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Personal Hygiene Self-Management of Chronically Unsheltered Homeless Women

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PERSONAL HYGIENE SELF-MANAGEMENT OF CHRONICALLY
UNSHELTERED HOMELESS WOMEN

by

Stephanie L. Durfor, RN, MSN

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

Doctor of Philosophy
in Nursing

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ABSTRACT

PERSONAL HYGIENE SELF-MANAGEMENT OF CHRONICALLY UNSHELTERED HOMELESS WOMEN

by

Stephanie L. Durfor

The University of Wisconsin, Milwaukee, 2015

Under the Supervision of Rachel Schiffman, PhD, RN, FAAN

Although the subpopulation of chronically unsheltered homeless women is a small percentage of the overall homeless population, this vulnerable group of women is very high risk for poor health status and negative health outcomes. Unsheltered homeless women are significantly higher risk for assault, physical/mental disorders, and substance/alcohol abuse compared to women residing in shelters or transitional housing. In the midst of a challenging physical and social environment, chronically unsheltered homeless women must manage their personal hygiene on a daily basis.

The purpose of the current study was to gain an in-depth understanding of the personal hygiene self-management (PHSM) of chronically unsheltered homeless women. Guided by the Individual and Family Self-Management Theory (IFSMT), narrative inquiry was used to answer the following research questions: (1) What was the experience of chronically unsheltered homeless women in personal hygiene self-management? (2) What personal hygiene self-management behaviors did chronically

unsheltered homeless women report carrying out? and (3) Can the PHSM experience of chronically unsheltered homeless women be mapped onto the IFSMT?

Purposive, snowball sampling resulted in the recruitment of a final sample size of 10 participants ranging from 36 to 77 years of age (median age was 57.5 years). Time living outdoors for the women ranged from 2 to 53 years (median time living/sleeping outdoors was 10 years). Recruitment took place in a mid-sized, coastal city in Southern California with a year-round mild climate.

Data collection was obtained through semi-structured interviews. Within-case analysis profiled the experiences of each individual woman. Cross-case analysis searched for similarities and differences across all ten of the women. Following cross-case analysis, five common themes emerged: Maintaining Safety, Blending In, Managing Sleep, Sustaining Health, and Problem-solving.

Living in fear on a regular basis required the women to constantly be concerned for their safety. Maintaining their safety was the most serious challenge the women faced while living/sleeping outdoors and was a prevalent theme across all participants. Blending in with the general public was a theme across the women which posed some challenges. The women worked hard to blend in with the general public because the consequences of not blending in were negative. The positive outcomes of blending in included the ability of the women to have an easier time navigating around town, reduced their experience of being stereotyped or judged by the public for being a homeless person, and contributed to a reduction in the overall fear and stress the women experienced on a daily basis. Quality of sleep was an ongoing challenge for the majority of the women. The sleep challenges the women faced were related to safety concerns and

nocturnal urinary frequency. Self-management behaviors carried out by the women were related to sleep locations and guarded sleep time.

Prevention or treatment of health conditions with limited resources was an ongoing challenge for the women, yet many of them were able to find ways to sustain their health. Natural remedies were generally preferred, as they were typically cheaper and viewed as safer by the women. Limited means and a challenging environment in which the women lived and slept required them to be resourceful in self-managing their personal hygiene. The women were creative in problem-solving their needs.

Findings determined the PHSM of the chronically unsheltered homeless women in the current study supported the concepts and relationships of the IFSMT. Despite living and sleeping in harsh, unsafe conditions, all ten of the women were successful in their personal hygiene self-management and sustaining their physical health. Although some chronically unsheltered homeless women performed certain personal hygiene behaviors to prevent the development of or reduce the severity of a health problem, a significant finding was the women primarily engaged in PHSM to be able to blend in with the general public. These behaviors were performed in order to improve their quality of life.

Establishing trusting relationships with the women was crucial to the recruitment of participants and completion of the study. One recommendation is to establish trust and rapport with chronically unsheltered homeless women prior to the launch of a study. Recommendations for further research include exploring PHSM in different geographical areas, especially areas with inclement weather, gender differences in PHSM among the homeless population, and a community-based participatory research approach.

Implications for practice should include interdisciplinary services based on trauma-informed care. Assisting chronically unsheltered homeless women with enrollment in the Affordable Care Act would provide the women with necessary healthcare resources, especially dental care. Policy implications involve homeless shelters offering daily showers to the unsheltered population, with services tailored to the specific needs of homeless women. Programs to assist chronically unsheltered homeless women in gaining access to permanent housing could potentially address several of their PHSM issues, such as keeping clean, managing their sleep, and toileting needs. Living inside, the women would no longer have the stigma of being homeless; therefore, they would blend in more with the general public and potentially increase their sense of safety.

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Chapter 1

Statement of Problem

Chronically unsheltered homeless women are very high risk for poor health status and negative health outcomes (Nyamathi, Leake, & Gelberg, 2000). Compared to women residing in homeless shelters and transitional housing, unsheltered women are three times more likely to have poor physical health, and greater than twelve times more likely to have poor mental health status, greater substance/alcohol abuse, more sexual partners, and experienced physical and sexual assault (Nyamathi, Leake & Gelberg, 2000). For the unsheltered homeless individual, the daily challenge of meeting basic needs (e.g., food, shelter) may interfere with accessing healthcare (Hwang, 2001). Unmet medical needs are higher among unsheltered homeless women compared to those who reside in shelters (Lewis, Andersen, & Gelberg, 2003) and include a myriad of acute and chronic health conditions. This chapter will present potential challenges experienced by chronically unsheltered homeless women, the prevalence of homelessness, and the significance, nursing perspective, and purpose of the current study. The theoretical framework that guided the current study, the Individual and Family Self-Management Theory (IFSMT) (UWM Self-Management Science Center, 2015), in addition to the research questions, will also be presented.

On a daily basis, chronically unsheltered homeless women are challenged to secure clean, safe running water, and privacy for personal hygiene, hand washing, and oral care, putting them at high risk for illness or diseases. Poor living conditions and limited access to healthcare placed homeless populations at great risk for communicable diseases, especially scabies, body lice, and louse-borne diseases (Badiaga, Raoult, &

Brouqui, 2008). Lack of personal hygiene predisposed the homeless population to secondary bacterial infections, and skin conditions were a main reason homeless individuals seek medical attention (Raoult, Foucault, & Brouqui, 2001).

Problems with their feet were another concern for the homeless. Poor foot hygiene due to lack of bathing, unwashed socks, prolonged exposure to moisture and/or cold weather, ill-fitting shoes, overgrown toenails, and prolonged walking and standing contributed to an array of foot problems (Raoult et al., 2001; Muirhead, Roberson, & Secrest, 2011). Common conditions included plantar callus, heel fissures, corns, bunions, plantar fasciitis, tinea pedis, onychomycosis, foot ulcers, and cellulitis (Raoult et al., 2001; Muirhead et al., 2011). Inadequate oral care could lead to missing teeth and periodontal disease, resulting in infections, pain, and difficulty eating (Collins & Freeman, 2007). Episodes of homelessness could contribute to difficulty maintaining adequate personal and menstrual hygiene (personal hygiene during menstruation), contributing to genitourinary problems and infections such as abnormal vaginal discharge, severe pelvic pain, and dysuria (Wenzel, Andersen, Gifford, & Gelberg, 2001). Poor skin hygiene could result in breast issues, such as bacterial mastitis (Wenzel et al., 2001).

Personal hygiene behaviors, especially hand washing, oral care (including access to clean, safe running water), and adequate waste disposal (especially for feces), were crucial to aid in the prevention of the spread of illness and disease (Centers for Disease Control and Prevention [CDC], 2012; Larson & Aiello, 2001). These basic amenities were often unavailable to chronically unsheltered homeless women. Women residing in homeless shelters or transitional housing had access to indoor plumbing and basic personal hygiene products (soap, shampoo, toothbrush, toothpaste), allowing them the

ability to better manage their personal hygiene behaviors (bathing, hand washing, oral care, elimination, and menstrual hygiene).

For chronically unsheltered homeless women, their environment mirrored that of developing countries or the environment following disasters or emergencies. Both the CDC (2012) and the World Health Organization (2012) provided guidelines regarding the self-management of personal hygiene post-disaster emergencies, which were similar challenges for chronically unsheltered homeless women (e.g., clean water for bathing, hand washing, oral care, and adequate human waste disposal). Healthy People 2020 presented social determinants of health as a new objective for the nation, with an important social determinant of health being the availability of resources to meet daily needs (U.S. Department of Health and Human Services [HHS], 2012), resources often unavailable to chronically unsheltered homeless women. This leads to question whether chronically unsheltered homeless women, under such difficult circumstances, were able to self-manage their personal hygiene and health conditions.

Compared to other vulnerable populations, the homeless population experienced significantly more health conditions stemming from social issues such as social isolation, competing needs, inadequate or overcrowded housing, in addition to mental and physical illness, and victimization (Gelberg, Andersen, & Leake, 2000). Homeless persons had high incidences of acute and chronic conditions and mortality rates, three to four times that of individuals residing in permanent housing (Kushel & Jain, 2007). Results from over 19,000 Vulnerability Index surveys of homeless populations showed 46% of respondents reported having at least one serious chronic health condition (Kanis, McCannon, Graig, & Mergl, 2012). Often due to delaying medical care, the homeless

population had higher rates of inpatient hospitalizations than individuals living in permanent housing (Kushel & Jain, 2007). Homeless individuals utilized hospitals and emergency departments four to five times more than the general population (D'Amore, Hung, Chiang, & Goldfrank, 2001).

Prevalence of Homelessness

Annually, communities are required by the U.S. Department of Housing and Urban Development to submit an estimated homeless census, using point-in-time data collection (U.S. Conference of Mayors, 2009). In 2008, approximately 664,000 people nationwide were homeless on a given night (U.S. Department of Housing and Urban Development [HUD], 2012). Homeless women were not as visible as homeless men, making it more difficult to count (Richter, Kovacs, & Chaw-Kant, 2012; Maurer, 2005); however, it is estimated that 20-30% of the homeless population are female (Gelberg, Browner, Lejano, & Arangua, 2004). Fewer female shelter beds, safety concerns, less likely to sleep outdoors, or more likely to temporarily stay with friends were some of the reasons homeless women were less visible than homeless men (Crisis, 2004). Of the overall homeless population, approximately 17% were considered chronically homeless (HUD, 2012). On an average night, 94% of the overall homeless population were single adults (predominately males), 4% were families (primarily females with dependent children), and 2% were unsupervised minors (National Coalition for the Homeless, 2009).

Of the overall homeless population, approximately 42% were African American, 38% White, 20% Hispanic; average age was 41 years; 26% of the homeless population had been diagnosed with a mental illness; 13% were physically disabled; 13% were

veterans; and 19% of females had been a victim of domestic violence (U.S. Conference of Mayors, 2009). In both Canada and the United States, the mortality rates of homeless individuals were four times that of housed, age-matched controls, with the median age of death between 40-47 years (Kushel & Jain, 2007). From 2007-2008, the homeless single adult population had slightly decreased and in some cities the numbers have leveled out (U.S. Conference of Mayors, 2009). Although the chronically unsheltered homeless population was a small segment of the overall homeless population, this subgroup was at greater risk for poor health status and outcomes and was often inadequately served by emergency shelters, emergency rooms, hospitals, and police departments, resulting in a considerable burden on a community (National Alliance to End Homelessness, 2010).

Homelessness can be costly to society. Due to lack of health insurance, barriers to access of healthcare services, and delay in seeking treatment, the homeless population were more likely to access the most costly healthcare services (e.g., emergency department) (National Alliance to End Homelessness, 2012). Nationally, the average inpatient cost for the homeless population was approximately six times higher per person per year compared to permanently housed persons, and can be up to \$34,000 per homeless person per year for multiple public services (medical services, incarceration, law enforcement, shelters) (Culhane, 2008).

Chronically unsheltered homeless women were a highly vulnerable population, yet very little is known about them (Edens, Mares, & Rosenheck, 2011; Kryda & Compton, 2009; Radley, Hodgetts, & Cullen, 2006). The challenge of personal hygiene self-management (PHSM) puts this population at risk for health conditions that may present an even more self-management challenge. Absent from the literature were studies

examining the personal hygiene self-management (PHSM) of chronically unsheltered homeless women. “The values, attitudes, culture, life circumstances of individuals who are poor, socially marginal, or culturally different from the traditional mainstream of society, and the communities in which they reside, must be recognized when planning health promotion and prevention activities” (Pender, Murdaugh, & Parsons, 2011, p. 287), but first one must gain a better understanding of the perceptions of the target population to be served. In the current study, the target population was chronically unsheltered homeless women.

Purpose of the Study

According to Maslow (1943), the need for food, water, elimination, and sleep were among the primitive physiological lower order human needs. Lower order needs must first be achieved for higher order needs (love, belonging, self-esteem, self-actualization) to come into focus (Maslow, 1943), often a tremendous challenge for the poor or homeless (Jasinki, Wesely, Wright, & Mustaine, 2010). The U.S. Department of Health and Human Services’ Healthy People 2020 objectives focused on some of the basic physiological lower order human needs, such as oral health, nutrition, physical activity, and sleep (HHS, 2012).

The environment in which one lives dramatically influenced health status (Pender et al., 2011). The living conditions and lifestyle of the homeless population contributed to a vast range of health concerns, warranting a need for both comprehensive and targeted health promotion research focused on homeless populations (Power & Hunter, 2001). Self-assessment of health status by homeless women varied depending on their homeless experiences (Jasinski et al., 2010). Both the length of time of each homeless episode and

the total number of times a woman was homeless were negatively associated with self-perceived health status (Jasinski et al., 2010). Improving the decision to engage in health practices made individuals critical in determining their own health status (Pender et al., 2011). On a daily basis, individuals made personal decisions that directly influenced lifestyle and the social and physical environments (Pender et al., 2011).

Health promotion was directed toward realizing overall sense of well-being, perceived quality of life, and positive health outcomes (Pender et al., 2011). While developing a strategy for a community-based health promotion program targeting homeless populations, Power and Hunter (2001) discovered maintaining personal hygiene was identified as one of the top four identified health issues suitable for health promotion interventions for homeless or marginally housed individuals. The remaining three health issues identified were related to substance use, effects of cold weather exposure, and the challenges of obtaining an adequate diet. Health promotion behaviors are recognized as key determinants of health and disease prevention (Baheiraei, Mirghafourvand, Mohammadi, Nejat, Charandabi, & Rajabi, 2011). Health promotion behaviors along with a healthy lifestyle should be considered important strategies in improving and maintaining health (Baheiraei et al., 2011). Personal, social, economic, and environmental determinants influence an individual's health status, and these determinants vary among different populations (Baheiraei et al., 2011). The current study explored a subset of health promotion behaviors, specifically personal hygiene behaviors.

Supporting vulnerable individuals to develop healthy lifestyle behaviors requires understanding and compassion by nurses (Sebastian, 2008). It is important for nurses to understand and identify the individual's health priorities and assist the individual in

achieving these priorities (Anderson & Hatton, 2000). Gaining access to the homeless subpopulation of chronically unsheltered women could be difficult. Due to isolation and often resistance to pursuing or accepting assistance, finding ways to engage the chronically unsheltered homeless population is one of the most significant challenges facing service providers (Jost, Levitt, & Procu, 2011). Promoting, maintaining, and restoring health is a critical role of nurses working with homeless populations (Di Martile-Bolla, 2008), and understanding the complex nature of health, health promotion behaviors, and homelessness (Wilson, 2005) is crucial to providing appropriate care.

Daily stressors in the lives of homeless women arose from precarious plans for food, bathing, and sleep (Jasinki et al., 2010). There could be interplay between lower order physiological needs. For example, poor nutrition or gastrointestinal disorders, and genitourinary infections (possibly due to poor personal hygiene) could have an effect on an individual's quality of sleep (Davis & Schuler, 2000). Environmental, psychosocial, and illness conditions may negatively influence sleep-wake patterns (Davis & Shuler, 2000). The daily physical, psychological, and social challenges facing a chronically unsheltered woman seems to pose greater obstacles in which to demonstrate personal hygiene self-management behaviors and achieve optimal health. Considering the difficult and challenging physical, psychological, and social context in which chronically unsheltered homeless women live and sleep, the purpose of the current study was to gain an in-depth understanding of the personal hygiene self-management of chronically unsheltered homeless women.

Definition of Terms

Chronically Unsheltered Homeless

The U.S. Department of Housing and Urban Development [HUD] (2006) differentiated between the terms unsheltered versus sheltered individuals. An *unsheltered homeless person* is defined as an individual who “resides in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, and or on the street” (p. 5). In the current study, identifying an individual as one who lives and sleeps outdoors was a synonymous term for unsheltered. A *sheltered homeless person* “resides in an emergency shelter or transitional housing for homeless persons who originally came from the streets or emergency shelter” (p.5). The *chronically homeless person* is defined by HUD as “a homeless individual with a disabling condition that has been continuously homeless for a year or has had at least four (4) episodes in the past three (3) years” (p.9). The definition of a chronically homeless person seemed to vary depending on the source of information. Not all definitions included the presence of a disability, nor cited the time frame of being continuously homeless or frequency of homeless episodes over a specific time frame (Kushel & Jain, 2007). For the current study, a chronically unsheltered homeless woman was defined as a female who resided in a place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, or on the street for at least one year consecutively or had at least four episodes of unsheltered homelessness in the past three years.

Self-Management

Self-management is defined as a “process by which individuals and families use knowledge and beliefs, self-regulation skills and abilities, and social facilitation to

achieve health-related outcomes. Self-management takes place in the context of risk and protective factors specific to the condition, physical and social environment, and individual and family. Proximal outcomes are self-management behaviors and cost of healthcare services; distal outcomes are health status, quality of life and cost of health. Self-management is applicable to chronic conditions as well as health promotion” (UWM, 2015).

Self-management is control over one’s life and environment, with the individual exhibiting the confidence to carry out an essential behavior to achieve a desired goal (Bodenheimer, Lorig, Holman, & Grumbach, 2002). The definition of self-management could vary across disciplines. When applied to healthcare, self-management is a dynamic process in which an individual manages a condition within the context of one’s daily life and maximizes health rather than conforming to prescribed orders implied by the term compliance or adherence (Grey, Knafl, & McCorkle, 2006). The individual manages resources to attain a sense of well-being (Martina, Stevens, & Westerhof, 2012). The term self-management indicates an individual or family is an active participant in the management of chronic diseases or health promotion (Creer, Renne, & Christian, 1976) by purposefully integrating health-related behaviors into daily functioning (Ryan & Sawin, 2009).

Self-management is a complicated, multidimensional phenomenon involving the physical and social environment and distinct characteristics of individuals and family members as they influenced health-related risk and protective factors (Ryan & Sawin, 2009). Self-management contributes to health outcomes that are both proximal (self-

management behaviors, healthcare services cost) and distal (health status, quality of life/sense of well-being, and direct/indirect cost of healthcare) (Ryan & Sawin, 2009).

Personal Hygiene Self-Management

Personal hygiene self-management (PHSM) is the process by which individuals use specific knowledge and beliefs, self-regulation skills and abilities, and social facilitation to develop personal hygiene self-management behaviors which prevent the development of or reduce the severity of health problems (conditions). Personal hygiene self-management behaviors (PHSMB) are behaviors/actions practiced by the individual related to health and cleanliness (O'Toole, 2005). For example, bathing, oral care, hand washing, elimination, and menstrual hygiene.

Personal hygiene self-management is health promotion. Personal hygiene self-management behaviors are a subset of general health promotion behaviors, and when the behavior are not performed, an individual is at risk for diseases and negative health outcomes, possibly resulting in health conditions which could become an added burden on an individual. Health promotion self-management behaviors (HPSMB) are actions taken to sustain or increase wellness (Mosby Medical Dictionary, 2009). A health condition is "a state of being, specifically in reference to physical and mental health or well-being" (Mosby Medical Dictionary, 2009, p. 410). The health condition may be acute or chronic.

The outcome of limited or absent personal hygiene behaviors (e.g., body odor, unkempt appearance, bad breath, diseases) might result in low self-esteem, negative body image, depression, or an individual being socially isolated, especially if the personal hygiene behaviors are not accepted by the dominant culture (Andrews & Boyle, 2003;

Smith, 2007). An individual could experience issues related to personal hygiene behaviors for a variety of reasons, such as lack of knowledge regarding appropriate behaviors, physical or mental health barriers, or inadequate or lack of resources (clean water, privacy for bathing, toothbrush/toothpaste, etc.). Any or all of these reasons might be barriers to personal hygiene behaviors for chronically unsheltered homeless women. Chronically unsheltered homeless women are faced with several potential obstacles to personal hygiene self-management, obstacles that might be related to the context and/or process of self-management.

Nursing Perspective

Caring for the most vulnerable members of a community is a role of the nursing profession, and care is often delivered from the perspective of profound commitment to social justice (de Chesnay & Anderson, 2008). Three core functions of public health are assessment, assurance, and policy development (American Nurses Association, 2007), and public health nursing practice focuses on improving conditions that influence poor health and poor quality of life for an entire community or target population (Smith & Bazini-Barakat, 2003). Public health nursing is population-based practice at three levels: systems, community, and individual/family (Smith & Bazini-Barakat, 2003).

Nurses play an important role in promoting, maintaining, and restoring health to poor and vulnerable populations such as the homeless (de Chesnay & Anderson, 2008). To deliver appropriate care and planning of services, nurses must consider the person, family, and community within the context of the environment (de Chesnay & Anderson, 2008). In working with the homeless population, nurses need to create a trusting environment, one in which the clients are treated with respect and compassion, free of

judgment (de Chesnay & Anderson, 2008). Social isolation, resistance to seeking care, or limited healthcare access, along with the well-established known high risk for illnesses, are some of the reasons nurses should focus on care of the homeless (Jost et al., 2011), especially the chronically unsheltered.

Chronically unsheltered homeless women are an incredibly vulnerable population with extreme risks for poor health status and health outcomes, yet access to this population could be difficult, resulting in minimal knowledge of personal hygiene self-management. When working with homeless populations, nurses (especially public health nurses) utilize physical and psychosocial assessment skills, communication techniques, and knowledge of appropriate community resources to design and implement appropriate interventions (American Nurses Association, 2007), and are in an ideal position to gain trust and access to chronically unsheltered homeless women. Lack of trust by the homeless population could hinder their access to services, resulting in inadequate identification of their needs (Kryda & Compton, 2009). Therefore, it is crucial to use a respectful, holistic approach in gaining a better understanding of the perceived needs of the homeless (Kryda & Compton, 2009). Vulnerable groups are underrepresented in research, including health promotion research (Pender et al., 2011).

Theoretical Framework

The IFSMT has been applied to the self-management of chronic conditions and health promotion. The IFSMT was used in the current study to assist in confirming components of the model and to potentially provide evidence whether the model helped with health promotion in vulnerable populations. Examining how the interaction between

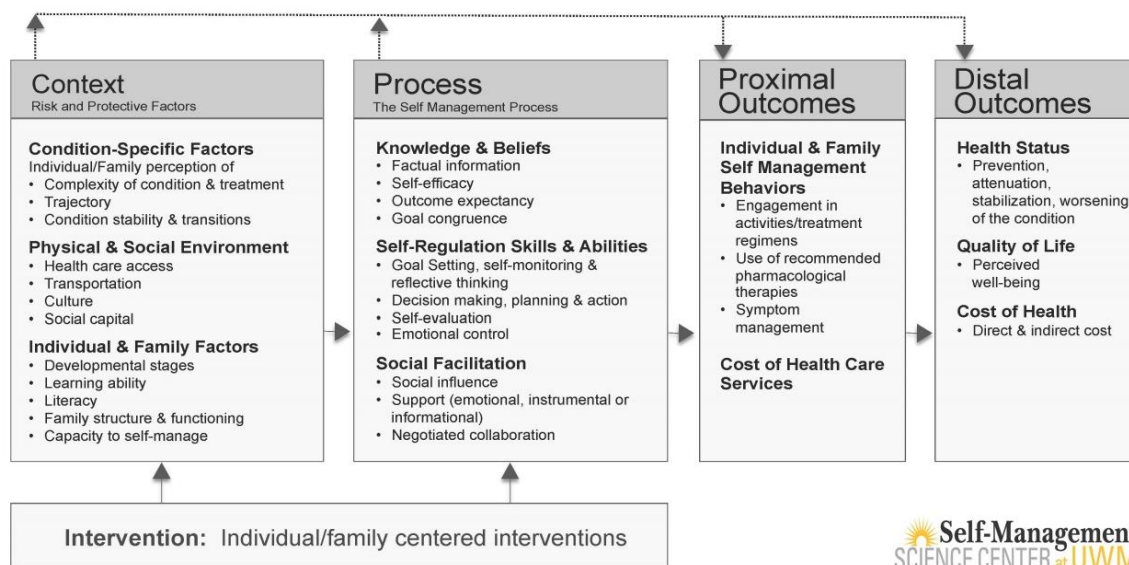
the context and process constructs influenced outcomes could guide appropriate interventions.

Participation in self-management behaviors by individuals and families have been shown to improve health outcomes (Ryan & Sawin, 2009). Participating in personal hygiene behaviors could be complicated, requiring the integration of these behaviors into one's lifestyle. Personal attempts to participate in healthy behaviors are often impeded by social factors incongruent with health (Ryan & Sawin, 2009). On a daily basis, individuals are required to make decisions regarding managing their illness (Bodenheimer et al., 2002). It is important for healthcare professionals to understand the context, process, and outcomes of self-management unique to an individual client or target population in order to support clients in acquiring the knowledge, skills, and social facilitation for health management (Ryan & Sawin, 2009). Such is the case with understanding the health promotion behaviors, specifically personal hygiene self-management behaviors of chronically unsheltered homeless women. The IFSMT, a descriptive, mid-range theory, expands on current knowledge of self-management of chronic diseases and health promotion and consists of three dimensions: context, process, and outcome (Ryan & Sawin, 2009).

The complex personal and social factors of chronically unsheltered homeless women could easily disrupt the ability to engage in personal hygiene self-management. The IFSMT guided the current study with the aim of gaining a better understanding of the process of personal hygiene self-management of chronically unsheltered homeless women. A model of the IFSMT is presented in Figure 1. The components of the model (context, process, and outcomes) will be expanded in the following section.

Individual and Family Self-Management Theory

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Ryan, P.A., & Sawin, K. J. (2014). Individual and Family Self-Management Theory [Figure]. Retrieved from www.nursing.uwm.edu/smsc

Figure 1

Context Dimension

The context dimension focuses on condition-specific factors thought to contribute to the participation in self-management of an individual, caregiver, or family. These factors involve the complexity of the condition, including the treatment and prevention of the condition and the impact these factors have on the necessary behaviors required for self-management. The physical and social environment is an important component of the context dimension, as well as the unique characteristics of the individual, caregiver, and family (Ryan & Sawin, 2009). Availability and access to essential resources is important to the self-management of a condition. Limited resources and/or the inability to access necessary resources could create barriers to the self-management of a condition and could be a point for interventions. The physical setting of the individual, caregiver, or family

could influence the ability to self-manage a condition, such as the quality of the residence (e.g., house, car, shelter, outdoors) or geographical location of the residence, including access to transportation to essential resources.

Characteristics of an individual, caregiver, or family could either improve or decrease the ability to self-manage a condition or health promotion. Important factors to assess are cognitive level and developmental stage which might influence literacy level, learning style, resourcefulness, and overall capability.

For chronically unsheltered homeless women, the complexity of condition they must deal with is the condition of personal hygiene. A critical concept within the context dimension for this population is the influence of their physical and social environment as it relates to the process of personal hygiene self-management. It is known that unsheltered homeless women experienced continuous risk exposure leading to significantly greater negative health outcomes (Nyamathi, Leake, & Gelberg, 2000) and the number and length of time the homeless were negatively associated with self-perceived health status (Jasinski et al., 2010). The physical and social environment presents significant challenges for this group of women. Their physical setting could mirror that of an environment post-disaster, for example, lack of running water, toilets, showers, or safe place to sleep, making it difficult to perform personal hygiene behaviors. The community in which these women live could improve or cause barriers in their quest for personal hygiene self-management. With limited resources, accessing transportation and accessing healthcare could be challenging, putting them at risk for issues related to personal hygiene behaviors possibly resulting in acute or chronic health conditions.

Chronically unsheltered homeless women might possess characteristics that promote or diminish their personal hygiene self-management. Despite the challenges, some of these women might be developmentally and cognitively capable of being resourceful in achieving personal hygiene self-management, attributes that are important to explore. However, due to a high incidence of mental illness, substance abuse, and victimization in this population, many of these women might not possess characteristics favorable to promote personal hygiene self-management.

Process of Self-Management

The process of self-management dimension consists of the concepts of knowledge and beliefs, self-regulation skills and abilities, and social facilitation (Ryan & Sawin, 2009). Self-efficacy, outcome expectancy, and goal congruence are key elements of the knowledge and beliefs aspect of the self-management process. Personal hygiene self-management is preventing the development of or reducing the severity of health problems through the PHSM process. For a chronically unsheltered homeless woman, PHSM involves the confidence she has to successfully engage in personal hygiene behavior(s), the belief that participating in the behavior(s) would achieve her anticipated health outcome, and her ability to resolve conflicting demands potentially interfering with her health goal attainment.

Self-regulation skills and abilities contribute to the process of health behavior change. Influencing the behavior change of an individual or family is goal-setting, self-monitoring and reflective thinking, decision-making, planning and engaging in a particular behavior, self-evaluation, and coping with personal responses (physical, emotional, and cognitive) related to the health behavior change (Ryan & Sawin, 2009).

This component of the self-management process involves numerous skills and abilities one must go through in order to achieve a health behavior change. Due to the complicated lives of chronically unsheltered homeless women, this iterative process might be a challenge to achieve personal hygiene self-management for some of the women. The concepts of self-regulation require an individual, caregiver, or family to adequately take control of the behavior, follow through and be able to self-evaluate, making adjustments accordingly. For chronically unsheltered homeless women, where considerable energy is spent securing basic human needs (food, clothing, shelter), this process might require more than they are able to accomplish.

Social facilitation of self-management behaviors refers to the social influence and support, along with collaboration between healthcare professionals and individuals and/or family. The influence of a respected person with perceived authority and knowledge could be the key to providing the encouragement for an individual to make a health behavior change. This social influence might come from a variety of sources (healthcare provider, family, friends, media, etc.).

Social support, with the goal of aiding or facilitating a health behavior change, could also come from an array of sources (emotional, instrumental, or informational). Important during the social facilitation aspect of the self-management process is the collaborative effort between the individual and those providing influence and support in achieving a health behavior change.

Family is one possible source of social support. In the IFSMT, the family unit is not restricted to biological family (Ryan & Sawin, 2009), which is significant for the chronically unsheltered homeless women who are often socially isolated and most likely

have broken ties with their biological relatives. The use of the IFSMT assisted in the identification of who was viewed as family, if anyone, for a chronically unsheltered homeless woman. Important to examine was whether a chronically unsheltered homeless woman was able to perform personal hygiene self-management in the absence of a family.

All three elements (knowledge/beliefs, self-regulation, social facilitation) contribute to self-management. For the current study, the priority process components explored were self-regulation skills and abilities and social facilitation.

Outcomes: Proximal and Distal

The IFSMT presents both proximal (self-management behaviors) and distal (health status, quality of life/perceived well-being, and both indirect and direct cost to health) outcomes. The proximal outcome specific to the current study was personal hygiene behaviors. A distal health status outcome explored was the perceived health status of chronically unsheltered homeless women. If a chronically unsheltered homeless woman performed the personal hygiene behaviors, then she was less likely to develop an acute or chronic health condition; therefore, requiring little to no healthcare services (proximal outcomes), resulting in perceived positive health status and well-being and a reduction in both indirect and direct health costs (distal outcomes).

Significance and Prevalence

Current social, political, and economic climate call for a reduction in health disparities in vulnerable populations, generating a need for vulnerable population nursing research (Flaskerud, Lesser, Dixon, Anderson, & Conde, 2002). The mounting cost of not providing services to these populations warrants the development of intervention programs to alleviate morbidity-associated costs (Flaskerud et al., 2002).

For the homeless population, context issues contributing to the inability to engage in personal hygiene behaviors are related to social isolation, lack of routine, cost of medical care, absence of family support, and failure to alleviate life stresses (Muir-Cochrane, Fereday, Jureidini, Drummond, & Darbyshire, 2006). Due to the instability of living conditions and lack of social support, the experience of being homeless itself is a significant predictor of failure to seek and maintain medical treatments, creating a challenge for healthcare professionals attempting to support homeless populations (Muir-Cochrane et al., 2006).

No study could be located addressing personal hygiene self-management of chronically unsheltered homeless women. Research specifically targeting chronically unsheltered homeless women, in general, revealed a significant gap of knowledge regarding this vulnerable homeless subpopulation. The majority of studies exclusively recruited female homeless participants from women residing in shelters or transitional housing, omitting those women who were unsheltered.

Considering the vulnerability and extremely high risk for negative health outcomes, a study was warranted to add to the body of knowledge regarding homeless females by examining the personal hygiene self-management of chronically unsheltered homeless women. Findings from the current study could provide the foundation for health promotion programs or other preventive services to best meet health needs of chronically unsheltered homeless women, especially since most healthcare visits by the homeless are associated with acute conditions with limited access to health promotion and preventive services (Stein, Andersen, Koegel, & Gelberg, 2000; Douglass, Torres, Surfus, Krinke, & Dale, 1999). In many settings, the inclusion of health-promoting

strategies are rarely incorporated into the delivery of healthcare (Ryan & Sawin, 2009), especially in healthcare for homeless populations.

Research Questions

To aid in gaining a better understanding of personal hygiene self-management of chronically unsheltered homeless women, the following research questions were explored:

1. What was the experience of chronically unsheltered homeless women in personal hygiene self-management?
2. What personal hygiene self-management behaviors did chronically unsheltered homeless women report carrying out?
3. Can the PHSM experience of chronically unsheltered homeless women be mapped onto the IFSMT?

Summary

Being homeless has a profound effect on health and requires a daily struggle for the fundamental necessities of life (Hwang, 2001), such as access to clean water and adequate human waste disposal. Personal hygiene behaviors, including bathing, hand washing, oral care (including access to clean, safe running water), and adequate waste disposal (especially for feces), are crucial to aid in the prevention of the spread of illness and disease (CDC, 2012; Larson & Aiello, 2001), basic needs often unavailable to chronically unsheltered homeless women.

Clinical experience has substantiated the association between homelessness and higher medical needs and is well documented in the literature (Institute of Medicine, 1988). Homeless individuals have higher rates of chronic illness, morbidity, and mortality

than those residing in stable housing (Kushel & Jain, 2007), with even greater rates for the unsheltered homeless female population (Nyamathi, Leake, & Gelberg., 2000). For most homeless persons, especially the chronically unsheltered population, obtaining food, water, shelter, and safety are higher priorities than seeking medical attention (Kushel & Jain, 2007), and obtaining these basic needs could consume them daily, leaving little room for anything else. Practicing personal hygiene behaviors could lead to the achievement of higher levels of health (Di Martile-Bolla, 2008) and should be a goal for all individuals. The perceptions of individual characteristics and experiences contribute to health behaviors (Pender et al., 2011).

Chronically unsheltered homeless women are very high risk for poor health status and negative health outcomes (Nyamathi, Leake, Keenan, & Gelberg, 2000), and demonstrating personal hygiene self-management might improve their health status and lead to positive health outcomes. Such a vulnerable population in need of assistance, yet little is known about them. Nursing research needs to evolve to examine the process of personal hygiene self-management within the challenging environment of this population. Absent from the literature are studies exploring personal hygiene self-management of chronically unsheltered homeless women. The current study filled that gap by gaining a better understanding of the context and process of chronically unsheltered homeless women as they strive to maintain or improve personal hygiene self-management.

A synthesis of the literature supporting the importance of studying personal hygiene self-management of chronically unsheltered homeless women will be presented in the next chapter. Chapter 3 will present a detailed discussion of the research design and methods/procedures for data analysis and synthesis. The individual personal hygiene self-

management experience of the women, through a within-case analysis, will be presented in Chapter 4. Chapter 5 will present a cross-case analysis and interpretation of the study's findings. A discussion of the study's findings, limitations, and implications for practice and future research will be presented in Chapter 6.

Chapter 2

Review of Literature

A century ago, female hobo, tramp, or lady vagabond were the labels given to women who lived a transient life as outcasts and wanderers (Cresswell, 1999; Maxwell, 1929). They were unsheltered homeless women. The life of a hobo was filled with hardship, deprivation, poverty, and ostracism. By society standards, female hobos were stigmatized and their lifestyle considered unacceptable and unladylike (Maxwell, 1929). Their life was tough and challenging and this was the main argument against any woman becoming a chronic hobo (Maxwell, 1929). Female hobos were stereotyped as having infectious diseases, debilitating wasting diseases, handicaps, and a general unkempt appearance (Reitman, 1937). Most of these women were engaged in an unrelenting struggle to remain human in the face of inhuman conditions (Liebow, 1993). During this time, women unsheltered and living on the streets were faced with the daily struggle to secure food, water, shelter, security, and safe sleep (Liebow, 1993).

Many decades later, the plight of chronically unsheltered homeless women has not changed. Unsheltered homeless women still experience social stigma, stress, alienation, and health issues (Radley et al., 2006). The stereotype of looking homeless is to be dirty and unkempt with a foul odor (Knecht & Martinez, 2009), a stereotype homeless women often try to overcome. Many homeless women believe that in order to be deemed worthy of assistance they must reconcile the stigmatization of being homeless (Williams, 2003).

The number and length of time being homeless is negatively associated with self-perceived health status (Jasinski et al., 2010), putting chronically unsheltered homeless women at a high risk for negative health outcomes. Researchers acknowledge little is

known about chronically unsheltered homeless women, despite being identified as a particularly vulnerable subgroup of the homeless population (Edens et al., 2011; Kryda & Compton, 2009; Radley et al., 2006).

One study was located that sought to learn more about the lives of unsheltered homeless women. Radley et al. (2006) sought to gain a better understanding of the lives of single women living on the streets or in a hostel in London, U.K. They also examined possible fears contributing to the challenges in the daily lives of homeless women and how the homeless women dealt with these fears. Twelve single homeless women were recruited, all of them white and middle-aged (age 42-60). Three women from the original cohort of 12 participants were asked to take photographs of their environment with follow-up interviews by the researchers. Findings of the study revealed the women had concerns for their safety, especially fear of being assaulted by homeless and housed men. During the day, the women spent time with male friends, but felt safer sleeping alone and hidden at night. The women cared about their appearance and keeping clean was a priority. They tried to eat healthy whenever possible. With limited financial resources, the women did their best to meet their needs. The study identified the importance of understanding how homeless women lived their lives, especially the interconnected nature of their physical and social surroundings as it pertained to their health. These findings were in line with the context dimension of the IFSMT, the framework that guided the current study.

The purpose of the current study was to gain an in-depth understanding of personal hygiene self-management of chronically unsheltered homeless women, and a review of the literature revealed an absence of research regarding this specific aspect of

the lives of these vulnerable women. Knowing there was limited research regarding the current study's target population (chronically unsheltered homeless women) and nothing on the specific topic of interest (personal hygiene self-management), the goal of this literature review was to explore what was known about chronically unsheltered homeless women and personal hygiene self-management of the homeless population, and to determine out of that literature what was relevant to the current study.

Search strategies used to locate relevant studies are discussed. An organized review of significant literature, starting with an overall look at the health status of homeless women, both sheltered and unsheltered, is presented. Following will be a presentation of possible explanations for the gap in the literature regarding chronically unsheltered homeless women. Health promotion behaviors in the homeless population, in general, are presented, followed by specific personal hygiene behaviors potentially problematic for chronically unsheltered homeless women. Studies related to self-management and the homeless population are presented with an application to the IFSMT.

Search Strategy

A critical review of current literature was required prior to the onset of the current study. To conduct this literature review, various information sources were used, including books, professional journals, and internet resources. Sources were accessed through multiple databases, including ProQuest, PsychINFO, Cochrane Library, Web of Knowledge, MEDLINE, Project MUSE, and JSTOR. Care of the homeless population was often an interdisciplinary collaboration primarily served by the disciplines of

nursing, social work, psychology, public health, and medicine. Databases were searched for research primarily from these disciplines.

Key words used in the search were unsheltered homeless women, homeless women, unsheltered homeless, non-sheltered homeless, homelessness, health promotion, personal hygiene homeless, and personal hygiene and self-management. Studies were selected based on their relevance to homeless women (sheltered versus unsheltered), the homeless population as a whole, followed by personal hygiene in the general population, personal hygiene specific to the homeless populations, and self-management.

Health Status of Homeless Women

Understanding the overall health issues of homeless women was important, as some of these issues may impede their ability for personal hygiene self-management. The health and healthcare disparities between vulnerable and majority populations were well documented (Teruya et al., 2010; Schanzer, Dominguez, Shrout, & Caton, 2007; Hwang, 2001). Health and health disparities were particularly distressing for homeless women (Teruya et al., 2010).

The purpose of a study by Teruya et al. (2010) was to gain a better understanding of the health and healthcare disparities among African American, Latina, and White homeless women in addition to race/ethnicity and factors that contributed to poor health or enabled homeless women to access better healthcare. Secondary data analysis was used from the Decision-making Study (DMS) data set. Data from the DMS was collected from 1994-1996 and recruited a purposive sample of 1,344 homeless women greater than 18 years of age, from 51 traditional or sober-living shelters and through street outreach in Los Angeles County, CA. Teruya et al., (2010) utilized data from 1,331 homeless women

from the DMS and used the expanded Behavioral Model for Vulnerable Populations to guide their study. Findings revealed white homeless women had more unmet health needs compared to African-American and Latina homeless women. Also, women in the study with a high need of care were homeless women suffering from depression, violence, and substance abuse. Knowledge was essential in order to determine the most vulnerable within a vulnerable population and to plan interventions to improve their health status (Teruya et al., 2010).

Nyamathi, Leake, & Gelberg (2000) provided a foundational study in comparing two groups of homeless women (sheltered versus unsheltered) by looking at the differences in health, behavior, victimization, and healthcare utilization. Purposive sampling was used to recruit 1,051 homeless women (860 sheltered and 191 unsheltered) from 47 traditional shelters and from the streets of Los Angeles, CA. Multiple logistic regression was used for data analysis. Compared to women residing in homeless shelters and transitional housing, unsheltered women were three times more likely to have poor physical health, and greater than twelve times more likely to have poor mental health status, greater substance/alcohol abuse, more sexual partners, and experience physical and sexual assault (Nyamathi, Leake, & Gelberg, 2000).

Lewis et al. (2003) conducted a secondary data analysis using a data set from the 1997 UCLA/RAND Homeless Women's Health Project. The purpose of the Lewis et.al (2003) study was to determine the perceived unmet medical needs and potential barriers to healthcare of homeless women. Data were obtained through structured interview from 974 homeless women aged 15-44 years. The Behavioral Model for Vulnerable Populations was adapted to predict unmet medical needs. Univariate analysis was used to

describe the characteristics of the sample, perceived barriers and facilitators. The association between variables, perceived barriers, and perceived unmet medical needs was determined through the use of bivariate analyses. The study's findings showed perceived unmet medical needs were higher among unsheltered homeless women compared to those who reside in shelters. For unsheltered homeless women, the daily uncertainties of basic needs were greater barriers to healthcare than having health insurance (Lewis et al., 2003).

The IFSMT context dimension addresses an individual's physical environment. The challenging physical environment of chronically unsheltered homeless women may present obstacles for personal hygiene self-management. Due to their environment, chronically unsheltered homeless women were confronted with the need to obtain safe running water for bathing, hand washing, and oral care, and the need for privacy for personal hygiene, putting them at high risk for illness or diseases. In a review of infectious diseases in the homeless population, Raoult et al. (2001) cited homeless populations with poor living conditions and limited access to healthcare placed this population at great risk for communicable diseases, and lack of personal hygiene predisposed the homeless to secondary bacterial infections and skin conditions. Compared to sheltered homeless women with access to basic conveniences and social support, unsheltered homeless women were at a higher risk for issues related to personal hygiene self-management.

While reviewing studies relevant to homeless women, a noticeable finding was the limited number of studies with unsheltered homeless women as participants. Predominately seen in the literature were participants recruited from homeless shelters or

transitional housing. Since the current study recruited exclusively from chronically unsheltered homeless women, it was important to understand the issues associated with the lack of recruitment and limited knowledge about chronically unsheltered homeless women.

Unsheltered Homeless Participants

Reviewing the literature provided some explanation why little was known about chronically unsheltered homeless women. The two key issues were limited access and mistrust. Due to easier access, many studies exclusively recruited female homeless participants from women residing in shelters or transitional housing, omitting those women who were unsheltered.

Lewis et al., (2003) used secondary data from the University of California, Los Angeles (UCLA)/RAND Homeless Women's Health Project (a cross-sectional study using structured interviews) and was the first descriptive, community-based probability sample of 974 sheltered homeless women where perceived barriers to care were used to predict unmet need for healthcare. Findings revealed perceived barriers to healthcare by sheltered homeless women. The study stressed that outreach and prevention programs exclusively targeting homeless women residing in shelters may miss the population of homeless women with the highest odds of unmet need for medical care, those who are unsheltered.

Another reason thought to contribute to limited studies relating to the chronically unsheltered homeless population (female and male) was mistrust of outreach workers for the homeless (Kryda & Compton, 2009). Using narrative inquiry with semi-structured interviews, Kryda and Compton (2009) interviewed 24 chronically homeless individuals

regarding their perception of outreach practices as it related to service utilization. Findings revealed the chronically unsheltered homeless population felt they were stereotyped by outreach workers as social outcasts, lazy, and drug addicted. This homeless population felt the outreach workers failed to demonstrate a genuine caring for them as individuals and strongly encouraged the use of shelters, something objectionable to those who prefer the streets. These factors contributed to a lack of confidence, mistrust, and service refusal. The issue of trust could easily be applied to any healthcare professional working with the unsheltered homeless population.

Experienced nursing researchers of homeless individuals and abused women, Anderson and Hatton (2000) shared their experiences gaining access to vulnerable populations for the purpose of research. A key obstacle they found was the potential issue of trust between researcher and participant (Anderson & Hatton, 2000). In addition, vulnerable individuals were challenged by their daily struggle to obtain basic needs (food, clothing, shelter), leaving them limited time and energy to participate in a study (Anderson & Hutton, 2000).

Health Promotion Behaviors in Homeless Population

Health promotion behaviors are actions taken to sustain or increase wellness (Mosby Medical Dictionary, 2009). Personal hygiene self-management behaviors, a subset of general health promoting behaviors, was a component of the current study. Since the literature was absent of any studies directly examining personal hygiene self-management behaviors of any homeless population, the search widened to studies investigating health promotion behaviors in the homeless population as a whole. Very limited research was located.

One study closest to the current study examined health promotion behaviors of sheltered homeless women (omitted unsheltered women) (Wilson, 2005). Using Pender's Health-Promoting Lifestyle Profile (HPLP II), Wilson's cross-sectional, descriptive study collected data over a five-month period and found sheltered homeless women (n=137) practiced health promotion behaviors in all subgroups of the instrument (lifestyle, health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management), with the lowest scores being physical activity and nutrition. These findings could not be generalized to chronically unsheltered women as the environments differed between the two populations. To capture a more realistic picture, the self-management of health promotion behaviors needed to be examined within the context of an individual's environment. A sheltered woman had some basic needs already met for her, such as food, clothing, and shelter, the ability to engage in regular personal hygiene, social interaction, and often on-site medical care, depending on the shelter. The daily physical, psychological, and social challenges facing a chronically unsheltered woman would seem to pose greater obstacles in which to demonstrate personal hygiene self-management and achieve optimal health. Wilson's study primarily addressed the context dimension of the IFSMT. The process of self-management of personal hygiene was not mentioned.

Power and Hunter (2001) addressed some aspects of the IFSMT process dimension of social facilitation, specifically social influence. Participants were recruited from *Big Issue* vendors, a newspaper sold on the streets by homeless individuals, providing them with a source of income. One hundred *Big Issue* vendors were surveyed in addition to in-depth interviews and focus groups. Following a participatory research

design, their study was conducted over a nine-month period in 1999. The vendors were very visible and well connected to the homeless population and assessed to be a potential social influence to act as peer-health advocates for health promotion education. The most common health promotion needs cited in the study were related to substance abuse, exposure to cold weather (especially for the unsheltered population), obtaining adequate nutrition, and maintaining personal hygiene to avoid skin conditions and parasites. Findings suggested this community-based peer intervention could work for outreach to the hard-to-reach homeless populations such as those unsheltered.

Personal Hygiene Behaviors

Due to the instability of living conditions and lack of social support, the experience of being homeless itself was a significant predictor of failure to seek and maintain medical treatments (Muir-Cochrane et al., 2006). For the homeless population, potential issues contributing to the inability to engage in personal hygiene behaviors may be related to social isolation, lack of routine, cost of medical care, absence of family support, and failure to alleviate life stresses (Muir-Cochrane et al., 2006).

The literature revealed a few studies that may be applicable to personal hygiene in chronically unsheltered homeless women. Aiello and Larson (2002) presented a literature review regarding the epidemiological evidence between hygiene practices and infections, an overview of hygiene measures and infection outcomes over the past two decades, and suggestions for future research. Findings revealed epidemiologically there was a positive correlation between hygiene and infectious diseases at both the personal and environmental level and suggested further research into maintaining a reduction in infections attributed to personal and environmental hygiene interventions in numerous

high risk settings. The surroundings of chronically unsheltered homeless women would be considered one of those high-risk settings.

Bathing and hand washing issues could lead to skin issues and communicable diseases, especially scabies, body lice, and louse-borne diseases (Raoult et al., 2001), issues common among the homeless population, especially the unsheltered. Lack of personal hygiene behaviors predisposed the homeless individual to secondary bacterial skin infections, with skin conditions being identified as main reasons homeless individuals sought medical attention (Raoult et al., 2001).

Extended exposure to moisture, poor foot hygiene, ill-fitting footwear, and prolonged walking and standing contributed to significant foot problems in the homeless population, placing them at risk for foot and skin infections (Muirhead et al., 2011). Foot deformities and peripheral neuropathy were common foot problems often underreported by the homeless population (Chong, Yamaki, Harwood, d'Assalenaux, Rosenberg, Aruoma, & Bishayee, 2014). These issues were even more pronounced in the unsheltered homeless population. Raoult et al., (2001) reviewed infections in the homeless populations, with infections of the feet being among the most common issues. Lack of personal hygiene was cited as a key contributor to secondary bacterial skin infections, including infections of the feet.

Acknowledging the high risk for infections of the feet and skin in the homeless population, Muirhead et al. (2011) examined the reasons homeless adults utilized foot care services. Guided by the Behavioral Model for Vulnerable Populations, an 18-item questionnaire (items related to health history, general healthcare utilization, foot care beliefs and practices, and use of foot care services) was used to survey one hundred

homeless adults. Findings revealed that despite the majority of the participants appreciating healthy foot care, the conditions of shoes, socks, and foot odor were major deterrents to using foot care services. Another issue identified was the timing of the foot care services. The study found foot care services for the homeless should be during the day when the homeless were not distracted by trying to secure shelter for the night. For the unsheltered homeless population, securing safe sleeping would likely be a priority over foot care services.

Research regarding oral health and the homeless population presented a bleak picture. Coles, Chan, Collins, Humphris, Richards, & Williams (2011) conducted a study to determine the effect of oral-health-related factors and depression in homeless individuals. A non-probability convenience sample was used to recruit 853 homeless individuals located in Scotland, U.K., 598 (70%) with completed data sets. The majority of the participants were white males between 16-67 years of age (mean age was 32.6 years) who primarily resided in shelters (only 2% were unsheltered). Questionnaires were administered to assess depression, dental anxiety, and quality of life. In addition, each participant was given an oral exam to assess for tooth decay and/or missing teeth. Data analysis consisted of latent variable path analysis to determine the effects of oral health status on depression. Findings of the study revealed there was an identified link between depression and oral-health issues in homeless adults, often due to the embarrassment from poor oral hygiene such as dental caries and missing teeth (Coles et al., 2011).

Limited access and utilization of oral healthcare in sheltered homeless children and families resulted in poor oral hygiene (Di Marco, Lundington, & Menke, 2010). Di Marco et al. (2010) conducted a quasi-experimental study using a convenience sample of

120 sheltered homeless families (including 236 children), assessing predictors of access to dental healthcare, general dental health status, and effectiveness of a shelter-based dental care program. Findings revealed mothers had adequate knowledge of dental health, with a positive belief in dental healthcare. A collaboration between dentist and/or healthcare practitioners and the homeless families was a predictor in the families accessing dental care. The availability of a shelter-based dental program was also associated with homeless families accessing dental care.

Through snowball sampling of single homeless individuals, Collins and Freeman (2007) surveyed 317 predominately sheltered homeless males and identified inadequate oral care may lead to missing teeth and periodontal disease, resulting in infections, pain, and difficulty eating, resulting in health and social factors. Being self-conscious due to the appearance of their teeth, homeless individuals had the potential for issues with poor nutrition and social exclusion. The study supported prolonged homelessness can have a negative effect on oral health status. Applicable to the current study was participants were recruited from several hostels and day centers targeting some unsheltered homeless individuals.

Using structured interviews, Wenzel et al. (2001) studied gynecological symptoms and subsequent medical care in 974 homeless reproductive-aged women (aged 15-44 years) recruited from shelters and homeless meal facilities in Los Angeles County, CA. Data were analyzed using multivariate linear regression to assess the relationship of predictors of two variables, gynecological symptoms/conditions and use of medical care for those symptoms/conditions. Findings supported the importance of adequate medical care and treatment for gynecological issues (irregular menstrual periods, abnormal

vaginal discharge/bleeding, breast issues, dysuria) in homeless women. Difficulty maintaining adequate personal and menstrual hygiene (personal hygiene during menstruation) contributed to gynecological problems and infections such as abnormal vaginal discharge, severe pelvic pain, breast issues, and dysuria (Wenzel et al., 2001). Compared to sheltered homeless women, being an unsheltered homeless woman was associated with increased needs and increased unmet needs for gynecologic care due to issues regarding healthcare service utilization (Wenzel, et al. 2001).

Adequate waste disposal and hand washing (especially for feces) were crucial to aid in the prevention of the spread of illness and disease (CDC, 2012; Larson & Aiello, 2001). For chronically unsheltered homeless women, their environment emulated that of a post-disaster area or developing countries. Both the CDC (2012) and the World Health Organization (2012) provided guidelines regarding the self-management of personal hygiene post-disaster emergencies, which were similar challenges for chronically unsheltered homeless women (e.g., clean water for bathing, hand washing, oral care, and adequate human waste disposal). Content sources for the CDC guidelines were from the CDC National Center for Environmental Health and the National Center for Injury and Violence Prevention and Control, in addition to the United States Department of Health and Human Services' Agency for Toxic Substances and Disease Registry. Guidelines from the World Health Organization were based on recommendations of the Water, Engineering and Development Centre of Loughborough University in Leicestershire, United Kingdom.

No study could be located that directly addressed the issues of human waste disposal and the homeless population, despite the potential link between appropriate

waste disposal and the spread of illness and disease (CDC, 2012; Larson & Aiello, 2001). This issue may warrant further study, as the city of San Francisco, CA, has an ongoing issue of human waste from their unsheltered homeless population soiling their Bay Area Rapid Transit (BART) downtown stations. According to the online newspaper *SF Gate*, in July 2012, the sheer volume of human waste shut down several of the downtown BART escalators by gumming up the wheels and gears, resulting in lengthy closures for repairs, increased cleaning costs, and an unpleasant odor for morning commuters (Kane, 2012). The unsheltered homeless population slept in the BART stations and, due to the fact the downtown public bathrooms were closed at night, homeless individuals used the station to relieve themselves of urine and feces (Kane, 2012) and placed many people at risk for the spread of disease.

Sleep health, including sleep deprivation and sleep disorders, has been associated with health issues such as obesity, diabetes, cardiovascular disease, immunity issues, and a cause of motor vehicle deaths (Grandner & Pack, 2011). A large portion of women suffered from issues with sleep-wake patterns, and sleep disruptions was one way women coped with environmental and psychosocial difficulties in their everyday lives (Davis & Shuler, 2000). Research was primarily focused on sleep health in the general population. Considering the challenging environment and psychosocial issues often experienced by homeless women, sleep health may be an even bigger concern in homeless women, especially women living and sleeping outdoors.

Very little was found in the research regarding sleep health in the homeless population, especially unsheltered homeless women. A study by Davis and Schuler (2000) examined the lifestyle factors associated with sleep, along with altered sleep-wake

patterns in homeless women. Fifty women (aged 18-44 years) were recruited from a small homeless women's clinic located in downtown Los Angeles, CA. All of the participants identified as homeless; however, the study did not specify unsheltered vs. sheltered living situations. The majority of the women in the study were single. A self-administered 521-item questionnaire contained seven items pertaining to sleep patterns. Sleep patterns were self-reported via the questionnaire. Results from the study revealed the majority of the women slept six hours or less per day. Half the participants slept both during the day and at night. Safety concerns were cited by the women as the primary reason for restless sleep during the night leaving them tired during the day and in need of a nap. Other reasons for restless sleep during the night were worrying about money and being lonely. Many women in the study shared that sleeping was a way to cope with their stress.

Self-Management

Personal hygiene issues discussed above are of significant concern for the homeless population, especially the unsheltered homeless individuals living and sleeping outdoors; the longer unsheltered, the greater potential for poor health outcomes. To date, the literature has primarily focused on the context dimension of the IFSMT, particularly the physical and social environment. Unknown is the process of self-management of personal hygiene in any homeless population. The goal of the current study was to primarily focus on the IFSMT process of self-regulation and social facilitation in personal hygiene self-management in chronically unsheltered homeless women.

Self-management of a condition by homeless individuals was found in the literature, although scarce. Muir-Cochrane et al. (2006) explored the experience of

homeless young adults' self-management of psychiatric medications. Through interpretive phenomenology, the study conducted in-depth interviews with homeless young adults with mental health issues (n =10), specifically interested in the self-management of their medication. The central elements identified were related to issues surrounding obtaining medication, managing medication, side-effects of the medication, and interactions with illicit drugs. Managing these issues were primarily related to the physical and social environment of the homeless youth, such as financial resources to obtain the medication, obtaining food to take with the medication, safe places to store the medication, and being in a safe environment if side effects (such as dizziness), especially if mixed with illicit drugs. One important finding applicable to the current study was regular contact and support from healthcare professionals increased adherence with medication and provided a foundation for a trusting relationship between the homeless youth and healthcare professionals.

A self-management program for Hepatitis C (HCV) included homeless participants in the sample, but was not exclusively a sample of homeless individuals (Groessler, Weingart, Stepnowsky, Gifford, Asch, S. M., & Ho 2011). Of the 137 participants, 14% were homeless. The purpose of this randomized, controlled study compared an HCV self-management intervention program and the quality of life of HCV-infected individuals and compared outcomes from those receiving information only and those who attended self-management workshops. Findings revealed those who attended the workshops (including support from healthcare professionals) had a better reported health-related knowledge, improved self-efficacy, and improved quality of life. Findings

from this study provided some credence to social support described in the process dimension of the IFSMT.

Summary

Chronically unsheltered homeless women are high risk for poor health outcomes due to potential issues surrounding personal hygiene self-management. Some women from this population may be more successful than others in their personal hygiene self-management.

It was important to explore the self-regulation and social facilitation concepts that may be contributing to the process of personal hygiene self-management in this population. A comprehensive literature review revealed a significant gap in studies targeting chronically unsheltered homeless women. The current study filled that gap.

The following chapter will be a detailed discussion of the research design and methods/procedures for data analysis and synthesis. Scientific rigor will also be presented.

Chapter 3

Methods

The purpose of the current study was to gain an in-depth understanding of personal hygiene self-management (PHSM) of chronically unsheltered homeless women. Guided by the IFSMT, the current study explored, from the perspective of chronically unsheltered homeless women, the context and process of personal hygiene self-management. Narrative inquiry framework and design was used. This chapter presents an in-depth discussion of the research design, sample selection, and details regarding data-collection, analysis and synthesis. Concluding the chapter will be a discussion of human subject protection, scientific rigor, and an overall summary of key points.

Research Approach

Design. The qualitative research perspective seeks understanding, interpretation, and meaning through hearing personal narratives, giving voice to those overlooked and using the language of participants in research (Duffy, 2007), and allows for discovery rather than test variables (Corbin & Strauss, 2008). A person narrates her own story that has meaning and interpretation within the individual and social context of their lived experiences (Duffy, 2007). Through narrative, participants express their emotions, thoughts, and interpretations, and communicate why their story is worth telling (Chase, 2008). Narratives divulge significance, prominent beliefs and values of the time and place in which one lives and contributes to one's identity (Duffy, 2007).

Narrative inquiry, a form of qualitative research, is systematic, purposeful, and practical (Reissman, 2008), taking personal stories (narratives) of individuals and collectively using them as a source of data (Duffy, 2007). Narrative inquiry provides robust data (Clandinin & Connelly, 2000), aiding in the comprehension of how

participants establish order and make sense of the course of events and actions in their lives (Reissman, 1993). To provide the chronically unsheltered homeless women a format in which to share their personal experiences of PHSM and to capture the richness of the data, narrative inquiry was determined to be the best design for the current study.

Sample. Exploratory studies are used to gain a better understanding of an issue or problem and increase knowledge of a field of study (Grove, Burns, & Gray, 2013). The goals of nonprobability sampling methods are to locate participants who best represent the population of interest and advance knowledge in a field of study (Wood & Ross-Kerr, 2006). In purposive sampling, a type of nonprobability sampling, the researcher consciously selects participants possessing certain characteristics desired for the study, in order to increase understanding of the subject of interest (Grove et al., 2013). Purposive sampling can lead to information-rich, in-depth cases (Ferguson & Islam, 2008). For the reasons cited above, purposive sampling was used in the current study.

Initial sampling began with establishing inclusion criteria (Charmaz, 2006). For the current study, inclusion criteria included: (a) female, (b) minimum of 18-years-old, (c) English speaking, (d) currently living/sleeping outdoors (unsheltered) or in a vehicle or had a history of living/sleeping outdoors or in a vehicle, (e) met the criteria for being chronically unsheltered homeless (as opposed to be acutely unsheltered), and (f) cognitively able to consent for herself. Screening questions were used to determine eligibility for the study (Appendix A). Due to potential trust issues, it was anticipated that this population may be sensitive and resistant to too many questions regarding personal information. Screening questions for the current study were cognizant of this potential concern and included only pertinent questions to determine eligibility. Exclusion criteria

included: (a) male, (b) under age of 18-years-old, (b) non-English speaking, (c) does not meet the chronically unsheltered criteria, and (d) cognitively unable to consent for herself.

Sample selection. In qualitative research, sample size is not an essential feature of the analysis; therefore, there is little guidance on determining the size of a sample (Gerrish & Lacey, 2010). In some cases, determinates of sample size are the availability of resources and the feasibility of obtaining participants (Gerrish & Lacey, 2010). Small sample size (usually fewer than 25) is often seen in exploratory studies seeking an in-depth understanding of a subject (Wood & Ross-Kerr, 2006), and those with a narrow domain can be accomplished with a sample size of 10-15 participants (Munhall, 2007). In qualitative research, selection of participants should focus on the appropriateness of information and experiences a participant may bring to the study and not people per se (Sandelowski, 1995). For the current study, sample selection focused on women and their potential to provide appropriate, meaningful information to address the purpose of the study and answer the research questions.

Following University of Wisconsin, Milwaukee's Institutional Review Board approval, recruitment began (Appendix B). Recruitment of participants started at a women's homeless clinic. The non-profit parent organization of the women's homeless clinic was very cognizant and protective of the potential exploitation of their beneficiaries. Therefore, a letter of support for this research and permission to recruit from any of their four homeless clinics was obtained from the organization's Board of Directors and submitted with the UWM IRB application.

The women's homeless clinic was a small female-only, nurse-run clinic, providing integrative services to both sheltered and unsheltered women; however, the target population was unsheltered homeless women (both acute and chronically unsheltered). At the time of the current study, the student principal investigator (PI) had been the volunteer medical director for the women's homeless clinic for several years and, due to this long-standing role, had established trust and rapport with many of the chronically unsheltered homeless female clients. There were approximately twice as many sheltered women (23 women) as unsheltered women (10 women) at a typical clinic.

A recruitment flyer was created and posted at the women's homeless clinic. Being both the volunteer medical director and the student PI, direct recruitment of participants by the student PI could have been viewed as coercion by potential participants. Potential participants could fear they would be denied services at the women's homeless clinic if they declined to participate in the current study. Therefore, initial recruitment took place by the women's homeless clinic coordinator, resulting in one eligible participant. Another eligible participant was recruited by a nurse practitioner working at a city park homeless medical clinic sponsored by the parent organization of the women's homeless clinic. Further recruitment took place by two homeless women. One homeless woman was the first participant to be interviewed for the study and the other woman was living in a shelter and did not meet the inclusion criteria to participate herself. Both women were regular clients at the women's homeless clinic. At their request, the flyer was reduced in size so they could distribute the mini-flyers to other homeless women. The mini-flyer was sized to take up limited space in the belonging bags of potential participants. Three potential participants, recruited by one of the homeless women, expressed interest over

the phone to meet and learn more about the study. All three of the women failed to appear at their agreed upon date, time, and location established during the phone call. Snowball sampling resulted in the recruitment of nine eligible women willing to participate in the study. The total number of eligible participants willing to participate in the study was 11 women.

Interested participants initiated contact with the student PI. Contact was made via cell phone or in person at the women's homeless clinic. Some of the potential participants did not have their own cell phone, so they borrowed a cell phone from another homeless woman to make the initial contact. At the time of initial contact, any questions by the participants were answered by the student PI and eligibility for the study was determined.

Data Collection Procedure

Once a meeting location was selected by a participant, establishing trust and a rapport with each participant was very important. Initially, the meeting started with general social conversation allowing the participant to get comfortable with the student PI, as not all of the participants were known to the student PI prior to the interview. Once the student PI assessed the participant's readiness to begin the interview process, the informed consent script was read to each participant by the student PI. The participants were given the opportunity to ask questions regarding the informed consent script. None of the participants had any questions regarding the informed consent script and all verbally agreed to participate in the current study.

Oral, informed consent to participate in the study and consent to be audio-recorded was obtained and documented at the bottom of the oral consent script form (Appendix C). For the participants consenting to be audio-recorded, their oral consent

was audio-recorded in their own voice. Oral, informed consent was audio-recorded for nine participants. Two participants denied permission to be audio-recorded; therefore, their oral, informed consent was documented by making a notation at the bottom of the oral consent script form stating they consented to the study and they did not agree to be audio-recorded.

Two audio-recorders (one digital recorder and one cassette recorder) were used, in the event one of the recorders failed during an interview. This situation occurred once during the study, with the digital recorder malfunctioning. Fortunately, the cassette recorder captured the entire interview. The face-to-face interview began with audio-recording (or handwritten for two participants) the responses to three screening questions: (1) Where do you live and sleep? (2) How long have you been living and sleeping there? (3) How old are you?

The interview proceeded with a semi-structured interview format to allow participants the liberty of sharing their experiences on their own terms, allowing for the flexibility to change directions depending on the participant's responses (Wood & Ross-Kerr, 2006). To assist in the development of an interview guide, a matrix was created to ensure each research question was addressed by at least one interview question. Based on this matrix, an interview guide with open-ended questions and probes was created and used during the interviews (Appendix D). The interview guide was arranged by lines of inquiry following the research questions. It was estimated the interviews would take between 30-60 minutes to complete; however, the actual interviews were each approximately 1 to 2 ½ hours in length. Once the women began talking about their experiences, they had a considerable amount to share. Considering the transient nature of

the homeless population, it was imperative to capture as much pertinent information during the initial interviews. Due to the length of the interviews and the detailed information shared by each participant, one interview per participant was sufficient to answer the research questions.

Eleven participants consented to the study, yet only ten women completed the entire interview and the study. The one participant who withdrew herself from the study initially gave oral consent to participate in the study; she would not consent to be audio-recorded, but agreed to note-taking during the interview. She said she just wanted to talk. She did seem a little nervous during the interview, but responded to the questions. However, midway through the interview, the participant stated she changed her mind and did not want to proceed. She politely declined the offer to continue the interview at another time or at another location. She was assured that nothing from the conversation would be used in the study.

Field Notes. Field notes were kept by the student PI in a handwritten notebook. Taking extensive notes during the interview could have been distracting and disruptive to the interview flow; therefore, the field notes were written immediately following each interview. After the conclusion of the interview and both the participant and the student PI left the interview location, handwritten notes were entered into the field notebook. Field notes contained observations, personal reflections, and anything the student PI felt was important to recall to add to the data.

Of the final ten participants completing the study, all but one participant agreed to be audio-recorded. The one participant uncomfortable being audio-recorded agreed to note-taking during the interview. Notes written during her interview contained a few

words or short sentences to assist with recall for more detailed documentation immediately upon conclusion of the interview. Since there was no audio recording of her interview to potentially refer to for clarification, her interview was typed up in detail shortly after the conclusion of the interview.

Confidentiality. To ensure confidentiality, participant alphanumeric ID codes and pseudonyms should be used for each participant throughout data collection, analysis, and dissemination (Gerrish & Lacey, 2010). For the current study, alphanumeric ID codes were used during the transcription process and for the NVivo 10[®] coding during the early analysis phase. The alphanumeric ID codes were changed to pseudonyms during the within-case and cross-case analyses and will be used during future dissemination of the findings. The digital recorder and cassette tapes of each interview, along with the hard copies of transcribed interviews, were kept in a locked box with only the student PI having access.

Transcripts. In order to become immersed in the data and to become familiar with the details of the interviews, computerized word processing was used by the student PI to transcribe all interviews verbatim and included nonverbal nuances. Using Microsoft® Word 2013, all transcriptions were encrypted with password protection, electronically stored and backed up. Clarity of the content and flow of the interview was important; therefore, the transcript format included interview date, time, location, participant alphanumeric ID, and the initials SPI to indicate student PI. Participant alphanumeric ID and SPI initials were used to indicate who was speaking and responding throughout the interview. Transcripts were single-spaced with double spacing between speakers, with lines of the interview numbered for easy referencing (Munhall, 2007).

Margins were set to allow room for coding and notations. To ensure accuracy of the transcriptions, a dissertation committee member compared the digital recordings to the typed transcripts. A hard copy was made of each transcript to enable ease of reading and the ability to hand-code in the margins. Hard copies of all the transcripts were stored in a locked box with only the student PI having access.

Incentive to Participate. Upon completion of the interview, participants received an incentive for sharing their experiences and assisting in the process of the current study. The incentive was presented to the participant as a thank you gift. At the conclusion of the interview, each participant was given \$10 cash as a thank you gift. Each thank you gift was recorded in the field notebook.

It seemed apparent that an incentive should pertain to personal hygiene, as this was the main focus of the study; however, personal hygiene products were readily available to the participants through donations at various resources serving the homeless population. Securing adequate food on a daily basis could have been an issue for the chronically unsheltered homeless women, so an incentive of a \$10 gift card to a local grocery store was considered as an incentive. However, some of the participants may have had difficulty accessing the grocery store to redeem the gift card due to the geographical location. Therefore, the grocery store gift card was deemed less than ideal. To best meet the needs of all participants, an incentive of \$10 cash was the best option, as it could easily be used for whatever the participant determined they needed to purchase. All of the incentives were personally funded by the student PI.

Data Analysis and Synthesis

Narrative data analysis for the current study was both deductive and inductive and focused on “what” was said as opposed to “how” it was stated, with the content of the narrative being the exclusive focus (thematic analysis) (Reissman, 2008). Following completion of the interview transcriptions, it was important to put into place a plan for managing, analyzing, and synthesizing large volumes of data and reducing it in a meaningful way (Bloomberg & Volpe, 2008). The qualitative data analysis software program NVivo 10[®] was utilized to assist in managing and analyzing the data.

The data analysis process began with reading through each of the ten transcripts several times to gain an overall sense of the PHSM experience of the individual participants. Audio recordings of the interviews were listened to multiple times, including shortly after each interview, during the transcription process, and referred to as necessary throughout the analysis process for clarification of information. Once there was a general sense of the experiences of each participant, the next step was to closely examine the individual experiences of each of the participants.

Within-Case Analysis. The next step in the data analysis process was to examine each transcript individually by conducting an in-depth exploration of each participant in the study (Corbin & Strauss, 2008). During the reading of a transcript, notes were made in the margins to capture initial thoughts, keeping in mind the research questions and theoretical framework.

Following the general read-through and initial hand-written coding of the transcripts, the reduction process began. Through the use of NVivo 10[®] software program, initial analysis began with coding the data. The first set of codes followed the

interview guide developed to answer the first research question regarding the experience of chronically unsheltered homeless women in PHSM and specific PHSM behaviors the women report carrying out. NVivo 10[®] nodes were organized by specific PHSM behaviors: (a) showering, (b) foot care, (c) oral care, (d) toileting, (e) menstrual hygiene, and (f) sleep health. For each of the PHSM behaviors listed above, each participant's transcript was read through searching for each woman's experience with the specific PHSM behaviors and was coded accordingly. The data were further reduced to subcategories of a PHSM behavior. For example, the PHSM behavior of toileting was reduced to the sub-nodes of urination, bowel movement, and toilet paper.

Following the completion of the coding of the six PHSM behaviors for the ten participants, the ten transcripts were then coded in NVivo 10[®] for the categories of self-identified priority health need and self-reported overall health. Self-identified priority health need and self-reported overall health were questions from the interview guide and were asked to address the second research question related to the IFSMT.

Within-case analysis began with the first participant and worked through all ten participants. Each within-case analysis began with a narrative summary of the participant providing descriptive information and her overall experience as a chronically unsheltered homeless woman. The narrative summary was followed by addressing the first research question regarding the participant's overall PHSM experience and specific personal hygiene behaviors the woman reported carrying out: (a) showering, (b) foot care, (c) oral care, (d) toileting, (e) menstrual hygiene, and (f) sleep health.

Following the presentation of the self-management experience of specific personal hygiene behaviors of each participant, self-identified priority health need, self-

reported overall health, and an overview of the self-management of personal hygiene were presented. Excerpts from a participant's transcript were interspersed throughout her within-case analysis to support statements made by the student PI. This process allowed a greater understanding of each woman's experience of her personal hygiene self-management and the overall experience of living and sleeping outdoors for a considerable amount of time.

Cross-Case Analysis. Following the completion of within-case analysis, cross-case analysis began. The focus of this step was to look for similarities, differences, consistent themes across all the participants, and to assist in making sense of data from multiple sources (Yin, 2009). Data analysis focused on the purpose of the research, to gain a better understanding of the PHSM experience of chronically unsheltered homeless women. Rereading all the transcripts and the within-case analyses was necessary to truly grasp common themes across all ten participants.

The iterative process of open coding to more refined, narrow coding took place looking for patterns and themes. A hard copy was made for each NVivo 10[®] node for ease of reading and further coding. Each node contained excerpts from a participant's transcript that was applicable to the topic of the node. As each printed node was read through again, key words were highlighted or circled with notes made in the margins, further reducing the data.

Handwritten data summary tables were used to organize the data. Initial data summary tables were organized by concepts of each research question. Relevant themes/categories that emerged from these initial data summary tables were extracted and

reorganized into a more refined summary table. Notations and memos were noted throughout the process.

This process continued until it was determined all relevant themes and subthemes had been extracted and categorized. Exemplar statements from participants were used throughout the findings to support themes. These statements were documented verbatim and coded with the pseudonym.

Synthesis of the Data

Once large amounts of data were broken down into several different categories, closely examined and analyzed in order to make sense of it all, synthesis brought it all back together to address the purpose of the study and answer the research questions (Bloomberg & Volpe, 2008). A table was created, including the interpretation and conclusion of each finding. Findings were described and interpreted, attaching meaning throughout the narrative discussion.

Mapping PHSM Experience onto the IFSMT

According to The IFSMT, self-management is applicable to chronic conditions as well as health promotion. One focus of the current study was to determine whether the personal hygiene self-management experience of chronically unsheltered homeless women could be mapped onto the IFSMT. Through the use of computer software, this was achieved by mapping (visual display) components of the current study's findings to individual components of the model. This assisted in confirming components of the model and to provide evidence that the model can be applied to health promotion of chronically unsheltered homeless women.

Human Subjects Protection

In narrative studies, a researcher enters into a personal and moral relationship with the participant and it is important for a researcher to be cognizant of boundaries and potential exploitation of the research relationship (Gerrish & Lacey, 2010). Ethical issues considered included UWM IRB approval to maintain protection of the participants.

Participants were provided informed consent including: (a) the purpose of the study, (b) the role of the student PI, (c) an explanation and reassurance regarding confidentiality of their identity, (d) confidentiality of any persons or places named during the interview, (e) inclusion criteria, (f) incentive criteria, and (g) dissemination of results.

It was important to ensure the documents were at an appropriate reading level and recognize some potential participants may be unable to read warranting the need to read the informed consent document to them (Anderson & Hatton, 2000). The informed consent and interview guide was written at an 8th grade reading level (UWM Informed Consent, n.d.). It emphasized participation was strictly voluntary and withdrawal from the study could occur at any time. The design of the current study did not threaten participants with physical or mental harm. Ethically it was the responsibility of the student PI to accurately represent the experiences of the women in the study.

For the current study, some of the participants were known to the student PI through their access of medical care from the women's homeless clinic where the student PI was the volunteer medical director. It was very important to reassure each participant that participating in the study or an expressed disinterest in participating in the study would, in no way, influence their ability to continue to access medical care or services at the women's homeless clinic. A statement to such was included in the informed consent.

Oral Consent

Due to the potential challenge of recruiting participants, oral consent was the most appropriate way to obtain consent from the participants in the current study. Some potential recruitment challenges were: (1) the transient nature of this population warranting the need to interview at that moment, (2) a potential participant with inconsistent mental health status having a period of cognitive clarity to be able to consent, (3) impatience on the part of a potential participant for a lengthy written informed consent, or (4) illiteracy of a participant.

A script of the oral consent was submitted to UWM IRB for approval and included the same key elements of the written informed consent (UWM Oral Consent, n.d.). The oral consent script (Appendix C) was read to the potential participants by the student PI allowing sufficient time for the women to consider participation in the study. Any additional questions were answered prior to obtaining oral consent. On the audio-recording, each participant was identified using an alphanumeric ID code. Oral consent was audio-recorded in their voices. In the case of participants denying consent to be audio-recorded, the oral consent script was read to the participant by the student PI, questions were answered, and the participant was verbally asked if she agreed to participate in the study. Once the woman agreed to participate in the study, the student PI repeated the oral consent back to the participant for confirmation. Once confirmed, a handwritten notation was made on the consent form.

Scientific Rigor

Scientific rigor implies a systematic process used in planning, developing, analyzing, and evaluating research and is important to the validity and reliability of a

study (Grove et al., 2013). Validity and reliability are concepts often used in quantitative research. In qualitative research, a comparable concept to validity and reliability is trustworthiness (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Trustworthiness of a study focuses on whether the findings are presented in a manner representing the reality of the experiences of the participants (Bloomberg & Volpe, 2008). Trustworthiness consists of four aspects: credibility (validity), dependability (reliability), confirmability (objectivity), and transferability (generalizability) (Morse et al., 2002).

Credibility (validity) of a study refers to whether the findings are accurate from the perspective of the researcher, participants, and reader (Morse et al., 2002). This process begins through the identification of any researcher biases or assumptions recorded in field notes/memos throughout the research process (Bloomberg & Volpe, 2008). Clearly presenting researcher biases were important for the current study since the student PI had an established relationship with many of the participants and some prior knowledge regarding their personal hygiene self-management. It was important to remain in the role of student PI and not medical director of the clinic and to only include data obtained from the interviews and not information from prior knowledge of some of the participants.

Prior to the start of the current study, there were a few assumptions by the student PI regarding the PHSM of chronically unsheltered homeless women. One assumption was the women probably did not perform personal hygiene behaviors daily due to lack of resources and competing demands. Another assumption was the participants performed PHSM behaviors primarily to prevent a disease or treat/improve an existing condition.

Biases and assumptions were written down in the field notebook prior to the onset of the interviews.

In narrative research, credibility of a study is strengthened through the degree of collaboration between the participants and a researcher. Participants should be given the opportunity to review and validate their narratives written by the researcher and to validate the study's findings (Munhall, 2007). For the current study, due to the transient nature of the proposed population, one very realistic issue was the inability to go back to participants to validate interpretations of the findings. Five of the participants were located and reviewed their individual narrative and the findings of the current study. The women were satisfied with their individual narratives and felt they were accurately represented. A few women asked for minor edits primarily the removal of some detail in their narrative summary which they felt may be too specific potentially jeopardizing their confidentiality. These requests were granted. The women validated the five themes identified in the cross-case analysis and continued to stress the safety concerns they faced on a daily basis. The women seemed proud of their strong character and ongoing ability to successfully manage their personal hygiene under such challenging conditions.

Every effort was made to locate the remainder of the participants to clarify data or validate interpretations. The search effort included city parks, beaches, downtown area especially the public library, and shelters. Other homeless women living/sleeping outdoors were consulted as to the possible whereabouts of missing study participants being careful to maintain confidentiality regarding the reason for the inquiry.

Dependability (reliability) should be transparent and supported through the use of an audit trail and consist of detailed explanations and decisions made regarding the data

collection and analysis process (Munhall, 2007). In the current study, an audit trail included transcribed interviews (raw data), coding schemes, data summary tables, and field notes. Confirmability (objectivity) implies the study's findings are an outcome of the research as opposed to assumptions, biases, and subjectivity of the researcher (Munhall, 2007). An in-depth, transparent audit trail can assist in the confirmability of a study.

Transferability (generalizability) was achieved through rich descriptions communicating a realistic portrayal of the experiences of the participants and detailed portrayal of the context presenting an element of shared experiences (Gerrish & Lacey, 2010; Bloomberg & Volpe, 2008). Qualitative research does not expect generalizability however transferability of findings may be beneficial in that there may be a match between the research context and other context as determined by the reader (Bloomberg & Volpe, 2008). Findings from the current study could be applicable to the personal hygiene self-management of other vulnerable populations living within a comparable context of a challenging social and physical environment.

Summary

Through the use of narrative inquiry, the current study sought to gain an in depth understanding of personal hygiene self-management of chronically unsheltered homeless women. Research questions were answered through participant interviews where data were collected, transcribed, and analyzed using thematic analysis with the assistance of the qualitative computer software program, NVivo 10[®]. Attention was paid to the safety and confidentiality of the participants.

Following this chapter will be a presentation of the study's findings. Through within-case analysis, Chapter 4 will present the individual personal hygiene self-management experience of the women.

Chapter 4

Findings: Description of the Participants

This chapter will begin with demographic characteristics of the participants followed by a narrative summary of each woman with individual participant's experiences of PHSM while living and sleeping outdoors for long periods of time.

Participant Demographic Characteristics

Participants of the current study included 10 unsheltered homeless women who had lived and slept outdoors or in a vehicle for at least a year prior to participating in the study. Pseudonyms were used to maintain privacy. During demographic data collection, participants were only asked to identify their age, where they lived/slept, and the length of time living/sleeping outdoors. Issues with mistrust of health professionals by the homeless population and the importance of creating a trusting environment were the reasons for limiting the number of demographic-related questions (Kryda & Compton, 2009, de Chesnay & Anderson, 2008). However, additional demographic data emerged from the interviews (marital status, children, education, drug abuse history, incarceration history and co-morbidities) and will be presented in this section. The general profiles of the participants in the current study were middle age, white, educated, unmarried, unaccompanied women who had lived outdoors for approximately a decade. They reported some type of mental illness, a history of being incarcerated, and skin and musculoskeletal issues as their leading health issues (Table 1).

Table 1.

Demographic Characteristics of Study Participants

Participant	Age	Education	Years Outdoors	Sleep Locations	History Rape/Violence	Substance Abuse/Drugs	Co-morbidities	Mental Illness	Incarceration History
Mary Jane	56	High School Graduate Some College	23	Carport of commercial building	Yes	History of substance abuse	Diabetes: Type 2	Bipolar Disorder	Yes
Maxine	60	High School Graduate Some College	2	Outside a church Beach	Yes	Medical Marijuana	Skin Issues	Bipolar Disorder	Yes
Joanne	53	High School Graduate Some College	2	Beach Porch of commercial building Shrubs	Yes	Prescription Pain Medications	Chronic Back & Neck Pain	History Psych. Hospital	No
Rita	66	Did Not Graduate High School	53	Back of garages Bushes Car	Yes	None	Leg/Neck Pain Arthritis Lymphedema	None Identified	Yes
Yolanda	45	High School Graduate	9	Bushes by railroad tracks	Yes	History of substance abuse	Umbilical Hernia	Anxiety	Yes
Lynette	59	High School Graduate Business School	15	Bushes	Yes	None	Macular Degeneration	Schizophrenia	No
Sharon	54	High School Graduate	2.5	Tent in wooded area	Yes	Prescription Pain Medications	Chronic Back Pain	Anxiety	No

Table 1 (continued).

Demographic Characteristics of Study Participants

Participant	Age	Education	Years Outdoors	Sleep Locations	History Rape/Violence	Substance Abuse/Drugs	Co-morbidities	Mental Illness	Incarceration History
Lena	59	High School Graduate	10	City Park Car	Yes	Unknown	Hypertension Osteoporosis Diabetes: Type 2	History Psych. Hospital	Yes
Amber	36	High School Graduate	10	Parks Beach Bushes Railroad tracks Under a bridge	Yes	History of substance abuse	Umbilical Hernia Chronic Pain Fibromyalgia Hypertension “Bad Lungs”	Panic/ anxiety Paranoia	Yes
Eleanor	77	College Graduate Some Graduate School	44	Storage shed Fenced storage yard Carport Wikiup Ravine, creek bed Porches Garages	Yes	None	Anemia Rib Fracture Arthritis	Anxiety	No

Participants ranged in age from 36 to 77 years old. Median age was 57.5 years. Demographic data collection did not include a question regarding ethnicity; however, the majority of the women appeared to be white with the remainder being Latina. During the interview, one white woman shared she was part Native American. At the time of the interviews, none of the women were married. Several women had a history of being married (60%) and the remainder of the women had never married (40%). Some of the women currently had a significant other in their life (40%). Half the women were mothers. The number of children per woman ranged from one to four and the level of involvement in childrearing varied across the women. All of their children were independent adults and the frequency of contact with their children varied among the women.

The women in the study were educated. The majority of the women (80%) were high school graduates. Of these women, one earned an associate's degree; one earned a bachelor's degree with some graduate level education. One woman attended a business school and two women in the study were currently enrolled in the local community college.

Time living outdoors for the women ranged from 2 to 53 years. Median time living/sleeping outdoors was 10 years. All of the women had experience living/sleeping outdoors (as opposed to a vehicle) for the majority of their time unsheltered. Locations of habitation included bushes, ravines, back of garages, storage shed, carports, churches, freeway underpass, tent next to railroad track, cemetery, construction site, creek beds, city parks, beaches, and a wikiup. They found places where they could hide. At the time of the study, 70% of the women were still living/sleeping outdoors. One woman was

living in a shelter, and two of the women had finally gotten housing and had been inside for eight months.

Most of the women (60%) reported no history of or current use of alcohol or illegal substance with the exception of one woman who legally used medicinal marijuana to treat her chronic musculoskeletal pain. Three of the women were very open and shared their history of alcohol and/or substance use which they admitted contributed to their incarceration history.

Over half of the women (60%) disclosed a history of incarceration. Some women spent a few days in a county jail for minor infractions such as sneaking into a hotel to shower while others spent years in a state prison for substance use or weapons charges for stabbing someone in self-defense. A few women went to prison multiple times.

Overall, the women were considerably healthy considering their difficult living conditions. Skin conditions were the most common physical issue reported. Their skin issues were in the form of lice, scabies, bug/spider/rat bites, and tinea pedis.

Musculoskeletal problems were present among half the women in the study. Of those five women, chronic neck and/or back pain caused the most difficulties. A history of work injuries or a car accident was the main causes of their chronic neck and/or back pain.

Other musculoskeletal problems were osteoporosis, arthritis, lower extremity edema, and fractured ribs.

Mental illness was self-reported by 90% of the women with anxiety being the most common condition. Bipolar disorder, schizophrenia, and depression were also present in some of the women per their report. A few women talked about having a mental health diagnosis (bipolar or schizophrenia) but disputed their diagnosis, therefore

declining to take medication. Some of the women had spent time in a psychiatric hospital, a few had multiple admissions. In the face of mental illness, chronic pain, and navigating the world alone the women were challenged to self-manage their personal hygiene.

Description of Individual Participants

Ten chronically unsheltered homeless women shared their overall experiences of living and sleeping outdoors for long periods of time and shared the experience of trying to manage their personal hygiene under such difficult circumstances. The individual PHSM experiences of each participant will be presented along with what each woman identified as her priority health need and strategies for sustaining health.

Participant One - Mary Jane

Narrative Summary

Mary Jane was a friendly, small statured 56-year-old, Caucasian woman who had lived and slept outdoors for 23 years. Her face was tan with a warm smile. Her hands were worn and calloused due to many years of physical labor outdoors. She walked with a slight limp due to a sore knee she said was due to several years of jumping in and out of dumpsters and hauling large weights of recyclables 12-14 hours per day, six days per week, for more than 20 years.

After over two decades being outdoors, Mary Jane finally got housing. At the time of the interview she had been in a studio apartment for 8 months. Mary Jane was a thoughtful hostess offering snacks and beverages at the start of the interview. Although recently housed, Mary Jane had clear, vivid memories of her experience of living and sleeping outdoors for a considerable amount of time.

She attributed her homelessness to issues with substance abuse resulting in a loss of employment and housing. Currently she was clean and sober for 14 years and was very proud of this accomplishment. She had been to prison twice (a total of five years) for stabbing someone in self-defense. When she was released from prison she went back to the streets. When she first became homeless and naïve to life on the streets, she was raped and was able to stay in a battered woman's shelter for a few months giving her a brief break from an unsheltered life.

She had been homeless in a few different cities in California. For privacy reasons, Mary Jane chose to live outdoors over living in a homeless shelter. When asked how she managed her personal hygiene needs and living outdoors she replied,

Oh a lot harder than living inside or even if you're staying inside a shelter. If you're staying inside a shelter everything's there for you. You always have a bathroom, you're, when you get up in the middle of the night to go to the bathroom, it's always there. There's a shower there. You always have a place to change your clothes.

Showering

Taking care of her personal hygiene needs was challenging. For Mary Jane, showering, washing her hair, and using deodorant daily was important to her and she did everything possible to make that happen. Mary Jane identified taking a shower as her priority personal hygiene behavior to try and accomplish each day. Personal hygiene items (she referred to them as "hygienes") such as deodorant, shampoo, or soap were often in limited supply at shelters so, if unavailable, she would purchase them herself to ensure daily cleanliness.

Well, I don't like to be dirty. It doesn't feel very good to be scuzzy and dirty and you feel better about yourself if you're clean. I mean you feel healthier when you're clean. And nobody likes to walk around in dirty clothes and all sweaty and sticky. Whew, when you haven't had a bath.

Her response to life before she was homeless was

I was always very clean before I became homeless. I always, I wasn't the type of person that had a messy house, let laundry stack up or didn't shower or anything like that. I was always very clean when I had my own place.

Mary Jane explained she valued being clean and tidy because

Uh, actually my mother's just the opposite...I hate to say that but her house was messy and I mean cluttered and messy and you know and she wasn't like the neatest person in the world. So maybe I just didn't want to be like her. You know what I mean. I didn't want to be like my mother.

Both her grandmothers were neat and tidy so she learned from them. It is clear she tried to maintain those values even while living and sleeping outdoors.

In cities without shower facilities for homeless individuals, Mary Jane would wash up in public bathrooms using soap from the dispenser and washed and dried herself with paper towels. Clothes would be washed in the sink then dried in the sun. She would find rags in recycling bins or dumpsters to use for bathing and when she would get a little money she would wash them at the Laundromat with her clothes. In one city Mary Jane became friends with a local barber with a shower in the back of his shop. He would charge her \$4 per shower. Here she was able to shower five days per week when the barbershop was open.

In a city where homeless shelters provided services to the unsheltered homeless population, in addition to those residing in the shelters, she had the ability to shower every day. However, Mary Jane would skip her shower on Sunday. The exception to taking a shower was the ability to make money. She explained

Yeah, the only thing is Sundays. I never took a shower because I was out recycling all day long. I was out for 16 hours. So, I wanted to use that time to get in as many hours as I could get in so I didn't go to the shelters. So, I wanted to make some extra money that day so I went without a shower on Sundays.

Foot Care

During her years outdoors, chronic foot fungus (tinea pedis) was an issue for Mary Jane. This was especially a problem during the rainy season. She described the experience as

The itching and all that. And the burning and all that and cracking, your feet are cracking. And callouses. I had callouses on my feet just from the constant walking and all that. You know your feet are itching and swelling and all that and just getting all nasty.

Shoes and socks were only removed when she showered and slept.

Cuz I was in my shoes all day long and I wanted to get out you know cuz by that time they were pretty itchy. So, I like yeah [laughing]. You know when you're walking around all day it's a relief to take your shoes off.

After each shower, she would sprinkle baby powder in her socks and shoes which she said would help with the odor, provide some cushion but did not help with the fungus.

Her tinea pedis was finally under control when she learned to soak her feet in vinegar from a volunteer podiatrist at a women's homeless clinic.

Oral Care

Mary Jane had such a warm smile but it was clear that oral care had been a challenge for her over the years. Her teeth appeared stained and crooked, with some missing. When she chewed food it looked like she had sensitive teeth. She had not been to the dentist in many years. She did, however, try to brush her teeth daily. Brushing her teeth was fairly quick and easy to accomplish in public bathrooms or an outdoors faucet. She could get free toothbrushes and toothpaste from shelters or a women's homeless clinic. She did not identify issues with her teeth as a health concern.

Toileting

Living/sleeping outdoors and going to the bathroom was difficult for Mary Jane. She explained

Um, because I've always had like bladder problems and you know I have like bladder infections I'd always have to go all the time. A lot of time you can't get to a bathroom and you're peeing behind a bush somewhere and you're going inside a dumpster enclosure trying to look for a cup to pee in or something, you know. You're peeing out in the dirt or like in a parking lot behind a car or something. You're hoping the police don't see you and give you a ticket.

Two years ago she received a ticket from the police for public urination and described the experience as

Yeah, so I got caught right at the intersection. I was peeing behind a cactus and something and a police officer pulls up and right when I had my pants down, you

know [laughs]. So he wrote me a ticket and I had to go to court on it and I explained to them that I had a bladder control problem and the judge, who was a woman, she says well, this is like a serious health hazard but she says I'll get you off the hook this time. This time I'll dismiss it but you get another ticket like this she says, we can't have this continue she says, if you get another ticket like this you'll either have to pay a fine or do community service or whatever. Or if you don't, you know pay your fine or do your community service then you'll have to go to jail.

For the general public, using a bathroom in a business probably would not be a problem but if an individual was a homeless person, using the bathroom, even if an item was purchased, could be an issue. Mary Jane explained

Uh, a lot of time businesses, they won't, they don't want to let you use their bathroom even if you're a customer [inaudible] because you're a homeless person. Um, just they, for health reasons, they're afraid you might have something or maybe if they had problems with people like doing drugs in the bathroom or smoking cigarettes or just in general making a mess. Um, maybe, uh, like a vaginal disease or something. Like cooties or something [laughs].

The majority of the time she was unsheltered, Mary Jane urinated and defecated somewhere outdoors. She shared her experiences of places she would go to have a bowel movement

Um, yeah, if you could climb in a dumpster that was fairly empty. Yeah, if you could get inside the dumpster or just behind a tree somewhere. It was a lot easier to do it behind a tree. But if you had to do number 1 you could just go behind the

dumpster and just get a cup and just do it in a cup and pour it in the dumpster. It's the number 2 that's a problem.

When asked about the use of toilet paper, especially after a bowel movement, she responded

Uh, you didn't. You didn't use any. Nope. I mean cuz that would make an even more mess then you would have to throw the toilet paper on the ground [laugh]. You know and I didn't want to carry it around. I don't want to carry around used toilet paper. Like even in a bag or whatever cuz it attracts flies and maggots and all that and it stinks. So I just didn't use.

So, she did not use toilet paper after urinating or after a bowel movement, only when she had the opportunity to use an indoor toilet. According to Mary Jane, diarrhea and burning while urinating were not uncommon for her, "um, maybe cuz poor sanitation cuz I was never able to wash my hands."

Menstrual Hygiene

During the conversation regarding her toileting experiences, Mary Jane shared the difficulties of managing her menstrual period while living outdoors. Key concerns included getting adequate supplies, the inconvenience of finding a place to change a pad, and dealing with the mess of overflowing onto underwear and pants. She described the experience

And then if I was on my menstrual period, oh my god, help me [laugh]. Well, um, I, say, well the last couple of years I was on the streets I was going through menopause. So I was getting periods infrequently, which was good. But I'd say before, I'd say 2009, I was actually getting like two periods a month and they

were heavy. And, I mean some of the shelters I was getting pads there and sometimes buying the pads but it just wasn't enough, you know I was bleeding through 'em and then I would lose control of my bladder when I was on my period. So, I was just a mess. You know. Sometimes I couldn't find a place to change.

Mary Jane chose to use pads as opposed to tampons because she found them more sanitary and less likely to cause an infection

Actually pads were better because tampons I'd have to insert 'em and your hands are dirty and whatever, it's not very sanitary. So even though tampons gave me more protection it's like you know you don't want to insert anything when your hands are dirty. So, I just used pads and then I started using Poise®. I started using that.

Changing and disposing of soiled pads presented a problem and pads were easier to change compared to a tampon. She described that experience as

I had to keep it on sometimes or, cuz, what am I going to do. I didn't have a place to throw it. You know sometime I could behind a dumpster, could make it to a dumpster enclosure I would go in there and like change a pad real quick and throw the dirty one in the dumpster. If I was in an area where there's no dumpsters I just had to wait until I got to one.

It was not uncommon for Mary Jane to saturate her pad and overflow onto her clothes. With limited access to a bathroom, little money, and limited access to laundry facilities, walking around with underwear and pants soaked with menstrual blood and urine created a difficult situation.

Yeah, sometimes my clothes were a mess. By the time I, I mean I, or sometimes when it was late at night when I knew people were asleep or whatever maybe I could go behind a dumpster enclosure or into a parking lot or something and just like, uh, take my pants and underwear off real quick and put something else on. Yeah but that was taking a chance cuz you're out in the open, you know. Yeah, you know your wallet is in your pants, you're just like an opportunity to get raped and robbed, you know.

In the event of soiling her clothes, Mary Jane found it necessary to keep about a week worth of clothing with her in her shopping cart. Her routine was to do laundry once per week so dealing with clothes soiled with urine and blood for several days was an issue.

This is how she described that experience

It was all, I had to put it in a trash bag. I had to black bag it. And then when I opened up the bag on laundry day, wooh, the ammonia smell would bring you to your knees. It just reeked. It just smelled to high heaven. Had to throw the trash bag out and everything. I couldn't reuse the trash bag. You know. Wooh. It was like. I didn't want to dump the stuff in the laundry basket cuz it was too dirty so I'd just have it in the trash bag and just dump the whole thing in the machine and pull the trash bag out. Because I didn't want to put it in the laundry basket because the stuff's so nasty.

Mary Jane found it difficult to get free pads or tampons. As she was going through menopause her menstrual flow increased as did her urinary incontinence. Therefore, she recognized that urinary incontinence pads or briefs would be the best solution as they were more absorbent than menstrual pads. Even though the urinary incontinence pads

were more expensive than menstrual pads, Mary Jane prioritized her expenses to be able to purchase the incontinence pads and briefs. She said, “But if you need them, it’s like, I mean, you have to get them”.

Managing Sleep

Mary Jane worked many long hours in order to meet her basic needs. Her primary sleeping location was under a carport behind a local business. Even though she could safely access the carport after the business closed (around 6:00pm) typically she would not arrive until midnight to 1:00am due to working her “night spots” on her recycling route. To avoid being spotted by employees of the business and potentially losing a safe sleeping location, Mary Jane had to be packed up and out of the carport by 6:30 am. Despite only getting five hours of sleep per night, Mary Jane described her quality of sleep as good and felt rested in the morning, “Heavy, I didn’t sleep that many hours but it was heavy, cuz I was tired you know”. The carport kept her dry, wool blankets and an Army sleeping bag kept her warm. Mary Jane’s many blankets kept her warm at night but the blankets served an even more important purpose, they gave her comfort.

It felt comfortable. You know like a baby that’s like wrapped in like a little cocoon. So, the same like a little baby. Like with me I had to have a lot of weight on me cuz out on the streets it’s like, I felt comforted by all that. Cuz the weight kept me warm. I associated weight with warmth, you know what I mean.

She always slept in her clothes but made a point to remove her shoes and socks to air out her feet. “Um, usually my clothes but I would take my shoes and socks off... Just to air my feet out”

Priority Health Needs

Mary Jane identified her top health need as being able to properly manage her Type 2 Diabetes Mellitus (DM) especially regarding nutrition. Diagnosed 15 years ago in prison, she felt she was adequately educated by the prison system on managing her DM. Frustrating to her was that she knew what she needed to do but had been unable to maintain these behaviors while being unsheltered. Obtaining appropriate food was a main obstacle. Mary Jane ate at least one meal per day at one of the shelters where the food choices were limited and high in carbohydrates such as pasta or rice and beans. She knew these foods were not good for her diabetes but the food was free and better than being hungry. She denied getting her blood glucose checked regularly or taking medication, “I didn’t have access to a clinic and I was too busy like getting cans and all that”.

Sustaining Health

Mary Jane felt her overall health was good while living outdoors and credits staying clean and sober, working long hours, and having a lot of stamina as factors contributing to her good health. Mary Jane made a conscious effort to try and keep herself as healthy as possible. Prior to being homeless she took daily vitamins and tried to continue this practice while living outdoors. It was important to her to regularly take vitamin and calcium supplements so she budgeted her money to be able to afford them.

Uh, because the recycling is very physical and then I was going through menopause so it was important to up your calcium intake when you’re going through menopause so I don’t get brittle bones. I don’t get osteoporosis. When you’re getting older and you just need more vitamins and all that. Your body’s not as strong as it used to be.

Mary Jane appeared to be in good health considering her life circumstances. She talked of only one incident of body lice many years ago and ongoing issues with tinea pedis that she managed well enough as not to impede her ability to recycle and earn an income. Based on the information she shared, the only chronic disease she revealed was Type 2 DM. Mary Jane was educated on the requirements of self-managing her diabetes. However, due to the inability to obtain proper nutrition, lack of resources for a blood glucose monitor and medication, difficulty accessing healthcare, and constant stress, she was unable to properly manage her disease while being unsheltered. She said the regular exercise she got while recycling was one positive towards controlling her blood glucose levels.

Conclusion

For over two decades of living/sleeping outdoors, Mary Jane was successful in maintaining her personal hygiene and overall health. She developed a routine that included daily showers, oral care, and weekly laundry. Keeping clean was clearly a priority. Mary Jane prioritized her money to support her personal hygiene and health. Prior to being homeless, maintaining personal hygiene and taking care of her health was important to Mary Jane. Once homeless, she tried to mirror these practices to the best of her ability.

Participant Two-Maxine

Narrative Summary

Tall and slender Maxine had very tanned skin with long curly hair fashioned in twisted strands. She was 60-years-old, Caucasian, friendly and spoke with a rapid pace. Her clothes were bright in color with coordinating nail polish and self-made jewelry.

Maxine had experienced several episodes of living/sleeping outdoors with each episode lasting approximately two years. Although not totally clear, it appeared her unsheltered experiences had occurred over the past 10 years. Circumstances contributing to her periods of homelessness were not revealed. The interview took place on the campus of the community college.

At the time of the interview, Maxine had been living/sleeping outdoors for the past two years and a few months prior to the interview she finally secured an apartment. She described her experience of living/sleeping outdoors as “horrible, uh, terrible because you could get raped. You always have people trying to steal from you.” Trying to get her basic health needs met was “horrible”.

Showering

To keep her skin clean and to keep from smelling, Maxine identified showering as her top priority personal hygiene behavior even though she usually only showered three times per month. She had access to daily showers at the local shelters but she preferred to shower at a women’s homeless clinic which was only held three times per month. She cited issues with shelter employees, having to shower with a group of women and shower time limited to 5-10 minutes as reasons for avoiding the shelters. The women’s homeless clinic allowed women to shower alone for an unlimited period of time. Due to the limited shower time at the shelters, Maxine was unable to wash and condition her long curly hair. To solve this problem she wore her hair in twisted strands which required less maintenance.

Maxine was resourceful and when she had some extra money she would take a bus to a beach about 10 miles away where she would set up a tent, camp, have an indoor bathroom and shower. For \$6 per night, Maxine would stay the two night maximum to have easier access to a shower and a toilet. Another opportunity to shower was from a woman in the neighborhood. It was unclear the circumstances of this relationship but according to Maxine, in exchange for a shower, Maxine would cook healthy meals for her.

Foot Care

Maxine had a long history of intermittent tinea pedis and was careful to wear shower shoes in public showers and would inquire whether a facility used bleach in between showers. During the periods where she had housing she treated her foot fungus by rubbing garlic and olive oil all over her feet, a remedy she had used for years. While living/sleeping outdoors she found it easier to use vinegar so she would soak her feet in either red or apple cider vinegar. Both remedies were equally effective, according to Maxine.

Oral Care

Every morning Maxine would go to a coffee house to brush her teeth. In order to use the bathroom she would purchase something. If caught by employees she ran the risk of getting kicked out. Free oral hygiene items (toothbrush and toothpaste) could be easily obtained from the local shelters however she did not frequent any the shelters as she found them to be “abusive”. So she got her oral hygiene items from a women’s homeless clinic when she came to shower.

Toileting

Maxine expressed serious safety concerns regarding her experience of using a bathroom while living/sleeping outdoors, especially at night

Yeah. It's horrible like I when I was there at the church there was a time somehow the lady that worked in the preschool left the door open so we go in there and pee during the night. But after a while she didn't. She stopped because I think the, uh, what ya call, the Deacon, said not to. So then yea where I lived, where I stayed, I would have to walk two blocks to a port-a-potty and you could get raped or everything so I hated it I just peed right there in the bushes at the church. Because I'm not going to risk getting raped. If I have to poop I would go risk getting hurt. Cuz in the middle of the night you have to pee. And then you get woken up out of your sleep. You have to risk all your stuff getting stolen, which did.

In addition to safety issues, another concern for Maxine associated with having to toilet outdoors was that often she smelled like urine or stool.

Boys don't but women like imagine it when you're peeing outdoors and sometimes you have toilet paper and sometimes you don't or if you go in a port-potty you start stinking like a port-a-potty and you smell. Like when you pee outdoors it splashes on your feet sometimes when you're peeing it's the pee splashes on you. I don't know how, I mean that's the worst thing and the next day it's like I'll be cold and I want some, I mean that was the most embarrassing stuff in the world it like sometimes I would have money and I'd try to buy wipes so in the morning wipe my legs down and everything and if you don't have those I'd go

in the XX (coffee shop) and just go right outdoors because people would start complaining that that woman stinks like piss and get her out of here or open the door.

Although skin wipes were better than nothing, Maxine found them too drying to her skin and preferred to use soap and water whenever possible. She only used toilet paper if it was supplied in the port-a-potty or the coffee shop. She worried about needing to have a bowel movement in the middle of the night

I'm not going to poop out in the church. If I had a bowel movement I would go to the port-a-potty but most of the time, it would, I would, thank god, would come in the morning at XX (coffee shop).

Menstrual Hygiene

Maxine had housing while still menstruating but admitted that being on your period would be difficult to manage while living/sleeping outdoors. She stated she went through early menopause. She could not remember her exact age but stated it was between 40 and 45 years old.

Managing Sleep

Maxine's sleeping location was often in a hidden location outdoors of a church. She felt her quality of sleep was good and often slept through the night. Having to urinate during the night was the main reason for interrupted sleep. She planned ahead by having a coffee cup with her at night and would urinate in the coffee cup, put a lid on it, and in the morning dumped the urine in the closest port-a-potty. Her sleeping location kept her dry from the rain. During the summer months she kept warm but during the cold winter months she would seek out the warming centers when available.

Priority Health Need

Maxine identified her priority health need while living/sleeping outdoors was finding healthy food. During a time when her sole nutrition was from one of the shelters she got really high cholesterol from the “starchy stuff and fattening stuff” served at the shelter. After learning of her high cholesterol during a doctor’s visit she decided to buy her own food. Affording and preparing healthy food posed a challenge while living/sleeping outdoors. She did not use added salt, she did not eat fat, and she only drank almond milk. She ate a lot of seaweed for minerals and drank carrot juice. She shopped at the farmer’s market where she bought a lot of fruits and vegetables, especially avocados. Safe food storage was also an issue while being outdoors. A whole loaf of bread would mold so she would buy one roll at time. A favorite meal was tuna from the deli on a roll from the bakery, a satisfying meal only costing her \$2.50-\$3.00.

Currently Maxine’s priority health need was an issue with her skin. She reported to having some type of skin mites all over her body and in her hair. A few small, brown, oblong shaped items were noted on her arms however it was unclear as to their origin. She stated the mites were crawling out of her skin. Concerned it might be cancer, she sought the expertise of a dermatologist. According to Maxine, she was told it was not cancer but was not given a diagnosis, just some anti-itch cream. Talking about it was so stressful she requested to stop the interview to take a break. A few minutes later she returned and resumed sharing her experience. “They’re all in my skin. It’s, it’s torture” and stated the mites do not itch but sting when they bite her. She thought they might be caused by her psychiatric medication. She had a plan to seek a second opinion.

Sustaining Health

While living/sleeping outdoors, Maxine felt her overall health was fine especially in the summer months when it was warmer weather. During the cold months she had difficulty with her left leg that has a metal plate in it from a fall down some stairs. She stated she had to wear clean socks during the cold weather otherwise she experienced leg cramps.

Maxine maintained her health by getting regular preventive care. She got a mammogram yearly and to-date had two colonoscopies and had planned to schedule a third one. At age 50 years old, polyps were found on her first colonoscopy so she was very conscientious about getting them regularly. All of her medical records were organized and stored in a storage unit.

Conclusion

The biggest challenges for Maxine was showering, shampooing her hair, and going to the bathroom. The foundation for her challenges in showering/shampooing was based on trust. She knew she could shower daily at one of the shelters but due to her mistrust of the facility she chose to not shower. The policies of the facilities regarding very limited shower time made it impossible for her to adequately shampoo her hair.

Safety concerns, especially the fear of being raped, inhibited Maxine from using appropriate bathroom facilities during the night. This fear resulted in the necessity to urinate in a cup and hope her bowel movement could wait until morning when she could use a bathroom in a coffee shop. Having to urinate or defecate outdoors created another unacceptable personal hygiene issue for Maxine; smelling like urine or stool, something

she found humiliating. She did the best she could to manage these personal hygiene issues.

Trust was important to Maxine and the topic came up several times during the interview. Maxine experienced issues with trusting health care workers, facilities, and organizations serving the homeless population. Maxine offered insight into issues with trust.

... when you're training people to work that with homeless women or anybody homeless... The one thing I would advise ... is that if you promise someone something or just never promise anything unless you can really follow through... Because then it gets people discouraged or not trusting cuz most people out there, a lot of us out there, that don't trust the system or don't trust (Maxine).

Participant Three-Joanne

Narrative Summary

At 7:30 am, Joanne was sitting at a back table of a fast food restaurant quietly reading a book with an overstuffed backpack by her side. Joanne was 53-years-old, Caucasian and appeared older than her stated age. Her long straight brown hair was pulled back in a ponytail. Her clothes were clean and in good shape. She was articulate and spoke in a quiet voice. She would intermittently grimace with pain especially when repositioning herself in the booth. She revealed she had chronic back pain due to a work injury ten years ago. At the time of the interview, Joanne was a full-time student at the community college studying business.

At the time of this interview, Joanne had been living/sleeping outdoors on and off for two years. She did stay at a shelter when she could but that was limited to only ten days per month. “And being out on the streets for 20-23 days is a real pit. It damn near exhausted me. I mean, physically I can’t do it.” To get respite from living/sleeping outdoors, occasionally Joanne would split the cost of a hotel room with another homeless woman.

Yeah money-wise, it’s just not practical. And for a night’s sleep it’s not practical at all. Literally that’s what you do, you just crash. There’s no point in it. It’s not exactly an enjoyable trip to go to get a hotel. But it’s comfortable to sleep in a bed and not have to worry about where you are going to sleep, watch a little bit of T.V.. You know, and get some information about what’s going on in the world. Cuz that’s one thing that is very hidden, put away from us, except for the paper. You know, we can always buy a newspaper but as far as television goes, or us being current on news, not many of us are. I try to be.

She had a history of living/sleeping outdoors for many years with her husband. “Yeah, I’d had quite a bit of experience where, you know, we’d just go camping. I mean, that’s just what we’d do.” Even with her husband Joanne recalled the experience as scary.

Joanne said living/sleeping outdoors was scary because

Um, for one, you never really know where you are going to sleep. Um, two, you are on constant guard. Three, you are always approached by some male. You never know exactly, you know, you can’t really take them at face value cuz you never know what their intentions are. Um, people have a tendency to lie. So, when you are sleeping on the beach you’re pretty much out there by yourself and that’s

extremely scary because you can't yell loud enough. There's not anybody out there.

She preferred to keep to herself but, for safety reasons, sometimes she would pair up with another woman at night.

Showering

For Joanne taking a shower every day was inconvenient. She explained the many reasons why showering was difficult for her.

Yeah, location-wise or time-wise. It's just not convenient. Either that or it's just exhausting. You know you just get to a point where one of the big things is you get comfortable just not doing shit. You don't go anywhere to get really dirty.

And like me yesterday and the day before, all I've done is get up, get dressed, well I'm already dressed, but get up go sit down, read a book, go to the park, read a book. So, I mean don't need a shower.

Typically she showered 2-3 times per week at one of the shelters or sneaked into the showers at the marina. In order to blend in with boat owners, she pointed out the importance of not looking "scruffy" when you are down at the marina. It was important how one presented in public. Shampooing her hair too often caused her hair to dry out; therefore, she only washed her hair every 3-4 days.

Foot Care

Joanne said her feet were in pretty good shape. She rarely got foot fungus and she attributed this to the fact that she primarily wore sandals so her feet were able to stay dry. In the winter she wore tennis shoes and removed them as often as she could. She knew

about soaking her feet in vinegar to prevent/treat foot fungus but due to difficulty lifting her legs, this practice was unrealistic for her. In regards to foot care, she stated

We can take care of them but where? I mean, I'd love to sit down and then rub my feet and then put on a pair of socks and leave them overnight. Save my socks somewhere. Oh, it all sounds really ideal. I'll get them out of my top drawer.

Oral Care

Supplies (toothbrush/toothpaste) were plentiful at the shelters or at a women's homeless clinic but due to her back injury, Joanne has difficulty lifting her arms making brushing her teeth challenging. Because of her physical limitations she only brushed her teeth once per week. She said her "mouth is a mess" with a lot of broken teeth. She was surprised her teeth did not hurt. Two years ago Joanne attended a free dental exam event and was told she was in need of \$16,000 worth of dental work. Due to extremely limited funds, Joanne had not followed up with her dental care. Due to her poor oral health she was limited in foods she could eat and but said she preferred soup anyway. She added, "But actually I'm not doing too bad. I'm really not."

Toileting

Using a bathroom when you live/sleep outdoors is inconvenient, according to Joanne.

If you're outdoors, you're outdoors. It becomes inconvenient and you are probably going to end up in a situation where you are going to get stomach cramps. Because there really isn't places to go. Besides that, luckily my system doesn't seem to be working as well as everyone else's. But usually I'm in a situation where I am here [fast food restaurant] when I have to go.

Joanne did not carry toilet paper. It was one more thing to carry and often the toilet paper got wet in her backpack. She used napkins if she had access to some. She tried to use bathrooms in businesses since there were no public bathrooms in the downtown area.

Menstrual Hygiene

Joanne lived in a house during her menstruation years. She went through menopause at age 40. She did say managing menstrual periods while living/sleeping outdoors would be a nightmare. It would be difficult to get supplies, no privacy to change pads/tampons, or no place to wash your pants if you overflowed. Carrying extra clothes was a problem because it added more weight to carry. She felt pads would be better than tampons mainly because pads would be easier to change and she worried about toxic shock syndrome with tampons.

Managing Sleep

Quality sleep was an issue for Joanne especially when sleeping outdoors. Adequate rest and sleep were identified as her priority health need. Typically she slept up on a porch of a commercial building behind shrubs or a fence. She said the best shelter so far had been hiding behind a shrub on a piece of cement. Due to her fear of getting raped, she no longer slept at the beach. She had slept at the courthouse and found that exciting, “I’ve slept at the courthouse. Yeah, which is actually kinda neat. I’ve lived here all my life. I kinda went, a lot of people don’t get to do this. It’s kinda cool.”

Joanne stated she was in constant pain. Dealing with chronic pain was exhausting and she often needed to rest/nap during the day. This posed an issue because there was no place for her to nap during the day. Recently she could not stay awake and fell asleep on her sleeping bag in a park. She was ticketed by the police for unlawful lodging. A fine

she would have difficulty paying. During the night, sleeping outdoors on hard cement contributed to her back pain resulting in poor quality of sleep. A typical night sleeping outdoors was going to bed at 11:00 pm and up and out of the sleeping spot by 4:00 am. Five hours of sleep per night was inadequate and contributed to her need for a mid-day nap.

There really isn't any place to lay down. Ya know, and just take a damn nap. A lot of us need it. You know we're unnerved. A lot of us stay pretty uptight. We're not sleeping at night. Because you're staying point or you know you're always on guard.

Priority Health Need

Joanne's chronic pain contributed to her inability to get quality sleep often leaving her exhausted during the day. When asked her priority health need, without hesitation, Joanne responded that being able to rest was a bigger priority than her chronic pain.

Rest. Places when you're sick to rest. That is a big problem. Cuz we get worn out or we get a cold or the flu very easily especially at the Mission. Even being out. We are real susceptible to getting pneumonia. And we just don't have any place to get warm and rest. And without getting roused by the police department. If I had my sleeping bag out during the day time, they consider it gear. So it's camping gear.

In an attempt to get some rest in a safe place, Joanne described one incident where she was ticketed by local police for unlawful lodging. It was a day when she was exhausted from trying to cope with her back pain. She needed a nap. She needed to find a place to

sleep where she would not be disturbed or caught by the police. One place she could sleep was the beach but that location had been proven to be unsafe.

I was in the post office cuz I was scared of getting raped down at the beach cuz there was a guy that was hanging around me and he wouldn't leave me alone. He actually followed me to the post office. And he still wouldn't leave me alone. I said, somebody's going to come into the post office and catch you. I had my bag and all. I was sleeping.

She was approached by a police officer who did not make her leave but said he had to give her a ticket. A ticket she could not pay.

Sustaining Health

Joanne wished her overall health was better but said except for the chronic pain her health was pretty good. She began to cry and said the pain is starting to give her depression. The pain was constant and the bad days outweigh the good days. Recently, in addition to her back pain, she had been experiencing overall "horrible" body pain. She did get regular medical care and sought care for her new pain. Following several tests there was no diagnosis. She tried to manage her pain with over-the-counter anti-inflammatory/pain medications.

During the interview, she did identify oral care as a problem but did not list it as a priority health need. She had not had a mammogram in 4-5 years and her last pap smear was 2-3 years ago so these are also health needs that should be addressed.

Conclusion

Due to chronic back pain, meeting her personal hygiene needs had been a challenge. She used the term inconvenient several times when discussing efforts required

in meeting her personal hygiene needs. Despite her pain and the inconvenience, Joanne had learned to adjust. On days where she was experiencing increased pain and discomfort, showering would be too difficult so she minimized her physical activity so as not to generate sweat. She took advantage of better days and attended to her personal hygiene needs on the days she felt stronger.

Participant Four-Rita

Narrative Summary

Rita was welcoming, soft-spoken with an enjoyable laugh. She was 66-years-old, Caucasian/part Native American, average build with her medium length blonde hair hidden under a sun hat. The interview took place at a women's homeless clinic after hours. Since she was 13-years-old Rita had predominately lived and slept outdoors. She has been homeless in four different states throughout her lifetime. During her teenage years she hung out with friends and slept in cars and garages. Rita said it was too scary to be "out there without nobody" and spent many years living/sleeping in a car or van with a boyfriend and then her husband. In regards to her safety she shared, "Oh lots safer being with my boyfriend. And a lot safer when I was with my husband, too. Because if you are just a lone woman you are just such a target". In times were she was alone she would befriend males to sleep next to at night. For the past few years, Rita had been alone living/sleeping in her car.

Showering

Showering was cited by Rita as her priority personal hygiene behavior to get done daily. Rita showered and washed her hair daily or "anytime I want", she said. Several

years ago she joined a 24-hr gym with a very low monthly fee. Being clean and showering every day was a big priority for Rita and her boyfriend

We showered, we cleaned up wherever we could, and often. When we could.

Because he was kinda a clean freak. You know, we'd even go to the river and clean up if we had to. We didn't care. Water is water and you can usually find water in bathrooms and everywhere. It's not necessary to be dirty.

Rita felt it was important to be clean and brush her hair so she did not look homeless. People were less likely to mess with her if she did not appear to be homeless. "I think you're asking for big trouble if you look like a homeless person."

In general, she said it is easy to get a daily shower in town. "Oh yeah, they have lots of showers you can take here. It's not really sensible somebody can go around all dirty and acting like filthy bums like they do because they're so sick." The only time she was arrested was because of a shower. She and a boyfriend got caught sneaking into a hotel to shower.

Foot Care

Rita denied problems with her feet. She cleaned her feet daily during her shower and aired them out nightly while sleeping in the back of her car.

Oral Care

Rita's teeth appeared to be in good shape. Part of her daily personal hygiene routine was to brush her teeth. If she brushed her teeth in her car she spits in a jar and discarded it later. Sometimes she waited until she was at the gym to brush her teeth using a sink. She stated she was able to do a much better job brushing her teeth in the bathroom at the gym.

Toileting

Rita did not have a bathroom in the area where she parked her car to sleep so going to the bathroom was a challenge. So during the night she used a jar if she needed to urinate and a plastic bag for a bowel movement. She did use toilet paper after a bowel movement and put the used toilet paper in the plastic bag and zipped it closed. The plastic bag was discarded in a public garbage can when she was up and out of her car. She tossed the urine from the jar outdoors but was clear to say she did not throw her urine on the property where she parked her car. During the day Rita used the bathroom in businesses. She was always prepared in case a public bathroom was not accessible. She hid behind a garbage can, urinated in a cup, and then tossed it.

Menstrual Hygiene

When she was younger, managing a menstrual period while living/sleeping outdoors was a challenge. “Well you just have to make it with what you’ve got.” With limited resources, Rita would fold tiny clothing, pieces of fabric, rags or use as a sanitary pad, if she had one. When the make-shift pads became saturated with blood she would throw them in the garbage can and make a new one. When she had bad menstrual cramps she did not have the money for medication requiring her to tough it out. If she really needed a supply, her boyfriend would shop lift the item for her to use.

Managing Sleep

Over the years, Rita had slept in many locations such as up on a porch behind a church, dark areas of the beach, hidden behind the railroad tracks using a bush as the front door, cars and vans. Sleeping in hidden places with a male companion made for a

safe sleeping environment. When she felt safe she had no issues with sleeping. However she shared

Well when I was alone for a period of time. I used to stay up all night and go to sleep in the day time. And I'll be darn if somebody don't try and wake you up to ask you how much you want to sell your body for [laugh].

Currently she was sleeping alone in her vehicle in a safe parking location provided by the city.

Priority Health Need

Rita identified her priority health need as healing her shoulder and legs. Many years ago Rita was hit by a car and remained with residual pain in her legs, shoulder and neck. She had arthritis and lymphedema in her legs and pain in her neck and shoulders. Acupuncture to her shoulder had given her some pain relief. She was able to get free acupuncture at a women's homeless clinic. "It's healing a little bit and uh, my legs [rubs her knees] I always have to worry about the swelling and the soreness." The pain behind both knees had been diagnosed as arthritis. She wore support stockings and had saved enough money to buy some more expensive compression stockings she thought would help with her leg swelling.

Sustaining Health

The need to get healthier was how Rita described her overall health. Getting physically healthier referred to improving the pain in her neck, shoulder, and legs. "My overall health. I need to get more healthy. Physically. Physically, a lot more healthy. I think it would help me mentally too."

Conclusion

Rita had lived and slept outdoors for many years. Over the years she had learned to find the resources she needed to get her personal hygiene needs met. Overall, she had been successful in getting her personal hygiene needs met. She had no major health issues related to inadequate personal hygiene. Her main health concerns (arthritis/pain in leg, neck, shoulder) were related to a prior accident. Due to her low-cost gym membership she was able to shower, shampoo, and brush her teeth daily. She had figured out a system for toileting that worked for her. Although not ideal, urinating in a cup or defecating in a plastic bag seemed to work for her. This practice had not resulted in any health concerns.

Participant Five-Yolanda

Narrative Summary

Early in the morning, while still dark outdoors, 45-year-old Yolanda rode up on a bicycle smiling and waving. She was Hispanic, petite, cheerful, and well-groomed with make-up and curled hair. The interview took place at a back table in a fast-food restaurant. Nine years ago Yolanda's mother passed away leaving her homeless in a city in which she was born and raised. This new life was challenging for her.

Yeah, it was different. It was really hard. It was hard to adjust to living on the streets and not having nobody [begins to cry]. And then, from coming from a family structure and then it taken from you is hard. It's very hard. Very difficult and, um, hard to adapt to that kind of lifestyle.

Being a native of the city, Yolanda said she knew the safest places to hang out and sleep and was often protected by homeless men she knew prior to being homeless herself.

Yolanda had been living/sleeping outdoors on and off for the past nine years. Yolanda left her home to sleeping by a tree. That first night by the tree was difficult but Yolanda tried to stay positive.

I try to make everything into a positive perspective. I really do and I feel nothing's a mistake. And I don't know why or what reason, at that time, why it was happening to me. But I know the Lord never makes mistakes. There's a purpose and meaning for it. So I mean I kept that kind of perspective when I was sleeping in that bush. And I was okay. I didn't feel uncomfortable. I didn't feel unsafe or nothing.

Over the years Yolanda would get a break from living/sleeping outdoors. Her respite from life outdoors came when she spent time in prison.

Cuz when I wasn't on the streets, when my mom passed away I was back in prison. So I was in a shelter and I was okay. I ended up being locked up because I had no place [clears her throat], excuse me, I had no place to live anyways.

Due to drug related issues, Yolanda had served a total of six prison terms, two years each term. In some ways, being in prison was better than living/sleeping outdoors; in prison she had shelter and was able to meet her basic needs. Currently she was working hard on her sobriety and at the time of this interview she was staying at one of the shelters.

Showering

When Yolanda was living/sleeping outdoors she showered daily. She said there were several places homeless women could go to shower and there was no excuse for any homeless person to not shower every day. Yolanda cited showering as the most important personal hygiene behavior to get done daily. When asked why it was important for her to shower every day she replied

Absolutely. Cuz I feel your appearance is what a lot of people these days stereotype you by. By being cleaner, being dirty, it matters how you are and me being that way. I just like to be clean. I makes you feel better refreshed and you're able to go more places and do more things, you know.

According to Yolanda, it was important to be clean so you blend in with the general public. She provided an example of why it is important to blend in around town.

Yea, absolutely because you have to. When I say stereotype. Stereotype is a big thing especially when they stereotype women who are homeless then they really segregate you from everybody else. And the public won't come and help you or do anything. When your hair's all matted and looks like a big nest they're not going to come and help you but for a lady that's hair's in a ponytail with her hair pulled back. You know.

Showering daily and keeping her skin clean had contributed to Yolanda sharing that she had never experienced lice or scabies or other issues with her skin.

Foot Care

In addition to staying clean by showering everyday Yolanda tried to take good care of her feet. She used foot lotions and scrubs and did her own pedicures. She admitted it was difficult to keep up with the maintenance of her feet without regular access to a bathroom.

Oral Care

Yolanda had a lot of missing teeth which she attributed to getting hit by a car when she was a child. She said the roots of her teeth disintegrated resulting in the loss of some of her permanent teeth. She broke off her back teeth by repeatedly using her teeth to open beer bottles. She denied going to the dentist regularly when she was using drugs because the drug use took priority. During her incarcerations she received regular dental care. Currently she brushed her teeth everyday either at the shelter or a gas station bathroom.

Toileting

Finding a bathroom did not present a problem for Yolanda. She could always find a bathroom somewhere such as a gas station or business. “There’s always a bathroom provided somewhere. If there’s not a bathroom, there’s a bush.”

Menstrual Hygiene

Yolanda was able to manage her menstrual periods while living/sleeping outdoors. She carried all her belongings in a backpack including menstrual hygiene supplies and wipes. She could usually find a bathroom to take care of her needs.

Managing Sleep

Bushes by the railroad tracks was one of Yolanda's sleeping locations. Last month she found herself sleeping there with her young adult son. She said it was scary but felt safer with her son next to her. In general, she felt relatively safe living/sleeping outdoors. "You see it's like, these days nobody really messes with the homeless anymore. So my safety out there, I really don't worry about it." Yolanda felt protected by the homeless community.

No. I never do. You know what I say. I've been out here on the streets since Sept 9th. I have, uh, I have met the most [begins to cry] beautiful and the most best people out here on the streets. The most people with the most kindness and the most morals and values are homeless people. And I feel more safe around a homeless person than I do with somebody in society that is rich and greedy. I swear I do. They got open hearts and these men, well out here and they will help you.

Yolanda admitted women living/sleeping alone outdoors are particularly vulnerable. If she was unable to pair up with someone she would protect herself by carrying a big knife. One night Yolanda found a sleeping place under a large statue of Jesus outdoors a church. Armed with her "buddy" (her knife) she fell asleep under the statue. "I was safe. I didn't feel one bit of harm. That was one of the best sleep I've ever had. Why? Because I was underneath my Father's arms. Right underneath him. I stayed right there."

Priority Health Need

Anxiety was identified by Yolanda as her priority health need followed by needing a hernia repaired. Due to a lack of medical insurance Yolanda had been without her psychiatric medication for a month (diagnosed with schizophrenia, anxiety, and depression). She had been actively advocating for herself to get medical coverage.

Uh, for me to get my meds, I have to go through so many hoops and leaps and all this stuff and I've done everything and they still haven't given me my meds. I've been out of jail for 33 days with no medication. My anxiety goes up and down, up and down, up and down all day long.

While she was waiting for her medication Yolanda was trying to cope with her anxiety on her own. "I read, write, I pray. I draw. I try to sit myself still because I'm very motivated and hyperactive. On the natural"

Yolanda's second priority health need was to get her hernia fixed. She pointed to her stomach when talking about her hernia so it was most likely an umbilical hernia. Once she was able to secure medical insurance she planned to follow-up with getting a hernia repair. Yolanda was knowledgeable and independent regarding re-establishing medical insurance and accessing medical care. She discussed her teeth as being an issue when talking about her overall health however she did not list her oral health as a priority health need.

Sustaining Health

Yolanda felt her overall health was very good. She felt she was healthier than the average woman and could probably out run a man right now. Yolanda had a strong

family history of diabetes and recently she sought medical treatment at one of the shelters regarding tingling down both of her legs and the sensation of water dripping down the back of her legs. She was told these could be symptoms of diabetes and planned to follow up at the shelter medical clinic. Yolanda denied hypertension and stated she had a good immune system, great metabolism, and good vision.

She was spiritually intact and that was important to her. Even when she was using drugs she felt she was spiritually intact. Yolanda credited her mother and grandmother (both deceased) for bringing her up to recognize and value her spirituality.

Conclusion

While living/sleeping outdoors Yolanda was able to manage her personal hygiene. Showering daily was easy to accomplish as well as being able to find a bathroom for her toileting needs. Yolanda reported no history of any skin issues (e.g., lice, scabies, tinea pedis) related to inadequate personal hygiene. She acknowledged her oral health was poor and received dental care while incarcerated. Currently she was brushing her teeth daily. Contributing to her adequate self-management of her personal hygiene needs may be the fact that her homeless episodes were interrupted by time in prison where her basic needs were met.

Participant Six-Lynette

Narrative Summary

Just prior to sunrise, Lynette walked out of the dark parking lot into the light of a small, local coffee shop. Her petite frame was weighted down by an oversized backpack

and a bedroll under her arm. Before offering a greeting Lynnette stashed her bedroll under a bench in front of the coffee shop; looking around to see if anyone saw her actions. She was bundled up with a jacket and a hat pulled down over her eyes. Lynnette was a polite, soft-spoken 59-year-old, Caucasian woman with a frequent nervous laugh. Sitting at a table with coffee, Lynnette kept looking around and expressed she felt uncomfortable being the only females in the room and requested to move to another location.

After driving across town, the interview was relocated to a back table in a fast food restaurant. Lynnette admitted she had not eaten at all the previous day so getting her breakfast needed to occur prior to an interview. With some food in her stomach, Lynnette was ready to talk. She provided oral consent for her participation in the study but declined to be audiotaped fearing the tapes would get into the wrong hands. Lynnette did consent to writing notes about her responses however during the interview she often looked down to see what was written.

Lynnette had been living/sleeping outdoors for 15 years and had been homeless in several states. Thirty-six years ago her four year marriage ended in divorce. Lynnette said she suffered a nervous breakdown after the divorce and spent two years in a mental hospital. There she was diagnosed with schizophrenia but refused to take medication as she disagreed with the diagnosis. She mentioned a nine year span where she lived in a broken down recreational vehicle (RV) with a boyfriend. Lynnette had been in town for two years. Prior to that she lived further south in another beach town. Living/sleeping outdoors had been difficult for Lynnette. When asked how it had been for her, she replied,

“Really hard [pause]. It takes a psychological toll on you. More than physical. You’re invisible. You are viewed as less than an animal. Trash. I should be dead. The things I’ve been through. I should be dead.”

Lynette tried to blend in with the general population by not appearing to be homeless. One way to blend in was to shower regularly and have clean clothes. Carrying around a bedroll was an obvious sign of being homeless. During the day she hid her bedroll in the bushes outdoors the library or the courthouse so she could walk around with just her backpack.

Lynette talked a lot about her safety and worried about getting raped or robbed. She had been attacked twice since living/sleeping outdoors. One time she was raped and the other time she was physically attacked by a homeless man while standing in line for food. She wanted help making homemade pepper spray to use as protection, especially at night.

Showering

Taking a shower and washing her hair were identified as Lynette’s priority personal hygiene behaviors. “Don’t feel right if I’m dirty.” When Lynette lived further south she was able to shower every other day at the pier. Since being in town she only showered three times per month at a women’s homeless clinic. In between showers she washed up in public bathrooms stressing the importance of rotating bathrooms so no one got suspicious. For safety reasons, she explained it was important to change her habits so no one could figure out her routine. Lynette would not shower at the shelters because

there are too many people. In the past, she had scabies and lice one time that she got treated at a women's homeless clinic.

Lynette worried about being judged by others for being homeless. "Judgment. People judge you if you're homeless. People will judge you if you're dirty. They judge you less if you are clean and don't look homeless."

Foot Care

Being without shoes during the night was not safe, according to Lynette. Therefore, she always had her shoes on while she slept. She tried to remove her shoes during the day to air out her feet. Lynette had a history of multiple occasions of tinea pedis and treated it by airing out her feet more often.

Oral Care

Brushing her teeth daily was important to Lynette and she was able to accomplish this behavior each day. She got toothpaste and tooth brushes from donations at a women's homeless clinic. She would spend money on supplies if necessary. She preferred organic toothpaste but it was expensive. Overall, she said her teeth were pretty good and did not cause issues with eating. She said she could use a cleaning and needs a filling.

Toileting

Lynette used port-a-potties or public bathrooms whenever possible. When those options were unavailable she would go to the bathroom behind a dumpster or in a bucket inside her pop-up tent she set up in the park. Due to safety issues, Lynette worried about needing to use the bathroom during the night. She watched what she ate later in the day

and at night so she did not have to have a bowel movement in the middle of the night. She tried to hold her bowel movement until morning where she could use a bathroom. She would not spend money on toilet paper instead she used anything soft she could get for free from businesses such as paper napkins.

Menstrual Hygiene

Lynette went through menopause sometime between ages 40-44 years old. She did not remember exactly when it occurred. When she was menstruating she was living/sleeping outdoors. She found the experience dehumanizing. Lynette would use socks as menstrual pads when she could not get actual pads. It was easier to get socks from donations than menstrual pads. Once soiled, the sock was thrown away and replaced with a new sock. Occasionally she could get menstrual pads from donations and, if absolutely necessary, she would spend money on menstrual pads.

Managing Sleep

Sleep was an issue for Lynette. Even though she typically got about seven hours of sleep per night (9:00pm- 4:00am) the quality of her sleep was poor. For safety reasons, she was a light sleeper and constantly felt the need to be aware of her surroundings. Lynette found nighttime to be very stressful by always having to be on guard. "I get bad vibes at night." Because of her poor quality of sleep, Lynette needed naps during the day. The pop-up tent she set up in the park was one place she could occasionally nap during day. Lynette felt having a place to shower every day and getting enough rest would make her life better. "If you don't sleep, it affects your life."

Priority Health Need

Priority health needs identified by Lynette were her issues with her eyes, her leg, eating right, and sleep. Lynette had macular degeneration in her left eye and being without insurance was making it difficult for her to get treatment. Lynette went to the public health clinic but said she “got the run around” and “didn’t like the attitudes there especially from the doctor” so she left without completing the appointment. She talked briefly about having trouble with her left leg getting stiff when she walked but did not go into detail.

Due to limited resources eating healthy on a regular basis was difficult for Lynette. She did the best she could with the little money she received monthly. Lynette mentioned more than once that her quality of sleep was an ongoing issue. Sleeping throughout the night was stressful for Lynette since she constantly worried about her safety. Since the shelters were too overwhelming for her and she did not have the resources for housing, Lynette had chosen to live and sleep outdoors.

Sustaining Health

Lynette felt her overall health was good but as she was “getting older things are breaking down” referring to her macular degeneration and her stiff left leg. She talked of other health challenges she faced while living/sleeping outdoors. Caring for contact lenses was a challenge while living/sleeping outdoors. Lynette often did not have the money for cleaning/soaking solutions. At night she would not remove both contact lenses at the same time. She always left one contact lens in place. “I always keep one in so if

someone walks up on me I can see what they look like.” She did not own a pair of eyeglasses.

Most of the Lynette was able to get enough food. She received about \$200 per month in food stamps and tried to eat healthy as much as possible. She preferred to buy her own food. Lynette would not go to the shelters for food because the shelters were too crowded. Lynette would not accept food from strangers. “People don’t like the homeless. I worry they’ll put something in the food.” Typically she ate only one large mid-day meal so the food would hold her overnight.

Conclusion

Managing her personal hygiene needs while constantly worrying about her personal safety was a considerable challenge for Lynette. Despite the constant concern for her safety, Lynette managed to complete her personal hygiene behaviors daily. Keeping herself neat and clean was important to Lynette. So every day, if she was unable to shower, she figured out a place to wash up. Also important was to brush her teeth daily which she was able to accomplish. One motivation for keeping physically neat and clean was to not appear homeless so she could blend in with the general public while walking around town. According to Lynette, the value of being viewed as a member of the general public was that she was treated with more respect by people and not bothered by the police.

Fear of personal safety also contributed to Lynette’s poor quality of sleep. Having to sleep with one contact lens in place to see a possible intruder put Lynette at risk for eye

injuries. Poor quality of sleep and the stress of constantly worrying about her safety left Lynette exhausted resulting in the need for her to nap during the day. Sleeping during the day in public places could be challenging for Lynette and was not always possible for her.

Participant Seven-Sharon

Narrative Summary

On a cool day early in the morning, Sharon came down the street with a male companion by her side. After briefly stopping at the pre-arranged meeting location, her male companion went off toward the public bathroom to wash up. Sharon walked toward the picnic table. With each step her face grimaced with discomfort and her medium frame leaned forward and to one side. Sharon was 54-years-old, Caucasian with a kind, gentle demeanor. She was soft-spoken and appeared exhausted and in pain.

Born and raised locally, Sharon had been homeless in other cities besides her hometown. For a little over a year she had been living/sleeping outdoors in the bushes approximately 10 miles from downtown; an area of town where she grew up. Recently she was able to afford a tent to provide shelter while in the bushes. Living/sleeping outdoors had been tough for Sharon.

Um, [pause] it's kinda scary at first, you know, not knowing anybody, not knowing what people are like around me. You know I mean I have the dog with me and he's sorta of watch dog. You know, stranger alert, that kinda thing. Um, and possibly being chased by the police.

Sharon preferred this particular part of town because she felt safer than being downtown. She avoided going downtown as it triggered panic attacks caused by a previous attack and rape. Sharon had a significant history of abuse and had been diagnosed with post-traumatic stress disorder (PTSD). She had a history of being abused by her father, former husband, and raped by her brother when she was seven years old.

When asked about her PTSD diagnosis she replied

Um, childhood abuse. Sexual, physical, mental, all that. And I still struggle with that even though I had years of counseling, you know. People have walked up to me and they say, how'd you get out here. And I say, it's a really long story, it's really bad and I couldn't handle it. That's all I can tell you, you know.

Sharon was very close to her mother and when she died several years ago Sharon experienced a nervous breakdown. In addition to PTSD, Sharon had been diagnosed with a panic disorder and being bipolar. Currently she was not on any medication for her mental health issues. Her physician was no longer in practice and Sharon had been having difficulty securing consistent medical and mental healthcare. Her service dog helped with her anxiety. Sharon was very emotional and cried often while sharing her childhood experiences and experiences of living and sleeping outdoors as an adult.

Showering

The area of town where Sharon lived/slept had only one public bathroom in a city park and there were no public showers. This created a challenge for Sharon to shower and shampoo her hair. Sharon named taking a shower or washing up (keeping clean) as her

priority personal hygiene behavior. “Um, pretty much just the pit and wash stuff, you know. Just try to keep stuff clean.” In the public bathroom Sharon washed up in the sink which she said was deep enough to shampoo her hair. “I try to wash every 3 or 4 days. You know, I don’t want any bugs.” She got washcloths and towels from a local donation box and bought soap and shampoo out of her small monthly disability check. Sharon rarely got the opportunity to take an actual shower and shampoo her hair.

Once in a while I do have a friend, um, who lives in a car part-time and a room part-time. And she let me come and take a shower a couple of times, you know. Just recently. I was able to take a shower.

Another reason Sharon avoided going to the downtown area and homeless shelters was due to her concern about contracting scabies, lice, or bed bugs.

Foot Care

Currently Sharon was having issues with her feet. “They’re a little rough right now. A little rough condition.” She dropped something on her toes causing a bruise. Overall, taking care of her feet was a priority for Sharon. Sharon was born with webbed toes on both feet causing a lot of issues for her growing up.

They separated those when I was 14-years-old because the kids were teasing me so bad. Between my webbed toes, crooked fingers, birth mark, you know. I was different. I was funny looking, skinny little thing so they teased me. It hurt, it hurt, it hurt and finally we went and did a skin graft from my side and separated my toes.

Because of her surgery many years ago, Sharon tried to take good care of her feet.

So, if I wear shoes too much we have this, this, this, the, the scars start breaking up. So yeah, I have to keep my feet dry. I've had sunburns on my feet, you know, from wearing sandals, you know. So, you know, I go back and forth between wearing sandals and shoes.

Oral Care

Sharon had no teeth. She had been without teeth for 5-6 years and did not reveal how she lost all her teeth. Dentures were unattainable due to the high cost. Sharon described the experience of living without teeth, "It was difficult at first, you know, self-conscious and all that but I just had to get over it." A big challenge for Sharon was finding food she could mechanically eat, provide enough nutrition, and was affordably priced in an area of town with limited restaurants and grocery stores. A free dinner was provided weekly by a local church however often Sharon was unable to eat the meal due to undercooked vegetables.

Toileting

Meeting her toileting needs could be a challenge for Sharon. With only one public bathroom in the area, sometimes Sharon had to rely on the kindness of employees at local businesses to let her use the bathroom. "You know, the 7-Eleven, you know they have a bathroom there. Some of the restaurants, you know. The shops. They're pretty nice to me."

She had experienced urinary and bowel incontinence when she could not get to a bathroom in time. For that reason, she carried extra pants with her at all times. Sharon

was only able to do laundry once per month so in between laundry day she washed her dirty clothes out by hand in the public bathroom and laid them outdoors to dry in the sun. When she urgently needed to use the bathroom, Sharon had relied on the kindness of strangers. “Once in a while I’ll feel comfortable enough to stop by somebody’s house and knock on the door, hey, I’ve got an emergency I gotta pee, you know” and occasionally someone would let her use their bathroom.

Menstrual Hygiene

Sharon’s last menstrual period was over a year ago. She did not remember exactly but said it just went away. When she was menstruating Sharon was living in her RV and said she did not have any problems adequately managing her menstrual hygiene.

Managing Sleep

Just outdoors of town, Sharon slept hidden away deep in the bushes. For her safety, she was careful not to reveal the exact location. For a long time Sharon had slept on the ground in a sleeping bag without padding. Several years ago Sharon was in a car accident resulting in multiple back surgeries leaving her with chronic back pain. Sleeping on a hard surface contributed to her pain making it difficult to sleep and difficult to get up each morning. A few weeks ago, Sharon was given a thin exercise mat to put under her sleeping bag but it was not enough cushion for her back pain. Sharon had been living/sleeping outdoors by herself for the past year. About two months ago she had allowed a male companion to join her.

Sharon and her male companion retreated to their sleeping location early evening. Their nightly schedule revolved around the best times to go undetected.

And, um, we try to fly under the radar of the police and the people. We get there 7-7:30, you know, and by the time I get up at like 6, you know, to make sure we get out before anybody sees us. So, it's a long day being outdoors all day like that, you know.

For what appeared to be an adequate amount of hours of sleep, Sharon's quality of sleep was poor leaving her tired and in need of a nap during the day. Her sleep was interrupted by urinary frequency and urgency.

I wake up every 2 hours to go to the bathroom. Behind a bush. Yeah, I have to get out of the tent. Get out in the cold and look around for animals. Yeah, there's mice, there's raccoons, there's skunks.

Sharon recently got some medication for her urinary urgency but so far the medication was not working. "Yeah, yeah, yeah. I just got them a few days ago but I don't know, he said the dose needs to be upped, you know to make it more effective. So I can't get a full night sleep." So between her constant back pain and urinary frequency, Sharon did not get a lot of sleep during the night leaving her tired during the day.

Yeah, they don't like to see nobody sleeping. They give people tickets for sleeping during the day. You know to be told you can't sleep outdoors and you can't sleep during the day, you can't sleep at night. You know you can't sleep outdoors, period. You know you can't sleep unless you have a house. Pretty much. So I've gotten camping tickets.

Priority Health Need

Food was identified by Sharon as her priority health need. The main issues were getting enough food every day and finding food with adequate nutrition she could mechanically eat.

Cuz I don't have no teeth. So it's trying to find the foods I can process. Yeah, yeah. You know cuz my body doesn't like to process stuff quite right. So you know I get indigestion. I get heartburn. So I have to. I'm probably not getting enough of the vitamins that I need.

Limited financial resources and limited food options in her area of town made it difficult for Sharon to meet her nutritional needs. "Because I have no way to cook food so I have to eat at the restaurants here." Sharon shared that she often felt hungry causing stomach pains and a lot of stress.

I'm hungry all the time. When my body's like getting stressed out, I think I've got my throat cut or something cuz I'm not eatin, you know. And my stomach starts going, starts getting hunger pains and like I gotta get something, you know. That's what's worse and then you got to buy something otherwise I do like everybody else does. But I don't want to ask anybody for food. I just can't sneak up and hey, can you help me out, I'm hungry? I can't do that.

Sharon would look for food in dumpsters even though in the past she had gotten ill from food obtained from a dumpster.

I've found really good food in the dumpsters. It's stuff people throw away and there's no reason for them to throw it away. I'm a pretty good judge of what's

good and what's not, you know. I've found Top Ramen, I found frozen meat and chicken stuff like that, you know, that people just throw out from their freezer.

On occasion, Sharon would take the dumpster food to the park, have a barbecue and share a meal with other homeless people in the area.

Sustaining Health

Despite chronic back pain, no teeth, inadequate food and nutrition, and mental health issues, Sharon thought her overall health was not too bad.

I don't feel bad. Um, I think. I don't have a cold, I'm not, I got allergies, you know. Um, and the pain of course. I've got bone spurs in my neck. And so that's added to it and they haven't even started looking into that yet.

Sharon had been without adequate pain management since her physician stopped practicing medicine a few years ago. She had to try and manage her back pain by stretching exercising and ibuprofen with fair results. Recently she was able to get care through a spine institute so her pain management was slowly improving.

So with my pain medication is now being managed with ibuprofen, Percocet, and morphine. And the doctors at the spine institute are trying, the one doctor he doesn't want me to be on anything at all. He wants me to suffer, yeah. Get injections. The injections don't work that well, for very long. And uh, I says, you know, we're talking about quality of life here, you know. Without the pain medication to mask the pain I wouldn't be able to do anything. I'd be laid out. He said, yeah, but it just masks it. I said there is quality of life we're talking about here. You know.

Sharon woke up in pain. She usually took her pain medication on an empty stomach (due to little to no food) and did not have the luxury of waiting for the medication to take effect before having to move around. To avoid detection, Sharon had to get up and out of her sleeping location early in the morning.

I wake up in pain, okay, so it takes like an hour for the stuff to start working. To get into my system. So I just have to start moving around. And most the time I don't have the luxury of being able to take my medicine before I have to jump about and get the heck out of there, you know. So, I start off in the morning, it's like, ow, ow, ow, ow, so it's like, talking about getting a 9 [on a 0/10 pain scale] first thing in the morning.

Sharon's other health concerns were the absence of all her teeth which directly contributed to her eating/nutrition problems. In the past she had inquired about dentures but was unable to afford the \$1,900 cost. Since Sharon did not see her financial situation changing any time soon she had no plans to get dentures, at this time. Finding appropriate food was an ongoing challenge for Sharon. Under the circumstances she did her best to find nutritional food she could afford and mechanically eat.

Conclusion

For Sharon, self-managing her personal hygiene was a huge challenge. Sharon lived/slept in an area of town with only one public bathroom she could use to keep clean and use the toilet. Keeping clean, ideally by taking a shower, was cited by Sharon as her priority personal hygiene behavior. For Sharon, taking a shower was not possible on a regular basis so every 3-4 days she washed up and shampoos her hair in a public bathroom.

The downtown area had more opportunities for Sharon to get a daily shower and use a bathroom however she was located approximately 10 miles from the downtown area. To get downtown required a private car or taking the city bus. Due to chronic back pain, Sharon was limited physically, making it almost impossible for her to take the bus. The biggest obstacle for Sharon to go downtown was her history of being physically attacked downtown so, venturing to the downtown area could trigger anxiety attacks.

Managing her sleep was also a big issue for Sharon. Sleeping on the ground, hidden in the bushes, caused significant back pain for Sharon, therefore interfering with her quality of sleep and making it difficult to get up in the morning. In addition to her back pain, urinary frequency throughout the night also contributed to her inadequate sleep quality. Poor sleep quality left Sharon exhausted during the day with no safe place to nap.

Sharon took good care of her feet so foot care was not an issue for her. She was menopausal so managing her menstrual hygiene was also a non-issue. Sharon had no teeth so brushing her teeth was not an issue and she did not mention the need to care for her gums.

Participant Eight-Lena

Narrative Summary

Lena was 59-years-old, Hispanic, petite, energetic, and fast-talking. She arrived at the fast food restaurant with a big smile and happy disposition. Lena had been living and sleeping outdoors for 10 years. Lena usually lived/slept in a car but had experience

living/sleeping completely outdoors. Occasionally she would spend a night at one of the shelters. For the majority of time Lena had been living/sleeping in a car or completely outdoors she had been by herself. She preferred it that way. “Always. Always by myself. Always. I loved it. I’m independent.” Currently she was living/sleeping in a van with a boyfriend of five months.

Lena lived/slept outdoors by choice. “The reason I choose to be outdoors is because I know God has something better for me. And I like being outdoors. I like being in peace.” For the most part she felt safe living/sleeping outdoors by herself. “I feel safe, now. I’ve always felt safe as long as I keep God in my heart and in my prayers.” The exception was the two times she was almost raped. Lena had a history of rape and domestic violence. She had been raped twice while walking at night and, for many years, was a victim of domestic violence by her former husband. “He used to beat me up black and blue [crying]. Put me in a mental institution four times and my mom stood for it, including my sister.” According to Lena, she was never given an official mental health diagnosis. “No, there was nothing wrong with me. It was my ex-husband that wanted to get rid of me.” She admitted to being depressed and sad during that time in her life.

Lena’s life had been tough for her. She was estranged from a lot of her family and missed her children and grandchildren. The details of their estrangement was not revealed. Lena was emotional and cried often while sharing her experiences of living/sleeping outdoors for many years.

Showering

Lena said it was very hard to take care of her basic health needs while living/sleeping outdoors. “Very hard. I don’t have any place to shower.” Showering

every day was important to Lena and showering was listed as her priority personal hygiene behavior to try and accomplish each day. “I like to keep clean so if I can’t take a shower, I do whatever to keep clean in other ways, like using, you know, wipes or those little towels we’ve been getting at the women’s homeless clinic or at the park getting water, whatever.” Between the shelters and a women’s homeless clinic Lena had access to a daily shower and took advantage of those resources.

Foot Care

Keeping her feet in good shape was important to Lena and she accomplished this by taking a shower as often as possible. When unable to shower Lena got creative with cleaning her feet. “I get water and put it in a little bucket or whatever or an empty bottle of water and just put water from the park and do it that way.”

Oral Care

Lena had a lot of missing teeth. Most of her missing teeth were in the front and when she talked fast it could be difficult to understand her speech. Lena’s missing teeth made it difficult for her to eat certain foods. Lena identified her teeth as her priority health concern. “I’m losing all my teeth. But I blame that on the dentist that did the work.” She did not elaborate on the reason her teeth are falling out. She did brush her remaining teeth every day and got oral care supplies (toothbrush/toothpaste) from donations or she bought them herself.

Toileting

Frequent urination was an issue for Lena, especially at night. She woke up frequently during the night to urinate and would go to the closet fast food restaurant or

urinate in a can inside the van. In the morning she discarded the urine in the park. During the day she was able to find a public bathroom or a bathroom in local businesses. Her bowels were regulated for the day time so she was able to use a public bathroom or one in a business. If she was really desperate to use the bathroom she could go to her uncle's house. Her boyfriend would spend money on toilet paper so she could use it during the night when she needed to urinate in a can.

Menstrual Hygiene

Lena was not currently menstruating. She went through menopause sometime between ages 43 and 47 years old. She did not remember exactly how old she was at the time. She said menopause was pretty uneventful for her. She was living in a house during the years she was menstruating so she did not have any experience managing menstrual periods while living/sleeping outdoors.

Managing Sleep

Lena and her boyfriend sleep in a van she said needed to be fixed up. They would go into the van at night around 8:00 pm, at the latest 9:00 pm. Lena got up around 5:00 am to make a lunch for her boyfriend to take to work. She felt safe because her boyfriend was with her. Lena shared that her quality of sleep was really poor. "Right now, not good. I go to bed really tired." For the past 5-6 days she said she had been sleeping in, sometimes as late as 9:45am because of her urinary frequency and too much stress in her life. "Too much stress. Too many problems."

One thing Lena shared was that she always slept in her bra and underwear. This practice seemed really important to her. It was a practice her grandmother and mother taught her.

I never sleep with no bra. I always wear a bra so I won't have saggy boobs

It's uncomfortable if I do not. He gets mad but I say, you know what, I don't want saggy boobs. Never have. I can't. I don't like it. I feel dirty. I don't like it. Cuz my grandmother never did. My mom never did. I'm old school [laugh].

Priority Health Need

Getting new teeth was listed as her priority health need, "Right now. Not like diabetes cuz I'm taking care of it but this would be my teeth." Lena said recently she had gone to a dentist to talk about a plan for getting dentures but the plan was on hold since she ended up in the emergency department with chest pain.

Sustaining Health

Lena rated her overall health as somewhere in the middle, "I'd say 50/50 good. Not all good. Not all bad." Lena's health issues she needed to manage were diabetes, hypertension, osteoporosis, high cholesterol, and recently, chest pain. She got regular medical care at either one of the public health clinics or the medical clinic at one of the shelters. Lena took medication for her diabetes and hypertension so she felt she was taking care of those conditions. The diagnoses of osteoporosis and high cholesterol were new so she was not on any medication at this time. Recently Lena went to the emergency department for chest pain. Lena said her chest pain was a result of too much stress in her

life. She followed up with the nurse practitioner at one of the shelters who was assisting Lena with getting a cardiology appointment.

Two years ago Lena got her first mammogram at age 57. She was about to get her second mammogram soon. Her last pap smear was approximately three years ago and had an appointment for a pap smear next month with the nurse practitioner at one of the shelters.

Conclusion

Lena felt it was difficult to get her basic needs met while living/sleeping outdoors. Despite that sentiment Lena appeared to be a very resourceful woman who managed to get her personal hygiene needs met almost daily. If she was unable to find a place to shower she would wash up at one of the city parks. Keeping clean every day was a priority for Lena. She took good care of her feet on a regular basis. Oral care was an issue for her with many missing teeth but she was able to brush her remaining teeth daily. Lena had a system in place to manage her nocturnal urinary frequency by using a can and toilet paper. Overall, Lena managed to get her basic needs met on a daily basis.

Participant Nine-Amber

Narrative Summary

Medium height and slender, Amber was friendly and welcoming. Amber was 36-years-old, Caucasian with a demeanor that was positive and confident. Except for a few minutes at a coffee shop patio, the majority of the interview took place on a downtown city bench. Amber seemed eager to share her experiences of living/sleeping outdoors for 10 years although she commented that she had some memory loss.

But, it's kinda like all a blur. A lot of it I don't remember because I have memory loss but it's like, gee, it's like, god, like even the last 6 months before I moved into recovery, even the first months of recovery, it's all a blur. I don't even remember where I was. I'll have a flash memory of being at the beach or but, um. But a lot of stuff I blocked out. Uh, I lost my mind.

At the time of the interview Amber was staying at one of the shelters. Amber described the experience of living/sleeping outdoors as exhausting and "Uh, [pause] really stressful [laugh]." When asked in what way, she replied, "Uh, well you're prey." Prey for the many psychopaths and sex offenders Amber said are wandering around town.

They prey on homeless women. And the homeless women I notice that have been chronically homeless for a long time are so used to getting raped that it doesn't really phase them after a while. I've met a lot of women like that and it just breaks my heart. Yeah, you kinda of, it's, you would never know, you would never possibly know what it was like unless you've experienced it yourself. And it's like you enter a whole different kind of dimension, I guess. But like reality changes completely.

A local native, Amber had a very difficult childhood. She had an unconventional childhood by living in a teepee up in the mountains with no running water. Although unconventional, Amber had positive memories of this time in her life. At age 12 her parents divorced and at that time Amber said "my mom went permanently insane." Amber spent the next several years moving from place to place such as friends of the family and foster care families. During this period of her life she was psychologically,

emotionally, and mentally abused. As a result Amber suffered from “PTSD really bad from tons of trauma, uh, anxiety disorder, constant panic attacks.”

Amber spent her adolescent and young adult years heavily involved with drugs and alcohol. Amber shared how her life was during that time,

Yeah. Well mine got worse because it made me, uh, I had mental health problems that I got from being abused as a kid and then when I was in my 20s I became an alcoholic and a drug addict. I fell into the street. And then, uh, so being a crazy addict on the street I just got crazier over the years. Like my last 2 years, before 2 years ago before I started, I started changing my life 2 year ago, but before that, the last 2 years before that I was, it was, I was crazy. I was as bad as it gets. When you see a street person at their ultimate worse. I mean I was barefoot, I didn't bathe, I was covered in bugs. I would yell at people that weren't there and scream at the buildings and be all bloody and dirty and covered in food sauce.

During this time in her life Amber repeatedly had unhealthy relationships with men,

I was attracted to bad, creepy men and I was attracting them and letting them, you know, and then I'd get mad at them and then I had to realize it was myself. And well like my own sexuality grossed me out. How I was sexually and what I'd been through too, sexual abuse and rape and just like a bunch of gross stuff.

Amber had been clean and sober for the past two years and making great progress.

Oh yeah, yeah, yeah. And plus I was so, I was dying from alcohol and drugs. I got real bloated. I was a black out drinker for 15 years. I've had alcohol poisoning and hangovers thousands of times. I've always been super sensitive mentally and physically so like drugs made me even sicker than other people.

She was actively participating in a sobriety program and dedicated to getting healthy. At the time of the interview, Amber had just learned she would be getting her own room with a private bathroom in single residence occupancy hotel. She was looking forward to her new room and getting off the streets and said, “The first thing I’m going to do is sleep for the first week. I’m so exhausted.”

Showering

While living/sleeping outdoors Amber said it was very difficult to get her basic needs met especially taking a shower. She cited the reasons it was difficult was due to her mental illness, drug use, and access to resources. Her anxiety kept her from being around a lot of people at the shelters so she was unable to take a shower. During her days of excessive drug use and serious mental illness Amber said taking a shower was not important to her. She did not shower or wash up. The longest she went without washing up was a month. Complaints from people regarding how bad she smelled eventually led Amber to clean up more often, “Um, yeah, yeah, usually I’d get embarrassed because somebody would say something so, I’m French so my armpits stink, so, uh, now I bathe every day.” Amber explained why she was unable to shower or clean herself up

No, usually it was just due to just being freaked out, mentally ill and, um, I got, the more I was homeless and bouncing in between places the more disgusting and dirty I got. I had lice for 2 years.

Since she had been clean and sober with stable mental health, Amber identified taking a shower and keeping clean as her priority personal hygiene behavior to get done.

Foot Care

Amber did not mention any issues with her feet. She cleaned her feet each time she took a shower.

Oral Care

Taking care of her teeth was not a priority for Amber when she was living/sleeping outdoors with substance abuse. Despite the neglect of her teeth, Amber said she did not end up with long term dental issues.

Yeah, actually my teeth. Uh, none of them have fillings. They're all called virgin teeth. Not only did I not brush my teeth and eat really bad but I smoked a lot of drugs and I don't, they x-rayed my teeth, I only had one bad tooth. I had to get, the root was cracked so I had to have it taken out but it had a cavity they found first. That was my first cavity.

Since she had been clean and sober, Amber brushed her teeth daily.

Toileting

Amber did not mention any issues regarding access to bathrooms during the day or needing to use a bathroom during the night. She shared one experience regarding urinating during a time in her life when she was heavily using drug.

Then when you throw, you know when you have a bunch of mental illness and then justifiable paranoia, as some psychiatrist told me I had once. And you throw speed or crack into that you'd get, I mean I'd be so freaked out I, I remember one time holding my pee for over a day, I was too freaked out to pee.

Menstrual Hygiene

Amber had regular menstrual periods while living/sleeping outdoors. She shared that when she was really stressed out and using drugs her flow would be more toxic (heavy). Most of the time she had menstrual supplies (tampons) to manage her menstrual period. She would buy supplies in advance so she was prepared or ask another woman for a tampon or pad if caught without menstrual supplies. Amber shared one experience when she was caught without supplies and her boyfriend came to the rescue.

All of a sudden my period just spewed, especially if you're being really stressed out and using drugs your flow will be more toxic. So, it just like flowed and I didn't have any underwear on, I didn't have any tampons, I didn't. I was like, what do I do? So, he got up and he took off his pants and he took off his little uh, what are they, his tighty whities, there not white but, uh, his little briefs, his briefs, and he, uh, took off a sock and he rolled up his sock and I put on his underwear and I put the sock in there [laugh]. He told me to do that. He's like, here I know what to do. He knows women very well. He's older, he's 63.

Managing Sleep

Sleeping in hidden places around town were the safest locations for Amber. She had slept in city parks, the beach, under bushes, under a bridge, and next to the railroad tracks. She slept outdoors alone, with friends, or men in particular. Often Amber would try to find men to camp with to feel protected.

Uh, I usually, I'd usually try and find men that I felt would protect me to camp with. I slept under a bush next to the freeway. I slept under a bridge in a tent next

to the railroad tracks with a vet. That got creepy. Usually all the situations got creepy so I just bounced, you know.

Staying awake all night was typical for Amber. “I usually couldn’t sleep when I was outdoors so I’d usually sleep during the day.” She usually did not have difficulty finding a hidden location to sleep during the day.

Priority Health Need

Quitting smoking was identified as Amber’s priority health need. Also on her list was getting a hernia fixed and issues with her back. “Quitting smoking. Uh, I want to exercise every day. I want to get money to get strong. I’m very weak and tired. And, um, uh, back x-ray, hernia operation, um, just a lot of stuff.” Amber planned to use her chiropractor to fix her back. Her umbilical hernia would need to be surgically repaired. This would be her second hernia operation.

I had a hernia operation about a year ago and then I didn’t. I don’t know if it didn’t heal right or something but or it might another one. But I worked at a flower stand on and off for 14 years so there’s a lot of heavy lifting so that’s how it got ’em.

Amber did not discuss how she planned to quit smoking. She did smoke two cigarettes during the interview.

Sustaining Health

Because of her issues with her hernia and back, Amber ranked her overall health as poor. But she believed everything will turn out fine.

Yeah I have faith and hope that I can turn everything around so before, um, I believe in miracles so, so even if I have something deadly inside me like cancer and then I get diabetes which I'm sure if it hasn't sprouted in my body yet, it's just dying to.

Amber felt her many years of constant stress and PTSD contributed to her physical problems.

Especially from the stress has been, stress, PTSD. Stress and PTSD has been the worse problem I've ever had so, um, and that's all of the stress and the PTSD and the mental illness is resulted in me behaving in ways that have caused me to become physically ill. So as I get older I take less psych meds and more physical meds [laugh].

While living/sleeping outdoors Amber had periods where she would not get enough food. "I've had problems with food before, going hungry and starving and you know being thirsty and unable to function." But for the majority of her time living/sleeping outdoors Amber was able to get enough food daily. She said it was easy to get food because people would see "a pretty girl outdoors and they're skinny, they're like, oh my god" and then would give her food.

Conclusion

Due to her mental illness and excessive drug/alcohol use while living and sleeping outdoors, Amber had difficulty managing her personal hygiene on a regular basis. During this time in her life finding and using drugs or alcohol were her priority and these activities consumed a large part of each day. As a result Amber would go days or weeks

without taking a shower, washing up, or brushing her teeth and hair. However, she did seem to adequately manage her menstrual hygiene while living/sleeping outdoors.

Since Amber had been clean and sober she had been able to accomplish her personal hygiene behaviors on a daily basis. Taking care of her personal hygiene needs seemed to be part of Amber's goal of taking control of her life and getting healthy.

Participant Ten-Eleanor

Narrative Summary

Small-framed, gray-haired Eleanor had a kind, tanned, weathered face. Sitting in a city park, inside her small pop-up tent, Eleanor was smiling and welcoming. She was ready to share her remarkable experiences of living and sleeping outdoors for many years.

Eleanor was 77-years-old, Caucasian and had chosen to live and sleep outdoors for the past 44 years. For Eleanor, the past four decades had been spent spiritually searching. Prior to beginning her spiritual journey Eleanor grew up in Southern California with her parents and a younger sister. Her mother was very controlling and they were not close. Eleanor went on to attend a prestigious university in California. In late 1950 she graduated with a sociology degree and stayed to pursue graduate school. While in college Eleanor was very active in the civil rights movement and helped to form the Students for Racial Equality organization on campus. "We started the movement to get the campus opened up to have political speakers." Her first job out of college was as a community organizer in a big city on the east coast. Over the years she had many jobs:

research assistant, childcare, preschool teacher, caring for adults and children with special needs, and assistant to a baker.

Eleanor began her spiritual journey in the mountains of California where she lived and slept among the redwood trees. In her late 30s, her spiritual path took her close to the Canadian border where she walked from the mountains of California to northern Washington, stopping for the winter in Oregon. “I started when it was spring, I was following the wildflowers and it was wonderful. On the coast, you know, Big Sur.” Once in Washington she joined a group of young adult apple-pickers, took care of their children, and led a simple life.

Eleanor’s life and life decisions were guided by messages from God. She shared how God’s messages came through to her,

I get these dreams that I know are from God. They wake me up and I can tell when they’re from God and they’re really a message I really need to think about.

They come with a special feeling, they’re very vivid. And they come in the morning when it’s just time to wake up.

After her time in the Pacific Northwest, Eleanor eventually found her way back to Southern California and continued her simple life living/sleeping outdoors. Eleanor said the longer she lived/slept outdoors the easier it got. “Oh sure. Sure. And you’re, there’s less fear because you’ve learned you can take care of yourself and stuff.” She had not viewed her life outdoors as stressful. In fact, just the opposite. “It’s less stressful. Really lack of stress because inside with all of the baloney that goes on in these apartment houses and stuff.”

Eleanor preferred to travel alone living/sleeping outdoors. “You see being with somebody can be very, you can, well if you’re in the city it attracts attention, the police and things. So it’s easier to just kind of navigate if you’re solo.”

Eleanor had learned to cope with safety concerns living/sleeping outdoors. She said she felt safe, “Um, most the time. But it’s not because, it is really is safe. It’s just that I’ve just learned to just not accept being anxious or fearful.” In all her years living/sleeping outdoors Eleanor had only been attacked one time. Over a decade ago, she struck up a conversation with two brothers in a park. The men followed her as she headed to her sleeping location.

In 2003 two brothers attacked me. And, uh, dragged me over this fence and it was December 7, 2003. And one of them stuck a rag in my mouth and the other one, and held me tight, while the other one was pulling off my clothes. And he stuck his finger up me but that’s all he did but he heard a noise and they jumped the fence and ran away. So fortunately that the fence they dragged me over was people I knew so as soon as they fled I could just stagger over to their place and they called the police, 9-1-1.

Following that incident Eleanor was able to get off the streets and safely spend a week in domestic violence housing. From there she was able to arrange living in a room in a house, rent-free for four months. Uncomfortable arranging Section 8 housing in order to pay rent and a yearning to return to the mountains, Eleanor returned to her life living/sleeping outdoors where she had been ever since. “I did want to go back to the mountains, too. The more I was down here the more I wanted to go back to the

mountains.” Eleanor still had a desire to return to the mountains to live/sleep but realized this location was no longer an option for her.

“Oh, but you know I’m too old now. I can’t. For one thing I need, I do need the walker. And it’s just too dangerous getting up there and back.”

Showering

Eleanor, by choice, did not shower or wash up every day, especially in the wintertime. “Well you get used to not being real clean in the wintertime [laugh] and you know you get sort of out of your old fastidious habits, you know, and you just try and get over it, you know.”

According to her, she stopped bathing daily a long time ago.

No, oh no. I don’t shower every day. That’s long in the past that I shower every day. I’ve had times when I was out in XX [an area of town] that, I mean, I’d hate to tell you how long. When I lived, when I camped in the mountains there was like a mile hike that would take me up to this park where there’s cold showers. And I’d wash my hair in the cold water there and sometimes I would go down and bathe in the creek. Being careful not to get it soaped up or anything. I don’t want to hurt the little fish.

She knew of the availability of showers at the shelters but usually chose to not shower there because she found the shower times and shower arrangement to be inconvenient. “For a shower. But you have to do it so early. There’s so many. There’s a long line and you get 10 minutes. Which goes very fast if you want to wash your hair.” If Eleanor decided to shower she would go to the shelter with afternoon shower times or a women’s homeless clinic.

When Eleanor was younger and living with the apple-pickers, at the end of the apple harvest, the group would have a celebration and one of them would build a large homemade community bath.

He had, um, one of these, I almost forgot this, um, one of these 50 gallon metal drums that you put oil in. And he built a fire under it and he made it warm. I mean pretty hot actually. He made a sauna situation he put it right next to the, what do you call it, the cistern. So people would come and it was a big celebration really you would, he wouldn't build a fire every day and you took turns. And I got to be the last one where I got to be in the hot water and then you get out and get in the cold water.

In addition to rarely showering, Eleanor seldom did laundry. According to Eleanor, going to a Laundromat took too much time and costs too much money. "I don't want to waste money on things like that and also money plus I just hate Laundromats and I just hate, they, you know, machines ruin your clothes really." Spending the majority of her day walking all over town searching for low cost, healthy foods was the main reason Eleanor did not have time to go to the Laundromat. "This is part of why I got so focused on trying to stay healthy on as little as possible. And thinking of food is the main thing for that. But, it's like I hardly have time for anything else."

Since Eleanor did not do laundry very often she tried to pick up clothing donations so she had clean clothes to wear. Eleanor had access to a water faucet next to her sleeping location where she could hand wash some items of clothing and hang them in the sun to dry. "I do a little bit of hand washing on the weekends. I wash out my panties and bras and socks and stuff and sometimes a shirt or a jacket. But, um, I have a

sort of a pile.” Of course, hand washing clothes happened more often in the summer months when she had more sun to dry her garments.

Foot Care

Foot and fingernail fungus was an ongoing issue for Eleanor. “I have fungus. Nail fungus.” She had seen the podiatrist at a women’s homeless clinic where she could get free containers of white vinegar and was encouraged to use white or apple cider vinegar on her feet and fingernails.

Yeah, and I knew already about vinegar but, um, and it works. But it’s getting the time and the place to soak your feet. And I have it real bad on here and sometimes at least in the daytime I can stand or sit and have my finger in vinegar.

Oral Care

It was clear when talking to Eleanor that she had major oral care issues. She had a lot of broken off or missing teeth, especially in the front of her mouth. However, during the interview, she did not initiate any discussion regarding the poor condition of her teeth. Eleanor said she brushed her teeth daily in the bathroom of a coffee shop.

Yeah, I need to because I could easily get bad infections in my teeth. Well, because once you get an infection you know that it is important. In fact, you know, the only, you know people stay away from the dentist because of the pain well it’s the pain that’s driven me to the dentist. I’ve never gone and got my teeth clean since I’ve been on the streets because it’s too expensive. \$85 for the cheapest one.

Eleanor would spend money on supplies (toothbrush/toothpaste) or get them from donations at a women's homeless clinic. The issue with her teeth was addressed in relation to the need to blend her food. Eleanor was asked if she blended her food because she did not have many teeth. "Yeah. I have a thing that I can grind it up pretty small and I do that quite a bit." In addition to her blended food, Eleanor also bought healthy freeze-dried soups that were lighter to carry compared to cans and easy to reconstitute with water from her faucet, and was easy for her to eat. The exact cause of the issues with her teeth was unknown.

Toileting

During the day, Eleanor could usually use the bathrooms in local businesses. If not, she urinated in a cup hidden inside her pop-up tent she sets up in city parks. When asked about using bathrooms in business she replied,

Yeah, most the time. When, sometimes when I'm in this [her small pop-up tent in the park] and I have my cup with me and I, you know, I'm in a big hurry because sometimes when you get my age you're in a pretty big hurry. It gives me enough privacy, you know, if I face this way and I have a skirt or something and so then I just pour it out [laugh].

Finding a place to have a bowel movement could be a challenge when living/sleeping outdoors. Sometimes Eleanor could find a bathroom to have a bowel movement but if not, she seemed to have figured out how to manage her bowel movements.

Sometimes, but most of the time I have to do it too early so I have a plastic, I have a supply of plastic bags and I do it in one and then put it in another so you can't

see what it is. And then I dump it in the trash where people put their doggie shit, too.

During the night, Eleanor's sleep was interrupted by urinary frequency. "I have to get up several times and go to the bathroom." When asked where she goes to the bathroom at night she replied,

Right there. See I have a large cup that I pee in and then I have a thing with a good aroma sealed top [laugh] that I pour it in and I try to dilute it. So that when I water the plants I don't stink everybody out.

Eleanor would not spend money on toilet paper but would use it if she could get it for free. Recently she found several unused rolls of toilet paper in a dumpster and took them back to her sleeping location. She had a toilet paper supply for a while. If Eleanor had free toilet paper she would use it after urinating and after a bowel movement otherwise she did not use toilet paper. "I use it for both, if I have it."

At one point in her life, Eleanor refused to use toilet paper based on environmental issues. "Well, I mean, for a long time I just wouldn't use it on general principle the idea that we cut down trees to wipe our butt." Over the years, to stay true to her beliefs, Eleanor was creative with her toilet paper.

I tore rags and I would use those for the pee. You know people throw away so much good stuff, I would just throw it [the rags] away. No, I did sometimes wash them because it was sort of the principle that I want to wash my own. There's always newspapers you can rip and make strips and make them soft by soaking them.

Years ago when Eleanor was on her trek from California to Washington she shared that she created a pair of underwear from an old sweater.

And I found in a thrift store a badly shrunken wool sweater that was real soft.

That was my underwear. It was great. So at the end of the winter I said wool and wool kept me alive all winter. I would put my feet through the sleeves and I, you know, I could button it up. It was a really good underwear, you know. Yeah. But I mean it was cold up there.

Menstrual Hygiene

Eleanor lived/slept outdoors during her menstruating years. With very limited resources, Eleanor was creative with menstrual hygiene supplies.

Oh, okay, um, when I used to, when I did on my trek north I had always either a very heavy wool sock or a very heavy wool mitten. And I would just wash it out.

It would absorb and I had a pretty heavy flow.

She would slide the wool sock or mitten in her underwear. When Eleanor had some money she would buy tampons but worried about getting toxic shock syndrome. “Before when I did have more money I used to use tampons and I’m very glad that I survived that without getting toxic shock because you forget towards the end of your period.”

Eleanor went through menopause sometime in her 40s. She did not remember exactly how old she was at the time. “I’m not sure. It was early I’m sure.” She had no children and had never been pregnant.

Managing Sleep

For the past two years, Eleanor had been sleeping in a roof-less, fenced storage yard behind a professional business. She had permission from the owners as long as she

was not in her sleeping area during their business hours. Eleanor really liked her sleep location because it was isolated, safe, and had a water faucet she could use for drinking water or to wash her dishes or clothes. When it rained, Eleanor vacated the storage yard and headed to one of her three secret sleeping locations in town. “Um, I have a, um, three places within easy walking distance of each other closer to downtown that protect me from the rain and I can go to any one of those three and it’s always worked out.”

Eleanor admitted she did not always get enough sleep resulting in her need to nap during the day. She had been able to safely nap in her pop-up tent in the park. Her bedtime varied depending on the time of year.

Um, not always the same time either. It changes partly when the light changing.

Um, but that’s the one thing I really like about where I’m living is that it’s easier to go to bed earlier because I don’t have lights. I do have a book habit [laugh].

On weekdays, once the business was closed, Eleanor could enter her sleeping location in the storage yard and she must be out of the location before the business opens. So, she would enter her sleeping location around 5:00 pm-6:00 pm but when she actually arrived depended on how far she had walked during day. “I do, I walk so far a lot of times it takes me a long time to come down.” Her time of actually falling asleep also varied and depended on how long she read or listened to the radio. “Sometimes I lay awake a long time listening to something really interesting on the radio and then I have to sleep the next day.” Eleanor preferred sleeping in a location without electricity. “So many nights I sat up reading too late because I had electricity [laugh]. And I feel so much better if I go to bed early. You get better sleep before midnight.” Currently she only read as long as there was daylight and she listened to a battery-operated radio.

Her quality of sleep varied. “Sometimes yes, and not always. But when I don’t I can usually sleep in the daytime.” Her nocturnal urinary frequency contributed to her poor quality of sleep. Eleanor got up several times a night to urinate. She urinated in a cup so she could stay safe in her sleeping location.

Eleanor was up and out of her sleeping location by 7:40 am. It was important to her to leave her sleeping space neat and tidy before heading out for the day.

But, I wake up about an hour or more before I have to leave because I want, I just keep my place nice. You know, I mean, I just if I went to sleep without having, especially when it’s dark, without having cleaned up my food, where I’ve fixed my food, and stuff. Then I get up in the morning and I want to get that all done before I leave.

Over the years, Eleanor had slept in a variety of interesting places, always by herself and hidden from the public. “I’m a hider.” She had spent a considerable amount of time up in the mountains. She had slept in creeks and ditches. Currently, in addition to her main sleeping location in the storage yard, Eleanor had three other secret sleeping locations. Back in her days in the Pacific Northwest, Eleanor slept in an abandoned wickiup. “So this one guy decided that he wanted to go and try to get this other girl to marry him and he deserted his wickiup and he let me sleep in it.”

Priority Health Need

Keeping her blood count up (hemoglobin) was identified by Eleanor as her priority health need at this time. She recently was hospitalized for low hemoglobin levels which was due to a helicobacter pylori (H. pylori) infection. “Well right now I need to keep my, my blood up. My blood count up. Iron and all.” She was still unclear exactly

how she contracted the infection. “I wish that, you know it was a little more clear really exactly what caused this. I mean, everybody, you know I don’t blame the people that they have to guess with the information they’ve got.”

Eleanor tried to live her life as natural as possible so when she was prescribed antibiotics upon discharge from the hospital, she was reluctant to take the medication. Eleanor did agree to have the prescription filled at no cost to her but still would not agree to take the medication. “It’s not that I’ve decided not to take the antibiotic it’s that I haven’t decided to take it. It’s still open. I’m keeping it and stuff.” Although it was difficult, Eleanor realized it was important for her to go to the hospital. When asked how it was for her spending a few days in the hospital she replied, “Yeah, well I mean it’s not something I’d chose for a vacation [laugh]. Well, I realized it was probably saving my life.”

Being a firm believer in her spiritual journey and guidance from God, Eleanor believed her recent illness and hospitalization may be a sign from God.

And maybe, maybe, I needed this thing to happen with my blood to get me to the place where it will actually take place. And I’m feeling more alive and closer to God now and that’s the most important thing, I mean.

Sustaining Health

Eleanor appeared amazingly healthy considering she was 77-years-old and had been living/sleeping outdoors for over 40 years. She attributed her good health to the fact that she had been living/sleeping outdoors for so long. “Sure, the walking. The fresh air, the, uh, really lack of stress.” Until her recent hospitalization, Eleanor described her

overall health as good. “Well before this thing with my blood happened, you know, I’d say good but now that’s less true.” One of her concerns about meeting her basic health needs was finding inexpensive, natural remedies. “Um, [pause] well I’ve been very concerned about finding remedies that are cheap and healthy.” Natural remedies were preferred by Eleanor, “Well, it’s cheaper, always, for one thing. Plus it’s, you know, generally safer.”

Her current health issue was regaining her strength from her recent hospitalization. Eleanor seemed to be making good progress with this health need. Her poor oral health was an issue but was not identified as such by Eleanor. Currently she had foot and fingernail fungus but said she was treating her nails regularly with white vinegar.

She denied any chronic conditions such as hypertension or diabetes. Many years ago Eleanor suffered from arthritis in her knee but was able to eliminate the arthritis through a natural remedy. “Oh that went away. That was like, it had just started and it was like 50 years ago and it went away really pretty quickly after I started doing the ginger every day and but I keep it up.”

Eleanor had lice once and scabies a few times. Each time she was treated with permethrin cream but found this treatment unacceptable.

But anyway they put that stuff all over me and then says you’re supposed to shower in 12 hours. And I go, I’m going to be near a shower in 12 hours? So, it was on 24-hours and I go, this stuff, I know isn’t good for your liver and here it’s on me 24 hours.

Eleanor researched alternative treatments and came up with one. “I’ve got to find an alternative so, I did some research and I found out I can just put some sesame oil on it and it goes away. So that’s really great because it’s two dollars.”

While sleeping in a creek in the winter, Eleanor got hypothermia and fortunately was found by a passerby who called an ambulance.

Yeah, that’s how I got the hypothermia, was, I, one night it was really, really cold and I got dizzy and I couldn’t go down to my bedding because I was afraid. I didn’t know what was happening with the dizziness. I was afraid I wouldn’t get back up. And I was out all night on a cold, cold night with pretty warm clothes but I was going in and out of consciousness and then in the morning somebody found me.

One of the risks of sleeping in the mountains was getting bit by rattlesnakes or wood rats. One time Eleanor was bitten on the head by a rat. Worried about contracting a disease, Eleanor contacted the public health department and sought treatment at an emergency department where she was prescribed a “very expensive antibiotic”. Instead of the antibiotic Eleanor chose a more natural alternative.

What I decided to do was just eat a whole lot of garlic. So I did that and I didn’t get anything. But I didn’t know that garlic is a really good blood thinner. I bit my tongue one day and I got blood clots.

Eleanor had never had a mammogram but had gotten regular pap smears over the years. “I got pap smears for a long time and now they said you don’t have to bother with it, at the clinic. My mother got me started on getting pap smears and I used to religiously

do it.” She had an established relationship with one of the clinics and would utilize the medical care if she felt it was absolutely necessary.

To prevent spoilage and prevent possible illness, Eleanor had figured out how to safely store food in her current sleeping location in the storage yard. In addition to proper storage, Eleanor only bought food for a day or two. She was also aware of the temperature outdoors knowing food would spoil faster in the hot, summer months.

It’s a whole lot easier in the winter time. But I have a little bird cage that’s too sm, the things are too small for the mice to get in. Sometimes they can nibble close to the edge [laugh] but I have, I haven’t hardly seen any mice around there but I’m, I have, there’s a big file cabinet with one of the drawers opens that’s there, that wasn’t being used and I can put some stuff in there.

Conclusion

After decades of living/sleeping outdoors Eleanor had learned to prioritize her personal hygiene behaviors. Personal hygiene behaviors too time consuming usually did not get done on a regular basis such as doing laundry at a Laundromat and taking a shower. She would wash undergarments by hand approximately every week. Eleanor did not seem to substitute a shower for washing up on a regular basis. She did have a history of skin issues such as lice, scabies, and skin fungus but these conditions had not appeared often enough to be a result of infrequent skin care (showers/washing up).

Eleanor identified brushing her teeth daily as her priority personal hygiene behavior to try and get done every day. She had several broken or missing teeth and was concerned about getting an oral infection. Preventing an infection motivated her to brush her teeth daily.

Eleanor had figured out ways to meet her toileting needs in the middle of the night by urinating in a cup with an aromatic lid to mask the odor. If unable to hold a bowel movement until morning where she could access a public bathroom, Eleanor would have a bowel movement in a plastic bag. During the day she usually could access a public bathroom. Toilet paper was not a priority to spend money on and was only used if she could get it for free. In her youth, the refusal to use toilet paper was based on her conscience regarding social and environmental issues.

Back when she was menstruating and living/sleeping outdoors, Eleanor was creative in finding free supplies such as using socks or mittens as menstrual pads. She would wash them out to reuse and seemed to successfully self-manage her menstrual hygiene.

Summary

Although some experiences were difficult to disclose, each woman openly shared her experience of living and sleeping outdoors for long periods of time along with the many challenges of self-managing personal hygiene. The women were friendly, smart, and determined to meet their personal hygiene needs on a daily basis. Women shared creative ways they were able to safely perform personal hygiene behaviors to meet their needs.

This chapter presented each chronically unsheltered homeless woman's experience of living and sleeping outdoors for long periods of time. The following chapter will present the study's findings through a cross-case analysis of the data. The similarities and differences of PHSM across all of the women will be presented. Interpretation and synthesis of the data will also be presented.

Chapter 5

Findings: Self-Management of Personal Hygiene across Women

Personal hygiene self-management across the women in the current study will be presented in this chapter. The chapter begins with the challenges to personal hygiene self-management experienced by the women followed by protective behaviors the women reported carrying out. The PHSM experience and protective behaviors to personal hygiene self-management will address the first research question. The latter part of the chapter will address the second research question by mapping the personal hygiene self-management of chronically unsheltered homeless women to the IFSMT.

Challenges and Protective Behaviors to Personal Hygiene Self-Management

Although their journey of homelessness varied, the ten participants in the current study shared similar experiences and challenges while living and sleeping outdoors for a significant amount of time. Life for these chronically unsheltered homeless women was a challenge and trying to self-manage their personal hygiene under such difficult circumstances was an even bigger challenge. The women managed their challenges by performing certain protective behaviors to self-manage their personal hygiene. Challenges, and common themes across the women, included Maintaining Safety, Blending In with the general public, Managing Sleep, Sustaining Health, and Problem Solving.

Maintaining safety. Living in fear on a regular basis required the women to constantly be concerned for their safety. Maintaining their safety was the most serious challenge the women faced while living/sleeping outdoors and was a prevalent theme across all participants. Their physical and social environment presented a harsh and

frightening context in which to live and sleep. The experience of living and sleeping outdoors was described as scary, stressful, and exhausting requiring the women to constantly be on guard. Living in fear every day, all day, for many years was their reality.

The chronically unsheltered homeless women revealed that while trying to self-manage their personal hygiene, their daily experiences produced significant fear and stress resulting in concerns for their safety. Living in fear required the women to perform certain protective behaviors to reduce their fears and keep themselves as safe as possible.

The majority (90%) of the women in the study disclosed they had been sexually assaulted or raped at least once while living/sleeping outdoors, some of them had experienced sexual assault or rape multiple times. The self-management behaviors of the women were protective measures to stay safer and reduce their risk of being physically or sexually assaulted. While the women were sharing their experiences of being assaulted or raped as an unsheltered homeless woman, their demeanor was very matter-of-fact, lacking in emotion, and somewhat accepting.

And the homeless women, I notice that have been chronically homeless for a long time, are so used to getting raped that it doesn't really phase them after a while.

I've met a lot of women like that and it just breaks my heart. (Amber)

Some of the women shared a history of childhood abuse and/or domestic violence so for them, getting a break from abuse and assault had yet to happen. For these women, being abused or assaulted had become a way of life.

The risk of being assaulted was present during the daytime but the women were especially vulnerable at night. The women feared being assaulted during the night while sleeping and toileting. Guarded sleep was a protective behavior the women reported

carrying out to keep them safer during the night. Guarded sleep included self-management behaviors related to their sleeping location, hours of sleep, and finding ways to safely toilet during the night. The women looked for sleeping locations that were hidden from the street and out of the view of a passerby. Ideal locations were in neighborhoods or behind businesses. For safety concerns, it was important to go undetected as they entered and exited their sleeping area. To be able to go undetected in and out of their sleeping location, generally the women would have to go to bed late at night and get up very early in the morning. This behavior contributed to limited hours of sleep per night and overall poor sleep quality for many of the women, often leaving them in need of a nap during the day. Napping during the day created additional fears such as the risk of being assaulted or the fear of getting a ticket from the police for unlawful lodging.

For fear of being assaulted during the night, some of the women would stay up all night to stand guard. “You know we’re unnerved. A lot of us stay pretty uptight. We’re not sleeping at night. Because you’re staying point or you know you’re always on guard” (Joanne). Leaving one contact lens in place during the night was one protective behavior to be able to identify a possible assailant. “I always keep one in so if someone walks up on me I can see what they look like” (Lynette).

Ensuring their physical safety while attending to toileting needs during the night was an additional challenge. Half of the women in the study reported nocturnal urinary frequency putting them at risk of being assaulted during the night while trying to locate a place to urinate. The fear of being exposed and left vulnerable by leaving a safe, hidden sleeping location to use the bathroom required the women to put protective measures into

place. The self-management behavior most commonly performed by the women was to keep a jar or cup with them during the night and while remaining safe in their sleeping location they would urinate in the jar/cup in the middle of the night. Having a tight lid was important to contain the smell. The urine would be discarded in the morning outdoors the sleeping location or in a public port-a-potty.

The women figured out ways to stay safe and cope with their nocturnal urinary incontinence however, the need to have a bowel movement during the night presented a bigger safety issue. Having a bowel movement took longer than urinating leaving the women more exposed and vulnerable to be assaulted. Most of the women shared that fortunately their bowels moved first thing in the morning where hopefully they could access a public bathroom first thing in the morning. One protective behavior was to try to regulate bowel movements by adjusting what and when food was eaten so bowel movements would most likely occur in the morning when a public bathroom could possibly be accessed. Another option was to keep a large closable plastic bag in the sleeping location to use as a toilet for a bowel movement so they did not have to leave their safe sleeping location.

Sometimes, but most of the time I have to do it too early so I have a plastic, I have a supply of plastic bags and I do it in one and then put it in another so you can't see what it is. And then I dump it in the trash where people put their doggie shit, too. (Eleanor)

During the daytime, the women also feared getting assaulted while toileting or sleeping (napping). Throughout the day access to a public bathroom could be a challenge requiring the women to go to the bathroom outdoors. Urinating or having a bowel

movement out in the open put them at risk of being assaulted. In order to stay safe, the women performed protective behaviors related to safe places to toilet during the day when a public bathroom was unavailable. Safe places for toileting outdoors during the day were inside a dumpster enclosure or down inside a dumpster, behind trees or bushes making sure to stay hidden from view. It was important to be as fast as possible when toileting outdoors for fear of being assaulted or getting caught by the police.

Um, yeah, if you could climb in a dumpster that was fairly empty. Yeah, if you could get inside the dumpster or just behind a tree somewhere. It was a lot easier to do it behind a tree. But if you had to do number 1 you could just go behind the dumpster and just get a cup and just do it in a cup and pour it in the dumpster. It's the number 2 that's a problem. (Mary Jane)

Managing menstrual hygiene under unsafe conditions was a fear experienced by some women and presented a challenge to maintain their safety. Over half the women (60%) in the study menstruated while living and sleeping outdoors while the remainder of the women lived in housing during their menstruation years. Over half the women were menopausal at the time of the study.

The self-management behaviors for menstrual hygiene management were similar to those used by the women for toileting. During the day, if unable to gain access to a public bathroom, the women were required to change menstrual pads or tampons out in the open. A self-management behavior was to use menstrual pads instead of tampons because pads could be changed quickly behind a tree/bush or inside a dumpster enclosure leaving the women less exposed and reduced their vulnerability to assault. Using the dumpster enclosure kept them hidden and also provided a way to immediately discard the

used menstrual pad in the dumpster making their menstrual hygiene self-management more sanitary. “You know sometime if I could behind a dumpster, could make it to a dumpster enclosure I would go in there and like change a pad real quick and throw the dirty one in the dumpster” (Mary Jane).

All of the women had considerable experience being an unaccompanied homeless female meaning they had a history of living/sleeping outdoors alone, no dependent children in their care, and no partner. “Always. Always by myself. Always. I loved it. I’m independent” (Lena). At the time of the current study, 70% of the women were currently living/sleeping outdoors unaccompanied and many of them preferred to navigate around town alone.

On a daily basis, the women lived their life in fear, primarily fear of being assaulted (especially at night) resulting in safety challenges. It would seem that the women would feel safer if accompanied by at least one other adult but it appeared navigating alone was a protective behavior. The women who preferred going it alone were not necessarily relieved of their fears, they just felt if they navigated alone they could move around town undetected. Being undetected the women could secretly slip in and out of their sleeping locations. Being undetected at night and throughout the day made them less vulnerable and could actually reduce their risk of being assaulted or bothered by the police.

“You see being with somebody can be very, you can, well if you’re in the city it attracts attention, the police and things. So it’s easier to just kind of navigate if you’re solo... Um, most the time. But it’s not because, it is really is safe. It’s just that I’ve just learned to just not accept being anxious or fearful” (Eleanor).

Despite living and sleeping in such unsafe surroundings, 70% of the participants chose to navigate their environment alone. The most common reasons for choosing to be alone were fear of being assaulted or raped, wanting privacy, or being able to travel around town undetected. “You see being with somebody can be very, you can, well if you’re in the city it attracts attention, the police and things.” The challenge of going it alone was made easier by performing certain protective behaviors to be able to blend in with the general public.

Blending in. Blending in with the general public was a theme across the women which posed some challenges. The women worked hard to blend in with the general public because the consequences of not blending in were negative. The positive outcomes of blending in included the ability of the women to have an easier time navigating around town, reduced their experience of being stereotyped or judged by the public for being a homeless person, and contributed to a reduction in the overall fear and stress the women experienced on a daily basis.

Based on the experiences of the women, blending in with the general public made it easier for them to navigate around town. The easier they could navigate around town the more likely they were to be able to use a public bathroom and businesses. Having increased access to public bathrooms made it easier for the women to self-manage their toileting, menstrual hygiene, and oral care needs. The public bathroom could also be used to wash up if they were unable to access a shower.

In the daily quest to blend in with their surroundings, being clean and well-groomed was a priority for the women and a subtheme of Blending In. Protective behaviors were put into place to address this challenge. According to the women, the

main way to blend in and not appear homeless was to be clean. Keeping clean required personal hygiene self-management behaviors of a shower (washing up if shower was unavailable) and shampooing hair. The majority of the women in the study (90%) identified taking a shower as their top priority personal hygiene self-management behavior to try and accomplish daily.

Yeah, all means necessary when it comes to your cleanliness. All means necessary... Absolutely. Cuz I feel your appearance is what a lot of people these days stereotype you by. By being cleaner, being dirty it matters how you are and me being that way. I just like to be clean. I makes you feel better refreshed and you're able to go more places and do more things, you know (Yolanda).

Three local shelters offered daily showers to any homeless individual and several of the women utilized this resource. Utilizing a shelter shower required the women to adapt their individual routine and be willing to accept the shelters' shower procedure of 5-10 minutes per shower and showering together with approximately ten other women. Most of the women in the study were willing to accept these condition because the priority was to get a shower, be clean, and be able to blend in. Locally, there was a women's homeless clinic three times per month offering individual, private showers for an unlimited period of time. This resource was accessed often by the women. Other shower locations were a low cost gym membership to use the facilities especially the shower and toilet, pay \$4/day to shower at a beach bathhouse, or sneak into a shower at the marina.

Taking a shower was the preferred way to keep clean however if a shower was not accessible, the women were resourceful in finding ways to wash up. If unwilling or

unable to take a shower at one of the shelters, the women would risk being caught by the police to sneak into public bathrooms at beaches, parks, train stations, or to use an outdoors water faucet. When the women washed up in public bathrooms they typically used soap from the dispenser, paper towels and/or napkins located in the bathrooms because these items were free, convenient, and disposable. Carrying around wet, soiled towels was impractical for the women so disposable items were easier. “Taking a shower and keeping hair clean. Don’t feel right if dirty. People will judge you if you are dirty” (Lynette).

In addition to a daily shower/washing up to stay clean to be able to blend in with the general public, wearing clean clothes was also a necessity. Clean clothes was another subtheme of Blending In. At a minimum the women would regularly wash out clothes (especially underwear) in a public sink or faucet then lay the clothes out to dry in the sun. Several of the women would budget what little money they had to do their wash at a public laundry facility weekly or monthly. If unable to get their clothes washed, clean clothes were obtained from donation boxes at various locations around town.

The negative consequences of being stereotyped and judged by the general public was another reason the women felt it was important to blend in. The experience of being stereotyped and judged by the public was very distressing to some women.

I try to keep a positive attitude and figure if I do that then maybe they won’t look down on me. I’m part of you too and I’m part of society, I’ve lived here and I’ve paid my taxes and I’ve earned what I’ve got right now. Just cuz something happened bad to me and I had to file for disability does not mean that I’m done.

I’ll try and get back up. I just need some help (Sharon).

Being stereotyped and judged as a homeless person could result in the women being denied access to bathrooms or businesses and increased their chances of negative interactions with the police. Some of the women felt if they physically blended in with the general public they would not be stereotyped or judged and generally would be treated with respect.

Yea, absolutely because you have to. When I say stereotype. Stereotype is a big thing especially when they stereotype women who are homeless then they really segregate [sic] you from everybody else. And the public won't come and help you or do anything. When your hair's all matted and looks like a big nest they're not going to come and help you but for a lady that's hairs in a ponytail with her hair pulled back. You know. (Yolanda)

Negative interactions with the local police department was another challenge for many of the women. Fear of being harassed or arrested and fear of getting cited for public urination or unlawful lodging. A few of the women had received citations from the police for public urination and/or unlawful lodging or trespassing requiring the women to go to court and were ordered to pay a substantial fine (approximately \$300 for first offense, per the women). None of the women were able to pay the fine and were allowed to complete community service hours in lieu of the fine. According to the women, serving time in jail was a real possibility if a woman was unable to pay the fine, complete community service hours, or received too many citations. Protective behaviors the women put into place to reduce their interaction with police officers were related to their guarded sleep and performing protective behaviors in order to blend in with the general public, therefore not drawing attention of the police.

And you know you have to use your head when it comes to the police and don't be so obvious and look more not like a homeless person...I think you're asking for big trouble if you look like a homeless person (Rita)

Managing sleep. Quality of sleep was an ongoing challenge for the majority of the women. Although they averaged six hours of sleep per night the majority of the women experienced poor quality of sleep. Self-management behaviors carried out by the women were related to hidden sleep locations and guarded sleep time. Common reasons for poor sleep quality was being a light sleeper due to fear of being attacked during the night, chronic pain, or nocturnal urinary frequency. Half the women in the study were awakened multiple times during the night to urinate. All of the reasons that contributed to poor sleep quality caused the women to feel tired in the morning.

Feeling tired during the day resulted in the need to take a nap. Safely sleeping during the day made the women vulnerable and contributed to their safety concerns. Most of the sleeping locations during the night were in hidden places behind public property where the occupants and general public were not present. These locations were not options during the day as the chronically unsheltered homeless women could be detected putting them at risk for assault or ticketed by the police for unlawful lodging. Ongoing poor quality of sleep and the constant feeling of tiredness contributed to the women's stress. "There really isn't any place to lay down, ya know, and just take a damn nap. A lot of us need it" (Joanne).

One self-management behavior was to set up a pop-up tent in a city park and take a nap inside the tent. "It's perfect. I've had, at first the police would say things to me about it, you know. I'd say, I'm not camping, this is, they put these up on the beach to

keep the sun off of them” (Eleanor). For the women without a pop-up tent, they would try to find a hidden sleeping location for a nap or they would just spend their day tired and needing sleep. “And I usually couldn’t sleep when I was outdoors so I’d usually sleep during the day ... Yeah. I’m pretty good at hiding” (Amber).

Needing a nap during the day was an even bigger challenge for a chronically unsheltered homeless woman who was ill.

Rest. Places when you’re sick to rest. That is a big problem. Cuz we get worn out or we get a cold or the flu’s very easily especially at the [shelter]. Even being out. We are real susceptible to getting pneumonia. And we just don’t have any place to get warm and rest. And without getting rousted by the police department. If I had my sleeping bag out during the day time, they consider it gear. So it’s camping gear (Joanne).

Sustaining health. Prevention or treatment of health conditions with limited resources was an ongoing challenge for the women, yet many of them were able to find ways to sustain their health. Natural remedies were generally preferred. “Well, it’s cheaper, always, for one thing. Plus it’s, you know, generally safer” (Eleanor). The public library was used to research their health remedies.

Preventing and treating tinea pedis was a common challenge for the women. Calculated foot care was a protective behavior that addressed this challenge. Despite showering frequently the women were at high risk for tinea pedis because typically shoes and socks were worn constantly day and night. Some women felt it was not safe to remove their shoes and socks during the night. Many of the women reported having experiences with tinea pedis. The personal hygiene self-management of their feet

required the women to be resourceful. With minimal to no financial resources, some women found inexpensive remedies such as vinegar or garlic/olive oil to successfully treat their tinea pedis. In addition, some of the women performed the self-management behavior of airing out their feet during the safety of daylight. To air out and dry their feet, the women tried to remove their shoes and socks as often as possible. Finding a place to air out their feet or soak their feet was a challenge. A city park was a good location for removing shoes and socks and airing out their feet and also for soaking their feet or pouring vinegar or garlic/olive oil over their feet. The women were fairly successful in their foot care.

According to one woman, daily intake of ginger was used to eliminate arthritis in her knee. “Oh that went away. That was like, it had just started and it was like 50 years ago and it went away really pretty quickly after I started doing the ginger every day and but I keep it up” (Eleanor).

Treating scabies and lice while living/sleeping outdoors was a challenge for the women due to possible barriers to accessing the medication and the common treatment regimen was impractical to their living situation. Common treatment for scabies involved the generalized application of a topical cream left on the skin for approximately 12-hours then removal of the cream by taking a shower. Access to a shower several hours later was highly unlikely making it a challenge to adhere to the treatment. Leaving the medicated cream on their body for too long was a health concern motivating the search for a natural alternative treatment. “So, it was on 24-hours and I go, this stuff, I know isn’t good for your liver and here it’s on me 24 hours...I’ve got to find an alternative so, I did some

research and I found out I can just put some sesame oil on it and it goes away. So that's really great because it's two dollars" (Eleanor).

Common treatment for head lice had a similar challenge, access to the medicated shampoo and a shower to rinse the medication after an application time of several minutes. If a woman could gain access to the medicated shampoo, the medication was to be left on the head for 10 minutes then rinsed out of the hair. At the local shelters, maximum shower time for the women was 10 minutes, not enough time for the treatment. To address the aforementioned challenges of treating scabies and head lice in the homeless population, a single-dose of oral ivermectin, a broad-spectrum anti-parasitic medication, was cited in the literature as an effective treatment (Badiaga et al., 2008).

Prevention seemed to be the best way to sustain their health. Selected sleeping locations was one way to try and prevent contracting lice or scabies. Some women felt the crowded shelters were one place to contract scabies or lice so they avoided the shelters as much as possible while others carefully selected their sleeping location in regards to lice and scabies. "I got lice at XX [a shelter] in their chairs" (Maxine). Washing bedding and clothing was known by the women as one way to reduce the risk of reinfection of lice or scabies however having the resources to do laundry presented a challenge.

Medically prescribed treatments could be unattainable for some of the women due to lack of resources. An example was after a rat bite to the head, a woman got herself to the emergency department and was prescribed a very expensive antibiotic she could not afford. Concerned for her health she called the public health department to determine there were no reports of diseased rats in the area and sought an alternative remedy she

could afford. “What I decided to do was just eat a whole lot of garlic. So I did that and I didn’t get anything” (Eleanor).

One self-management behavior to sustain health was buying and taking daily vitamins and calcium supplements. Limited resources would budgeted to purchase vitamins and calcium supplements to try to maintain health and prevent osteoporosis.

Uh, because the recycling is very physical and then I was going through menopause so it was important to up your calcium intake when you’re going through menopause so I don’t get brittle bones. I don’t get osteoporosis. When you’re getting older and you just need more vitamins and all that. Your body’s not as strong as it used to be (Mary Jane).

It was obvious while talking to the women that oral hygiene was a challenge. Many of the women had missing teeth, no teeth, or a sore mouth while eating but, during their interview most of them did not identify oral hygiene as an issue. The women felt it was important to brush their teeth daily. They were able to easily find free toothbrushes and toothpaste through donations and would spend money on a toothbrush and toothpaste if they were unable to get the supplies for free. Blending in was very important to the women so having poor oral hygiene would be one way the women might not be able to blend in with the general public. Although in some societies, poor oral hygiene may not be considered a problem. The women did their best with performing oral hygiene on a daily basis but due to limited to no financial resources or insurance to pay for dental care, the women did not access regular professional dental care.

The literature identified a link between depression and oral-health issues in homeless adults often due to the embarrassment from poor oral hygiene such as dental

caries and missing teeth (Coles et al., 2011). One woman in the current study supported this finding and described the experience of living without teeth, “It was difficult at first, you know, self-conscious and all that but I just had to get over it (Sharon).”

Due to their poor oral health, finding foods they could mechanically eat presented a big challenge for some of the women. They also tried to eat as healthy as possible so to find healthy foods they could mechanically eat was important and they found ways to meet their needs. A battery-operated blender was used to blend all meals and purchasing soup or soft foods was a common self-management behavior. The women were willing to spend money to buy healthy foods they could mechanically eat. Overall, the majority of the women, with or without poor oral hygiene, were able to secure adequate food on a regular basis and did not identify food security as an issue.

Problem-solving. With limited means and a challenging environment in which the women lived and slept required them to be resourceful in self-managing their personal hygiene. The women were creative in problem-solving their needs.

Self-managing menstrual hygiene was a challenge the women needed to problem-solve. Commercial menstrual hygiene pads or tampons could be expensive and out of reach for many of the women. It was established menstrual pads were preferred by the women for the ease and safety while changing pads and for sanitary reasons Changing tampons outdoors with dirty hands put the women at risk for infections.

Actually pads were better because tampons I’d have to insert ‘em and your hands are dirty and whatever, it’s not very sanitary. So even though tampons gave me more protection it’s like you know you don’t want to insert anything when your hands are dirty (Mary Jane).

So when commercial menstrual hygiene pads were unattainable the women figured out alternatives. Socks were the most common alternative to a menstrual hygiene pad. A free pair of new socks was easier to obtain than menstrual hygiene pads from donations at homeless shelters or other places serving the homeless. Using a sock as a menstrual pad was viewed as “dehumanizing” (Lynette) so attempts were made to try and purchase or obtain commercial menstrual hygiene pads whenever possible. Usually, once soiled, the sock was thrown away and replaced with a new sock. A wool sock or wool mitten was used because wool was very absorbent.

Oh, okay, um, when I used to, when I did on my trek north I had always either a very heavy wool sock or a very heavy wool mitten. And I would just wash it out...It would absorb and I had a pretty heavy flow (Eleanor).

Generally, commercial toilet paper was not used by the women after toileting. Purchasing toilet paper was not a priority for the women which was one reason why they did not use it. Some women would take free napkins from local businesses to use as toilet paper in case they needed to toilet outdoors at a later time. Other alternatives to commercial toilet paper shared by the women were rags/cloth or wet newspaper.

Food safety was an ongoing challenge for the women. Due to poor sanitation, limited resources for hand hygiene, and consuming spoiled food (due to improper food storage or food from a dumpster) it was not uncommon for some of the women to have gastrointestinal issues. To address this challenge, protective behaviors were performed by the women. To minimize food spoilage, some protective behaviors were to only buy food for a 1-2 days at a time (e.g., one roll versus a loaf of bread), be selective of types of food purchased or stored (e.g., foods with a longer shelf-life), and adjust their food items

purchased/stored in the warmer weather of summer months (foods quicker to spoil) compared to the cooler temperatures during the winter months.

Yeah, I mean some things they go bad in a day. But and you have to really be careful of fish. I got very sick one time thinking it would be okay the next day. Even though it was at night when I had it. And I got sick, sick enough that I'm really careful (Eleanor).

Keeping food safe from rodents in the living/sleeping areas was also a challenge. Closed containers were used in addition to items like a salvaged small bird cage with narrow bar spaces so mice or rats could not get to the food. An abandoned file cabinet could be used to safely store food in a hidden sleeping location.

Diarrhea associated with spoiled food was a potential challenge for all of the women and an actual challenge for some of them. The biggest challenge was dealing with being incontinent of urine or stool because the women could not access a bathroom in a timely manner. A self-management behavior some of the women reported was carrying extra underwear and pants with them. This self-management behavior was put in place in case they could not find a safe place during the day to urinate or have a bowel movement resulting in them being incontinent of urine or stool. If incontinence occurred, then there was the issue of finding a place to safely get cleaned up and change into clean pants. Inside a dumpster enclosure was one location used for changing out of soiled clothes into clean clothes with the option to discard the soiled clothes into the dumpster.

Many of the self-management-behaviors performed by the women were purposeful in addressing more than one of their challenges. One example was the self-management behavior of urinating in a cup inside a dumpster enclosure during the day

addressed both the fear of being assaulted/raped and the fear of getting a public urination citation from the police. Also, sleeping in a hidden location, urinating in a jar/cup during the night to be able to stay hidden addressed the fear of getting assaulted and the fear of getting roused by the police and/or an unlawful lodging or trespassing citation from the police.

Application of the IFSMT

The IFSMT expands on current knowledge of self-management of chronic diseases and health promotion and consists of three dimensions: context, process, and outcome (Ryan & Sawin, 2009). Specific to the current study was the health promotion application of the IFSMT as it pertained to personal hygiene self-management of chronically unsheltered homeless women. The final research question sought to determine if the personal hygiene self-management experience of chronically unsheltered homeless women could be mapped onto the IFSMT. Analysis of the data concluded the PHSM experience of chronically unsheltered homeless women could be mapped onto the IFSMT and confirmed components of the model (Figure 2). All three dimensions of the model (context, process, and outcome) were pertinent to the personal hygiene experience of chronically unsheltered homeless women.

Personal hygiene self-management could potentially prevent the development of or reduce the severity of health problems through PHSM process. One of the assumptions of the IFSMT is, “Persons engage in behaviors for personally meaningful reasons that may or may not be directly related to optimizing their health status” (Ryan & Sawin, 2009, p. 225.e6).

Individual and Family Self-Management Theory Applied to Personal Hygiene Self-Management of Chronically Unsheltered Homeless Women

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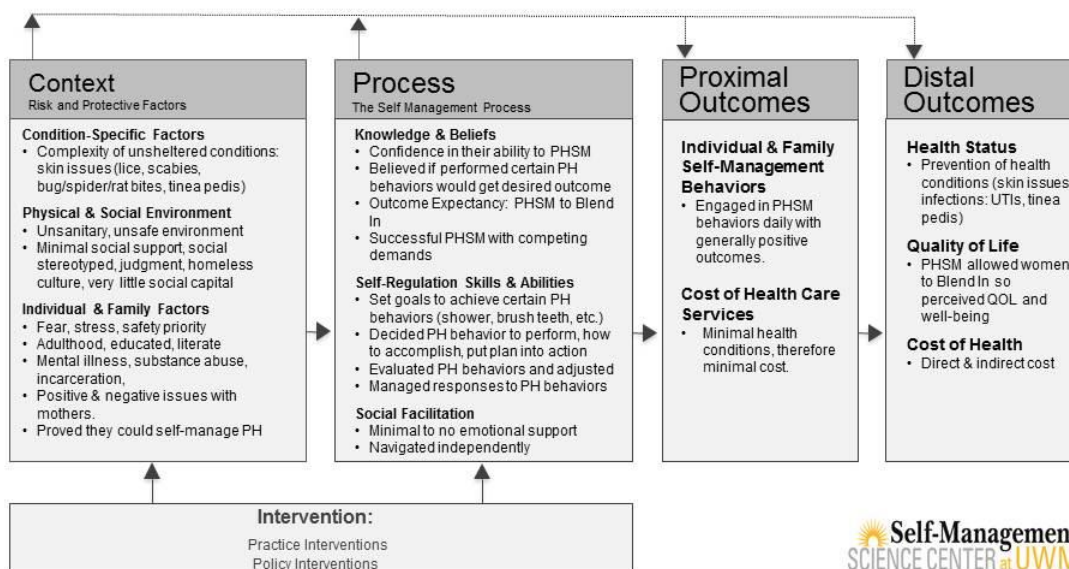


Figure 2. Model of PHSM of Chronically Unsheltered Homeless Women. Adapted from Individual and Family Self-Management Theory, by P. A. Ryan and K. J. Sawin, 2014, www.nursing.uwm.edu/smsc. Copyright 2009, 2014 by Ryan and Sawin. Adapted with permission.

Context Dimension: Risks and Protective Factors

The context dimension of the IFSMT addresses risks and protective factors that influenced the personal hygiene self-management of chronically unsheltered homeless women. The physical and social environment of this population had the potential to be barriers to self-managing their personal hygiene. For chronically unsheltered homeless women in the current study, their physical environment mirrored that of developing countries or the environment following disasters or emergencies. The physical environment of the chronically unsheltered homeless women included unsanitary, unsafe and potentially unhealthy conditions such as no running water, inappropriate places for toileting (e.g., dumpsters, plastic bags, bushes), exposure to rodents and insects,

unsanitary food storage, exposure to cold, rainy weather, and threats of physical/sexual assault.

The women who had been living/sleeping outdoors for over 20 years felt things got easier for them the longer they were outdoors. “Oh, sure. Sure. And you’re, there’s less fear because you’ve learned you can take care of yourself and stuff” (Eleanor). Over time they got acclimated to life outdoors, learned behaviors that contributed to personal hygiene self-management, became knowledgeable regarding community resources, and learned protective behaviors in maintaining their safety.

Well, for me it got easier because my body got physically acclimated to the cold and change of climate and all that and being out in the heat and wind and all that... Yeah because you just, um, well at first it’s stressful and then after a while you just like tolerated it and then after you’ve been on the streets so many years it just becomes comfortable. (Mary Jane)

The local shelters were a resource available and accessed by some women to take a daily shower. A key finding in the current study was the structure of the homeless shelters presented a barrier to PHSM of the women primarily the group showers and very limited shower times.

While trying to self-manage their personal hygiene, the social environment also presented challenges for the women. Social isolation was a reality for the women resulting in minimal to no social support and limited social capital. The women felt negatively stereotyped and judged by the general public for being part of the homeless culture.

The majority of the women (90%) shared information regarding the influential relationships with their mothers. The women were living their lives as chronically unsheltered homeless women in the context of a history of positive and negative relationships with their mothers. Information regarding their mothers was unsolicited and unexpected. Some of the women (40%) grew up with positive relationships with their mothers but after their mothers passed away things became unmanageable for the women. “When my mother passed away. When tragedy hit and I became homeless” (Yolanda). I lost it when my mom died, yeah. She was my best friend [crying]” (Sharon). For other women, they had a much different relationships with their mothers. They had mothers with mental illness, control issues, unapproachable personalities and unsanitary housekeeping practices. The women used descriptors such as “the demon possessed mother” (Rita), “she was a course, callous, hard woman” (Sharon), “she never cared for me. She never loved me...at age 22 I learned she wasn’t my mother” (Lena), and “my mom was really crazy but she was a really good mom...they finally got divorced...my mom went permanently insane...she’s never been the same since” (Amber). Whether the maternal relationship was viewed as positive or negative by the chronically unsheltered homeless women, the relationship had some impact on their PHSM.

No, I was always very clean before I became homeless. I wasn’t the type of person that had a messy house, let laundry stack up or didn’t shower or anything like that. I was always very clean when I had my own place. Uh, actually my mother’s just the opposite... I hate to say that but her house was like messy and I mean cluttered and messy and you know and she wasn’t like the neatest person in the world. So maybe I just didn’t want to be like her (Mary Jane).

Also important in the context dimension were factors specifically related to each individual homeless woman who was trying to self-manage her personal hygiene. Developmentally the majority of the women in the study were in middle adulthood bringing with them life experiences on which to rely on during the PHSM process. Many of the women lived in the midst of mental illness and with a history of substance abuse, physical or sexual assault, rape, or domestic violence. At the time of the interview, none of the women revealed current use of alcohol or illegal drugs. A few of the women used prescription pain medicine for their chronic pain.

All of the women were literate and capable of learning. The majority of the women (90%) had graduated from high school. Two women had earned college degrees, one had attended business school, two women were currently enrolled in a community college, and three had the goal of attending college in the future. There was no family structure for most of the women. All of the women had experience being an unaccompanied homeless female meaning they had a history of living/sleeping outdoors alone, no dependent children in their care, and no partner. Three women spent many years, by choice, unaccompanied. Two women were currently living/sleeping outdoors or in a car with a boyfriend but had a history of being unaccompanied. While two women had spent most of their unsheltered years with a partner, at the time of the interview, they had been living/sleeping outdoors unaccompanied for many years. The remainder of the women seemed to float between living/sleeping outdoors alone and being outdoors with at least one other adult. None of the women experienced living/sleeping outdoors with a dependent child.

Through confidence in their knowledge and the belief they could overcome the context of their environment, the women were able to self-manage their personal hygiene and get the majority of their needs met on a daily basis.

Process Dimension: The Self-Management Process

The process of self-management dimension consists of the concepts of knowledge and beliefs, self-regulation skills and abilities, and social facilitation (Ryan & Sawin, 2009). Self-efficacy, outcome expectancy, and goal congruence are key elements of the knowledge and beliefs aspect of the self-management process.

Knowledge and Beliefs

The chronically unsheltered homeless women in the current study demonstrated self-efficacy when it came to their personal hygiene self-management. The women demonstrated confidence in their ability to engage in personal hygiene behavior(s). They had the belief that participating in the personal hygiene behavior(s) would contribute to their expected outcome of blending in with the general population potentially leading to a better quality of life.

The chronically unsheltered homeless women had many competing demands from their physical and social environments potentially interfering with their ability for PHSM. The daily quest to maintain safety or to secure food and shelter were examples of demands competing with the ability to successfully manage their personal hygiene. Some ways the women managed these competing demands was to plan their day to get to one of the shelters in the afternoon for a shower then stay for evening meal. After a shower and food, they could then go to their hidden sleeping places located at various locations around town.

At night I went to the XX [a shelter] because it was so close to the storage unit and it was so close to the recycling center... You can get a shower there every day from 4 pm to 4:30... So, they had a lot of carbohydrates here but I mean it was just nearby (Mary Jane)

Mostly the women were able to meet their competing demands and manage their personal hygiene demands.

Self-Regulation Skills and Abilities

In the IFSMT, self-regulation skills and abilities assesses the problem-solving and decision-making abilities of an individual or family. The chronically unsheltered homeless women in the current study demonstrated remarkable problem-solving and decision-making abilities when it came to managing their personal hygiene. Every day the women would set goals for their PHSM. They would set a goal to achieve specific personal hygiene behaviors (shower/wash up, oral care, laundry, etc.), determine how they would accomplish the personal hygiene behaviors (go to a shelter, a public bathroom, etc.), and then put their plan into action. Along the way to accomplishing their daily personal hygiene goals, the women would evaluate the process and make adjustments accordingly. For example, if a woman was having difficulty with chronic pain and found it too exhausting to get certain personal hygiene behaviors completed that day, she would adjust her plan and goal.

You don't go anywhere to get really dirty. And like me yesterday and the day before, all I've done is get up get dressed, well I'm already dressed, but get up go sit down, read a book, go to the park, read a book. So, I mean, don't need a shower (Joanne)

The women were very resourceful when it came to their PHSM. In order to accomplish their daily personal hygiene goals they would often improvise. Examples of common practices among the women were (1) using socks for menstrual pads because socks were more plentiful as donations compared to commercial menstrual pads, (2) using soap and paper towels located in a public bathroom to be able to get clean for free, or (3) jump inside a relatively empty dumpster in order to have a bowel movement without being seen by the public or be caught by the police.

Toilet paper was an issue that was brought to the forefront during the interviews. Some of the women would not use toilet paper at all due to sanitary reasons.

Nope. I mean cuz that would make an even more mess then you would have to throw the toilet paper on the ground [laugh]. You know and I didn't want to carry it around. I don't want to carry around used toilet paper. Like even in a bag or whatever cuz it attracts flies and maggots and all that and it stinks. So I just didn't use (Mary Jane).

Most of the women would not spend money on toilet paper so they became resourceful and would use anything they could get for free such as napkins from a local business.

Um oh sometimes I tore rags and I would use those for the pee. You know people throw away so much good stuff I would just throw it away. No I did sometimes wash them cuz it was sorta the principle that I want to wash my own...there's always newspapers you can rip and make strips and make them soft by soaking them (Eleanor).

If the women could not get toilet paper or a toilet paper substitute (napkins, cloth, etc.) they would opt to not use anything at all to wipe after urinating or having a bowel

movement. It would seem that if the women were concerned with not looking homeless so they blended in with the general public they would use toilet paper after toileting so they did not smell of urine or feces. If the women were not using toilet paper on a regular basis then the daily shower or washing up became an important personal hygiene behavior to try and get done every day to achieve their goal of blending in.

One of the reasons the women made the decision to use menstrual pads over tampons was if the women had to change outdoors the pads could be changed quickly leaving the women less exposed and less vulnerable to being assaulted or caught by the police. Menstrual pads were also preferred over tampons due to health concerns. Living in unsanitary conditions with limited ways to wash their hands, inserting a tampon with dirty hands put the women at risk for infections and was something they worried about.

Several women shared they often did not have the resources to obtain commercial menstrual pads so they created their own. The self-management behavior performed to meet this need was creating menstrual pads out of clothing, fabric or rags folded into pieces, heavy wool mitten, or socks. Rolled up socks was the most popular homemade menstrual pad used by the women mainly because it was easier to get donated socks from local resources compared to donated commercial menstrual pads. Sometimes they would wash out the sock, let dry, and reuse but most of the time the rolled up sock was a single use item. Once saturated, the used sock was discarded in a garbage can (usually in the dumpster they were hiding behind to change their pad) and a fresh sock was inserted.

Following along the subtheme of Blending In, the women made it a priority to do their laundry weekly to biweekly. They would spend money on getting their clothes

clean. If unable to get their laundry done some of the women would get clean clothes via donations. The goal was to be clean and be able to blend in.

The women shared the frustrations that came with trying to manage their personal hygiene but they never let these frustrations detour them from at least attempting daily self-management behaviors. Emotionally they seemed to cope with the real or potential obstacles in order to meet their goal of PHSM. These obstacles were their reality and they seemed to accept that and move forward with their goals each day.

Social Facilitation

In the IFSMT, social facilitation of self-management behaviors often refers to the social influence and support and collaboration between a health professional and an individual and/or family. This social influence could also come from a variety of sources (family, friends, media, etc.).

Collaboration with health professionals was infrequent for the women and when they did collaborate with health professionals the benefit varied. Sometimes the interaction was useful such as the podiatrist recommending white distilled vinegar, an inexpensive remedy, to treat their tinea pedis. Other times the medical interaction was impractical like prescribing a medication the women could not afford. However, most of the time the women had limited social facilitation and had to rely on their own problem-solving skills.

Social support for most of the women was minimal to non-existent. Many of the women did experience some support from local shelters or the women's homeless clinic where they could shower, use the bathroom, perform oral or menstrual hygiene, and obtain personal hygiene items. A few women had experiences of a person from the

community regularly giving them small amounts of money that enabled the women to buy food or personal hygiene items. Family could be one possible source of social and emotional support. In the IFSMT, the family unit is not restricted to biological family (Ryan & Sawin, 2009) which was significant for the chronically unsheltered homeless women in the current study who were often socially isolated and many of the women had broken ties with their biological relatives. Some of the women had small support systems made up of a boyfriend or at least one other trusted adult. Findings from the current study discovered chronically unsheltered homeless woman were able to perform personal hygiene self-management in the absence of a biological family or significant social and emotional support.

Outcome: Proximal and Distal

The IFSMT presents both proximal (self-management behaviors) and distal (health status, quality of life/perceived well-being, and both indirect and direct cost to health) outcomes. One proximal outcome specific to the current study was the ability to successfully perform personal hygiene behaviors resulting in the self-management of their personal hygiene. All the women in the current study regularly engaged in personal hygiene self-management with generally positive outcomes.

Some chronically unsheltered homeless women performed certain personal hygiene behaviors for health reasons. “Well, I don’t like to be dirty. It doesn’t feel very good to be scuzzy and dirty and you feel better about yourself if you’re clean. I mean you feel healthier when you’re clean” (Mary Jane). Even though the women felt tampons provided more menstrual flow protection, menstrual pads (commercial pads or make-shift pads) were preferred by many of the women. Inserting tampons with dirty hands put them

at risk for an infection making pads a more sanitary option. They modified their self-management behavior and reduced their risk of getting an infection and sustaining their health. Foot care was another example of where many of the women performed certain self-management behaviors to prevent tinea pedis (e.g., soaking feet in vinegar, rubbing olive oil/garlic on their feet, and airing out their feet while sitting in the city park).

By performing certain self-management behaviors to prevent an acute or chronic condition the women required little to no healthcare services (proximal outcomes). A majority of women rated their overall health as good. Chronic pain was the primary reason a few women rated their overall health as fair.

Summary

Although the journey of homelessness varied among the women, all of them shared similar experiences and challenges while living and sleeping outdoors for a considerable amount of time. Five themes emerged from analysis of the data: Maintaining Safety, Blending In, Managing Sleep, Sustaining Health, and Problem-solving.

The women faced many challenges that needed to be addressed on a daily basis. Their most serious issue was living in fear requiring them to put protective behaviors in place to maintain their safety. Maintaining Safety was an important theme for the women. Part of maintaining their safety required the women to perform personal hygiene behaviors to present clean and well-groomed in order to blend in with the general public. The goal was not to appear homeless. The protective behavior of guarded sleep was a subtheme of Maintaining Safety. As a result of guarded sleep the women experienced poor sleep quality. Poor quality of sleep during the night left the women tired during the

day and in need of a nap making Managing Sleep a key theme of the study. With limited to no financial resources, the theme of Sustaining Health became important and the women found ways to sustain their health by using inexpensive, natural remedies. Whenever possible, natural remedies and organic foods were preferred by the women. The women were resourceful at figuring out ways to meet many of their daily needs (e.g., menstrual pads, safe food storage, etc.) putting Problem Solving as the final theme of the study.

The findings of the current study determined the PHSM of chronically unsheltered homeless women could be mapped on to the IFSMT. Within the context of difficult environmental and social factors with challenging individual and family factors, all ten women excelled in the process of PHSM. They had the confidence, knowledge, and ability to self-manage their personal hygiene with little to no social support. Although some of their PHSM was to prevent or manage a health concern, the primary distal outcome was to self-manage their personal hygiene to improve their quality of life. To better serve the needs of this small, at-risk subpopulation of the homeless community, interventions should be geared towards the context and process dimension of the IFSMT and be at both the practice and policy level.

Chapter 6

Discussion

The purpose of the current study was to gain an in depth understanding of personal hygiene self-management of chronically unsheltered homeless women. Ten women shared their experiences of self-managing their personal hygiene while spending years living and sleeping outdoors under challenging circumstances. This chapter will present the findings of the current study based on the literature, research questions, and the IFSMT. Following the presentation of the findings, recommendations, limitations of the study, and the implications for future research, practice, and policy will be presented.

Chronically Unsheltered Homeless Women

Of the over 600,000 total number of homeless individuals in the U.S., 35% were unsheltered (U. S. Department of Housing and Urban Development [HUD], 2013). Eighty-five percent of the unsheltered homeless population were chronically unsheltered individuals with 20-25% being females (HUD, 2013). California, the location of the current study, had the highest number of chronically unsheltered homeless population in the nation (36%) with 27% of that number being female (HUD, 2013). Although the subpopulation of chronically unsheltered homeless women was a small percentage of the overall homeless population, this vulnerable group of women were very high risk for poor health status and negative health outcomes (Nyamathi, Leake, & Gelberg, 2000). Compared to women residing in shelters or transitional housing, chronically unsheltered homeless women were significantly more likely to be physically and/or sexually assaulted, have poor physical and mental health concerns, and higher use of alcohol and substance abuse (Nyamathi, Leake, & Gelberg, 2000).

Despite their risks and vulnerability, very little was found in the literature about this population of women. Also missing from the literature was how chronically unsheltered homeless women self-managed their personal hygiene within the context of their challenging, unsafe physical and social environments. The current study sought to gain an in depth understanding of the PHSM of chronically unsheltered homeless women. Five themes emerged during data analysis: Maintaining Safety, Blending In, Managing Sleep, Sustaining Health, and Problem Solving. Findings from the current study revealed that in the face of adversity, the women were successful in their PHSM.

Description of PHSM

Wilson (2005) found homeless women residing in shelters shared a commonality with the chronically unsheltered homeless women in the current study by regularly practicing health promotion behaviors. One difference between the two groups of homeless women was the sheltered women had certain amenities available to them making their PHSM easier to achieve on a daily basis. Another difference was the sheltered homeless women were not as physically active compared to the unsheltered homeless women who walked a lot throughout the day to locate resources to assist them in getting their needs met.

Chronically unsheltered homeless women in the current study were successful in PHSM despite the many challenges they faced on a daily basis. In the midst of mental illness, histories of substance use and incarceration with minimal to no social/family support, the women had confidence in their ability to prioritize, plan, and successfully performed personal hygiene self-management. An important finding from the current study was the women were primarily motivated to self-manage their personal hygiene to

be able to blend in contributing to an improved quality of life and as opposed to preventing/treating a health concern.

The initial research questions explored the experiences of chronically unsheltered homeless women in personal hygiene self-management and the personal hygiene behaviors the women reported carrying out. All ten of the women had similar experiences of PHSM. Overall, the experience of the women was stressful, often overwhelming, especially when trying to self-manage their personal hygiene in such a harsh, unsafe environment. Yet, they were all successful with PHSM.

The many challenges the women encountered throughout their day were potential obstacles to PHSM. The most serious challenge the women faced was maintaining their safety due to constantly living in fear; fear of being physically assaulted or raped. Their physical and social environments were complex. Although the women in the study resided in an affluent mid-sized coastal city located in Southern California, much of their physical environment mirrored that of developing countries or the environment following disasters; unsanitary, unsafe, and potential exposure to unhealthy conditions. No running water or toileting facilities put the women at risk for illness and disease and negative health outcomes. Little to no financial resources of the women and the high cost of living in the community made it difficult for the women to find affordable housing requiring them to sleep in places such as the bushes, carports, or the beach. Although the women tried to find hidden locations in which to sleep, they were at risk of being physically or sexually assaulted. Despite some of the negative aspects of their physical environment, a positive aspect of their physical environment was the relatively consistent, year-round, mild climate making it more tolerable to live and sleep outdoors. Another positive aspect

of their environment was at least a few community resources in which the unsheltered women could access for personal hygiene behaviors, especially a shower.

In the midst of their complex environment, the women reported carrying out personal hygiene behaviors on a regular basis. Personal hygiene behaviors the women reported carrying out were taking a shower (washing up if a shower was unavailable), foot care, brushing their teeth (oral hygiene), managing menstrual hygiene, and toileting. Dumpsters and dumpster enclosures were common locations for urinating or changing a menstrual pad. Public bathrooms or faucets were commonly used for washing up and teeth brushing. City parks were an ideal location to air out their feet and/or apply vinegar to reduce foot fungus (*tinea pedis*).

According to the literature, due to instability in living conditions, social isolation, and lack of social and family support, the experience of being homeless in itself is a significant predictor of failure to seek and maintain medical treatment and are potential issues contributing to the inability to engage in personal hygiene behaviors (Muir-Cochrane et al., 2006). The women in the current study experienced all of these issues however most of them sought preventive healthcare (e.g., mammograms, pap smears, colonoscopies) and experienced successful PHSM.

In response to complaints from mainstream society, the literature revealed an increase in cities going to great lengths to exclude homeless individuals from prime real estate (Johnsen, Cloke, & May, 2005). Keeping the homeless from ideal locations involved punitive measures such as tickets or altering physical space to discourage the homeless from loitering in an attempt to contain, control, or eliminate the homeless population (Johnsen et al., 2005). According to the experience of the women, punitive

measures for sleeping or toileting were implemented regularly by the police department in their community. Living in an anti-homeless culture could make the women feel unwanted and alienated from the general public. Being identified as part of the homeless culture often had negative consequences for the women and this stigma contributed to living in fear and the need to maintain their safety. Living and sleeping in an environment filled with constant fear required the women to perform protective behaviors to maintain their safety and to enable them to self-manage their personal hygiene. The women learned if they could blend in with the general population they were less vulnerable to being physically and sexually assaulted and reduced the likelihood of being harassed by the police. Blending in also allowed the women greater access to local businesses and bathrooms. Crucial to blending in was to be clean and well-groomed making a shower the priority personal hygiene behavior to try and accomplish daily. The women were successful in showering almost daily. Despite living in an unsafe environment a protective behavior carried out by most of the women was to navigate alone. Going it alone allowed the women to navigate around town undetected drawing less attention to themselves. Less attention, in essence blending in, made them feel safer.

Studies regarding the unsheltered homeless population were very limited especially studies focusing on unsheltered homeless women. Possible reasons for the limited number of unsheltered homeless individuals as participants in studies were related to mistrust of healthcare professionals working with the homeless resulting in limited access to this population (Kryda & Compton, 2009). Participant recruitment for the current study supported these findings. In the role of medical director of the women's homeless clinic, gaining trust of the unsheltered homeless women in the community was

important in working with this population and was crucial to the recruitment of participants for the current study. Snowball sampling definitely contributed to gaining access to chronically unsheltered homeless women especially the women not known by the student PI. The one participant that withdrew consent to participate in the current study most likely withdrew due to a lack of trust of the student PI.

Mapping onto the IFSMT

The final research question sought to determine whether the PHSM of chronically unsheltered homeless women could be mapped onto the IFSMT. Findings from the current study revealed the PHSM of chronically unsheltered homeless women could be mapped onto the IFSMT in all dimensions (Figure 2). In the IFSMT the context dimension consists of risks and protective factors. For the women in the study, the context dimension presented more risks than protective factors. Their physical and social environment presented many potential barriers to PHSM. Their individual and family factors such as the feeling of living in fear, feeling unsafe, mental illness, substance abuse, and incarceration histories also presented potential barriers to PHSM. The women were successful at PHSM in spite of the difficult context of their lives.

The process dimension of the IFSMT was where the women excelled. They had the knowledge, belief, and confidence they could self-manage their personal hygiene. The women demonstrated decision-making in their selection of personal hygiene and protective behaviors to perform. With limited resources, they problem-solved ways to meet their personal hygiene needs (e.g., using a sock as a menstrual pad). Through effective decision-making and problem-solving the women figured out the way to improve their quality of life within the community was to be able to blend in with the

general public by not looking homeless. The distal outcome of an improved quality of life became the motivation for the process of PHSM. Because the women were successful in their PHSM, they had very few health concerns such as skin infections resulting in minimal need for healthcare services/costs (proximal outcome). The women were resourceful in successfully problem-solving issues related to managing their sleep, toileting, menstrual hygiene, and sustaining health. Natural, low cost health remedies were important to the women and they were able to obtain such remedies.

Interventions

Appropriate interventions have implications for practice and policies related to chronically unsheltered homeless women. Interventions could influence PHSM at both the context and process dimensions of the IFMT. Based on the findings of the current study, appropriate interventions implemented at the practice level could aid in the PHSM of chronically unsheltered homeless women. One subtheme of Managing Sleep was poor sleep quality and the need to nap during the day. One practice level intervention in the context dimension implemented at the women's homeless clinic was the addition of cots so the women could come in from the outdoors and safely nap in a private space.

The women shared their experience of taking showers at the local homeless shelters. Shelter shower policies seemed better suited for men such as group showers for 5-10 minutes per shower. All of the women shared a history of abuse, physical/sexual assault, and violence. Based on a history of trauma the women needed privacy while showering. Compared to men, women may have different personal hygiene needs warranting private showers for longer shower times.

Shower policy and practice intervention at the women's homeless clinic provided the women private showers with unlimited time per shower. Due to the high rates of trauma histories in the lives of homeless women, especially those who are unsheltered, a similar policy and practice intervention should be implemented to provide the ability to shower in privacy and to allow longer shower times

The women shared the challenges of accessing menstrual hygiene products (menstrual pad and tampons) and the expense of purchasing urinary incontinence pads. Many of the women problem-solved this challenge by using donated socks as menstrual pads. One woman prioritized her minimal recycling income to purchase urinary incontinence pads to meet her personal hygiene need. A practice intervention would be to provide a regular supply of free menstrual pads, tampons, and urinary incontinence pads at locations serving homeless women. At the women's homeless clinic this intervention was put into practice several years ago as these were some of the most requested items by the women. The women's homeless clinic obtained these items primarily through donations and when donations were low, these items were purchased through a grant supporting the clinic.

Interventions aimed at the IFSMT process dimension might address self-efficacy, knowledge, support, and/or problem-solving. Four primary information sources addressing self-efficacy are performance accomplishments, vicarious experience, verbal persuasion, and physiological states (Bandura, 1977). The use of the four information sources could play an important role in interventions appropriate for PHSM of chronically unsheltered homeless women. Potential self-efficacy interventions could be a training session/workshop where a health care professional demonstrates a personal

hygiene behavior such as proper foot care for the homeless women. After the women observe the demonstration (vicarious experience), they are given the opportunity to practice the behavior (performance accomplishments) with feedback and encouragement from the health care professional (verbal persuasion). The training session/workshop could be conducted in a group setting or on an individual basis depending on the physical or emotional state of the individual woman. A one-on-one intervention may be more effective for a homeless woman experiencing considerable stress and anxiety.

To increase the women's knowledge, the women's homeless clinic offered monthly, nurse-led health education classes focused on personal hygiene issues (e.g. foot care, oral care, scabies/lice, sexually transmitted diseases, and sleep health). In addition, classes were provided on priority health concerns for this target population such as self-breast exam, menopause, hypertension, diabetes, nutrition, and self-defense. The health care professionals and general volunteer staff at the clinic provided ongoing support and encouragement to the homeless women in their PHSM.

Problem-solving interventions could assist the women in strategizing more effective ways of managing their personal hygiene. The intervention could be in a group setting or on an individual basis. A health care professional and homeless woman could brainstorm options for meeting their personal hygiene needs. Role-playing could also be a strategy in assisting the women in walking-through potential scenarios they may encounter while trying to perform certain personal hygiene behaviors. An intervention incorporating role-playing and problem-solving could be effective in assisting the women in overcoming current barriers to PHSM.

Some interventions need to go beyond the individual level to impact the environment and policies related to chronically unsheltered homeless women. One policy level intervention relevant to chronically unsheltered homeless women is the structure of homeless shelters. The current structure of some homeless shelters appear to primarily cater to the male population such as dormitory-style sleeping quarters along with group showers with very limited shower times. Homeless shelters may meet the needs of a large number of homeless women but for this small, at-risk population of chronically unsheltered homeless women, some shelter policies made certain services inaccessible such as the shower services. With the significant history of abuse, assault, and violence, the women may have more privacy needs than offered through group showers or dormitory sleeping quarters. Presenting the findings of the current study to the leaders of homeless shelters may influence a change in practice for homeless women.

Homeless women, especially those unsheltered, have a significant history of trauma including abuse, assault, and violence and are at a constant risk of trauma on a daily basis. The state of homelessness is also viewed as a traumatic event (Rayburn, Wenzel, Elliot, Hambarsoomians, Marshall, & Tucker, 2005). Providing services for homeless women must take into consideration the traumatic risks and experiences of the women they serve. A context- related intervention at the practice level is a medical clinic using a trauma-informed care service model. A trauma-informed care service model includes an integrated, culturally competent, strength-based services implementing the principles of trauma awareness, safety, recovery, empowerment, respect, collaboration, and minimize the possibility of retraumatization (Elliott, Bjelajac, Falot, Markoff, & Reed, 2005).

Recommendations

Gaining trust and establishing a rapport with unsheltered homeless women could improve access to this population and improve their adherence to interventions. Gaining their trust would not be immediate so it would be important to have patience in developing a relationship with these women especially prior to recruiting them for a research study. The student PI, when functioning in the role of medical director of the women's homeless clinic, found that consistency and reliability were important factors in gaining trust and establishing a rapport with homeless women. It was important to be a consistent presence at the women's homeless clinic so the women became comfortable with the medical director (student PI). Being reliable and following through, especially when promising something to the women, assisted in establishing trust. Also important was treating the homeless women with dignity and respect. Being comfortable giving a homeless woman a hug or holding onto her hand, even when a woman arrived dirty and unkempt, contributed to establishing trust. Out of respect it was important to ask permission of the homeless women prior to touching them.

Due to the transient nature of the homeless population, another recommendation is to clarify and verify the data with the participants in a timely manner. Every attempt should be made to locate participants for clarification and verification of data soon after the interviews while participants are still in the community.

Limitations of the Study

Limitations of any research study must be acknowledged (Bloomberg & Volpe, 2008). The primary limitations identified for the current study were related to the context dimension of the IFSMT. The first limitation may be the geographical location of the current study. The current study was conducted in a mid-sized coastal city in Southern

California with a number of resources for the homeless population. These resources provided the chronically unsheltered homeless women options in which to perform personal hygiene behaviors. Urban and especially rural communities may not have as many resources for the homeless population making it much more difficult to self-manage personal hygiene. Another possible geographical limitation was the year-round mild climate of the study's location making it easier to navigate around town accessing resources to meet personal hygiene needs. Chronically unsheltered homeless women living/sleeping in areas with inclement weather may have a more difficult time accessing resources to assist them in their PHSM.

Trust and an established relationship prior to the current study between chronically unsheltered homeless women and the student PI in the role of primary healthcare provider was important in recruitment of participants for the current study. Trust issues could be a study limitation. Of the ten women in the current study, seven of the women had an established, trusting relationship with the student PI. The remaining three women in the study were unknown to the student PI prior to the meeting for the study's interview. These remaining three women were recruited by a homeless woman they trusted who assured these women of the trustworthiness of the student PI. The one woman in the study who withdrew consent mid-way through the interview was also unknown to the student PI prior to the interview meeting. Withdrawing consent for the study was most likely related to a mistrust by the woman for the student PI. Without establishing trust between chronically unsheltered homeless women and a researcher, recruitment of participants for a study may be difficult.

Small sample sizes are often seen in studies seeking an in depth understanding of a topic (Wood & Ross-Kerr, 2006) and those with a narrow focus could be accomplished with a sample size of 10-15 participants (Munhall, 2007). The small sample size and homogenous sample was a limitation to the current study. A small sample size and homogenous sample may prevent generalizability to larger, diverse populations of chronically unsheltered homeless women. Although there was saturation across the ten transcripts in the current study, a larger sample size-might uncover additional themes not revealed in the current study. A larger sample size, especially including participants from varying geographical locations and varying community resources, could provide even more knowledge regarding the PHSM of chronically unsheltered homeless women.

Implications for Future Research

The current study sought to gain an in depth understanding of a vulnerable homeless subpopulation; chronically unsheltered homeless women. To date, very little is known about this group of women often hidden within a community. Although the current study was able to capture a glimpse of their experience of living and sleeping outdoors for long periods of time, more research is necessary to fully understand the lives of these women. Participants in the current study were all recruited from the same mid-sized urban city making a fairly homogenous sample. Expanding recruitment to different geographical locations could provide additional information. Research with chronically unsheltered homeless women in rural or inner-city locations, potentially having fewer homeless resources, would be helpful in determining if access to resources improves PHSM. Comparing and contrasting the PHSM of chronically unsheltered homeless

women from a variety of geographical locations would be beneficial in gaining a better understanding

Research regarding gender differences in PHSM would be important to explore. The current study exclusively recruited female participants. The women in the study were constantly concerned for their safety and many of their protective behaviors were purposeful in ensuring their safety. The women were motivated to perform certain personal hygiene behaviors to blend in with the general public in order to improve their safety and quality of life. Chronically unsheltered homeless men may or may not be as successful in PHSM compared to the women and the men may have a different motivation for PHSM. This information could determine appropriate gender-specific interventions.

Community-based participatory research (CBPR) takes a collaborative, partnership approach emphasizing equal involvement between the researcher, community members, and organizational representatives in all aspects of the research process (Israel, Eng, Schulz & Parker, 2005). CBPR can be used to address social and health disparities (Minkler, 2010) and could be an effective research approach for chronically unsheltered homeless women. Due to the collaborative nature of CBPR approach, establishing trusting relationships with members of a vulnerable population would be important (Garcia, Minkler, Cardenas, Grills, & Porter, 2014) something already established regarding chronically unsheltered homeless women in the current study. Providing the women the opportunity of ownership of their experiences could be very empowering for this group of often invisible homeless subpopulation.

The women in the current study were primarily middle age. As this population of homeless women age, their needs may change. An implication for future research would be related to the older adult homeless population and issues common with this age group such as sensory impairments, dementia/Alzheimer's disease, and management of chronic diseases including palliative or hospice care.

Implications for Practice

Many of the women in the current study received basic medical care at a free women's homeless clinic run by an all-volunteer non-profit organization. The target population for this clinic was unsheltered homeless women. Many medical issues were managed at the women's homeless clinic reducing the need to access an emergency department. Another advantage of the women's homeless clinic was the medical care was administered right away reducing barriers to accessing care at a larger medical clinic such as the county public health clinic or the emergency department. Treating scabies and lice was a common medical issue treated at the women's homeless clinic. The clinic offered free ivermectin oral tablets, a more practical intervention for this population compared to permethrin topical cream. Chronically unsheltered homeless women in other communities could benefit from a similar clinic.

An implication for practice could be assisting uninsured chronically homeless individuals sign up for health insurance under the new Affordable Care Act. It has been established that the issues of mistrust by homeless individuals for healthcare workers therefore targeted outreach and direct assistance with health insurance enrollment would be a good strategy in assisting this population secure medical homes (Tsai, Rosenheck, Culhane, & Artiga, 2013). The Medicaid expansion of the Affordable Care Act, could

increase the rates of health insurance and healthcare utilization of uninsured homeless individuals (Tsai et al., 2013). With health insurance, homeless individuals would have greater access to preventive care, medication, mental health services, and substance use treatment (Bharel, Lin, Zhang, O'Connell, Taube, & Clark, 2013; Tsai et al., 2013). Greater healthcare utilization by homeless individuals, through established medical homes, could reduce emergency department and hospital visits by this population (Bharel et al., 2013). Medically prescribed treatments would be more attainable to homeless individuals, often a challenge for the women in the study due to lack of resources. Obtaining health insurance through the Affordable Care Act would also provide the homeless population with professional dental care, a service greatly needed by the women in the current study.

Interdisciplinary collaboration could potentially improve access to services for this population of homeless women. Collaboration between the disciplines of nursing, social work, or psychology could assist homeless women in determining their potential eligibility for disability or other appropriate benefits that may assist in accessing housing or an array of services.

Implications for practice at the nursing education level is to provide education to nursing students regarding the best approach to working with homeless women especially targeting strategies to establish trust and rapport with this population of women and other vulnerable populations. Incorporating simulations into nursing curriculum is an effective teaching method. A key focus of a simulation should be a scenario demonstrating how to interact and communicate with an individual from a vulnerable population in a way that relays respect. More importantly would be to demonstrate what a lack of respect looks

like in an interaction. One of the individual narratives from the current study could be utilized as a case study for the foundation of a simulation scenario. In addition to the nursing profession, other disciplines could benefit from these scenarios such as social work and public health.

Implications for Policy

Providing appropriate interventions for homeless women, especially the small, at-risk subgroup of chronically unsheltered homeless women, have implications for both practice and policy. One important intervention applicable to both practice and policy is providing services embracing the philosophy of trauma-informed care. In order to be effective, the core principles guiding trauma-informed services must be adopted at a policy level by all members of an organization. Once adopted by the organization, the principles need to be put into practice to consistently provide services respecting the needs and challenge of vulnerable women with trauma histories.

Being clean and well-groomed was found to be the key self-management behavior the women reported carrying out in order to keep themselves safer and experience a perceived improved quality of life. Daily access to a shower and shower times of useful length should be part of providing care for unsheltered homeless women in a community. If feasible, local homeless shelters should provide access to a daily shower to homeless women who do not reside in the shelters. Also helpful could be donated personal hygiene items including packages of moist wipes and waterless shampoo. Free donated menstrual hygiene pads or tampons could assist the women in self-managing their menstrual hygiene.

Mobile shower buses, targeting the homeless population, are a new concept being launched in a few communities. Refurbished city buses or unused hazmat trailers are repurposed to provide free showers and toilets to homeless individuals. Free laundry services are available in a few locations. One location has a shower specifically designated for delousing for those homeless clients infected with lice.

Assisting chronically unsheltered homeless women in gaining access to permanent housing could potentially address several of their PHSM issues such as keeping clean, managing their sleep and toileting needs. Living inside, the women would no longer have the stigma of being homeless; therefore, they would blend in more with the general public which would increase their sense of safety. For the homeless women wanting to be housed, many communities have organizations (e.g., Common Grounds) targeting the chronically homeless population or those individual/families at risk to become homeless to find safe, secure housing typically with on-site supportive services to assist with the transition to stable housing.

Conclusion

Life as a chronically unsheltered homeless woman was a stressful, frightening, and challenging experience for the women in the current study. Maintaining Safety was the most serious challenge faced on a daily basis and was a major theme across all the participants. PHSM in the midst of such a difficult environment put them at risk for being unsuccessful however; all of the women in the current study were able to successfully self-manage their personal hygiene. Their primary motivation to PHSM was a perceived improved quality of life which included less risk of being assaulted and being able to safely navigate around town.

In mapping PHSM of chronically unsheltered homeless women onto the IFSMT it was discovered the women prevailed in the process dimension of PHSM. They demonstrated self-efficacy and the ability to plan, implement, and evaluate their personal hygiene and protective behaviors. In the midst of no social or family support, all of the women had the knowledge and motivation to perform certain behaviors that kept them as safe as possible and self-managed their personal hygiene. Having little to no resources, they kept themselves healthy by problem-solving natural health remedies and eating as healthy as possible.

Although the outcomes achieved by the women were generally positive, it came at some cost. Additional health outcomes remained unmet especially their oral health. Interventions can be implemented at both the practice and policy level to address needs at the context and process dimension of the IFSMT to better meet the unique needs of this highly vulnerable population of women. Findings from the current study determined the IFSMT was applicable to health promotion in vulnerable populations and is an implication for further research.

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Appendix A

Screening Questions

Screening Participants

Study's Inclusion Criteria: (a) female, (b) minimum of 18 years old (c) English speaking, (d) lives/sleeps outdoors or has a history of living/sleeping outdoors or in a vehicle (at least one year consecutively or has had at least four episodes of unsheltered homelessness in the past three years) and (e) cognitively able to consent for herself

Screening Questions

1. Where do you live and sleep?
2. How long have you been living and sleeping there?
3. How old are you?

Being cognitively able to consent for herself: *If a woman contacts me regarding interest in participating in the study and is able to answer the above three questions then it will be determined she will be cognitively able to consent for herself.*

Once it is established a woman meets the inclusion criteria, oral consent will be obtained using the oral consent script.

Appendix B



Jessica Rice
 IRB Administrator
 Institutional Review Board
 Engelmann 270
 P. O. Box 413
 Milwaukee, WI 53201-0413
 (414) 229-3182 phone
 (414) 229-6729 fax

<http://www.irb.uwm.edu>
jrice@uwm.edu

New Study - Notice of IRB Expedited Approval

Date: July 31, 2013

To: Rachel Schiffman, PhD
 Dept: College of Nursing

Cc: Stephanie Durfor

IRB#: 14.028

Title: Self-Management Needs of Chronically Unsheltered Homeless Women

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been approved as minimal risk Expedited under **Categories 6 & 7** as governed by 45 CFR 46.110.

In addition, your protocol has been granted approval to waive documentation of informed consent as governed by 45 CFR 46.116 (d).

This protocol has been approved on **July 31, 2013** for one year. IRB approval will expire on **July 30, 2014**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a continuation for IRB approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found on the IRB website.

Unless specifically where the change is necessary to eliminate apparent immediate hazards to the subjects, any proposed changes to the protocol must be reviewed by the IRB before implementation. It is the principal investigator's responsibility to adhere to the policies and guidelines set forth by the UWM IRB and maintain proper documentation of its records and promptly report to the IRB any adverse events which require reporting.

It is the principal investigator's responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities the principal investigator may seek to employ (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.) which are independent of IRB review/approval.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project

Respectfully,

Jessica P. Rice
 IRB Administrator



Melissa Spadamuda
 IRB Manager
 Institutional Review Board
 Engelmann 270
 P. O. Box 413
 Milwaukee, WI 53201-0413
 (414) 229-3173 phone
 (414) 229-6729 fax

Continuing Review - Notice of IRB Expedited Approval

<http://www.irb.uwm.edu>
msadamud@uwm.edu

Date: July 30, 2014

To: Rachel Schiffman, PhD
Dept: College of Nursing

Cc: Stephanie Durfor

IRB#: 14.028

Title: Self-Management Needs of Chronically Unsheltered Homeless Women

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been approved as minimal risk Expedited under **Category 6 and 7** as governed by 45 CFR 46.110.

This protocol has been approved on **July 30, 2014** for one year. IRB approval will expire on **July 29, 2015**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, a Continuation for IRB Approval must be filed by the submission deadline. If the study is closed or completed before the IRB expiration date, please notify the IRB by completing and submitting the Continuing Review form found in IRBManager.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records, and promptly reporting to the IRB any adverse events which require reporting. The Principal Investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project

Respectfully,

Melissa C. Spadamuda
 IRB Manager

Appendix C

PARTICIPANT IDENTITY CODE: _____

Oral Consent Script

Self-Management Needs of Chronically Unsheltered Homeless Women

(This script will be read to potential participants and their oral consent will be audio recorded)

Hi, my name is Stephanie Durfor and I am a doctoral student in nursing doing a research study called *Self-Management Needs of Chronically Unsheltered Homeless Women* at the University of Wisconsin, Milwaukee College of Nursing. My research is under the direction of Dr. Rachel Schiffman and a committee of experienced researchers from the University of Wisconsin, Milwaukee.

PURPOSE OF STUDY

We are asking you to take part in a research study. We are trying to learn more about the self-management needs of homeless women who have lived outdoors or in a vehicle for some time. You are being asked to tell me in your own words how you take care of your needs, especially your health needs, while living outdoors. This information will help us in learning the best way to assist you with your needs and the needs of other women like you.

Being a part of this study involves you and I getting together to talk one or two times for about half- an-hour to an hour each time. We can meet in a place that works best for you. At the end of each meeting you will be given a Thank You gift of \$10 cash--a total of \$20 cash if you meet with me two times.

To be sure I get everything you are saying I would like to audiotape our meetings. This way I can fully focus on you and learn from your experiences. Of course, this is only if you agree. If you do not want me to tape our conversation you can still be a part of the study. I will just take notes while we talk. Sometimes talking about experiences may bring up uncomfortable feelings. If this happen to you, I can arrange for you to talk to someone about these feelings.

I want to make sure you know that your identity will be kept private. Your name and all of your answers will be written down using a special identifying number. All papers relating to this study will be kept in a locked file, and all electronic data will be in a special code and stored in password protected computer files. Only people who are directly involved with the study will have access to these files. When the study is completed and results reported, all records will be destroyed.

Your involvement is totally voluntary. You can choose to not be a part of this research study. If you decide to be a part of the study you can stop at any time. Your decision to be a part of this study will not have anything to do with the care you receive at the women's clinic or park clinics.

Do you have any questions?

Are you willing to be a part of this study? YES _____ NO _____

Do you give me permission to audiotape our meeting(s)? YES _____ NO _____

If now is not a good time for a meeting, when do you think we could meet?

What time would you like to meet?

Appendix D

Interview Guide

Interview 1

The purpose of the first interview will be to capture as much of the pertinent information as possible as a second interview may not be possible.

Getting the Participant Comfortable (prior to the actual interview)

1. Thank you for agreeing to talk with me. How are things today?
Brief general conversation
2. Do you have any questions of me before we start?

Interview Questions

1. Tell me what it is like for you to live and sleep outdoors?
2. What is it like for you to take care of your basic health needs under these circumstances?
Things like finding places to go to the bathroom, having a chance to wash your body, brushing your teeth, keeping your skin clean especially your feet, dealing with being on your period.
3. (*Based on their answers*) Which are the most important of these for you to try and get done every day or every couple of days?

Why is/are [*basic need(s) identified by the woman*] important to you?
(*Example: Why is getting your teeth brushed every day important to you?*)
4. What bothers you the most about meeting your basic health needs? What makes it the most concerning for you?
5. Who, if anyone, do you feel supports you in getting your basic needs met?
6. Some women say finding a safe place to sleep, wash their body and care for their feet are their top needs. Others might say finding the right food to eat. What are your top health needs?
7. How would you describe your overall health?
8. If you could have one thing that would make your life easier or better, what would that be?

Interview 2 (if necessary)

The purpose of the second interview will be to clarify or elaborate on information shared during the first interview or to obtain information missed during the first interview.

Interview Questions

1. The last time we talked, you said_____.
2. Since we last talked does anything come to mind that you would like to share with me today?
3. Has anything about how you care for your basic health needs changed?
4. Tell me a little bit more about what you meant by_____.
5. How have things been for you in general?

CURRICULUM VITAE

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EDUCATION

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PUBLICATIONS

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