling overwhelmed by the uncontrollability of stigma or disempowered by feelings of worthlessness, then, these participants were able to experience the determination, self-efficacy, and willingness to accept the help from others that is needed to make the changes necessary for managing stigmatization processes in a helpful way.

A final explanation may relate to self-regulatory ability. Inzlicht and colleagues' (2006) research provided support for the idea that stigma and stigma management can weaken stigmatized individuals' ability to utilize self-regulatory processes during subsequent activities (e.g., attempts to maintain abstinence from alcohol and drugs). However, perhaps due to their involvement in mental health/substance-related treatment and their utilization of shelter-related services, the participants in this study were able to increase their self-regulatory strength. Baumeister et al. (2006) suggested that self-regulatory capacity or power can be renewed with rest or time (e.g., rest from living on the streets) and that self-regulatory strength can be increased with exercise or practice (e.g., via mental health/substance-related intervention).

Strengths of the Study

Although the construct of stigmatization has received a considerable amount of attention in the empirical literature (Crocker et al., 1998), individuals facing

homelessness comprise a population that has been surprisingly underexamined as a unique stigmatized group (Kidd, 2007; Lee et al., 2004; Thompson et al., 2004). The studies that have examined stigmatization of those who are homeless, either directly or indirectly (Bentley, 1997; Boydell et al., 2000; Kidd, 2007; Lankenau, 1999; Miller & Keys, 2001; Osborne, 2002), point to the idea that at least some individuals are well aware of their devalued social status, experience identity transformations and negative outcomes as a result of homeless stigmatization, and attempt to manage both stigmatization and its undesirable outcomes. None of these studies, however, have offered a specific, comprehensive theory as to how individuals facing homelessness experience and respond to stigmatization. Furthermore, none of these studies have related their findings to the preexisting literature on stigma. The purpose of the present study, therefore, was to build a comprehensive, grounded theory of how individuals who are homeless experience and respond to social stigmatization while accounting for some of the limitations in the literature to date.

This study contributes to the literature on stigma and homelessness in several important ways. First, unlike much of the previous literature related to stigma and homelessness, the present study focused directly on building upon the stigma research that has been conducted thus far and reviewed earlier in this manuscript; homeless stigmatization was therefore studied from a more comprehensive and intentional perspective than usual via this research project. Additionally, the theory discovered via this study has been compared with the preexisting stigma literature to initiate conversation about the degree to which current conceptualizations of stigmatization (e.g., Major & O'Brien, 2005; Miller & Kaiser, 2001; Shih, 2004) apply to the homeless

population of interest. Although the purpose of the current study was not to formally test any of the current models of stigmatization, the theory it yielded may help to inform them.

Second, as stigma researchers suggest that the within-group variability of stigmatization should be examined from the perspective of the stigmatized themselves, an exploratory qualitative approach was taken to obtain this perspective. A specific subgroup of the homeless population was targeted to rule out the influence of confounding variables and to acknowledge the vast heterogeneity that characterizes homelessness: African American men with co-occurring mental illness and substance use disorders who are experiencing chronic homelessness. By focusing on such a specific subgroup, more individualized recommendations could be made in congruence with study results.

Third, the current study addressed limitations of previous research on homeless stigmatization in that it was specifically designed to inform application of the theory it yielded using the perspective of individuals facing homelessness. For instance, in the current study, individuals experiencing homelessness were asked how stigmatization influences their perceptions of the supportive services that are available to them and their willingness to use programs offered by mainstream society. They were asked for their perspective on what they believe will help them cope more effectively with stigma in the future. Qualitative methodology was selected for this project because of its ability to incorporate and highlight the homeless voice into empirical research and its application (Christian, 2003).

Finally, the impact of multiple stigmatization and its additive effects (Conner & Rosen, 2008) was examined via the current study. The literature on homeless stigmatization to date has not emphasized or explored the fact that many individuals who are homeless are multiply stigmatized despite the probability that carrying multiple stigmas may influence the way one experiences and responds to stigmatization. As such, the targeted population for the study was one that faces multiple sources of stigma: stigma due to homelessness, stigma due to racial/ethnic minority status, stigma due to mental illness, and stigma due to substance misuse. A theme of stigma due to criminal history also emerged during data analysis, which is not surprising given the marginalization of individuals with criminal backgrounds (e.g., via restricted access to rental housing; Malone, 2009).

Limitations of the Study

As with all empirical pursuits, there were some notable limitations associated with the current study's sampling and methodological decisions that are worthy of identification and discussion. First, face-to-face interviews were used for data collection purposes. Although there are numerous advantages associated with this approach to data collection, face-to-face interviews are also accompanied by drawbacks. For example, it is possible that the study participants did not feel comfortable disclosing sensitive information or information they expected to be perceived as socially undesirable given the various demographic mismatches between themselves and study interviewers (Darlington & Scott, 2002). Although the men who participated in the study seemingly disclosed a good deal of sensitive information about themselves, it is possible that they

would have shared additional or differing information should there have been more demographic matches with interviewers.

Second, although the current study resulted in rich information about how the current participants experience and respond to multiple stigmatization processes, several themes emerged from the study that were not fully explored. For example, participants discussed how the impact of stigmatization processes has changed as well as how their strategies for coping with stigmatization processes have changed. However, the study did not fully investigate when these changes occurred or what caused them to occur. As another example, participants spontaneously described facing stigmatization for other conditions (e.g., criminal history), though these processes were not examined in depth. It is probable that these themes were not fully explored because saturation (Corbin & Strauss, 2008) was not determined during the more advanced stages of data analysis. For the current study, saturation was determined by primary team discussion of when no new themes or unanticipated information appeared to be emerging during interviews vs. during the more advanced stages of data analysis. Had there been more fluidity between data collection and analysis during this study, it is possible that themes not fully explored would have been investigated further (e.g., by modifying the interview protocol to obtain more theme-related data and/or interviewing additional participants).

Finally, given the high turnover rates at homeless shelters and difficulties maintaining prolonged contact with study participants, the grounded theory yielded from data analysis was not member-checked (Lincoln & Guba, 2000) by the study participants. Member-checking offers another form of auditing that can be used to assure the trustworthiness of a qualitative research study (Lincoln & Guba, 2000). Notably,

however, internal research team auditing was utilized as well as external auditing by a research team member who was “blind” to the study and could offer an outside perspective.

Clinical Implications

Data analysis yielded the identification of a core psychological demand imposed upon and shared by the participants in this research study: management of multiple stigmatization processes. The men who participated in this study reported that they are multiply stigmatized, have been disempowered by the effects of multiple stigmatization processes, and possess a need to manage the effects of being multiply stigmatized in a helpful way. The grounded theory emerging from this study offers a variety of implications for clinical work with this population.

First, mental health providers working with African American men facing co-occurring mental illness and substance use disorders and experiencing chronic homelessness should be aware of the degree to which these individuals experience stigmatization and the degree to which stigmatization can impact their psychosocial functioning in a negative manner. Asking about, acknowledging, and validating stigmatization experiences may help to enhance therapist-client rapport in session. Assessing the impact of stigmatization on clients’ feelings (e.g., negative or unwanted emotions), thoughts (e.g., self-concept, self-efficacy, beliefs about other individuals), and behaviors (e.g., interpersonal distancing, treatment-seeking behaviors, substance misuse) may provide direction for therapeutic intervention. Helping clients work through stigmatization experiences may be an important, empowering focus of therapeutic

intervention, as the study participants stated that they would want to discuss stigmatization experiences with their mental health providers.

Second, mental health providers working with this unique population (and potentially other stigmatized groups) should acknowledge the probable interrelations among degree of stigmatization, impact of stigmatization, and coping strategies for managing stigmatization while noting that coping strategies for stigmatization can be fostered. It may be helpful for clinicians to assess the degree to which their clients are impacted by stigmatization and how they respond to stigmatization processes. Helping clients to acquire and practice adaptive coping strategies for managing stigmatization may represent an important focus of therapeutic intervention with individuals facing homelessness and other stigmatized conditions. Emotional processing, cognitive restructuring, identity exploration, behavioral activation, role-playing, assertiveness training, stress management, self-care, psychoeducation, etc., can all be used to help clients manage stigmatization experiences more effectively.

Cognitive, cognitive-behavioral, and narrative therapies in particular may be useful in helping clients to make the transition from stigma-based disempowerment to empowerment. Cattaneo and Chapman (2010) have defined empowerment as “an iterative process in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action toward that goal, and observes and reflects on the impact of this action, drawing on his or her evolving self-efficacy, knowledge, and competence related to the goal. Social context influences all six process components and the links among them” (p. 647). As such, clinicians may assist clients through the empowerment process by helping them to define power-oriented goals, enhance their

sense of self-efficacy through increased knowledge and skill, and consider the interaction between actions and outcomes.

Finally, mental health providers are in a unique position to advocate for and reach out to this stigmatized group. Given their knowledge of stigmatization processes and awareness of the negative outcomes associated with stigmatization, mental health providers can work with representatives from other disciplines and within specific agencies to reduce sources of stigmatization and/or microaggression (e.g., inappropriate labeling or lack of people-first language, the use of degrading procedures like having individuals wait in long lines outside of shelters for entry during check-in or meals, poor communication between staff and clientele, staff usage of stereotypes or lowered expectations, pathologizing group values or communication styles, promoting myth of meritocracy; Sue et al., 2007). Mental health providers may elect to provide workshops about stigmatization to both staff and clientele to reduce its presence in agencies where individuals facing homelessness go to find relief from stigmatization.

Perhaps by doing so, stigmatization in homeless assistance programs will be reduced, and treatment utilization may be improved. Although the majority of the current study's participants suggested that being stigmatized actually encouraged them to seek professional treatment (at least after a certain point in time), this was a finding in contrast to previous studies on homelessness, mental illness, substance addiction, racial minority status, and help-seeking behaviors. For instance, the research strongly suggests that the stigma of mental illness and substance addiction is one of the reasons why individuals who would benefit from treatment services often do not seek them or participate in them fully (Corrigan, 2004; Gary, 2005a; Lavack 2007). Individuals of racial/ethnic minority

status, additionally, are also less likely to seek and receive health care, which may be due to structural/economic barriers, mistrust of service providers, and lack of culturally-sensitive services (Gary, 2005b).

Directions for Future Research

There are a number of ways that future studies can build upon the findings from this research project. First, results of this study suggested that the impact of stigmatization processes and the coping strategies used by the study participants to manage stigmatization have changed over time, though many questions remain as to “why” and “when.” Other types of studies (e.g., follow-up, longitudinal, ethnographic, quantitative) may help to elucidate these processes as well as the probable interrelations among degree of stigmatization, stigmatization impact, and coping strategies for managing stigmatization. It will be important for these studies to incorporate the potential moderating effects of variables such as engagement in mental health/substance-related counseling and duration of abstinence from alcohol and drugs. As noted previously, the participants in this study reported multiple or lengthy episodes of homelessness, and they had likely had multiple affiliations with various homeless assistance programs. It would be interesting to have more information about their level of engagement in previous/current programs, how it may have changed over time, and how its relationship with their stigmatization management processes may have changed over time. Many questions have yet to be answered (e.g., “Would the participants have reported similar experiences managing stigmatization in the past? Earlier in their homelessness? During a previous stay at HSA? Is there an additive effect of exposure to multiple homeless assistance programs or mental health/AODA counseling programs on stigma

management processes? What role is their current context actually playing? Where did they develop their current coping strategies? If their current programming comprises one of the ‘active ingredients’ to enhancing empowerment, what about it is so helpful?”).

Second, future studies can examine and fine-tune the current model of stigmatization and homelessness by testing its applicability to both (a) larger groups of study participants who fulfill the same inclusion criteria utilized in this study and (b) other subgroups of the homeless population. It would be interesting to examine whether other subgroups of the homeless population would report experiencing and responding to stigmatization in similar ways. Some comparison groups worthy of investigation include non-sheltered homeless groups, women facing homelessness, adolescents and young adults experiencing homelessness, individuals who are still using alcohol and drugs, and individuals with criminal histories, military backgrounds, extensive medical histories, etc. Within-group variability of the homeless population and homeless individuals’ experiences with stigmatization represents an important avenue for both investigation and intervention.

Third, given that the study participants suggested that talking with mental health professionals may represent a strategy for improving their ability to manage stigmatization, it would be worthwhile to develop measures and interventions associated with attending to clientele’s stigmatization experiences in treatment. For example, it would be interesting to determine whether stigma-specific interventions are found to be helpful or effective.

Fourth, it was interesting that participants typically identified homelessness as the especially difficult or more upsetting stigma they face. As discussed previously, a

possible explanation for this finding may be the correlates between homelessness and other stigmatized conditions and how homelessness can contribute negatively to these other conditions (i.e., being homeless restricts accessibility of resources and makes it difficult to overcome other stigmatizing conditions). It is not surprising, therefore, that consumers of homeless assistance programs typically prioritize housing over mental health/substance-related counseling, consistent with Housing First approaches to reducing homelessness (Tsemberis et al., 2004). Some models of care (e.g., Continuum of Care), however, operate under the assumption that psychiatric stability or sobriety should precede permanent supportive housing (Tsemberis et al., 2004). It would be interesting, therefore, for future studies to compare stigmatization management processes of individuals participating in Housing First vs. Continuum of Care approaches to homeless intervention and how each approach is perceived by the consumers of interest.

Finally, the participants in this study identified general society, family, and friends as their primary stigmatizers. Future studies may wish to investigate how general societal stigmatization may differ from familial/peer stigmatization in terms of impact on and responses used by stigmatized individuals. It would be interesting to determine if what the study participants describe as stigmatization by family and friends is actual stigmatization, an intentional response used to encourage their loved ones to seek help, both, or neither.

Overall Summary

In summary, the purpose of the current study was to explore how a specific subgroup of the homeless population experiences and responds to multiple sources of stigmatization: African American men facing chronic homelessness and co-occurring

mental illness and substance use disorders. Grounded theory research methodology (e.g., Corbin & Strauss, 2008) was used to examine this topic. Twelve men participated in individual interviews during which they were asked to discuss their beliefs about stigma, personal experiences being stigmatized, the perceived impact of stigmatization on their psychosocial functioning, coping strategies they employ in response to stigmatization, and treatment-seeking behaviors.

Results revealed that (a) the participants have been multiply stigmatized, (b) they perceive the stigma of homelessness as the most difficult stigma with which to contend, and (c) they believe it is more difficult to be stigmatized for multiple reasons than for a single reason alone. Results also indicated that the impact of stigmatization on the participants' lives has changed over time (from disempowerment to empowerment) and that the participants have altered their strategies for coping with stigmatization (from unhelpful and destructive to helpful and constructive). Results offered a number of implications for clinical intervention with the population of interest as well as several directions for future research to pursue.

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Appendix A

Participant Fake Name _____

Background Information Form

Please answer the following questions to the best of your ability.

1. How old are you?
2. How many times have you experienced homelessness?
3. How long has it been since you did not experience homelessness?
4. If you have experienced homelessness more than once, how long do you think you have experienced homelessness altogether?
5. How long have you been affiliated with the HSA?
6. What are you receiving mental health and/or substance use services for (e.g., depression, alcohol dependence)?
7. How long have you been receiving these services?
8. How would you describe your physical health? Do you have any medical conditions?
9. Are you employed? If so, where? If not, when were you last employed and what did you do?
10. What is the highest level of education you have had the chance to complete?
11. What is your marital status (e.g., single, married, separated, divorced, widowed)?
12. Do you have any children? If so, do you see them?
13. Have you served in the military? If so, when and what branch? Did you see combat?

Appendix B

Participant Fake Name _____

Interview Protocol

Say something like, “Now we are ready to begin the interview. Before I turn on the recorder, I want to remind you not to use any real names during the interview to protect your privacy. I will be calling you by your fake name. I/we might take some notes as you speak in case we have a problem with the recording later. Okay? Here we go.”

****TURN ON RECORDER****[Introductory Questions/Questions to Ask Prior to Cueing for Stigma]

Say something like, “Here’s the first question.”

1. How are individuals facing homelessness treated differently from non-homeless individuals, if at all?
2. Why do you think this is the case?
3. How does this impact you, and/or how does this make you feel?

[Stigma-Related Questions: General]

Say something like, depending on their answers to 1-3 of course, “Great. Thank you. We’re going to talk more about that in a minute, but first let’s talk about the concept of stigma...” or “Those were some interview warm-up questions. Now we’re going to talk about this idea of stigma...”

4. As you probably already realized from your appointment reminder form, this study deals with the concept of stigma. Are you familiar with this term?
 - a. If the answer is yes: Tell me what stigma means to you. [If the response is substantially off, the interviewer will provide a definition of stigma. Even if the response is on target, the interviewer will reiterate using the definition below.]
 - b. If the answer is no: [The interviewer will provide a definition of stigma.]
 - c. Definition of stigma: A personal characteristic (e.g., a physical condition, personality attribute, membership in a social group) that is considered unacceptable or undesirable by others and results in the social devaluation and/or maltreatment of the individual who has it [Clarify this definition as needed to ensure participant understanding...perhaps provide

an example. “For example, a child who is extremely overweight might be considered to have a stigma. Because he is overweight, he might be treated differently or valued less by other kids... stigmatized. He might be bullied, or chosen last for team sports.”]

Say something like, “Does that make sense? The idea of stigma or being stigmatized? Okay. I want to make sure because I’m going to be using those terms a lot during the interview.”

5. Some people might say that individuals who are homeless are stigmatized [you know, treated differently/valued less/treated poorly] while others may not. What do you think?
 - a. If participant agrees individuals who are homeless are stigmatized, proceed with #6.
 - b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #7.

6. How and why might individuals who are homeless be stigmatized?

Who does the stigmatizing [or who stigmatizes them]?

7. Some people might say that African American individuals are stigmatized while others may not. What do you think?
 - a. If participant agrees African Americans are stigmatized, proceed with #8.
 - b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #9.

8. How and why might African American individuals be stigmatized?

Who does the stigmatizing?

9. Some people might say that individuals with mental illness [or mental health problems] are stigmatized while others may not. What do you think?
 - a. If participant agrees individuals with mental illness are stigmatized, proceed with #10.
 - b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #11.

10. How and why might individuals with mental illness be stigmatized?

Who does the stigmatizing?

11. Some people might say that individuals with alcohol and/or drug addictions [or problems] are stigmatized while others may not. What do you think?
- If participant agrees individuals with addictions are stigmatized, proceed with #12.
 - If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #13.
12. How and why might individuals with addictions be stigmatized?

Who does the stigmatizing?

[Stigma-Related Questions: Personal Experiences]

Say something like, “Okay, now these questions might seem more personal because they are asking about your unique experiences with being stigmatized [or being treated differently/valued less/treated poorly]. So here we go.”

13. As an African American individual who has been homeless and faces mental illness [or mental health problems] and substance addiction [or drug and/or alcohol problems], have you personally been stigmatized?
- If the answer is yes, proceed with #14
 - If the answer is no:
 - Ask why the participant does not feel he has been stigmatized
 - Ask what he thinks helps him to avoid being stigmatized
 - Ask if others would disagree with his statement that he has not been stigmatized and why there may be a discrepancy in opinion
 - Ask if the participant knows (directly or indirectly) of any similar individuals who have been stigmatized and tailor questions #14-16 as needed. Ask “how were they stigmatized,” “who/what stigmatized them,” “what do you think caused the stigmatization/do you think it was because of their [blah blah],” “do you think it had a stronger or weaker impact on them...,” “were certain stigmas more problematic for them/which/how/why,” “when did they become aware of being stigmatized,” etc., for #14-16. Then, starting with question #17, ask the rest of the questions about the participant himself, tailoring the wording to match the idea that he hasn’t been stigmatized – where applicable (e.g., instead of asking “what is it like to be stigmatized,” ask “what do you think it’s like to be stigmatized”). Also, skip #22 and #27-29.

14. How have you been stigmatized? [Really get him to elaborate on this one/give examples]

Who or what has stigmatized you [treated you differently/poorly or valued you less]?

[As you ask these two questions, tell participant you acknowledge that he may have been stigmatized by multiple sources in multiple ways...and get him to tell you all those ways]

15. What do you think caused the stigmatization? [Allow participant ample time to respond before introducing the following questions]

Was the stigmatization because of your homeless status, your mental health problems, substance/addiction problems, race, or other reasons? [Have participant list the specific reasons vs. just saying yes to this whole question]

Did you face stigma related to anything other than homelessness, race, mental illness/mental health problems, or addiction/substance problems? [Ask participant to specify the source(s) of stigmatization vs. giving a simple “yes”]

[If participant has been stigmatized for more than one reason (e.g., an addiction in addition to homelessness)...ask]:

- a. Do you think being stigmatized for multiple reasons (*cite whatever reasons he gave you* - e.g., being homeless AND African American) has had a stronger or weaker impact on you than if you had just been stigmatized for a single reason (*cite just one of the reasons he gave you* - e.g., being African American)?

Explain.

- b. Are certain stigmas or combinations of stigmas more difficult, problematic, or upsetting for you than others? (e.g., being African American vs. being homeless)

If yes, which, how, and why?

- c. Can you provide a rank ordering of the stigmas you face with 1 being the most difficult, 2 being the second most difficult, and so on? (e.g., being African American might be the most difficult)

16. When did you first become aware of being stigmatized [noting it might be different for different stigmas]? How has that changed over time, if at all?

[Stigma-Related Questions: Subjective Experiences]

Say something like, “Okay, now that we know how you’ve been stigmatized and for what reasons, we’re going to ask some questions about how being stigmatized has impacted you. The first one is...”

17. What is it like to be stigmatized?
18. How does being stigmatized impact you? Physically? Mentally? Emotionally? Behaviorally? Socially?
19. How does being stigmatized impact the way you think about yourself, if at all?
20. How does being stigmatized impact the way you think about others, if at all?
21. How does being stigmatized impact the way you think about people who are homeless, if at all?
22. Has any of this been different in the past [remind participant what “this” is]?

If so, how?

[Stigma-Related Questions: Coping with Stigmatization]

Say something like, “Great. Now we’d like to know how you deal with being stigmatized. So...”

23. How do you deal with being stigmatized in general? What do you do? [really probe here for a response...acknowledging he might deal with it in a variety of ways, and different sources of stigma differently]

Is it helpful or not? Why/why not?

Is it different from how you’ve dealt with being stigmatized previously?

If so, what did you do previously?

Was it helpful or not? Why/why not?

24. How do you think you could handle being stigmatized better? What would help you?
 25. Would you want to talk about your experiences of being stigmatized with someone who might be able to help?
- Why/why not?
26. What would you want to be done about stigmatization?

[Stigma-Related Questions: Specific Example]

Say something like, “We’re getting closer to the end. For this next part of the interview, we want a specific example of a time you’ve been stigmatized, how you reacted to it, and how you dealt with it. A real specific example of a one-time thing, you know?”

27. Describe a particular time that you felt stigmatized.
28. How did you react to being stigmatized?
29. How did you deal with being stigmatized?

[Treatment-Related Questions]

Say something like, “Even closer to the end! Now some questions about the HSA...”

30. How did you decide to come to the HSA and commit to programming?
How long did it take to make that decision?
31. Did anything help you make the decision?
Did anything hinder you?
32. What is it like for you, as an African American man facing homelessness, mental health problems, and drug/alcohol problems (and stigmas – *if he says he’s stigmatized*), to seek supportive services from others?
33. What helps you do it?
What prevents you from doing it?
34. Has stigma impacted your decision to seek services?
If yes, how so?
Which stigmas? [If minimal response, probe about specific stigmas. For example, ask, “Has the stigma of homelessness/being African American/mental illness/addiction impacted your decision...?”]
35. Why do you stay at the HSA and in HSA programming?
36. In a few words, or one sentence, how did you become an individual facing homelessness?

[Closing Questions]

Say something like, “We’ve made it to the end! Just a couple quick questions to close the interview.”

37. Is there anything else you would like to add to this interview that we didn’t talk about?
38. What made you decide to participate in this study?
39. How has this interview affected you, if at all?

****TURN OFF RECORDER****

Synonym Cheat Sheet

The terms “stigmatized,” “stigmatizing,” and “stigmatization” may be used interchangeably with their synonyms and/or definitions during interviews to enhance participant understanding of the questions. These synonyms and/or definitions include the following phrases:

Stigmatized:

- “treated poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “devalued/shamed by others because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “discriminated against or excluded because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Stigmatizing:

- “treating poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “devaluing/shaming someone because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “discriminating against or excluding because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Stigmatization:

- “process or act of treating poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

- “process or act of devaluing/shaming someone because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “process or act of discriminating against or excluding because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Example of Synonym Usage:

- Instead of wording #17 as is during the interview, I may modify it using one of the synonyms such that I end up asking: “What is it like to be treated poorly because of your ethnic minority status?” vs. “What is it like to be stigmatized?”

Appendix C

Participant Fake Name _____

Interview Protocol

Say something like, “Now we are ready to begin the interview. Before I turn on the recorder, I want to remind you not to use any real names during the interview to protect your privacy. I will be calling you by your fake name. I/we might take some notes as you speak in case we have a problem with the recording later. Okay? Here we go.”

****TURN ON RECORDER****[Introductory Questions/Questions to Ask Prior to Cueing for Stigma]

Say something like, “Here’s the first question.”

40. How are individuals facing homelessness treated differently from non-homeless individuals, if at all?
41. Why do you think this is the case?
42. How does this impact you, and/or how does this make you feel?

[Stigma-Related Questions: General]

Say something like, depending on their answers to 1-3 of course, “Thank you. We’re going to talk more about that in a minute, but first let’s talk about the concept of stigma...”

43. As you probably already realized from your appointment reminder form, this study deals with the concept of stigma. Are you familiar with this term?
 - a. If the answer is yes: Tell me what stigma means to you. [If the response is substantially off, the interviewer will provide a definition of stigma. Even if the response is on target, the interviewer will reiterate using the definition below.]
 - b. If the answer is no: [The interviewer will provide a definition of stigma.]
 - c. Definition of stigma: A personal characteristic (e.g., a physical condition, personality attribute, membership in a social group) that is considered unacceptable or undesirable by others and results in the social devaluation and/or maltreatment of the individual who has it [Clarify this definition as needed to ensure participant understanding...perhaps provide an example. “For example, a child who is extremely overweight might be

considered to have a stigma. Because he is overweight, he might be treated differently or valued less by other kids... stigmatized. He might be bullied, or chosen last for team sports.”]

Say something like, “Does that make sense? The idea of stigma or being stigmatized? Okay. I want to make sure because I’m going to be using those terms a lot during the interview.”

PRESENT VISUAL CUE TO PARTICIPANT and say “Just in case, here is a visual aid of what we just talked about for you to use if you need to during the interview.”

44. Some people might say that individuals who are homeless are stigmatized [you know, treated differently/valued less/treated poorly] while others may not. What do you think?

- a. If participant agrees individuals who are homeless are stigmatized, proceed with #6.
- b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #7.

45. How and why might individuals who are homeless be stigmatized?

Who does the stigmatizing [or who stigmatizes them]?

46. Some people might say that African American individuals are stigmatized while others may not. What do you think?

- a. If participant agrees African Americans are stigmatized, proceed with #8.
- b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #9.

47. How and why might African American individuals be stigmatized?

Who does the stigmatizing?

48. Some people might say that individuals with mental illness [or mental health problems] are stigmatized while others may not. What do you think?

- a. If participant agrees individuals with mental illness are stigmatized, proceed with #10.
- b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #11.

49. How and why might individuals with mental illness be stigmatized?

Who does the stigmatizing?

50. Some people might say that individuals with alcohol and/or drug addictions [or problems] are stigmatized while others may not. What do you think?

- a. If participant agrees individuals with addictions are stigmatized, proceed with #12.
- b. If participant does not agree, ask why he does not think so and why others may disagree with him. Then go to #13.

51. How and why might individuals with addictions be stigmatized?

Who does the stigmatizing?

[Stigma-Related Questions: Personal Experiences]

Say something like, “Okay, now these questions might seem more personal because they are asking about your unique experiences with being stigmatized [or being treated differently/valued less/treated poorly]. So here we go.”

52. As an African American individual who has been homeless and faces mental illness [or mental health problems] and substance addiction [or drug and/or alcohol problems], have you personally been stigmatized?

- a. If the answer is yes, proceed with #14
- b. If the answer is no:
 - i. Ask why the participant does not feel he has been stigmatized
 - ii. Ask what he thinks helps him to avoid being stigmatized
 - iii. Ask if others would disagree with his statement that he has not been stigmatized and why there may be a discrepancy in opinion
 - iv. Ask if the participant knows (directly or indirectly) of any similar individuals who have been stigmatized and tailor questions #14-16 as needed. Ask “how were they stigmatized,” “who/what stigmatized them,” “what do you think caused the stigmatization/do you think it was because of their [blah blah],” “do you think it had a stronger or weaker impact on them...,” “were certain stigmas more problematic for them/which/how/why,” “when did they become aware of being stigmatized,” etc., for #14-16. Then, starting with question #17, ask the rest of the questions about the participant himself, tailoring the wording to match the idea that he hasn’t been stigmatized – where applicable (e.g., instead of asking “what is it like to be stigmatized,” ask “what do you think it’s like to be stigmatized”). Also, skip #22 and #27-29.

53. How have you been stigmatized? [Really get him to elaborate on this one/give examples]

Who or what has stigmatized you [treated you differently/poorly or valued you less]?

[As you ask these two questions, tell participant you acknowledge that he may have been stigmatized by multiple sources in multiple ways...and get him to tell you all those ways]

54. What do you think caused the stigmatization? [Allow participant ample time to respond before introducing the following questions]

Was the stigmatization because of your homeless status, your mental health problems, substance/addiction problems, race, or other reasons? [Have participant list the specific reasons vs. just saying yes to this whole question]

Did you face stigma related to anything other than homelessness, race, mental illness/mental health problems, or addiction/substance problems? [Ask participant to specify the source(s) of stigmatization vs. giving a simple “yes”]

[If participant has been stigmatized for more than one reason (e.g., an addiction in addition to homelessness)...ask]:

- d. Do you think being stigmatized for multiple reasons (*cite whatever reasons he gave you* - e.g., being homeless AND African American) has had a stronger or weaker impact on you than if you had just been stigmatized for a single reason (*cite just one of the reasons he gave you* - e.g., being African American)?

Explain.

- e. Are certain stigmas or combinations of stigmas more difficult, problematic, or upsetting for you than others? (e.g., being African American vs. being homeless)

If yes, which, how, and why?

- f. Can you provide a rank ordering of the stigmas you face with 1 being the most difficult, 2 being the second most difficult, and so on? (e.g., being African American might be the most difficult)

55. When did you first become aware of being stigmatized [noting it might be different for different stigmas]? How has that changed over time, if at all?

[Stigma-Related Questions: Subjective Experiences]

Say something like, “Okay, now that we know how you’ve been stigmatized and for what reasons, we’re going to ask some questions about how being stigmatized has impacted you. The first one is...”

56. What is it like to be stigmatized?
57. How does being stigmatized impact you? Physically? Mentally? Emotionally? Behaviorally? Socially?
58. How does being stigmatized impact the way you think about yourself, if at all?
59. How does being stigmatized impact the way you think about others, if at all?
60. How does being stigmatized impact the way you think about people who are homeless, if at all?
61. Has any of this been different in the past [remind participant what “this” is]?
If so, how?

[Stigma-Related Questions: Coping with Stigmatization]

Say something like, “Now we’d like to know how you deal with being stigmatized. So...”

62. How do you deal with being stigmatized in general? What do you do? [really probe here for a response...acknowledging he might deal with it in a variety of ways, and different sources of stigma differently]

Is it helpful or not? Why/why not?

Is it different from how you’ve dealt with being stigmatized previously?

If so, what did you do previously?

Was it helpful or not? Why/why not?
63. How do you think you could handle being stigmatized better? What would help you?
64. Would you want to talk about your experiences of being stigmatized with someone who might be able to help?

Why/why not?

[Stigma-Related Questions: Specific Example]

Say something like, “We’re getting closer to the end. For this next part of the interview, we want a specific example of a time you’ve been stigmatized, how you reacted to it, and how you dealt with it. A real specific example of a one-time thing, you know?”

65. Describe a particular time that you felt stigmatized.

66. How did you react to being stigmatized?

67. How did you deal with being stigmatized?

[Treatment-Related Questions]

Say something like, “Even closer to the end! Now some questions about the HSA...”

68. How did you decide to come to the HSA and commit to programming?

How long did it take to make that decision?

69. Did anything help you make the decision?

Did anything hinder you?

70. What is it like for you, as an African American man facing homelessness, mental health problems, and drug/alcohol problems (and stigmas – *if he says he’s stigmatized*), to seek supportive services from others?

71. What helps you do it?

What prevents you from doing it?

72. Has stigma impacted your decision to seek services?

If yes, how so?

Which stigmas? [If minimal response, probe about specific stigmas. For example, ask, “Has the stigma of homelessness/being African American/mental illness/addiction impacted your decision...?”]

73. Why do you stay at the HSA and in HSA programming?

[Closing Questions]

Say something like, “We’ve made it to the end! Just a couple quick questions to close the interview.”

74. In a few words, or one sentence, how did you become an individual facing homelessness?

75. Is there anything else you would like to add to this interview that we didn't talk about?
76. What made you decide to participate in this study?
77. How has this interview affected you, if at all?

****TURN OFF RECORDER****

Synonym Cheat Sheet

The terms “stigmatized,” “stigmatizing,” and “stigmatization” may be used interchangeably with their synonyms and/or definitions during interviews to enhance participant understanding of the questions. These synonyms and/or definitions include the following phrases:

Stigmatized:

- “treated poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “devalued/shamed by others because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “discriminated against or excluded because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Stigmatizing:

- “treating poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “devaluing/shaming someone because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “discriminating against or excluding because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Stigmatization:

- “process or act of treating poorly/inappropriately/unfairly/badly because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.
- “process or act of devaluing/shaming someone because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

- “process or act of discriminating against or excluding because of ‘X’ characteristic” with ‘X’ referring to homelessness, ethnic minority status, mental illness, substance use disorder, co-occurring disorders, etc.

Example of Synonym Usage:

- Instead of wording #17 as is during the interview, I may modify it using one of the synonyms such that I end up asking: “What is it like to be treated poorly because of your ethnic minority status?” vs. “What is it like to be stigmatized?”

Visual cue:

Being ***stigmatized*** may involve...

- Being treated poorly or unfairly
- Being valued less than other people (devalued)
- Being shamed
- Being discriminated against
- Being excluded

All because of a characteristic you have that other people believe is undesirable or unacceptable.

Appendix D

██████████ Counseling Clinic Services
Authorization for Release of Patient Information

I, _____

Client's Name

Date of Birth

Authorize:

Name Rebecca Mayor, Keyona Jarrett, Brittany Barber, Shirley Newcomb, Lucia Stubbs, Darnell Durrah

Organization Marquette University – Stigma Study Research Team

Address Dept. of Counselor Education & Counseling Psychology, Marquette University College of Education, ██████████

City, State & Zip Code Milwaukee, WI 53233

Phone (414) ██████████

Fax N/A

To Disclose To / To Receive From:

Name ██████████ Counseling Clinic Staff

Attention ██████████

Address ██████████

City, State & Zip Code ██████████

Phone ██████████ x ██████████ Fax: ██████████

I understand that the specific type of information to be disclosed includes:

(Please check all that apply)

_____ All Medical Records

_____ Discharge Summary

_____ Alcohol and/or Drug Dependency Records

_____ Mental Health Treatment Records

___X___ Other : Verbal and written information pertaining to the Stigma Study

This disclosure is being made for the following purpose(s):

_____ Continuing Care

_____ Legal/Court Case

_____ Personal Reasons

_____ Coordination of Care

___X___ Other: To complete research study

I hereby release ██████████ Counseling Clinic from all legal responsibility that may arise from this act.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, HFS 75.03 (8).13, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand the information disclosed may include reference to or treatment of alcohol/drug abuse, emotional illness, or HIV/AIDS Testing results. A patient treated for emotional illness has the right to access treatment records during treatment and after discharge, according to Wisconsin State Statute 51.30. Copies of the records are also obtainable upon discharge.

This consent is in effect until December 31, 2010 unless otherwise stated here N/A, and can be revoked at any time upon the client's written request.

Signature of Client

Date

Signature of Witness

Date

Appendix E

Stigma Study – Checklist for Participant Inclusion

Fake Name of Prospective Participant*: _____

Referral Source: _____

Release of Information Completed? ** (circle one): Yes No

Inclusion Criteria (please check off each):

___ African American man

___ 25-60 years old

___ Homeless status = Chronic (as defined by HUD) – but staying at HSA now

___ History of/currently being seen for co-occurring disorders as indicated below:

___ One or more Axis I disorders (non-substance): _____

___ One or more substance use disorders: _____

___ No apparent substance intoxication

___ No apparent thought disorder

___ No apparent cognitive impairment

___ Willing and able to meet with MU researchers to complete interview (2 hrs)

Times Unavailable to Meet *** (if known): _____

Good Candidate for Interview on MU Campus? (circle one): Yes No

TB Status:

Screen Results (circle one): Positive Negative

Any History of TB or History of Positive Screen? (circle one): Yes No

*To be entered by Stigma Study Research Team Members

**To ensure prospective participant has given permission to referral source for this checklist form and the information on it to be used by the researchers

***Due to [] Programming/Commitments to [] Counseling Clinic

Appendix F

Marquette Stigma Study – Information for Referring Staff

Thank you for helping me to recruit participants for my dissertation research! Please let me (Rebecca/Becky Mayor) or any of my research team members (Keyona, Brittany, Shirley, Lucia, Darnell) know if you have any questions. My office number at Marquette is 414-████████. Below are some “procedures” to follow when helping me find potential participants. Note that we are looking to interview 12-18 people, so we would need up to 20 referrals total. We welcome these referrals on a rolling basis (i.e., don’t wait until you have 20 to give them to us!). Additionally, we would like to be done with interviews by the end of May, if possible, so the sooner we get referrals, the better – from our perspective. ☺

1. Review the 2-page “packet” distributed by ██████████. It contains a ██████████ Release of Information form (ROI) and a Stigma Study Checklist for Participant Inclusion. Note that all of the inclusion criteria on the checklist need to be fulfilled in order for an individual to be eligible for the study.
2. If you come across a client who fulfills these inclusion criteria, ask him if he would be interested in participating in a Marquette research study that involves being interviewed by psychology graduate students for 1-2 hours either at the ██████████ or on Marquette’s campus (in the former ██████████ Counseling Clinic). Tell him that he would be compensated for his time with a \$10 gift card to a fast-food restaurant (e.g., Cousin’s, McDonald’s). Tell him that the purpose of the study is to learn how society thinks about and treats the homeless and how this affects people facing homelessness. Tell him that researchers want to learn about this topic from African American men with mental health problems and drug or alcohol use problems who are experiencing homelessness. Remind him that his decision to participate (or not participate) is voluntary and will not impact his ability to receive services from the ██████████.
3. If the client would like to participate in the study, tell him that you need his permission to complete a Checklist with/about him and give it to the researchers to use for the study. Have him complete and sign the ROI as an indication of this permission. Note that his name at the top of the ROI should be legible. Note also that his name will not be on the Checklist itself because the researchers will add a “fake” name later – for privacy. Tell the prospective participant that one of the researchers will come to the ██████████ soon to meet him and see if they should schedule an appointment for the interview.
4. Complete the Checklist. Please ensure that the information about TB status is filled out – this is important for determining where the interview will be held (i.e., Marquette or ██████████) in order to accommodate/protect the health-related needs of one of the researchers. A “good candidate” for a Marquette interview will be someone with no history of TB and no history of a positive TB screen - and someone who you think would do “well” with a Marquette interview (e.g.,

someone who won't have much difficulty finding his way to campus, someone likely to keep his appointment, someone lower risk).

5. **When the ROI and Checklist are complete**, give them to [REDACTED] or put them in the large manila envelope in [REDACTED]'s mailbox labeled "Marquette Stigma Study – To Be Scheduled." When there are ROI/Checklist packets in this envelope, [REDACTED] will contact the researchers. The researchers will then come to the [REDACTED] to meet the prospective participants and schedule interviews. It is likely that they will ask [REDACTED] or other referring sources for assistance finding/introducing the prospective participants.

Appendix G

Procedures for Meeting/Scheduling Participants

***Take this form, the interview schedule form, the appointment form(s), and the MU map(s). And a writing utensil. ☺ Meet [REDACTED] (if applicable). Get the referral form “packets” from the stigma study envelope in [REDACTED]’s mailbox (it’s a big manila envelope – I think labeled MU stigma study). These referral form “packets” include a release of information form and a checklist (2 sheets stapled together).

***Look over the packets to ensure they are complete and the participant is eligible for the study (call me if anything seems questionable before meeting the participant). Note that the participant’s name will only be on the release and not on checklist. When we do the interview, we will put a fake name on the checklist. Make special note of where the interview can be conducted (MU vs. [REDACTED] – only schedule at MU if they are a good candidate for an MU interview, have no TB history, and a negative TB screen) and times when the participant is unavailable to do the interview per the checklist. The interview should not conflict with their [REDACTED] programs.

***Find the participant – perhaps with staff help. Introduce yourself/tell him he was referred to you by (referral source – should be on checklist) as someone interested in our research study. Remind him that the study involves being interviewed by psychology graduate students for 1-2 hours at the [REDACTED] or on Marquette’s campus (in the former [REDACTED] Counseling Clinic) – whichever place you intend to schedule him for. Tell him that he will be compensated for his time with a \$10 gift card to a fast-food restaurant (e.g., Cousin’s, McDonald’s). Remind him the purpose of the study is to learn how society thinks about and treats the homeless and how this affects people facing homelessness. Tell him the researchers want to learn about this from African American men who are experiencing homelessness. Only mention the fact that we are looking for people with mental health problems and drug or alcohol use problems if you are in an environment where his confidentiality can be protected – or if he asks on his own, etc. Ask if he has any questions/wants to be scheduled for an interview.

***Use the interview schedule to find a time for the interview. When a time is agreed upon, record on the interview schedule the time/date/location of interview, the interviewers, and the participant’s real name. Then, complete the appointment form to give to the participant. If the interview will take place at MU, give him a map of MU and review the directions with him. Ensure that he seems to understand where he needs to be when/how to get there.

***Thank the participant for his interest. Point out the phone number on the appointment form (414-[REDACTED] – my office) as the one he should call with any

questions/concerns or cancellation needs. Do NOT give out any of our cell phone numbers.

***Gather the materials (i.e., this form, interview schedule form, and release/checklist packets), guard them with your life (because they contain private info), and call me ASAP. Let me know the interview details so I can inform whomever will be involved/book rooms and then arrange a time to hand over the materials since we will need them for the interviews.

Thank you for your interest in our research! Your interview appointment has been scheduled for:

Date: _____

Time: _____

Location: _____

You will meet with

Becky/Keyona/Brittany/Shirley/Lucia/Darnell for up to 2 hours. If you need to cancel or reschedule the interview, please call 414-██████████ and leave a message well before your appointment.

Appendix H

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS

A Study of Stigma with Men Experiencing Homelessness
 Principal Investigator: Rebecca Mayor
 Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate. Please note that your participation (or non-participation) will not impact your relationship with the shelter or homeless assistance program from which you were recruited.

PURPOSE: The purpose of this research study is to learn how society thinks about and treats the homeless and how this affects people facing homelessness. The researchers want to learn about this topic from African American men with mental health problems and drug or alcohol use problems who are experiencing homelessness. People who participate in the study will be asked questions about how they have been treated by society and how they handle this. As a participant, you will be one of 12-18 participants.

PROCEDURES: As a participant in this study, you will be interacting with 1-2 student researchers for about 2 hours. First, you will be asked to fill out a brief survey about your background, which will take about 5-10 minutes. You will then be interviewed about your experiences as an African American man facing homelessness, mental health problems, and drug or alcohol use problems. This interview will be audio taped/recorded so that it can be transcribed later and your comments can be recorded accurately. The audio recordings will be destroyed after they are transcribed, and transcripts will be destroyed 7 years after the study is finished. To protect your privacy, your name will not be used on the surveys, tapes, or transcripts. In fact, for confidentiality purposes, you will be asked to use a fake name during the interview.

DURATION: Your participation will involve 1 face-to-face meeting and/or telephone interaction with the researcher(s). This meeting will take about 2 hours. If the interview is interrupted for some reason and you still want to continue participation in the study, a second face-to-face meeting or telephone interaction can be scheduled to finish the interview.

RISKS: There are some minor risks related to participation in this study. The risks are probably no more than you would experience in everyday life. However, it is possible that the questions asked during the interview may cause you to become upset. Some of them are very personal and ask you to remember times in your life when others treated you poorly or inappropriately because you are an African American man facing

homelessness, mental health problems, and drug or alcohol use problems. If the interview becomes too upsetting for you, it can be stopped at any time, and you can be referred to an on-site shelter staff member (e.g., case manager) who can assist you. Finally, it is important for you to know that the researchers are required to report information about you to the proper authorities if you share any intention to harm yourself or others, or if you share abuse or neglect of a child, disabled adult, or older adult.

BENEFITS: The benefits related to participation in this study include contributing to scientific research and particularly to the field of psychology. Your participation in the study may help people understand the research topic better, especially those who work with the homeless.

CONFIDENTIALITY: All information you share in this study will be kept confidential (with the exception of intent to harm yourself or others and abuse/neglect of a child/disabled adult/older adult – see the “Risks” section of this sheet). All of your information will be given a code number or fake name rather than using your real name or other information that could identify you as an individual. When the results of the study are published, you will not be identified by name, but the researchers may use direct quotations of what you say during the interview. The study data will be destroyed by shredding paper documents and deleting electronic files 7 years after the completion of the study. In the meantime, study data will be kept in a locked file on Marquette University property. Only study personnel will have access to it, though research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies. It is possible that information from your interview or background information survey will be used for future research purposes.

COMPENSATION: You will be compensated for your participation with a \$10 gift card or gift certificate to a local fast-food eatery (e.g., Cousin’s Subs), even if your participation in the study ends early or you do not want to finish the interview. You will receive the gift card or certificate at the end of your meeting with the researchers.

INJURY OR ILLNESS: Marquette University will not provide medical treatment or financial compensation if you are injured or become ill as a result of participating in this research project. This does not waive any of your legal rights or release any claim you might have based on negligence.

VOLUNTARY NATURE OF PARTICIPATION: Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled (i.e., the gift card/certificate). Should you wish to skip any questions or end your participation at any time, simply tell the researcher(s). If you withdraw from the study, information you already shared about yourself will not be used in the study. However, the researchers will keep a record on the number of participants who withdraw from the study, if any.

CONTACT INFORMATION: If you have any questions about this research project, you can contact Rebecca Mayor, the Principal Investigator, by calling her at (414) [REDACTED]. If you have questions or concerns about your rights as a research participant, you can contact Marquette University's Office of Research Compliance at (414) [REDACTED].

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT, AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Participant's Signature

Date

Participant's Name

Researcher's Signature

Date

Appendix I

Receipt of Confirmation

By signing below, you agree that you received a \$10 gift card/certificate for participating in "A Study of Stigma with Men Experiencing Homelessness."

Signature:

Date:

Appendix J

Interviewer/Assistant Interviewer Debriefing Form

1. Participant fake name and date of interview?
2. Length of interview?
3. General reactions to the interview? How did it go overall? Any concerns?
4. Any noteworthy observations of the participant? Anything that could influence the quality of the data positively or negatively?
5. What was the general “message” of the interview? How does it fit into the larger context of the research study? Themes?
6. Anything stand out about the interview? What will you remember most about it?
7. Recommendations to improve the study protocol? Any areas of difficulty for the participant/interview? How was it managing the time?
8. Recommendations to improve the consenting/interviewing process?