

# No Way Out: The Impact of Intimate Partner Violence on Homelessness and the Consequences of Poor Health Outcomes

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*University of Central Florida*

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NO WAY OUT: THE IMPACT OF INTIMATE PARTNER VIOLENCE ON  
HOMELESSNESS AND THE CONSEQUENCE OF POOR HEALTH OUTCOMES

by

KRISTINA BRYANT

M.A. University of Central Florida, 2016

B.S. University of Central Florida, 2007

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## **ABSTRACT**

IPV victimization leads many women who suffer from unstable housing into homelessness. These victims are in danger of severe negative health outcomes that are already prevalent in the homeless community, as well as seen in victims of IPV. This study seeks to explore the impact that IPV victimization has on negative health outcomes in the homeless community, compared to the negative health outcomes that homeless women face who are not homeless because of IPV victimization. This study hypothesized that women who are homeless because of IPV victimization face more severe negative health outcomes. The data for the current research is from the Florida Four-City Study of Violence in the Lives of Homeless Women project (Jasinski et. al., 2010) and includes 737 respondents. There was statistically significant findings to support the hypothesis in the health outcomes for the current episode of homelessness for being treated at a clinic for mental problems, self-reported depression, and self-reported anxiety for women who blame their current episode of homelessness on IPV victimization.

Keywords: IPV victimization, homelessness, health outcomes

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## **LIST OF ACRONYMS**

### **ACRONYMS**

IPV=Intimate Partner Violence

DV=Domestic Violence

PTSD=Posttraumatic Stress Disorder

HIV=Human Immunodeficiency Virus

STD=Sexually Transmitted Diseases

## CHAPTER ONE: INTRODUCTION

The negative health consequences of the co-occurrence of homelessness and intimate partner violence (IPV) are explored throughout this study. It is estimated that about 4.8 million women are victims of intimate partner violence (IPV) every year (Yoo & Huang, 2012). Of these 4.8 million women that experience IPV, it is estimated that the result leads to 1200 deaths, and 2 million injuries in the United States alone (Black & Brieding, 2008). The socioeconomic levels of IPV victims vary greatly. However, poor women are disproportionately affected (Aizer, 2011). Furthermore, abuse and violence towards women victims may lead many to become homeless (Jasinski, Wesley, Wright, & Mustaine, 2010). In fact, the National Coalition for the Homeless (2017) acknowledges domestic violence as one of the most common contributing factors to homelessness for women. Their webpage also states that "...50% of the cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness..." (Nationalhomeless.org, 2017, p. 1). However, until recently the connection between IPV and homelessness has been largely ignored and understudied (Goodman et al., 2009; Riley et al., 2014). One possible consequence of ignoring this issue leads to a public health disaster as many IPV victims who become homeless, suffer extreme negative health and social outcomes.

### Negative Health Outcomes

It is well known, and empirical evidence has consistently showed that IPV, and other violence against women results in a host of negative health outcomes in its victims (Campbell, 1996; Campbell et al., 2007; Clough et al., 2013; Jasinski et al., 2010). Yet, few studies have examined the severity of the negative health outcomes of IPV victims who are homeless.

Negative health outcomes commonly associated with victims of IPV include depression, increase

hospital visits, reduced quality of life, increase work/school absence, PTSD, mental illnesses, alcohol abuse, drug abuse, and revictimization (Campbell et al. 2007; Jasinski et al. 2010; Rollins et al. 2011). Homeless victims are at risk of suffering almost these same identical negative health consequences as IPV victims (Ponce et al., 2012). More so, it is theorized that women who live in poverty, including homeless women, may suffer further consequences due to a lack of resources, increased drug and alcohol abuse, the need for survival sex, prostitution, lack of healthcare, and unstable housing (Frias & Angel, 2007; Goodman et al., 2009; Jasinski et al. 2010; Raphael, 2000; Rollins et al., 2011). However, Baker et al., 2010 acknowledges an additional need for research on IPV and housing instability "...that moves beyond simply documenting the association between the two but also attempts to understand why such an association exists" (p. 431).

Thus, the current research theorizes that women who are homeless because of IPV victimization face more severe consequences of negative health outcomes than those who are homeless due to reasons other than partner violence. Current research and knowledge of violence against homeless women is limited and there are many gaps in existing research. Wenzel et al., (2006) suggests this link has been understudied because the homeless and economically poor women have been underrepresented in studies. For example earlier research such as, the National Violence Against Women Survey (Tjaden & Thoennes, 2000) one of the largest surveys conducted on violence against women, uses public telephone numbers to collect their samples. Many homeless women may not be able to be reached by telephone (Wenzel et al., 2006) and various obstacles, such as not paying a phone bill, may prevent poor women from having a phone as well. In fact, the dataset used for this study showed that less than 50 percent of the women interviewed had a telephone number where they could be reached (Jasinski et al., 2010).

Therefore, the objective of the current study is to build on previous research to examine the relationship among partner violence victimization, homelessness, and severe negative health outcomes.

### The Importance of This Study

It remains an important issue to closely examine the risk that women face when they become victims of abuse and the negative health outcomes that will arise as a direct result. As it currently stands, IPV victims have unmet needs for safe housing (National Coalition for the Homeless, 2017). For example, the National Network to End Domestic Violence (NNEDV) explained this crisis in detail:

In just one day in 2015, over 31,500 adults and children fleeing domestic violence found refuge in a domestic violence emergency shelter or transitional housing program. That same day, domestic violence programs were unable to meet over 12,197 requests for services because of a lack of funding, staffing, or other resources. Sixty-three percent (7,728) of unmet requests were for housing. Emergency shelter and transitional housing continue to be the most urgent and unmet needs for domestic violence survivors (nnedv.org, 2016).

Therefore, safe emergency shelter is a huge first step in meeting the needs of women fleeing from domestic abuse (National Coalition for the Homeless, 2007). These women face the risk of being homeless, which may increase their negative health outcomes, as this paper seeks to explore.

## CHAPTER TWO: LITERATURE REVIEW

Tens of thousands of domestic abuse victims with no stable housing, flee their violent situations everyday throughout the United States (National Network to End Domestic Violence, 2016). In fact, evidence has suggested that domestic violence is among one of the leading causes of unstable housing including homelessness, for female victims (Baker et al., 2010).

Furthermore, much research indicates that intimate partner violence (IPV) and homelessness, co-occur at high rates (Gilroy et al., 2016; Goodman et al., 2009; Netto et. al., 2009; Ponce et al., 2014; Schuster et. al., 2011). Additionally, patterns of abuse and homelessness are commonly associated with each other throughout much of this research. For example, Jasinski et al., (2010) discuss two common patterns including (a) a women returns to her abuser after initially fleeing and becoming homeless because of a desperate need for safety, protection, and basic necessities, and (b) after the women escapes from abuse, she eventually links up with another male abusive partner. Both of these situations show a patterned effect of fleeing domestic violence, becoming homeless, and then becoming a victim of domestic abuse again, which could be used to show a relationship why such a large percentage of homeless women are victims of IPV.

Because of this connection of IPV and homelessness occurring at such high rates and producing parallel effects, it is very important to view the crisis through both lenses, because many health outcomes, including external situational and internal psychological difficulties, are missed when viewed through just one of the lenses (Goodman et al., 2009). Being the victim of IPV and being homeless can lead to many negative health consequences, including external injuries, emotional suffering, and the pattern of becoming revictimized, thus, unable to escape homelessness and violence. Although these consequences can also occur among victims of IPV who are not homeless and individuals who are homeless but not victims of IPV, when they are

combined, the victims are doubly jeopardized (Baker et al., 2010). Thus, the next few sections will explore these different negative health outcomes that are commonly seen in victims of IPV who are also homeless. Because many of the health consequences are co-dependent on each other and are a direct result of being homeless and a victim of IPV, these sections will focus on the relationship between homelessness and potential negative health outcomes, IPV victims and negative health outcomes, and the intersection between homelessness, IPV, and negative health consequences.

### External/Physical Health Outcomes

Poor physical health is prevalent among women who experience violence in various forms of IPV. One obvious negative physical health outcome of IPV victims is the severe physical injuries that many abuse victims encounter at the hands of their abusers. These physical injuries can include broken bones, cuts, stab wounds, internal injuries, and general injuries from being beaten or raped (DeKeseredy & Schwartz, 2009). Furthermore, women who are IPV victims may increase their use of drugs and alcohol to coat their pain and circumstances from their violent experiences (Jasinski et al., 2010), causing their risk of health condition from the drugs and alcohol to increase. IPV victims may also not seek treatment for their injuries, or get help for their addictions in an effort to hide their abuse (Schuster et al., 2011). This could lead to even greater negative external health consequences. For example, infections from untreated stab wounds, and permanent damage to untreated broken bones are common (Whitebeck et al., 2015). IPV victims can also suffer from low self-esteem, which can lead to poor general health as a result of not taking care of themselves (Raphael, 2004). IPV victims can suffer from a host of negative external health outcomes and they can become exaggerated when fleeing the abuse leads to homelessness.

Homeless victims also experience major health consequence, including drug and alcohol abuse (Black & Brieding, 2008; Jasinski et al., 2010; Riley et al., 2014; Wenzel et al., 2006). It is well known that alcohol use is a leading risk factor for negative health outcomes that leads to lowered life expectancy and disability, while illegal drug use is associated with even more severe health outcomes (Berman et al., 2015). Alcohol and drug use negatively effects one's external health.

There are many other general health conditions frequently seen throughout the homeless population, including high blood pressure, high blood cholesterol, cardio-vascular disease, joint disease, chronic pain/disease, and poor general health (Black & Breiding, 2008; Whittaker et al., 2017). These conditions effect the everyday lives of the victims, who are already suffering. Furthermore, poor hygiene leads to an increase risk for negative health conditions. These victims also are at risk for HIV and other STD's (Wenzel et al., 2006) due to their risky behaviors including drug use and survival sex. Unsanitary living conditions, inadequate diets and exposure to the elements can also lead to widespread disease, infections, (Jasinski et al., 2010) and various health related concerns, causing physical harm to their health.

The physical health conditions that victims of homelessness face, are further exaggerated by their lack of health care, including access to medical and dental care (Baker et al., 2010; Goodman et al., 2009; Riley et al., 2014; Wenzel et al., 2006). Without proper healthcare, health conditions are less likely to improve. However, even if medical and dental health care is available to the homeless population, it is probable that they only seek medical help after a health crisis, and not for preventable measures and regular checkups (Jasinski et al., 2010). Furthermore, if they do receive needed medication, storing it safely is a problem when living on the street (Butcher, 2017) as it is likely to become lost, stolen, or ruined. In addition, many

women do not feel safe taking prescription drugs on the street because it can make them groggy, which is an unsafe condition for women when living on the street (Butcher, 2017).

When these two crisis collide (homelessness and IPV), the negative physical health consequences are magnified. As noted, there are many physical health related risks and conditions that IPV victims deal with when living without a stable home. These risks and conditions come with extreme barriers to keeping them homeless, while being homeless magnifies their physically deteriorating health and risk of violence, causing a co-occurring effect of homelessness and IPV victimization. In addition to their physical health, their mental health is also severely affected.

#### Emotional/Mental Health Outcomes

The impact that homelessness has on mental health has been widely researched and is one major contributing obstacle to becoming housed. According to much research, the negative mental health outcomes of homeless women, is almost identical to the negative health outcomes of IPV victims, as shown throughout this section. Many researchers agree that homeless women who are also victims of IPV, suffer from mental and emotional health outcomes such as Posttraumatic Stress Disorder (PTSD), anxiety, depression, and various life stressors (Black & Breiding, 2008; Butcher, 2017; Jasinski et al., 2010; Shuster et al., 2011). The American Psychiatric Association (2013) diagnoses PTSD as "...exposure to actual or threatened death, serious injury or sexual violence..." (p. 271) and is a negative outcome of trauma exposure. Therefore, many, if not all IPV victims may suffer from PTSD (Schuster et al., 2011). Furthermore, many researchers believe that homelessness is a traumatic event in itself and being homeless alone can cause one to suffer from PTSD (Goodman et al., 2009; Schuster et al., 2011; Whitbeck, 2015).



Various life stressors that homeless women encounter include inability to find and/or keep a job, living conditions, threats of physical or sexual violence, childcare, unpaid bills, lack of transportation, insufficient resources to parent their child, hunger or food insecurity, a lack of social support, physical health problems, and a social services systems that hinders their efforts to help themselves (Goodman et al., 2009). These various life stressors can add to their emotional trauma and cause even deeper emotional harm. All the stressors and trauma present in their life, can also cause depression and anxiety (Whittaker, 2017).

As mentioned earlier, homeless women typically lack health care, including and especially mental health care. Additionally, it is common for homeless women and IPV victims to be socially isolated with no informal or formal support systems (Goodman et al., 2009). Thus, they must find ways to cope on their own. However, coping strategies may also be dangerous to their mental health. For example, they may include substance use and abuse (Whitbeck et al. 2015). Denial is another form of coping, which typically involves trying to escape or not think about the current situation (Shuster et al., 2011). Therefore, evidence supports that coping strategies used by homeless IPV victims are linked to negative mental health outcomes (Littrell & Beck, 2001).

Powerlessness can also cause victims to endure further mental and emotional negative health (Goodman et al., 2009). Powerlessness can be defined as "...the experience of being manipulated by another individual with more authority or control, as in the case of IPV, [or] the more general experience of lacking control of a situation, an important context, or significant aspects of one's life, as in often the case in impoverished women..." (p. 311). Powerlessness is also likely to cause depression and anxiety (Shuster et al., 2011). Consequently, the concept of powerlessness, which can lead to depression and anxiety, can be seen in both IPV victims and

impoverished and homeless women. Thus, combining the two, creates a magnified outcome. In fact, all the mental health issues mentioned in this section are vulnerabilities of both IPV Victims and homeless people and therefore, when combined, the results of poor mental health outcomes are heightened. However, it is not only the physical and mental health of victims that co-occur in these victims, it is also the reciprocal vulnerabilities that reinforce the co-occurrence of homelessness and IPV victimization.

#### Vulnerabilities of IPV and Homeless Victims

As shown in the above sections, there are many relatable vulnerabilities of IPV Victims and homelessness that seem to keep IPV victims, homeless, and homeless women, victims of IPV. A few such vulnerabilities of homeless victims include survival sex or prostitution, dealing drugs, panhandling, lifestyle conditions, and high rates of alcohol and drug use (Nyamathi et al., 2001). Survival sex and prostitution are often used as strategies to gain necessary resources to live, but participants usually suffer unimaginable violence (Jasinski et al., 2010). For example in one case study, a former prostitute described her experience of witnessing, and being the target of physical beatings, attacks, rapes, and verbal attacks (Raphael, 2004). Other street related risky activities, such as panhandling, can exhibit these same violent assaults.

Homeless victims may also have difficulties finding employment, contributing to the difficulty to escape their circumstances. For example, many homeless victims may have attained a criminal record for engaging in common survival activities, such as prostitution (Frederick et al., 2013), which can hinder legal employment. However, a possible criminal record is not the only thing that hinders a victim's ability to obtain a normal job. Homeless victims may also lack general survival skills (money management, time management, parenting skills, stress management, home management, and self-care) that influence and affect their ability to not only get a job, but also obtain stable housing, forcing them to be homeless (McNulty et al., 2009).

Victims of IPV also deal with many road blocks that enables the reciprocal pattern of being a victim. For example, evidence has also shown that many other factors influence IPV victims from obtaining employment. This research shows that many IPV victims fail to get a job, or keep a job because their abuser sabotages their efforts to do so (Baker et. al., 2010; Netto et. al., 2009; McNulty et. al. 2009; Raphael, 2000). For example, abusers often stalk and harass their victims at work (Baker et al., 2010), block transportation and communication to get to work, and break child care commitments (Raphael, 2000). Furthermore, victims may be unable to keep a job because of their physical state and mental health, such as depression, anxiety, PTSD, defensive avoidance, impaired cognitive functioning, concentration, memory, orientation, task initiation, and other executive functioning (McNulty et al., 2009). A lack of childcare, or affordable childcare may also larger contribute to a victim's inability to work (Raphael, 2004). Some of these issues may also be to blame for a poor rental history, which also affects their ability to live in stable housing. A women's poor rental history could be impacted by the need to move to elude their abuser, difficulty paying rent leading to evictions and poor credit (Baker et al., 2010).

In addition, many support services such as welfare and other public assistance benefits programs designed to help women in these crisis, actually aren't helping IPV victims at all. For example, welfare reform now has welfare-to-work requirements, which causes many IPV recipients to lose their benefits (Roschelle, 2008) because of the many above listed reasons of being unable to work. These policies have it made almost impossible for women to become financial independent (Riger & Staggs, 2004). Thus, these women are left struggling and unable to find work and receive much needed public assistance benefits, leaving these women with no other options but to either stay with their abuser, or become homeless.

When these two crisis are combined (IPV victims and homelessness), the effects are doubly enhanced. Homeless individuals are at an extreme risk for violence, and are even more prone to violence when they are victims of IPV (Nyamathi et al., 2001). They also face extreme challenges when seeking employment. Homeless victims and IPV victims deal with intense physical, emotional, and mental traumas that force their circumstances to be reciprocal, keeping the victims both homeless and enhancing patterns of abuse.

### Compared to Who?

Even though a pattern of IPV victims and homelessness has been a common theme throughout this literature, not all women who are victims of IPV become homeless. Even though some studies have shown that women in upscale marriages may have a higher percentage of underreporting (Weitzman, 2000), evidence suggests women with incomes below \$25,000 were almost twice more likely to experience domestic violence than women with higher incomes (Yoo & Huang, 2012). Household incomes affect the day to day life of families in general.

One prior study used the stress and resources theory to suggest when domestic violence occurs in households that are also living in poverty, it may increase the risk of lack of resources which can contribute to effecting health outcomes (Yoo & Huang, 2012). For example, mental health can be severely affected by IPV, and can worsen when left untreated by a lack of resources, which is usually not an issue in victims who live in affluent communities. A lack of resources can also mean external and internal injuries going left untreated, or treated by low-quality health care facilities (Raphael, 2000). For example, one study, *Saving Bernice: Battered Women, Welfare, and Poverty*, highlights a story surrounding a poor women named Bernice who explains a commonly heard story seen in poverty stricken households, about the effects that domestic violence had on her and her children, including severe asthma attacks and depression (Raphael, 2000). She relies on government granted healthcare to treat her and her children, and

they never truly recover (Raphael, 2000). The study also suggests that women in poorer households are forced by their perpetrator into having more kids and being on welfare by violent threats and the inability to work (Raphael, 2000; Riger & Staggs, 2004).

Furthermore, women in low-income households tend to stay in the violent situations for longer periods of time because they lack the economic resources to help them escape and they depend on their partner for economic resources (Frias & Angel, 2007), which elevates the amount of time the women are exposed to the abuse, causing more harmful effects. While on the other hand, women who live in affluent communities tend to have more resources and greater social support (Costello et al., 2005).

Studies have further shown that poor and affluent neighborhoods are unequal, and poor neighborhoods have a higher history of abuse and violence (Lareau, 2003). Thus, the neighborhood alone can also have an effect on staying in the abuse for too long, exacerbating the abuse and effected outcomes. For example, homeless DV Victims often come from low-income neighborhoods where abuse and violence and the negative effects it has on victims are a norm, thus they ignore and not treat critical harmful dangers that are similar to friends and neighbors (DeKeseredy & Schwartz, 2009).

More research is needed to address the concerns and determine the difference in how poverty households, that lead to homelessness, differ from high-income households in terms of how women are impacted in order to provide more helpful and better resources to victims effected most. For now, this study intends to focus on just the sample of homeless women who suffered intimate partner violence and the health consequences they face. The goal is to be able to provide recommendations on improvements for policies, and other ways in which these women can be better helped to lessen the negative health outcomes they face far too often. Thus,

this study focuses on the research question of what the impact that IPV victimization has on the population that suffers from unstable housing and the health consequences they may encounter. The hypothesis is that IPV victims who are homeless, suffer more negative health consequences than homeless women who are homeless from reasons other than IPV victimization.

## CHAPTER THREE: METHODOLOGY

### Data

To accurately conduct a study on the impact IPV has on homelessness and the negative health consequences the victims suffer, secondary data was used from the Florida Four-City Study of Violence in the Lives of Homeless Women project (Jasinski et. al., 2010). The study was designed to gather information on the lives of homeless women, the violence and realities they encounter while living on the street, the consequences they suffer, the factors associated with their experiences of violence, and the types of interactions with the criminal justice system they encounter. The hope is that through understanding these experiences, communities and lawmakers can eliminate and/or design policies to improve their situations. The parts of the interview that were used as part of this study, included the questions relating to the reason for their homelessness, the number of times the participant was homeless and health related questions, including questions relating to their physical and mental health.

### Participants

The study interviewed 737 homeless women (n=737), found in the four largest Florida cities including Orlando, Miami, Tampa, and Jacksonville. The researchers used structured quantitative questions, as well as in-depth qualitative questions during the interview process. The interview consisted of 241 questions that mainly focused on the violence they experienced in their lifetime. Other questions included, asked about their personal background (where they are from, ethnicity, marital status, family life, etc.), use of drugs and alcohol, forced and non-forced criminal activity (prostitution, shoplifting, etc.), length of homelessness, reported incidents and interaction with the criminal justice system, employment, medical care (health, mental, and dental), how their free time was spent, and questions relating to their partner.

The 737 study participants had an average age of 37.5 (twenty-eight percent of the women were under thirty, forty-seven percent were between thirty and forty-five, twenty-four percent were between forty-six and sixty-four, and fewer than one percent were older than sixty-four) (Jasinski et al., 2010). Forty-seven percent of the women identified themselves as black, roughly thirty-three percent identified as white, and fifteen percent identified as Hispanic or Latina. Forty-three percent of the participants in the study were never married, forty percent were divorced, separated, or widowed, and only seventeen percent were married or cohabiting with a partner. Furthermore, the group of participants were well educated with about two-thirds having a high-school diploma or less and more than one-third having additional education. Close to eighty-percent of the women interviewed had at least one child, regardless of marital status, with the average number of children being 2.39.



Table 1: Demographics of Participants in the Sample

Variables	N	Percentage
Age	729	
Under 30		27.89
30-45		42.25
46-64		29.78
64+		.08
Ethnicity	730	
Black		46.85
White		33.83
Hispanic/Latino		14.52
Other		4.79
Marital Status	733	
Never married		43.11
Divorced/Separated/Widowed		39.84
Married/cohabiting		17.05
Education	732	
High School Diploma or less		64.90
Additional Education		34.50

## Variables

In order to examine the research question, the analysis will look at the relationship between IPV victimization and negative health outcomes. Therefore, the primary variables will be the *reason for homelessness (first time and current time), IPV victimization, or other and negative health outcomes.*

*Reason for homelessness (IPV or other).* To determine the reason for homelessness (IPV victimization or other), two questions from the dataset will be considered. These questions include the following: (a) What led you to leave your residence the 1<sup>st</sup> time you became homeless? and (b) Are you currently homeless due to violence against you by an adult partner? Question 'a' was an open ended question for the respondent. Therefore, the researcher coded each answer into two categories, IPV related (1) or other (0). Question 'b' offered the respondent one of three choices: (a) yes, it is the main reason, (b) yes, it is one of many reasons, or (c) no, not a factor. This study recoded the variable as either yes (1) or no (0).

*Negative health outcomes/access to health care/preventative health care/health consequences.*

To determine negative health outcomes, the literature review was used to gain insight on potential poor health consequences, access to health care, and preventative health care of the population studied. Therefore, the following questions from the dataset were considered for this variable: (a) Do you have any chronic medical problems that require special attention or that interfere with your life? (b) Are you currently taking any prescribed medication on a regular basis for a medical problem? (c) When was the last time you went to a doctors for a regular checkup? (d) In your lifetime, have you been admitted to a hospital for any psychological or emotional problems? (e) In your lifetimes, have you been treated for any psychological or emotional problems as an outpatient in a clinic? (f) Has any health professional, counselor, social

worker, or other clinician told you that you have a psychological or emotional problem, or that you are mentally ill? (g) Are you very, somewhat, or not at all depressed? and (h) Are you very, somewhat, or not at all anxious? Many of these questions were coded as yes or no answers, except if they had regular doctor's visits, which was coded as having seen a doctor less than a year (0), or more than a year ago/never (1). Response options for the depression and anxiety variables included very, somewhat or not at all depressed or anxious. These two variables were then recoded to not at all or somewhat (0) and very (1).

*Number of times spent homeless.* The question that will be used to determine the number of times homeless, will be "number of times homeless in life". This answer was coded as 1-30 and 98 (more times than respondent can remember). For this study, the answers were grouped as only homeless once (0), and homeless more than once (1).

*Race (used as a control variable).* The race variable was recoded as black (1), and all other (0).

*Education (used as a control variable).* The education variable was recoded as high school or below (0), and additional education beyond high school (1).

*Marital Status (used as a control variable).* The marital status variable was recoded as partnered (married or cohabiting) (1), and not partnered (divorced, single, widowed, separated) (0).

Table 2 shows the recoding of the variables.

Table 2: Re-coding of Variables

Variable	Re-Coding
Reason for homelessness	1=IPV victimization, 0=Other
Number of times homeless	1=More than once, 0=1 time
Race	1=Black, 0=Other than black
Marital Status	1=Partnered, 0=Not partnered
Education	1=more than a high school diploma, 0=high school diploma or less
Chronic medical condition	1=Yes, 0=No
Taking prescribed medication	1=Yes, 0=No
Doctor's checkup	1=a year or more, 0=less than a year
Admitted to a hospital for mental/emotional problems	1=Yes, 0=No
Treated at an outpatient clinic for mental/emotional problems	1=Yes, 0=No
Professional diagnosis of mental/emotional problem	1=Yes, 0=No
Self-reported depression	1=depression describes respondent very well, 0=depression describes respondent somewhat or not at all
Self-reported anxiety	1=Anxiety describes respondent very well, 0=Anxiety describes respondent somewhat or not at all

### Analytic Strategy

SPSS was used for all the analyses in this study.

In order to examine the research question as outlined in the above sections, the frequency distributions of the variables were examined to understand how many women in the sample were homeless due to IPV, then, a chi-square test was performed. A chi-square test was used because it allows for a better understand the relationships between all the variables and to determine how likely it is for the observed distribution (health consequences) is due to IPV victimization or not and because it is the most appropriate test for nominal level data. Lastly, logistic regression was used to determine the relationship between IPV victimization, episodes of homelessness (one or more than one), and if being a victim of IPV was statistically significant in suffering greater negative health outcomes than those who answered they were not a victim of IPV. Logistic regression was used in order to accurately describe the data and explain the relationship between the binary dependent variables and independent variables. Two separate models were used to determine the relationship between the reason for homelessness (IPV or other), negative health outcomes, as shown in the below figures.

The dependent variable *negative health outcomes*, is measured through a variety of negative health consequences that the participants identified they did or did not suffer, as discussed above. These negative health outcomes were examined separately. The independent variable is the *reason for homelessness (IPV or other)*. Figure 1 shows this relationship for the first time the respondent was homeless, while figure 2 shows the relationship for the current reason the respondent was homeless. These variables were questions asked during the interview process. The figure shows how the relationship was determined. Once again, the hypothesis is that the women who are homeless because of IPV victimization will have more negative health

consequences than the women who report they are homeless due to a reason other than IPV victimization.

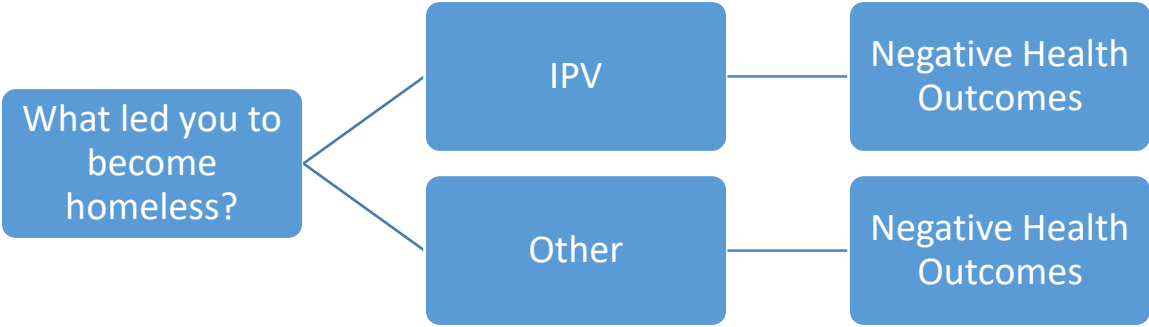


Figure 1: Reason for Homelessness the First Time and Negative Health Outcomes

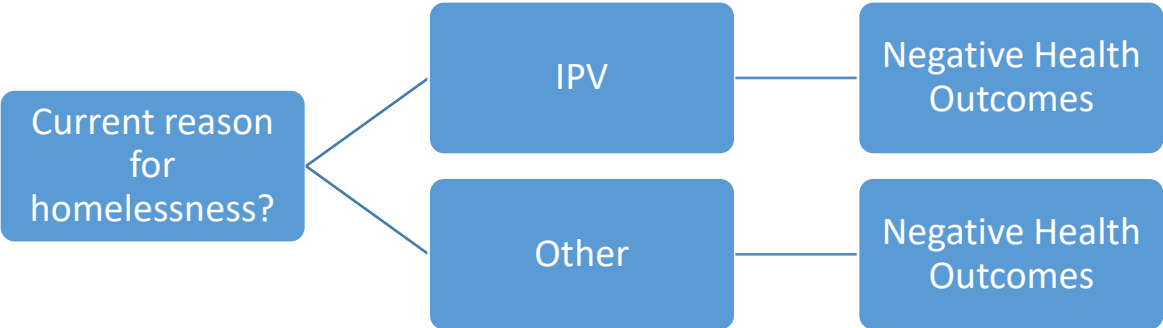


Figure 2: Current reason for Homelessness and Negative Health Outcomes

## CHAPTER FOUR: FINDINGS

Table 3 shows that 23.59 percent of the homeless women in the study attribute their first episode of homelessness to being victims of IPV, while 25.40 percent of women attribute their current episode of homelessness to being victims of IPV. Two-hundred and seventy seven women in the sample were only homeless one time.

Table 3: Reason for Homelessness

Episode of homelessness:	%IPV:	%Other:	N
1 <sup>st</sup> :	23.59	76.41	729
Current reason:	25.40	74.10	733

Table 4 shows the results of the frequencies distribution of negative health outcomes for the entire sample regardless of why they are homeless. Table 4 reports that 38.7 percent of the women in the whole sample had a chronic condition, 36.8 percent of the women reported regularly taking prescribed medication, 79.6 percent of the women had a doctor's checkup within a year, 30.8 percent of the sample population had been admitted to a hospital for emotional or mental problems, 34.6 percent had been treated at an outpatient clinic for mental illness, 62.09 percent felt they were very depressed and anxious.

Table 4: Health Outcomes for all Women in the Sample

	%Yes	N
Chronic medical problem	38.70	718
Regularly taking prescribed medication	36.80	726
Received doctor checkup within a year	79.60	716
Admitted to a hospital for psychological or emotional problems	30.50	726
Treated at an outpatient clinic for psychological or emotional problems	36.40	717
Professional diagnosis of psychological/emotional problems or mentally ill	34.60	716
Depressed (self-report)	62.09	728
Anxious (self-report)	62.09	728

Table 5 shows the results for the chi-squared test looking at the association between negative health outcomes/access to healthcare (dependent variable) and whether or not IPV was the reason women in the sample were homeless. The results show a statistically significant difference between the respondents who believe they are homeless due to IPV victimization and the respondents who do not believe they are homeless because of IPV victimization in the health outcomes of: (a) being admitted to a hospital for psychological or emotional problems, (b) treated at an outpatient clinic for psychological or emotional problems, (c) professional diagnosis of psychological/emotional problem, or mentally ill, (d) believe they are very depressed, and (e) believe they have anxiety. The bivariate analyses (Table 5) demonstrated



that women who reported they were homeless for their current episode of homelessness due to IPV victimization were more likely to experience emotional or mental negative health outcomes. Furthermore, almost double the percentage of women who were currently homeless due to IPV, believed that depression described them 'very well'. Also, almost double the percentage of women who were currently homeless due to IPV, believed that anxiety described them 'very well'. In addition, almost half of the women who reported they were homeless due to IPV victimization, also reported they had been treated for mental/emotional problems at an outpatient clinic, compared to just a third of the women who reported they were homeless due to reasons other than IPV. Additionally, more than ten percent more of the women who were currently homeless due to IPV compared to those not homeless due to IPV, had been admitted to a hospital for emotional or psychological problems and had a professional diagnosis of mentally ill problems. These findings suggest that women who are homeless due to IPV victimization, have greater mental and emotional health consequences than women who are homeless due to reasons other than IPV victimization. Thus, the results are significant, and help to support the hypothesis that women who are homeless due to IPV, suffer greater negative (mental) health outcomes, than those homeless from other reasons not related to IPV.

Table 5: Chi-Square Test of Current Reason for Homelessness (IPV or not) and Negative Health Outcomes

	%IPV No	%IPV Yes	Sig.
Chronic medical Problem	37.60	45.70	.054
Regularly taking prescribed medication	36.60	39.20	.523
Received doctor checkup within a year	82.10	82.10	.998
Admitted to a hospital for psychological or emotional problems	28.10	39.00	.005**
Treated at an outpatient clinic for psychological or emotional problems	33.10	49.70	.000***
Professional diagnosis of psychological/emotional problems or mentally ill	32.90	42.70	.016*
Self-report depression	16.10	30.60	.000***
Self-report anxiety	17.70	28.10	.003**

Note. \*\*\*=p<.001, \*\*=p<.01, \*=p<.05,

Table 6 shows the logistic regression results of reason for homelessness (IPV victims versus non victims) the first time the respondent was homeless and their health outcomes/access to healthcare. Table 6 presents that eight logistic regression models that were conducted, corresponding to each of the negative health outcomes/access to healthcare. The models and variables that were statistically significant include: (a) model 2 (prescribed medication): marital status; (b) model 3 (doctor checkup within a year): race; (c) model 4 (admitted to a hospital): number of times homeless and marital status; (d) model 5 (treated at an outpatient clinic): number of times homeless, race, and marital status; (e) model 6 (diagnosis of mental illness): number of times homeless, race, and marital status; (f) model 7 (self-diagnosed depression): number of times homeless; and (g) model 8 (self-diagnosed anxiety): number of times homeless.

The results from Table 6, show that women who were homeless the first time because of IPV victimization do not suffer more negative health outcomes, not supporting the hypothesis for this model. However, the findings do show that women who are homeless more than once, have higher odds of being admitted to a hospital for mental health problems, treated at an outpatient clinic for mental health problems, have a professional diagnosis of a mental illness, and have self-reported depression and anxiety. Thus, it should be noted that a common theme was discovered, as women who were homeless more than once, suffer more mental health problems than women who were only homeless one time. Also, the control variable, *race*, increased the odds of experiencing three negative health outcomes. Black women were more than two times more likely to not have had a doctor's checkup within the last year. Black women were also more likely to have been treated at an outpatient clinic for mental health problems and have a mental health diagnosis. In addition, the control variable, *marital status (partnered or not partnered)*, increased the odds of experiencing negative health outcomes. In fact, the results

show that women who are not partnered are more likely to be on prescription medication, admitted to a hospital for emotional/mental problems, treated out an outpatient clinic for mental problems, and have a professional diagnosis of mental or emotional problems. And lastly, the control variable, *education*, was not significant.

Table 7 shows the logistic regression results from the eight models predicting negative health outcomes/access of healthcare for women who identified the reason for homelessness (IPV victims or something else) for the current episode of homelessness. The results shows a statistically significant relationship between following models and variables: (a) model 2 (prescribed medication): marital status; (b) model 3 (doctor checkup within a year): race and education; (c) model 4 (admitted to a hospital): number of times homeless, marital status and education; (d) model 5 (treated at an outpatient clinic): current reason for homelessness, number of times homeless, race, and marital status; (e) model 6 (diagnosis of mental illness): number of times homeless, race, and marital status; (f) model 7 (self-diagnosed depression): current reason for homelessness and number of times homeless; and (g) model 8 (self-diagnosed anxiety): current reason for homelessness and number of times homeless.

The results in Table 7 show that the women in this study who said they were currently homeless because of IPV victimization were overall more likely to experience negative mental/emotional health outcomes. Furthermore, the variable, *number of times homeless*, also increased the odds of experiencing negative mental/emotional health outcomes, including being admitted to a hospital for mental health issues, treated at an outpatient clinic, having a diagnosis of mental illness, believing they are very depressed, and believing they are very anxious. Once again, Table 7 shows that black women were more than twice as likely to not have been to a doctor's checkup within the past year. However, the other race category (white, Hispanic, Asian,

and other) were more likely to be treated in an outpatient clinic for mental health problems and be diagnosed with mental health problems. The results also showed that partnered women were more likely to be admitted to a hospital for mental health problems, but not partnered women were more likely to be on prescription medication, treated at an outpatient clinic for mental health problems, and diagnosed with mental health problems. Table 7 also reports that women who are less educated are more likely to not have had a doctor's checkup within the last year, but women who are more educated are more likely to be admitted into a hospital for emotional or mental health problems. Overall, the results show women who are currently homeless because of IPV victimization, are more likely to experience negative mental/emotional health outcomes than women who are homeless for other reasons.

Table 6: Logistic Regression Predicting Negative Health Outcomes and Access to Healthcare (First Time homeless)

	Model 1 (Chronic Medical)	Model 2 (Prescribed medication)	Model 3 (Doctor Checkup)	Model 4 (Admitted to hospital)	Model 5 (Treated at outpatient)	Model 6 (Diagnosis of mental illness)	Model 7 (Self- diagnosed depression)	Model 8 (Self- diagnosed Anxiety)
Reason for first time homeless (IPV/other)	.050 (.951) [.786]	.075 (1.007) [.687]	-.357 (.700) [.121]	.204 (1.226) [.298]	.083 (1.087) [.665]	.269 (1.309) [.162]	-.336 (.715) [.161]	.058 (1.060) [.796]
Number of times homeless (1/more than 1)	.241 (1.273) [.123]	.026 (1.026) [.868]	-.112 (.894) [.578]	.896 (2.450) [.000]***	.796 (2.217) [.000]***	.746 (2.108) [.000]***	.676 (1.966) [.001]**	.384 (1.468) [.046]*
Race (Black/other)	-.123 (.884) [.435]	.075 (1.078) [.637]	.748 (2.112) [.000]***	-.280 (.756) [.101]	-.552 (.576) [.001]**	-.695 (.499) [.000]***	-.127 (.881) [.511]	-.136 (.873) [.480]
Marital status (partnered/ not partnered)	-.339 (.716) [.112]	-.436 (.647) [.048]*	.064 (1.066) [.812]	-.698 (.498) [.005]**	.540 (.583) [.017]*	-.734 (.480) [.002]**	-.156 (.856) [.551]	-.494 (.610) [.080]
Education (HS diploma or less/ additional)	.175 (1.1910) [.286]	-.091 (.913) [.586]	-.402 (.669) [.050]	.105 (1.111) [.553]	.308 (1.360) [.070]	.157 (1.170) [.363]	-.331 (.718) [.114]	.127 (1.136) [.523]

Table includes B value, odds ratio in parenthesis, and p value in brackets.

Note: \*= $p < .05$ , \*\*= $p < .01$ , \*\*\*= $p < .001$ ,

Table 7 Logistic Regression Predicting Negative Health Outcomes and Access to Healthcare (Current Episode of Homelessness)

	Model 1 (Chronic Medical)	Model 2 (Prescribed medication)	Model 3 (Doctor Checkup)	Model 4 (Admitted to hospital)	Model 5 (Treated at outpatient)	Model 6 (Diagnosis of mental illness)	Model 7 (Self- diagnosed depression)	Model 8 (Self- diagnosed Anxiety)
Current reason of homelessness (IPV/other)	.281 (1.324) [.113]	.069 (1.071) [.700]	-.008 (.992) [.974]	.358 (1.430) [.054]	.606 (1.832) [.001]**	.299 (1.348) [.104]	.731 (2.078) [.000]***	.580 (1.786) [.005]**
Number of times homeless (1/more than 1)	.201 (1.222) [.202]	.009 (1.009) [.953]	-.174 (.840) [.390]	.848 (2.2334) [.000]***	.723 (2.061) [.000]***	.699 (2.011) [.000]***	.536 (1.709) [.006]**	.306 (1.358) [.005]**
Race (Black/other)	-.129 (.879) [.411]	.083 (1.087) [.596]	.685 (1.983) [.001]**	-2.47 (.781) [.144]	-.531 (.588) [.001]**	-.699 (.497) [.000]***	-.159 (.853) [.412]	-1.32 (.876) [.491]
Marital status (Partnered/not partnered)	.306 (.582) [.154]	-.459 (.632) [.038]*	.017 (1.074) [.791]	.672 (.511) [.007]**	-.496 (.609) [.029]**	-.716 (.489) [.003]**	.053 (.948) [.840]	-.445 (.641) [.117]
Education (HS diploma or less/ additional)	.177 (1.193) [.279]	-.044 (.957) [.789]	-.403 (.668) [.049]*	.120 (1.128) [.049]*	.317 (1.374) [.063]	.146 (1.157) [.397]	-.238 (.789) [.253]	.233 (1.262) [.240]

Table includes B value, odds ratio in parenthesis, and p value in brackets.

Note: \*= $p < .05$ , \*\*= $p < .01$ , \*\*\*= $p < .001$

## CHAPTER FIVE: CONCLUSION

As widely discussed throughout this study, IPV is one contributing factor to the homelessness of many women in today's society. Furthermore, homeless women and victims of IPV are faced to struggle with multiple risk factors that lead to poor negative health, thus it was hypothesized, that women who are homeless because of IPV victimization, suffer more negative health consequences than those who are homeless for reasons not related to IPV victimization. The results of this study found that women who stated IPV victimization was the reason for their current episode of homelessness, is statically significant for many negative health outcomes/access to healthcare, especially for being treated at an outpatient clinic, self-diagnosed depression and self-diagnosed anxiety. Thus, emotional or mental health problems is more severe in women who are currently homeless because of IPV victimization. This is a public health crisis with a broken system (Butcher, 2017) that needs immediate attention from researchers and lawmakers. Previous research has given good insight on the large scope of these problems, and small steps have been taken such as the attention given to the safe housing crisis in this country (National Coalition for the Homeless, 2017), but women are still being failed by this broken system every day.

The results for this study did show that IPV victimization does impact some negative health related outcomes of homeless women and there is a large percentage of women who list IPV as a reason for their homeless. This is evident as violence is so common throughout the homeless population. One possible reason for the pattern is because both IPV and homelessness cause one's mental health to deteriorate and are not able to find helpful or permanent solutions for either problem (Goodman et al., 2009). Also as previously mentioned, Jasinski et al., (2010) provides two theories for the common patterns of the reason for a reciprocal effect including (a)



a women returns to her abuser after initially fleeing and becoming homeless because of a desperate need for safety, protection, and basic necessities, and (b) after the women escapes from abuse, she eventually links up with another male abusive partner. These patterns show a serious need for attention to this crisis, more widely available mental health counseling for women in these situations, and more resources to help women get on their feet after fleeing from abuse.

These findings are noteworthy and show cause for concern of the public, greater attention for researchers, and policy change from lawmakers. Committing to solving the housing crisis in this country is one way that could contribute to lessening the problem. For example, one researcher examined the case of a young women who suffered severe deteriorating health from living on the street and being a victim of violence. Butcher (2017), shared the story of this women whose local hospitals spent more than \$750,000 on her medical care, all of which could have been addressed by just getting her housing with a safe place to store her medication and the security of a lock. Unfortunately, her situation isn't uncommon. Housing stability, can create safer environments for the homeless, and especially those fleeing abuse since their general well-being could be in grave danger (Campbell et al., 2007).

Furthermore, even though great strides have been taken in the domestic violence movement, little has been done for the low-income population at risk of homelessness in terms of long-term emotional needs, well-being, and material security (Goodman et al., 2009). Low-income IPV survivors also need advocates to address their short and long-term financial situations. These women need coping tools and real options in their struggle. This crisis needs continued ongoing attention from researchers to be able to produce helpful research designed to influence useful solutions.

Although this study makes a contribution to the colliding crisis of IPV victimization and homelessness, a few limitations should be noted. The answers given in the data were the answers given by the sample population, and thus it has just been their perception documented in the data. For example, the participants were asked “What led to homelessness the first (and most recent) time you were homeless?” the answer to this question was their belief of the reason, and may not have actually been the real reason. This could also cause underrepresented numbers of women who may have been forced homeless from being a victim of IPV. For example, many women simply answered that they were leaving a bad situation, broke up with their significant other, got into fights with their partner, or other like answers that could have been violent, but since they did not specially mention violence, they were not counted as IPV victims in this study. Other limitations could be in the narrowing down of health related questions that lead to poor health. Many other factors could contribute to poor health, and just because they were not a part of this research, does not mean they do not suffer from negative health.

In conclusion, this research shows that there are negative emotional and mental health consequences for homeless, IPV victims and that IPV victimization has a large impact on negative health outcomes/access to healthcare. Although this study found evidence that there are severe negative mental health effects of homeless, IPV victims, further research is needed to more carefully examine this issue. This study used a large dataset, where women in four major Florida cities contributed to the provided data, thus this study is beneficial to the overall effects of homeless, IPV victims, as it shows the major concerns of negative emotional and mental health outcomes and the possible pattern of women in this target population. These findings support the need for research, stronger advocates for this population, and increased funding and constructive plans by community members and law makers. Additional research can offer

enhanced solutions for these common problems seem throughout the communities in the country. It is crucial to gain immediate attention to this public health crisis and enhance domestic violence resources to get safe and affordable housing, victims away from the homeless scene and culture, ensure adequate wages, and provide necessary support, in order to experience less drastic negative health outcomes for IPV survivors who face homelessness. Researchers, advocates, healthcare organizations, lawmakers, and community members should work together to provide long term physical care, mental care, material security, and housing stability to keep underprivileged IPV victims from falling through the cracks.

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