In a recent article on the state of victimology, Sandra Walklate (2011) noted the tendency of researchers to focus near-exclusively on maladaptive responses to criminal victimization. With some notable exceptions, issues such as resiliency and the capacity for crime victims to experience post-traumatic growth have received little scholarly notice (Ronel and Elisha 2011). The lack of scholarly attention to these issues has been particularly striking in relation to research on homeless adult women, one of the most vulnerable and highly victimized groups in society. In a search of the relevant research literature, we noted several hundred journal articles examining the negative effects of violent victimization on homeless females. By way of contrast, we could locate only three papers that dealt with homeless women's capacity for resiliency (Boes and van Wormer 1997; Humphreys 2003; Stump and Smith 2008), and no research articles exploring the ability of homeless women to experience post-traumatic growth following experiences of violent criminal victimization. Whether intentional or not, such gaps in the literature promote a view of homeless women as not only an inherently vulnerable group, but as one whose members are incapable of overcoming the adversity of victimization and exercising agency in positive ways. As Boes and van Wormer (1997: 408) note of the literature on female homelessness more generally, there is a "is a profound tilt toward the pathological," that we would argue is especially disconcerting when issues of victimization are raised.

Drawing on research conducted in Chicago and Detroit of homeless women's experiences of violent victimization, we present an alternative view that is rooted in their thoughts, beliefs and experiences. Through analysis of semi-structured interviews with sixty women, our data reveals the extent to which victimized homeless women exhibit signs of resiliency through both positive attitudes and coping behaviours. Their words also demonstrated support for the position that responses to violent victimization are dynamic and perhaps best

understood from a life course perspective (Rutter 1987). Intriguingly, we also found that while a majority of participants saw mental health programs as a desirable means of facilitating the process of overcoming trauma (Bogar and Hulse-Killacky 2006), such views were not universally held. Instead, it would appear that willingness to enter therapeutic programs to deal with issues related to violent victimization is a complex decision, rooted in how a woman understands and weighs what she perceives to be the personal costs and benefits of receiving counselling for victimization. As we argue in the conclusion of this paper, these findings have significant implications for the delivery of mental health services for victimized homeless women.

Resiliency: the often overlooked factor

Resiliency is generally understood as an individual's capacity to overcome significant adversity and hardship through positive modes of adaptation. Within the social scientific literature it has been conceptualized as a "combination of innate personality traits and environmental influences that serve to protect individuals from the harmful psychological effects of trauma or severe stress, enabling them to lead satisfying and productive lives" (Bogar and Hulse-Killacky 2006: 319). Some researchers have further suggested that we can delineate between three different forms of resiliency: as a positive outcome in the face of adversity; as continued positive functioning in ongoing adverse circumstances; or as recovery after significant trauma (Schoon 2006). Others note that not only is it possible to overcome trauma, but to also experience post-traumatic growth (PTG) (Tedeschi and Calhoun 1996). Such personal growth can range from small but meaningful attitudinal or behavioural shifts to profound life changes (ibid).

Studies consistently demonstrate that the confluence of various social/structural and personal factors can influence the degree to which an individual will be resilient in the face of significant life stressors (Bogar and Hulse-Killacky 2006; Schoon 2006; Valentine and Feinauer 1993). Such factors include having strong social support, good emotional and social skills, good problem solving skills, ego resilience, low neuroticism, optimism and spirituality (Valentine and Feinauer 1993). To be clear, though, the presence or absence of some or more of these factors is not an automatic guarantee an individual will be more or less insulated from the effects of trauma, as there are no universal protective factors (Rutter 1987). Instead, resiliency is an uniquely individual protective process, as demonstrated by the fact that what might serve one individual as a protective factor may be a risk factor for another. The ability to positively adapt to significant stressors also appears to be a context-dependent process: whereas an individual may be resilient in relation to one type of trauma, they may be less so in relation to another, or they may be resilient in relation to some outcomes but not others (Rutter 2007). Resiliency is also a dynamic process that can develop contingently, as individuals become exposed to various experiences that strengthen existing positive personal characteristics and/or lead to the development of new social ties (ibid).

While the literature on resiliency encompasses research on how individuals process a diverse range of traumatic events, in the sub-field of criminal victimization most researchers have focused on domestic violence and child sexual abuse. Of particular interest is Ratican's (1992) statement, based on clinical observation, that she could find no correlation between the severity of sexual abuse reported and her clients' degree of psychological impairment. The lack of a direct cause and effect between abuse severity and trauma severity is attributed to the mediating presence of social supports and internal resources (ibid.). Similarly, in their study of

resiliency among adult female survivors of childhood sexual abuse, Valentine and Feinauer (1993) identified six factors that they saw as important in explaining how internal and structural factors mediate the impact of sexual abuse on the development of trauma symptoms. These factors include: emotional support outside the family; healthy self-esteem; spirituality; external rather than internal attributions of blame; having an internal locus of control, and; possessing a positive attitude (ibid). The dynamic nature of individual responses to abuse was also highlighted by the fact that some of the research participants in this study shifted their perceptions of the abuse over time, coming to accept that the abuse was not their fault and that they could successfully move on (ibid). In a more recent study of resiliency among adult survivors of childhood sexual abuse, Bogar and Hulse-Killacky (2006) found that the research participants they identified as 'resilient' had adopted a number of cognitive and behavioural coping strategies – from praying to depersonalizing to pursuing education or becoming involved in family or community – that helped them maintain a sense of having overcome histories of abuse.

Although we are beginning to develop a better understanding of how some individuals can successfully overcome – indeed, grow from – experiences of violent victimization, to date none of this work has focused on one of the most heavily victimized groups in society: homeless women (Evans and Forsyth 2004; Weseley and Wright 2009). We know from Boes and van Wormer (1997)'s descriptive study of the lives of two homeless women encountered in an Emergency Room setting that such individuals have inner-strengths that allow them to persevere in adverse settings. We also know from Stump and Smith's 2008 study of the capacity of homeless women to experience post-traumatic growth following multiple traumas that women without a wide network of social supports can and do survive by calling upon internal resources. Indeed, they found that individuals within their sample of fifty women experienced levels of

growth "comparable to those found in samples with less trauma exposure" – that is, some of the women in their study were *more* resilient than individuals in groups we would expect to have greater access to various forms of social support (ibid: 478). Similarly, Humphrey's (2003) study of women residing in a San Francisco area shelter for victims of domestic violence, found that while research participants had suffered significant psychological distress, they also demonstrated higher levels of resilience than other groups, including individuals in public housing and Alzheimer's caregivers (ibid). As intriguing as these results are, it is important to note that two of these studies did not look specifically at violent victimization and, in particular, the capacity of homeless women to be resilient in the face of one or more experiences of violence in their lifetime.

In the present study, we draw on interviews with homeless women about violent criminal victimization and their attitudes towards accessing various forms of post-victimization assistance – in particular, mental health counselling – in order to reveal the extent to which victimized homeless women exhibit signs of resiliency. Further, we draw on their expressed attitudes to develop a complex portrait of the relationships between the resiliency of the women interviewed and their desire for mental health services to overcome the negative effects of violent victimization.

Method of inquiry

This paper is informed by an analysis of data drawn from an ongoing study of barriers to three modes of service provision that criminally victimized homeless women are often unable to access post-victimization: policing, medical and mental health services. To explore these issues, we conducted one hundred and one in-depth semi-structured qualitative interviews with seventy-nine homeless women and twenty-two community service providers in Detroit and Chicago.

To locate potential research participants, we developed a non-probability sample consisting of the maximum number of service providers who 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 total, thirteen community organizations[1] (six in Detroit and seven in Chicago) agreed to participate.

Table 1: Sample characteristics

Demographic information	Detroit	Chicago	Total n
Ethnicity			
African America	20	29	49
Caucasian	3	3	6
Latina		3	3
Native American		1	1
Pacific Islander		1	1
Totals per city	23	37	60
Age			
18-30	11	10	21
31-45	5	13	18
46-70	7	14	21
Totals per city	23	37	60
Length of homelessness			
1 day to 29 days	4	6	10
1-6 months	7	9	16
6 months to 1 year	5	5	10
1 year to 3 years	2	4	6
Over 3 years	5	13	18
Totals per city	23	37	60

Of the seventy-nine women interviewed, sixty reported experiences of violent criminal victimization. It is these sixty interviews that we draw upon in the present study. The women represented here were predominantly African-American; however, our sample also included

[1] Except for one organization providing homelessness outreach services, each of the participating community organizations were shelter-based, although several also provided more comprehensive services, including transitioning clients to permanent housing, medical and counselling services.

Caucasian, Latina, Native American and Pacific Islander women. The youngest woman interviewed was eighteen and the oldest was seventy. The women we met had a diverse range of experiences of homelessness. One young woman had been homeless for one week, whereas another woman had been homeless for the better part of twenty years. Several women reported having experienced multiple periods of homelessness.

This phase of the project was conducted in two stages. In the first stage, we conducted preliminary interviews, using an interview guide consisting of five main areas of research interest: **a**) basic demographic information; **b)** experiences of victimization over the life course; **c**) experiences of, or attitudes toward seeking assistance from i) police, ii) medical staff and iii) mental health services; **d**) views as to facilitators and barriers to accessing services post-victimization, and; **e)** recommendations for future programs, policies and/or services. These preliminary interviews were each recorded and then subsequently transcribed and coded. To code the interviews, we used open coding – that is, data was analyzed thematically, with particular attention paid to how emergent themes addressed the research questions posed. To assist in the development of a list of appropriate themes, the research team relied on research notes taken during each interview. During debriefing sessions, team members also compared notes and developed both new lines of questions and new themes, as potentially interesting areas of inquiry developed. In the second stage of coding, focused coding was employed; members of the research team manually coded transcripts through line by line readings in order to solidify themes selected and identify subthemes.

Drawing on the themes that emerged during our initial phase of research, for the second stage of this study we created a set of interview checklists to guide our questions and to enable us to conduct preliminary coding of answers. Checklist responses were subsequently compared to

the answers that emerged through the focused coding that was conducted after the interviews were transcribed. In order to ensure inter-rater reliability, coding of transcriptions was independently verified by another team member.

Experiences of violent victimization

> "I have a baby on the way. I was molested. I was raped, actually. That's how I got him"
> – young pregnant woman, Detroit.

In each of the interviews we conducted for this study, we asked female research participants a series of questions about their experiences of criminal victimization. Our questions covered both violent and non-violent forms of victimization over one's life course, ranging from petty theft to serious violent offenses such as sexual assault and attempted murder. As we were aware that simply asking 'have you ever been sexually assaulted?' might not lead to disclosures of victimization for a variety of reasons, if we received negative responses, we made a point later in the interview to confirm those responses. In several instances, after we had built rapport with participants, previously negative responses changed and individuals became more forthcoming about episodes of violent victimization.

Table 2. Types of violent victimization reported

Forms of victimization	**n**
Adult	
Physical assault (intimate partner)	36
Sexual assault	28
Physical assault (non-intimate partner)	24
Robbery	18
Attempted murder	3
Childhood/adolescence	
Child abuse – physical	28
Child abuse – sexual	25
Gang-related violence	13

In analyzing our interview data, we found that the women had reported, in total, eight different forms of violent victimization they had experienced over their life course. In keeping

with similar other studies (Tischler, Rademeyer and Vostanis 2007), the most frequently reported form of victimization was physical assault by an intimate partner. Indeed, several of the women we met were homeless after fleeing abusive domestic situations. For other women in our sample, though, intimate partner violence was only one of several experiences of different forms of abuse in lives marked by violence. For instance, after relating a childhood of abuse and gang violence, a middle aged woman in Chicago said simply of her marriage in adulthood, “there was beatings.” Similarly, when we asked a middle aged woman in Detroit if she would ever report the sexual violence she had experienced on the streets to a police officer, she responded negatively. When then asked whether the possibility of having to deal with a male police officer was a consideration, her response introduced previously undisclosed experiences of intimate partner violence. “It’s a shameful thing that happened. My husband hit me.”

Previous research has also shown that homeless women are frequently the victims of sexual violence (Evans and Forsyth 2004), thus it was of little surprise to find that occurrences of sexual assault were also high in this group, with sexual assault by an acquaintance being the from most frequently reported. For instance, a Latina woman in Chicago related the following experience: “It happened 3 years ago and ... I was drinking with this guy and ... I know him. I didn’t want to be with him. So, anyways, I don’t know what happened. He got me drunk. And he had sex with me.” A young African-American woman in Chicago revealed that she had been sexually assaulted by a family member of her deceased husband: “this man grabs me and takes me under the porch on one of the buildings and raped me.” Some women reported multiple episodes of sexual assault, as was the case with an older woman in Detroit with a long history of homelessness. In response to the question ‘have you ever been sexually assaulted?’ she answered:

A: An attempted rape. I was actually raped once and an attempted the second time out there. It wasn't in Michigan, it was in Florida.

Q: How many times have you been sexually assaulted?

A: Altogether you mean? It's been several times.

Homeless women who have been sexually abused as children have been found to be at increased risk of sexual victimization as adults (Hudson, Wright, Bhattacharya and Sinha 2010). In our sample, we encountered fourteen women who reported both forms of victimization.

Of the women in this study, twenty-four reported experiences of physical assault in adulthood, usually by strangers, although occasionally by acquaintances or family members. One middle-aged woman in Detroit reported being randomly attacked by another shelter client. Her assailant struck her in the face hard. When asked if this was an unusual event, she replied, "I've had people try to attack me. Once somebody bit me in the arm and I was in the hospital." Another woman stated that it was not unusual when she was sleeping outside or panhandling to have random strangers throw things at her. For others, violence was connected to previous experience in the sex trade, or disputes with adult family members.

For forms of victimization experienced during adulthood, we obtained the lowest reporting rates for robbery and attempted murder. Eighteen of the women reported having been robbed. One young woman stated that she wasn't immediately aware of what was happening when a man flashed a knife and grabbed her purse, because she was listening to loud music. Another woman was robbed while she was out with her children. In this case, the assailants used physical force. As she described the scene, "All my kids were crying. I had blood on me. I was pregnant." When we asked if this was her only experience of robbery, she responded, "Nooo! [laughs]. I wish it was. I've been robbed a few times. Jumped." Three women reported incidents

of attempted murder. These reports included incidents involving domestic violence situations in which a partner or former partner brandished a gun or attempted to choke the woman to death.

We also asked about violent victimization experienced during childhood and adolescence. In total we received twenty-eight reports of physical abuse and twenty-five of sexual abuse. When we examined the data more closely we found that altogether thirty-seven of the women had reported histories of childhood abuse. Among these women, was a young African-American woman in Chicago who simply stated, “It’s like I had some very traumatic experiences during my childhood with emotional and psychological abuse, physical abuse and stuff.” A woman in Chicago with a history of severe family violence began recounting her history as follows: “I was raped by the time I was three. Sorry, five. Five. When my Dad was in the house.” She then went onto detail how her father “whupped me. Busted my skin.”

Twelve of the women cited adolescent histories that included gang violence. One was a young woman in Detroit, who initially responded negatively to queries about victimization. When she was asked again later in the interview about the violence she had been exposed to in her life, she began to open up: “Abuse, gang violence, fights and all that.” A woman in Chicago who had grown up in a violent family environment reported that “at 12 years old, I was associated … it’s just something that happens.” She then went on to provide several examples of gang-related violent victimization, including having had guns pulled on her, being threatened by rival gang members and experiences of sexual assault. “I used to hang with the gangbangers,” she explained, “I was not gang. They raped me.”

It is worth noting that fourty-eight of the women represented here reported multiple instances of violent victimization. One young woman, who had been homeless for approximately two years, explained her experiences as follows: “While I’ve been homeless, I’ve been raped.

I've had my stuff stolen. I've had guys hit me. I've had people throw things at me just because I'm homeless." Given the fact that most of these women sought to overcome the effects of the victimization and other adversities they had faced, as is discussed in the following section, the extent to which most had been violently victimized is, we feel, significant.

Resiliency after violence

"I still got a long road ahead of me, but ... yeah, I'm stepping up there"
– Latina woman who had been sexually assaulted.

In order to better understand the extent to which our informants exhibit resiliency, we initially asked women in our study about how they saw themselves and their ability to function in the world immediately after their victimization and since, as well as the extent to which they felt they had overcome their experience(s). In response, the words women used most often to describe themselves as resilient were variations of 'strength.' For example, describing how she was dealing with the trauma from her past, a woman who had fled an abusive husband stated, "I feel like I have to be strong." She felt that, in her case, early experiences of adversity and her family's response to it had conditioned her to accept and believe that she could overcome hardship through personal strength: "I lost my parents when I was young. So I've always heard, 'You're the oldest. You've got to be strong.'" When we asked a young African-American woman in Chicago about how she had dealt with sexual assault and other traumatic experiences, she stated with pride that she had gone through such things "and I still kept my head up strong." As a result, in subsequently coding their responses, we looked for words and phrases such as 'strong', 'moving on,' 'getting over it,' as well as indications that women were taking positive steps to put victimization behind them, such as pursuing positive personal and/or employment-related goals. Throughout this paper we treat these variations of 'strong' as denoting resiliency when discussing our study participants and their views.

In the second stage of this phase of the study, we asked women directly if, after everything they had been through, they see themselves as 'strong' (indicating that we meant strength in terms of resiliency). In those situations where an individual replied in the negative, we then asked if they saw themselves as 'vulnerable' because of their victimization and its effects, or some mixture of 'strong' and 'vulnerable,' and then created space for the women to elaborate upon their answers. As with the first stage of this portion of the study, the majority of the women self-identified as 'strong', seeing themselves as either having overcome the effects of violent victimization and other adversities or as being in the process of doing so.

Table 3. Resiliency self-identification

	n	**%**
'Strong' (resilient)	52	
'Vulnerable'	6	
Both strong and vulnerable	2	

In total, fifty-two of the sixty women in this study saw themselves as resilient and/or as having become more resilient following their experience(s) of violent victimization. For instance, a pregnant 19 year old victim of sexual assault, with a history of child abuse resulting in placement in the foster care system, said of herself, "I'm a strong person." Speaking of her history of abuse, she noted, "it made me a stronger person." She was comfortable referencing that history because, "in the end, it make me stronger talking about it. You become something more than an assault victim."

Feelings of resiliency (personal 'strength') were often illustrated with specific examples, or through discussions of positive coping strategies and/or personal goals adopted. One such example is provided in the words of a 36 year old African American woman who had survived childhood physical abuse and adult domestic violence. When asked if she sees herself as a resilient person (as 'strong'), she replied, "I do considering where I've been and came from,

yeah. I have a friend that's my support system. He gets me through like everything. I have two other ones. They get me through everything that I'm going through. They make me so strong today."

In contrast, feelings of vulnerability were expressed by six of the respondents, such as the woman who stated that the lingering effects of her trauma and subsequent experiences with substance abuse, had made her feel "shame" because she had seen herself as "so different from everybody else." A woman in Detroit, who was battling major depression and had made multiple suicide attempts, similarly said that she did not see herself as strong. When asked how it was that she was able to continue functioning in her daily life, she replied, "I didn't want my kids growing up saying my momma didn't love me enough, she killed herself. That's what kept me here." Another woman with a history of physical abuse felt weak and vulnerable because she was dealing with ongoing mental health issues that caused her to leave her home state. "When am I gonna stop running?" she asked, "when I am going to learn to fight?"

As individuals often express contradictory self-perceptions, we were not surprised to discover that two participants saw themselves as strong and resilient in some ways, but as vulnerable or weak in others, or as fluctuating between the two conditions based on internal or external factors. One of these women was a 29 year old who had been homeless for a few months. She said of herself, "I feel that I'm very strong, especially to deal with the things that go on." However, she subsequently added, "I know that here lately, I've been feeling a little weak. Just the littlest things gets to me and I feel that there's no hope." Similarly, a 24 year old Chicago women stated, "I don't think I'm a weak person, but I know that there's many times where I feel weak."

In analyzing our interview data it became immediately apparent that despite one's personal qualities or level of social support, overcoming the adverse effects of violent victimization is a *complex process* that occurs over varying degrees of time. Most women related that they found it difficult, if not impossible, to process or discuss their victimization with others immediately after the experience. One of the most positive, outgoing women in our sample summed her attitude towards life as: "I'm going to tell you what's good about my day … and make you smile." In speaking of the immediate aftermath of a sexual assault, she noted that she was unable to tell anyone. This open, friendly person explained, "Once that happened, I shut down for a little while." Similarly, one of the toughest women we encountered during this study – an individual with a history that included time in street gangs and in prisons – similarly revealed that for a long time she was unable to articulate to anyone what had happened to her as a child and young adult:

> Q: Do you think that if 30 or 40 years ago if you would've sat down with somebody and just got this stuff off your chest, been able to talk about it ... [the woman starts to cry] could you even talk about it?
>
> A: [shakes her head 'no'].
>
> Q: You couldn't even talk about it? It was too deep?
>
> A: [continues crying] Yes.

As with the woman quoted immediately above, we found that women with the capacity for resiliency also experience variable periods where the signs of trauma and resilience are co-present in their lives (see also Ronel and Elisha 2011). "A lot of the time I tend to be cryin' a lot," said a young women with a history of sexual abuse, "but what is the point of bein' cryin', you know?" This latter sentiment was shared by several other women who, like this young woman, were grappling with the effects of trauma while seeking to move beyond their

victimization. Another young woman who perceives herself to be largely successful in placing her victimization firmly in the past said that, occasionally, emotions engendered by her victimization “will bubble up.” As she explained, “I’ve had my moments where it’ll be something stupid that happens and I’ll start getting really pissed off or I’ll start crying … it just happens.” Similarly, a woman who survived childhood abuse says, “it used to eat me up, really, really bad. But now it’s not as bad.” However, she also admitted that, “I still get a little emotional about it.” A woman in Detroit who had been a gang member at the age of ten explained her process as follows: “you don’t ‘get over’ ... you work through it. When you work through something, there’s steps to it.”

Sources of resiliency

We asked the women in our study to what factors they attributed their resiliency (‘strength’). The majority stated that they saw themselves as positive people with an optimistic outlook that helps carry them through adversity. As a 43 year old woman we met in a Detroit shelter explained of herself, “I’m a good morning person … I’m grateful that I woke up this morning and I’m not where I was. I feel like my worries are few because I woke up this morning.”

As in other studies of resiliency (Valentine and Feinauer 1993), several of the women cited positive social relations with other homeless women or staff members in their shelter as a major source of support in dealing with the effects of their victimization. One woman described the support she receives from her friends in the shelter in the following terms: “Most of us that’s in the shelter have the same problems. So, might as well talk about it with them. We [are] like a little family.”

Others stated that spirituality helps them a great deal. “I pray a lot,” an African-American woman in Chicago said, “I ask God to remove those things that I have no control over.” A woman in Detroit with a history of gang violence, explained that her spiritual faith helps her to envision a positive future: “I see myself in a house. And I know all I endured to get there. I already picked out my colour. I already know what I want my living room and dining room to look like … this is just a test, that’s the spiritual part of me.”

For still other women, being actively engaged in physical or mental activities outside of the shelter helps them cope with both residual issues from the past, as well as present stressors associated with being homeless and/or shelter living. One woman we met in Chicago lifts weights, and another takes her dog (who lives nearby with a sister) for daily walks. A middle-aged Native American woman advised that she likes to “go for long walks over out at the beach” or to “go and sit in the library and pick up a book and start reading … and get lost in it.”

Self-blame and feelings of responsibility over one’s victimization are often significant sources of distress faced by victims of sexual assault (Breitenbecher 2006; Ullman and Filipas 2006; Ullman 1996). In the case of some of the women we met who self-identified as ‘strong’, their ability to be resilient was aided by the fact that they recognized what was done to them was not their fault. For example, in speaking of the childhood sexual abuse she suffered, an African American woman in Detroit noted that she was unwilling to accept blame or responsibility for what happened to her, stating that this attitude helped her deal with the trauma that the abuse engendered. As she said, “I never thought that it was my fault.” A women in another Chicago shelter, who had herself been the victim of intimate partner violence as an adult and sexual abuse as a child, similarly refused to accept responsibility for the victimization: It’s not mine, so you can have it.”

The majority of interviewees also attributed some or all of their resiliency to their development of cognitive coping strategies that allowed them to compartmentalize their feelings, and thus to mentally and emotionally distance themselves from their victimization. Most of the women described such strategies using terms such as ‘moving on’ or ‘letting go.’ For example, one woman stated that to deal with the violence in her past, she made a conscious decision to “let it go, otherwise it will kill me.” A woman in Chicago had so completely distanced herself from thoughts of her experience of sexual assault that when we initially asked her if she’d ever been sexually victimized, her first response was negative. She then contradicted herself, acknowledging that “it don’t bother me like that because I like put it in the back of my head.” Another interviewee acknowledged that she actively compartmentalizes her experiences of victimization: “I cannot think about any negatives … I know there’s no one else I can push it off on. If I think of everything’s that happened, it’s not gonna do me any good to get depressed. It’s just gonna drive me down.” For this young woman, it is important to “do what I need to do” in order to “get my life together.” In instances where this strategy was cited, we learned that the distance provided through compartmentalization allowed a woman to gain new perspective on her experience and its aftermath. Rather than staying rooted in the trauma of the victimization, women who spoke about compartmentalization – as the previous quote demonstrates – tended to see it as a tool to help them in the pursuit of their life goals. “I trained myself so that if something happened, I will leave it, let it go and move on,” said a young woman in Detroit, “since then when something bad happened to me I kinda let it go and move on.” For her, this strategy is critical because, as she said of herself, “You gotta future to look to.’”

The desire to overcome the trauma of violence (to ‘let it go’) is often closely associated with dreams of a positive future. Indeed, the majority of women in our sample held positive

personal aspirations and/or were taking steps to make their dreams a reality. Some of their stated goals were small and personal, such as the desire of a middle-aged woman in Detroit to visit her relatives in Canada. Another woman wanted to repair her family, and so while at the shelter, she and her husband were attending various programs to gain sobriety and regain custody of their children. A middle-aged woman we met in Chicago with the history of family, gang and domestic violence, was released from prison with a singular desire to rebuild her relationship with her sons, with whom she was now in contact. Other dreams involved fresh starts through employment or education. For example, a couple of the women spoke of plans they had made to begin over in new cities or states. One woman in Chicago explained how she was overcoming the negativity and hardship in her past as follows: "I haven't been a very nice person all my life. God may be punishing me. I'm comin' back. I'm goin' to school!" She was not alone; a number of the women in our study were either attending school or planning on beginning courses. A young victim of domestic violence was attending law school, while another young woman who had been forced into sex work was finishing her last year of high school in order to "transfer to either Wayne State or UCLA or any southern Baptist college for psychology." Some of the aspirations shared involved other potentially life-changing courses, as in the cases of the two young women in Detroit who told us they wanted to enter the navy and the air force respectively, to learn occupational skills, develop personal resources and see the world.

Attitudes toward mental health counselling

> [To a question about receiving counselling to deal with violent victimization] "It all depends on the person. It all depends on how willing they are to think about it"
> – African-American woman in Chicago.

It is somewhat axiomatic to view mental health services as a desirable, if not necessary, component of an effective treatment plan for dealing with the effects of violent victimization and

other traumatic experiences (Bogar and Hulse-Killacky 2006). Thus, initially, we expected to find that resilient women would generally hold positive attitudes towards mental health services and thus be more willing to attend therapeutic-oriented programs, as part of a process of 'active healing' (ibid). While this was largely the case, what we discovered was a more nuanced, diverse set of responses towards the use of mental health services. These findings were reflective of the fact that the women interviewed tended tend to differentially weigh the costs and benefits of counselling, assessing whether therapeutic services would meet their individual needs (also see Finfgeld-Connett (2010) for discussion of women's assessments of services).

In relation to views of mental health counselling, we began by asking each woman if she had previously attended a mental health counselling program[2] to deal with the victimization and/or was currently utilizing professional mental health services. Such services include both individual counselling sessions with a trained therapist, as well as group therapy programs.

Table 4. Use of counselling services

Category of usage	Resilient (n)	Vulnerable (n)	Both (n)	Total (n)
Currently in counselling	9			9
Currently in counselling and have received counselling previously	6	3		9
Received counselling previously only	18		1	19
No counselling ever received	19	3	1	23
	52	6	2	60

We found that eighteen of the women were currently in counselling, mostly as a result of mandatory counselling programs at their shelter or because they had specifically sought out services that were not offered to them at their shelter. Nine of those individuals currently in

[2] This included both one-on-one counselling sessions and group therapy.

counselling, had also previously received counselling services. A further nineteen women had received counselling previously, but were not currently enrolled in individual or group therapy programs. And, despite having often extensive histories of childhood abuse and experiences of adult violence, twenty-three of the women in this sample stated that they had not received or sought mental health services of any kind.

Table 5. Attitudes towards counselling services

Category of usage	Resilient (n)	Vulnerable (n)	Both (n)	Total (n)
Counselling seen as useful	33	4	2	39
Counselling seen as not useful	12	2		14
Mixed views	7			7
	52	6	2	60

As per our central research questions, we asked participants about their experiences and attitudes toward using mental health services. In the majority of cases our assumption was borne out and women who self-identified as strong or resilient did hold favourable attitudes towards the use of mental health services. For example, one of the women interviewed, who is herself dealing with the effects of intimate partner violence without support, felt that counselling would be a good option for her because victimization-related issues “may hit you at different moments, it would be nice just to have somebody there to talk with, to get it out.” A woman in Chicago, who had sought treatment for major depression after leaving an abusive partner, stated repeatedly that she views herself as a strong woman and that being strong is not antithetical to seeking assistance when it’s needed. The Latina woman who had been sexually assaulted said of her counselling sessions, “I’m dealing with the stuff that I do know now and hopefully it brings out some more stuff so that I don’t hide it in the back of my head, so that it don’t come out later and hit me in the face.” Another young woman from Chicago stated that her visits with her therapist

are beneficial to aiding her growth process: “I do talk about things that’s going on with me because if I do hold it in, I have resentments. I left everything out, resentments and anger and all types of stuff within me. 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].” She added, “as long as I got it out of me, I’m free.”

Four of the women who self-identified as ‘vulnerable’ saw counselling as potentially useful for helping them to resolve issues arising from past experiences of violence. Among this small groups is a woman who said of herself, “I need help and I know I need help. Why won't nobody listen to me? What do they want me to do? Hurt myself or hurt somebody else before they listen to me?”

Similarly, both of the women who self-identified as simultaneously ‘resilient’ and ‘vulnerable’ were of the view that mental health programs are beneficial to recovering from violent victimization. Indeed, one the women stated that she felt that lack of counselling services was a significant hindrance to her ability to overcome past victimization. What she wanted she said, was “just want one person. My own person that I could really, really talk to”, a counsellor to help her “get put on that balanced path, so that I can go forward and stop looking back.”

Positive views of the merits of counselling were not, however, universally held. In fact, one third of the women either saw counselling as not being useful or held, at best, mixed views as to the utility of such services. This finding was particularly the case for resilient women, several of whom felt that counselling would entail costs that would not outweigh any potential benefits. In particular, these women felt that the process of reliving their experiences of violent victimization in a therapeutic setting would hinder any progress they had made on their own in putting their victimization behind them. A pregnant, young woman in Detroit exemplified this

view: “For some people that type of method do work. Young girls they just want to take their mind off it. They want it to be over with.” A woman in Chicago explicitly stated that she sees therapy as potentially side tracking her from continued progress in overcoming her victimization. Of counselling she said, “I myself wasn’t willing because I was thinking, ‘why think about it? Why let it back in my brain?’ … I’d have to go there again … You’re not going to really concentrate on anything else. I myself am trying to concentrate on exactly what I have to do, nothing else.” As counselling can be a mandated part of a program offered by a community service provider, and thus inescapable, some of the women stated that they actively thwart the process by refusing to disclose their victimization and/or avoiding discussions of other things in their lives that they see as ‘bringing up the past.’ One young woman openly resented her shelter’s mandated counselling, “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. Just sit there and keep telling them about it. Thinking about it. It’s just going to sit on your brain.” In counselling sessions, she spends as little time as possible answering her counsellor’s questions, using various verbal tactics to avoid answering any questions she doesn’t wish to answer, and pointedly watching the clock.

Not surprisingly, given that the women in our sample had frequently experienced multiple instances of violent victimization, the issue of trust and the negative costs of trusting strangers with one’s intimate details was a recurring theme in some of our interviews. To facilitate the use of mental health services, one of the shelters we visited has both a psychiatrist come once a month for individual counselling sessions and arranges weekly transportation to a nearby clinic for group therapy. However, as one long time shelter resident noted of other residents, a lot of them refuse to attend counselling because they “are afraid to really open up.” A woman in Detroit similarly referenced trust issues, in particular the concern that a psychiatrist

will reveal a client's personal information. As she explained, "psychiatrist's got a friend. She might not mention no names, because she knows the laws, but ..."

Yet other resilient women stated that they saw themselves as having more or less put past violence behind them and felt they had no need for counselling services to deal with any related issues. We note that their expressed views were often self-contradictory. For example, a thirty-nine year old woman in Chicago diagnosed with clinical depression emphatically stated that she would not want mental health counselling services because she had put her experiences of childhood physical and sexual abuse behind her. However, when asked at another point in the interview if she felt that she was "over her abuse" and its symptoms, she acknowledged, "I wouldn't say I'm over it, but I don't think about it. I just don't think about it at all." Still other participants revealed that they attend counselling services and share various aspects of their life with their counsellor, they did not see any personal or social utility in discussing their victimization. The most notable example is the woman in Chicago who spent an hour with one of the researchers revealing intimate details of multiple horrific experiences of victimization. When she was asked how much of her past, if any, she shares with her therapist, she replied, "[whispers] I never talk. My past life ... my psychologist, I wouldn't tell her the things I told you because she's in a therapeutic situation." When clarification was sought as to what she meant, she advised that our research could help others, whereas she didn't see any point in rehashing her history for a therapeutic goal, when she already begun to make peace with that history. This was not an uncommon response, several of the women currently receiving counseling – including some who thought counselling was helpful – acknowledged that they had not disclosed past victimization to their therapist/counsellor for similar reasons.

Lastly, in relation to the seven women who had mixed views as to the utility of mental counselling programs, we note the fact that each woman in this group had had experience with counselling programs – either currently and/or in the past. Thus, their ambivalence was based on personal experience. In analyzing their interviews it appears that while therapeutic benefits were derived from the experience of talking out their problems, these women felt the therapy they were receiving was not getting to the root of their issues and thus was of limited use.

Meeting women where they're at

> "I'mma put it to you like this. For me, I could get distressed because Keebler didn't put enough chips in the chocolate chip cookies. I could, because that's my thing. I like the chocolate chips. For other people … [shrugs]"
> – 43 year old woman in Detroit.

The purpose of this paper was to explore resiliency among homeless women who have been victims of violence. Our data reveals that *contra* the image of the pathological victim found within social scientific accounts, the majority of homeless women we interviewed expressed resilient attitudes and behaviours and were in various stages of attempting to overcome their victimization and its adverse effects. We also found support for the position that resiliency is a dynamic process that varies by individual and can co-occur with symptoms of trauma (Rutter 1987). Further, we observed that perceptions of the utility of therapeutic counselling in aiding the process of overcoming trauma vary. For many women of the women sampled, counselling is clearly seen as a welcome positive step towards overcoming victimization; however, our data suggests that we ought not to assume that this is the case for all. One third of the women interviewed saw mental health counselling services as not useful or as being, at best, of limited use. For some women, particularly those processing pain that is perhaps still too fresh or deep, counselling was actually seen as a potential impediment to their ability to 'get on' with life and recovery. Others felt that they had already successfully overcome their victimization and so are

less inclined toward counselling services and in some cases exhibited resentment over forced participation in mandatory counselling programs.

We note that the present study is not without limitations. Although efforts were made to address issues related to disclosure, one important potential limitation we have to consider is the possibility that levels of victimization reported do not accurately reflect research participants' actual experience – that is, our report rates may be lower because of participants' unwillingness to disclose victimization. Thus, the actual number of victimized women in our original sample may have been higher than sixty. Future researchers in this area need to be sensitive to disclosure issues and to take active steps to minimize them. Further, our study sampled women who are utilizing services, and thus excluded women who are on the streets and do not access community resources. Our justification for focusing on the former was that our initial research interest was in service access issues and thus we sought the views of those already accessing services. Had we not excluded women who do not currently access services, our sample would perhaps have generated higher rates of victimization and fewer resilient women. Regardless, our results clearly indicate the need for broader study of resiliency and trauma across more diverse groups of homeless women.

Why is further study necessary? As our own research demonstrates, there is a complex inter-relationship among individual and social factors in both the process of overcoming victimization and its effects, as well as in influencing women's attitudes towards counselling services. Continuing research in this area has significant implications for the effective delivery of mental health services. Through improved understanding of the factors that encourage resiliency, we can create mental health programs that better capitalize on homeless women's strengths rather than simply emphasizing their vulnerabilities (Ingram et al. 1996). Further, improved

understanding of resiliency processes would aid in the development of a therapeutic perspective that recognizes that women's paths post-victimization are unique and dynamic, so that programs can be tailored appropriately. In short, we will be doing a better job of helping to empower women, rather than treating them as weak and pathological.

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