There is little question that homeless women, as a group, have routinely been found to have high rates of behaviours viewed as pathological (Tam, Zlotnick and Bradley 2008; Boes and van Wormer 1997). In the present paper, we argue that social-scientific perspectives that focus solely on pathology not only stigmatize homeless women, but tend to obscure the root causes of these behaviours. In particular, the emphasis on individual pathology fails to account for what can often be inaccessible, substandard and/or inappropriate mental health treatment for dealing with the effects of untreated trauma.

In the pages that follow, we employ trauma theory in order to better understand the life experiences of adult homeless women and their mental health needs. Previous research on trauma among homeless women has demonstrated that this group experiences high rates of significant life stressors that frequently result in such symptoms of trauma as anxiety and depression, suicidality and substance abuse (Goodman and Dutton 1996; Padgett, Hawkins, Abrams and Davis 2006; Perron, Alexander-Eitzman, Gillespie and Pollio 2008). Drawing on data collected from seventy-nine in-depth semi-structured interviews with women residing in shelters in Chicago and Detroit, our research similarly demonstrates that the homeless women in our sample have experienced multiple forms of trauma and other significant stressors over their life course, events which continue to have serious negative effects on their mental and emotional well-being.

Trauma and its effects are, however, only one part of the problem. Given the extent to which these women are affected by trauma over their life course, access to high quality mental health care services should be a critical need (Finfgeld-Connett 2010). And yet, we know little of the extent to which homeless women receive such services. Indeed, while problems with accessing mental health services have been addressed within the literature (Hatton 2001), the

quality of the mental health care received by adult homeless women remains largely unknown. Thus our second goal in this paper is to utilize the data collected to explore women's experiences with accessing and consuming mental health services. Our analysis reveals that it is not simply the case that homeless women are often unable to access mental health services, but that they often receive substandard or inappropriate care. Therefore we conclude that it could reasonably be argued that the 'pathological homeless woman' is a construct tied to women's experiences with a health care system that frequently fails them.

Beyond pathology: trauma

In this paper we employ the concept of trauma as a means of reframing homeless women's circumstances in order to better understand their experiences with mental health services. For our purposes, we define psychological trauma as "a set of responses to extraordinary, emotionally overwhelming and personally uncontrollable life events" (Goodman, Saxe and Harvey (1991: 1219).These events produce traumatic memories which are stored in the brain in a fragmented fashion, "remaining highly charged within the mind and often unable to be articulated or verbally described" (Flemke 2009: 125). While experiences of trauma and its effects are variable among individuals (ibid), studies suggest that exposure to painful life events can lead to cognitive changes – including altered perceptions of self-worth, shifts in attitudes towards others (lowered trust and intimacy) and the development of harmful beliefs (Goodman and Dutton 1996; Janoff-Bulman 1992). Such experiences can also increase one's risk of developing a mood disorder such as depression (Rayburn, Wenzel, Elliott, Hambarsoomians, Marshall and Tucker (2005), or one of the cluster of anxiety disorders such as Post-Traumatic Stress Disorder (PTSD) (Yeater, Austin, Green and Smith 2010).

In relation to homeless women, the research literature has consistently demonstrated that members of this population experience episodes of significant stressful life events, both prior to and following homelessness (North, Smith and Spitznagel, 1994). For example, many women experience physical and sexual violence prior to becoming homeless (Goodman et al., 1995; D'Ercole and Struening, 1990), and domestic violence is often a major factor in causing women's homelessness (Browne and Bassuk 1997; Williams 1998).

Experiences of violent victimization are, however, only one of several forms of significantly stressful life events that can produce symptoms of psychological trauma. Some researchers have noted that homeless women experience high rates of prolonged marital and intra-familial conflict (Wagner and Menke 1991). Some homeless citizens have survived natural disasters, fires and floods, combat situations or experienced life threatening accidents (Taylor and Sharpe 2008; Yeater et al. 2010). Becoming homeless is itself a stressful process, one that frequently involves a precipitating financial crisis or familial dispute (Goodman et al. 1991).

The experience of *being* homeless can also be traumatizing, as it entails the loss of one's familiar surroundings, social relationships and social roles (ibid.). For example, the experience of being with a permanent residence, of living precariously in shelters and other temporary arrangements, or on the streets, has been shown to be both physically and psychologically stressful and has been linked to higher morbidity rates among homeless citizens (Cheung and Hwang 2004). For those individuals with pre-existing psychiatric conditions, or with untreated psychological trauma from prior negative experiences, homelessness may worsen pre-existing mood, anxiety and/or cognitive disorders (Goodman et al. 1997; D'Ercole and Streuning 1990). Researchers have also consistently noted links between violent victimization and symptoms of undiagnosed Post-Traumatic Stress Disorder (North et al. 1994; Stewart et al. 2004). Experiences

of physical and sexual assault also greatly increase the likelihood of developing depressive symptoms, as well as being strongly associated with substance abuse problems (Padgett and Streuning 1992). Not only is experiencing violent victimization a predictor of psychological distress for homeless women (Ingram et al. 1996), but it has also been found to worsen psychotic symptoms of those women who are mentally ill (D'Ercole and Streuning 1990). Women who have experienced other types of traumatic events, such as natural catastrophes, combat situations and so on, are also often underdiagnosed for PTSD (Taylor and Sharpe 2008). Suicidal ideation is another documented effect of trauma: in one study Ambrosio et al. (1992) found that almost two-thirds of the homeless women in their sample had contemplated suicide in the year prior to the study; one third stated that they had made a suicide attempt during the same period.

Aside from permitting a means of reframing pathology as untreated symptoms of trauma – thereby removing some of the stigma these women face – trauma theory also refocuses our attention to existing mental health services. In particular, we are forced to ask: how do existing mental health services respond to women's psychological trauma? Unfortunately, this is a question that does not appear to have generated much research interest. In the present paper, we have sought to answer this question by asking homeless women about their access and use of mental health services.

Method of inquiry

This paper is informed by data collected for a larger study that aimed to improve understanding of homeless women's health, mental health and policing service-related needs, the quality of services they currently receive, as well as problems with respect to accessing those

services post-victimization[1]. To explore these issues, in 2011 we conducted one hundred and one in-depth semi-structured interviews with seventy-nine homeless women and twenty-two representatives of service agencies. These interviews were facilitated through the active participation of fourteen community organizations serving homeless women in Detroit and Chicago.

To locate potential research participants, we developed a non-probability sample consisting of the maximum number of service agencies that work with homeless women in each of these cities and asked these organizations if they would agree to participate in our research. Participation was defined as facilitating access to both organizational staff and clients.

In the pages that follow, we draw exclusively on the interviews conducted with the seventy-nine homeless female participants. Interviews were typically of an hour's duration. At the beginning of each interview, we asked participants for background information in order to understand the demographics of our sample. The women who volunteered to participate in our study were disproportionately African-American. Their ages ranged from eighteen to seventy**.** They also had a diverse range of experiences of homelessness; from a first-timer with one week at the shelter to older women who reported decades of cycling in and out of homelessness.

– Table 1 here –

[1]Although the primary focus of our research was collecting data on issues related to victimization, we also asked about and received information concerning other traumatic events experienced.

The project was conducted in two stages. In the first stage, we conducted twenty-six preliminary interviews with women in both cities, using these interviews as an opportunity to test our interview guide, refine our questions and develop new lines of inquiry. Each recorded interview was subsequently transcribed and coded using open coding – that is, data was analyzed thematically. To assist in the development of a list of appropriate themes for coding, the research team relied on notes taken during interviews and on the results of debriefing sessions. We then engaged in focused coding, wherein members of the research team manually coded transcripts during line by line readings.

The results of the first stage of research were then used to inform the development of an interview checklist that was created to guide the second stage of interviews. In this second stage, we returned to both research sites and conducted an additional fifty-three interviews. The checklist also allowed us to conduct preliminary coding of answers during the interview, which we later compared to the coding results from transcription of the interviews. To further ensure inter-rater reliability, all coding was independently verified by another team member.

Traumatic experiences and other significant life stressors

To provide a better understanding of the extent to which the women in our sample had experienced significantly stressful life events, we have grouped them in the table below according to where these events occurred in the life history of the respondent.

– Table 2 here –

Clearly, each of the seventy-nine women we interviewed had experienced both the process of becoming homeless and homelessness itself and, during the course of an interview, often related how emotionally upsetting they found both experiences. One interviewee, a thirty-four year old African-American woman living in a Detroit shelter, was so upset when she arrived at the shelter that she had a panic attack. As she explained, “I was so nervous when I first came here. Seriously, I’ve never had an anxiety attack before in my life, but I think that day I did. I was like shaking. I was like, ‘oh my god, oh my god, oh my god.’ I’m just sitting here and it was breaking me down. ‘I can’t believe that I’m homeless. I’ve worked on my life. I can’t believe this.’ A fifty-three year old survivor of domestic violence became so depressed over being homeless that she signed herself into a psychiatric ward fearing that she would commit suicide. “It got really bad. I just wanted to run in front of a truck or something.”

Of the seventy-nine women interviewed, fifty-nine reported experiencing other forms of significantly stressful life events throughout their life history[2], with most reporting more than one form. Of these, the highest reported rates for events occurring during adulthood were for intimate partner violence. Some respondents spoke of past relationships long since ended; however, more commonly, women stated that they had become homeless after leaving a violent partner. Several

[2] To be clear: 59 reported other forms of trauma aside from their experiences of becoming or being homeless.

of the women's stories echoed the experiences of an African-American woman we interviewed in Chicago: "he was abusive. I stayed in that marriage for 20 years and I was crying for help."

Women also cited experiences of sexual violence, with the majority of these assaults perpetrated by acquaintances or people otherwise known to the victim. In a minority of cases, respondents were sexually assaulted by strangers, as happened to one woman who was kidnapped and sexually assaulted while engaged in sex work. Physical assaults by non-intimate partners were also frequent and included incidents of random physical violence from other homeless citizens and passersby on a street, as well as assaults by family members, acquaintances and others. In one instance, a woman engaged in caretaking work was repeatedly assaulted by the son of her employer. As she explained of the man, "He had very black rages to where he was very physically abusive."

Other less frequent forms of trauma experienced in adulthood included witnessing violence and the loss of a loved one. Nine study participants reported the death of a loved one, three of whom also lost their homes as a direct result of this loss. One of these women was a 34 year old widow who had become homeless when she lost benefits for a child who had also died. Three of the women interviewed reported traumatic incidents of witnessing violence against others. In one case, a woman hid under blankets while armed gunmen robbed other residents of a crack house. A Detroit woman whose ex-partner had been threatening to kill her, her children and her new partner, watched as the former husband broke into their house with a gun and was subsequently shot and killed by her new boyfriend.

Traumatic experiences in childhood and adolescence were also common. The most frequently reported were forms of physical and sexual violence. One young woman in Detroit stated that "My Mama she used to beat me all the time. With poles. Extension cords. All that

stuff.” She also reported multiple experience of child molestation: “I been molested by my sister’s side, her family. And my blood family.” Thirteen of the women reported experiences of gang-related violence – from beatings to sexual assaults – usually as a result of gang affiliation.

Nine participants cited having lost parents or siblings in childhood, deaths that caused significant emotional and mental distress. Among these was a woman in Detroit who stated that she had “been in counselling for most of my life, since my mother committed suicide when I was 12.” She added, “I attempted it a year later.” Some of the women also reported experiences in foster care, which often led in turn to physical or sexual mistreatment in childhood or adolescence.

But what negative emotional, cognitive or other mental health effects, if any, resulted from the experiences reported? To ascertain the effects of violence, the death of a child and other traumas on the well-being of our research participants, we asked each participant a series of questions about symptoms of trauma that had emerged after their experience(s). To assist in this process, we went through a checklist of common symptoms associated with anxiety and depression with each of them. To determine which symptoms to ask about, we drew on the relevant literature on post-traumatic co-morbidities within homeless populations (c.f. Flemke 2009; Lam and Rosenheck 1998; Goodman and Dutton 1996).

– Table 3 here –

In total, sixty-seven women reported one or more symptoms of trauma. As can be seen in Table 4 below, equal numbers of individuals reported one or more symptoms of anxiety and depression, while the majority reported one or more symptoms that could be categorized as related to anxiety, depression and/or some other mental health issue. Most commonly, though, women’s symptoms did not fall solely into one symptom category; indeed, fifty-nine women reported symptoms across categories (ie. anxiety and depression or substance abuse and anxiety).

– Table 4 here –

We began this section of the interview, by asking about symptoms associated with the range of anxiety disorders (ie. general anxiety disorder, obsessive-compulsive disorder, posttraumatic stress disorder, social anxiety disorder and panic disorder). Women reported experiencing persistent negative thoughts, claustrophobia, compulsive behaviours, somatic symptoms such as trembling, sweating and teeth grinding (bruxism), as well as intense fears of being watched or judged by others. In relation to the latter, a battered woman in Detroit spent months avoiding public spaces because of the fear that strangers would know that she had been physically abused by her husband and thus judge her negatively. Experiences of panic attacks were not uncommon. For instance, in the following excerpt, a fifty-four year old African-American woman in Detroit describes her experience of a panic attack:

A: I went to the hospital because of heart racing to the point where I couldn’t even talk.

Q: Did you think that you were having a heart attack?

A: I thought I was, but when I went to the hospital they looked me over and everything

and told me it was an anxiety attack.

Q: Did anybody, at the time, refer you to counselling to deal with it?

A: No. Male doctors always think it’s in women’s heads.

Fifteen of the women stated that they had had one or more flashbacks to traumatic experiences or events from their pasts. For instance, after responding affirmatively to every symptom of anxiety on our checklist, a 26 year old single mother in Chicago acknowledged that she also experiences traumatic flashbacks: “I was sexually molested by my uncle. Certain situations can trigger a flashback where it can make it seem like I’m in the same position or situation with my uncle, where he’s crying or he’s touching me.”

In relation to major depression, women reported a number of symptoms they had experienced, including prolonged periods of intense sadness, being unable to get out of bed, difficulties in grooming and other self-care, and feelings of anger or listlessness. One woman in Chicago developed major depression after she left an abusive partner. Among her symptoms were difficulties in self-grooming: “I wasn’t showering. To brush my teeth was such a chore.” Another woman said that she had recently begun counselling because, “I wouldn’t get up and eat. I would just lay there all day in a foetal position.” Twenty-four respondents had had suicidal thoughts and eight had made one or more attempts. One woman noted a suicide attempt triggered by a post-traumatic flashback: “I was trying to slit some veins in my arm just to take myself out. You can see the remainders of the scars right there.” A minority of our participants reported fatalistic feelings. The most succinct example of fatalism we expressed by a twenty-three year old woman who summed her attitude towards life as: “I feel like whatever gonna come for me, gonna come for me.” Eight women also cited episodes of social isolation, stating that they had withdrawn from friends and family.

Seventy-two of the seventy-nine women interviewed reported symptoms that fall within multiple categories of mental health issues, the symptoms of which can be caused by or exacerbated through trauma. For example, several of the women in our study stated that they “had a problem with intense anger.” As an example, a 39 year old African-American mother of six in Detroit, said of her anger, “I just get so angry, so upset that I ... I would get so angry and keep it in because I don’t talk to nobody. I just get sweaty and dizzy. I make myself sick.”

Twenty-three women had substance dependencies, most often involving alcohol or street drugs (cocaine and heroin). One Chicago woman – who had lost her partner, home and her business – had recently been released from prison for the offense of driving under the influence and was currently in a court mandated recovery program. Another woman in Chicago had been physically and sexually abused as a child and subsequently become a victim of domestic violence in adulthood. Currently in a recovery program for heroin addiction, we asked her about the nature of substance abuse. “I was the one that got high to cover up my feelings,” she said.

Less frequently, women reported sleep disturbances, such as chronic insomnia, night sweats and recurring nightmares involving past events. A number of women also had problems forming trusting relations with others, including intimate partners, case workers and acquaintances. It was not uncommon for these women to say, “I don’t trust anybody”. Lack of trust in others made some women feel further isolated and alone. “I want to be open again,” a victim of intimate partner violence said, “trust a little more.”

Accessing mental health services

To determine their use of mental health services, our interview schedule included several questions about past and current usage.

– Table 5 here –

Of the sixty-seven women reporting one or more symptoms related to trauma, fourty-four had some experience of using mental health services. We asked each of these women how they initially accessed those services.

For women residing at two of the shelters visited, attendance at group and individual counselling services is part of a mandatory package of therapeutic treatment designed to foster clients’ transition to more stable situations. One of the shelters is mainly inhabited by older women, who have been released from incarceration or are transitioning from a substance abuse program. The other shelter is for younger women hoping to transition to permanent housing. Therapeutic programs for the latter group are part of a suite of programs intended to facilitate that transition. Six women, however, had lost custody of their children to the foster care system and were required to attend counselling sessions in order to maintain visitation rights.

Several of the shelters operate voluntary programs in which a psychiatrist, psychologist and/or certified mental health counsellor comes to the facility for individual sessions. Aside from the fact that participation is entirely voluntary, women noted that they were convenient and did not require a referral. Ease of access is a particularly major issue, as many of the women stated that they lacked the means to visit services outside of their immediate neighbourhood.

A number of the women currently receiving mental health services stated they had sought out such services on their own initiative, because there were no programs in place at their shelter

and/or the shelter did not provide information on available mental health services in their city. One 24 year old Chicago woman, who resides in a shelter with few resources, sought outside assistance from a medical clinic following a suicide attempt. As she explained, "I just went to the front desk and asked, 'please, can you refer me to some counselling?'" When we asked a Latina sexual assault survivor if she was receiving mental health services through her shelter, she stated that no one at the agency had ever discussed therapeutic programs with her that were not directly related to addiction recovery. Thus, she initiated counselling through an off-site methadone program.

Q: Is it part of the program or did you specifically have to ask for it?

A: I asked for it.

Q: Did you ask for it for issues generally or to deal with [the sexual assault]?

A: To deal with it after it came out. I kept having the flashbacks. Just little bits and pieces. I just wanted to understand what was going on with me more better.

Still other women had received mental health services as a result of psychiatric hospitalization following a threatened or recent suicide attempt. For instance, one woman with a history of depression and anxiety following years of domestic violence stated that she had been in psychiatric wards, "quite a few times." Each time, she attended individual and group counselling sessions. Having been recently released from another hospitalization, she lamented the fact that she could not find outpatient treatment services: "I didn't know where to begin besides the hospital and I'm tired of the hospital now. I want to do something different. I think I'd rather go into outpatient meetings, but I don't know where to go."

Approximately one third (n=23) of the women – stated that they had never utilized any form of mental health service at any point in their lives. In examining our data, we identified three specific factors inhibiting women from accessing mental health services: 1) fear of being

viewed as 'crazy'; 2) distrust of counselling and/or believing that counselling would not be useful, and; 3) the failure of service providers to develop a detailed case history that would reveal trauma and/or to provide information on available mental health services.

Three of the women interviewed expressed concerns that they might be judged by others as mentally ill if they were to seek mental health counselling. For one of these women, her concerns stemmed from the fact that her mother had a history of serious mental illness. Her fear was that she had inherited her mother's illness and would therefore also be institutionalized. Ironically, during the course of our interview with her, she was calm, lucid, and showed no obvious signs of cognitive distortions. Conversely, a fifty year old African-American woman in Detroit, who also had explicit fears about seeing a psychiatrist, related a series of highly improbable stories involving terrorists, God telling her to build a boat to ferry the people of Canada to Michigan and a conspiracy implicating various high ranking citizens in identity theft and fraud. The third woman similarly related a conspiracy story involving identity theft that caused her to distrust mental health professionals.

In some instances, women chose not to use counselling services because they did not see therapy as beneficial. When asked why this was so, the most frequent answer was a wish to not rehash traumatic events from the past. Some felt that they had 'moved on' and that therapy would actually set back their personal recovery rather than help them move forward. For example, a young woman in Chicago explained her rejection of counselling to deal with anxiety from a sexual assault as follows: "I don't get the point of counselling because why keep talking about it again and again? It's just going to make it worse." Other respondents similarly painted a picture of the therapeutic session as one in which the patient is forced to relive an agonizing experience over and over again without tangible benefit.

A third major barrier to accessing mental health services was service agencies' failure to ask women about trauma and mental health needs. Whereas some women were able to seek out services on their initiative, others just fell through the cracks. One such individual, a thirty-three year old mother in Detroit, articulated her problem in the following exchange:

> Q: Did you ever get any counselling for anything?
>
> A: No.
>
> Q: Has anybody ever asked you about any of the violence in your past?
>
> A: No.
>
> Q: So nobody ever asks you these questions and you never get any services?
>
> A: No, they just give you a booklet to fill out and you just check off what you want from them. They take the book and they do that for you.
>
> Q: If you wanted to go see a counsellor, could you go see one?
>
> A: I don't know. I never asked. And if a person don't offer you something, you don't know what to ask for. A lot of people nowadays don't tell you what's available.

Consuming mental health services

For the fourty-four women who had experience with mental health services, we asked whether they found these services useful for meeting their perceived therapeutic needs. As Table 6 below demonstrates, the majority of women who had had exposure to mental health services stated they felt they had received some positive benefits from the mental programs attended. Others, however, were less enthusiastic, as we discuss shortly. A minority were somewhat ambivalent, believing that therapy was sometime useful, but not always.

– Table 6 here –

Of women who said they found counselling to be effective, among the reasons provided were that they often felt better having someone with whom they could discuss their issues. The simple act of ‘venting’ in a safe place was seen as a therapeutic benefit. As one woman in Detroit explained of her attendance at individual counselling sessions, “If I’m holding things in and I know I’m not happy about it, of course I’m not going to be the person I really want to [be].” A fifty-eight year old African-American woman who had survived sexual assault and domestic abuse saw her sessions with a psychiatrist as providing opportunities for personal growth: “you can see the picture from the outside that you really couldn’t see until you talked to somebody else.” A 43 year old African-American woman with a significant history of violent victimization was receiving mandatory counselling as a requirement of being allowed child visitation. Although she acknowledged her sessions were more focused on resolving present issues than on addressing traumas from past events, she felt that they were still useful. As she explained, “when I get there I talk about situations and I feel 100% better.”

Many of the women interviewed, including some of those who disliked individual counselling sessions, saw group therapy as an effective means of examining and dealing with issues, particularly for those who had felt isolated or ashamed of past events. As an example, a Chicago woman with a history of childhood abuse stated of her attendance at group sessions, “it was like everybody in there had a certain thing that I had. It helped me break out of my shell.”

Ten of the women stated they did not find their experience of mental health services useful. For some women, the involuntary nature of a program created resentment and was seen to be a waste of their time. For others, the times at which programs were offered were inconvenient or they had difficulties arranging appointments. For example, one woman struggled to make therapy sessions because of conflicting work hours and another noted that her difficulties with

therapy stem from the fact that "it's kind of hard to get in touch with my therapist." The form in which therapeutic programs are offered is also frequently seen as undesirable. For instance, a woman in Detroit with a history of domestic violence said that she would have preferred individual counselling, as she found group therapy "depressing." "I don't want to sit up in somebody's face all day long," she said, "and cry about situations." More commonly, though, women simply felt the counselling they received did not effectively address the root causes of the problems they face. Mental health professionals either seldom asked women about traumatic events in their pasts or failed to explore these events in any detail. When we asked one young woman with a history of childhood physical and sexual abuse if she had ever received what she perceived to be effective counselling to deal with her childhood abuse, she replied, "It's weird, but no. I've met a lot of counsellors or therapists, we've never specifically touched on that subject."

Other respondents had mixed feelings about the usefulness of the mental health services they were receiving. For instance, a fifty-year old African American woman in Chicago was seeing a psychiatrist in order to deal with depression. When we asked if she found it helpful, her response indicated ambivalence: "Yeah. Sometimes. Not all the time." One woman saw therapy only as useful to her goal of regaining permanent custody of her children. Aside from that purpose, she found therapy to be counterproductive in helping her grow as an individual because she could not trust her therapist who reported back the contents of their sessions to her child services case manager.

In order to better understand women's experiences of mental health treatment, we asked a series of in-depth questions about the nature of the services they received. We found that despite the fact that women often said that the services they received were beneficial, there were some

significant limitations with respect to the treatment received. Identified limitations include: women not being asked to provide detailed case histories, thus therapists often lacked information relevant to the woman's present situation; participants were sometimes provided inappropriate treatments for their particular issue(s); respondents sometimes felt alienated from counsellors who did not appear to actually be listening to them, and; some women were over-diagnosed or received what they felt to be misdiagnoses.

In some instances, women reported that mental health professionals had not taken a detailed case history, thus the woman was never asked about relevant experiences of trauma. The case of a 36 year old woman in Detroit illustrates this point. The woman had a history of physical abuse in childhood and domestic violence as an adult. We asked whether her therapists at the mental health clinic she attends knew of her history of abuse. She replied:

> A: No, because they never asked me.
>
> Q: You're kidding me?
>
> A: I'm serious. The only thing ever asked me is what do I want as far as my goal, what do I want to get out of being there. They never asked me about my childhood, they just diagnosed me with depression, and if they was to hear about my childhood they would see why I was depressed.

A woman in Chicago with a history of domestic violence was attending psychiatric counselling through the Cook County hospital system. When asked whether she and her therapist had discussed her victimization with her, she replied, "they didn't ask me all that." She had assumed that the therapist already knew of the domestic violence from hospital admittance records and that he didn't feel that it was relevant to addressing her issues with depression. In similar fashion, women with substance abuse issues in their history were likely to note that that their sessions never or only rarely touched on issues related to past trauma. Instead sessions were focused, as a woman in Chicago said, on "recovery and staying clean."

Whereas some women received counselling from professionals who did not recognize or address underlying trauma, other women received what appears to be inappropriate care. Indeed, one of the women who had described herself as satisfied with the results of her therapeutic counselling sessions provided an excellent example of this. She had left an abusive husband and sought help through both a battered women's shelter and the state department of human services. The government office sent her to an agency that provides psychiatric and other counselling services, where she was diagnosed with major depression and general anxiety disorder. The service provided her with medication and individual counselling sessions. When asked detailed questions about the treatment plan for her anxiety – a condition which is often treated with a combination of drug, cognitive behavioural and relaxation therapies (Levkoff, Chen and Fisher 2006) – we were told that her counsellor taught her a series of positive affirmations to practise in the mirror. She had no idea what cognitive behavioural or relaxation therapies.

Some women felt alienated from the counselling process as a result of their perception that counsellors were simply 'going through the motions'. One of the most vocal critics of mandatory counselling was a young woman in Detroit who felt that her counsellor lacked the interest to stay focused during their sessions:

> A: She'll ask me, 'how's your Mom?' And I'll tell her about my Mom. Then a couple of questions later she'll say, 'so, how's your Mom?' You get what I'm sayin'? Cuz it's kinda frustrating [voice rises] cuz here this question comes up again. Are you listening? … It's kinda like what type of counsellor do I got? She's not taking notes!

Another woman, a 38 year old who had experienced multiple traumatic events – including the deaths of two of her children – initially stated that her experiences with mental health counselling had been useful. Later in the interview, as she became more comfortable discussing her life, she revealed that her last experience with a psychiatrist had ended when, in response to

her discussing her feelings of anxiety over childcare issues, the psychiatrist had told her, “you just need to get a grip on it. This is just normal stress.” When we asked her if the psychiatrist had been more empathetic, she would have felt she could trust her enough to disclose her history, the woman replied, “I probably would have.” This was not this participant’s only negative experience with psychiatrists. She also reported that, “I got very startled when I went to one psychiatrist and she looked me over and she say, ‘you’re going to be this way for the rest of your life.’ When you hear that, that’s tragic to a person, especially when you don’t feel that way.”

Of those women who had received clinical diagnoses, some were perhaps correctly sceptical, seeing themselves as either over-diagnosed or misdiagnosed. The best example of both forms was recalled by a young mother in Chicago, who had survived sexual assault and domestic violence. She had received three different diagnoses and felt that the last one, in particular, was wrong.

> A: Actually, my first diagnoses was Borderline Personality Disorder. Then I was diagnosed with anxiety. My last diagnosis was bipolar.
>
> Q: With bipolar, you’ve obviously had episodes of depression, right?
>
> A: Deep depression. Then I have manic episodes. But a lot of that was drug induced, I think. I think that helped me probably get that diagnosis.

She then confirmed that her drug of choice during this period was cocaine and that she had been a heavy cocaine user, sometimes not sleeping for periods of up to seven days. She attributed her episodes of mania and depression to her cycles of drug use. Another woman, also recovering from substance abuse, was similarly diagnosed as bipolar by a psychiatrist while she was still actively using. When we asked about this diagnosis, she said, “now that I’m sober I can see [better] how my moods are. I’m not bipolar.”

Concluding remarks

This paper explored homeless women's experiences of accessing and consuming mental health services. Our study has revealed that homeless women are frequently not provided with sufficient mental health services to deal with the various forms of trauma and stressors – such as the long term psychological effects of physical and sexual assault – experienced over their life course. In addition to being unable to access mental health services, the quality of the mental health treatments upon access can be substandard and/or inappropriate for dealing with the traumas and stressors experienced.

An unique aspect of our study is the use of the concept of trauma to understand homeless women's experiences. Whereas the pathological perspective found in much social scientific work labels and stigmatizes women's behaviours, trauma theory recasts behaviours as symptoms developed in response to stressful and traumatic life events. Using this framework, we can begin to see more clearly how a lack of available quality mental health services contributes to the inability of some women to overcome lingering emotional and psychological effects of trauma.

Another unique aspect of our study is that we went directly to the user population to generate data regarding mental health services available to homeless women. By interviewing homeless women directly, we heard firsthand experiences of their inabilities to access services, as well as about deficiencies in the services provided.

The study is not without limitations. One particular issue that trauma researchers must contend with is 'memory recall' – that is, respondents being unable to remember experiences in their pasts and/or intentionally blocking out experiences in an effort to deal with untreated trauma. Although we took active steps to ameliorate this problem by developing an approach that guided participants through experiences over their life course, we have to contend with the fact

that, despite our best efforts, reported rates of trauma may be lower due to under-reporting.

Second, a significant contributor to women's homelessness is domestic violence. In contacting service agencies, we experienced difficulties in accessing shelters that specifically accommodated victims of domestic violence. The main concern with conducting research at these facilities was confidentiality; immediately after filing complaints with police, the victims would seek shelter from their spouses. Although victims of domestic violence were represented in our sample, without the inclusion of domestic violence facilities, the reported rates are lower.

A final limitation of our study is that we limited our sample to include only homeless women who were utilizing the services of shelters. Thus, our sample excluded women who chose not to access service agency programs. Our justification for this decision was that our initial research interest was in access issues related to service provision, therefore we were seeking ought the experiences of existing service users. Had we not excluded non-service users from the sample, we may have encountered significantly higher rates of individuals with trauma, who had either had negative experiences with mental health services or refused to use such services.

Despite these limitations, this study clearly demonstrates that there is a need for greater access to quality mental health services for homeless women. We would also argue that there remains a pressing need for further empirical research in this area. Such future research should attempt to address some of the limitations we have identified, including gaining access to domestic violence shelters and to women who are not currently using community-based services. The most salient policy implication of such research is that it will create support for initiatives that not only increase access to mental health services for homeless women, but moreover increase the quality of care provided. In short, we need evidence that will help guide the

development of programs and policies to improve health outcomes for this highly marginalized section of the general population.

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