“The System is Built to Exclude Them”: Using Sociality to Manage Health Amongst Women Experiencing Homelessness

by

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners. I understand that my thesis may be made electronically available to the public.

Abstract

The lives of women experiencing homelessness are often invisible from both statistics and the public eye. Yet, to support the population, specifically their health, their lived experiences must first be understood. Practicing engaged anthropology, this research uses a combination of non-participant observation, a focus group, and semi-structured interviews with both residents and staff at a shelter open to women, families, and trans and non-binary individuals. The shelter, Valdridge House, is in a medium-sized city in Southern Ontario. Using anthropological understandings of structural violence and gendered dynamics of homelessness alongside the data collected, this research explores how women experiencing homelessness manage their health through sociality within the shelter. Adapting to the perceived inaccessibility of the healthcare system, the residents use sociality to narrate their mental health and trauma, placing blame on their environment for their situation rather than individual fault. Here, they create support amongst residents without any perceived judgement. However, alongside this supportive dynamic, it is shown that structural violence still impacts the shelter sociality negatively, where theft and tensions are still present alongside the group bonding.

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If you are touched by the contents of this thesis, I encourage you to find a way to support those experiencing homelessness around you to demonstrate that there are spaces with support, and without judgement beyond the confines of the shelter.

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Asserting the Health of Women Experiencing Homelessness as a Public Issue

Chapter One

Introduction

The homeless body has structural violence inflicted on its lived experience, exposing her to extreme conditions that manifest poor physical and mental health (Kawash 1998). Women face additional barriers due to gender hierarchies when attempting to manage both their health and their homelessness (Benbow et al. 2019). Recognising the public issue nature of this situation, my research takes a qualitative approach to understand the lived realities of women experiencing homelessness at a shelter in Southern Ontario, specifically regarding their health and how they manage their health whilst navigating their gender and homeless status. To assert this research as being a core example of public issues anthropology, I will first explore what a public issue is and how anthropologists have advised that they are researched. Then, I will show why the health of women experiencing homelessness deserves to be recognised as a public issue in and beyond anthropology. Finally, I will discuss the publics that this research is intended for.

How to Study Public Issues

To address the importance of the health of women experiencing homelessness, it seems first opportune to discuss what defines a public issue, and what responsibilities exist in studying a public issue. In this context, a public issue is thought of as something relevant to the lives of the general public rather than only being of interest to other anthropologists and scholars (Vine

2011). Examples of public issues studied previously, they are often central to media debates and bound within political discourse, requiring activist intervention (Bangstad 2017).

Throughout this project, engaged anthropology has been used which, in this context, also refers to public, activist, and applied anthropology due to their copious overlap. Thus, henceforth the term engaged anthropology will be used. Robin (2016) offers a definition of an engaged intellectual applied here to anthropology, drawing attention to the political aspect which is often considered innate in a public issue:

> "She is […] the literary equivalent of the epic political actor, who sees her writing as a transformative mode of action, a thought-deed in the world…[she] wants her writing to have an effect, to have all the power of power itself" (Robin 2016).

Although some authors may differ slightly in their definition of engaged anthropology, Robin (2016) offers a concise synthesis. Within the Americanist anthropology tradition, it has been suggested that engaged anthropology is the fifth sub-discipline. However, I agree with Darnell (2015) who suggests that all anthropology should be engaged otherwise it is insufficient. Anthropology does indeed have theoretical implications, but it should also necessitate application or else it is wasting practical influence and is not truly anthropology (Darnell 2015).

Adopting this perspective, this research considers the root of the public issue and reflects research practice that gives value to the voices of the research subjects who are regularly stripped of power. As discussed, a public issue ought to reach beyond the academy. Indeed, Fassin's (2017) writing on engaged anthropology concurs that the anthropologist is indebted to the public which provides them with the knowledge. In using qualitative methods

this research has gained in-depth responses from the participants and translated the realities of the women experiencing homelessness.

Public Issues Anthropology in Practice

My research, including its topic, its theoretical framework, its methods, and its intentions are apt for a public issue approach within cultural anthropology. In attending to the voices and narratives of women experiencing homelessness, this approach is also informed, in my research context, by feminist research principles. A suggestion of these three primary principles is as follows: focus research on the experiences of women and girls, reduce power imbalance between researcher and participants, and reflect a dedication to social justice and provoking social change (Burgess-Proctor 2015). Recalling the definition of engaged anthropology, the last principle, in particular, demonstrates compatibility. Speaking explicitly to research within anthropology, it is well suited to the application of both engaged anthropology and feminist research principles with its valorisation of research that gains a deep understanding of a population, especially through ethnographic methods.

Although there are existing guidelines on how to research a vulnerable population within methods literature (Van Wijk and Harrison 2013), these are insufficient for truly protecting those facing extreme vulnerability from perceived harm. The use of feminist research principles provides a better understanding of how to work with a vulnerable population, whilst still recognising the agency within them to want to share their stories. Indeed, without the cooperation of homeless women at the shelter, my data collection would be heavily flawed and the data insufficient. By combining feminist research principles that recognise the power in vulnerable populations with engaged anthropology, this research

highlights the voices of those marginalised, and draws attention to the problematic structures that require change.

The Health of Women Experiencing Homelessness

It is essential to recognise how homelessness is, by definition, a public issue in that the homeless population is living and suffering amongst our community thanks to society's failure to provide adequate support (Tsai, O'Toole, and Kearney 2017). Without it, the understanding that the homeless individual is there through individual fault and personal choice pervades, thereby discouraging the structural changes that would help resolve the causes of homelessness (Harvey 2005). Secondly, the mere existence of feminism shows how women's positioning in society represents a public issue. Despite progress for women, they are still consistently subordinate to men on a global scale. And within the context of my own research topic, women's positioning leaves them more vulnerable to poverty, depression, mental health issues, and interpersonal violence than men (Benbow et al. 2019). The final element to my research is health, specifically the premise that everyone has the right to the highest attainable standard of health. Yet, the homeless population is subjected to lower standards of both physical and mental health (Buccieri 2016; Fransham and Dorling 2018), as well as to lower standards of treatment from healthcare institutions, further enforced by gender dynamics (Bungay 2013). Thus, combining these three components of my research asserts the topic as being understood as not one public issue but three.

Despite Canada's welfare system, homelessness has been considered 'in crisis' since the 1980s (Gaetz 2010) and can affect men, women, and youth, further vary according to age, race, sexuality, etc (Watson 2000). Unfortunately, there is a lack of current statistics on

homelessness in Canada, with the most reputable and recent being Gaetz et al. (2016) in association with the Canadian Observatory on Homelessness. According to these statistics, in a year, 235,000 Canadians experience homelessness, 27.3 percent of whom are women and 18.7 percent of whom are youth. However, because of their lack of permanent shelter, homeless people are a difficult population to accurately record for statistics both broadly and on specific issues such as healthcare access. Of course, statistics cannot be relied upon completely as they may only represent those visible to the public (Evans, Collins, and Anderson 2016). This difficulty may also signify why women experiencing homelessness are often inadequately accounted for, as they do not occupy public spaces in the same way that men do (Schmidt et al. 2015). For example, women are more likely to stay in a friend's home or an abusive situation (Casey, Goudie, and Reeve 2008). As these cases are 'hidden' it is possible to see how it prevents women from being proportionately represented. Although both official and estimated statistics suggest that most of the homeless population are men, this ratio does not detract from the injustice that the women are facing nor the need to research women experiencing homelessness. To adequately support this female percentage of the homeless population it is imperative to use engaged research as a first step to then highlight the issues and allow informed structural adjustments. In doing so, we can attempt to redress the multiple marginalities that women experiencing homelessness embody.

As I have alluded to, women experiencing homelessness are often either invisible as they remain in private settings, or they opt to find private settings within the public. For example, women choose to sleep by dumpsters behind buildings rather than in doorways on main streets where men are often found. Women experiencing homelessness have also been found to prioritise their appearance more compared to men, as a way of maintaining dignity and being able to not appear as homeless to the public. Given that these values of appearance

and carefully avoiding violence are not cited when researching men experiencing homelessness, it is possible to see the benefits of using a gendered perspective to adequately understand the range of what it means to be homeless. These differences between genders demonstrate what are considered strategies of resistance (Casey, Goudie, and Reeve 2008) particularly in how women navigate public space, and in fact how they do so by not being in it. The application of this term can be seen within my research through the participant's reluctance to use healthcare institutions and find alternate ways to manage their health amongst one another.

Beyond these tactics used by women experiencing homelessness, their health must also be navigated. Within other research as well as my own, the prevalence of mental health issues amongst the population is evident. This finding points to how those with mental health issues are more vulnerable to poverty and homelessness, but homelessness is also known to breed mental health issues given the harsh and extremely stressful conditions that people are forced to live under (Bungay 2013). Furthermore, my research identifies how mental health was discussed by both shelter residents as well as shelter staff as being a barrier to finding housing, specifically with being able to attend housing appointments. Thus, mental health issues reflect a daily struggle within the lives of women experiencing homelessness on top of the overall poor physical health that they face.

Of note is the root of these mental health issues. Within both my participant group as well as existing research, it is widely accepted that adverse childhood experiences are a major pathway into homelessness, including violence, addiction, and abuse in the home (Schmidt et al. 2015). This fact is not specific to women and is, in fact, often a pathway for men also.

However, gender-based violence specifically is a primary cause for girls and women to leave their homes and live on the streets, whereas, for men, it is not considered significant. These adverse childhood experiences, which may include sexual abuse, can form unresolved trauma that is translated into unhealthy adult relationships. Consequently, women often continue to be victims of abuse into their adult lives exaggerating the risk of homelessness further (Rosmalen-Nooijens, Wong, and Lagro-Janssen 2011).

Histories of abuse are extremely important to consider when attempting to provide women experiencing homelessness with health support as the correlations discussed show how these histories continue to pervade their daily lives and can be a barrier to finding housing. This reality was apparent within my own research. It is essential to recognise these examples of trauma and gender-based violence as health issues given the strong correlations between these and the mental health struggles and substance abuse that follows (Schmidt et al. 2015). The high rates of these issues amongst women experience homelessness in turn, further asserts the status of this problem as being a public issue that necessitates attention and change.

Venue for Publication

Most important to myself as the researcher, I intend to distribute copies of my research within the shelter to make it as accessible as possible to those residents who participated, other residents, as well as the staff at the shelter. In doing so, I hope to commit to my values as a researcher in enacting both engaged anthropology as well as feminist research by encouraging academic work that can be spread amongst *all* the publics that it concerns. Of course, without those who consented to participate in this research and entrust me with their stories this research

would not have been possible. Thus, I hope this distribution creates an opportunity for feedback from those involved.

Furthermore, I want this research to reach those who may not already have an invested interest in the concerns of the research population. For this reason, I have chosen *Gender, Place and Culture* as a possible venue for publication for my second chapter. I have suggested this journal with the hopes that its international credibility will encourage global interest in this specific intersection of women experiencing homelessness. By communicating the ways in which women experiencing homelessness use the shelter as a place to enact specific forms of sociality related to their health, I hope to empower the population within academia despite the structures that inflict violence and poor health on them.

Conclusion

This research identifies ways in which women experiencing homelessness enact agency within the shelter through adaptations to the various external forces that marginalise them for their being homeless, their gender, and their mental health. Namely, how they consider certain spaces as safe and non-judgemental where they embrace labels of having experienced trauma and ongoing mental health issues. In this sense, an aspect of my research concerns the geography of women experiencing homelessness, showing how certain resources and the healthcare system are perceived as inaccessible to the population. In resistance to this inaccessibility, the shelter becomes a location that, despite ongoing theft and strains, is still considered safe in that they share deeply personal stories with other shelter residents with a perceived lack of judgement. By understanding the lived experiences of the population,

research can, firstly, encourage further research into the complexities of this issue, and, secondly, provoke public interest in bettering the health and the overall lives of the population.

"The System is Built to Exclude Them": Using Sociality to Manage Health Amongst Women Experiencing Homelessness

Chapter Two

Introduction

Despite Canada's advancing movement of women's rights and intersectionality both in public discourse and academically, the woman experiencing homelessness often remains on the outskirts of this progression. In Canada, it is estimated that 27.3 percent of the 235,000 homeless in a year are women (Gaetz et al. 2016). In fact, the actual percentage of this statistic is assumed to be much higher due to the difficulties in recording the 'hidden homeless' population, which women are more likely to be a part of. This term refers to individuals who choose to stay with friends, family, in an abusive situation, or simply hiding from the public and, thus, cannot truly be quantified (Casey, Goudie, and Reeve 2008). Within this research I am mobilising the definition of homelessness offered by the Canadian Observatory on Homelessness (see appendix A for the full definition): "The situation of an individual or family without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it." (Gaetz et al. 2012). Although there are varying categorisations of what constitutes the homeless, I use this definition for its inclusion of those without *safe* housing as it accounts for how situations of domestic abuse are not adequate shelter. As women are more likely to be victims of domestic abuse, this understanding of homelessness allows for an understanding of how gender can impact experience as both a cause and a feature of homelessness. Furthermore, specifying safety is important for seeing the conditions in which mental health issues arise and become so prevalent within the population which is shown within my research.

To address a portion of the homeless population that are stigmatised for their gender as well as their being homeless, this research examines how women experiencing homelessness locate their health within this experience. To identify the health issues faced by women experiencing homelessness, their causes, and how women manage and narrate them, I conducted research at a shelter, Valdridge House, in a medium-sized city in Southern Ontario. Here, I used a combination of non-participant observation, a focus group, and in-depth interviews with shelter staff and shelter residents to gather data that could account for the experiences of the population. These methods were informed by feminist research principles that foreground the experiences of women and focus on reducing the power imbalance between researcher and participant (Burgess-Proctor 2015).

Using anthropological understandings of structural violence and gendered dynamics of homelessness alongside the data collected, this research identifies how women experiencing homelessness understand and describe their health issues in and outside the shelter setting. In the face of a perceived inaccessible healthcare system, gender-based violence, lack of affordable housing, and insufficient state support, these women manage their health through sociality and narration based on complex understandings of different social spaces and different audiences. I conceptualise sociality as intrinsically linked to the greater power dynamics that influence human interaction (Herzfeld 2015). The idea of power within this research refers to macro ideas of structural violence alongside the power within the shelter through rules and cases of theft between residents, as well as the interpersonal power dimensions of human interaction that may be differentiated by age and race, etc. The presence of power then also reminds us that although there may be affective dimensions within shelter relationships, this can be parallel with an instrumentality of gaining individual power and the relations are not necessarily dualistic (Osburg 2013). Thus, the shelter, which automatically marks the residents

as being ‘homeless’ just by its physical boundaries, is a prime site to understand how structural violence influences its victims’ interactions, manifesting in both friendship and tensions where interactions cannot escape the contextual power.

Drawing on women’s narratives of health, homelessness, and social relations in and outside the shelter space, the research shows the significance of mental health discourse and the gendered context of its invocation for understanding how women experiencing homelessness enact their agency as social beings. Women discuss mental health as both a shared experience to connect to one another in the shelter space and a way to narrate how their environment causes their situation. In doing so, they complicate the scholarship on homelessness in neoliberal contexts that emphasise the tendency of the homeless, both men and women, to blame themselves for their suffering that is caused by structural violence (Bourgois and Schonberg 2009; Farrugia 2011; Lyon-Callo 2000; Parker and Fopp 2004; Woolford and Nelund 2013). This uncovering of a new understanding of homelessness asserts both the narration as well as the embodiment of structural violence in women experiencing homelessness as being a site to understand the impact of structures in unfamiliar ways.

A View from the Top: Understanding Structural Violence

To understand how and why individuals that belong to a certain group face unequal hardships, sociologist Johan Galtung (1969) introduced the concept of structural violence. In its inception, it was applied to homelessness by identifying how structural violence can impede on people meeting their basic needs and leave them in vulnerable economic and social positions. Since then, the term has gained traction across disciplines, including anthropology, as a way of diverting blame away from a marginalised individual towards the power imbalances hidden

within a social hierarchy (Farmer 2004). Bourgois and Schonberg (2009, 16) offer a concise definition that shows the application of structural violence to any marginalised group: "Structural violence refers to how the political-economic organisation of society wreaks havoc on vulnerable categories of people".

Despite the blatant emphasis on 'structural' within the term itself, it is, in fact, an approach that combines the everyday experiences of an individual within a group with the recognition that these experiences are the embodiment of structural violence. Structural violence can then be understood as a critique of the idea of one's agency within a hierarchy and particularly of neoliberal ideology, thus, shifting the blame from the individual to the systemic factors for whatever inequality is at hand. For example, a prominent feature of neoliberalism, which is the social and economic context in Canada and elsewhere (Johnstone, Lee, and Connelly 2017), is the discourse of equal opportunity where with hard work anyone can achieve their goal and ascend the class ladder (Harvey 2005). Thus, the ability to climb the class ladder implicitly means that those at the bottom are there by their own failings (Kingfisher 2007). However, structural violence disrupts this narrative (Farmer 2004).

In fact, structural violence suggests that neoliberalism has created both winners and losers by removing forms of social solidarity and social welfare systems such as unions and social housing, thus, forcibly removing what many people relied on for support and stability. Following these changes, the winners are those with capital and the poor become the losers who supposedly through both choice and fault are unable to partake in the free market (Knight 2015). This minimised state intervention and less social support, targets those of lower socioeconomic status which not only includes the already homeless but also leads further

members of the public into homelessness (Young and Moses 2013). Therefore, not only does pre-existing stigma cause marginalisation to certain groups e.g. racism, neoliberalism serves to institutionalise this ideology and displace the fault to the individual.

Anthropology as a discipline is well suited to the study of structural violence, which has been used in support of marginalised groups as a way of striving for large scale social change. A prime example within anthropology is the work of Paul Farmer (2004), who, writing on experiences of AIDS and tuberculosis in Haiti, contextualises the ongoing effects of colonialism on Haitian individuals. This linkage of structural violence with health is popular amongst anthropologists who are confident that poverty is a social determinant of health, and poverty itself is a result of a complex web of social relations of power dynamics whereby certain groups become disproportionately vulnerable (Bourgois 2001; Nguyen and Peschard 2003; Scheper-Hughes 1996). Indeed, research outside of Canada with neoliberal contexts finds that the homeless blame themselves for their situation which matches the political ideologies (Bourgois and Schonberg 2009; Farrugia 2011; Lyon-Callo 2000; Parker and Fopp 2004; Woolford and Nelund 2013). However, this finding was not the case within my own data. Participants narrate their experiences through mental health and environmental factors, showing a displacement of the individual blame that neoliberalism encourages. Perhaps this disparity is due to Canada's relatively, more prominent welfare system, but structural violence is still very apparent in the levels of poverty they experience. Yet, its victims' narrations show a complexity to how and to what extent it is internalised.

Having shown structural violence as a key term to conceptualise inequalities within the health and the overall existence of homelessness I now turn to gender-based inequalities that

constitute a key characteristic of structural violence in the context of employment. Discussions of structural violence are crucial in showing how women are often denied jobs or employed in lower-paying and less secure jobs (Montesanti and Thurston 2015). The financial insecurity that women face is crucial to gendered structural violence. Furthermore, research on interpersonal gender-based violence is adamant that women often stay in abusive situations because they do not feel they have another option (Bungay 2013; Duff et al. 2011; Oliver and Cheff 2012). Gender-based violence against women is recognised as a public health issue that results from women having been placed in vulnerable societal positions due to unequal power arrangements (Montesanti and Thurston 2015). Thus, it is a key example in showing how women are faced with violent interpersonal relationships because of the violence inflicted structurally, reminding that these forms of violence are undeniably linked. Recalling the definition of homelessness and its inclusion of safety, the conditions of living with domestic abuse shows how homelessness for many women may be characterised by this suffering.

Talking further about *how* women experience homelessness, research suggests that women form strategies of resistance to 'doing' homelessness, such as managing their appearance where men do not (Casey, Goudie, and Reeve 2008; Shier, Jones, and Graham 2011). Given the increased vulnerability that women experiencing homelessness have to gender-based violence, it can be understood as an effort to reduce the risk by not appearing 'homeless' or struggling financially. Indeed, women experiencing homelessness are more likely to be relatively homeless, or 'hidden homeless' by staying with a friend or in an abusive and unsafe situation (Casey, Goudie, and Reeve 2008). This behaviour, in turn, demonstrates the difficulties of understanding the population who are notoriously hidden from the public compared to their male counterparts. Yet, with the research that has been done, there is an understanding of how women use space differently when negotiating their homelessness to

resist the external labelling of what it means to be the 'homeless woman' and give control to the individual as to how she is perceived.

Regardless of the subject, structural violence is vital for many social justice movements that attempt to resolve a public issue. The recognition of structural violence is important, as it is a reminder that sexism and other forms of oppression do not only occur through interactions, rather they have been built into the fabric of society to privilege certain people. There is a consensus among the analyses of gendered structural violence that attention must be paid to the individual levels of everyday violence that women face as a result of the structural. With the lens of homelessness, structural violence can be used to see how gender-based violence can impact the homeless woman's experience. A pivotal feminist mantra is that the personal is political and applying an understanding of structural violence to women's experiences aligns with this idea.

Methodology

Methods

Data was collected using a combination of non-participant observation, a focus group with four staff members, and in-depth interviews with six residents at Valdridge House. For a full description of the methods used, please see appendix B.

Context

Despite Canada offering better social support than other comparable countries, such as the United States, its policies are formed within a neoliberal discourse which has meant continuous

cuts to social supports leaving many in poverty and simply cycles of these issues (Kingfisher 2007). Neoliberal effects in Canada have had the most consequences on the already vulnerable populations, with gender, class, and minority statuses having the potential to worsen one's reaction to neoliberal policies thanks to notable cutbacks to social spending (Calhoun, Wilson, and Whitmore 2014). Although there are social supports, these supports have been insufficient since the homeless population is still very much present.

Within Canada, the tactics for poverty reduction have been targeted towards job readiness for individuals (Benbow et al. 2019), with only minor increases to social assistance that have had no recognised success at reducing poverty (Plante 2018), and thus, homelessness. In Ontario specifically, this shift can be understood as being from welfare to workfare, where funds are centred on an individual making effort to work regardless of how low or high the wages are, regulating income based on perceived productivity within the societal norms (Dolson 2015). Ontario's Poverty Reduction Strategy (2018) negates to discuss gender, implicitly suggesting that there does not need to be considerations made between genders for how experiences of poverty may differ (Benbow et al. 2016). Furthermore, the strategy lists 'vulnerable groups' to note what groups need further social support, which did not include any gender until recently (2018). 'Persons in female lone-parent families' are now included here, accounting for the fact that single mothers who have custody of their children are considered the group most likely to experience poverty in Canada (Yeo et al. 2015). However, women are still more vulnerable to poverty than men (Reid 2008), thus, only mentioning those who parent still neglects the importance of gender in poverty, and in turn, experiencing homelessness. Furthermore, it neglects the unique experiences that gender brings to homelessness, which Benbow et al. (2019, 180) list as "intimate partner violence, trauma, increased rates of

depression, and other mental health issues, as well as discrimination within health and social sectors".

The lack of attention to gender within Ontario's Poverty Reduction Strategy (2018) is telling about the overall issue of gender blindness to women experiencing homelessness. With an understanding of structural violence, the lack of gender recognition is extremely problematic for the population's lived experiences. Valdridge House is in part government-funded, thus, this funding is being determined based on these foundational principles that Ontario ha. These principles prioritise expenditure on work readiness and a disregard for gender. Although Ontario's Poverty Reduction Strategy (2018) does recognise how certain marginalised groups must be seen as vulnerable for extra support (including but not limited to Indigenous people, newcomers, persons with disabilities), without gender there will not be a structural level change (Galabuzi 2009).

Despite Canada's neoliberalism, Siddiqui et al. (2013) suggests that Canada is more resilient to neoliberalism than the US, given that despite both governing within a neoliberal framework, Canada's population maintains better health. Interestingly, Canada began implementing neoliberalism in the 1980-90s, arguably, to create easier integration with the US economy for trade who had already implemented prior. This delay can perhaps help explain why neoliberalism is seemingly less harsh in Canada than the US (Calhoun, Wilson, and Whitmore 2014) as the ideology behind neoliberalism does not pervade the Canadian mindset in the same way. Where the US population is understood as internalising the premise of individual opportunity and inevitable success with hard work, Canada has shown resiliency to this idea. The dilution of neoliberalism in Canada can be attributed to Canada upholding its

provision of social services as a human right. A core example of this dilution is healthcare. In the US, healthcare access is largely determined by status in the labour market, whereas Canada's universal healthcare system was maintained throughout the introduction of neoliberalism. However, even with a universal healthcare system, this does not guarantee equal access for women experiencing homelessness. Not only do certain prescriptions cost and family doctors are harder to obtain, but my analysis will also show that the population feels as though healthcare is inaccessible largely for the stigma they receive.

Regarding housing policy in Ontario and Canada, the withstanding neoliberal impact is particularly evident through financialisation whereby homeowning is increasingly difficult alongside the ratio of rent to income rising. With this austerity laden process also comes with a lack of new affordable housing, meaning the rising demand for affordable housing is not met. Toronto, also in Ontario, between 2010 and 2016 saw the social housing waitlist increase from 71,879 to 98,907 (Kalman-Lamb 2017). The situation of those on the list is unknown, however, it can be inferred that individuals are either experiencing homelessness or at-risk of becoming homeless. Instead of acknowledging the social need behind these numbers, housing affordability is instead indicative of market need which focuses on revenue. At the expense of these values, is the existence of a homeless population that bears the most severe repercussions of a neoliberal housing market (Johnstone, Lee, and Connelly 2017).

Regardless of certain disparities with the US, the impact of neoliberalism has degraded the lives of many in Canada and Ontario, targeting the vulnerable which is including but not limited to women experiencing homelessness. However, as I have stated, a neoliberal framework is not necessarily comparable between each country that implements it. Despite the

similarities between the US and Canada, there is a stark difference between the internalisation of neoliberal values within the social imaginary. Throughout 'Righteous Dopefiend' (2009), participants narrate their experiences through individual blame within the US. Yet, within my own dataset in Ontario, Canada, participant's narration of their experiences disrupts this dialogue and instead places the blame on environmental factors as though they have no individual power in their situation. This finding alludes to an understanding of structural violence, specifically via neoliberal policies, that deprives them of adequate shelter. Upon further data collection, perhaps the neoliberal tendencies within participants may become apparent, as it did within Woolford and Nelund's (2013) research in Manitoba. However, this research demonstrates a resistance within my population that may spread across Canada whereby citizens, including the victims of structural violence, do not succumb to the ideology in the same way that occurs within the US.

Site

The research was conducted at a shelter, Valdridge House, from July to October 2019. Ethics approval was obtained from University of Waterloo. Valdridge House, open to any women, trans and non-binary individuals, and families experiencing homelessness, is in a medium-sized city in Southern Ontario. The 'singles' who enter the shelter alone are placed in rooms of either three or four beds with other 'singles'. If an individual has a child/children in their custody they can have a private family room. Together, there are roughly 70 beds available.

Valdridge House is a four-story building, with two floors of rooms, one floor of staff offices, and a ground floor with a kitchen/dining room and a communal seating area. Residents congregate to relax outside on a terrace or by the entrance which is set back from the main

street. It is located a short three-minute walk from the downtown area of its city, nestled between government buildings and newly built luxury apartments that overlook the shelter. Indeed, the neighbouring city had experienced gentrification first which forcibly moved those marginalised to the shelter's city, yet now it is facing the same processes that prioritise businesses and affluence over the social need of affordable housing within the city nor in proximity.

Valdridge House is inconspicuous from the outside but the marginalised who use the shelter services know it well. The actual entrance is discrete and set back from the street meaning that there is no foot traffic from passers-by near the entrance. Instead, anyone that comes to the front door is either a resident or there to visit a resident. The shelter has a curfew for when the residents must return by, and if someone does not use their bed for two consecutive nights then they risk losing their bed if someone new comes to seek shelter. Residents are required to leave the shelter during the day, leaving in the morning before being able to return at 4 pm which is when dinner is served. However, families can come and go throughout the day under the premise that they may need access to their room for a child. It is around the time that dinner was served that I would arrive at Valdridge House and spend two to three hours there roughly four evenings a week. Within the kitchen, residents queue for food before eating either in the dining room, in their rooms, or the communal areas. As it was the summer, most residents spent time in the outside areas. Staff sometimes pass through the communal areas as they do other tasks but there is not a sense of constant supervision.

Overall, there is a tranquil atmosphere, with residents spending time together socialising, whilst others pass by, ofttimes engaging in small talk about how their day had been

or where they were going. The inside of Valdridge House was equally peaceful as residents pass each other and exchange pleasantries. The terrace had flowers that had been planted by residents, with wind chimes, and regular visits from birds. Various benches are covered in writing, with phrases like ‘keep your shine’ and ‘little things mean so much’. Residents move the benches around the terrace, shifting them to face each other to form a conversational area when they are talking. Outside of the entrance is a children’s play structure, but this space is more often frequented by drug users who leave behind drug paraphernalia. Because Valdridge House is open to families, there are also men at the shelter, however, these numbers are small and those congregating are still mostly women. The drug users and the non-drug users tend to stay distant from one another in communal areas, situating themselves at opposite ends of the spaces. This behaviour seemed to reflect an underlying understanding of a binary between residents on who would take the ‘hard’ drugs and who would not rather than actual dislike.

Analysis

This analysis will show how women experiencing homelessness find alternate ways to manage their health due to not accessing the healthcare system, and instead use social relations amongst residents that empower women to label themselves by their mental health and trauma despite the isolation and strains caused by structural violence. Within this research, sociality is being used with the understanding that it is a way in which surrounding power dynamics are manifested through behaviours (Herzfeld 2015). For instance, despite the shelter not having constant surveillance, residents still face the daily rules of leaving the shelter and returning to ‘not lose’ their bed as well as the threat of expulsion if an altercation were to occur. Thus, interactions within the shelter represent friction between the individual’s autonomy and a regulatory paradigm making them a key way to understand power within a setting. In some

cases, the responses to power may be resistance and in others docility, but regardless they are informed by structures (Rozakou 2016). An understanding of an individual's narratives is essential to seeing the impact of structures, and, in turn, how structures should be changed (Dossa 2002). Henceforth I will integrate quotations from the participants of this research allowing their own narration to take precedent.

Mental Health and the Shelter Environment

Although there were many 'health issues' present amongst residents, the dominant issue throughout was mental health. The staff expressed how the residents were overall "high acuity", meaning that residents are likely to present unexpecting medical conditions that require more response and are not predictable (Fazel, Geddes, and Kushel 2014): "We have many clients that have lots of health issues […] whether it's drug use, or lifestyle, or just simply because they've been homeless for a number of different years" (Staff member). Yet, mental health issues were extremely visible and dense amongst the shelter population.

It is not surprising that mental health issues are rife within the shelter. It is already understood that mental health can be both a pathway into homelessness as well as a result of what it means to experience homelessness. Furthermore, those who are experiencing homelessness are likely to have been living in poverty beforehand and, consequently, with high levels of stress that deteriorate mental health (Bungay 2013). This trend is also the case for what happens at Valdridge House, which residents describe as being a stressful and undesirable environment. Cath, a 35-year-old resident who had been at Valdridge House for roughly three months at the time of the interview, expressed how she felt her existing mental health issues became struggles:

> "[I have] concerns of my mental health deteriorating while I'm here. I've been put on stronger antidepressants and I still feel lousy every day…worse each day. It's because not only do I have a great deal of stress, but the environment is just absolutely chaotic. There's no structure at all. I wasn't struggling [before Valdridge House]. I've been mentally ill for many years, but I have not been struggling without any medication for the past seven years until I came here. I anticipated taking steps backwards coming here because the environment is chaotic and I have chronic post-traumatic stress disorder. That's because I lived in a very unhealthy environment when I was a kid. So, to be in the loud obnoxiousness constantly is bringing flashbacks to stuff that I haven't had to face because my environment is serene when I'm able to build it on my own" (Cath, 35)

Cath's mental health diagnosis went far beyond PTSD, and she was certainly not alone in expressing the difficulties of managing her mental health. Although she stated that she is now taking medicine within the shelter, she still expressed a feeling of "taking steps backwards" (Cath, 35). She blamed this feeling on environmental factors, referring to the social conditions at the shelter and how it reminds her of her childhood experiences. In this manner, we see how Cath understands her mental health as being determined by things outside of her control now that she is experiencing homelessness rather than blaming herself for her homelessness and the struggles that it entails.

Each resident that I interviewed expressed a multitude of mental health diagnoses and how, again, they see the shelter environment as worsening their experiences. As Laura, 26, said: "Even if you're not feeling those [mental health] issues yourself, you're around it so much that you're going to adapt to your environment, and you're going to start feeling those things." Once again, Laura is understanding her mental health as being determined by that external to her, such as the behaviour of others. Note how this displacement of blame alludes to the structural violence that they are facing, through Cath and Laura's narrating of their individual experiences being outside of their control.

Participants were not only open about their mental health with me within interviews, but it was also a daily conversation topic in communal areas amongst other residents and myself. Here, residents would talk openly about their medication, how they were feeling that day and the root of their mental health issues. Residents expressed that this behaviour was not 'normal', explained Amanda, 28:

> "Even if there are people that don't have mental health issues, there's enough of us that do that you feel very understood or at the very least not judged. Like I myself have a couple of different mental health diagnoses, I have bipolar, borderline personality disorder, histrionic personality disorder, anxiety, insomnia, mild PTSD. So that's actually quite a bit and it sounds like a lot. I don't want to use the word normal because there's no such thing as normal but, for lack of a better term, a normal person walking down the street…if I were to admit all that they're like "What the hell? What is wrong with you?". Whereas here I'm like "Well, I have all these [diagnoses] but when I take my medication it calms me, it keeps me level, and I'm okay", and they're like "Yeah, I got you because I'm on this for this and it makes me the same way". But other people they just hear all that and they're like "You are going to like stab me in the eye with a fork aren't you?", and you're like, "…no"" (Amanda, 28)

Here, Amanda identifies an apparent uniqueness of the shelter as a space where mental health is a shared experience. Here, by communicating her diagnoses she is legitimising them, whereas, Amanda sees beyond the shelter as heavily stigmatising mental health and not something she would be comfortable talking about, showing a calculated negotiation. Amanda also constitutes herself and those in the shelter as an 'other' to what is considered normal. This distinction could be understood as spatial in how the physical bounds of the shelter allow for these conversations. But it also demonstrates the labelling of 'normality' or 'abnormality' within a category that could be 'homeless', or 'someone with mental health issues', or perhaps both. But this label is used instead in a positive way in that it refers to how she bonds and forms friendships within the shelter, resisting what she thinks an outsider would perceive her willingness to talk about mental health as. With this analysis, we see how residents use the aforementioned negative shelter environment to create an environment of understanding amongst one another. Residents see these conversations as a way to "look out for each other"

(Laura, 26), and although "[fellow residents] may not necessarily have answers or be able to tell you, like, guide you to where to go, but just sometimes having that sympathetic ear to listen makes all the difference in the world…you know" (Pauline, 40). In this, the non-binary nature of shelter sociality is evident in both the affective manner that residents feel support, as well as the inferable instrumentality of exchanging support with one another.

Those experiencing homelessness are often isolated from family and pre-existing friendships (Neale and Brown 2016), resulting in feelings of exclusion from their life before homelessness and distrust for strangers (Aldridge et al. 2018). Yet, the shelter is a space that creates implicit trust in certain situations from what residents expressed as a lack of judgement. Jo, 37 explains the significance of this trust to her:

> "I don't pass judgment on people. I've been through a lot in my life and I know shit happens, life is not always, and people have their own issues from dealing with whatever they've dealt with in life, right. And I've got my own issues and knowing that there are people out there who care and don't judge me for my issues because of what I've been through, it makes a big difference. When you know there are people out there judging you it makes that struggle and what you're going through so much more difficult because they don't understand. Like some people have had great lives. They have money. They have homes. They have family. They have everything. And then there's people like me who, I'm in a situation where I've got nothing. And I'm struggling and it's like…people don't always understand what it's like to be at that rock bottom" (Jo, 37)

Indeed, I will go on to explore how this trust is still challenged within the shelter. However, within this discussion of mental health, residents expressed feeling no judgement and see it is an opportunity to find ways to relate to one another. I witnessed various occasions where intense and honest discussions of mental health occurred without residents necessarily knowing each other's names prior. It is not possible to say whether this feature of the population is due to gender, but the linkage between social connections and positive mental health is considered more significant amongst women than men (Buer, Leukefeld, and Havens 2016; Kawachi and

Berkman 2001). The shelter, understandably, is a space that marks these women as experiencing homelessness. Thus, one dynamic of the shelter sociality, as demonstrated above, is the support that it creates whereby residents can interact with one another through a discourse of mental health, knowing that by being within the physical bounds of the shelter they are likely to have similar experiences. Discourses can reflect "continual acceptance, resistance, and negotiation" (Speed 2006, 29), and here residents are demonstrating the choice to legitimise their biomedical diagnoses and accept them within the shelter.

Residents have found ways to adapt to what structural violence has inflicted and shown agency in reshaping the environment to suit their needs. Despite the imposition of structural violence, it is not to say that the residents have no agency. Certain degrees of agency may seem restricted by lack of power, but there is not a *lack* of agency, but a question of *how* agency is enacted which may be resistance, and it may be submission (Ortner 2001). Here, I am using agency to explain how residents adapt to a distinct lack of power from their multiple marginalities and exhibit a supportive social dynamic that can be seen for both its affective and instrumental capacity.

Gendering Experiences and Narrating the Self into Structure

Thus far, I have identified how the shelter acts as a locale for residents to narrate their mental health and in turn, find and offer support. Beyond mental health, residents also delve into the roots of their issues. In doing so, the influence of gender on their lives becomes apparent. It does not seem appropriate to quote the explicit stories of trauma that participants had experienced, but these were shared both within interviews and within these communal social interactions that I have mentioned. Women experiencing poverty are more likely to have

experienced intimate partner violence, trauma, depression, and other mental health issues than their male counterparts (Benbow et al. 2019), and gender-based violence is considered a significant pathway into homelessness for women (Schmidt et al. 2015).

As my research did not take a comparative approach to gender by also researching the experiences of men, I cannot comment on the accuracy of this suggestion within my research site. However, each shelter resident that I interviewed had experienced gender-based violence and discussed it at their own volition. For example, Eleanor, 33, felt that her previous experiences of sexual assault were barriers to being able to find housing.

> "The one thing I'm struggling with and I'm working on it right now is actually looking for a place because I'm afraid to leave. Once I find a place [to visit], I don't go to the viewing unless my son is with me […] I was never ever afraid of the world but (post-trauma) it's been a struggle to leave home because, […] it could be anybody that does that" (Eleanor, 33)

Although participants did not identify the gendered dimension to their experiences, structural violence explains this pattern. Indeed, it has been established that women face far disproportionate levels of violence than men on the grounds of their subordinate positioning in the social order (Montesanti and Thurston 2015). To truly understand what the health issues being faced by this population are, there must be the recognition that these rates of violence are not coincidental, and gender is a significant determinant of the health issues being experienced within this population. Violence against women is a health issue in and of itself (Krantz 2002), however, within my own research mental health was cited as the most pressing issue by participants. But with a structural violence lens, it is possible to see how gender-based violence is a systemic problem that threatens the wellbeing and safety of these women, leading to mental health issues that become the primary talking point (Teruya et al. 2010). Thus,

gender-based violence can be understood as both a health issue, a cause of (mental) health issues, and as a pathway into homelessness for women.

As I have stated, the population discusses their trauma and their subsequent mental health issues openly within the shelter. In this way, mental health becomes a way of communicating trauma and narrating their experiences through diagnoses and medication. Narrative coherence when discussing one's trauma is considered central for empowering the individual, giving them the control to tell their story and make sense of it. In this sense, it reflects a dimension of the shelter sociality whereby the individual asserts their agency in the situation (Borg 2018) and residents give each other the setting to enact their narrative coherence. The affective dimension seems blatant within this finding that emphasises mutual support via narrative coherence. Consequently, the idea of mutual support can be seen for its pragmatical tactic of offering support, with the understanding that this support will then be reciprocated.

When residents discussed their homelessness, it took an individualised approach, meaning that there was no mention of systemic causes of poverty such as cuts to social support, unequal distribution of power, or a sense of the patriarchy disadvantaging them because of their gender. Staff, however, explicitly discussed this matter:

> "Think about the social determinants of health…our population doesn't even come close [to a good standard of health]. You think about employment or some type of you know reasonable income, housing, health, gender, geography, my goodness, they're just disadvantaged at all of those levels and the system is built to exclude them." (Staff member)

Understandably, homelessness is a lonely and survival-oriented experience (Rokach 2005). Accordingly, it is unsurprising that residents do not devote time to discussing the political roots of their status. However, the way that residents use their environment to explain the state of their mental health demonstrates opposition to the neoliberal ideas of individual fault that are seen within Ontario's policies. In using mental health and trauma to relate to one another, it acknowledges that these issues go beyond the individual experience, creating an understanding of marginalisation at a structural level, that their situation is not their fault.

Adapting to Survive

Having identified how shelter sociality acts as a way to support one another in managing their health, it then poses the question of why? Why do residents not use resources made available to them as a way of managing their health? To answer this question, it is necessary to explore both the workings of the shelter and the population's lack of access to institutions like the hospital. Furthermore, it provokes a contention between when and where women experiencing homelessness are seemingly accepting of being labelled by their mental health, trauma, and homeless status.

The primary answer to why residents do not address health issues, both physical and mental, was the concern of losing a bed in the shelter.

> "I don't know if it's because they don't feel like the staff is trained well enough [on mental health], or if it's that they're afraid that if they say the wrong thing they're going to lose their room, like "You're a problem now"…I feel like that could very well part of it." (Laura, 26)

This perceived fear of losing a bed was central to the everyday discourse within the shelter with stories of residents not going to the emergency room at night with a health concern because of this fear, as well as residents being discharged for a night and relocated to a different shelter as a repercussion for bad behaviour within the shelter. However, I cannot confirm nor deny whether it is the reality of how the shelter operates as I did not witness it happening within my time there. Nevertheless, it was perceived as a real threat to the residents and a key reminder that Valdridge House restricts autonomy. Thus, it shows how the sociality of residents managing their health amongst one another is deeply influenced by the shelter's power.

As I have mentioned, group conversations that can be understood as a way of narrating trauma and blaming environmental factors occur amongst shelter residents. It was also identified how residents will look out for one another for any health issue. In fact, Maxine discusses how residents shift the organisation of the shelter to aid each other:

> "There are a couple of people in the shelter that used to be PSWs or used to even be nurses, and so I do find that it's quite common for people to go to those people instead and be like "Hey, do I need to go to the hospital, or can I be okay, or what can I do to just treat this?" Because again, there's a fear of going to the hospital and the doctor. There's a fear of being judged, or just losing your room, or being held. But if you're going to [a resident] then they're not going to hold you overnight. They're not going to keep you for observation. They may watch you themselves for a couple of days to make sure you're okay, but you're not losing your room and they might be able to tell you a cheaper alternative than medication or whatever, right? […] There's one person who shared a room with somebody who was constantly ODing in the bathroom. She ended up saying it was too much for her to keep finding her roommate OD'd in the bathroom, and she ended up getting one person that was trained as a nurse and asking them to switch her room so they could keep an eye on her because it was, it was too much." (Maxine, 30)

Again, it is evident how residents see their social relations as an opportunity to look out for one another alongside a sense of reciprocity in forming alliances. This shows an adaptation to the perceived fear of what it would mean to talk about health with anyone other than residents,

which may be losing a bed or feeling judged by someone who has not been in the same position as you. Here, we see how the sociality, with both affective and instrumental components, has developed in accordance with what residents are able to manoeuvre and becomes a method of survival, whereby looking out for other residents, you are also forming bonds that could, in turn, look out for you.

Beyond what happens within the shelter, the second facet to this question is why the homeless population refrains from using the healthcare system despite their being high acuity and facing higher health issues than the general population (Buccieri 2016). The data presented thus far shows that residents do have access to healthcare with their discussion of diagnoses and medication, however, this access seems limited and is via resources targeted towards homelessness rather than the conventional healthcare system. The staff regularly spoke of how women experiencing homelessness are stigmatised within healthcare, calling it a "red tape system" (Staff member) which means residents rebuff accessing healthcare, or are treated unfairly when they do. This understanding was communicated through various anecdotes of residents who would resist going to the hospital because of previous experiences they had had, for example:

> "There's a client who doesn't go to the hospital because she has a history of mental health and addictions and when she goes they're assuming that [a physical health issue is] one of those things…I mean she only goes when it's so bad that they can actually see what the problem is because otherwise they just think it's her mental health or addiction. I think there's a lot of clients who experience that" (Staff member)

Indeed, staff identified this experience as a major problem that they heard from residents and in what they had witnessed themselves. Staff sees it as a deterrent from using the healthcare system, as residents are uncomfortable with being labelled by their mental health or drug use for any health issue. This trend is likely to occur with both men and women experiencing

homelessness when they try and access institutions that their appearance suggests they are not suited for and reflects a deep-rooted problem in the stereotypes that are formed around those experiencing homelessness as all being dangerous and addicts (Martins 2008) as if it means they are not deserving of the same healthcare treatment.

However, there is also a gendered dimension to this issue. Women, whether visibly homeless or not, are recognised as facing unfair treatment in the healthcare system on the grounds of their gender (Bungay 2013). Staff drew attention to this discrimination, talking about the typical encounter that they see their residents having when going to the emergency room in pain: "Yeah and then you're visibly female-identified and "you're just being hysterical" (Staff member). So, with my research pointing to how women experiencing homelessness choose to *not* manage their health through healthcare systems where possible as a way of avoiding the external labelling, the context in which the sociality has adapted is logical. Just as it is understood within the shelter that fellow residents are likely to have experienced similar trauma and mental health issues, it is known that the healthcare system does not suit the population and, thus, they create a dynamic within the shelter of caring for one another particularly with substance use.

Furthermore, participants discussed a general dislike for using local resources that both men and women had access to, as they feared large groups of men that congregate outside the buildings. Casey, Goudie, and Reeve's (2008) work on 'strategies of resistance' suggests a similar behavioural pattern but specific to women experiencing homelessness in the UK and how they navigate space differently to men based on their gender dynamics and heightened vulnerability. Valdridge House is in a city with other shelters targeted to those who have

experienced domestic abuse. Thus, that each participant of mine had experienced abuse yet was at Valdridge House suggests a resistance to the label of 'victim'. Rather than access another shelter and receive catered support, it shows the participants' unwillingness to be labelled by an institution yet a readiness to label themselves within the shelter's sociality with other shelter residents and with myself as a trusted researcher.

Disrupting the Alliance

Thus far I have presented the research site in terms of alliances and bonding between residents. Although this sociality reflects both affective and instrumental relations, it is still seemingly positive overall. This case holds true in many situations and certainly within the realm of mental health. However, it is ignorant to not recognise the contradictory behaviour that occurs. I have identified how the population adapts to not using the healthcare system by creating strategies within the shelter to care for one another. However, another adaptation is how the amongst the shelter it is common for residents to have their medication stolen by one another.

> "It's common for people in single rooms to find other people have stolen their medications. Like last week it happened, somebody stole their roommate's medications and the person found their medications in the other person's purse and lost their crap, which I don't blame them, I would too. Because it's hard enough to get medications, especially if you don't have a family doctor and if you're on something that could potentially be addictive then they're only going to give you so many at a time. If people are stealing them, well, can you prove that those were stolen and you're not selling them yourself? The doctor doesn't want to give you them. And then what do you do?" (Holly, 27)

Although I do not want this research to criminalise the population further than the public perception already does (Amster 2003), these circumstances are the reality of what occurs within Valdridge House and tell us something more about how the population responds to structural violence. This point is where the data returns to the understanding of homelessness

as being an individual experience that is grounded in personal survival (Rokach 2005)**.** Indeed, residents are placed on housing lists where they are, in a sense, competing to find housing which serves as a reminder that these systems mean residents must look out for themselves.

When discussing sociality within the shelter, it is not the intention to suggest that power only translates to an essentialised story of friendship and alliance. Responding to structural violence, the shelter becomes a space where residents can narrate their experiences together, and together blame factors external to them for their status. However, of equal importance to shelter sociality is how structural violence has created still leaves the residents living in extreme poverty struggling to get by and often faced with addiction (Fazel, Geddes, and Kushel 2014) that drives them to behave in these manners that contradict what is seen within the shelter's communal spaces.

In particular, we can see how residents resist external labelling of having mental health issues and instead use each other to gain narrative coherence in a setting that they perceive as being without judgement, unlike in a hospital. Furthermore, they create adaptations such as switching rooms within the shelter to help each other avoid going to the hospital and avoid the threat of losing a room. It is not clear whether these seemingly favourable dimensions to the shelter sociality are tactical in forming alliances as it was not stated by residents nor staff. But with the inclusion of how residents still thieve and betray one another, it is possible to see how this sociality is more than the supportive communal behaviours. By identifying the various complexities that this population faces in terms of their health, this analysis has shown how sociality between the women at Valdridge House is a complex web of responses to structural violence and power within the shelter setting that is seen in both positive and negative forms.

Conclusion

Anthropology as a discipline has allowed this research to consider both the macro and micro levels to what this population is experiencing and show how women at Valdridge House embody structural violence. My research has shown how women at Valdridge House respond to a healthcare system that they feel is inaccessible by forming spaces to narrate their mental health and trauma within the shelter as well as be candid with such labels having felt excluded from doing so in the institutional 'public' spaces like hospitals. This demonstrates a dualistic sociality in its capacity to be both affective and instrumental for the residents.

The communal spaces within the shelter can thus be recognised for the capacity to be used as a way of managing one's health. Women experiencing homelessness have their opportunities unfairly limited by their socio-economic status, their gender, their health, and potentially further factors, which can be seen in how residents still discuss theft and tensions at the shelter. Residents narrate their health in a way that displaces the blame from themselves despite neoliberal ideologies and instead show recognition of how they have been marginalised from a structural level beyond their control. This finding reveals a new way to see how the homeless understand their situation and is crucial to showing how, together, the population embodies their marginalisation as well as their resistance to it.

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Appendices

Appendix A: Canadian Definition of Homelessness

"Homelessness describes the situation of an individual or family without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing." (Gaetz et al. 2012)

Appendix B: Methods

To collect data, I used general observations of the workings of the shelter and communal areas, combined with a focus group with shelter employees, and face-to-face semi-structured interviews with shelter clients. I began visiting the shelter three to four times per week during the evenings when dinner was served when most residents would be there and be more likely to congregate in areas to socialise. My regular presence at the shelter was both for observation and to build relationships with the shelter residents to try to make them comfortable with my presence. By having generic conversations with residents regularly and talking openly about my research and my intentions so that there was utmost transparency, I was able to achieve this comfort. Of course, I cannot guarantee that the observations I made during this time are an accurate portrayal of what would have occurred if I had not been there as a researcher as some residents may behave differently knowing that I am a researcher (Erlandson et al. 1993).

Following observation, I invited individuals to participate in one-on-one face-to-face interviews once I felt that they trusted me and seemed open to talk with me during the latter part of my time researching. Not everyone that I invited to interview agreed to, however, in these situations, it reaffirmed that the individuals were comfortable saying no to me which meant I had not coerced them in any way. Overall, I conducted interviews with six shelter residents. I did not place any restrictions on potential participants other than them being over the age of eighteen to be able to assure consent and have used the shelter for at least one night as it can be inferred to mean that they are experiencing homelessness. Aside from these factors, the group was not selected based upon anything else.

The final participant group of shelter residents was made up of six cis-gendered women between the ages of 26 and 40, one of whom was Indigenous, and the other five were white. With only one Indigenous participant, it was not possible to conclude how this feature of her identity may affect her experiences within my research context, but the disproportionate amount of Indigenous people experiencing homelessness is an important feature of Canadian homelessness (Bingham et al. 2019; Kingfisher 2007). As all participants were cis-gendered women, sex and gender can be understood as aligning within my research. Other potentially intersecting characteristics were not mentioned. Indeed, structural violence leaves certain groups of people, in this case, women, vulnerable to intense and unwarranted suffering. This matter does not mean that every woman will face structural violence to the same degree, certainly there are intersecting marginalities that harm some women more than others, such as having lower socioeconomic status (Sokoloff and Dupont 2005). Not only may women be more vulnerable to homelessness because of these intersections, but it may also worsen their experience of homelessness.

Interviews were then conducted in a private and discrete room within the shelter where I then audio recorded the process. The interviews followed a semi-structured interview guide that allowed the interview to largely be shaped by how the participant responded (Bernard 2018). A focus group was also conducted with four staff members at Valdridge House following the same process as the interviews. By interviewing staff, I was able to gain the perspective of those who have seen a multitude of women use the shelter to complement the individual experiences of the resident interviews. The recordings were then transcribed, and subject to thematic analysis. To maintain the anonymity of the participants to the highest level possible, participants' stories will come under multiple pseudonyms to avoid possible speculation on who the individual may be. I will also vary a participant's age by within three

years to once again protect the participant but allow consideration of how age may impact their experiences.