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

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Purpose of the Study

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 and the potential barriers they face. Therefore, the current study used a qualitative 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.

Methods and Procedure

Recruitment for this study occurred at the Welcome Center Shelter in Windsor, Ontario, Canada. The final sample resulted in 10 women experiencing homelessness or an unstable housing situation and who had experienced intimate partner violence with a current or past romantic partner. The women completed the study at the WCS in a private room. First, three surveys were completed: a demographic questionnaire, the Experiences with Domestic Violence Scale, and the Intimate Partner Violence Strategies Index (IPV-SI). Following the surveys, participants completed an interview that took on a trauma-informed approach (Lalonde et al., 2020). The interview examined the following topics: living situation and homelessness narrative, perceived formal support needs relating to homelessness and IPV, barriers and facilitating factors associated with accessing formal support services, how intersecting social positionings may have affected barriers and experiences with formal support services, and the effect of the covid-19 pandemic on barriers and formal support service use.

The surveys were analyzed by computing mean scores and percentages. The interviews were analyzed using Braun & Clarke’s (2019; 2021) reflexive thematic analysis. This analysis was used to explore individuals’ experiences and to find patterns within the narratives. This analysis took on a feminist and intersectionality lens by asking questions around power relations,
analyzing structural oppression, and how the intersection of a woman’s identity shaped her lived experiences (Kelly, 2011; Lafrance & Wigginton, 2019; Syed, 2010).

**Results**

Seventy percent of the sample was Caucasian, 10% were Black, 10% identified as multiple ethnicities, and 20% were Indigenous. The mean age of the sample was 44. All participants had at least some form of high school education or higher. Employment status varied, with 30% of the sample seeking opportunities, 20% on disability, 10% employed full-time, and 10% retired. Fifty percent of the women stated that they were limited in the amount of activity they could do because of a long-term physical or mental health condition, disability, or health problem. Ninety percent of the sample had children, and the average number of children was 2.5. Finally, the average length of time being homeless was 30.8 weeks, and the average number of times being homeless was three. The quantitative surveys demonstrated high rates of domestic violence experienced by the sample of women ($M_{score}= 11.1$; scores ranged from 0-12). The results of the *IPV-SI* indicated that the most endorsed strategies when attempting to get help during a violent relationship involved resistance and placating (avoiding conflict).

As for the qualitative findings, the main factor leading to homelessness was *conflict and precarious circumstances leading to housing instability*. All the women experienced instability in their housing due to either violence and conflict or precarious, unstable and dangerous situations. The main barriers to accessing formal services included *strained and flawed systems* (waitlists for services, insufficient space, and lack of dog-friendly rooms), *psychological barriers* (being scared, pride and perception of violence affecting help-seeking, and mental health issues such as anxiety, depression, and post-traumatic stress making it harder to seek help), *experiences of dismissal and minimization* (not taken seriously and lack of respect and empathy from providers), and *financial obstacles* (not having money for services). The most common needs for this sample of women were the *foundations to survive* (shelter, food and clothing), *health and well-being* (mental and physical health), and *finances and employment*. The most common facilitating factors to accessing services were support networks (e.g., friends, family, shelter staff, etc.) and being *resilient and proactive* (e.g., putting in their own effort, wanting to show self-love, and standing up for themselves). Finally, the social positionings that affected the women’s experiences with formal services and homelessness the most were their class/socioeconomic status, and their race/ethnicity. For example, some women were stigmatized
by others based on their class, and some women experienced racism and discrimination solely because of their race and ethnicity when attempting to access help and formal services.

**Conclusion**

Overall, the following study highlighted the most common facilitating factors and barriers to accessing formal support services for this sample of women experiencing homelessness and IPV in the Windsor community. The findings also revealed that there is a cyclical relationship between precarious circumstances, violence, and conflict and homelessness. These circumstances led to homelessness, but it continued to occur in different ways for many women during their homeless experience. The findings from this study, along with other participant suggestions, can be used to implement changes in protocol, procedures, and programs offered for the populations they are trying to serve. Service providers can consider the larger barriers regarding systemic issues to implement change by working towards adding additional services, expanding the current capacity of their services, pushing for more funding, and training their employees in empathy.
References


