NARRATIVE WELLNESS: VOICES OF PEOPLE WHO ARE EXPERIENCING HOMELESSNESS

A thesis presented

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Abstract

This qualitative study using narrative research was designed to explore the ways in which six participants who are homeless understand wellness in the world. The purpose of this research was to provide a more in-depth analysis of how people who are experiencing homelessness understand their wellness and the factors that support equitable access to wellness. Using thematic narrative analysis, and the social-ecological model to frame the research question, the following five themes emerged: (a) traumatic events that lead to unwellness without a home; (b) barriers to wellness while living without a home; (c) turning point towards social wellness; (d) cultural challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home. A distinct perception of understanding wellness was revealed by a whole-person approach through access to social networking.

Keywords: Wellness education, Nutrition, Homeless, Shelters, Social Support, Narrative research
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CHAPTER 1: INTRODUCTION

Homelessness is an increasingly prevalent problem in the United States. In Massachusetts alone, the homeless population has increased by 40.4% since 2007, due to significant budget cuts for mental institutions. The domino effect has been horrific and as a result, Massachusetts has among the highest rate of homelessness in the country (Levitt, 2015). Moreover, health disparities are far greater in this population than the general population and could be deterred if given equal access to preventable healthcare (Moy, Chang & Barrett, 2013). Furthermore, food insecurity and chronic disease, such as obesity, cardiovascular disease and diabetes, are the costliest, preventable health problems that lead to unnecessary death, with mortality rates twice as high than the general population (De Pergola & Silvestris, 2013).

Due to the high cost in healthcare, there has been more encouragement for people to take proactive and holistic approaches for their own well-being (Koh & Sebelius, 2010). This new paradigm to healthcare approach refers to "wellness". Wellness is the cornerstone of everyone’s well-being. In this research the wellness construct is defined as preventable health, through access to equitable nutrition and physical activity resources. All human beings deserve opportunities and access to wellness and it should not be a privilege of the wealthy or be misused by the bureaucracy. People who are experiencing homelessness deserve to have access to wellness education and opportunity for wellness activities.

There is not enough research to use for creating best practices for equitable access to healthcare for homeless people. People have the right to shape their own wellness paradigm, which includes policies, practices, governance and ownership. This study qualitatively investigated the degree of equitable access to wellness for people who were experiencing
homelessness. The growing gap of health and wealth injustice in the United States calls for a revived shift for improving the access to wellness for the poorest populations. Research can be part of the catalyst for this shift and help define best practices for providing equitable access to wellness for the homeless.

**Homelessness and Health**

Health issues for people who are experiencing homelessness is a major health challenge for not only those who are homeless, but also the health care professional. Homeless people face many of the same health problems of today's society (cardiovascular disease and diabetes), but they are also faced with living conditions and social isolation that tend to make treating and coping with these conditions, more of a challenge. Due to the rise of homelessness and the increase need for medical attention, those caring for the homeless must collaborate to create new innovative approaches.

One modernized way to combat the rise in health disparities among people who are experiencing homelessness, is for researchers and practitioners to provide access to wellness. According to The World Health Organization (2014), wellness is not about the absence of disease, but instead, a more holistic approach to physical, intellectual, and social well-being. However, wellness through a social-ecological lens in health care is a new approach in preventive care (Organization, 2014). Wellness is a right for all human beings and everyone should have equitable access to wellness education and programs for improving well-being. Yet, people who need it the most have the least access, as they are trying to survive in extremely high stress situations and often in crisis.
The reality is everyday life struggles for people who are experiencing homelessness often take precedence over preventable health measures, which can inhibit a homeless person’s ability to access wellness (Ogden, Carroll, Kit, & Flegal, 2014). Furthermore, many health promotions are unrealistic for many people who are experiencing homelessness, which often leads to mistrusting the intentions of providers when trying to access health care (Aviles & Helfrich, 2004).

**Wellness developments.** The correlation between positive wellness outcomes, including proper nutrition and physical activity are well established in the research (Dollahite, Pijai, Scott-Pierce, Parker, & Trochim, 2014). Research suggests more focus should be on all aspects of providing knowledge for one’s well-being, including physical, social, emotional, mental and spiritual health. The World Health Organization (WHO, 2003) claim that the recognition of well-being and quality of life development are a core domain of health and wellness and should no longer be ignored.

However, empirical literature exploring equal access and education to wellness for people who are experiencing homelessness is limited (Lam, Sherbourne et al., 2016). Therefore, this study sought to understand how people who were experiencing homelessness understand wellness through a social-ecological lens.

**Rationale and Significance**

This research project took an in-depth look at the key aspects for equitable access to health for people who were experiencing homelessness to understand their wellness and themselves in relation to it. The findings of this study will help healthcare professionals understand the challenges related to wellness access as well as the successful outcomes possible
for this population. The study’s findings contribute to the advancement and equitable access to wellness education and programs for people who are experiencing homelessness.

**Problem Statement**

In order for people who are experiencing homelessness to have equal access to wellness education and programs, it is crucial to understand the barriers they experience. When reviewing relevant research for this study, much of the existing literature contains negative perceptions of people who are experiencing homelessness as “un-willing to partake in caring for their health”. Consequently, most of the research seems to be related to health care costs, rather than providing equal access for wellness for people who are experiencing homelessness (Winters, Armitage et al., 2010).

**Statement of Purpose and Research Questions**

The purpose of this research was to understand how people who were experiencing homelessness in Boston, Massachusetts understand wellness in their everyday lives, and to develop an inductive understanding of the wellness phenomena in question. In line with the purposes of narrative research, this study aimed to examine people who were experiencing homelessness and identify themes related to their experiences with wellness. Then, create a space for their voices to be heard and followed research questions were addressed:

*How do people who are experiencing homelessness, in Boston, Massachusetts understand wellness?*

**Positionality Statement**

It is important to first identify the scholar-practitioner’s different life experiences (Jupp & Slattery, 2010). My identity is based on a being raised in an Irish Catholic household, where the
daily dinner meal was meat, mashed potato (cooked with lots of salt and butter), and gravy. As a result of this unhealthy eating pattern and poor lifestyle habits, many of my family members developed cardiovascular disease and died at a young age. I was determined to learn more about wellness because of the unhealthy eating habits and risk behaviors that were passed down from generations in my family. I acknowledge my own family’s wellness background to understand my own bias and experiences and how I report my findings of the individuals in this study (Briscoe, 2005).

I have been working in the wellness field as a member of an applied research team for over 20 years to promote evidence-based and best practices. I feel my expertise will help people who are experiencing homelessness get access to wellness and prevent or manage chronic illness by practicing more holistic and practical approaches to healthy eating rather than traditional science driven health promotions. My role as a researcher in this study was to listen to the participants’ stories about their experiences and collaborate with them in re-telling their stories.

**Theoretical Framework**

In order to gain an understanding of how people who were experiencing homelessness construct meaning from wellness, the research was guided by the Social-Ecological Model (SEM) theory (Bronfenbrenner & Morris, 2006). Also, referred to as the bioecological theory of human development, this theory shows how one must consider interconnections between relationships and environments, to produce positive results (Bronfenbrenner, 2001). Social-ecology integrates a holistic approach for the interpersonal connection with society, culture, economics and polity, with the aim to empower development of equitable wellness programs for
the needs of people who are experiencing homelessness (Control and Prevention 2010). It focuses on the importance of individual and relations outside that influence the person (Crosby, Salazar et al., 2013). To research a group at the individual level focuses on gaining a better understanding of the experiences of people who are experiencing homelessness. The concept of the social-ecological model, is to look at the deeper issues of homelessness as they relate to well-being and the “micro” and “macro” causes that are contributing factors to equitable wellness, such as: individual, social policies, institutional structures, and environmental conditions (Control and Prevention, 2010).

For the theoretical framework to be shaped with respect to the research questions, social policies, institutional structures, and environmental factors must be considered, because it’s harder for many experiencing homelessness to have access to wellness due to the lack resources within their environment (McLeroy, Bibeau et al., 1988). In a homeless case, both economic and geographic factors create an environment that works against the individual. Environmental factors affecting people who are experiencing homelessness can also be social, political, and cultural in nature.

For the purpose of the study, the five levels, according to McLeory’s (1988) were used to make the argument that wellness is based on the interplay connections of human behavior between individuals and their systems and environments, forging a method of inquiry that is different from a focus on individuals isolated from their interdependent contexts. McLeory’s emphasis on health education is especially useful to my analysis as it allows me to think through the social-ecological model for approaching access to wellness education and programs, where wellness is dependent on a balance among four dimensions: (a) Individual dimensions that focus
on personal character (e.g., self-esteem, age, mental status, general knowledge, beliefs and perceptions, cultural rituals, mastery, control), (b) Interpersonal dimensions (e.g., interaction between close groups such as: friends and neighbors that lead to social identity and social support), (c) Community dimensions (e.g., housing, churches, healthcare centers), (d) Environmental and societal or collective dimensions (e.g., equity, access, and justice). Thus, in this ecological viewpoint, wellness is not considered at the individual only, but it results, from and is maintained by the harmonious intersection of strength occurring at the individual reclaimable collective nodes.

**Conclusion**

This research project is divided into five chapters. The first chapter has provided a brief introduction to the research problem, the significance of the research, and proposed method of study. Chapter 2 explores the research on accessing equitable wellness for people who are experiencing homelessness by examining topics in the literature review such as: health trajectories and chronic diseases, wellness programs and strategies and literacy and social support. Chapter 3 explores in detail the methods for this research project, including a description of the narrative approach, selection of participants and safeguards to ensure that this study was conducted without bias and in accordance to the guidelines set for by IRB and solid qualitative research methods. In Chapter 4, the research from the people who were experiencing homelessness interviews will be presented with the analysis. Chapter 5 discusses the implications of this research for people who were experiencing homelessness’ access to equitable wellness as well as discuss recommendations for further research.
CHAPTER 2: LITERATURE REVIEW

This literature review explored the wellness of people who were experiencing homelessness and the factors that influence their access and knowledge to health. The current, published literature has a strong emphasis on the mainstream population’s health and wellness. As a result, this research study focused on other marginalized populations, to a lesser degree. Due to the lack of research on wellness for people who are experiencing homelessness, the research intends to lay groundwork for further knowledge on this topic. This chapter is organized into four major literature themes that focus on an overview of this population's health trajectories and risk factors; wellness approaches and strategies; and the need for improving wellness knowledge and access to social support through the communities for sustained wellness in people who are experiencing homelessness.

The first literature theme is a brief overview of the health trajectories and risk factors seen in people who are experiencing homelessness, and the high cost of health care among this population. The second literature theme provides an overview of current wellness approaches and strategies, illustrating the importance of these for overall health. The third literature theme is related to the need for improving wellness knowledge. The fourth literature theme emphasizes the importance of wellness in the homeless community and major factors contributing to wellness access for people who are experiencing homelessness. The last section of the literature review summarizes previous literature addressing people who are experiencing homelessness.

**Health Trajectories Among People who are experiencing homelessness**

Historic changes in healthcare have affected the homeless and the changes need to be examined to improve understanding of chronic risk factors that influence change over time.
Thorpe (2005) claims that over the past 20 years there has been a growing body of literature about the high cost of health care in the United States. He states that although people are living longer, they are also being treated for five or more health related diseases on average. The author also states that chronic conditions contribute to the increase in Medicare, suggesting that wellness can lead to improved health care among people who are experiencing homelessness (Thorpe, 2005). Thus, decreasing chronic disease through equal access to wellness for all is essential to decrease the rising healthcare cost over the last few decades in the United States.

**Chronic disease risk factors.** The most common chronic disease is obesity. Currently, the United States reports that two thirds of American adults are overweight or obese (Ogden, 2014), defined as a body mass index (Body Mass Index) of 30 or greater. Several studies have found a significant relationship between the chronic disease of obesity and food insecurity in adults (Pan, Sherry Njai & Blanck, 2012). Pan et. al (2012) examined the relationship between obesity and stresses from food insecurity in 12 states in the United States using a redesigned food insecurity questionnaire in a national survey. The questionnaire asked about how often the individual stressed over not having enough money for healthy foods. The findings of this study showed food insecurity and obesity were highest among non-Hispanic blacks and a household income below the poverty level. Additionally, it was found that food insecure adults had 32% greater probabilities of being obese than food secure adults (Pan, et al., 2012). Further research needs to be carried out to explain whether food insecurity is a risk factor related to obesity and investigate whether interventions that increase food security, will improve admission to health care outcomes.
Along with the obesity epidemic in this population, there is a strong association between food insecurity and HIV or hospitalization. Weiser, Hatcher, Frongillo, Guzman, Riley, Bangsberg and Kushel, (2013) conducted a longitudinal study with homeless persons who also had HIV and were partaking in (Weiser, Frongillo et al., 2009). They examined the relationship between food insecurity and hospitalization in emergency cases using the Household Food Insecurity Access Scale. The study, conducted from 2007 to 2010, revealed that food insecurity is associated with increased emergency health services use among homeless and at-risk for homeless persons that are HIV-infected. Most hypoglycemic incidences in hospitals were due to food insecurity and, as a result, needed more serious medical attention. The researchers contended the paradox of having diabetes and spending more on health services means decreasing monies available for food (Weiser et al., 2013). This study showed that addressing food insecurity in this population would decrease healthcare costs, but it did not specifically address any solutions for how to do this, such as diabetes management classes in hospitals.

Notably, Dr. Gozdzik’s food insecurity intervention study in 2015 showed cardiovascular disease was highest among men and those with alcohol addiction, even when controlling for BMI (Gozdzik, Salehi et al., 2015). These results were among 353 homeless individuals living in a housing development with mental illness in Toronto, Canada. Calculations included a 30-year heart disease risk, which allows for a longer measured time for modifiable CVD improvements. This study took into account the effects of behavior changes, such as smoking cessation, but did not specifically address access to knowledge of behavior changes (e.g., educating about the importance of eating more fruits and vegetables) or other wellness practices that could be implemented (Gozdzik, Salehi, O’Campo, Stergiopoulou & Hwang, 2015).
Finally, Savage, & Lee (2010) conducted research examining the prevalence of chronic diseases comparing the homeless to mainstream populations. A higher percentage of homeless population had at least one chronic disease compared to the mainstream population, 29% had heart disease compared to 16.5% of the mainstream population, and the life expectancy was estimated at 44 years compared with 78 years in the mainstream United States. Savage (2010) argued that hospital visits decrease when staff are more compassionate, by taking time to hear about the patients lived experiences (Savage & Lee, 2010). The author outlined strategies for nurses to assist the homeless at hospitals with chronic disease and mortality. These measurement tools assess chronic disease, but do not address giving access to better equitable preventive or wellness practices. Some studies point to better measurement tools as stated by Savage & Lee (2010) with lifestyle intervention programs as a way to decrease chronic health conditions. A recent study by Gilstrap and Malhotra’s (2013) also confirms that intervention programs are a way to decrease chronic health issues for homeless persons (Gilstrap et al., 2013). The intervention program examined whether the metabolic syndrome (MetSyn) was a strong predictor of diabetes and heart disease in low-income patients participating in the research over a two-year span. The program included an interdisciplinary team of doctors, a nutritionist, a physical therapist, and a psychiatrist. The program showed a decrease in certain lifestyle factors such as stress and depression. At the baseline, 62.5% of women had hypertension and 21.9% had diabetes, including a significant decrease in HbA1c in year 2 ($p < 0.01$). In regard to their nutritional health, fewer participants skipped meals, fewer ate outside of the home and more implemented portion control. A decrease was noted in fat intake ($p = 0.05$) and sugar added foods while participants ate more fruits and vegetables (Gilstrap et al., 2013). Findings in this
program showed lifestyle changes in marginalized populations, including social support and exercise classes in groups were positively associated with weight loss. Hence, wellness programs that incorporate physical activity and healthy eating habits have been shown to decrease preventable chronic diseases among homeless populations.

**Nontraditional health risk factors.** Although chronic risk factors are prevalent in this population, there are also many non-traditional health risk factors that are ignored. A report by Williams (2003) summarized the past decade of events, including poor economics and unemployment that have had a major effect in the United States that could explain other factors contributing to food insecurity and homelessness. Williams (2003) compared gender differences among these populations and showed men had lower health disparities than women. Although men across all socioeconomic categories have poor health compared to women, lower income in minority men and middle-class black men were seen as the most prevalent for poor health among all groups. Numerous influences add to the higher health risks of men: poor socioeconomic status, poor employment factors, and reactions to stress; each are at-risk to substance use and other health risk behaviors (Williams, 2003). This also suggests more homeless men have working jobs, but cannot afford housing, which furthers the risk of poor health by living in shelters with poor living conditions. Research also reveals serious medical risks associated with the mental stress related to losing their job, including high blood pressure, heart disease, stroke, and diabetes as well as increased mortality, including suicide (Burrows & Laflamme, 2010). Therefore, chronic disease is major problem in the lives of this population due to lack of consistent access to healthcare and moving around within various living environments.
Homeless individuals’ exposure to stressful personal and environmental factors such as social exclusion, exposure to the elements, sleep deprivation, and malnutrition directly affect their wellness (Weinreb, Goldberg et al., 1998). Consequently, prevention and recovery from homelessness is significantly hindered by the effect that homelessness has on the social, psychological, emotional, physical, spiritual, and intellectual wellness of an individual. Research indicates that people who live on the streets or spend most of their time outside are at greater risk for frostbite and hypothermia, especially during the extreme winters (Pillay, 2016). Although not all deaths in homeless individuals are due to severe weather climate, the risk of death from other causes increased more in people who have experienced them in the past (O’Connell, 2005). O’Connell (2005) examined other nontraditional risk factors that may contribute to health problems, including heavy smoking, drug use, and alcohol consumption. In this study, other diseases that homeless individuals are faced with include liver and kidney disease, HIV/AIDS, pneumonia, and tuberculosis (O’Connell, 2005). The implications from O’Connell’s (2005) study suggest the need for exploring all social-ecological factors when treating homelessness, so as not to exclude equally important factors that may be less obvious or discussed in the medical field.

Brady and Sonne (1999) examined alcohol and other drug usage among vulnerable populations and showed strong social support can be a major influencing factor in wellness for this population. Many studies agree that the homeless in the United States have a high incidence of drug and alcohol abuse, but Brady and Sonne (1999) showed how homeless individuals in the United States have a higher incidence of alcohol and drug abuse than most other countries, as well as a higher incidence of mental illnesses. According to Frezel and Khosla (2008) the
United States socially disadvantaged individuals have serious alcohol and drug addiction, and mental disorders were higher in comparison to the mainstream U.S population, compared to the United Kingdom, mainland Europe, and Australia (Fazel, Khosla et al., 2008). These findings reveal that more research is needed to find out what preventive or wellness factors are being used outside of the U.S to create better health outcomes for people who are experiencing homelessness.

Lastly, these results also indicate that the diseases people who are experiencing homelessness suffer from can be modified by dietary and lifestyle changes. However, preventing these diseases will require a more holistic approach, equitable access to wellness education and programs, and increased access to social support from the healthcare profession to change behaviors related to this population (White, Seims et al., 2016).

Wellness Approaches and Strategies

**Wellness definition.** An emergent body of empirical literature related to people who are experiencing homelessness indicates that wellness strategies can positively reduce modifiable risk factors, and improve well-being and quality of life. The World Health Organization (2003) define wellness as, “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmary”. Starting with a seminal review of the published book, *High-Level Wellness*, written by Dr. Dunn (1959), who founded the movement of wellness, defines wellness as, “an integrated method of functioning, which is oriented toward maximizing the potential of which the individual is capable,” (Dunn, 1959). He was looking for a holistic way people could achieve wellness beyond illnesses. In 1972, Travis and Ryan (2004) created a graphic representation called the illness-wellness continuum. The right half of the scale has
increments of wellness, and the left half has increments of disease (Travis & Ryan, 2004). This model has been the status quo in the medical field, creating the message that even when disease was absent people could suffer mental health conditions.

Although there is a broad range of definitions of wellness, there were also many similarities among the diverse definitions (Ardell, 1977; Clark, 1996; Dunn, 1977; Hettler, 1980). Currently, Myers, Sweeney, and Witmer (2000) defined wellness as “a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community.” The researchers’ approach encompassed a variety of attitudes and behaviors connected to the wellness construct toward taking charge of one’s own health needs based on the same approach of humanistic psychology. Furthermore, healthcare is not designed to understand the needs of people who are experiencing homelessness and therefore, access is a problem and trust is an issue. Hence, in order to establish access to wellness programs, further examination is needed to find ways to promote equal access, specifically for people who are experiencing homelessness.

**Models of wellness.** Wellness is multifaceted (O'Donnell, 2008) and not comparable to the absence of disease (Allen, Piette et al., 2014; Ryff & Singer, 1998b). O’Donnell (2008) defined wellness as physical, intellectual, and spiritual health components, (O’Donnell, 2008). Wellness programs are holistic in that they attempt to interconnect the fields of health, e.g., physical, spiritual, etc. Traditional medical practices, such as disease model, are not realistic approaches to chronic disease discourse experiences by numerous people who are experiencing homelessness each day (McCauley, 2004; Swarbrick, 2006). Hence, wellness is becoming a new paradigm in the healthcare profession. Over the past two decades, various models of wellness
have been created. The founder of the National Wellness Institute (NWI) and the first to theorize the mechanisms of wellness, Hettler (1980) defined wellness as “a conscious, self-directed, and evolving process of achieving full potential.” Hettler (1980), believed wellness was more than being free from illness, rather it’s about changing and growing toward well-being and encompasses the following six dimensions as “mental, emotional, physical, occupation, intellectual, and spiritual aspects of a person’s life”.

As a result of the wellness theory, two tools for measuring wellness were created, the Lifestyle Assessment Questionnaire (LAQ; National Wellness Institute, 1983), and Testwell (National Wellness Institute, 1988), a reduced measurement tool (Palombi, 1992). There are other researchers who have developed similar models. Ardell’s (1977) model indicates stress control and how someone can make sense of his or her health through the following five constructs: self-sufficiency, nutrition, stress reduction, physical, and environmental.

In comparison to earlier models Witmer & Sweeney (1992) used Adlerian counseling model as a basis for embedding research through health and wellbeing. Studies have been directed to a change to a wellness model (Myers et al., 2000), which states five themes intersecting life responsibilities, to include the following: jobs and leisure, spirituality, friendship, love, and self-direction.

Research shows one way to empower people who are experiencing homelessness to achieve access to wellness is by helping them understand the wellness wheel (Gill, Barrio Minton, & Myers, 2015). The wellness wheel is a tool to display the several important areas in one’s life that must be addressed for optimal health. Each dimension of the wellness wheel is connected to other parts of one’s life (e.g., emotional, intellectual, occupational, and physical).
The physical part of the wheel involves regular physical activity and good nutrition, all needed in this population for better health (Gleason, Truong et al., 2016).

The negative stigma of homeless individuals as lazy, lethargic, and cast away from society (Cohen & Wagner, 1992) not only ignores the problems in their health, but also perpetuates it. Witmer and Sweeney (1992) found participants had shared experiences of coping with stigmatization and the negative effects of not feeling a part of society. Despite negative social stigma, homeless individuals revealed hope and motivation and exploration of spiritual counseling.

**Wellness programs.** Rustad and Smith (2013) showed there could be an improvement in health outcomes for people who are experiencing homelessness through access to nutrition education. A study was conducted at a community center in Minneapolis, and Saint Paul, Minnesota with 118 low-income women, ages 24-45 years living in homeless shelters. Three training sessions were employed through experimental and hands on lectures. The outcome showed an increased awareness of knowledge pertaining to healthy foods, grocery shopping, cooking, and overall energy balance (P<.05). The findings from this study showed knowledge increased in wellness by using a holistic approach.

Other research has focused on integrating components of Bandura’s self-efficacy theory (Bandura, 1977, 1982) into the scope of holistic wellness. Research conducted by Pappas (2015) introduced a wellness program to improve knowledge about heart disease among 77 participants at a mental health rehabilitation center. The researcher developed and implemented educational material using a self-efficacy theoretical framework. The researcher noted the program empowered participants to take action to manage their own health care through wellness.
education, and the linked lowering blood pressure to nutrition, which may be especially effective in people who are experiencing homelessness with behavioral health conditions (Pappas, 2015). Although, Pappas’s study was limited in its generalizability, it proved to be a programmatic framework for sheltered institutions, and existing healthcare professionals can be trained to lead such programs “in house,” increasing the ability to provide more viable training outcomes (Pappas, 2015). Such interventions may also have a greater reach, if more healthcare professionals provide training to large community groups.

The larger body of research depicting the health benefits of increase wellness knowledge for diabetes management has compelling results. Researchers, Gucciardi, Vahabi, Norris, Del Monte and Farnum (2014) reviewed and synthesized the current literature for methods in teaching prevention and management of diabetes in marginalized populations. The most successful relationships in wellness practices were seen in studies that partnered with shelters to promote healthy food choices and provided diabetic snacks (Gucciardi, et al., 2014). Future research could replicate these findings among this population.

Other programs aimed at promoting wellness in this population include physical activities. The Physical Activity Guidelines for Americans (Hassel, 2006) include eating a healthful, balanced diet while being physically active is essential for maintaining a healthy body and feeling well. These guidelines are issued by Health and Human Services (HHS) (Tabak 2016), which describes the criteria for physical fitness that promotes health. In addition, the (Hsieh, Rothman et al., 2016) provides physical fitness criteria for all ages. Another study conducted by Kennedy (Kennedy, 2015) noted it was important to have empathy for homeless individuals by supporting them to lose weight through exercise, but also included nutrition
behavior changes. Shahnazari, Ceresa, Foley, Fong, Zidaru and Moody (2013) claim that regardless of weight, healthy eating and physical activity help support feeling better and having more energy. Strong evidence shows heart disease can be reversed with nutrition counseling and dedication from the person and a team approach. Improved diet like lower cholesterol, lower salt, stress management, moderate alcohol use and smoking cessation makes people feel less isolated and more connected.

Another wellness initiative within this population is SAMHA (Khaliq et al., 2016). This agency, within the U. S. Department of Health and Human Services, provides public health leadership to reduce addiction and emotional trauma in United States communities. SAMHSA (2016) has proven to be successful in encouraging veterans to use the eight dimensions of wellness in lifestyle factors: physical, social, environmental, financial, emotional, intellectual, occupational, and spiritual (Pappas, 2015). Additionally, The Health Empowerment Lifestyle Program (HELP) (Tucker, Wippold et al., 2016), was culturally tailored to assist minority populations about diabetes, hypertension, or overweight/obesity and appropriate management of the conditions. This program was designed to assist African-Americans about preventing illness, which in turn led to self-care and improvement in overall health, and quality of life (Kumanyika, 2012).

Boston Health Care for the homeless (Baggett, Campbell et al., 2016) has assisted with medical, behavioral, and dental healthcare, including preventive care, to an estimated 11,000 people who are experiencing homelessness. Health care was taught in academic hospitals and shelters. The program’s missions are caring and education to decrease health disparities in this
vulnerable population (O'Connell et al., 2010). This connects to this research project as it hopes to also address preventive care for the homeless in a community setting.

Another community program, a diabetic health program, The Neighborhood Medical Center (NMC), provides health attention to those who are underserved (Rodríguez, Campbell, & Kirksey, 2013). This program has shown to be effective in weight loss through nutrition and diabetes self-management, including carbohydrate counting and reading food labels. Another program, The Million Hearts, is a cardiovascular treatment for social disadvantage individuals to support their health and wellness. This shift from the top down approach of delivering healthcare that has failed to evoke the individual’s intrinsic motivation or health behaviors, to programming that invokes a person’s intrinsic motivation (Taylor, Carter, Bradley, Savoy, & Goldenberg, 2015).

Prilleltensky (2005) designed an intervention study to examine the effects of health coaching intended to reduce the risks of chronic, preventable diseases. The study recruited 12 underserved individuals with mental health problems in homeless shelters in San Francisco, California. This study’s findings revealed how the motivational power of coaching was effective in reducing chronic health problems in the homeless. These wellness interventions are linked to this research as showing the importance of alternative holistic methods for combating health risks in this population.

**Wellness and Knowledge**

The theories of Boss, Freire, and Knowles (2000) and (Freire, 2000) are the foundation for wellness knowledge and education. Although, noted that helplessness is a learned trait that can be reversed through education. The perception of their situation is the key factor (Craig,
1988), Freire’s (2000) theory seeks to empower people through critical reflection followed by taking action for one’s life. Freire (2000) also believed professionals become more active by working with vulnerable populations to encourage their transformation and bring about larger social justice. Knowles (Knowles, 1984) stated the adults should be used to develop education programs to be effective toward the adult learner.

**Wellness and health literacy.** Poor health consequences and inadequate health literacy has been linked with greater use of emergency departments, longer hospital stays, and increased health care costs (Fetter, 2009). Health Literacy, is a vulnerability associated with people who are experiencing homelessness and their lack of access of healthcare services. Researchers (Parker & Ratzan, 2010) defined health literacy as "the skills and ability of those requiring health information and services are aligned with the demand and complexity of information and services" and is a strong predictor of health (Van Der Heide, Wang, Droomers, Spreeuwenberg, Rademakers, & Uiters, 2013).

According to Berkman, one must have the ability to read and write and critically understand printed and numerical material, and finally, have good skills in oral communication (Berkman, 2011). Another study, done by Coppenrath (2001), showed a lack of nutrition and labeling knowledge among this population (Coppenrath, 2001). Researchers (Davison, Share, Hennessy & Knox, 2015) showed nutritional literacy had a positive effect on people when considering foods. Furthermore, the researcher’s state that with adequate nutritional counseling, homeless individuals increased food knowledge and made better food choices. This study stated the importance of practitioners and healthcare workers wrongly assuming that a patient can read and understand directions and labels. Another issue they cited was in relation to health care
professionals not understanding cross-cultural barriers between themselves and the patients; often, there were gaps in training medical students who were treating this population (Betancourt, 2003).

Van de Heide (2013) confirms that health literacy is a strong predictor of health among people who are experiencing homelessness (Van der Heide et al., 2013). Coppenrath (2001) examined twenty-one homeless people from Santa Monica on nutritional literacy. The study collected 24hr food recalls and did interviews on nutritional literacy and found that knowledge of nutrition and labeling among this population was limited (Coppenrath, 2001).

Another issue revealed in the literature was about health care professionals not understanding cross-cultural barriers; often, there were gaps in training medical students who were treating this population (Betancourt, 2003). Recommendations were further supported by the National Patient Safety Foundation and the “ASK me” curriculum to teach behavior change and health literacy (Hawkins, Kantayya, & Sharkey-Asner, 2010). Finally, the accrediting organization Joint Commission, noted the gaps and barriers related to health literacy that need to be addressed in patient centered communication among this population (Saver, 2012). These groups therefore, tend to have greater difficulty understanding medical terminologies and following appropriate medication regimens. This leads to poor control of their medical conditions, adverse effects with diet and furthermore increases their risk for additional health outcomes.

**Wellness and Social Support**

Renger (2000) explained that wellness include interacting with others, the community, and environment (Renger et al., 2000). The National Collaborating Centre for Determinants of
Health stated the importance of wellness was based on one’s social network. Ryff and Singer (2006) showed a decrease in mortality associated with people who are more socially connected, including the size of the social networks and rate of communication with relationships (Ryff & Singer, 2006). Durlak’s (2000) researcher revealed that peer approval, strong communication, and conflict skills are major constructs of wellness. Social interconnectedness seems to be a positive association with wellness in this population.

The importance of social networking as lead to a new emerging field with the vulnerable populations. Once such field is called health coaching, which provides support for vulnerable populations. Health coaches assist homeless people to learn to use the health care resources available to them for preventive care in a supportive way (Jordan, 2013). The researcher conducted an intervention study of twelve underserved individuals receiving health coaching for 12 weeks in California. The findings from this study indicated that motivational coaching is effective for providing social support and establishing goals for wellness (Jordan, 2013).

**Synthesis**

I analyzed literature that provided insight into the challenges faced by people who are experiencing homelessness. The literature presented evidence of wellness strategies in socially disadvantaged individuals while in the homeless environment. The literature reviewed attempted to create a broader understanding of how wellness initiatives for people who are experiencing homelessness increases overall health and quality of life.

I found that examining issues related to people who are experiencing homelessness varies based on various social-ecological factors, including health-related social needs (like food insecurity and health behavior) to improve access, health equity and well-being. In order to
promote equitable access to wellness education and programs for everyone, healthcare professionals must devise new innovative wellness practices to improve wellness in people of homeless.

CHAPTER 3: METHODOLOGY

The goal of the research was to understand the experiences of people who are experiencing homelessness and their perspectives about wellness. The participants in this study were between 6 adults, men and women between the ages of 40 - 70 years old, who were homeless and living in a shelter for more than three months, in Boston, Massachusetts.

An extensive literature review revealed the need for further investigation of people who are experiencing homelessness and their perspectives on wellness. I found it necessary to apply a qualitative methodology to gain an understanding of their individual’s experiences and perceptions on wellness. Qualitative research gives voice to unrepresentative populations and allows their ideas to be presented on their own access and knowledge of wellness. I explored four major themes from the literature review and they are as follows: health trajectories and risk factors; wellness approaches and strategies; and the need for improving wellness knowledge and social support for sustained wellness in this population. The following research question is being addressed: How do people who are experiencing homelessness, in Boston, Massachusetts understand wellness?

Given the goal of this study, I believe qualitative research was the most suitable method. According to Draper & Swift (2011), qualitative research of narrative and observation are increasingly being used in healthcare settings (Draper & Swift, 2011). Although, the medical field still emphasizes the importance of quantitative approaches (Fade & Swift, 2011) which is
numeric driven and does not always capture the true essence of real life issues. Qualitative research is a viable alternative to the top-down deductive disease model approach. It allows participants within their own environment to give “voice” to express their own views about their wellness experiences. It provides a reflective process and the silent nuance in discovering knowledge, and behavior as well as introducing new themes (Rubin, 2012). Hence, I conducted a phenomenological design to understand underserved populations’ interpretation of their own wellness.

**Research Tradition**

I believed a narrative research to be the most appropriate approach for this study. Although, qualitative studies can be conducted through a range of different methods, the research believed narrative research to be the best approach. Narrative research provides in-depth exploration of stories to provide entry into the inner world of the participants (Clandinin, 2013; Clandinin & Connelly, 2000). “The essential theme of the method is that narrative is a way to try to make sense of experiences that are created in a narratively phenomenon” (Clandinin, 2013, p. 16) “that represents a personal history of the social aspects of a person's inner world and the social and environment influence” (Clandinin & Rosiek, 2007, p.41). Furthermore, the narrative analysis, reflects the narrative experience of the present through the stories that is co-created or constructed. In the case of this study, the ways in which people who are experiencing homelessness make sense of their access to wellness experiences in the world are being investigated (Smith, Flowers, & Larkin, 2009). In the context of this study, the use of narrative inquiry allowed for a chronological timeframe of the events that took place in a particular place at a particular time of a person who was homeless.
This research takes on the subjective dimension that includes an interpretive paradigm, to seek to understand the world through the individual experience (Burrell & Morgan, 1979). Ponterotto (2005) states our worldview is based on the interconnections of beliefs and assumptions about the world as we know it and a conceptual framework for the context for research studies. The paradigm that further guides my views and beliefs for this study are from a constructivist-interpretivist view. A constructivist-interpretivist approach takes on multiple views while studying the phenomena (Broom and Willis 2007). The medical field has always emphasized the importance of deductive reasoning, which may be at times be viewed as detached and irrelevant to real life issues (Broom & Willis, 2007). Currently, the value of qualitative methods of narrative and observation are being considered more in healthcare settings. There is an empirical question to be answered using observational methods in qualitative studies, which can provide validity. An advantage in using qualitative methodology is the reflective process and the silent nuance in discovering knowledge and behavior, as well as introducing new themes (Rubin, 2012).

As healthcare professionals, one must examine wellness techniques, in order to provide subjective human responses of human environments and make sense of the wellness phenomena in question. This research study considered reality to be socially constructed and the aim of this research was to vitalize an inductive reasoning approach.

Finally, this research study accepts that the experiences of people who are experiencing homelessness in terms of wellness are socially constructed. The research study holds an epistemic position and embrace the subjectivity as being essential to the research because each individual experiences the same environment differently. Therefore, because I believe reality is
explained by social factors and aimed to produce subjective results, I favored inductive reasoning.

**Participants selection criteria.** I identified participants for this study who met the following study criteria: 6 adults, men and women between the ages of 40 - 70 years old, people who were experiencing homelessness and living in shelters in, Boston, Massachusetts. All of the participants had been living in homeless shelters for at least three months.

**Recruitment and Access**

Ethical approval was granted by the Northeastern University IRB committee (see Appendix A). The study participants were recruited from a community wellness organization (Back on My Feet) that partners with local shelters located in the urban city of Boston, MA. Study information was provided to the director, who assisted with recruitment by permitting dialog about the study during several group events. Those interested in participating in this research were given a letter to review about the study. If interested, the director scheduled an appointment for the participant to meet me.

All participants were self-identified as being in shelters in Boston, Massachusetts for at least three months. Due to the diverse homeless population, efforts were made to recruit from a varied of ethnic backgrounds.

I recruited 6 participants for this research project. All interviews were face-to-face, with the interviews lasting 60 minutes. The interviews were performed in a location of the participant’s preference to allow for flexibility. All interviews were recorded and transcribed verbatim by the research. The results were analyzed using narrative analysis. To ensure
confidentiality, the participants were assigned a pseudonym. The data were recorded and data were immediately transcribed.

**Participant profiles.** Six participants were purposively selected to obtain a homogeneous group. Theoretical sampling were designed to identify participants who had an association with the phenomenon of being people who were experiencing homelessness, living in shelters for more than three months located in Boston, Massachusetts for the last year. Homogeneity was carried out to find similar groups with similar traits or living conditions related to the social phenomenon studied (Smith & Osburn, 2003).

**Data storage.** Creswell (2012) states it is essential to store data and materials from the study safely (Creswell 2012). The research maintained a level of data integrity by having two copies of the data. The data were protected from any possible damage by storing one copy in a locked desk in my office and another in a private home office in a locked file cabinet. Data management procedures were implemented, including assigning each participant a pseudonym on all documents.

**Trustworthiness.** I realize that trustworthiness is extremely important and carried it out with rigor, reliability, and validity. The research followed the narrative research protocol to report the study’s findings.

**Protection of human subjects.** The research sought out the Northeastern University IRB approvals for this study. The research complied with IRB privacy and confidentiality procedures for human participants. The research required signed consent forms from the participants, which were filed away with the locked data. I took extreme precautions to participant cultural views and advised them, they may stop participating in the study at any time.
Data Collection

A semi-structured interviewed guide was developed for the qualitative interviews. The guide prompted participant’s perceptions of what wellness means to them, including the barriers and facilitators to wellness. The interviews were tape-recorded with the participants’ consent.

Data Analysis

In order to provide a framework for the narrative data, the qualitative interviews were first transcribed by rev.com, and re-read three times for full context of the participant’s meaning. Transcript data was uploaded to Atlas-Ti version 6. (Hapberg, Germany), a qualitative data analysis software program, in order to facilitate the analysis. The software allowed for first using a word cruncher tool to compile a list with the most-used terms in the transcript data, in order to know the main lines of participant’s words. These methods explored the data, as the first step of the analysis process.

The frequency of code words was used to further devise categories and subcategories to identify segments of the interview text that provided an indication of participant alignment with the concepts by the different aspects of the social-ecological theoretical model (McCleory, 2010). This directed content analysis (Hsieh & Shannon, 2005) and provided a platform for the initial analysis of the interview data. New codes were added to the coding scheme as ideas and concepts were discovered. The most significant findings from this analysis are presented in the content analysis section.

A content analysis focused on emergent major themes and sub-themes within the transcript data. The following five themes emerged: (a) traumatic events that lead to unwellness without a home; (b) barriers to wellness while living without a home; (c) turning points towards
social wellness; (d) culture challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home. Participants' responses were compared and cross referenced to ensure that each participant's quote was appropriate and relevant to a specific theme. The emergent themes was determined by comparing the participants’ answers to each of the research questions.

To protect the anonymity of all participants, protections based on the Health & Human Services (HHS) regulations for protecting human subjects (“Protection of human subjects,” 2009) and the policies of Northeastern University (Northeastern University, 2014a) were followed based on the consent form. Participant confidentiality was implemented with the use of a codebook that linked participant’s names with other identifiable data and audio, transcripts, and notes (Josselson, 2007).

CHAPTER 4: RESEARCH FINDINGS

The purpose of this study was to explore the ways in which people that are living in homeless shelters experience wellness. This study was framed by the following question: How do people who are experiencing homelessness, in Boston, Massachusetts understand wellness?

This chapter provides an introduction to the study participants, followed by a presentation of the narrative research findings in terms of content analysis focused on emergent themes within the data. The following five themes emerged: (a) traumatic events that lead to unwellness without a home (b) barriers to wellness while living without a home; (c) turning points toward social wellness; (d) culture challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home.
Study Participants

There were six participants in this study who have been homeless. Four participants were from a local women’s shelter in Boston, Massachusetts and two were from a Veterans shelter in Boston, Massachusetts. Two of the participants were male and four of the participants were female. This profile of the participants was discussed in detail below.

To protect anonymity, any personally identifiable information was removed from the interview excerpts used in this dissertation, and the participants’ biographical profiles were only partially revealed. Fictitious names were used to further protect participants’ anonymity. Appendix D summarizes the participants’ characteristics. These characteristics include age, gender, ethnicity, and education. A biographical profile for each participant follows.

Ciera. Ciera is a single female in the 50–60 age range. She noted her ethnicity as African-American. I met Ciera for the first time at a women’s shelter in Boston, Massachusetts. The interview lasted an hour. Ciera is a petite woman with a very soft voice and a serious demeanor. She was very engaging and willing to talk about her life. She immediately told me she was a Christian woman. She told me she had a high school diploma and was enrolled in a university for her bachelor’s degree, but had had a crisis in her life that prevented her from finishing. She has been living in a shelter in Boston, Massachusetts for the last eight months. Ciera stated, “It's a spiritual thing…I've learned through healing in God...he's bringing me back to become a cleaner. I asked her how she defined wellness. She stated, “Being normal…I think that’s how I would define it… being a healthy woman all the time and not somebody that has emotional problems” (Personal communication, October 12, 2016).
Ciera perceived wellness as being a healthy person; she felt she is not healthy due to her mental challenges. She has a substance abuse issue and alluded to the fact that she was trying to get clean. Wellness is not being in the shelter but she does not know what wellness is supposed to be. This is what she is learning presently—how to be well.

**Keita.** Keita is a female in the 50–60 age range. She noted her ethnicity as Honduran. She has a high school diploma. I met her for the first time at a woman’s shelter in Boston, Massachusetts. She has a serious manner but was willing to talk about her life. The interview was one hour long. She told me she had a baby when she was a teenager in high school. She said she is divorced and loving it. Keita then said when her family and work life became unmanageable, she was hospitalized. She was diagnosed with mental illness and suffers from depression. Keita has expressed that her depression is an obstacle for her to lead a healthy and active lifestyle. She stated the following, “I was in a deep depression, so I was in the bed for years, so when I started to come out I joined [wellness organization]” (Personal communication, October 12, 2016)

I asked her to describe what wellness meant to her. She stated the following: “I would describe wellness as mentally stable, physically fit, eating right, exercising, having a good social life…Basically showing up for your own life every day” (Personal communication, October 12, 2016)

Keita only briefly mentioned her past life, which involved an abusive stepfather and becoming a teenage mother, both leading to years of mental illness. Keita is at a place in her life where she is ready to take on life. She described understanding her wellness as a whole-person wellness approach and is actively aware of, and making choices toward, a healthier lifestyle.
Roy. Roy is a male in the 40–49 age range. He noted his ethnicity as German and Polish descent. He also is a Veteran. He has a bachelor’s degree. I met Roy for the interview at a local coffee shop in Boston, Massachusetts. He is well over six foot five and has a large build. He has a very friendly manner and loves to talk about his experiences. The interview was well over an hour long. He stated he has been married and divorced twice. He said he has adult children, but did not want them to know he was homeless. He has been homeless for two years. He previously lived in a veteran’s homeless shelter but just this month moved into an assisted living residence. Roy mentioned that he had worked as a construction worker most of his life until he hurt his shoulder. He stated he loved working in a physical manner. Since he no longer could do manual labor, which he loved to do, Roy decided to pursue a college education through the Veterans program. When he decided to come to Boston for his master’s degree through the Veteran’s program, things took a turn for the worse. He thought he was guaranteed a job and a place to live in Boston while pursuing his degree, but when he got to Boston, there was no job or place to live. He then became homeless and ended up at the Veterans shelter in Boston.

I asked him to define what wellness meant to him. He said, “You can say don’t quit in life, and people are like, ‘oh gee I haven’t heard that metaphor before but thanks for the advice,’ but that attitude was important for my mental simulation.” (Personal communication, October 19, 2016)

Roy is a Veteran and like many military people, trained in mental toughness. He used the metaphor of “don’t quit” to describe how he perceives wellness. His perception of having a mental attitude is what he believes has gotten him through tough times.
**Terry.** Terry is in the 50–60 year age range. He noted his ethnicity as being Caucasian. He also said he was a Veteran. He had been living in the same homeless shelter as Roy for over two years. I met Terry for the first time at a local coffee shop in Boston, Massachusetts for an hour interview. He was very energetic and eager to talk to me about himself. Terry told me he has an electrical engineering background with chiropractic experience. He was also in the marines for four years. He mentioned how the economy was not good for jobs and he found himself unemployed. He tried to develop new skills and go into business for himself, but when he no longer could live with family to help support him, he became homeless. I asked Terry if he could tell me what wellness meant to him and he stated the following:

Wellness to me meant having a job and providing for myself. Being self-reliant and self-responsible and being able to deal with my own things in life. To be able to live the life I want to live (Personal communication, October 6, 2016)

Terry referred to having employment with understanding his wellness. He described the ability to work and to have the resources to take care of himself as influencing is wellness. He also said, with a laugh, that wellness means not getting sick. I asked him how does he not get sick and he said, “I take a good positive attitude...inner peace.” Terry also describes understanding his wellness as having no illness complaints. He states his positive energy allows him to reach a sense of wellness which he calls his inner peace. Terry’s perception of wellness is similar to Roy’s, who is also a Veteran. His perception of wellness is to be in control of his own life, free of sickness and being able to choose the path he would like to follow for himself.

**Lylia.** Lylia is in the 61–70 year age range and noted her ethnicity was African American and Native American Cherokee. She also said she was from the Southern part of the country. I
met Lylia early one morning in front of a shelter in Boston, Massachusetts. She went to school for an undergraduate degree and then attained a master's degree in Education from a college in Boston. She is a Christian and mother of three children, two of which are from her second husband. She is a grandmother of seven. She has been coming to a shelter in Boston since her second marriage ended in divorce, to help find housing and food. I asked her if she could tell me what wellness meant to her. She stated the following, “Wellness is physical, mental, and spiritual health.” (Personal communication, October 12, 2016)

Lylia also described a whole-wellness approach. She is a strong-willed woman, so she is not easily influenced by others. She stated that there is help at the shelter, but she doesn’t always trust the people here with getting the right answers or help. She stated that you have to be your own advocate. She also revealed she is willing to take the necessary steps to keep healthy.

Amira. Amira is in the 50–60 age range. She noted her ethnicity as African American. She is a divorced mother of two children with six grandchildren living in Boston. I met Amira while waiting outside of a woman’s shelter in Boston, Massachusetts. She had just finished her group walk with another woman at the shelter. She was willing to talk about her life. She is a Christian woman and originally from the Southern part of the country. She has an associate’s degree in early childcare from a local college in Boston. She also volunteers for a literacy program for children. She told me she was at the homeless shelter because she was in an abusive marriage and lived at the shelter for safety. I asked her to tell me what wellness meant to her. She stated:

Wellness means physically, emotionally, you're well. That you can take care of yourself. You're able to move your body and not be sedentary…wellness is overall a factor of how
you see yourself. You take care of your body, your mind, and your soul and your spirit.

That's wellness to me. (Personal communication, October 31, 2016)

Wellness to Amira means being able to take care of yourself after leaving an abusive marriage. She also mentioned physical fitness and being active so that you look good. Amira also described wellness as a holistic approach to well-being, which includes being physical and emotionally well.

**Emergent Themes**

The interview transcription texts were used as material for analysis and identified emerging themes that ranged beyond the a priori codes derived from the social-ecological framework. The review of the texts in this analysis provided insight into the experiences, and five major themes emerged about understanding people who are living in shelters, their access to wellness based on the research questions and the analysis of the narratives. The following themes emerged:

**Theme One: Traumatic Events Leading to Unwellness Without a Home**

The first theme revealed that all participants indicated a time in their lives when they were not well. While talking about the past, most of the participants revealed a traumatic experience and the spiral effect that triggered inequitable access to wellness. All the participants experienced trauma; three were acute and three were chronic trauma. All of them used unhealthy behaviors (e.g. drugs, overeating, alcohol and isolation) as a way of coping with their traumatic situation at the time. The following list includes the subthemes: acute trauma: onetime events and chronic trauma: long-term events.
**Acute trauma: One-time events.** One subtheme was acute trauma: onetime events that left some participants needing a home. Acute trauma is often a onetime event such as a car accident, unemployment or any experience that causes a physical or emotional situation; three out of six participants revealed experiencing acute trauma. Ciera experienced a tragic event that spiraled into a series of crises in her life that left her homeless. When I asked how she became homeless, living in a shelter, her story took me by surprise. She began to tell me how she was going to a university, a liberal arts school to become a teacher which was something she had always wanted to do. Then, an unforeseen accident brought her to this point in her life today. First she was injured brought to a medical center, where she stayed in a rehabilitation center for one year. After the year was up, she had to leave so she went to stay with a family member, but then left due to family problems. For someone who had a plan in life, she suddenly had no place to go and was in desperate need of a home. She is now living in a shelter in Boston and while at a medical center, to rehabilitate herself both physically and emotionally. She had to start completely over and is in a shelter because she feels her life is in a crisis. Ciera stated the following:

> I was in an accident when I was at a university studying to be a teacher and I was in physical therapy at a local medical center for about a year where I lived at when I couldn't stay on campus no more. Anyway, when I had some family problems I then left there and now live in a shelter in Boston, Massachusetts. At least I have shelter, a place to stay until I get back on my feet. This is a very serious time in my life. I don't share with people because it's my problem. It just makes me more mature and helps me to understand more what God has for me to do in my life. (Personal communication, October 12, 2016)
Ciera feels her life is in a downfall due to a tragedy that left her with extensive injuries and kept her from pursuing her education. Like many Christians, Ciera relates suffering to getting closer to God. In Ciera's perception, her suffering and faith in God will make her a healthier person. While Ciera is struggling to rebuild her life, she feels relief that she has a place to live.

Roy mentioned that he had worked as a construction worker most of his life until he hurt his shoulder. Since he no longer could do manual labor, which he loved to do, Roy decided to pursue a college education through the Veterans program. When he decided to come to Boston for his master’s degree through the Veterans program, things took a turn for the worse. He tried to get a job but no one would hire him so he went to a nearby shelter.

**Chronic trauma: Long-term events.** Another subtheme was chronic trauma: long-term events. Other participants revealed experiencing long-term family and domestic violence that led to mental illness and chronic stress. As previously stated, chronic, long-term stress was expressed by four out of six participants. Keita stated that she experienced childhood trauma that spiraled into her adult life. When she was young her mother remarried and her stepfather was abusive. This led her towards other abusive relationships with men and drugs, and becoming pregnant in high school. Keita stated the following:

All throughout high school, I was playing sports, but then I didn’t do much physical activity because I had a baby so I was running around carrying her around. Yeah, I had her in high school (Personal communication, October 12, 2016)
Later down the road when her family and work life became unmanageable, Keita was hospitalized for a nervous breakdown. She was diagnosed with mental illness and suffered from depression. Keita states, “I was in a deep depression so I was in the bed for years.”

Early childhood trauma can lead to a lifetime of unwellness and it can take many years to build wellness up again. As in Keita’s case, her childhood trauma led to a lack of self-esteem and addictive drugs that continued in her adulthood. Normalcy to Keita means being by herself and not currently being in a relationship. This allows her to push forward and now she is in a place where she can choose a path in life as she works towards achieving her goals of finding a job and having a home.

Other participants revealed having chronic health conditions that lead to their unwellness including cardiovascular, stroke and diabetes. Lylia stated that she has multiple health problems: I've had 2 strokes but I got the drug TPA so I have left side weakness but other than that I have high blood pressure…I'm pre-diabetic..that's what they say. I take lots of medicine but I exercise a lot (Personal communication, October 12, 2016)

Lylia describes how she just had two strokes because of her high blood pressure and prediabetic conditions. Being homeless and having long-term chronic risks such as high blood pressure often leads to more serious health disease. Normalcy to Lylia is perceived as speaking up for herself and overseeing her health by exercising, eating right, taking her medication and going to the doctors. This makes her feel like she is in charge of her own life.

Theme Two: Barriers to Wellness While Living Without a Home

The second theme that emerged was barriers to wellness while living without a home. This theme reflected many challenges that all six participants faced as they started to work their
way back toward wellness. There were many structural obstacles to obtaining the necessary resources to equitable wellness, including housing, food, medical, and support. After experiencing a traumatic event, two of the participants were on the street before living in a shelter and two lived in a shelter at one time or another. The following list includes the subthemes: barriers to accessing housing, barriers to food, barriers to medical resources and barriers to social support.

**Barriers to accessing housing.** A subtheme that emerged in the second theme was barriers to accessing housing. Most participants living in shelters expressed having very limited or no resources for housing. This often led to medical problems, being out in the cold or living in a shelter with large amounts of people with various health conditions. Most of the participants revealed there are rarely advocates available to facilitate the communication between the outside world and the individuals experiencing homelessness. Several participants expressed their frustrations with this and that they were unable to obtain stable housing. Roy described the difficulties, even as a Veteran, to obtain housing, which took over two years of relentlessly not giving up. He felt that he had less of a case, because he did not have major drug or health issues, so he felt overlooked. Roy stated the following:

That it's almost impossible for you in a shelter...and I kept attacking housing…I’m a Vet, yeah. But that [the benefits] doesn’t always work, I’ve never had drug issues, and if you don’t have certain issues, you don’t qualify for those benefits…so I had to rely on Boston housing, which I don’t mean to put them down but they [housing] did not help me.

(Personal communication, October 19, 2016)
Roy described overcoming obstacles in pursuing his goal to get housing. In Roy's perception, he should be given housing because he was a Veteran and had served the country. He turned to his local council for help but was told he did not qualify for its priority housing list as he did not have a problem with drugs or alcohol and was not vulnerable.

**Barriers to food.** Another subtheme was barriers to accessing food. Many participants revealed barriers to accessing healthy food. Food obtained from the shelter can be unhealthy, as stated by Terry, who talked about the poor quality of food in shelters that can cause obesity and health problems:

> The food at the center—at the shelter—is mediocre at best…They take all the leftover doughnuts and all the leftover treats and pastries and stuff and they bring it to us at night. But, the thing with health is that what they give you for dietary food is terrible there, it’s like white bread, flour, carbohydrates, guaranteed to blow you up. Like you don’t even have to eat that much, it’s still going to make you fat, because it’s horrible food. (Personal communication, October 6, 2016)

Terry revealed his food choices in the shelter are unhealthy and but he eats it out of necessity.

Roy discussed his experience being in a shelter and lack of kitchen facilities to maintain a healthy life and the problems with sharing resources with others. Roy stated the following:

> When you’re in a shelter, you don’t have your own fridge and even if you had to share it, you know when people eat your stuff, people steal your phone, it’s just depressing. It’s also mental too. Food is your comfort if you don’t have a spouse, it’s like ‘oh food, you’re there for me’, you dive into it. And you have little money, so you’re buying
Twinkies, Milky Ways, soda and then boom, you’re exploding. (Personal communication, October 19, 2016)

Roy perceived normalcy as having a home where he could securely store and maintain his food in a refrigerator, which would then allow him to select food that could lead him to a healthier lifestyle.

Keita explained the barriers she faced with lack of access to equitable food, money, and trying to be overall healthy. She stated the following:

Barriers to wellness, when it comes to down to food, not having the money to buy nutritious things. Being homeless, not having a kitchen to put food in so those were barriers; homelessness and no money to buy nutritious stuff and even if I had the money to buy it, where will I put it? (Personal communication, October 12, 2016)

Keita due to her background grew up experiencing healthy eating so she knows the food she is currently eating is detrimental to her health. She perceives normalcy in this country as having enough money to purchase healthy foods. As a child, these types of foods were naturally available due to the environment in her homeland. Presently, the blockage to obtaining these healthy foods is due to her current socioeconomic status.

The above participants all felt they had major difficulties accessing healthy food in the shelter. Also, the participants felt that by having access to only unhealthy food, contributed to their weight gain and health problems.

**Barriers to medical resources.** Another subtheme was barriers to medical resources. Poverty and poor health are intertwined for the participants in this study. Additionally, there are significant system failures in the medical field that were revealed by the participants. Some of
the participants talked about being discharged from the hospital into homelessness, which they felt reduced their chance of recovery. One participant had no place to go after her accident and became homeless while trying to walk again.

Many participants also felt a mistrust for medical professionals, which led to a disconnect for understanding their medical diagnosis or correctly taking their medications. Some of the participants talked about the barriers experienced in healthcare. Amira, who had a serious stroke, but discussed it as only a minor problem, may be in denial of what happened to her as a way of coping with her medical condition. This denial can interfere with her health and understanding that the purpose of the medicine she is currently taking is to prevent another stroke. Amira stated the following:

I’m in good health. I had a slight health scare [2 strokes] in August about my blood pressure. I was diagnosed with high blood pressure and my doctor suggested that I lose weight. Right now, I’m taking blood pressure medicine and stuff like that, but usually I’m in good health, so it was just recently I had a health screening. (Personal communication, October 12, 2016)

Living on the streets can lead to major health problems, as in the case of Ciera, who was in a major accident and hospitalized for over a year. This left her mentally drained. She relied on the medical field and community to help her through a difficult time in her life. Ciera stated the following:

I was in an accident when I was at a university studying to be a teacher and I was in physical therapy at a local medical center for about a year, where I lived at when I couldn’t stay on campus no more. Anyway, when I had some family problems, I had to
come to Pittsburgh. I then left there and now live in a shelter in Boston, Massachusetts. At least I have shelter, a place to stay until I get back on my feet. I'm just learning to walk right again. I went to the local medical center, which they told me they gave me a chance because they know I'm a long-distance runner. They gave me an opportunity to see what I could do and how well my legs heal so that I could get back on my feet.... This is a crisis in my life…it’s messed up. (Personal communication, October 12, 2016)

Roy talked about his diagnosis with diabetes after becoming homeless and his lack of connection with the medical field. He stated the following:

I never had diabetes before and I was shocked with the stuff I was eating; I just have an incredible stomach, but at times I would get real tired. I do have sleep apnea, but the weight just amplified it; I would be sitting there going down like a blackout. Even the nurses are terrible. You [nurses] should be saying that [nutritional advice]. (Personal communication, October 19, 2016)

Keita also talked about her recent diagnosis with high blood pressure and being told by her doctor to lose weight. She also felt she left the doctor’s office with many unanswered questions that seem to frustrate her. She stated the following:

I am interested to know for my age, weight, what is it that I am supposed to eat? How many calories do I need a day? How much protein considering my high blood pressure and everything else? How much exercise am I supposed to do? I don’t know what I’m doing...I probably need less salt? Personal communication, October 12, 2016)
After facing many health challenges from living on the street and in the shelter, the participants felt a lack of communication with the healthcare professionals to facilitate their health.

**Barriers to social support.** Another subtheme was barriers to accessing social networking. Barriers to social support were also mentioned by many participants, including the rigors of life on the streets. Even as a Veteran, there are certain characteristics needed to get specific assistance. The Veterans seemed to have a distrust in the system and felt outraged for the poor treatment they were getting after serving their country and being fine citizens. Terry talked about how things get stolen in shelters and the problems with policies and administration support. Terry stated, “This is the sad part too, it gets stolen. A lot of the food that comes in, the staff that works there steals it.... I bet you there is a lot of inherent corruption in any shelter” (Personal communication, October 6, 2016)

Several of the participants spoke about the lack of specific support in homeless shelters, including the stealing and lack of qualified staff using the money correctly. Lylia reflected on some of the staff in the shelters and staff burnout and training. She stated, “If they're getting burnt out, they need to take a break and get someone else” (Personal communication, October 12, 2016)

Roy mentioned the challenges he faced while living in a shelter. He talked about how his shoes were stolen the very first night he was in a shelter. The shelter gave him a pair of cheap sneakers, but because of his extra-large feet, he began walking around with a limp. He ended up going to the hospital for bad knees after his feet finally gave out from walking. Roy stated the following:
You see, a lot of people don’t realize, like, when you donate to shelters and all, people steal the good stuff. So, if you think you’re doing them a favor donating $150 sneakers, they’re taking them, and they’re selling them. (Personal communication, October 19, 2016)

Roy also talked about going to town hall meetings when he first came to the Veterans shelter and becoming frustrated with the lack of real support from the CEOs of the shelters for not spending money on healthier food. Roy stated the following:

Those town hall meetings, I used to blow them off and that’s why the CEO hates me, but I think they are stupid…they are meaningless. You don’t talk about important stuff like a diet plan…. They’re [CEO] not going to spend money on food and all and you know he doesn’t want his wage touched so he gets a nice big bonus. I guarantee you that’s what happened. That’s real life, that’s business. I said there’s a lot of money in poverty—you get money for them [homeless]. (Personal communication, October 19, 2016)

Here Roy tries to make sense of what happened, but feels a sense of mistrust form the people running the shelter. Many of the participants felt a lack of belonging and distrust for those they felt were supposed to assist them with access to equitable health.

Theme Three: Turning Points Toward Social Wellness

The third theme that emerged was turning points toward social wellness. Participants started to view their health differently once they felt a sense of social belongingness. The participants described social support to help them increase their access to wellness. The subthemes included positive access to housing, positive access to food, positive access to medical resources, and positive access to social networking.
**Positive access to housing.** The first subtheme from theme three was positive access to housing. Several participants highlighted that certain advocates in the community helped them reach their turning point to obtaining housing. Roy talked about finding support from a housing advocate that helped facilitate him getting housing. He felt this was his turning point toward wellness, after living on the street for two years. He said that if it was up to him, he might have never received it. Most people do not have the support or determination he had. Roy stated the following:

That was mainly a [housing program] group and was tenacious… kept attacking her superiors and that’s what you gotta do because they’ll be like, ‘I don’t like this guy’ and they’ll put your folder over there and it will sit for, there’s people saying five years, and I said you know what, you didn’t fight. (Personal communication, October 6, 2016)

After multiple, unsupportive hurdles, several of the participants reached their turning point for housing when they gained the support they needed. Gaining house has been shown to be the most successful point to getting back into society.

**Positive access to food.** Another subtheme was positive access to resources to buy healthy food. Having access to resources to buy healthy food is essential for most of the participants living in a shelter. Some of the participants receive food stamps, SNAP benefits and go to the farmers’ market. Others had positive food access from the shelters and gained nutrition knowledge from the community. Keita stated how she has learned better eating habits and has positive food access now while living in a shelter. Keita stated, “I just really ate anything, not really worrying about portion size or anything. I am now more conscious about what I eat. I
now take nutrition classes at the shelter and a nutrition class at a university” (Personal communication, October 12, 2016)

Keita described the perception of knowing what to eat and how much to eat in the shelter. In Keita's perception, the nutrition classes have helped her become more aware of eating healthy. Having access to food and nutrition education in shelters leads to better health.

**Positive access to medical resources.** Another subtheme was positive access to medical resources. Some medical facilities helped participants find advocates in the community to achieve their health goals; as in the case of Ciera, who was told at the medical center that they would help her walk again because they knew she was a long-distance runner and helped her find a running group in the community. Ciera stated the following:

They [medical center] gave me an opportunity to see what I could do and how well my legs heal so that I could get run again. Yeah, it's messed up, so I'm blessed so far. I have a lot of other problems, but it's okay. God's helping me. I just feel blessed that I can walk. I have a lot of pain in my legs. (Personal communication, October 12, 2016)

Lylia feels her medical visits to the doctors are a priority and she goes frequently for maintaining her health. She stated the following:

Make sure you go and have your physical…I go at least once a year. It is good to know that you can go. Some people don't go. I have lost a couple of pounds which is good so it’s getting better as far as my weight. (Personal communication, October 12, 2016)

Both women described the positive benefits from the advice of those in the medical field. Also, all participants expressed pursuing medical assistance on a regular basis as being important
to achieving their present health status and keeps them heading in the right direction to achieving wellness.

**Positive access to social networking.** Another subtheme was positive access to social networking. Many of the participants in this study did not have close family or a network of people to rely on. Most participants who did seek out support through shelters, churches, and community organizations revealed that it was essential in helping them support their understanding about accessing wellness.

Ciera also felt the running group she joined was bridging a gap between being homeless in a shelter and her wellness. She talked about how it helped her get more physically fit to gain employment again. She talked about the health benefits of running with her mind and body. Ciera stated the following:

The wellness running program is helping me so eventually I can go back to work...and it is not just running, it helps me make choices. It helps me to look at my life in a way of truthfulness. I started running when I was a little girl. I could run so fast. I was in all kinds of athletic thing… I run my problems out. I enjoy running for that reason. This program is one of the best things that could've happened to me. Most people who are runners, the people that run don't get depressed that easily because we solve our problems as we're running. (Personal communication, October 12, 2016)

Ciera described her present day running as the trigger that reminded her of happier times as a youth participating in athletic events. This is what she perceived as a normal time in her life. She feels the running is giving her the inspiration to continue her school in educational and obtaining her dream of employment in that field, which will also lead to acquiring a home.
Lylia talked about what motivated her to join a running group too. She said that she wants to mentor other women in her situation to help them. She stated, “I joined [wellness organization] because I always wanted to run with a group and I also would like to inspire women that’s my age that they can still do it” (Personal communication, October 12, 2016)

Keita described how she accesses a lot of resources in the community to support her wellness. She said the following:

I take wellness meditation at [shelter]. I take a nutrition class at a shelter in Boston and a nutrition class at a local university. I joined a wellness organization because I needed structure in my life and I wanted a social type of activity to do. (Personal communication, October 12, 2016)

Roy talked about how being in a running group makes him motivated to take better care of himself. He also feels more positive because it keeps him on track. Roy stated the following:

Mentally it helps you; it makes you feel better about yourself, like you’re accomplishing something. You need groups to keep active, even the wellness group I belong to here, they’re incredible groups. When you’re with people who are striving for something, it makes you strive. I’ve always been into exercise, I don’t look like I used to, but I was always weightlifting, every day. (Personal communication, October 19, 2016)

Roy described his running as a sense of accomplishment. He reflected to the days when he lived in a home worked, exercise, and lifted weights. This was a time in his life he considered what normal looked like for him. He now feels the support he is getting from the running group and the feeling of his accomplishments, he gets from running is helping him achieve his goals of getting his life together again.
Theme Four: Culture Challenges Faced While Seeking Wellness Without a Home

The fourth theme that emerged was culture challenges faced while seeking wellness without a home. Some of the participants discussed important differences among cultural groups as seen through the lens of cultural traditions in regards to wellness. Some of these differences were based on participants’ cultural beliefs about food practices, such as Southern foods, that might compete with their learning to eat a healthy diet. Amira mentioned how she tries to eat certain foods for her health, but she went on to say, “I love my pork chop ham hocks and stuff like that…I used to eat a more traditional Southern style of eating” (Personal communication, October 12, 2016)

Another participant, Keita, an immigrant, who still holds onto food practices from her culture of origin. Keita talked about her lack of access to whole foods from Honduras, where she grew up, and how abundant unhealthy food is in the United States. In her youth, this presented her with lots of challenges in eating healthy and feeling different from her peers. At home, she would eat the familiar food from Honduras that her mother would prepare, but then she would be exposed to the highly processed and convenient foods at her friend’s home. This often left her feeling out of place and different from the other children. Keita stated the following:

Well, I come from Honduras, so I grew up on Honduran food. A lot of boiled bananas, boiled yucca. No processed foods. Cornflakes for cereal, no sweet cereal. No Kool-Aid. I had that stuff when I went to visit my friends. My friend’s house had the Kool-Aid, the sweet cereal, the good cookies, you know. They had like chocolate chips and stuff like that; we didn’t have that stuff in our house. (Personal communication, October 12, 2016)
Acculturation can be a challenge for many immigrants and sometimes causes conflicting emotions about food they are currently exposed to versus the foods from their native country. Keita talked about the tough transition of coming to America as an immigrant. Her mother was very strict with her eating habits. Keita’s perception from coming from a different country and her mother controlling the food, made it challenging to eat healthy, and still stays with her today. She talks about the food in the shelter as not being the food from her country and how she does not know how to eat healthy with unhealthy choices. Thus, she has gained a lot of weight and she revealed this has led to other chronic health problems.

Some participants felt a strong sense of shame about being homeless, based on their cultural norms and values. Roy, whose family is Polish, reported not wanting his family to know he was homeless because he felt ashamed to tell them. Roy stated the following:

My father wasn’t a good person, but my grandfather was incredible. He was from Poland and so this is a guy who came over to America, learned to speak English, did whatever he had to do. He had a mentality that you never stop. I guess I had the mentality of my grandfather, just like, I got to do what I got to do. (Personal communication, October 19, 2016)

Roy’s grandfather may not have understood homelessness because of the stereotype attached to it. Stereotypes about homeless people are that they don’t work hard enough, can’t pull themselves up by their bootstraps, and are somehow lazy or deficient. In Roy’s perception, his grandfather succeeded beyond all odds through hard work. Therefore, Roy felt as if he was violating his cultural value system.
Theme Five: Self-care and Spiritual Approaches to Wellness Without a Home

The last theme that emerged was self-care and spiritual approaches to wellness without a home. Many of the participants expressed practicing a holistic approach that included the mind, body, and spirit to heal, and help them with their health problems. The perception of health is now well-defined as a holistic practice with multiply components that includes physical, emotional, social, and spiritual (Hettler, 1980).

Although the route to accessing these methods seemed to vary among participants, a transitional pattern for wellness emerged from the participants using the whole-person approach to wellness.

Ciera was trying to overcome her adversity in experiencing homelessness by going to spiritual council. Her spirituality and faith helped her through her experience of homelessness. Ciera discussed her spiritual methods and perceptions of how she was trying to effectively cope with her situation. She stated the following:

I'm going through a lot right now, so Christ is in my life and I'm looking to the Lord for everything. I'm just believing by faith that whatever I go through, that He's in it. I should be able to come through it no matter what it is. This [spiritual] program is helping me to get through it. (Personal communication, October 12, 2016)

In the above statement, Ciera recognizes how her life is going through a major transformation and how she has gathered strength from God. Ciera refers to her current state as a journey guided by her faith in God, of coming to a new way of thinking, and of becoming a stronger person. She draws upon her spirituality for becoming a “healthier person” and the spiritual world to which she relates to as a way of motivating herself to reach her health goals.
This represents the higher spiritual and psychological side of wellness dimension that is used to transcend challenging situations and change the course of things.

Most of the narratives indicated significant elements of a change in participants’ lives to the whole-person approach of wellness. All the participants mentioned, in their own words, integrating aspects of the six dimensions of wellness: mental, emotional, physical, occupational, intellectual, and spiritual beliefs and meanings of a person’s life, to promote well-being in their life. Lylia also describes many of the dimensions of how she perceives her current wellness:

Feeling good about where you are even if you haven’t achieved your goal. If you set a goal to lose certain amount of weight, you feel happy when you wake up. You’re not sad because wellness can be mental wellness. You’re feeling good about where are in your life, feeling good about your weight and just feeling good spiritually. (Personal communication, October 12, 2016)

The participants’ narratives revealed major patterns that promoted the whole-person approach to wellness and supported their understanding of wellness. These included accesses to mental and medical treatment, nutrition, and physical activity.

**Concluding Statement**

This chapter presented a summary of the findings of the study and each theme and subtheme supported by appropriate text from participants’ narratives. These five emerging themes were: (a) traumatic events that lead to unwellness without a home; (b) barriers to wellness while living without a home; (c) turning points toward social wellness; (d) culture challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home. Most participants described experiencing a traumatic
event that led to their homelessness and their unwellness. They further described the many barriers while trying to access equitable wellness, including housing, food, and medical resources while living in a shelter. Things began to change when they could obtain support through a social networking and apply a whole-person approach to wellness. Finally, those who had access to equitable wellness through alternative and integrated services in the community felt successful in accessing wellness on their own; they were left feeling supported. From the individual narratives and inductive analysis, five themes and their accompanying qualitative subthemes emerged to accurately explain the understanding of wellness. These will provide resources to the community and create the basis for informing healthcare professionals. All participants felt they could access equitable wellness through social networking. The following chapter will examine the implications and significance of these findings, as well as the existing literature on wellness to determine ways to positively impact the homeless population. The following chapter will discuss the five emerging themes and their implications as well as offer recommendation for future research.

CHAPTER 5: INTERPRETATIONS, RECOMMENDATIONS AND CONCLUSIONS

As noted, the purpose of this narrative study was to explore the ways in which individuals who are homeless understand their wellness. The participants in this study found a holistic whole-person approach to equitable access to wellness—mind, body, and spirit; social support; and social networking.

The main question for this narrative inquiry was as follows: How do people who are experiencing homelessness, in Boston, Massachusetts understand wellness? This question served as the framework for discussion when capturing the narrative voices of six individuals who
currently or recently lived in a homeless shelter. The study explored and documented their development journeys toward equitable access to wellness. Five common themes emerged: (a) traumatic events that lead to unwellness without a home; (b) barriers to wellness while living without a home; (c) turning points toward social wellness; (d) culture challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home.

This chapter will offer a discussion of the participants’ narratives as they relate to the research question, the theoretical framework, and the wellness literature. Additionally, this chapter will highlight the implications for practice based on the study findings, discuss the limitations of the study, and offer recommendations for future research, followed by a summary of the work and final conclusions.

**Discussion**

The purpose of this research was to understand the wellness of individuals who are experiencing homelessness and living in shelters. The objective of the analysis was as follows: to introduce a narrative analysis of the narratives of homeless people and their access to wellness as an important method in determining meaning in people’s lives about their wellness and how these meanings are created.

The narratives revealed the participants’ journey and transformation to wellness. Individuals experiencing homelessness often live in stressful environments and are exposed to traumatic events that led to increased health problems. The participants first described the barriers they experienced with not having access to wellness, but then many of them experienced a positive change as they gained support for accessing wellness through the whole-person
approach—mind, body, and spiritual connection. Social networking and alternative wellness support, such as the gained awareness of spirituality, seemed to be a protective factor in social wellness for many of the participants. The narratives of participants also offered relevant information to the healthcare and education sectors. In addition, the analysis of the narratives yields several interesting concepts that can guide future studies, which may explore best practices for wellness in homeless shelters. These are outlined in the following pages.

This narrative research on understanding individuals who are homeless experiencing wellness can contribute to the limited research on a holistic approach to social wellness. A comprehensive review of published research provided no model designed to date to encapsulate individual wellness risks in the context of social and structural drivers of the wellness for this population. Research builds on past frameworks by examining situated individual factors in the network community and public policy context.

Theme One: Traumatic Events That Lead to Unwellness Without a Home

Most of the participants spoke about a range of personal experiences and events that led toward unwellness before and after experiencing a traumatic event without a home. These personal or individual factors included their wellness perceptions, attitudes, behaviors, and beliefs. Because of content analysis, two subthemes were identified within this first theme: acute trauma: onetime events and chronic trauma: long-term events. Each of these subthemes is discussed below.

Acute trauma is a onetime event and played a significant role in the participants’ understanding of wellness, revealing a vulnerability toward inequitable access to wellness through the lens of their personal history. In addition, the experiences caused by trauma were
life changing and often led to unresolved mental health issues. Study findings are consistent with the literature that reported individuals who experience trauma often use alcohol and drugs to cope with the situation (Brady & Sonne, 1999). Other participants spoke about the struggles of limited resources and stress due to inequitable access to services. A few attributed the downfall of the economy and over-regulated government rules to their unwellness.

In addition to acute trauma, many people who are experiencing homelessness in this study were exposed to chronic trauma that was long term, occurring during early childhood, through domestic abuse, and experiences with war. Consistent with the literature, the findings showed that those who reported a history of long-term trauma are often admitted to an emergency facility (Fetter, 2009). The findings from this theme are important to other homeless people who seek self-care and a paradigm shift away from the disease model. Also, the findings are important to healthcare professions serving people who are experiencing homelessness; the narratives revealed that trauma and addictions were shown to be the contributing factors in becoming homeless.

**Theme Two: Barriers to Wellness While Living Without a Home**

Consistent with the literature, the following sub-themes were revealed within the second theme: (a) barriers to accessing housing; (b) barriers to accessing food; (c) barriers to medical resources; and (d) barriers to social support, including roles and limitations of wellness shelters within the community.

Most participants did not have interpersonal relationships including, family, friends and other individuals to support their wellness. The lack of interpersonal relationships increases the risk of developing physical health problems due to the barriers to limited access to resources that
promote wellness, such as housing, healthy food choices, medical resources and social support. Roy remarked about the barriers to accessing healthy food in the shelters, which is consistent with the literature. He stated:

The stuff they give you at the shelters is garbage—it’s on a level of what they serve to elementary school kids, and they wonder why kids are so fat. It’s garbage, it’s flour, it’s sodium, it’s carbohydrates and soda. Nutrition should be in every place, I don’t know if you [researcher] could bring it to the shelters” (Personal communication, October 19, 2016)

Most participants who did not have access to positive social support revealed experiencing a higher challenge accessing wellness. This is consistent with the literature that reveals the barriers of social support in this population (Frezel & Khosla, 2008). Another barrier consistent with the literature was that most participants revealed not having adequate advocates to help them find wellness support while living in homeless shelters.

The findings revealed that for some participants, these barriers caused major obesity and lack of understanding of their medical diagnosis. Major obstacles reported were: (a) affordable housing; (b) unhealthy food; (c) lack of supportive treatment for people with mental illness and; and (d) employment issues.

Community norms and values that do not promote wellness in shelters presented significant barriers to accessing wellness, as well as barriers to other healthcare services. These findings lay the foundation for future studies focused on social support within the community that can provide wellness programs in nutrition and physical activity for individuals experiencing homelessness, with the goal to increase wellness.
Theme Three: Turning Points Toward Social Wellness

The third theme that emerged was turning points toward social wellness that provided equitable access to wellness. Consistent with the literature, narratives revealed how working toward wellness was developed once there was social support and social networking. A specific factor within this third theme comprised interpersonal relationships, including friends and other individuals who may directly influence wellness. The subthemes included: (a) positive access to housing; (b) positive access to food; (c) positive access to medical resources; and (d) positive access to social support.

Participants who revealed experiences with a social network that provided health knowledge, social support, and reinforced protective social norms showed higher access to wellness. Women were explicit in this regard, stating that after accessing support while in the shelters, they better understood wellness as being able to take care of oneself. The findings from this third theme showed the importance of communities to promote social networking.

The community level includes relationships among organizations and institutions to help individuals work their way back to wellness. Equitable access to wellness varied per individuals’ experience within the community. The findings revealed that some participants found treatment and recovery management in the community and felt that it helped relieve the pressure of going through a difficult time. Maslow’s Hierarchy of Needs (1968) model states we must meet our basic physiological needs for survival. Once people experiencing homelessness meet these needs for safety, they can look for social belonging through people to promote wellness, which can then move to better self-esteem and finally, self-actualization.
Randall (2012) stated that people develop their natural identity of themselves based on their experiences with human caring. Homeless wellness identity is contingent on fostering environments which acknowledge an individual’s voice (Randall, 2012). In this study, the content of the self and participants’ wellness narratives was examined for the ways in which the participants reflected on themselves and their wellness and how these constructions connect to larger social support for well-being.

These findings lay the foundation for future studies focused on social support within the community that can provide wellness programs in nutrition and physical activity for individuals experiencing homelessness, with the goal to increase wellness.

**Theme Four: Cultural Challenges Faced While Seeking Wellness Without a Home**

The fourth theme that emerged were the perceptions, cultural norms, and values regarding wellness coping mechanisms related to equitable access to wellness. Inequitable social norms contribute to lack of wellness and cultural differences that prevent wellness practices for those suffering from substance abuse or mental disorders while trying to find safe housing. This finding is consistent with the consideration given to mental illness in individuals who are homeless and often have trouble narrating the complexities of life (Chopra, Sullivan, Feldman, Landes, & Beck, 2008).

Immigrants face additional challenges with wellness due to cultural differences and changes, such as moving from a place where there are affordable whole foods to a place where there are more processed foods. Some immigrants are at a disadvantage because the food they are used to consuming is no longer available. The food they can afford in poorer neighborhoods has less variety due to the lack of supermarkets and is cheaper if obtained at fast food
establishments. These findings show the complexity of acculturation, as stated by Keita’s narrative story, and confirm that migration can impact well-being due to the new culture and challenges to their identity (Bhugra & Becker, 2005). The findings from this theme show the importance of cultural competency, which is necessary when educating individuals who are homeless about nutrition-related issues.

From this theme, healthcare leaders may further understand the importance of cultural norms and how they need to be addressed to prevent people who are experiencing homelessness and living in shelters from seeking medical and nutritional support.

**Theme Five: Self-care and Spiritual Approaches to Wellness Without a Home**

The final theme that emerged was self-care and spiritual approaches to wellness without a home. While traditional healthcare practices have always focused on the physical ailments of the body, a new paradigm was described by the participants to help promote a more positive holistic approach to self-care. This whole-person approach, which includes taking care of the mind; body; and spirit, is a new concept in the medical field used to reduce stress and increase resiliency, as well as to gain housing, healthy food, and employment. The promotion of whole-person wellness helps bridge the gap between the medical field and self-care. Healthcare professionals can positively influence individuals experiencing homelessness to make healthy decisions in their own lives by creating practices for self-care practices that provide sustainability. The whole-person wellness approach has led to a new paradigm that empowers individuals experiencing homelessness.

The participants that stated they had access to alternative and integrative methods were gaining wellness and becoming healthier. Many of the women in the shelters had spoken about
access to the whole-person approach in the shelter through the many self-care services that were offered, including mediation, yoga, nutrition, and physical fitness.

Although the two Veteran participants were informed about wellness policies such as the Veterans programs, they felt it did not promote access to wellness in a timely manner. One Veteran participant did mention public policy for education as a Veteran, but felt he was not assisted in the process. The Veteran discussed his difficulty in continuing to get an education while homeless. He did not know where he was going to sleep at night and had money to buy food, so that made it difficult to continue attending school. Both Veterans were bitter and frustrated by the injustice and unfair events that led to being homeless and the lack of administrative assistance for Veterans and their circumstances.

There was a lack of standardized support across shelters in the narrative findings. Some of the shelters had better food and safety policies than others. Shifting the focus to social justice contexts, advocacy and wellness policies are key to well-being for those people who are experiencing homelessness and living in homeless shelters seeking wellness. The shelters that provided wellness skills training focused on reducing health problems.

Provisions are limited through lack of funding for wellness services. People living in shelters deserve equal access to healthcare, a safe place to live, employment to make a living, and access to affordable and healthy food. Many of the participants saw a doctor only for an emergency rather than for routine health visits. Some medical professionals did not effectively communicate how to take care of medical problems to participants. Some participants had serious health care risks, but addressed these as only minor problems. These participants may be in denial of their medical conditions as a way of coping to maintain sanity. Other participants
may not understand the purpose of the medicine they are prescribed: to prevent another serious health problem from arising. The findings from the final theme can provide awareness to policymakers for homeless policies related to alternative methods for wellness.

**Analytic Memos.**

My assumptions and passions before this project were to conduct a research project that would help people who are experiencing homelessness improve their eating habits and wellness. I have always loved learning about nutrition and teaching healthy behaviors to the public. In the past, I have always conducted quantitative research using dietary assessment methods. This form of dietary data is a great way to analyze one’s food patterns and help make improvements. I think it is extremely important to get the word out to this population that healthy eating can be simple and obtainable for everyone if taught right.

I started to shift my way of thinking when I heard real world stories from the participants and began to understand what they were going through within their individual realities. For example, Roy mentioned that the “lack of kitchen facilities” and ill-fitted footwear prevented him from leading a healthy life. The stories started to be linked together as others also mentioned not having a choice in the selection of food given to them in a shelter. This made me realize there was just not one problem to be solved about “how to eat healthy” but a multitude of problems that needed to be considered together, including environmental and socioeconomic factors. This changed my thinking from my traditional role as the ‘nutrition expert’ to being more open to addressing the problems that real individuals face in their life situations with a more flexible, collaborative approach. The participants may not have been so open about their background if I had simply conducted a survey (like those dietary assessment tools I was
accustomed too) as opposed to having a personal conversation with them for several minutes about issues that matter to them personally. This growing trust was imperative for my research project. I realized that without their voices and collaboration, I would not have gained insight to find more meaningful answers to practice-based problems about eating healthy while experiencing homelessness.

Rather than just providing predetermined information about how to eat healthy, I now understand that I need to look through a broader lens when asking the questions surrounding their health problems. The health outcomes should be more understandable to the participants and relevant to transfer into practice in a meaningful way. This research also made me understand the scholar piece as I learned that by reading the literature and understanding the theories behind the social ecological theory, I could apply knowledge into practice. I learned the different levels of this theory and what was missing or could be enhanced in the participants. I learned how important intrapersonal relationships can be while experiencing homelessness. Most people take support they receive in their everyday lives for granted, but the participants did not have that support to get them through difficult times. What facilitated their change towards wellness was a feeling of social belongingness through their community.

My current vision as a scholar-practitioner, given the process of this project, is to always give a voice to the participants I’m involved with, to have a full understanding of potential barriers and needs. It is essential to develop a strong bond and a sense of connection to achieve real-world wellness and healthy eating solutions together. This realization made me grow more as a critical thinker, and these stories changed my thinking and made me grow as a scholar-practitioner.
Implications for Practice

Based on the findings of this doctoral thesis, the areas of implication for practice are evident in the perceptions of how homeless individuals understand wellness. Most participants understand their wellness by utilizing a whole-person approach that is accessible through social networking.

Healthcare professionals who are aware that homeless individual’s perceptions of wellness may differ from their own will focus on learning about these differences to inform educational practices. Only then can healthcare professionals educate individuals who are homeless in the use of preventive measures to improve their health.

These findings are valuable because they can inform practice about specific interventions that can support future wellness practices and policies in homeless shelters across the country. This study can be expanded to other urban cities with different wellness organizations within the communities. This study could also be expanded to a quantitative study to measure and evaluate the nutrient intake and physical activity of participants who are participating in a wellness organization to assess health and wellness outcomes. The following are five practical interventions based on my participants’ voices:

1. Health Literacy Booklet: Many of the participants had health problems. For example, Keita stated she was confused about her high blood pressure and her doctor’s advice her to lose weight. She did not understand how to eat healthy and lose weight at the local shelter or what foods would interfere with the blood pressure medicine she was taking. This health literacy booklet would explain the most common illness in shelters and the medicines prescribed. It would elaborate about medicine side effects, what not to eat with certain diseases or
prescriptions, and explain the purpose of the medicine. Keita did not understand that the medicine she was prescribed was to prevent another stroke. The booklet would recommend the DASH diet for those who have a high BMI, cholesterol, or blood pressure and explain simple ways to lose weight safely. It would list different types of foods available in a shelter and ways to eat healthy within those parameters.

2. Healthy U4U Workshop: This workshop would highlight specific foods served at the shelters one could eat to stay healthy. We would explain the basic interactions of certain medications with food. Participants could be trained on the DASH diet while eating within their own environment. For example: Keita’s doctor told her to lose weight to improve her health, but she did not know how to simply “eat healthier”. At this workshop, she would be trained about portion distortion, healthier foods and ways to improve her eating, and different forms of exercise that would help her realistically lose weight.

Keita also mentions how she would, “eat anything and not really worry about portion sizes.” A practical intervention would be to conduct the Healthy U workshop and Portion distortion classes for those experiencing homelessness at the local YMCA, in Boston, MA. This would inform people who are experiencing homelessness of moderate amounts they could consume to prevent unnecessary weight gain while living in shelters.

3. Local Workshops: Teach workshops to local staff members at shelters on how to cook, serve, and advise people on eating healthy, appropriate portions, through the USDA MyPlate Dietary Guidelines. For example, Roy seemed frustrated with the food offered at the shelter and thought if more people were trained about nutrition then they would serve better food “The food at the center–at the shelter–is mediocre at best”. He felt they did not address important
topics such as a “diet plan” to keep veterans healthy. Local workshops could be conducted at the veteran’s shelters conducted by Northeastern University students about eating healthy while experiencing homelessness.

4. Wellness Training: Conduct and train members at local spiritual places to provide guidance and support about wellness. This may include conducting a Healthy U workshop about nutrition, physical, and alternate wellness (yoga, meditation) at the local church in Boston, MA. Ciera said, “I'm going through a lot right now, so Christ is in my life and I'm looking to the Lord for everything.” Wellness events at the local churches in Boston would make an impact on those experiencing homelessness as many people find religion to be a motivating aspect of their lives. Training local staff and clergy on wellness and healthy eating could boost support to members who are experiencing homelessness.

5. Curriculum for Allied Health Professionals: Create a curriculum for nursing and other allied health that includes Healthy U4U, physical, and alternate wellness (yoga, meditation) in higher education programs. Roy expressed his frustration about nurses he encountered not giving any “nutritional advice”. Nurses are usually the first-person participants interact with at hospitals and they should be able to give basic nutrition advice to patients if asked.

Limitations

This study has several limitations. First, the study was conducted with participants recruited from one wellness organization program. Other wellness organizations may have different experiences and perceptions of wellness. Second, I had worked with the community organization at a wellness event. More exposure to other wellness organizations and shelters may yield different relationships or enrich those found in this investigation. Third, this study
was done in one city. Differences in culture in different cities may affect the overall finding. Finally, this study relied on self-reported data and therefore may be limited to subjective data. It is quite possible that the participants’ memory or accuracy might have been compromised.

Nonetheless, this investigation represents a narrative study of one group of homeless individuals in Boston, Massachusetts about their perception to access their wellness. This study is the first to provide insight about the wellness of people who are experiencing homelessness and living in homeless shelters and thus provides valuable information for future studies and programs for this population.

**Recommendations**

Narrative research is an important source of information for exploring how understanding wellness influences homeless individuals’ health and well-being. The results of these narratives would aid in how healthcare professionals better assist the lives of people who are experiencing homelessness and living in homeless shelters.

There are two key recommendations derived from the research undertaken in this study. These recommendations address the need for: (a) social structural wellness services in communities; and b) wellness advocates in shelters.

**Social Structural Wellness in Communities**

The primary recommendation that emerged from this narrative research is the importance of social wellness within the community for individuals experiencing homelessness. Communities are the foundations for providing connections that create a sense of social belongingness with people who do not have interpersonal relationships. The research calls for
social justice in creating the structures and institutions to achieve basic human needs for equitable wellness by establishing supportive wellness partnerships and social environments.

**Wellness Advocates in Shelters**

It is crucial to hire more diverse advocates in shelters to guide individuals toward achieving equitable access to whole-person wellness approach and a quick return to society. Many shelters could hire more staff, such as health coaches and social workers. These trained professionals could be the advocates for people in need of legal advice, skills, and training for employment and finding housing. Also, they could mediate communications with doctors and facilitate development of health literacy.

This research supports the development of whole-person wellness programs in all homeless shelters that are designed to accommodate an integrative holistic, multidimensional practice that includes physical, intellectual, social, and spiritual wellness. By engaging in a whole-person approach, individuals experiencing homelessness will gain important mental, emotional, nutritional, and physical factors that support transition back into society. For example, all individuals seeking a shelter could be screened for trauma and mental health so they can get the appropriate support services and guidance. More attention is needed from the healthcare system and shelters to recognize the signs of trauma that need to be addressed to provide short and long-term care.

Other services for creating standardized whole-person approach to wellness in shelters may include sound nutrition and physical activity policies, with the goal of treating anyone entering a homeless shelter with dignity by listening to their voices and allowing them the equitable access deserved for emotional, nutritional, and physical wellness.
Conclusion

This qualitative study has explored the ways in which 6 people who are experiencing homelessness in Boston, Massachusetts understand wellness in their everyday lives. In line with the purposes of narrative research, this study interviewed people who are experiencing homelessness and identified themes and subthemes related to their experiences with wellness.

The social-ecological theoretical framework (Figure 4) suggests that equitable wellness is linked to the interrelations of one's personal and environmental factors that influence an individual's social wellness. The literature implied that an alternative approach to the traditional disease model led to more holistic social influence on the health of individuals experiencing homelessness. According to the six participants interviewed in this study, a whole-person approach to wellness through social networking is important in guiding their decisions. While themes were diverse as to individual perceptions of the different dimensions of wellness, the main inferences of the narratives are that wellness choices are made based on social wellness. Equitable social wellness access for all individuals experiencing homelessness is needed to provide opportunities to gain success in integrating back into mainstream society.

Chapter 5 concludes this narrative research study. The findings of the narratives found five themes that revealed a sense of social wellness influences in helping people who are experiencing homelessness and living in homeless shelters make positive changes. These themes included: (a) Traumatic events that lead to unwellness without a home; (b) barriers to wellness while living without a home; (c) turning points toward social wellness; (d) culture challenges faced while seeking wellness without a home; and (e) self-care and spiritual approaches to wellness without a home. Recommendations from this narrative study invite all
healthcare and community stakeholders to participate in wellness practices that the whole-
person wellness approach, as well as social structure including strong ties to communities and
shelters. It further suggests that additional research be conducted to better understand and create
effective and equitable wellness practices in urban communities.
References


O'Connell, J. J., Oppenheimer, S. C., Judge, C. M., Taube, R. L., Blanchfield, B. B.,


http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/index.html


homeless and marginally housed HIV-infected individuals in San Francisco. Journal of general internal medicine, 24(1), 14-20.


Appendix A - Northeastern University IRB Approval

Recruitment Letter

Dear All,

My name is Janice Maras and I am a student studying Ed.D. Doctorate of Education at Northeastern University. I am conducting a research on “Narrative Wellness: Voices of People who are experiencing homelessness”. Since you are an individual who has/had experiences with being homeless and participates in a wellness organization, I would like to invite you to take part in my research study, which is to understand the wellness experiences in regards to people who are experiencing homelessness living in shelters.

Your decision to participate or not will not have an influence on the care you are receiving from the wellness organization. If you decide to participate in my research, I will conduct an interview with you that will lasted about 60 minutes which was done at a private place of your convenience in Boston, MA. A $5 coffee card was provided for your participation.

If you are interested, please email: Kathleen Lau, Director of Back on My Feet at Kathleen@backonmyfeet.org.

Thank you very much.

Sincerely,

Janice Maras

Doctoral Candidate 2016

College of Professional Studies

Northeastern University
Appendix B – Consent Form

Northeastern University, College of Professional Studies

Name of Investigators: Principal Investigator - Billye Sankofa Waters, PhD, Student Researcher
– Janice Eileen Maras, MS

Title of Project: Narrative Wellness: Voices of People who are experiencing homelessness

Request to Participate in Research

We would like to invite you to participate in a research project. The purpose of the research project is to give insight into your experiences of being in a homeless shelter and accessing wellness? We hope this research project will help others experiencing homelessness achieve equitable access to wellness while in a shelter.

You must be at least 18 years of age to participate in this research project.

The study will take place at a public location you choose and will take about 60 minutes. If you decide to participate in this research project, we will ask you to participate in an interview (conducted by Janice Maras) about your experiences in understanding your wellness.

There is no foreseeable risk of the study, other than that the questions might provoke some emotion for you.

Your part in this study will be handled in a confidential manner. Although some information related to the services that you receive may be shared with the researchers; there is no risk of loss of anonymity. Any reports or publications from this research study will only use pseudonyms, and will not identify you or any other participant.

There are no direct benefits for your participation in the study. However, the information
learned from the study may provide valuable insights to assist in providing strategies for better access to equitable wellness education and programs for people who are experiencing homelessness.

The decision to participate in this research project is entirely up to you. You may at any time refuse to answer any questions or withdraw at any time.

If you have any question, please feel free to contact Janice Maras at Maras.ja@Husky.neu.edu or the Principal Investigator, Billye Sankofa Waters, PhD

If you have any questions about your rights as a participant, you may contact Nan C. Regina, Director, Human Subject Research Protection, 960 Renaissance Park, Northeastern University, Boston, MA 02115. Tel: (617) 373-4588, Email: irb@neu.edu.

You may call anonymously if you wish.

Part II: Certificate of Consent

I agree to take part in this research?

I have read, understood, and had the opportunity to ask questions regarding this consent form. I fully understand the nature and character of my involvement in this research program as a participant and the potential risks. I agree to participate in this study on a voluntary basis, and understand that I can depart from the research study at any time.

___________________________________  ___________________________________
Research Participant (Printed Name)      Date
Research Participant (Signature)  Date

Signature of the person who explained the study to the  Date
Participant above and obtained consent

Printed name of above
Appendix C
Interview Protocol Form

The following prompts are representative of questions that will be asked in the interview. In line with a narrative inquiry, this interview will be semi-structured and additional prompts will be expected throughout the interview.

I. Personal or Intrapersonal Level

1) Please can you share with me the basic information about yourself?
   a. Prompt - age, ethnicity, where you’re originally from, education level.

2) Prior to entering a homeless shelter, how would you describe your overall health?

3) Please could you tell me what wellness meant to you before living in a shelter?

4) Can you tell me what barriers you faced before living in a shelter while seeking wellness in your life?

II. Interpersonal and Community Level

5) Can you tell me what your health is like now that you are living in a shelter?

6) Please could you tell me what wellness means to you now living in a shelter?
   a) Prompt – can you define the term “wellness”

7) How do you access wellness now while living in a shelter?
   a) Prompt – can you tell me if there are any barriers to accessing wellness now?
   b) Prompt – can you tell me if there are any ways that promotes your access to wellness now?

III. Public Policy
8) Can you tell me about any the government or non-government run programs available to you while living in a shelter?

9) Are there any programs that could be improved or created to improve your wellness?

That concludes our interview. Thank you for participating in this research.
## Appendix D

*Table 1. Demographic Profiles of Participants*

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<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Education</th>
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<td>50 - 60</td>
<td>African American</td>
<td>High School</td>
</tr>
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<td>Keita</td>
<td>Female</td>
<td>50 - 60</td>
<td>Honduran</td>
<td>High School</td>
</tr>
<tr>
<td>Roy</td>
<td>Male</td>
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<td>German / Polish</td>
<td>Bachelor’s degree</td>
</tr>
<tr>
<td>Terry</td>
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<td>Caucasian</td>
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<td>Lylia</td>
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<td>African American / Cherokee</td>
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</tr>
<tr>
<td>Amari</td>
<td>Female</td>
<td>50 - 60</td>
<td>African American</td>
<td>Bachelor’s degree</td>
</tr>
</tbody>
</table>
Appendix E

Figure 1

Subcategories Supporting Themes
Appendix F

Figure 2

*Wellness Barriers*

![Barriers Chart]

- Barriers to support
- Barriers to social stability and social capital
- Barriers to medical resources - including education
- Barriers of housing
- Barriers of food access
Appendix G

Table 3

Turning Points Towards Social Wellness

![Turning Points Diagram]
Appendix H

Figure 4

*Modified Social-Ecological Model for Individuals Living in Shelters Seeking Wellness*