Homelessness and Intimate Partner Violence: Women’s Barriers and Experiences With Accessing Formal Support Services and the Impact of Their Intersecting Identities

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Homelessness and Intimate Partner Violence: Women’s Barriers and Experiences With Accessing Formal Support Services and the Impact of Their Intersecting Identities

by

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May 15, 2023
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ABSTRACT

Women experiencing homelessness and intimate partner violence (IPV) can endure many hardships, including a lack of shelter and necessities, financial issues, unemployment, and physical and mental illnesses (Acosta & Toro, 2000; Hwang, 2001; Ponce et al., 2014). Despite these adversities, many women experiencing homelessness and IPV do not use formal support services due to factors related to finances, inaccessibility, controlling partners, and stigma, among other factors (Campbell et al., 2015; Fugate et al., 2005; Narendorf, 2017). The current literature lacks studies that examine the formal service experiences of women who have undergone both homelessness and IPV the potential barriers they face. Therefore, the current study used a qualitative-dominant design and explored the formal service needs of these women, the barriers and facilitating factors associated with accessing services for needs related to both IPV and homelessness, and how the women’s social positionings affected their experiences with these services. Interviews with 10 participants were conducted, and a reflexive thematic analysis was employed using a critical feminist and intersectionality lens. The most common factor that led to their current living situation was conflict and precarious circumstances leading to housing instability. The most common barriers were system, psychological, dismissal, minimization, and financial barriers. The most common needs for this group of women were health, employment, finances, and the foundations to survive (e.g., home and necessities). The most common facilitating factors were having a support network and signs of resilience, growth, and proactivity. Finally, the social positionings most commonly affecting their experiences were class and race and ethnicity. The findings of this study will be turned into a report for formal support services in Windsor and potentially used to improve services available for this population of women
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# TABLE OF CONTENTS

DECLARATION OF ORIGINALITY ........................................................................ iii

ABSTRACT ........................................................................................................ iv

ACKNOWLEDGEMENTS .................................................................................. v

LIST OF FIGURES ............................................................................................ x

LIST OF APPENDICES .................................................................................... xi

LIST OF ABBREVIATIONS/SYMBOLS ............................................................... xii

CHAPTER 1: Introduction ................................................................................... 1

  Health and Homelessness ............................................................................. 1

  Barriers to Services ...................................................................................... 2

  Barriers and Formal Support Services ......................................................... 3

  General Barriers to Accessing Services ....................................................... 4

  Women and Intimate Partner Violence (IPV) ................................................. 6

    Types of Violence ....................................................................................... 7

    IPV and Well-Being .................................................................................. 10

  Barriers for Women Experiencing IPV ....................................................... 10

  Formal Support Service Use Experiences ................................................... 13

  The Severity of IPV and Help-Seeking ......................................................... 15

  The COVID-19 Pandemic ............................................................................ 16

  Theoretical Models ...................................................................................... 18

    Feminist Theories ...................................................................................... 18
Limitations ...................................................................................................................... 84
Implications and Future Directions ............................................................................ 86
Conclusion ...................................................................................................................... 89

REFERENCES ............................................................................................................... 90

APPENDICES .............................................................................................................. 113
Appendix A: Experiences of Domestic Violence Scale ............................................. 113
Appendix B: Demographics Survey ............................................................................ 114
Appendix C: Intimate Partner Violence Strategies Index ........................................ 116
Appendix D: Interview Guide ...................................................................................... 118
Appendix E: IPV Introduction Video ......................................................................... 122
Appendix F: Recruitment Script .................................................................................. 123
Appendix G: Recruitment Sign-up Sheet ................................................................... 125
Appendix H: Consent Form ......................................................................................... 126
Appendix I: Protocol for Duty to Report .................................................................. 130
Appendix J: Letter of Information .............................................................................. 131
Appendix K: Interviewer Resource List ..................................................................... 133
VITA AUCTORIS .......................................................................................................... 134
LIST OF FIGURES

Table 1. Demographic Characteristics of Sample………………………………………………..49
LIST OF APPENDICES

Appendix A *Experience of Domestic Violence Scale*

Appendix B *Demographics Questionnaire*

Appendix C *Intimate Partner Violence Strategies Index*

Appendix D *Interview Guide*

Appendix E *IPV Introduction Video*

Appendix F *Recruitment Script*

Appendix G *Recruitment Sign-up Sheet*

Appendix H *Consent Form*

Appendix I *Protocol for Duty to Report*

Appendix J *Letter of Information*

Appendix K *Interviewer Resource Sheet*
LIST OF ABBREVIATIONS/SYMBOLS

IPV = Intimate Partner Violence
SES = Socioeconomic Status
CHAPTER 1

Introduction

Health and Homelessness

In Canada, it has been found that more than 235,000 individuals experience homelessness within a given year (Gaetz et al., 2016). Specifically, in Windsor, Ontario, the number of homeless individuals can climb to approximately 201 in a single night (City of Windsor, 2016). Typically, this subgroup of individuals faces a multitude of adversities, especially regarding their mental and physical well-being. For example, mental health disorders are more likely to occur in individuals with lower SES (e.g., anxiety; Steele et al., 2007). Further, the prevalence of mental health disorders for both women experiencing homelessness and the homeless population, in general, is notably more significant compared to the rates of the general population (Alvidrez & Azocar, 1999; Barrow et al., 1999; Connelly & Crown, 1994, as cited by Shelton et al., 2009; Rodriguez et al., 2009; Rodriguez-Morento et al., 2020).

Homelessness can also exacerbate mental health issues that are already present (Guenzel et al., 2020). Many homeless individuals also live with chronic health diseases (e.g., seizures and musculoskeletal disorders; Daiski, 2007; Hwang, 2001). Other hardships experienced by individuals who are homeless are lack of shelter and basic needs (e.g., food), unemployment, and financial struggles (Acosta & Toro, 2000). Compared to the general population of homeless and low SES individuals, women are more vulnerable to experiencing these hardships; they are less prone to accessing and using formal support services due to the overwhelming number of barriers they face in their environments, like financial problems or lack of correct information about resources.
Barriers to Services

Hardships and barriers to accessing formal support services are especially prevalent for women who experience intimate partner violence (IPV; Alvidrez & Azocar, 1999; Barrett & St. Pierre, 2011; Raj & Silverman, 2002; Rodriguez et al., 2009; Wilson et al., 2007). IPV refers to any form of harmful behaviours committed by one’s previous or current romantic partner (Modi et al., 2014). IPV is considered a significant public health problem due to its overwhelming prevalence and the lasting effects it has on both the individual and the community (Raj & Silverman, 2002; World Health Organization (WHO), 2021). Women enduring IPV often experience high rates of mental health disorders, physical health problems, and lack of shelter if they flee their abusive relationship (Adams et al., 2012; Gilroy et al., 2016; Ponce et al., 2014; Vijayaraghavan et al., 2012). Despite the need for help and safety, these women often experience barriers such as being controlled by their partner or feeling embarrassed about being an IPV survivor (Ponce et al., 2014; Wilson et al., 2007). Due to these barriers, women often do not seek formal support services such as domestic violence shelters, healthcare, or law enforcement, along with others (Ponce et al., 2014; Wilson et al., 2007).

Many studies have been conducted with women experiencing homelessness and women who have endured IPV; however, less research integrates both homelessness and IPV when studying women’s experiences with formal support services and the potential barriers. Therefore, the purpose of this study was to explore the lived experiences of women who are homeless and who have also endured IPV. More specifically, the goal
was to examine the unique barriers experienced by these women regarding their access to formal support services, how these barriers may affect other aspects of their lives, their experiences when they have used or tried to use formal support services, and how their unique identities may have affected the barriers they face.

**Barriers and Formal Support Services**

A considerable amount of existing research has examined barriers to seeking formal support services. Barriers can come in many forms, and according to Scheppers et al. (2006), a barrier refers to a variable that limits and gets in the way of using a service. For example, not knowing how to speak the common language used in a specific area can prevent the use of services (Scheppers et al., 2006). When it comes to IPV, barriers can be factors that prevent the survivor from reaching safety or leaving their relationship, as described by Grigsby and Hartman’s (1997) barrier model, discussed in a later section.

There are two different kinds of support that an individual can access when they require some form of resource: informal and formal support services. Informal support refers to reaching out for help from the individuals surrounding a person, whether that be co-workers, friends, family members, or neighbours (Shiba et al., 2016). On the other hand, formal support refers to assistance from a trained professional and is available to the general public (Shiba et al., 2016). Examples of formal support services that both homeless individuals and IPV survivors often need are domestic violence shelters or hotlines, healthcare services, homeless shelters, mental health services (e.g., therapists), law enforcement services (e.g., police or lawyer), etc. (Fugate et al., 2005; Sullivan et al., 1994). Women specifically experiencing IPV often benefit from services such as housing, counselling, and childcare programs (Robinson et al., 2020). Furthermore, these services
are often sought out once the violence has escalated or if their informal support is no longer helping (Fiolet et al., 2019; Robinson et al., 2020).

In the present literature, there has been a focus on studying informal support, as this type of support is used more often as a source of help compared to formal support services (Ansara & Hindin, 2010; Barrett & St. Pierre, 2011; Fugate et al., 2005; Tenkorang et al., 2017). Overall, there is a need to understand the complexity of barriers that can affect a woman’s ability to access formal support services (e.g., finances or lack of transportation), specifically for women experiencing both homelessness and IPV. Accordingly, the proposed study will focus on formal support services.

**General Barriers to Accessing Services**

Previous literature has identified a myriad of common barriers that individuals who experience low SES and homelessness encounter when attempting to access formal support services. Examples of these barriers include information, finances, acceptability, poor experiences, availability, and stigma (Alvidrez & Azocar, 1999; Campbell et al., 2015; Krausz et al., 2013; Narendorf, 2017; Ponce et al., 2014; Solorio et al., 2006; Steele et al., 2007). Many homeless individuals struggle with informational barriers, which consist of not knowing what health services are available, what exact services they may need to access, or where to access the information they need to determine which treatments or services they should use (Narendorf, 2017; Solorio et al., 2006). In fact, these individuals are often unaware that specific treatments exist for their problems (e.g., posttraumatic stress disorder [PTSD]; Guenzel et al., 2020).

A more salient barrier this population faces is financial concerns that make it harder to access formal support resources. For example, some studies suggest that the
cost of accessing healthcare, private practice therapy, and other formal support services is too much for the homeless population (Guenzel et al., 2020; Narendorf, 2017; Nickasch & Marnocha, 2009; Solorio et al., 2006; Steele et al., 2007). Even in countries like Canada that have universal healthcare, individuals face situations in which the prescriptions they need for mental and physical health concerns are not covered or will only be covered for a short period (Campbell et al., 2015). Research findings indicate that if a homeless person can barely afford to eat, it is unreasonable to think they can afford expensive medication (Narendorf, 2017). Similar to financial issues, there are often reports of availability/accessibility barriers, in which the services are too far away, or there are waitlists to get in to see a doctor or the wait times to get a particular treatment they need are too lengthy (Guenzel et al., 2020; Ha et al., 2015; Narendorf, 2017; Solorio et al., 2006; Steele et al., 2007). Transportation barriers also exacerbate finance issues due to the additional cost required to go to appointments (e.g., bus tickets or cab fare; Guenzel et al., 2020; Narendorf, 2017; Solorio et al., 2006; Steele et al., 2007).

Another significant barrier revolves around acceptability, which encompasses factors such as thinking that they can manage the problems they are experiencing on their own, believing there is no need for help, or being too afraid to ask for help (Krausz et al., 2013; Solorio et al., 2006; Steele et al., 2007). This barrier is also present when an individual has a mindset that treatment will not work and will not help them with their presenting mental health concerns (Solorio et al., 2006; Steele et al., 2007). In other words, some individuals who need help may discredit the effectiveness and efficacy of the treatments they need. Along the same lines, stigma barriers are common. Stigma can occur for those who report embarrassment when discussing personal issues (Alvidrez &
Azocar, 1999; Solorio et al., 2006), whereas others report that the stigma and shame surrounding mental health is a barrier because they do not want to be seen or labelled as crazy (Guenzel et al., 2020). Further, a study by Ha et al. (2015) that investigated the barriers among homeless youth found that they did not want to use shelters due to the negativity and stigma surrounding the label of being homeless. Overall, acceptability and stigma barriers demonstrate that individuals’ perceptions of the effectiveness of formal support services and fixating on how others may perceive them for using services can act as barriers to seeking formal help.

The aforementioned barriers demonstrate how many obstacles are faced when accessing formal support services for low SES and homeless individuals, whether systematic, cultural, or cognitive. A powerful quote from a participant in a study investigating the intersection between homelessness and mental health, as well as the use of services and barriers to accessing them (Narendorf, 2017), clearly illustrates this:

When I tried to get it (Public Medical Card), it was like they needed an ID. Okay, well what do I need to get an ID? Well you need a voter's registration card. Okay, how do I get that? Well, you need proof of residence. Okay well if I am homeless, I don't have a proof of residence, cause I'm living on the streets. (p. 59)

Taken together, homelessness and SES, or one’s environment and living conditions, can create numerous barriers that make it difficult for individuals to access formal support services, even if they are willing to seek out the treatment they need.

**Women and Intimate Partner Violence (IPV)**

A specific population that is less prone to help-seeking is women experiencing homelessness (Alvidrez & Azocar, 1999; Duke & Searby, 2019; Rodriguez et al., 2009;
Vijayaraghavan et al., 2012). Although numerous factors can contribute to a woman becoming homeless, it is well-known that one of the leading causes is intimate partner violence (IPV; Duke & Searby, 2019; Sullivan et al., 2019). Statistics show that compared to women who have not experienced IPV, those who have are four times as likely to experience unstable housing (Pavao et al., 2007). For example, many women become homeless because they are fleeing a relationship in which they experienced IPV or because their abuser has caused them to be absent from work or purposely ruined their credit, leading to housing instability (Adams et al., 2012; Gilroy et al., 2016; Ponce et al., 2014). Some women flee not just for their protection, but for their children's safety leading to homelessness due to being financially unstable on their own (Galano et al., 2013). On the other hand, when already homeless, women are at high risk of experiencing IPV and being exposed to more violence overall; this is said to be due to their daily activities and not having someone to protect them from the violence (Jasinski et al., 2002, as cited in Gilroy et al., 2016). Overall, IPV is most often a part of the cycle that can significantly contribute to a lack of shelter and other basic needs (e.g., food) and may not disappear as a result of fleeing the original abusive environment.

Types of Violence

**Power and Control Wheel.** IPV is harmful behaviour carried out by one’s former or current romantic partner (Modi et al., 2014). More specifically, according to the World Health Organization (WHO, 2021, Introduction section), IPV is, “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.” Pence and Paymer (1993) constructed the Power and Control Wheel model
to demonstrate the key factors that are involved in coercive controlling domestic violence. This model describes eight different tactics that can be used by the abuser in this type of violence: coercion and threats (e.g., threatening to leave the partner), emotional abuse (e.g., abuser humiliating partner), intimidation (e.g., destroying objects), economic abuse (e.g., abuser taking the partner's money), male privilege (e.g., abuser choosing the women's roles in the house), minimizing, denying, and blaming (e.g., abuser acting like the violence did not occur), using children (e.g., making threats to take the children away), and isolation (e.g., abuser taking control over where the partner goes and who they see; Chavis & Hill, 2009; Pence & Paymer, 1993). The center of the model indicates that the abuser intends to gain control and have power over the partner, and the outermost portion demonstrates that the abuser may use both physical and sexual violence and abuse to gain this power and control (Chavis & Hill, 2009; Pence & Paymer, 1993).

**Johnson’s Typology of Violence.** In addition to the types of violence that make up the Power and Control Wheel, there are other forms of violence in relationships. One particular form of violence outlined by Johnson, coercive controlling violence, has higher rates of male perpetrators in heterosexual relationships (Kelly & Johnson, 2008). This type of violence involves asserting male privilege, intimidating and dominating one’s partner, emotionally abusing them, coercing them, and/or physical violence (Raj & Silverman, 2002). This refers to the same type of violence as the Power and Control Wheel, and the primary explanation for this form of violence stems from the idea that the abuser wants to gain power and control over their partners (Chavis & Hill, 2009; Kelly & Johnson, 2008).
It is also important to note that not all IPV involves power and control tactics. The three additional types of violence outlined by Johnson (2006) include situational couple violence, violent resistance, and separation-instigated violence. These different types of violence are defined based on the motives of control from the violent individual(s), and these reasonings are characterized by the patterns of control that are attempting to hold power over their partner (Johnson, 2006).

Situational couple violence occurs when one or both individuals in a romantic relationship display and enact violence but are not attempting to control their partner (Johnson, 2006). For example, physical abuse may be present, but they are not telling their partner where they can and cannot go or controlling their money, movements, and life. In addition, situational couple violence tends to occur from arguments that escalate into physical harm (Johnson, 2006). This type of domestic violence has been found to be the most common among married individuals and co-habiting partners (Kelly & Johnson, 2008).

IPV is considered violent resistance when one partner is violent and not controlling, while the other is both violent and controlling (Johnson, 2006). This violence occurs when one partner becomes violent because of the other partner’s actions and is often done by women as a way of self-defence (Johnson, 2008). This resistance is often found to be automatic to protect oneself (Kelly & Johnson, 2008).

The final of Johnson’s (2006) four types of violence is separation-instigated violence (Kelly & Johnson, 2008), in which the violence is brought out by a separation or divorce between the partners, and there was no prior history of harmful behaviours.
Overall, there are many different types of violence that a woman can experience in a romantic relationship, whether with a partner with the same or a different gender identity.

**IPV and Well-Being**

As might be expected, experiencing IPV has been shown to significantly affect a woman's health and well-being (Modi et al., 2014). For example, IPV can lead to mood disorders, posttraumatic stress disorder, anxiety, substance use disorders, and mental health issues (Afifi et al., 2008; Mertin & Mohr, 2001; Vijayaraghavan et al., 2012; Wilson et al., 2007). In a study by Wilson et al. (2007) that examined the barriers to care faced by women who experienced IPV, one woman openly reported that she experienced depression as a result of her abusive ex-husband. Violence in a relationship can affect mental and physical health. Yet, participants in the study described that they perceived mental health issues as more problematic than physical health issues (Wilson et al., 2007). Despite this finding, in a 2012 study by Vijayaraghavan and colleagues examining the use of and access to healthcare services, women who had experienced homelessness and IPV were more likely to report having a sexually transmitted infection than women who had not experienced IPV. Many women also experience physical injuries from the violence and abuse experienced in their relationships (Wilson et al., 2007). Regardless of how damaging IPV can be to both mental and physical health, there are numerous barriers experienced by survivors of IPV who are experiencing homelessness when trying to access formal support services.

**Barriers for Women Experiencing IPV**

Regardless of their status regarding being homeless or not, when considering women who have endured IPV all will experience some similar and unique barriers to
accessing formal support services compared to the general population with no IPV history. The most prominent barriers described in the literature are partner-related barriers. For example, women often feel their safety will be jeopardized if they leave to get help, their partners often do not want them to be around staff who are males, and the women are often being controlled by their abusive partner, restricting their ability to leave (Ponce et al., 2014). Some women also do not want to lose their relationship due to seeking formal support (Ponce et al., 2014), or they feel it is their job to keep their family together (Evans & Feder, 2014). Similarly, women may experience protective tendencies. Fear of getting their partner in trouble has stopped women from seeking counselling services; women may think that if they access these services to better their well-being they must end the relationship (Fugate et al., 2005). These barriers clearly demonstrate the power and control an abuser can have over their partner not only in their daily lives but also when they consider seeking help and formal support services for the hardships they have endured.

Studies have further revealed findings regarding factors that serve to increase barriers to seeking formal support services. These barriers include abusers threatening women with physical harm, fear their partner would find out, and feeling emotions like shame, hopelessness, and embarrassment (Fugate et al., 2005; Wilson et al., 2007). In other words, women may try to contact formal support services, but their partners often get in the way and stop them from doing so, whether by using physical constraint or some other abusive tactic (Fugate et al., 2005). When it comes to shame and embarrassment, survivors describe feeling these emotions for simply being in a relationship that involves abuse; these feelings then prevent them from getting help for physical or mental problems.
These emotions have additional impacts such as leading to fear of judgement from the healthcare providers they might try to contact (Fugate et al., 2005; Satyen et al., 2018; Wilson et al., 2007). Emotions like fear come into play too. In a paper by Ponce et al. (2014) exploring the co-occurrence of IPV, homelessness, and behavioural health problems, it was noted that some women fear being retraumatized by the events they experienced, which stops them from seeking formal support services. Overall, conflicts with one’s partner and feeling stigma-related emotions (e.g., embarrassment and fear of judgement) can affect whether women reach out for assistance and support.

Women also experience barriers in relation to their environment. If a woman is affected by homelessness and not just violence within their relationship, they have multiple adversities to overcome. When homeless, one may have more immediate stressors to worry about (Wilson et al., 2007). For example, a woman may prioritize finding stable housing or a job so that she can support herself and her family before she would consider using formal support services for her mental or physical health (Wilson et al., 2007).

Another broader barrier that restricts some women from seeking formal services is their culture and ethnicity. Often one’s cultural beliefs can affect how one views IPV; for instance, violence may be seen as acceptable (Barrett & St. Pierre, 2011; Reina et al., 2014). There can also be a fear of deportation among immigrant survivors, such that seeking formal support services is avoided by this population (Bui, 2003; Raj & Silverman, 2002; Reina et al., 2014).
An essential takeaway regarding barriers and seeking formal support services is that many of these studies examined women generally rather than women experiencing homelessness or included only a few homeless women in their samples. The literature on the formal service use and experiences of women experiencing both IPV and homelessness is sparse (Fugate et al., 2005; Ponce et al., 2014). Therefore, this population of women requires additional study due to their unique experiences and the multitude of hardships that they encounter.

**Formal Support Service Use Experiences**

Despite the previously mentioned barriers, some women do access formal support services. Previous research states that around 75% of women experiencing IPV try to access informal and formal support services (Kaukinen, 2004; Sabina & Ho, 2014). However, the current literature shows mixed results regarding how helpful these experiences are for them. For example, in the 2021 study by Li and colleagues that examined help-seeking experiences of Chinese women who endured IPV, some women noted how therapy was helpful for their mental state; however, other participants felt as though their therapist was not supportive and experienced language and cultural barriers. Pajak et al. (2014) similarly examined the formal support service experiences of women who endured IPV and found that some participants experienced empowerment, autonomy, and a positive change in their identity. In contrast, some women experienced accusatory behaviours from professionals, were victim-blamed, or felt that the service providers were not meeting their needs (Pajak et al., 2014). Finally, women in Bacchus et al.’s (2003) study that examined formal support service experiences relating to IPV discussed that healthcare providers often did not provide information on community
resources that were needed when the women disclosed their abusive experiences. Thus, even when women could access formal support services, their experiences were not always positive. Moreover, some women unfortunately encountered and endured further barriers. Overall, it is crucial to further study these experiences, especially with women experiencing many hardships due to both IPV and homelessness.

The literature also notes specific barriers to different types of formal support services. For example, medical and mental health services often have waitlists and insufficient availability for appointments (Solorio et al., 2006). Women experiencing IPV often fear calling the police for help due to the worry of their partner retaliating (Cloutier et al., 1999). Other barriers that affect calling the police are having a past arrest and finding the police generally unhelpful (Abel & Suh, 1987; Hamilton & Coates, 1993).

A study by Fugate and colleagues (2005) provided more insight into why women experiencing IPV are less likely to seek certain services. This study involved interviewing 491 women to understand their non-use of support services (Fugate et al., 2005). The authors found that the explanation of not needing the service or it not being useful was common for using an agency or counsellor, police, and medical care. Similarly, wanting to protect their partner and preserve the relationship was also found for these three services; however, this reasoning was found to be higher for not going to the police and least likely for not accessing medical services. Furthermore, women were apprehensive about calling the police because they feared that both themselves and their partners would face the consequences of law enforcement (Fugate et al., 2005).

A similar study represents the unique barriers when accessing the legal system for women experiencing IPV. Gezinski and Gonzalez-Pons (2021) examined the barriers to
accessing the legal system for survivors of IPV in the US. Survivors and service providers were interviewed (N = 102), and the results demonstrated that (a) there were difficulties finding legal representation that was affordable and had availability; (b) there were difficulties getting a protection order and the process was often (re)traumatizing for the women; (c) overall revictimization in the court setting occurred; 4) and disparities in accountability existed leading to the victim being looked at as the perpetrator (Gezinski & Gonzalez-Pons, 2021).

As for the needs relating to homelessness, most studies identify similar barriers for the main types of services accessed by this population, such as shelters, healthcare, and mental health care. As previously discussed, these barriers included waitlists which are common for most of these services, fear and embarrassment, acceptance, lacking information, and financial barriers (Alvidrez & Azocar, 1999; Campbell et al., 2015; Guenzel et al., 2020; Krausz et al., 2013; Narendorf, 2017; Nickasch & Marnocha, 2009; Ponce et al., 2014; Solorio et al., 2006; Steele et al., 2007). To conclude, it is important to consider how there are unique barriers to different types of services for women facing homelessness and IPV, as each service can bring on distinctive challenges.

**The Severity of IPV and Help-Seeking**

The relationship between the severity of IPV and whether a woman seeks help has been consistently demonstrated in the literature. Survivors of IPV often do not seek formal support services and turn, instead, to informal support, like opening up about their situation with friends and family (Ansara & Hindin, 2010; Barrett & St. Pierre, 2011; Fugate et al., 2005; Tenkorang et al., 2017). Despite this, the more severe the abuse experienced in the relationship, the more likely a woman is to seek some form of help,
whether it be formal or informal (Barrett & St. Pierre, 2011; Coker et al., 2000; Fugate et al., 2005; Goodson & Hayes, 2021; McFarlane et al., 1997; Tenkorang et al., 2017). The use of shelters has also been linked to the severity and frequency of violence experienced (Galano et al., 2013). According to a systematic review conducted by Lelaurain et al. (2017) on IPV and help-seeking behaviours, the severity of the violence experienced in a relationship was the most cited factor when it came to whether the survivor would seek help or not from informal and formal support services.

Fugate et al. (2005) discuss why severity might play the role it does in help-seeking. There is a potential threshold for abuse one can endure; as the survivor becomes more fearful of the abuser and the injuries are heightened, there is a point at which they may not be able to handle it anymore and seek help (Fugate et al., 2005). Other researchers have likewise discussed potential reasons for the relationship between the severity of IPV and help-seeking. For example, McFarlane et al. (1997) theorized that a woman experiencing violence in a relationship might seek help from the police. Following this, the partner may get in trouble with law enforcement, which subsequently leads to increased severity of IPV, or a harsh punishment imposed on the woman because she used a formal support service. Overall, the barriers and complexities to reaching out for help, whether that be formal or informal, are complicated and need further examination.

The COVID-19 Pandemic

The COVID-19 pandemic has undoubtedly impacted the frequency of IPV and homelessness. Research has demonstrated that the stay-at-home orders and the COVID-19 pandemic, in general, led to an increased risk of experiencing IPV due to being inside
with the abusive partner for extended periods (Nnawulezi & Hacskaylo, 2020; Parrott et al., 2021; Piquero et al., 2021; Ravi & Schrag, 2021). A study conducted by Lyons and Brewer (2021) that examined online forum posts made by IPV survivors during the pandemic found reports of abusers using the pandemic as an excuse to abuse their partner, punishing them if they left during a lockdown, or using lies to control their partners (e.g., stating their partner is positive with COVID-19 when they were not). This highlights the effect of the pandemic on both the increase of incidents and additional contexts of domestic abuse.

The pandemic also made it more difficult for IPV survivors to seek and receive support and access resources like transportation, food, and employment (Hall & Tucker, 2020; Nnawulezi & Hacskaylo, 2020; Ravi & Schrag, 2021). Lyons and Brewer’s (2021) study found individuals reporting that shelters were full. Even when formal services were still available during the pandemic, places such as housing shelters had to follow the rules of social distancing and not allow new individuals to come in (lockdown) due to the potential spread of the virus (Lyons & Brewer, 2021; Nnawulezi & Hacskaylo, 2020; Ravi & Schrag, 2021). In addition, some services moved online and became remote, making it more difficult for some to access services due to a lack of technology access (Nnawulezi & Hacskaylo 2020; Yakubovich & Maki, 2021).

Relatedly, homeless individuals experienced increased risks during the pandemic. Homeless individuals were more likely to be exposed to the virus, have medical co-morbidities, and lack access to care and treatment during the pandemic (Baral et al., 2021). There were also reports of additional barriers for individuals experiencing homelessness during the COVID-19 pandemic. Tucker and colleagues (2020) conducted
a study with individuals aged 18-25 experiencing homelessness (28% of the sample female). They found that over half of the participants stated that the pandemic had made it more challenging to get enough food. The participants further reported that the pandemic added barriers to accessing mental health and substance use services (Tucker et al., 2020). Similarly, a study performed by Kaur et al. (2020) in the UK interviewed providers to understand how the pandemic impacted services for homeless individuals. They found that some participants described services moving online due to restrictions, and further explained that some service users struggled with virtual communication, findings it less effective (Kaur et al., 2020).

Taken together, the unique context of the COVID-19 pandemic affected the levels of IPV experienced and homelessness. Further, the pandemic was shown to increase barriers and make it more difficult for IPV survivors and homeless individuals to access formal services for their related needs (e.g., shelters, healthcare, therapy). Due to the impact of the pandemic, this study also considered and explored how the pandemic uniquely affected women’s potential barriers and experiences with formal support services for needs related to both homelessness and IPV.

**Theoretical Models**

**Feminist Theories**

Feminist theories, which are sociological theories, have been used to describe why IPV occurs, specifically to women. A sociological theory in the context of IPV builds on viewing these behaviours in terms of larger societal structures and the sociocultural context in general rather than studying pathology on an individual level (Bell & Naugle, 2008; Lawson, 2012). In general, radical feminism views IPV through
the lens of gender, stating that gender plays the most central role in these acts of IPV, followed by variables of power and dominance\(^1\) (Anderson, 1997; Dobash & Dobash, 1979; Johnson, 1995, 2005, 2006; Kurz, 1989). More specifically, the inequality aspect of gender, particularly women being underrepresented and not treated equally in many areas of society, is what is often cited by many feminist theorists as a leading factor in the occurrence of IPV (Chesworth, 2018).

Another fundamental view is how gender has been socially constructed. These views explore how males and females take part in what Chesworth (2018) calls “a hierarchical socialization process” (p. 81). More simply, when constructing gender, society have sorted specific behaviours and labels and paired them with a particular gender, leading to what constitutes “male” as being more superior and valuable (Smith & Hamon, 2012, as cited in Chesworth, 2018). These sociological theories further examine IPV by dissecting sociocultural factors (Chesworth, 2018). More importantly, radical feminism stands on the notion that violence towards women occurs for men to have power over women and control them and that this is the by-product of a patriarchal society (Dobash & Dobash, 1979, as cited in Chesworth, 2018). This radical wave of feminism maintains that men are socialized by society and culture to believe they should dominate women (Dobash & Dobash, 1979, as cited in Chesworth, 2018).

It is important to note that not all violence is perpetrated by men toward women in heterosexual relationships. However, feminism is still of importance as it is relevant to the experiences of many women who belong to societies that value male dominance and power and prescribe gender roles indicating that women are “less than” (Raj &

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\(^1\) There are different waves of feminism and they each conceptualize violence differently.
Finally, feminist theories also highlight the mechanisms of coercive controlling violence. This type of violence is often perpetrated by men towards women; therefore, it can be due to the socialization of male power and control, which are some of the main factors in coercive controlling violence (Kelly & Johnson, 2008). Overall, feminism generally provides us with an understanding of some of the root causes and potential reasons why IPV occurs in certain instances.

**Intersectionality Theory**

The literature presented exhibits that there is a relationship and intersection between culture, ethnicity, social class, gender, and housing stability with experiences of oppression and systems of power, or in other words, social inequities (Atewologun, 2018; Chavis & Hill, 2008; Kelly, 2011). The theory of intersectionality is a critical framework that was initially formed when describing the experiences of Black women in relation to employment discrimination (Crenshaw, 1989). This theory posits that we should be examining the impact of social categories like race, gender, social class, etc., together and how they converge to influence one's experiences, as well as the relationship between these categories and structural systems of privilege and oppression (e.g., racism and sexism; Atewologun, 2018; Crenshaw, 1991). Intersectionality has been viewed as the race, class, and gender perspective, and researchers use this approach to highlight the voices of minorities and/or marginalized groups and their experiences with social inequities (Mann & Grimes, 2001; Sokoloff & Dupont, 2005). Another aim of this theory is to demonstrate the differing experiences of each unique group of intersecting identities, rather than a common perspective of all (Chavis & Hill, 2008; Mann & Grimes, 2001; Sokoloff & Dupont, 2005).
In terms of IPV and formal support service use, when combining all social categories that are a part of a women's identity, it results in each person having their own distinctive experience (Chavis & Hill, 2008). For example, a Black Canadian woman of a lower class may have a different experience compared to a middle-class Latina Canadian woman because of the intersection of their racial and class identities. Not only can a woman experience oppression because of their gender (e.g., patriarchal views of women affecting their home life), but also because of racial discrimination and classism (Crenshaw, 1991). Another instance of intersectionality demonstrated in the literature involves immigrant women. Not only does being a woman impact their IPV experience and formal support service use, but so does their culture, race, and immigrant status – as immigrant women often fear being deported (Bui, 2003; Crenshaw, 1991; Raj & Silverman, 2002; Reina et al., 2014). As we know from previous literature, the intersection of gender and socioeconomic status (SES) can affect the use of services, such that women with lower SES are more likely to experience mental health concerns and less likely to seek formal help due to a multitude of barriers like finances, lack of information, or lacking acceptance (Campbell et al., 2015; Krausz et al., 2013; Narendorf, 2017; Ponce et al., 2014; Steele et al., 2007). Taken together, depending on which social categories one identifies with, it can increase or decrease the chances of experiencing IPV and the severity of it, affect the barriers women face in accessing formal support services, and influence how structural systems affect their experiences (Clark et al., 2016).

Examining experiences as a result of each women’s unique identity is critical. According to Crenshaw (1991):
Where systems of race, gender, and class domination converge, as they do in the experiences of battered women of color, intervention strategies based solely on the experiences of women who do not share the same class or race backgrounds will be of limited help to women who because of race and class face different obstacles (p. 1246).

In other words, research that explores one general population is less effective for helping diverse ranges of women with differing cultures, races, and social classes. Consequently, this study aims to fully consider the participants’ intersecting identities and how they relate to structural systems of oppression and affect their experiences.

**The Barriers Model**

The current literature describes many barriers that affect access to formal support services for women who are experiencing IPV. Grigsby and Hartman (1997) developed a model to explain the clusters of barriers experienced by women who endure IPV which prevent them from reaching safety. The model consists of four different layers: barriers in the environment, barriers that are due to family/socialization/role expectations, barriers from psychological consequences of violence, and barriers from childhood abuse and neglect. The model emphasizes that layer one, the environmental barriers, should be focused on first because if the layers that address internal variables are examined first, it may lead the woman to believe that she is the problem in the relationship (Grigsby & Hartman, 1997).

Layer one, barriers in the environment, focuses on an array of challenges the woman can face due to her external surroundings. Grigsby and Hartman (1997) discuss challenges such as receiving misinformation or a lack of information about services, the
batterer preventing the woman from leaving the relationship, expenses that are associated with leaving (e.g., childcare and medical bills), and a lack of transportation. The model further describes how poor police and criminal justice assistance, inaccessibility to attorneys, and poor religious guidance can all act as environmental barriers. A subsection of layer one also includes inaccessibility to shelters due to waitlists, discrimination, language barriers (e.g., no interpreters), no accommodation for disabilities, cultural barriers (e.g., services based only on specific cultures), and fear of deportation. Overall, layer one primarily focuses on the woman's external environment and how it can prevent reaching safety and using formal support services (Grigsby & Hartman, 1997).

Layer two focuses on barriers resulting from family, socialization, and role expectations. Further, this layer’s key focus is on values and beliefs, specifically relating to relationships (e.g., having patriarchal views), religion (e.g., beliefs about ending a marriage), one’s family of origin (e.g., how one’s parents view divorce), and general beliefs about abuse (e.g., acceptable or unacceptable; Grigsby & Hartman, 1997). For example, Grigsby and Hartman (1997) discuss women potentially becoming desensitized to violence due to its prevalence in American society. It may also be the case that a woman’s family has passed down specific values and beliefs about violence or leaving one’s partner once married (Grigsby & Hartman, 1997).

There are also barriers that stem from the psychological results of experiencing violence, and these make up the third layer of Grigsby and Hartman’s (1997) model. For example, the woman may use defense mechanisms due to being terrorized (Grigsby & Hartman, 1997). This layer includes further barriers such as sleep and psychological consequences, experiencing posttraumatic stress disorder, being isolated (e.g., losing
relationships with others in their life) or being brainwashed, and complying with the abuser (Grigsby & Hartman, 1997).

The final layer consists of barriers that stem from abuse and neglect in childhood (Grigsby & Hartman, 1997). Women may learn from an early age that anyone has the capability to abuse them due to experiencing abuse by their parents or other family members (Grigsby & Hartman, 1997). Further, psychological disorders resulting from childhood trauma can act as a barrier to accessing formal help and escaping abuse (Grigsby & Hartman, 1997). Overall, abuse can affect a woman’s mental state, and her early childhood experiences may negatively influence her; as a result, these factors can act as barriers to her seeking safety and formal support services (Grigsby & Hartman, 1997).

The layers of barriers in this model are clearly illustrated in the present literature. For example, previously mentioned studies describe partner-related barriers that fall under layer one. For example, the abuser often physically prevents the woman from leaving and using formal support services by threatening or restraining her (Ponce et al., 2014; Wilson et al., 2007). An instance of layer two, family, socialization, and role expectations, is demonstrated in a study by Reina et al. (2014) examining factors that affected help-seeking in Latina immigrants. In this study, some women discussed abuse as if it were acceptable, in turn leading to no help-seeking (Reina et al., 2014). Overall, the barriers model produced by Grigsby and Hartman (1997) highlights and explains the complexity of barriers and the underlying factors that affect a woman’s choice to seek safety and services when experiencing IPV. While conducting the qualitative data analysis, the researchers were mindful of the different layers of this model.
Behavioral Model of Health Service Use

The current literature undoubtedly demonstrates that there are different factors affecting whether or not one will use the formal support services available to them. Andersen and Newman (1973) created a model to demonstrate variables that can affect whether an individual will utilize health services. The original behavioural model of health service use (BMHU) posits that predisposing characteristics, enabling factors/resources, and need, otherwise known as illness level, all affect health service use (Andersen & Newman, 1973; Andersen, 1995). Predisposing characteristics refer to particular attributes present in an individual prior to needing health services (Andersen & Newman, 1973). For example, demographic features like age, gender, ethnicity, or social-structural attributes like education level and occupation, and one’s prior attitudes towards the medical system and personnel and diseases can affect service use (Andersen & Newman, 1973). Enabling factors and resources are the methods available to individuals who permit them to use health services (Andersen & Newman, 1973). Enabling factors can refer to income, insurance, accessibility to services, and the number of healthcare facilities and personnel within their area (Andersen & Newman, 1973). The last variable that affects the use of services is need or illness level. For individuals to access or use health services, they must acknowledge that there is something wrong with them and that there is a legitimate reason to use the service (Andersen & Newman, 1973).

The BMHU has been applied to formal service use in IPV survivors (Choi et al., 2021). For example, Choi and colleagues (2021), who studied help-seeking behaviours in college students experiencing IPV, found that factors such as the survivor’s gender, sexual orientation, age, and level of training on IPV all affected whether they sought help
or not. These findings demonstrate that predisposing and enabling factors can, in fact, affect help-seeking for formal support services. Current literature has also supported the finding that enabling factors such as lack of money or physical inability to access services can affect formal service use for both women experiencing homelessness and women who have endured IPV (Guenzel et al., 2020; Narendorf, 2017; Solorio et al., 2006; Steele et al., 2007; Wilson et al., 2007). Overall, the BMHU provides us with an understanding of the underlying factors affecting formal service use in the general population and in populations such as women experiencing homelessness and IPV. Given that this study took an intersectional approach, factors such as predisposing characteristics (e.g., gender and ethnicity) and enabling circumstances (e.g., finances and overall class) were discussed and considered in the analysis and results.

**Stigmatization Model**

As seen from previous studies, stigma can significantly affect whether a woman uses formal support services when experiencing homelessness and IPV (Fugate et al., 2005; Guenzel et al., 2020). Overstreet and Quinn (2013) developed a model that describes how different types of stigmas surrounding IPV can affect the survivor at the individual, interpersonal, and sociocultural levels. More specifically, this stigmatization model posits that the sociocultural environment can negatively affect individuals who experience IPV (Overstreet & Quinn, 2013). The authors further elaborate that a higher level of cultural stigma results in higher levels of both internalized and anticipated stigma; in turn, these overall levels of stigma influence whether the survivor will seek help or not (Overstreet & Quinn, 2013). Cultural stigma refers to cultural ideologies and beliefs that tend to invalidate the experiences of an IPV survivor; this stigma can then
affect whether the survivor uses support services or not (Overstreet & Quinn, 2013). Stigma internalization refers to the action of a survivor internalizing negative beliefs about IPV (e.g., “victims” of IPV are weak; Overstreet & Quinn, 2013). On the other hand, Overstreet and Quinn (2013) describe the concept of anticipated stigma as how fearful a survivor is about being stigmatized if individuals around them find out that they have experienced abuse in a relationship.

Overstreet and Quinn’s (2013) stigmatization model discusses two other factors that can affect both internalized and anticipated stigma: centrality and salience. The concept of centrality considers whether the IPV survivor believes their IPV identity is an important aspect of how they define themselves (Overstreet & Quinn, 2013). For example, suppose a woman does not consider being an IPV survivor a central part of her identity (e.g., not perceiving she is in an abusive relationship). In that case, this can reduce stigma as well as decrease help-seeking. The factor salience refers to whether or not the experience of IPV is more or less cognitively accessible to the survivor (Overstreet & Quinn, 2013). For instance, salience might be high right after experiencing an act of abuse and, as a result, increasing stigmas and decreasing help-seeking. In addition, high salience might lead the survivor to recognize the severity of the abuse and, in turn, lead to the use of formal support services (Overstreet & Quinn, 2013).

Overall, the stigmatization model demonstrates the relationship between different types of stigmas and help-seeking. This model is supported by present literature that has shown how women sometimes feel ashamed of being an IPV survivor and think that their healthcare provider will judge them for either being in an abusive relationship or for not having left it yet (Fugate et al., 2005; Wilson et al., 2007). Other current findings indicate
that some women will not disclose abuse because they believe it would bring stigma or shame to them or their families (McCleary-Sills et al., 2016). In conclusion, the stigmatization model and current literature make it apparent that stigma can act as a barrier to using formal support services. Overall, stigma is a concept that should be seriously considered in research when examining the lived experiences of women enduring IPV.

**Psychosocial Readiness Model**

The psychosocial readiness theoretical model developed by Cluss et al. (2006) can be used to explain the underlying mechanisms that affect an IPV survivor’s readiness to seek help and change their abusive situation. This model was derived from qualitative interviews with IPV survivors (Cluss et al., 2006). The premise of this model is how internal and external factors affect the readiness for change (e.g., accessing safety) within an IPV survivor. This model accounts for different change levels, such as whether the survivor is leaving the relationship or taking other actions while still in the relationship (e.g., opening their own bank account). The internal factors account for their awareness (e.g., whether she believes the abuse is occurring or not), perceived support (e.g., if she has support from friends or family), and self-efficacy or perceived power (e.g., power to make a change; Cluss et al., 2006). As for external factors, consider interpersonal interactions that occur within the environment and situational factors (Cluss et al., 2006). In this model, the external factors can be seen as positive or negative, meaning they can promote change or impede change (Cluss et al., 2006).

Cluss et al. (2006) highlight that the internal factors and their relationship describe the survivor’s readiness for change on a continuum. In other words, the valence
of the three internal factors will affect where the survivor is on the continuum and, in turn, this will influence whether the survivor moves towards making a change (Cluss et al., 2006). If the woman perceives that she has support from her social circle, acknowledges that the abuse is occurring, and believes she can leave the relationship, then she would be on the positive end of the continuum, which indicates the highest readiness for change. External factors, situational and interpersonal, can also affect one’s readiness for change at the same time as internal factors (Cluss et al., 2006). For example, a positive effect of an interpersonal factor would be that the survivor received, not just perceived, support from their sister, who helped them set up their own bank account. An example of a negative valence situational factor could be that the survivor does not have a house to live in. The positive valence example may lead the survivor to a higher readiness for change, whereas the negative valence example may lead to lower levels of readiness for change (Cluss et al., 2006).

Generally, this model provides us with an understanding of the processes that are likely to occur and the factors that affect whether an IPV survivor is ready to change their abusive environment and head toward safety (Cluss et al., 2006). The readiness for change model calls attention to the internal and external variables that can act as barriers and affect formal service use for women who have endured IPV and homelessness.

The Current Study

The present study aimed to understand the lived experiences of women undergoing homelessness who are also currently experiencing or have experienced IPV. More specifically, this study examined the formal service needs for this subgroup of women; Relatedly, we also examined the general barriers and facilitating factors
associated with accessing these services for needs related to both circumstances of experiencing IPV and homelessness because, as the literature demonstrated, these are often subsequent experiences. Finally, the study investigated how the women’s social positionings, or identities, may have affected their overall needs and experiences with these formal support services. In the context of this study, when considering formal support services for addressing the needs of both homelessness and IPV, the following were included: domestic violence shelters or hotlines, healthcare provider services, homeless shelters, mental health services, and law enforcement services (e.g., police or lawyer). This was not an exhaustive list, as other formal services were mentioned by participants. Overall, this study focused on the unique and combined experiences women had when experiencing both homelessness and IPV rather than one circumstance or the other. This research study explored four main research questions:

1) What are the formal service needs of homeless women experiencing IPV?

2) What are the barriers to accessing formal services for homeless women experiencing IPV?

3) What facilitates successful help-seeking for homeless women experiencing IPV from formal service providers?

4) How do the social positionings and standpoints of homeless women who are IPV survivors shape their service needs and experiences when accessing formal services?

The present literature demonstrates that women who are homeless and experiencing IPV face many hardships, including chronic health diseases, mental illness, lack of housing and basic needs, unemployment, and financial strain (Acosta & Toro,
Despite these circumstances, many barriers preventing these women from accessing formal services for basic or IPV-related needs (e.g., shelter or physical injuries) have been reported (Guenzel et al., 2020; Narendorf, 2017; Ponce et al., 2014; Wilson et al., 2007). Concerning intersectionality theory, it was essential to consider each woman’s unique experience and how intersecting identities like gender, class, race, health, and culture influenced formal support service use and the structural and oppressional barriers faced when trying to access them (Atewologun, 2018; Chavis & Hill, 2008; Crenshaw, 1991; Kelly, 2011). Therefore, the qualitative analysis inquired about the participant’s unique identities.

Despite the abundance of literature about help-seeking for IPV and homelessness, few studies have investigated the experiences of women enduring both homelessness and IPV while considering the unique barriers and facilitating factors in accessing formal support services, and their general experiences with formal support service use, all while taking an intersectional and feminist approach. Therefore, this study aimed to fill this gap in the literature by interviewing women who have lived through both homelessness and violence in a romantic relationship and examining their experiences with formal service barriers, formal service use, and the overall impact of their intersecting identities. Finally, there were no proposed hypotheses due to the qualitative aspect of the study and the analysis being exploratory in nature.
CHAPTER 2

Method

Recruitment

The participants for this study consisted of 10 women who resided in Windsor, Ontario. They were recruited from the Welcome Center Shelter (WCS). WCS is an organization that provides safe shelter for women and their families who are experiencing homelessness. The organization had granted access to the PI to visit the site and recruit participants to complete the study. This access was granted via email, stating that the project could be done if there was ethics approval and plans to debrief and follow up with the participants. Grant money was used to fund this project and compensate the 10 participants. For qualitative analyses, there are no formal guidelines when it comes to the sample size (Vasileiou et al., 2018). What some researchers take into consideration is data saturation, which occurs when they reach the point where acquiring more observations will not add any new information to the dataset, meaning no new themes are emerging (Green & Thorogood, 2004; Lowe et al., 2018).

There are generally no guidelines on how and when this type of data saturation has occurred (Guest et al., 2006; Malterud et al., 2016), and the method of saturation can be seen as generally inappropriate (O’Reilly & Parker, 2013). Braun and Clarke (2021a) argue that saturation is unsuitable for a reflexive thematic analysis, considering that the steps often involve deriving codes and themes that can be expanded, edited, or split into multiple codes. The evolving nature of codes in this analytic process is quite the opposite of data saturation (Braun & Clarke, 2021a). They further state that choosing a sample size is a pragmatic process; the researcher should consider their own expertise, the breadth of
the project and research questions, the depth of the data that will be gained from the participants, the type of method being used, and how the demands of the project will affect the participants (Braun & Clarke, 2021a; Sim et al., 2018). Therefore, based on the scope of this study, the depth of the interview questions, and the primary investigator’s previous experience with qualitative work, it was deemed appropriate that 10-15 participants would provide rich narratives.

For this study, the method of information power was also used to determine the sample size (Malterud et al., 2016). Information power considers the study aims, use of an established theory, method of analysis, quality of dialogue, and the specificity of the sample (Malterud et al., 2016). Malterud and colleagues (2016) state that fewer participants are needed when the study aims are more specific, it is supported by more existing theory, participants have highly specific characteristics, there is strong communication between participants and researchers, the researchers have good interview skills, and the analysis explores cases in-depth. The research aims for this study were more focused as opposed to being broad; there are multiple established theories and models relating to help-seeking for IPV and homelessness; the criterion for participants was very specific; and an in-depth cross-case thematic analysis was conducted. In addition, the primary researcher had never conducted interviews, but they had experience coding and listening to interviews in which they learned proper communication and dialogue. Comparing the characteristics of the proposed study to Malterud and colleagues’ (2016) dimensions for information power, a smaller sample size would be needed. Therefore, 10-15 was deemed an adequate sample based on the study characteristics.
Participants included in the study had to meet specific criteria. First, the women had to be homeless, meaning they either lived on the streets, were in one of the shelters in Windsor, or did not have a stable housing situation. They had to have experienced some level of IPV with a past or current romantic partner, and this experience could have ranged from minor to severe. If the woman experienced IPV with a previous partner, they answered the questions based on their past experience. The level of IPV was measured using the *Experience of Domestic Violence Scale* (see Appendix A). Although the Welcome Centre Shelter does not specifically cater to women who have experienced IPV, the staff communicated that the IPV rates of the women using the services at the site were high. Therefore, it was feasible that the target participants would have experienced IPV. The participants also had to have functional skills in reading, writing, and speaking in English. These criteria were chosen because the participants had to have the ability to understand the questions they were required to read and respond to in the study. The last criterion was that the participants had to be 18 years of age or older to provide informed consent on their own behalf. Furthermore, this research was aimed at examining adults’ experiences.

All the eligibility criteria were described in detail to the women when the researchers presented the option of participating in the study during the WCS drop-in sessions. This ensured that the women participating in the study had experienced or were experiencing IPV and homelessness, could speak and read English and were 18 years of age or older.
Recruitment Site Selection

The recruitment site for the study was the Welcome Center Shelter (WCS). The WCS is considered a formal support service given that the services are provided by trained professionals and are available for the public population of women (Shiba et al., 2016). One aim of the study was to examine the barriers women face when trying to access and use formal support services, yet the participants in the study had accessed one type of formal support already (the WCS). Although the participants had sought some form of formal service, they were able to discuss barriers they had experienced in the past or barriers they had experienced when trying to access other formal support services (e.g., police, healthcare, psychological services). Furthermore, by using a sample that had accessed at least one formal support service, the study was able to explore potential factors that facilitate overcoming barriers; at least for accessing housing assistance.

Measures

The study was conducted using a qualitative-dominant design while incorporating three brief surveys that were used to help describe the sample and provide contextual information. The three surveys included a demographics survey, The Experience of Domestic Violence Scale, and the Intimate Partner Violence Strategies Index (IPV-SI). During questionnaire completion, the primary researcher and one volunteer undergraduate researcher from the Health Experiences and Longevity (HEAL) lab at the University of Windsor were present to provide clarifications and help with reading if it was needed. A qualitative-dominant approach was chosen because qualitative designs allow for participants’ voices to be heard and for them to provide greater detail in their own words (Colorafi & Evans, 2016).
**Questionnaires**

**Demographics Survey.** The demographic survey asked about the participants’ age, race and ethnicity, gender, sexual identity, living situation, education level, relationship status, current employment status, disability status, number of children, and the country in which they were born (see Appendix B). This was used to gain more detailed information on the participants and the sample.

**Levels and Severity of Violence Experienced.** The *Experience of Domestic Violence Scale* was used to measure the participants’ levels of IPV that they had experienced in a current or past romantic relationship (Fujiwara et al., 2010). This scale was originally adapted from the *Index of Spouse Abuse* (Hudson & McIntosh, 1981) but modified to suit the Japanese language, and shortened to reduce the participant burden (Fujiwara et al., 2010). The scale has four items, but one was removed due to containing content that was not needed for this study (e.g., forced sexual contact). The participants rated each item on a scale from 1-4, 1 representing *not at all* and 4 representing *frequently*. The questions on this scale measured IPV experience in a brief and general way without going into details about the participants’ experiences (Fujiwara et al., 2010). This measure was scored by finding the sum of all four items for each participant to get an overall score, as well as finding the mean score for each item using all participants’ scores together.

**IPV Strategies for Safety.** The *Intimate Partner Violence Strategies Index (IPV-SI)* was created to measure women’s strategies to get help and access safety when experiencing domestic violence (Goodman et al., 2003). This scale contains 39 items and six subscales: *Formal network* (“Called a mental health counselor for yourself”), *Legal*
(“Called police”), Safety Planning (“Worked out escape plan”), Informal Network (“Stayed with family or friends”), Resistance (“Fought back physically”), and Placating (“Did whatever he wanted to stop the violence”; Goodman et al., 2003; see Appendix C). The items used the pronoun he, but for this study, the pronoun was changed to they or them to be more inclusive of their partners. The participants were asked whether they had used the strategy (Yes or No). If they responded with Yes, they were asked to use a 5-point Likert scale to rate the helpfulness of the strategy, ranging from 1 (Not helpful at all) to 5 (Very helpful). This measure was used to gain an understanding of the participants’ strategic responses to IPV and whether these strategies were helpful for them or not. Finally, the authors of the scale concluded that the IPV-SI has good interrater reliability, face, and convergent validity (Goodman et al., 2003).

With regards to scoring, percentages were calculated for each subscale for all participants. An overall mean was then calculated for all participants on each subscale. Further, a mean (including all participants) was calculated to average how many strategies were used throughout the entire scale. Percentages were also calculated for the most and least prevalent strategy (item percentage) used, and for each category.

**Interviews**

The interviews were planned to be 60-90 minutes long, and the average time was 40.4 minutes, with a range of 14-85 minutes. Furthermore, these interviews were semi-structured and audio-recorded only. These semi-structured interviews consisted of a set of questions planned in advance, and these questions were asked in a particular sequence for all interview participants; however, follow-up questions were asked if clarification was needed (Mueller & Segal, 2015; see Appendix D for interview script). The benefits of
this type of interview were that they led to the collection of the same type of information from all participants, meaning the findings were more reliable, and it helped to keep the focus of the interview (Mueller & Segal, 2015). Both the primary researcher and one volunteer researcher conducted the interviews. The volunteer researcher was from the HEAL lab at the University of Windsor.

The interview questions aimed to explore the lived experiences of women who have endured both IPV and homelessness. Particularly, the interviews touched on the following topics: living situation and homelessness narrative, perceived formal support needs relating to homelessness and IPV, barriers associated with accessing formal support services, experiences had when using and trying to use formal support services, how intersecting social positionings may have affected barriers and experiences with formal support services, the effect of the covid-19 pandemic on barriers and formal support service use, and factors that facilitated accessing services. Overall, the interview allowed for gathering a narrative of each woman’s experience and challenges with accessing formal support services and how they perceived their unique identities may have affected their personal accounts.

**Procedure**

The project received clearance from the Research Ethics Board at the University of Windsor before the study protocol commenced. Prior to data collection and conducting interviews, the primary investigator required interviewers to read through Lalonde and colleagues’ (2020) article describing a trauma-informed approach to studying IPV. Further, the interviewers were required to watch a webinar created by The Muriel McQueen Fergusson Centre for Family Violence Research (MMFC) and the Canadian
Association of Social Workers that described intimate partner violence in depth so that they had a general knowledge of the topic and were prepared for discussions and the content that can come up with the participants (see Appendix E for video link).

The participants were invited to sign up for this study in person at the WCS. The primary and volunteer researcher visited the organization once a week on Tuesdays at the Centre’s drop-in sessions and presented the option of participating in the study. The researchers briefly described the study’s purpose, the eligibility criteria, and compensation. They shared this information with all the women present at the drop-in session on the dates of the visits. See Appendix F for the recruitment script.

Following the recruitment speech, the primary investigator (PI) announced that the sign-up sheet (4 slots) would be left with the drop-in coordinator in the main drop-in area. The women were told to sign-up under a time slot during or after the drop-in session that day, and a sign-up sheet for slots following the next week’s drop-in session was also provided (See Appendix G). If a woman signed up for the following week and did not show up, the slot was offered to another willing participant. Because the original time slots for later in the day were not leading to much participation (e.g., 5pm), the time slots were moved to earlier in the day (e.g., 12:40pm). Therefore, the participation opportunities were then available either during or following the drop-in sessions. This was determined to be a needed change in time options offered due to women being more likely to participate while they were already on site, as opposed to waiting for a scheduled session. This time adjustment was suggested by the WCS social work programs coordinator.
When signing up, the women were asked to provide only their first names. Their first name was provided only on the recruitment sheet, but the rest of their forms with data (consent form, surveys, interview transcript) used ID numbers. Interviews were conducted on-site at the WCS so participants would feel comfortable in a familiar space. Overall, this procedure took place at multiple drop-in sessions over three months to reach the desired number of participants.

Once participants were deemed eligible and willing to participate in the study, they met with the PI or research assistant in a private room in the shelter. The room had a supply of water and snacks in case the participant needed or wanted refreshments. Next, they were given a consent form to read/go through with the interviewer (see Appendix H). The participants had the option to read it themselves or have the interviewer read it to them. They indicated their willingness to participate in the study by checking a box next to the section stating, “I consent to participate in this study” and by providing verbal consent, as well as providing consent to being audio recorded and for the use of anonymous quotations to be used in papers, publications, presentations, etc. All 10 participants consented to participate and to be audio recorded, and 9/10 participants consented to the use of anonymous quotations. The participants were asked to check a box rather than sign the consent form to ensure confidentiality due to their highly vulnerable status. During the consent form and study completion process, the PI or volunteer researcher was present to assist participants who needed clarification or help with reading. The participants were also asked if they would like a support person of their choosing with them during the interview.
Once the participant consented, she moved on to the three brief questionnaires. The participants first filled out the demographic survey, followed by *The Experiences of Domestic Violence Scale* and the *IPV-SI*. If needed, the interviewer was able to read out the questions and response choices for the participant. Following the completion of the questionnaires, participants completed the interview if they chose to continue with the study. Before this process began, the participants were reminded of the first consent form. The interviewer reviewed the consent form information, and following this, they were interviewed and audio-recorded by the PI or the volunteer researcher.

At the beginning of the interview, the participants were asked about any potential triggers they may have that the researcher should be aware of and were also informed that mentions of child abuse or other duty to report instances might need to be reported (See Appendix I). Throughout the interview, there was also embedded, ongoing consent and check-ins to ensure that the participant still wanted to continue. Furthermore, the participants were told they could take a break anytime. During the interview, all researchers followed the interview guide; however, they asked follow-up questions when they saw fit if more information and detail were needed.

Following the prepared interview questions, the participants were debriefed about the purpose of the study and were told they could withdraw their data at that point in the study before the interview had concluded. The participants had the chance to provide other information and comments that they thought would be useful. They were also allowed to ask any questions of the researchers. Upon completion, a letter of information was provided with a description of the purpose of the study and resources for mental health, domestic violence, and shelter services (See Appendix J for resources). Finally, all
participants were compensated with a $25 gift card for Shoppers Drug Mart. A gift card for this store was given to ensure that the participants could use the money for essentials like food or toiletries. The participants were given this compensation even if they chose to withdraw their data.

Due to the emotional intensity of the interviews, the primary researcher presented the option of debriefing sessions for the interviewers with the PI of the study and their supervisor if needed. These sessions consisted of confidential and de-identified discussions about the interviewing process to provide support to the researchers. The primary researcher also debriefed with their supervisor following all the interviews. The interviewers and transcriptionist were also given a resource information sheet in case they wanted further professional support (see Appendix K).

Following the completion of the data analysis, write-up, and thesis defense, the WCS will be provided with a summary of the study’s results. The shelter, and potentially the women who participated, and other residents, will be able to see the outcome of the study. Further, the results may be used to make changes in the center, other formal support services, and the community at large.

**Analyses**

**Transcription**

Before conducting the qualitative analysis, the interview audio files were uploaded to a OneDrive folder on the primary researcher’s password-protected account. The audio files were uploaded into a Word document using the transcribe feature, and the document transcribed the audio file on its own. The PI, the volunteer research assistant, and another volunteer undergraduate student read through the transcribed interviews
while listening to the audio recording to ensure that the transcription was accurate and that any identifying information (e.g., names and specific locations) was removed. These documents were used for the reflexive thematic analysis.

**Reflective Thematic Analysis**

A reflexive thematic analysis (RTA) was used to analyze the interviews. Generally, a thematic analysis is used to explore individuals’ experiences and how they make sense of them (Braun & Clarke, 2013). The RTA followed Braun and Clarke’s six steps and involved identifying codes within the dataset that were made up of conceptually similar patterns, and these codes were then turned into themes (Braun & Clarke, 2006). The codes and themes were derived when the researchers became familiarized with the dataset by reading through it multiple times and then interpreting the patterns they saw in the data (Braun & Clarke, 2006). This particular reflexive approach was a mix of inductive and deductive, meaning that the coding process was driven by the data and informed by previous research and theory (Braun & Clarke, 2021b). The models outlined previously, including the barriers model, the behavioural model of health service use, the stigmatization model, and the psychosocial readiness model, helped to inform potential themes and how they were named. Further, in terms of reflexivity, the coders played a significant role by interpreting the meaning of and being engaged with the dataset, as well as being aware of their own underlying assumptions and how they would affect the analysis (Braun & Clarke, 2019; Braun & Clarke, 2021b).

Braun and Clarke’s (2006) six key steps in the RTA process were followed for this analysis. First, the PI and the assistant researcher became familiar with the dataset by reading it multiple times while taking notes on their initial ideas and thoughts. After
reading the transcripts, the two coders met to discuss their initial thoughts and potential
codes. The second step involved creating codes with reference to the patterns that were
interpreted from the dataset in a way that was systematic. The system included using
tables with three columns; the first column was used for the codes, the second column
contained the transcript, and the third column was used for the larger themes. Both the
primary researcher and the research assistant used this process. Once this was done, the
two coders met to discuss their codes to ensure they were on the same page. No disputes
occurred. Third, the researchers analyzed the codes and combined ones that were similar
to create larger, overarching themes. This was done by meeting to discuss the codes and
what it was determined that the overarching themes would be. Following this, the
researchers reviewed the themes to see if they made conceptual sense in relation to the
overall data set and the research questions. The codes were then revised, combined, and
edited, when needed. Next, the researchers met and conversed about labels for each
theme that best demonstrated the encapsulated phenomenon or experiences being
expressed by the participants. Overall, the PI coded all 10 transcripts, and the assistant
researcher coded seven out of 10, to ensure triangulation (see Trustworthiness section).
The last step involved creating the report from the findings of the RTA (Braun & Clarke,
2006).

**Approach and Interpretive Lens.** The RTA was approached from a feminist
standpoint view. Feminist standpoint theory recognizes that knowledge and experiences
are socially situated, meaning that findings are not value-free (Wigginton & Lafrance,
2019). Therefore, an essential element of this view is strong objectivity, where the
researcher acknowledges and interrogates their positionality and subjectivity (Harding,
Further, the feminist standpoint approach highlights the voices of non-dominant groups and marginalized individuals (Wigginton & Lafrance, 2019).

A mix of a critical feminist and intersectionality interpretive lens was also used when exploring the data and creating themes. Generally, critical feminist psychology asks questions around power relations, reflects on how questions are being asked, recognizes that there is power and meaning making in language, involves self-reflection, and considers how the participants will be represented (Lafrance & Wigginton, 2019). Further, critical feminism acknowledges the failure in psychology to fully consider how knowledge is affected by culture and one’s circumstances (LaFrance & Wigginton, 2019). The lens of feminist intersectionality assumes that there are unique characteristics for all social groups, that one’s social identities interact and affect one’s experiences, and that we all have positions within social structures that affect power relationships (Kelly, 2011). Further, feminist intersectionality attempts to analyze the experiences of oppressed social groups and their positions and how these positions lead to inequality in accessing resources and social injustices (Kelly, 2011; Chavis & Hill, 2009). An intersectionality lens can be used to analyze structural oppression and how the intersection of a woman’s identity shapes her lived experiences (Kelly, 2011; Syed, 2010). Overall, the interpretive framework demonstrated the perspective and assumptions taken on by the researcher that informed the decisions they made when carrying out the analysis and describing the results (Green, 2014). Therefore, when conducting the RTA, the assumptions of feminist and intersectionality theory were considered, participants’ voices were highlighted, and social structures and power relations were considered.
**Trustworthiness.** Multiple procedures took place to establish trustworthiness and
credibility in the RTA. First, the volunteer researcher that assisted with the interviews
helped with the RTA coding process, otherwise known as investigator triangulation
(Carter et al., 2014). Investigator triangulation is when the research utilizes multiple
researchers to make study observations and decisions about the data (e.g., in the coding
process; Carter et al., 2014). Investigator triangulation helped confirm the findings by
having more than one researcher engaged in the process and allowed for multiple
perspectives of the data (Denzin, 1978, as cited in Carter et al., 2014). The second coder,
the volunteer research assistant, coded 7/10 interviews, while the PI coded all 10, so
triangulation of findings occurred.

In RTA, reflexivity is also important. Reflexivity occurs when the researcher
continuously considers their assumptions, beliefs, and internal dialogue and how they affect
the research process (Braun & Clarke, 2019, 2021b). To demonstrate this, the PI and
volunteer research assistant used reflexive journals (Nowell et al., 2017). In these
journals, the researchers kept track of their analytical and methodological decisions,
thought processes, and their assumptions and reflections about the study’s
processes (Lincoln & Guba, 1985 as cited in Nowell et al., 2017). Both the positionality
statements (see Positionality section) and reflexive journals were used to facilitate
bracketing, by allowing the researchers to explore and acknowledge their experiences and
how it related to the topic being studied, while also self-reflecting and being open-minded
(Drew, 2004; Starks & Trinidad, 2007).

The primary investigator and volunteer researcher met virtually on Teams at the
start of the analysis to discuss their general thoughts. They met one other time to discuss
their codes and to ensure that they agreed on the final codes and themes (Nowell et al., 2017). They also conversed constantly via Teams to finalize the theme labels. All the meetings that occurred were also recorded. Overall, having an audit trail was important for this study because it demonstrated transparency in the analytic process and evidence for the decisions that were made (Koch, 1994).

**Positionality Statements.** Positionality is important in qualitative research for the readers to understand how the researcher’s personal background and identity can shape the research being done and the assumptions they come in with about the research topic (Braun & Clarke, 2019, 2021a). I, the PI, am a 24-year-old woman. I have never experienced homelessness or IPV. With that being said, I have experienced many barriers to accessing formal support services. I have been put on waitlists, struggled with paying for some services due to finances, and have been gaslit and doubted by service providers. These experiences have made me hesitant at times to access further formal support services when I needed them. Part of the reason I chose to do this research was because of past obstacles and negative experiences I faced and wanting to make change for those who are vulnerable to more barriers than I have been.

These personal experiences can and have affected how I view some formal support services such as medical professionals and the healthcare system, so it was important to be reflexive throughout the project to ensure these experiences did not affect how I interpreted the findings and interacted with the participants. Although, within qualitative research, objectivity is not essential; the critical feminist and intersectional paradigms used acknowledge that it is impossible to not be influenced by personal feelings and experiences, but the important step is to recognize that they are present.
Therefore, throughout the research process I kept myself aware of these assumptions and experiences.

The second interviewer and coder on this project identified as a cisgender woman and has had the security of stable housing throughout her life. She attributed the experiences she gained as a residential youth worker as formative in her research interest development. The treatment program for which she was employed offered support to a resilient population with complex traumatic histories and experiences of dating violence, among other presenting concerns. Further, the prevalence of unsafe and insecure home environments posed an ongoing challenge. This exposure shaped her understanding of the social world and gave rise to her interest in bridging the research–practice gap, which, in turn, was something she regularly reflected upon throughout her involvement in this study.

CHAPTER 3

Results

Demographics

Ten women were recruited through the Welcome Center Shelter. The mean age of the sample was 44 years old (range = 28-70), and all participants identified as female, meeting the inclusion criteria. Fifty percent of the participants reported being limited due to a long-term physical or mental health condition, disability, or health problem; however, nine out of ten participants chose not to disclose the specific limitation. The average number of children the participants had was 2.5, with 90% of the sample having children. The participants reported the length of time they had been homeless; however, one participant’s response was unclear, so only nine responses were considered for this
variable. The length of time being homeless for the participants varied from three weeks to 3.9 years. The average length of time being homeless was 30.8 weeks. Furthermore, the average number of times being homeless was three for this sample. This excluded two participants, as one chose not to respond, and one did not provide a number. See Table 1 for the remaining demographic characteristics of the sample.

Table 1

Demographic Characteristics of Sample

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<tr>
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<td>70</td>
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<td>Indigenous/First Nations/Metis</td>
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<td>70-79</td>
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</tr>
<tr>
<td>Retired</td>
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</tr>
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</tr>
<tr>
<td>Employed full-time</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>
Prefer not to say 3 30
Relationship status
  Single (never married) 6 60
  Divorced 3 30
  Widowed 1 10
Country born
  Canada 10 100
Disability
  Yes 5 50
  No 5 50
Children
  None 1 10
  1-3 8 80
  4-6 0 0
  7-9 1 10
Length of time homeless
  1-5 months 5 50
  5-10 months 3 30
  1+ years 1 10
Times Homeless
  1-2 4 40
  3-4 3 30
  5 1 10

Quantitative Findings

All participants met the inclusion criteria and scored above zero on the
*Experience of Domestic Violence Scale*, where scores can range from 0-12, 0 being no
abuse experienced and 12 being the highest level of abuse experienced. Sixty percent of
participants' results demonstrated the maximum score on the experience of DV scale,
indicating high rates of domestic violence in the sample. The mean score was 11.1. Sixty
percent of participants reported *frequently* on the item asking about their husband or
partner being sufficiently violent towards them to cause injury. Eighty percent of
participants reported *frequently* on the item asking about their husband or partner
insulting them strongly enough to cause psychological harm. Finally, 80% reported
frequently on the item of *perceiving a strong threat from their husband or partner.*

Overall, the incidence of domestic violence experienced by this sample was high.

**IPV Strategies Index**

The results of the *IPV-SI* indicated that the most endorsed strategies involve resistance and placating. The most used strategy on the placating subscale was used by 90% of the women. This consisted of trying to avoid an argument with their partner. In the resistance category, 90% of the women fought back physically and verbally and left their homes to get away from them. The strategy that was used the least was trying to get help from their employer or coworker, which was used by only 10% of participants.

The results for each subscale indicate the average number of strategies used for each subscale and which strategy was used the most. For the formal network subscale, the average number of strategies used was 3.5 out of the 9 strategies (38.8%). The most used strategy in this subscale was calling a mental health counsellor for themselves, with 50% of the women using it. For the legal subscale, the average number of strategies used by the women was 1.2 out of the 3 strategies (40%). All the items on the legal subscale were endorsed equally, with 40% of the women using each strategy (filed or tried to file criminal charges, sought help from legal aid, and called the police). For the safety planning subscale, the average number of strategies used by the women was 4.2 out of the 10 strategies (42%). The most used strategy in this subscale was keeping money and other valuables hidden, with 70% of the women using this strategy. For the informal network subscale, the average number of strategies used by the women was 2.3 out of the 4 strategies (57.5%). Two strategies were used by 70% of the participants, the highest use on this subscale, and this includes *talking to family or friends about what to do to protect*
myself/children and stayed with friends or family. For the resistance subscale, the average number of strategies used was 5 out of the 6 strategies (83%). Three strategies were used by 90% of the participants, and this included fighting back physically, leaving home to get away from them, and fighting back verbally. Finally, for the placating subscale, the average number of strategies used was 4.1 out of the 5 (82%).

The scores for the helpfulness factor of each strategy were not calculated for this study. Based on a visual inspection, too many data were missing within this section of the measure. Therefore, due to the lack of participants filling out this section of the questionnaire, these results were not reported.

**Qualitative Findings**

Based on the four research questions, five domains were created in the RTA process. The five domains include Factors Leading to Homelessness, Needs of Women Experiencing IPV and Homelessness, Barriers to Accessing Services, Facilitating Factors, and Social Positionings’ Effect on Homeless Experiences and Access to Barriers. Four of the five domains contain more detailed subthemes that describe the women’s specific experiences within each area.

**Factors Leading to Homelessness**

The main theme in the interviews regarding factors that led to homelessness was Conflict and Precarious Circumstances Leading to Housing Instability. All the women in this sample became homeless or experienced instability in their housing due to either violence and conflict or precarious, unstable and dangerous situations. The types of conflict resulting in housing instability consisted of human trafficking, IPV, landlord
conflict, and familial conflict. Participant 01 discussed her experiences with both landlord and partner conflict and violence:

I was evicted from my home. Uhm, the landlord, I believe I wanted to raise the rent. So, there was that, and I believe there were complaints made. And I don't know who made them, but I believe they were done by my neighbours from him drinking all the time and being loud. And then the fighting. So, I think that was... also part of it.

Multiple participants described becoming homeless due to experiences with violence and abuse from their past romantic partner, and these women were the ones who had to find a new place to live when choosing to flee the abuse. Participant 07 mentioned, “I... jumped into the relationship that I shouldn't have when he was drinking and doing alcohol and drugs” and went on to explain how she eventually fled the relationship and had no housing of her own, leading to her using the shelter. Participant 10 described being homeless on and off for 29 years, and it all started “in another city a long time ago,” she explained, “With a gentleman that I, I moved into his apartment, and that's when it all started, and then it went kind of downhill from there.” Similarly, Participant 12 described the abusive relationship that led her to leave the situation and country she was living in, resulting in homelessness:

And he's acting like everything was totally fine. And so, to keep me from finding out that he was hacking, and that it was actually him and my sister stealing, he would actually beat me; every single day. Every day. So, calls to 911, calls to friends, all got rerouted to him. And calls that friends made to me, got rerouted to him. So, we were living out in the country, and I have no help whatsoever with an
autistic child. So, both like, toddlers, and for months and months- like months of like, being beaten. Yeah, I finally tried to escape, and my children were taken from me.

Sixty percent of the women experienced some form of extortion or trafficking, with Participant 03 being trafficked by an individual from the law, “Uh, I was human trafficked by a lawyer... and, uhm, I was told I'd be assaulted by guys, but nobody told me I was going to get raped.” The other mentions of human trafficking and extortion came from individuals the women knew or occurred when attempting to get money for the housing they had at the time. Participant 06 described difficulties with being behind on rent, leading to a need for money. She explained that she “was lured into being kidnapped and trafficking. I was on the missing document with the police.... I was, uh, lured into making $1000 helping somebody move.” Two other women experienced human trafficking and extortion from partners they initially thought that they could trust. When describing the formal services that she attempted to seek, Participant 11 recalled, “I discovered that my ex human-trafficked me.” Similarly, Participant 09 was told she would be extorted for money by an individual who she was seeing at the time, leading to conflict and later, homelessness.

A handful of women also mentioned issues and conflict with their landlord, whether it involved not paying rent on time, being forced out of their unit for no legitimate reasons, or not having the correct paperwork. Participant 05 recalled:

Uhm, back in 2019, uhm, a sheriff came to my door and told me that I had to get out of my home. Uhm, I was in Windsor housing and uh one paper I've misplaced or didn't make it into the paper package... and so they said I owe them one month
market rent which was $950. And- and I was on the assistance, couldn't afford to do that.

Two participants were evicted without any apparent just cause. One experienced a health crisis, during which time she was evicted from her apartment, leading to her being housed at the shelter, “while I was in the hospital, and I came back from the hospital, with nothing but the clothes on my (curse word), October the 8th or 7th or whatever date it was. And couldn't get into my apartment.” Overall, all the women expressed a form of conflict or precarious circumstance that led to them being either on the streets, in the shelter, or unstable in their housing situation.

These precarious circumstances and conflict not only resulted in homelessness and housing instability, but also continued to be a pattern in many of the women’s lives as they continually attempted to find housing. In other words, the women were unable to escape dangerous circumstances and conflict and continued to be surrounded by instability. For example, Participant 06 described her experiences with conflict at the shelter:

They do provide a lot. They give you Christmas presents, they give you gifts for your kids. They give you food every day. You know what I mean? They're not trying to... make you be without. They give you heat, shelter. I can't say nothing wrong about this place. The only thing is thieving- is the people that come in here. Stealing and stuff like- we all have to live together. We all have nothing. Come together like, you know what I mean?

This conflict further occurred between roommates at the shelter. Participants further described instances of disputes and dissatisfaction with the other women they roomed
with or difficulty finding housing with roommates. Participant 02 spoke about the difficulties she has living with her younger roommate, “when you're living with somebody who is completely the opposite. It's like living with a 12-year-old again. And she can't help it, or if she can, I want to smack her. [laughs] Because, oh man, it's horrible.” As can be seen, recurring violence and conflict with roommates made it difficult for some of the women to find further housing and be comfortable within the shelter. There were further mentions of difficulties when finding roommates to live with when looking for housing, where conflict occurred due to relying on one another.

Participant 10 highlights this well:

I found that it was really difficult to be able to stay put in one area, so I've been bouncing for years because you meet one and then you got to leave and then they—you're, you're in—if you're in any type of housing situation, it's even more difficult because there's a lot of mental illness in there, and that's where, for me, I got attacked more than once because of mental illness in these housing projects.

Overall, conflict and precarious situations were the most prevalent factor leading to women’s homelessness. Further, these precarious situations continued for some when trying to get back on their feet. This demonstrated both the internal and external circumstances of the system, being housed with others who were likely to cause or heighten conflict, and personal difficulties escaping their current living situation.

**Needs of Women Experiencing IPV and Homelessness**

There were three main subthemes generated regarding women’s needs in relation to both homelessness and IPV: *The Foundation to Survive, Health and Wellbeing*, and *Employment and Financial Assistance.*
The Foundation to Survive. Whether explicitly stated or not, all 10 women described the need of having a place to live. This need was either expressed in the difficulty involved in finding housing or in describing the importance of having housing for meeting other needs (e.g., employment). For example, Participant 05 stated, “I can say the only thing that I find is difficult, well find- trying to find a rental from here.” Others were more explicit, with Participant 02 discussing the importance of having a place to live, “Well, I’m a firm believer that you need a home first in order for everything to fall into place. Because you need a place.” Likewise, Participant 10 was very direct in this need, “I definitely need shelter.” Participant 09 described needing shelter first and foremost, followed by other essentials such as food and clothing. Akin to shelter, some women mentioned a strong interest in community and/or transitional living: “I would like to get into like, maybe like, community living.” Participant 12 expressed her need for transitional housing, which occurs as a step between living at a shelter and permanent housing (Gaetz, 2014), when also discussing her employment suggestions, “I w- I’d rather work later at night, or middle of the night. Something like that. Like, starting off with four hours, and then transitional housing to kind of move up from there.” Other basic needs for survival that participants mentioned were food as well as food banks, identifications, and clothing. Across the board, the participants expressed a need for basic necessities for survival: housing, food, and clothing.

Health and Wellbeing. Health and wellbeing were mentioned as frequently as the foundations needed to survive, if not more frequently. All participants described some form of health need, whether it was a physical health need or a mental health need. The most common health need was the need for mental health workers such as counsellors,
therapists, psychiatrists, and social workers. Most participants were direct in
acknowledging their need for mental health services; Participant 05 specified, “Mental
health is also very important too…. some sort of counseling would be good.” Not every
participant recognized this need for themselves, but other supports they had did. For
example, Participant 07, who experienced an extensively abusive relationship,
mentioned, “Like my mom said, you need to get counseling and you need to get some
help [after a relationship like that].” Participant 09 also expressed a need for self-esteem
building in workshops related to mental health, despite not acknowledging a personal
need for individual therapy or counselling.

Physical health needs for the participants involved surgeries, medications,
consultations with a primary healthcare provider, general medical needs, as well as
gym/fitness needs. For example, Participant 02 experienced extensive injuries as a result
of IPV and expressed her need for medical care:

I need like physiotherapy and chiropractor- honestly really bad. And like,
massages, uh, like, I got like- I did the math, and I got r*ped like, I would say
about 80 to 100 times every five months. And over four years. That's like- it said
it was like 600 and something to 900 and something times. It's like my bones hurt
a lot, and I've lost a lot of blood, like, due to that. Uhm, and like, I don't know,
like, broken bones and like seizures and like, I have scarring in my lip here from
like, uh, my teeth going through my face and... stuff and I have like- where I got
hit, I'm not sure they said that they weren't sure if I needed a metal plate in my
head.... But like it really, it's like burns like right here [gestures to head], like I
feel like it's on fire and it's like a big like, indent in my head. And then I have
more than one like, I have skull fractures and stuff in my head and that. So, like you can physically feel them with your hands and so.. (sighs) So, I just- I don't know. I think that like, if a girl gets trafficked and that she should really have like, make sure that before the cops leave that she has like, a doctor that like, is really like, you know what I mean?

Participant 02 expressed a similar experience with pain; however, this was ascribed to her advancing age:

I guess as individuals like for me it would be healthcare. Definitely, healthcare for me. And support in the way of physically supporting me. Physically, helping me, maybe with housework when I need it or whatever. It's come down to that now again where I have to have some physical help... like I'm in really a lot of physical pain, really, really, physical pain. As the weather warms up, and if I can get another treatment, maybe on my shoulders and my knee, or if they're going to do surgery, I don't know what they're going to do. They don't know what they’re going to do.

Medication was also expressed as a need, “So definitely, my medications and um, counseling,” and general referrals to healthcare practitioners, “referrals to like, doctors - and stuff like general doctors....” Taken together, the women expressed high levels of need for their personal health – both physical and mental- as was expected for this population due to the precarious circumstances and violence they have experienced.
**Employment and Financial Assistance.** The final subtheme was regarding employment and financial needs. Not only did the women mention a need for financial assistance and money, but some also discussed a need for employment and desiring help with finding employment opportunities. Participant 02 expressed the difficulties of finding employment when you do not have your basic needs met: “—but it's hard to have a job when you have no place to wash clothes or wash yourself, never mind clothes,” and went on to point out her need for money, “Money. Money is the root of all evil, you know, love of money. But it's not this cold in the scriptures. [Laughs] Money's a good one.” Similarly, Participant 09 expressed not having to have enough money to access certain environments and being looked down upon for her lack of money.

Two participants expressed wanting assistance with finding a job, as this was described as difficult due to their circumstances or race. Participant 12 expressed wanting assistance, especially with finding part-time jobs to slowly transition back into work:

think there needs to be more like, um, services for like, well, a lot of women I know, including me, don't want to work like, a full- like, we're not- I'm not ready for a full-time job yet... So I think, like maybe, more help finding a job where like, most women don't want to be around people.

Participant 09 also expressed the need for skills building workshops and training to prepare herself for the workforce. Overall, financial assistance and employment was a common theme amongst the women in this study.
Barriers to Accessing Services

There were four main subthemes concerning barriers to accessing formal support services for homelessness and IPV: \textit{Strained and Flawed systems, Psychological Barriers, Experiences of Dismissal and Minimization, and Financial Obstacles.}

\textbf{Strained and Flawed Systems.} The most common theme surrounding barriers to accessing formal services was related to strained, overwhelmed, and flawed systems. In other words, the women often expressed being put on waitlists for services, insufficient availability of beds and providers, a lack of rooms accommodating specific needs (e.g., dog friendly), or simply a lack of availability for services they needed. Waitlists was the most common issue mentioned within the system. This issue is demonstrated by Participant 10’s long wait time for mental health treatment, “I was on their waiting list for posttraumatic stress for five years.” Participant 06 similarly expressed her frustration with the long waits in the system:

The paperwork and all that just takes too long and you're just sitting here. Like I said already, they’ll give you all the help at the beginning. But then it seems like you just wait after that. Like it's just a long wait too. It's not like- things should move. If things moved quicker... people would be OK. This paperwork takes three months. So, you're homeless for three months before the paperwork even goes in. Participant 02 experienced delays in services for housing as well:

I was told I was going to get these places and they're working towards it, but then it got delayed. And then it got—the papers got misled, mismade, mislaid, and now, ‘well your time is running out’, and it's like… [sighs].
This waitlist barrier was magnified during the COVID-19 pandemic, such that participants expressed that services had insufficient bed space and experienced longer waitlists compared to pre-pandemic times, even for the Welcome Center Shelter, “they have less beds available and then they had to separate people, so it made me difficult to get into there.” Similarly, Participant 06 expressed concerns about the shelter during the pandemic, “Because even here, this place here, and they can only take so many people. At that time because the pandemic, you can't put all these people in the same place.”

Multiple participants expressed difficulties with getting into a shelter due to insufficient space and beds. While trying to be optimistic, Participant 02 recounted being turned away from the shelter due to a lack of space: “They just didn't have space for me at first. I was only turned down for the one night.” This forced many participants to find alternate shelters, which was a difficult task. In a similar vein, other women experienced longer wait times, “I've called, called, and called and called and eventually there was a bed available.” This barrier also occurred for human trafficking services and sober living services. One participant noted that this obstacle could contribute to ‘life or death’ and dangerous circumstances, especially when dealing with drug addiction:

There's ten beds in [city], um, for women who want to live sober... by the time somebody gets up on the list, they've either tried to kill themselves, or are in- in the psych ward, or they're out homeless, using drugs and are probably in psychosis, and have no idea what to do with themselves... When you're on a waitlist for a treatment center, or for sober living, or for [the non-profit mental health organization], or for a family doctor, that's life or death for addicts especially, and people who are already homeless.
Another system-level issue the participants described, specifically at the shelter, was a lack of pet-friendly rooms and requirements and other restrictive requirements for staying in particular rooms. Two participants described their experience of dog ownership while homeless and reported that they were unable to keep the dogs at the shelter due to a lack of rooms that could accommodate pets. This led to distress for these women, as they considered their pets to be a part of their family. This was demonstrated by the following quote:

Now, I have a dog. But I can't get into the dog room until that family with the dog leaves because there's only a couple [dog friendly rooms]... So, on a certain side, you can have a dog, but other side you can't, which is wrong I think. It's a family room. Who cares what it is, your family is your dog. If you're allowing pets, which they finally do, which is amazing. My- my dog is put up, he's good, but I mean if something happened where would I bring him? Where would I bring him? If I- if I- if I maybe he's being abused or something I need to bring him with me. You know or not treated like he- he's a part of the family.

Another participant had a similar experience and struggled with finding a place for her dog due to the lack of room availability at the shelter, “I had to basically save my dog from going to the Humane Society yesterday. And... my mom had a take her, and my mom can't keep her very long because she has other dogs.”

In a similar vein, another participant had difficulty with getting a particular room at the shelter due to requirements for family rooms and single rooms. Originally having her child with her when coming to the shelter, she mentioned, “I called, they said come in. I came in. But first they said, are you single by yourself? I don't think I have a room
for you. I said no. I'm with my son. They said ‘oh, that changes everything.’” However, due to the prices of cabs to get her son to school, she had to move him in with other family members, later noting, “Now they just say, ‘well if your kids not here with you, you can't stay.’ Well listen, my kid will be here when there's no school.” This left the participant in an unsettling situation, where she could potentially lose her spot at the shelter due to no longer fitting the requirements of the family room. Taken together, there were many barriers faced by women that related to the way different systems have been structured, leading to long wait lists, insufficient space, and a lack of certain rooms being available. This demonstrates the extent to which the systems are overwhelmed.

**Psychological Barriers.** Another common barrier revolved around women’s emotions, perceptions, and mental health. Participant 01 said, “I was scared” when talking about barriers to accessing services, and Participant 10 stated that “the emotional part” years ago got in the way of help-seeking. In other words, intrapersonal factors affected some women’s ability to seek help. It was also scary for Participant 06, as she said, “Violence is to tell... To tell somebody or to tell.” Emotions, such as pride, further impeded participants’ ability to seek help, as Participant 12 discussed her pride and perception affecting her help-seeking:

> Uh, I would say my perception. Because before I thought like ‘oh, it’s not going to happen to me.’ But it did.... personally, pride would be. Like, just the only one.... to come to like, acceptance I guess? Like, ‘look. I'm an abused woman.’

There were also expressions of not being ready for help, “ Uhm... at the time I wasn’t ready for time- I wasn't ready for counseling and stuff so I kind of pushed them away.”
Finally, one participant specifically expressed that her mental health state affected her ability to reach out for help, acting as a barrier:

I would say number one reason would be my anxiety, depression...It holds me back from doing a lot of things... and it's almost like it started with like a PTSD through the domestic violence- And kind of grew from there, like. Almost to the point where it's like. Well, if I'm that low, if I’m that piece of crap or whatever that got beat up and treated unfairly then who's going to listen to me, like who's going to want to help me kind of thing?

These findings demonstrate the impact that emotions and individual perceptions of readiness affected participants’ ability to seek out help and formal support services. Compared to the previous external, systematic barriers, these barriers demonstrated intrapersonal factors.

**Experiences of Dismissal and Minimization.** Participants reported instances of being dismissed or not taken seriously by service providers, including police officers, doctors, shelters, and services for human trafficking. Participants stated that they “always get turned down” or that “they [the service providers] didn’t care.” Three participants described instances with police officers who either did not take their situation seriously, were disrespectful, lacked empathy, or did not attempt to help them. Participant 12 described her poor experiences with a police officer and the effect of the power that they hold:

The other- the other chick, she was just going to let me go off on the street. Like, just like- like- like nothing. You know, and then she started making fun of me. And I was like, I was like, ‘glad you have a sense of humor.’ I'm like, ‘it's great.’ I
just, like, kind of let it slide. It's not that worth- It's not worth it to get her, especially with police officer, because they do have that power of authority over you.

Further comments were made about police officers in relation to power, and how women reported feeling that the police officers desired to maintain power and dominance over them while also lacking empathy and care during their interactions. These instances highlight the effect of social structures and power relations and how they affect women’s ability to receive proper care and assistance.

Other participants noted being fully dismissed by service providers when attempting to reach out for help. This often resulted in the women not being able to utilize services that they required to meet their urgent needs. Participant 10 described her experience when attempting to get medical help and was fully dismissed:

the doctor—I got my doctor to give me a note, a letter, to this mental health division. And what did they do? I went to a meeting. He wouldn't even put it [the note] in his hand. That's how rude he was.

She further discussed being turned down from different services, “when I tried to get into any shelters for the last umpteen years, I was rejected.” Participant 03 noted a similar experience with rejection and dismissal from shelters, “No women shelters would like, help me and they- everyone started saying I had mental health issues.” All these experiences demonstrate the common occurrence of being dismissed and belittled by providers, leading to services not being utilized by these women, even when they are in dire need and wanted to access these resources. Overall, these women had experiences of
oppression and dismissal, which highlighted the interaction between structural systems and the circumstances of this subgroup of women.

**Financial Obstacles.** Similar to financial need, a handful of women expressed financial obstacles when attempting to access services (e.g., transportation and medical services), or how in general, life as a homeless individual is unaffordable. For example, Participant 05 expressed that, “There's always worries about something coming with a cost” and Participant 02 made a point about obstacles of finances, “Homeless is not cheap, by the way. It is not. It's very expensive to be homeless. Let me tell you that.”

When trying to find housing, this participant further experienced financial difficulties:

They’ve already sent me a thing for a room, furnished room, for $700.00. It was like, ‘no!’ You know. So, like yes, I can refuse. Yes, I can. Yes, I can refuse. That is far too much money. I'm not spending that. Site unseen. Don't want it. Don't bother. If I'm going to pay that kind of money, I'll pay the extra and get a proper apartment. Not getting a furnished room for $700.

Others discussed the difficulty in trying to pay for services such as medical care. One participant could not get the surgery she needed due to the price being unattainable:

It took me 11 years to get some major surgery done in [province], because they didn't want to touch it with a 10-foot pole, and they told me to go back to the province that I originally got the surgery and I said, ‘I can't afford that. I don't have the money.’

Due to this wait, participants endure pain for years. Similarly, two participants noted financial difficulties in relation to getting or paying for transportation. When going to physiotherapy appointments, Participant 02 states that, “I have to pay for parking—you
know, I have to pay for, you know, like… If I didn't have a car, I wouldn't be able to walk to it because I can't. I can't walk that far.” Participant 06 also talked about the frustration and financial strain in paying for her child’s transportation between the school and the shelter, “I've paid twice already s- 90 uh, 3, 6, 9, a $120 for two days of school... $60.00 a day. So I paid 120 for two days, and I just said I can't do it.” Overall, financial barriers further impeded participants’ ability to access the services they needed, to gain housing, and to be mobile due to the cost of transportation.

**Facilitating Factors**

There were two subthemes that became evident in relation to facilitating factors for accessing formal support services: **Supportive Networks**, and **Resilience, Proactivity and Growth.**

**Supportive Networks.** The most prevalent facilitating factor amongst the 10 participants was having social support from those around them. The nature of this social network and support varied, and consisted of either family, friends, other women at the shelter, staff, or the providers of services. The women talked about feeling supported by others in their lives who encouraged them to get further help, pushed them to grow and heal, and provided help when they were in need. Some women noted that the providers they were seeing supported them by pushing them to do better and by displaying transparency and honesty. This was reflected by Participant 01’s statement when talking about her counsellor, “I think 'cause she's real. She doesn't beat around the bush, she’ll tell me exactly how it is,” and similarly stated by Participant 11 when discussing her mental health provider:
She's just very, very kind and very like, understanding um. Yeah, just um, very understanding, very kind, very, um, accepting of what I have to say, and if I've used, she doesn't judge. She- if I, um, like, she knows when I'm lying to her, so she can call me out on it. But yeah, if I- if I use, she doesn't judge me for using. She’s just, ‘okay, what's the next step that we can take?’"

Others talked about how “amazing” and “helpful” service providers have been for them, other than just providing the services they are required to provide. This was shown by the following quote, “She's like my life coach....Like I've accomplished so much in the time that I've been there, and had her with- as my like, worker.”

Other women noted that they receive a lot of support from their family members, who often encourage them to get help and leave their precarious circumstances. Participant 11 demonstrated this theme by talking about the support she gets from her son in relation to the abusive relationship she experienced, “He's there for me, and like, I told him it happened -The situation, and he's like mom, you need to move on with your life and get your life straighten up before you find another man.” This participant further identified getting support from her mother and her cousin who helps her with tasks on a weekly basis. Participants 2 and 10 discussed emotional support from their children and siblings.

The supportive networks also came from those at the shelter, both the other residents and the staff. Some women were able to make connections with other residents, felt comfortable at the shelter, reported being treated nicely, and did not feel judged by those around them. Participant 02 reflected on the support and connections made with other women at the shelter due to the similarities in their experiences:
I think the other thing too is support amongst people and not necessarily professionals, but sisters among sisters women among women. Even men among women. Like sharing experiences because you do, you do pick up people that you bond with here and like for instance, [name of other resident] and the baby. I laid eyes on that baby. I laid eyes on [name of other resident] and within minutes I knew she could be my friend. She is—We could be connected and we were and we became friends.

Similarly, two other participants discussed how well they were treated at the shelter, “They're nice, they're not rude because you're in here, they don't judge.” Participant 03 took it a bit further and compared how she is treated now at the shelter to her previous life experiences:

So, that I've been basically around violence my entire life and so that due to that-that like, here like everyone’s nice to me. Like I met like, some people give me their phone numbers and stuff like that and like, my life hasn't been like that probably like, in a long time.

Overall, the women described receiving social, emotional, and instrumental support from many different individuals in their lives that facilitated both their experiences with being homeless and seeking support services.

**Resilience, Proactivity, and Growth.** A handful of women’s stories demonstrated that their resilience, proactivity, and growth as a person was a facilitating factor in their journey when they tried to seek help and support services. Participants talked about being proud of themselves and being able to open up more. When discussing her experiences with anxiety when trying to access services, Participant 05 said, “Wasn't
so bad getting in the door, I was still kinda scared, I still am. But, I've opened up more since.” Others reflected on putting in their own effort and being proactive, and that is how they got help. This is reflected by Participant 06’s statement, “I’m putting my effort into it. It's my effort.... Like, I'm putting everything I got into it, and if you don't you can be lazy about it. There's other people that can use that spot.” Similar sentiments were shared by two participants about finally putting in the effort to take care of themselves and showing self-love; this can be shown by the following quote: “I got to take care of me. It's time... I did it for me, not for anybody else, so I've learned different things that work for me.” Participant 11 felt similarly, stating, ”it's just very recently that I've gotten to the point where it's like, 'Okay. Like, it's time for me. Time to love myself.'”

One other participant also emphasized being proactive, and how this helped her get the services she needed. Participant 11 discussed doing her own research and finding information for services on her own, “I do a lot of research on my own. Um. So, Google was a huge help... being proactive, and researching, and, um, doing things like, reading or something, in- before, until I get into that service.” Others emphasized being strong-willed and standing up for themselves when they did not get treated well. Participant 12 had a poor experience with a service and mentioned, “I've called them out, publicly. I've called them out, uh (service), publicly on Twitter.” Participant 10 discussed the difficulty of being on disability, and how she must be strong because of it, “When you're on disability, and like you know, you've got all these three strikes against you, it's harder. And if you don't have a voice, you gotta have a backbone.” Overall, these women demonstrated resilience, strength, and being proactive as facilitators in moving forward with getting help and assisting themselves.
**Social Positionings’ Effect on Homeless Experiences and Access to Barriers**

Although most participants did not believe that their identity or social positioning affected their homeless experiences or ability to access services, there were two subthemes that were generated from the interviews: *class* and *race/ethnicity*.

**Class Social Positioning.** A handful of women expressed the effect of their class, or socioeconomic status, on their experiences with homelessness and with formal support services. Being homeless and part of the lower class at this time in their lives resulted in others treating them differently; a lack of respect, being looked down upon, taken advantage of, and stigmatized. This was emphasized in the following quote from a participant who originally came from a well-off family:

> Class yeah, because, uhm... I- I was raised in a very, very well, well off family. I chose to be on my own. And it's like... I can go with my family somewhere and get anything I wanna in society, but when I walk into a store myself, I'm labeled. Why am I labeled? Like, I have $6000 in my pocket I'm going to buy something. But I- you're following me around the store.

Two participants described that the intersection of both health and class led to difficulties for them during their homeless experiences and when trying to access services, leading to oppression and a harder time getting jobs, “It's always money and health. That's what I think anyways. For me.... You know, I'm intelligent enough to have jobs. I had jobs. I'm creative enough. I know right from wrong. So, like really it's like money.” Participant 10 shared a similar experience, but also included gender, being a woman, in this intersection, “You got disability, you got gender you got income. All three. That is so hard to get through to people that, you know, and keeping us oppressed
in this country is all part of their strategy too.” Overall, this theme demonstrates how the
effect that one’s social class and its intersection with one’s health identity leads to
negative experiences (e.g., difficulty finding a job) and stigmatization by the greater
community.

**Race/Ethnic Social Positioning.** Although only three participants identified as not
being Caucasian, it was deemed important to describe how their race and ethnicity
affected their experiences with homelessness and trying to access services. Two out of
the three touched on these experiences, but they described the effect of their race and
ethnicity as extremely significant to their experiences. Both participants described how
their ethnicity/race made it much more difficult for them to access services, being denied
or not taken seriously, or led others to think that they do not deserve what they have due
to their identity. Participant 10 noted the struggle she has had with her identity:

> It's been a struggle for me. The Aboriginal status. And if you come from a
> background of Aboriginal status, everybody knows we've been through severe
> trauma and rape and everything else, so that has been a big—a big impact on my
> life as far as the Aboriginal descent.

While Participant 09 did not consent to the use of anonymous quotations, she described
in great detail her experiences with systemic racism and how racism impacted her
experiences being homeless and trying to access formal support services. Her identity, as
a black woman, exposed her to racial slurs and assumptions of her worthiness for
financial support, which contributed to her experiences with violence and homelessness.
This further affected her experiences with finding housing after becoming homeless, as
some landlords expressed racist behaviour and did not want someone of her race in their
unit. Finally, she expressed that she felt others looked down on her and saw her as ‘less than’ due to her identity.

The other participant, coming from an Aboriginal descent, expressed similar experiences. She faced racism in the medical field, the bank, and other services. She mentioned experiencing racism when trying to get approved for a mortgage:

I couldn't even—I had money in the bank to have—to get a mortgage. The bank that I dealt with did everything in her power, this manager, to make sure I couldn't get a house. A mortgage. She called everywhere and told them, ‘don't give her a mortgage. Don't give her a mortgage. Aboriginal.’”

To conclude, both participants experienced systematic racism; they were denied and dismissed from services solely because of their racial or ethnic identity. This impacted their ability to access housing, financial assistance, and medical services. This demonstrates the intersectional relationship between identity and structural systems of both privilege and oppression.

CHAPTER 4

Discussion

Summary of Major Findings

Quantitative Summary

The purpose of this study was to explore women’s lived experiences with homelessness and intimate partner violence (IPV). Furthermore, we examined barriers and facilitating factors to accessing formal support services and the impact social positionings have on these service experiences. Finally, the goal was to highlight marginalized women’s voices to fully understand their points of view and personal
journeys. The quantitative questionnaires demonstrated that the sample experienced high levels of IPV in either a current or past relationship. The scale on IPV ranged from 0-12, and the mean score for the sample was 11.1, indicating extreme levels of violence for most of the participants. The participants experienced varying lengths of being homeless, ranging from three weeks to almost four years. The quantitative measures also demonstrated that the most common type of strategies used by women experiencing IPV involved resistance and placating, specifically trying to avoid arguments with their partner, fighting back verbally and physically, and fleeing the home to get away from them. These findings are supported by a review conducted by Osborn and Rajah (2022) that aimed to understand women’s resistance to violence, and many articles in this review showed that women often use resistance and fighting back as a strategy for handling abuse. Similarly, a review conducted by Wood et al. (2021) examining the strategies used by women from low- and middle-income countries who were experiencing violence supports the result that many women try to avoid or placate as a strategy, although these behaviors are often only temporarily helpful.

These quantitative findings tell us about the high rates of violence and extended lengths of homelessness faced by some women in the Windsor community. More specifically, these findings demonstrate the co-occurrence of IPV and homelessness in the local community. The longest duration of homelessness was almost four years, despite the participant attempting to get housing throughout that time frame. This finding is significant because it shows the inadequacy of the current programs that aim to help individuals find affordable housing and get them back on their feet. In other words,
housing services in Windsor are not fulfilling the needs of a handful of homeless women in Windsor, and possibly more that were not a part of this study.

In addition, the findings regarding the most common strategies for IPV used by the women in the study are noteworthy because they are contrasting strategies, placating and resisting. Placating involves an attempt to lessen the anger someone feels, whereas resistance involves fighting back and opposing the other individual. We saw women in this study using both of these strategies, which could imply they are starting with one strategy and moving on to the other when it becomes ineffective. Researchers could examine the directionality of these strategies to understand their relationship better and see what external factors contribute to a woman’s decision to stop using one strategy and take on another.

**Qualitative Summary**

**Needs of Women Experiencing IPV and Homelessness.** The thematic analysis showed three important needs for the group of women in their current situation: health (physical and mental), the foundations to survive (housing and basic necessities), and employment and finances. The latter finding is consistent with other studies that emphasize financial support as a need for those experiencing both homelessness and fleeing from partner violence. For example, in a recent study conducted by Chiaramonte and colleagues (2021), they examined the service needs of instability-housed survivors of intimate partner violence and found similar results; these survivors' highest needs were vocational and transportation needs, financial and housing needs, child-related needs, and specialized needs including mental and physical healthcare. Past studies that examined the needs of homeless populations and other studies that examined populations that
experienced IPV support these findings related to mental and physical health (Daiski, 2007; Guenzel et al., 2020; Steele, 2007; Vijayaraghavan et al., 2012; Wang, 2001; Wilson et al., 2007). Financial needs are also commonly noted in the literature, thus supporting this finding (Acosta & Toro, 2000; Campbell et al., 2015; Narendorf, 2017). Overall, the needs that were noted in the following study are needs that individuals’ experiencing homeless and/or IPV commonly report in the literature.

These findings also give us a better understanding of how this community of women in Windsor can be assisted. Based on the participant’s responses, the current services are lacking in space, availability, and quality; thus, the services are not fully meeting the needs of these women. Thus, more services relating to healthcare (e.g., clinics), financial assistance and courses on financial management, and housing assistance and basic needs (food banks, donation centers, shelters, etc.) must be brought forth to help meet the urgent needs of this population.

**Factors Leading to Homelessness.** The most common reason for experiencing homelessness was conflict and precarious circumstances leading to continuous housing instability. All the women in this study described some form of conflict (e.g., IPV, family, landlord conflict) or dangerous circumstances (e.g., human trafficking) that resulted in them being homeless, and these precarious situations continued as the women tried to find housing. Conflict, especially partner violence, was the leading cause of housing instability and/or homelessness, so it was not a surprise that this was the most common factor leading to the housing situation for this sample (Daoud et al., 2016). Similarly, literature acknowledges that women who have experienced abuse are at a
higher risk of experiencing further abusive relationships and violence (Tjaden & Thoennes, 2000; WHO, 2012).

The findings on continuous precarious circumstances provide insight into the cyclical relationship between IPV, homelessness, and re-occurring violence. All the women in the study became homeless due to some form of violence and conflict, and this violence and conflict continued in some way or another for the women when experiencing homelessness (e.g., with landlords, partners, roommates). These findings are important because this relationship shows a continuous, additional obstacle for these women, conflict and violent circumstances, that in turn affect the women’s abilities to get back on their feet and find stable housing. This information is helpful to know from an intervention standpoint to inform governmental services and programs aimed at assisting women that have experienced IPV, homelessness, or a combination of both.

**Barriers to Accessing Services.** The results demonstrated that the most common barriers for women accessing formal support services were *Strained and Flawed Systems, Psychological Barriers, Experiences of Dismissal and Minimization, and Financial Obstacles*. System barriers consisted of long waitlists and lack of beds for services, difficulty getting specific rooms at shelters (e.g., rooms allowing pets), and lack of needed services. Psychological barriers included intrapersonal factors such as perceptions of their experiences (e.g., not acknowledging the violence they experienced), mental health (e.g., anxiety), and emotions (e.g., being scared). The dismissal and minimization theme included instances of not being taken seriously, being dismissed, and a lack of empathy and respect from providers. The final theme that was constructed was financial
obstacles, which included difficulties paying for services and the high cost of homelessness in general.

The above findings support previous research that has shown finances, flawed and overwhelmed systems (e.g., waitlists), and dismissal as common barriers for those experiencing homelessness or IPV (Campbell et al., 2015; Guenzel et al., 2020; Narendorf, 2017; Ponce et al., 2014). The findings on psychological barriers support multiple previous studies that have found how women who experience IPV or homelessness feel embarrassed to seek help, feel shame from being in a past or present abusive relationship, and feel scared and afraid to ask for help (Fugate et al., 2005; Krausz et al., 2013; Solorio et al., 2006; Satyen et al., 2018; Wilson et al., 2007).

These findings can also be compared to existing theories relating to help-seeking behaviours. Andersen and Newman’s (1973) behavioral model of health service use (BMHU) states that predisposing characteristics, enabling factors and resources, and need, otherwise known as illness level, all affect health service use. According to the BMHU model, enabling factors and resources consist of elements such as finances, accessibility to the services, and the number of health care facilities and personnel within the area (Andersen & Newman, 1973). Women in the current study demonstrated these factors, specifically financial barriers, and systemic barriers, such as waitlists and the lack of available services. In this model, the illness level refers to one’s acknowledgement that there is something wrong with them or that there is a need to use the service. This variable was present in the psychological barriers theme, in which some of the women found that pride and perception of the violence that they went through made it more difficult for them to seek help.
In addition, Grigsby and Hartman’s (1997) barriers model consists of different layers of barriers that affect help seeking, with one being environmental barriers. The focus of this layer is on the challenges in the woman’s external surroundings that affect her ability to seek help, and this was demonstrated in the findings of the study. Many women discussed barriers related to the systems of formal services, such as waitlists, costs, and transportation, as well as dismissal and minimization during interactions with service providers. Overall, the results discussing the barriers women faced when trying to access formal services support multiple theories in the literature that aim to describe the process of help-seeking for women that experienced IPV. Likewise, these findings support the experiences discussed in the literature for women who are experiencing both homelessness and IPV.

The findings regarding barriers are important because they provide us with a new understanding of specific obstacles that are prevalent in the Windsor community for women experiencing homelessness and IPV. It is clear from the data that some formal services lack quality care and empathy, and the current systems in place are overwhelmed and at total capacity; therefore, these women are not getting the proper care that they are entitled to have. Overall, these resources (healthcare systems, shelters, and police services) must better cater to these populations of women within the constraints of their financial limitations and their unique circumstances.

Facilitating Factors. Two factors that facilitate accessing formal support services were discovered in these findings: Support Networks and Resiliency, Growth, and Proactivity. Support networks consisted of supportive individuals in the women’s lives, whether that was family, friends, services providers, or other women at the shelter. The
theme of resiliency, growth, and proactivity incorporated instances in which the women talked about being proud of themselves for advocating, seeking out information, and putting in their own personal effort to get help successfully. These results are consistent with many previous studies that point out how supportive networks, otherwise known as a type of informal social support, help women become both more resilient and more likely to seek out help, while also acting as safety strategies for women experiencing abuse and facing homelessness (Chiaramonte et al., 2021; Flasch et al., 2017; Ramsay et al., 2019; Shanthakumari et al., 2014; Wood et al., 2021). Similarly, other studies have found that resilience, as well as becoming empowered and confident, have been factors that assist women dealing with IPV, homelessness, and accessing support services (Livingstone & Herman, 2017; Shanthakumari et al., 2014; Wood et al., 2021). These findings are noteworthy because they provide insight into ways in which we can assist women experiencing both homelessness and IPV. Offering resources such as workshops, courses, and support that promote resiliency, empowerment, proactivity, and adovcation can aid women in acquiring the services they need.

Social Positionings. Regarding social positioning, two salient themes were found in the data: class and race and ethnicity. For this study, it was found that women’s social class and economic status explicitly affected their experiences with being homeless and with accessing services, making life more difficult to navigate, and leading to stigmatization from others. Two of the participants’ race and ethnicity heavily influenced their experiences with both homelessness and accessing formal support services. They experienced racism and discrimination and were on occasion outright denied services or help because of their racial background. It is not a new finding that race and ethnicity
affect access to services, as a review completed by Waller and colleagues (2022) examining the intersection of African American women and their help-seeking experiences found that women of colour often have poorer interactions with formal service providers compared to other populations when seeking help for IPV. Similar findings have emerged for other minority groups such as Latinas and Indigenous peoples (Luebke et al., 2022; O’Neal & Beckman, 2017). As for class identity and social positioning, previous studies have discussed the stigma related to being homeless and identifying with a lower class, as well as poor quality interactions with services and unmet needs (Allen et al., 2014; Phelan et al., 1997; Schneider & Remillard, 2013). These experiences were clearly demonstrated in the current study.

The effect of social positioning on women’s experiences can also be explained by the theory of intersectionality. Both women’s class status and race/ethnicity affected their ability and access to the formal support services they needed. Intersectionality theory describes and examines how women’s identities (e.g., age, gender, race, (dis)ability, class) impact and influence their experiences and the association between these social positionings and structural systems of oppression (Atewologun, 2018; Crenshaw, 1991). The results of this study demonstrate that class, status, and race led to oppression, racism, and discrimination, making it more difficult or impossible for the women to obtain services. This was especially prevalent in structural systems such as medical services and police, where the women experienced discrimination and oppression based on their identity and were denied assistance. Overall, the findings confirmed that social positionings and one’s identity can lead to disadvantages based on these systems of power that cause some positionings to have privilege and others not. In other words, these
findings highlight both the stigmatization and oppression evident within Windsor’s services and the systems and structures within this community.

The findings from this study can also fit into Bronfenbrenner’s (1979) ecological systems model. This model contains five different systems that make up an individual’s environment: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner, 1979). The themes interpreted from the qualitative findings relating to formal support service barriers can be placed into these different systems.

In the center of this model is the individual, which would encompass the intrapersonal barriers these women face. These included the women’s emotions, perceptions, and mental health (e.g., anxiety, PTSD, and depression). The next layer is the microsystem, which includes the direct encounters an individual has in their immediate environment (Bronfenbrenner, 1979). The theme that fits into this layer is experiences of dismissal and minimization, as these interactions occurred directly between the women and service providers (e.g., doctors). The mesosystem includes interactions between an individual’s microsystems; similarly, the exosystem includes the impact of social structures and settings (Bronfenbrenner, 1979). The systems barrier fits into the meso/exosystem because it includes the impact of strained and overwhelmed services that had insufficient availability and space. There is also the macrosystem, which includes culture and societal norms and values (Bronfenbrenner, 1979). The theme that fits into this system is financial barriers since, for this group of women, the financial concerns result from their socioeconomic status and experiences of poverty. This theme could also fit into the individual-level system since class is a sociodemographic variable.
To conclude, Bronfenbrenner’s ecological systems model (1979) can be used to explain the different layers of barriers women experiencing homelessness and IPV face and how different factors at the individual, micro, exo, and macro-level can affect their experiences with formal support services.

**Limitations**

The following study had a few limitations. First, the sample comprised mainly of Caucasian women. The study lacked diversity, with only three participants identifying with a race or ethnicity other than Caucasian. Therefore, the findings from the sample cannot be generalized to more diverse and minority populations. This also limited the breadth of information that could be gathered on the impact of race and ethnicity on barriers and facilitating factors to accessing services. Despite this limitation, important results on race and ethnicity did emerge from the two minority women present in the sample. Specifically, interview data revealed that their identity made it more difficult to access services and led to them experiencing discrimination and racism.

The sample size of the study was also a limitation. The original aim was to gather 15 participants, but due to time, availability, and willingness, only 10 were attained. Although qualitative research can be done on smaller sample sizes and the sample number is often chosen by the researcher based on their own rules of thumb and expertise (Braun & Clarke, 2019), a larger sample could have added richer findings. Furthermore, additional themes could have been added and rearranged, as with RTA, themes are never fixed and can always evolve and be expanded (Braun & Clarke, 2019). With fewer participants, the findings also become less generalizable. Regardless, the findings can still
be used to help the Windsor community of women experiencing homelessness and IPV and lead to recommendations for formal support services in Windsor, Ontario.

The population of women that was interviewed for this study can also be seen as a limitation. These women experienced IPV, with almost all enduring physical, psychological, and emotional abuse. It is possible that the violence experienced led to trauma and/or physical disabilities, leading to memory impairment, as this has been shown to occur in numerous studies (Ali et al., 2013; Billoux et al., 2016). Relatedly, some of the women may have struggled with memory recall, which potentially may have affected the validity of the results. Similarly, it is unclear whether some of the terms used in the interview and questionnaires were understood by all the women. Participants may not have always asked questions if terms were confusing or difficult to understand. To mitigate this, the interviewers were present to answer questions and made it clear that the women were free to ask questions. Despite this approach, lack of understanding is still a potential limitation for this study.

Another noted limitation is the possible biases of the researchers who coded the data. Qualitative analyses are subjective, and it is up to the researcher how themes are generated and interpreted (Braun & Clarke, 2019). This subjectivity can lead to biases and the potential of the researcher being too influenced by personal feelings, beliefs, and opinions. To ensure that the study was reliable and valid and to reduce this possibility, multiple procedures were put in place such as positionality statements, a second coder (triangulation), auditing, and journalling, to minimize the impact of the researchers’ beliefs and to support transparency and effort to reduce bias.
Implications and Future Directions

Despite the limitations of the study, there are multiple implications that resulted. All the qualitative findings regarding the specific barriers and facilitating factors, replicated previous study findings to show the most common influences on service use for this subgroup of women. In addition, this study used a group that is not often studied in relation to barriers and facilitating factors for formal services – women who have endured IPV who are also currently experiencing homelessness. Therefore, the study adds to the literature that examines women who have or are experiencing both adversities. In addition, future research can attempt to replicate these findings with this specific population of women that is understudied and examine more diverse groups in Canada.

The findings of this study will also be used to create an infographic and report for the Welcome Centre Shelter and other formal support services in Windsor. This will allow both the WCS and other services to use the findings to implement changes in their protocol, procedures, and programs that are offered for the populations they aim to serve. Although not a part of the major findings, participants also did provide suggestions for the shelter that will be included in the report that could be used to further improve services. For example, multiple participants mentioned that the shelter should have more nutritious food as an option for them. Other suggestions included more cleaning products for residents, name tags for residents, more options for withdraw management, offering coffee, making more culturally diverse food options available, and a list of available formal services. These suggestions can be used to implement immediate changes to the current shelter services. The larger themes from the findings regarding systemic and
structural issues can then be considered by the service providers to implement change later by working towards adding additional services, expanding the current capacity of their services, training their employees in empathy and other responses (Ekman & Halpern, 2015).

The findings of this study point to a few avenues for future directions of study. First, this study lacked the diversity of ethnic and racial groups. The majority of participants were Caucasian women. The study also consisted of mostly heterosexual women, with few who had differing sexual identities. Future studies could be done with populations that come from more varied backgrounds and attempt to include a sample of more diverse sexual identities. This will allow for a better understanding of the intersection between race and ethnicity and women’s experiences with accessing formal support services for needs related to homelessness and IPV, as well as the differences in experiences with relationships that women have with abusive partners of other gender identities and orientations.

This study was conducted with a qualitative-dominant methodology. Mixed method designs are capable of leading to a greater understanding of the phenomenon being studied (Ponterotto et al., 2013; Tashakkori et al., 2012). Furthermore, using a mixed methods approach, as stated by Ponterotto and colleagues (2013) can, “shed light on the complex dynamics of ‘privilege’ in society” (p. 47) by gaining a deeper understanding of oppressed and marginalized groups. Quantitative components can be used to gain larger samples that could provide data that can then be generalized to other populations, and qualitative components can provide rich narratives of smaller samples that are more detailed and help to describe experiences in more depth. This approach
would also allow for further triangulation, as researchers can look for convergence of findings using multiple methods such as questionnaires and open-response questions and/or interviews (Doucerain et al., 2016). Other benefits include enhancement of and complementary findings for each method, using the findings from one method to develop the next method, using them to discover contradictions, and expanding the breadth of the research (Doucerain et al., 2016). Overall, using mixed methods approaches in future studies can help us further enhance our understanding of the experiences of women and IPV, homelessness, and formal service use.

Another methodological strategy that could be useful for future studies is focus groups. Focus groups allow women to hear others’ stories that are like and unlike their own and understand that they are not alone in their experiences (Plummer-D'Amato, 2008). This method could further help build a community among women participants and a potentially validating and supportive network, which has been shown to act as a facilitator for this group of women when trying to navigate formal support services, homelessness, and IPV (Chiaramonte et al., 2021; Ramsay et al., 2019; Shanthakumari et al., 2014; Wood et al., 2021). In addition, focus groups help facilitate discussion and evoke responses from participants they may not have thought to express in an interview and allow for expansion on others’ thoughts, opinions, and experiences (Plummer-D'Amato 2008). To conclude, future studies should use varying methodologies, such as mixed methods and focus groups to understand women’s experiences.

Finally, this study examined the general barriers and facilitating factors to accessing formal support services. We know that specific formal support services can involve different types of barriers, such as waitlists for health services and fear of
retaliation from abusive partners for police services (Cloutier et al., 1999; Solorio et al., 2006). Therefore, future studies should specifically examine different types of formal support to compare and contrast barriers and facilitating factors that arise. This would advance our comprehension of how accessing different services leads to unique obstacles for women experiencing homelessness and IPV.

**Conclusion**

To conclude, this study explored the detailed narratives and lived experiences of women experiencing homelessness and IPV and their facilitating factors and barriers to accessing formal support services. First, the findings highlight barriers related to flawed and overwhelmed systems, dismissal and minimization of women’s issues and severity of the problems, as well as psychological barriers, intrapersonal hurdles, and financial concerns. Second, findings emphasized the factors that help this group of women seek help, such as having supportive networks and being resilient, proactive, and finding ways to enable personal growth. Third, this study demonstrated that social positionings such as race/ethnicity and class status can lead to discrimination and oppression within societal structure systems when individuals attempt to access services. Finally, the study identified the common needs of this population, including health needs, financial needs, and needs related to basic foundations for surviving (e.g., housing and food). In summary, the current study provided rich information about barriers and facilitating factors to accessing formal support services for women experiencing IPV and homelessness.
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APPENDICES

Appendix A: Experiences of Domestic Violence Scale

(Fujiwara et al., 2010)

Please answer the following questions on a scale from 1-4, ranging from 1 (*not at all*) to 4 (*frequently*).

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all</th>
<th>2 Rarely</th>
<th>3 Sometimes</th>
<th>4 Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>My husband or partner was sufficiently</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>violent towards me to cause injury.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My husband or partner insulted me strongly enough to cause psychological harm.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I perceived a strong threat from my</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>husband or partner.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Demographics Survey

1) With which racial or ethnic group do you identify?
[ ] White/European/Caucasian
[ ] Black/African/Caribbean
[ ] Latin/South American
[ ] East Asian/Chinese/Japanese
[ ] South Asian/Indian/Pakistani
[ ] Indigenous/First Nations/Metis
[ ] Middle Eastern/Arabic
[ ] Multiple Ethnicities (specify which ones) _______________________
[ ] My ethnicity is (please specify) _______________________
[ ] Prefer not to say

2) How old are you? _______ years old
[ ] prefer not to say

3) What gender do you identify as? Please fill in the blank. ________________
[ ] prefer not to say

4) What is your sexual identity/sexual orientation? Please fill in the blank.
________________
[ ] Prefer not to say

5) What is the highest level of education you have completed?
[ ] Elementary School
[ ] Some High School
[ ] High School
[ ] Some college/university
[ ] Bachelor’s Degree
[ ] College certificate/degree
[ ] Master's Degree
[ ] Ph.D. or equivalent
[ ] Trade School
[ ] No school
[ ] Other: _________
[ ] Prefer not to say

6) What is your current employment status?
[ ] Employed Full-Time
[ ] Employed Part-Time
[ ] Seeking opportunities
[ ] Retired
[ ] Prefer not to say

7) What is your current relationship status?
[ ] Single (never married)
[ ] Dating
[ ] Common Law
[ ] Married
[ ] Divorced
[ ] Widowed
[ ] Prefer not to say

8) In what country were you born? ________________
[ ] Prefer not to say

Are you limited in the amount or kind of activity you can do at home, at work, or at school, or in other activities because of a long-term physical or mental condition, disability, or health problem?
[ ] No
[ ] Yes (if willing, please describe the nature of the limitation): __________
[ ] Prefer not to answer

9) How many children do you have? (e.g., 3) _________________
[ ] Prefer not to say

10) For how long have you currently been homeless? (e.g., 6 months) ______________
[ ] Prefer not to say

11) How many times have you been homeless? ________________
[ ] Prefer not to say
Appendix C: Intimate Partner Violence Strategies Index

(Goodman et al., 2003)

Please indicate whether you have or have not used each of the following strategies when experiencing partner-related violence. If you select yes, please indicate how helpful the strategy was on a scale from 1 (not helpful at all) to 5 (very helpful).

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>1 Not helpful at all</th>
<th>2 Not helpful</th>
<th>3 Somewhat helpful</th>
<th>4 Helpful</th>
<th>5 Very Helpful</th>
</tr>
</thead>
</table>

**Formal Network**
- Tried to get help from clergy
- Tried to get help from her employer or co-worker
- Talked to a doctor or nurse about abuse
- Called a mental health counselor for yourself
- Tried to get them counseling for violence
- Stayed in shelter
- Talked to someone at a domestic violence program, shelter, or hotline
- Tried to get help for *yourself* for alcohol or substance abuse
- Tried to get *them* help for alcohol or substance abuse

**Legal**
- Filed or tried to file criminal charges
- Sought help from legal aid
- Called police

**Safety Planning**
- Hid car or house keys
- Kept money and other valuables hidden
- Developed code so others would know I was in danger
- Worked out escape plan
- Removed or hid weapons
- Kept important phone numbers I could use to get help
- Kept extra supply of basic necessities for myself/children
- Hid important papers from him
- Put a knife, gun, or other weapon where I could get it
- Changed locks or somehow improved security

**Informal Network**
- Talked to family or friends about what to do to protect myself/children
- Stayed with family or friends
- Sent kids to stay with friend or relatives
• Made sure there were other people around

**Resistance**
• Fought back physically
• Slept separately
• Refused to do what they said
• Left home to get away from them
• Ended (or tried to end) relationship
• Fought back verbally

**Placating**
• Tried to keep things quiet for them
• Did whatever they wanted to stop the violence
• Tried not to cry during the violence
• Tried to avoid them

Tried to avoid an argument with them
Appendix D: Interview Guide

Thank you so much for your interest in my study and agreeing to participate in this interview. My name is Marissa, and I am a master’s student in Psychology at the University of Windsor. *Volunteer interviewers will state their own information*

Before we begin, is there anyone you would like to be here for support during this interview? This would be a qualified professional/staff member from the Welcome Shelter if you would like someone else present.

First, we want to make it clear that participation/non-participation will not impact the services you receive at the Welcome Centre. We will now start by going over the consent form that you were given before completing the questionnaires, where you either agree or disagree to participate in the study. As you know, the purpose of this interview is to explore the lived experiences of women facing homelessness who have also gone through partner violence/abuse. More specifically, this study will look at the services that are needed by women experiencing partner violence/abuse and homelessness. The study is also interested in understanding what might be challenging or helpful when accessing these services. The study further plans to explore the effect of the COVID-19 pandemic on women’s ability to find available services. Finally, the study will examine how women’s identities (so things like gender, social class, race, or age) may affect their experiences with services.

This study has been reviewed and approved by a research ethics board at the University of Windsor. Information that could identify you (like your name) will not be collected, so no one will be able to connect you to the information you share with me today. All of the information you provide will be kept confidential. Due to the sensitive nature of this topic, if the interview is interrupted for any reason, we will change the topic to ensure confidentiality and privacy.

The only time where personal information may need to be provided is with the to duty to report (e.g., a child being named who is at a risk of abuse, talk of wanting to harm yourself (suicide), or talk of wanting to harm a specific person[s], etc.). If information about one or more of these situations is provided during your interview, the researchers will need to alert the shelter staff and the procedures of the welcome centre will be initiated and followed during these situations. If suicide is mentioned, a trained staff member will have fairly open conversations around suicide, plans, ideas, supports that might be needed for you. If child abuse is mentioned, on-site social workers would follow up with Children’s Aid Society and a new case opening or notifying their existing case workers would occur. Finally, if intentions to harm others is mentioned, staff would meet with you to discuss and assess for risk and safety and notify the police if needed.

As we go through the interview, you can choose not to answer any question you do not feel comfortable with. If you need to take a break at any point in the interview, please let me know. This interview will take 60-90 minutes, and you will be provided with a $25 gift card for Shoppers Drug Mart. If you choose to drop out of the study after consenting
and starting the interview, you will still receive this compensation. Once the interview is complete and the data has been submitted, you cannot ask to be removed from the study due to us not collecting your personal information.

This interview will also be recorded on an audio recording device. After the interview, it will be uploaded onto a password-protected OneDrive account on the primary researcher’s computer. Following this, it will be deleted from the recording device.

* Participants will have a physical copy of the consent forms with them during this introduction. Other consent form information will be re-reviewed here. *

*Start audio recording here* - Participants will be informed that the audio has started.

Can you please confirm that you are willing to participate and that you consent to being audio-recorded?

Thank you. If during or right after the interview you no longer want to be a part of this study, please let me know and I will stop recording and delete your responses. After we leave today, I will not be able to delete any responses since your name will not be attached to the interview or your survey data.

Before we get started, are there any potential triggers that I should be aware of? This means any words or topics that upsets or stresses you out too much to talk about.

**Homeless experience**

First, I would like to hear your story about how you got into your current homeless situation. (e.g., how did you become homeless, how long have you been homeless, and has this happened on more than one occasion?)

How have things like your gender, class, race, or other aspects of your identity and background, affected your homeless experiences? (e.g., being a women affecting your situation).

**Perceived formal support needs**

We will now move on and discuss your formal support service needs. Formal support services can include support from a trained professional and is available to the public. Examples of these services are domestic violence shelters, healthcare provider services, homeless shelters, mental health services (e.g., therapists and counsellors), and law enforcement services (e.g., police and lawyers).

Would you like to continue with this topic?

Thinking about your experiences with homelessness and partner violence/abuse, what personal needs do you have that formal support services could help you with? (Provide example if they need one… shelter, food, financial support, mental health care, medical care).
What type of help or services do you think you require in order to address those specific needs? *Reiterate services if needed.

**Formal support service barriers and experience**

Thank you for sharing that information. We will now move on and discuss your experiences with formal support services for needs related to partner violence/abuse and homelessness.

Would you like to continue with these questions?

First, I would like you to describe any barriers or challenges you have experienced when it comes to accessing formal support services for needs related to homelessness and partner violence/abuse. Discuss as many as you can think of if you have experienced any. *Provide an example if they need one: financial or emotional difficulties*.

Follow up: What barrier or challenge has been your biggest concern?

What barrier has been the most impactful (or affected you the most)?

Overall, what have your experiences been like when attempting to access formal support services?

How have things like your gender, class, race, or other aspects of your identity and background, affected the challenges you have faced when accessing formal support services? (e.g., your race affecting your experiences with services/how you are treated)

Now I would like you to discuss the experiences you have had when you were able to use and access formal support services. Do you feel comfortable continuing?

If you have tried to access formal support services, what ones have you had access to? Could you describe your experience using these formal support services?

What was your worst experience? *If any. What was your best experience? *If any.

Follow up: Would you describe your experiences as generally good, bad, or a combination of both? *Can follow up with why.

**COVID-19 Pandemic**

Next, we will discuss the effects of the COVID-19 pandemic on your experiences. Would you like to continue/do you need a break?

How has the COVID-19 pandemic affected potential barriers and/or your experiences with using and seeking formal support services?

**Facilitating Factors**
The last topic we will be discussing is what helped you with overcoming any barriers. Do you feel comfortable continuing?

Since you are a user of the Welcome Center Shelter, we know that you have sought some type of formal support service.

What things have made getting help successful for you and reduced barriers, if any?

What was the process you went through to seek help here at the Welcome Center Shelter?

Wrap up

Those are all of the questions that I have prepared for you. Now, is there anything you feel is important for me to know that we have not covered?

Do you have any questions for me?

That concludes our interview. First, I would like to thank you for taking the time to participate in this study – it is greatly appreciated, and I commend you for taking the time to talk about your experiences! The hope is that the information from this study will be used to make positive changes in our community.

Like we discussed earlier in our conversation, the purpose of the study was to explore the lived experiences of women who have went through homelessness and partner violence and examine their formal service needs, the barriers they have faced in accessing formal services, facilitating or helpful factors, the effect of the pandemic, what their experiences are like when they have used services, and how their unique identities may have impacted their experiences.

I understand that some of the questions and topics we covered today may have caused you some sort of emotional distress. Because of this, we are providing you with a list of resources that are available to you here in the community and online if you feel as though you need further assistance after this study. Please feel free to use those resources if you are experiencing distress or want to talk to a professional.

*Interviewer will walk through the resource sheet with the participant.

I also want to remind you that this is the last time you can let me know if you don’t want to participate or use your answers in this study. After we leave today, I am not going to be able to remove you since your name will not be recorded. If you do withdraw, you will still receive your $25 Shoppers Drug Mart gift card.

If you want to learn about the findings of this study in the future, you can contact me at rakus@uwindsor.ca or the shelter, as they will be provided with the results, or find it on the University of Windsor website at https://scholar.uwindsor.ca/research-result-summaries/.
Appendix E: IPV Introduction Video

https://www.youtube.com/watch?v=KdUJHaDUZ6Y&t=1165s
Appendix F: Recruitment Script

Hello, everyone!

My name is Marissa Rakus, and I am a master’s student in the psychology department at the University of Windsor. I am conducting a research project called Homelessness and Intimate Partner Violence: Women’s Barriers and Experiences With Accessing Formal Support Services and the Impact of Their Intersecting Identities for my master’s degree under the supervision of Dr. Jill Singleton-Jackson. If you have already participated in this study or heard this recruitment announcement and do not want to listen to it again, you are free to leave or stay as you choose.

The purpose of the study is to explore the experiences of women facing homelessness who have also gone through partner violence/abuse. More specifically, the study intends to examine the formal support service needs of this group of women, overall experiences with formal support services (barriers, facilitating factors, and experiences using the services) the effect of the pandemic on formal service use, and how their unique social positionings have affected their formal service experiences.

I am here today to you to invite you to participate in a survey and interview in which you will be asked to fill out three brief questionnaires and verbally answer a series of questions by an interviewer about your experiences with formal support services for needs related to homelessness and partner violence/abuse.

Participating in this study will require approximately one and a half to two hours of your time and will be held in a private room here at the Welcome Centre Shelter. You will also be given a $25 gift card for Shoppers Drug Mart for your participation.

To participate in this study, you must be experiencing homelessness, meaning you either live on the streets, are in one of the shelters in Windsor, or currently do not have a stable housing situation. You also have to have experienced some level of partner violence/abuse with a past or current romantic partner. You also need to have functional skills in reading, writing, and speaking in English in order to understand the questions are required to read and respond to in this study. Finally, you must be 18 years of age or older.

We also want to make it clear that that participation/non-participation will not impact services you receive at the Welcome Centre.

If you are interested in participating in this study, you can sign-up under a timeslot on the following sheet. Please sign up using only your first name. These timeslots are for after
the drop-in session today, and there is another sheet for after the drop-in session next week. If you have any questions about me or my project, I am happy to answer them privately, during the informed consent process, or during the study.
Appendix G: Recruitment Sign-up Sheet

If you wish to participate in this study, please sign up for a time slot using only your first name.

Eligibility: Identify as a woman, currently homeless or living in a shelter, have experienced abuse with a past or current romantic partner, have functional skills in reading, writing, and speaking in English, and are 18 years of age or older.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Room</th>
<th>First Name</th>
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<tbody>
<tr>
<td></td>
<td>12:40pm</td>
<td>Medical room</td>
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<td>12:40pm</td>
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<td></td>
<td>2:30pm</td>
<td>Medical room</td>
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</table>
Appendix H: Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: **Homelessness and Intimate Partner Violence: Women’s Barriers and Experiences with Accessing Formal Support Services and the Impact of Their Intersecting Identities**

You are asked to participate in a research study conducted by Marissa Rakus and Dr. Singleton-Jackson from the department of Psychology at the University of Windsor for the purpose of Marissa’s master’s thesis.

If you have any questions or concerns about the research, please feel free to contact Marissa Rakus at rakus@uwindsor.ca or (Phone number) or Dr. Singleton-Jackson at jjackson@uwindsor.ca or (Phone number).

**PURPOSE OF THE STUDY**

The purpose of this study is to explore the lived experiences of women facing homelessness who have also endured partner violence/abuse. More specifically, this study intends to examine the formal support service needs for these women, and the barriers and facilitating factors related to accessing formal services for needs associated with partner violence and homelessness. The study further plans to learn about these women’s experiences when they do access formal services, as well as how the COVID-19 pandemic has affected their encounters with services. Finally, the study will investigate how the women’s social positionings, or identities, may affect their overall needs and experiences with formal support services.

**PROCEDURES**

**Questionnaires**

If you consent to participate in this study, you will first be asked to complete a series of questionnaires where you select the answer that best describes your experiences and opinions. These surveys/questionnaires will consist of questions about background demographics (e.g., ethnicity, age, gender, education level, etc.), experiences with violence in a romantic relationship, and strategies that you may have used to get help and access safety when experiencing partner violence. These questionnaires will take no longer than 30 minutes to complete.

**Interview**

Following the questionnaires, you will be asked to participate in an interview. During this interview, you will be asked to discuss your current living situation, formal support service needs related to homelessness and partner violence, barriers to accessing formal support services, experiences with using/trying to use formal support services, the impact of identity on barriers and experiences with formal support services, the
impact of the COVID-19 pandemic on formal help-seeking experiences, and factors that may have facilitated overcoming any barriers.

Participation in the interview should take 60-90 minutes and you will be compensated with a $25 gift card for Shoppers Drug Mart. Should you choose to complete the study, you will not be contacted in the future for follow-up sessions or subsequent related studies as this study only requires participation on one occasion.

Audio Recording
The interview will be recorded on a device strictly for audio recording. If you withdraw from the research, the audio file will be destroyed. The procedures for protecting each participants’ identity and confidentiality include the destruction/deletion of the audio file after transcription of the interview.

LOCATION
The survey will take place at the Welcome Centre Shelter in a private room. POTENTIAL RISKS AND DISCOMFORTS
The questions in this study may cause emotional distress or discomfort as they relate to sensitive issues and reflection on upsetting experiences. Please remember that you may end the questionnaire and/or interview and withdraw your data at any time for any reason without being penalized. You will still receive full compensation if you choose to start the study past the consent form and decide to withdraw. You can decline answering any question you do not feel comfortable with or take a break if needed. You will also be provided with a list of local and online resources for several mental health, domestic violence, and shelter resources at the conclusion of the interview, should you wish to seek support after completing the study.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY
The results of this study will enrich our understanding of the formal support service needs of women experiencing homelessness and partner violence/abuse, barriers and facilitating factors that affect seeking formal support services for this subgroup of women, the impact of the COVID-19 pandemic on help-seeking experiences, and how women’s unique social positionings affect their formal support seeking experiences. This study may provide information on ways to mitigate and alleviate the barriers to formal support services faced by women experiencing homelessness and partner violence/abuse. Such information may be used to help formal support services become more accessible and effective in the future.

There are no direct benefits for the participants who choose to participate in this research. The participants may gain knowledge about themselves by reflecting on their past and current experiences.

COMPENSATION FOR PARTICIPATION
Participants will receive a $25 gift card for Shoppers Drug Mart for participating in this study. You must consent to the study and begin participation, before choosing to withdraw, in order to receive the compensation.
We also want to make it clear that participation/non-participation will not impact services you receive at the Welcome Centre.

CONFIDENTIALITY
No identifying information (name, date of birth, phone number, etc.) will be collected for this study. Confidentiality may be breached only in an event of duty to report (e.g., mentions of a child being harmed or at risk of abuse, suicidal intentions, homicidal intentions towards a target person, etc.). If information on any of these instances is provided during an interview, the researchers will need to alert the shelter staff and the procedures of the welcome centre will be initiated and followed during these situations (e.g., risk assessments, reporting of child abuse or harm intended to others, or providing support services).

If suicide is mentioned, a trained staff member will have open conversations around suicide, plans, ideas, supports that might be needed for you. If child abuse is mentioned, on-site social workers would follow up with Children’s Aid Society and a new case opening or notifying their existing case workers would occur. Finally, if intentions to harm others is mentioned, staff would meet with you to discuss and assess for risk and safety and notify the police as warranted.

Interviews will be transcribed and any identifying information (e.g., age, workplace, residence) will be removed. To ensure confidentiality, the audio-recordings will be deleted off the recording device as soon as they are uploaded onto a password-protected computer. The physical copies of the questionnaires and consent forms will be kept in a locked filing cabinet, and only the primary researcher and their supervisor will have access to them. The interviews and questionnaire data will also be kept on a password-protected computer for a minimum of 5 years after completion and/or publication of the study. Only the primary researcher, faculty investigator, and research assistant will have access to this data. Participant quotations used in publications or presentations that may stem from this research will not be identifiable. Participants will be referred to in groups in any publications or presentations to protect the participants’ identities. If the data are not used for subsequent research or will not be published, the data will be destroyed.

PARTICIPATION AND WITHDRAWAL
You may choose to withdraw at any point in time during the study if you feel uncomfortable or do not want to continue for any reason. If you choose to withdraw after consenting and starting the study, you will still receive compensation. If you choose to withdraw during the consent form process, you will not receive compensation. Once the interview is complete and the data has been submitted, you cannot withdraw from the study due to no identifying information being collected. The investigator may withdraw your data from this research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS
A summary of the research findings will be provided to the Welcome Centre Shelter once the study is complete. Participants will also be able to review results online at the REB’s Summary for Participants platform. These findings will be available when the research has been completed, analysed, and summarized.

Web address: https://scholar.uwindsor.ca/research-result-
summaries/ Date when results are available: March, 2023

SUBSEQUENT USE OF DATA
These data may be used in subsequent studies, publications and presentations.

RIGHTS OF RESEARCH PARTICIPANTS
If you have questions regarding your rights as a research participant, contact: The Office of Research Ethics, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: ethics@uwindsor.ca

I understand the information provided for the study “Homelessness and Intimate Partner Violence: Women’s Barriers and Experiences with Accessing Formal Support Services and the Impact of Their Intersecting Identities” as described. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given access to have a copy of this form.

Please indicate your answer with an “X”:

☐ I consent to participate in this study.

☐ I consent to the use of direct and anonymous quotations from my interview responses to be included in any reports, publications and/or presentations that arise from this study.

☐ I consent to being audio-recorded for the interview portion of the study.
Appendix I: Protocol for Duty to Report

1. Marissa Rakus, the primary investigator (or the research assistants) will inform the participant that they may need to notify a staff member of the Welcome Center if suicidal intent, homicidal intent, or child abuse are discussed.

The following will occur if one of the situations is discussed:

1. If suicide is mentioned, a trained staff member will have open conversations around suicide, plans, ideas, supports that might be needed for you.
2. If child abuse is mentioned, on-site social workers would follow up with Children’s Aid Society and a new case opening or notifying their existing case workers would occur.
3. If intentions to harm others is mentioned, staff would meet with you to discuss and assess for risk and safety and notify the police as warranted.
Appendix J: Letter of Information

Dear participant,

The purpose of this study was to explore 1) the formal support service needs for women experiencing homelessness and partner violence, 2) the barriers and facilitating factors to accessing formal support services for needs related to partner violence and homelessness, 3) their experiences when they have accessed formal support services, 4) the effect of the COVID-19 pandemic on service experiences, and 5) how their social positionings have impacted their experiences when trying to access formal services.

If you want to learn about the findings of this study in the future, you can contact me at rakus@uwindsor.ca or the shelter, as they will be provided with the results, or find it on the University of Windsor website at https://scholar.uwindsor.ca/research-resultsummaries/.

Support services are listed below in case you felt any discomfort or distress when participating in the study. Should you want to access mental health, domestic violence, or shelter resources, please contact one of the following:

Traditional Stability Centre

Free, confidential walk-in services provided by professional mental health support workers.

744 Ouellette Ave., Windsor, ON
Open 7 days a week 8am-8pm
519-257-5224

Hiatus House

Provides crisis support and shelter for women and children in Windsor and area who are fleeing violence and abuse. This organization also provides education to women, men and children through counselling and group services.

250 Louis Ave, Windsor
24/7 HELP LINE: (519) 252-7781
We are open 24 hours a day, 7 days a week

Community Crisis Centre
Provides intervention services 24 hours a day, seven days a week to individuals who require immediate assessment, psychosocial intervention, medical intervention, and support.

744 Ouellette Ave., Windsor
519-973-4435

The Downtown Mission of Windsor

Provides emergency shelter, hot meals, and support.

664 Victoria Avenue, Windsor
519-973-5573

Crisis Hotline: Windsor Distress Centre (All Ages)

12pm-12am: 519-256-500
Appendix K: Interviewer Resource List

Student Counselling Centre

Free, confidential counselling provided by professional therapists.

CAW Student Centre Room 293

Monday-Friday: 8:30am-4:30pm

519-253-3000 ext. 4616

www.uwindsor.ca/scc scc@uwindsor.ca

Peer Support Centre

Free, drop-in centre where students can find talk to a trained peer counsellor.

CAW Student Centre Room 209, 2nd Floor

Monday - Thursday: 9am - 4pm, Friday: 9am - 1pm

(519) 971-3600

uwsa@uwindsor.ca

http://www.uwsa.ca/uwsa-services/psc/

Traditional Stability Centre

Free, confidential walk-in services provided by professional mental health support workers.

744 Ouellette Ave., Windsor, ON

Open 7 days a week 8am-8pm

519-257-5224
VITA AUCTORIS

NAME: Marissa Rakus
PLACE OF BIRTH: Windsor, ON
YEAR OF BIRTH: 1998
EDUCATION: Riverside Secondary School, Windsor, ON, 2016
University of Windsor, B.A., Windsor, ON, 2020