Advances in Nursing Science
Vol. 35, No. 2, pp. E47–E59

Family Homelessness Viewed Through the Lens of Health and Human Rights

Rebecca C. Lee, PhD, RN, PHCNS-BC, CTN-A

Families with children, many of whom are headed by a single mother, are the fastest growing segment of the homeless population. Guided by Leininger's Culture Care Theory and the ethnonursing research method, the purpose of this study was to discover the care meanings and expressions for a group of 12 Appalachian mothers living with their children in an urban homeless shelter. Reflected in each mother's words and embedded within the 3 universal themes that emerged was the need to be treated with human dignity and respect. This need was seen as vital to the health and well being of these families. **Key words:** *Appalachian culture*, *family homelessness*, *human rights*, *Leininger's Culture Care Theory*

MORE THAN 600 000 American families, including some 1.5 million children, will experience homelessness in any given year.[1] During the period from 2007 to 2009, there was a 30% increase in the numbers of families who were homeless.[2] These numbers do not include the additional families precariously housed and living in doubled-up situations or in substandard housing.

Within many metropolitan areas of the United States, Appalachian families comprise one unique cultural group experiencing poverty and its extreme of homelessness.[3] According to Leininger and McFarland,[4] care is embedded in people's social structure, worldview, language, and environmental context. The discovery of this knowledge allows for the provision of culturally competent nursing care that supports the health and well-being of all people.[4] Therefore, providing quality health care to Appalachian families experiencing homelessness must be built on an understanding of their experiences, values, beliefs, meanings, and practices within a cultural context.

Families who are homeless face violations of a wide range of human rights, including access to adequate, safe, and secure housing, as well as the right to be treated with human dignity and respect. The purpose of this article is to describe the interrelated nature of health, human rights, and homelessness from the perspective of 12 Appalachian mothers who participated in an ethnonursing research study while caring for their children in an urban family homeless shelter. These findings, along with implications for nursing research and practice, are presented within a human rights framework.

Author Affiliation: *College of Nursing, University of Cincinnati Academic Health Center, Cincinnati, Ohio.*

The study was supported through the International Association for Human Caring 2007 Leininger Award for Research.

The author thanks Edith Morris for guidance on dissertation study and also thanks Carrie Hall for editorial support in the preparation of the original manuscript.

The author has disclosed that she has no significant relationships with, or financial interest in, any commercial companies pertaining to this article.

Correspondence: *Rebecca C. Lee, PhD, RN, PHCNS-BC, CTN-A, College of Nursing, University of Cincinnati, PO Box 210038, Cincinnati, OH 45221 (Rebecca.lee@uc.edu).*

DOI: 10.1097/ANS.0b013e3182537432

BACKGROUND AND SIGNIFICANCE

Family homelessness

Beginning in the early 1980s, families with young children began to be seen in homeless shelters throughout the country, quickly becoming the fastest-growing segment of the homeless population.[5] Since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of members of families who are homeless, especially mothers and children, as well as the causes of family homelessness. Researchers have emphasized that many of the challenges facing these families are also the same as those confronting housed families who are living in poverty and living on the edge of homelessness.[5]

From an ecological perspective, there are several pathways to homelessness. This perspective emphasizes the context within which individuals and families live and the complex interactions that occur between personal, social, economic, and service system resources that impact their well-being, and, in this instance, housing security.[6] Structural factors contributing to the increase in family homelessness include scarcity of affordable housing, economic restructuring, poverty, and reductions in financial assistance from the government. The availability of housing for low-income persons has been greatly reduced through the gradual process of removal of affordable housing units from circulation due to gentrification and urban renewal. As housing niches for the poor have been lost, those who were most vulnerable, including urban-dwelling minorities, have suffered greater losses. The availability of rental units affordable to low-income renters has declined consistently over recent decades. In 1973, there were approximately 4.9 million low-cost, unsubsidized units in the private market. Despite increases in the demand for this type of housing, the number of available units fell to 2.8 million units by 1995.[7,8]

Economic restructuring to a low-wage, service economy has also contributed to the rise in family homelessness. Declining wages have put housing out of the reach for many workers. In addition to the rising unemployment rates, current employment options offer low wages, less job security, and few, if any, benefits, such as health care, leaving many families lacking the monetary resources necessary to secure and maintain housing.[7] According to the National Low Income Housing Coalition's 2011 figures, the average minimum-wage worker in most states would have to work 102 hours each week to be able to afford a 2-bedroom apartment at the fair market housing rate.[7] The fact that many individuals and families experiencing homelessness actually do work was confirmed by the US Conference of Mayors,[2] who found that between 15% and 25% of the urban homeless population are in fact employed.

Homelessness and poverty are inextricably linked. Poor people are frequently unable to pay for housing, food, childcare, health care, and education. For most Americans, being poor means you are an illness, an accident, or a paycheck away from living on the streets.[5] In 2010, 15.1% of the US population (46.2 million) lived in poverty, with that number on the rise. Furthermore, the 2010 poverty rate for children younger than 18 years was 18%—the highest rate for any age group.[9]

Reductions in financial assistance from the government, culminating in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, have, no doubt, contributed to the increase of poverty, and the fact that an especially large number of low-income, single African American mothers and children are unable to secure or maintain affordable housing.[8] The rhetoric of welfare reform, reinforced by the ideals of the Judeo-Christian work ethic, assumes that in a free market economy, if you work hard enough, you will always have your needs met.[10] However, it has been argued that the problem with this conceptualization of governmental assistance and welfare reform is that it rests on assumptions, no doubt, influenced by our country's history of racial discrimination, segregation, and job flight from the inner city.[11-13] When there are few jobs, and the ones available do not provide a living wage, it does not matter how hard a family works, they will not be able to take care of their needs for housing, food, and health care. These families join the ranks of the "working poor."[12,13]

The original intent of welfare, as conceived in 1935, was as a federal public aid system that would ensure the well-being of children by providing families with financial stability. No doubt, there were naysayers at the time who pointed their fingers at those parents deemed not to be working hard enough to get ahead. Nevertheless, the focus remained on the well-being of the children because they represented the future of the country and its economic security. However, over time, changes in the political climate on our country and the influence of a conservative political agenda resulted in calls for welfare reform. The resultant changes were successful in shifting the focal point of public attention away from vulnerable children and toward efforts aimed at reforming parents seen to be shirking their parental responsibilities. Thus, it can be argued that this tide of policy change dramatically altered the nature and intent of what were to be social safety nets for children, ultimately contributing to the rising tide of families with children who are experiencing homelessness and the instability and negative psychosocial effects on their lives.[8]

Homelessness is a life experience that has a profound impact on the health and well-being of each member of a family. Previous research has demonstrated the influence of homelessness on the physical and mental health of all family members. Children who are homeless are sick twice as often as other children, with higher rates of asthma and ear infections. These children are twice as likely to experience hunger and 4 times as likely to have developmental delays.[14] Children who are homeless also experience more mental health problems, such as anxiety, depression, and withdrawal. Nearly 1 in 3 children who are homeless have at least 1 major mental health disorder that interferes with daily activities compared with nearly 1 in 5 school-aged children who are not homeless.[15]

Children experiencing homelessness experience significantly more stress than housed children.[16] Over two-thirds of homeless mothers surveyed reported that their children had experienced an "at-risk" number of stressful events during the last 3 months, including parents divorcing or permanently separating, changing schools, witnessing violence, and being hospitalized. Exposure to trauma and stress, coupled with the experience of homelessness, is strongly associated with the emotional problems seen in these vulnerable children.[17]

Mothers suffer the ill effects of homelessness and poverty as well. In one longitudinal study, researchers found significant changes in the health of mothers who were homeless, with increased reporting of major depressive symptoms as well as poorer physical health.[18] Nearly one-third reported current chronic health conditions, including asthma, anemia, and ulcers—an especially disturbing statistic in light of the fact that the average age of these mothers was 27 years.[19] In addition, researchers found that one-third of the women surveyed reported having made at least 1 suicide attempt.[19]

Mothers experiencing homelessness report lifetime exposure to many of the same stressful events to which their children are exposed. These include their own childhood exposure to violence, recent divorce or separation from their spouse, and witnessing or being the adult victim of violence. In fact, some researchers have reported that up to 92% of homeless women have experienced severe physical and/or sexual assault at some point in their lives.[18,19]

Cultural context of Appalachian health

The geographical area of the United States currently defined as Appalachia comprises a 200 000-square-mile region that extends from southern New York to Mississippi.[20] However, outward migration from the Appalachian region began in the last decade of the 19th century as Appalachian residents left the area in search of economic opportunities not found in the region.[21] This migration spread Appalachians, and their culture, to many parts of the country, including many of the cities of the Midwestern United States.

Beliefs and practices rooted in Appalachian culture have consequences for the maintenance of health and prevention of disease. Denham[22-24] conducted a series of ethnographic research studies with families living in an Appalachian area of southeast Ohio and discovered that Appalachian mothers were the primary health care resource for the family, acting as gatekeepers as well as care providers. Health was seen as a holistic combination of physical, emotional, social, spiritual, and ecological dimensions, with an emphasis placed on family rather than individual health.

Despite previous descriptive and epidemiologic studies exploring the effect of homelessness on the health of mothers and children, and culture care knowledge related to individuals experiencing homelessness, there is a distinct gap in knowledge regarding the influence of *culture* on the experience of *family* homelessness. Yet, provision of congruent transcultural nursing care to African American and European American Appalachian families experiencing homelessness must be built on an understanding of their care meanings, expressions, and practices within a cultural context.

Health and human rights

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, set forth what has now become a widely accepted summary of basic human rights.[25] This document was based on a universal recognition of the inherent dignity and equal and inalienable rights of all members of the human family. In essence, human rights represent a common inheritance of universal values that transcend cultures and traditions.[25] Article 25 of this declaration speaks to human rights at their most basic level:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (Article 25, 1)

These are the rights to which we are all equally entitled, without discrimination. However, human rights entail both rights and obligations. Although each is entitled to his or her own indivisible human rights, respecting the human rights of others is also required. This sometimes includes the need to remind those in power of their responsibility to take positive actions to facilitate each citizen's human rights are fulfilled. Through close examination of the social processes and inequities that enhance vulnerability, one finds that the actions that influence vulnerability result from a lack of access to and respect of basic human rights that simply should not be negotiable.

"Respecting human beings from a spiritual, cultural, and holistic perspective, while caring for them, is essential for human care and caring."[4] Health, human rights, and culture are inextricably linked. The right to health is closely related to and dependent on the realization of other rights. These rights include the right to be treated with respect and human dignity, informed by cultural knowledge.

Vulnerability, marginalization, and stigma

The words "vulnerable" and "vulnerability" stem from the Latin word *vulnus*, which means "wound."[26] *The Merriam-Webster Dictionary* defines *vulnerability* as the capability of being physically wounded; open to attack or damage.[27] Vulnerability is influenced by the interrelationship of multiple factors that act in an additive or even multiplicative way to increase risk for poor health outcomes. Certain groups within our society, such as those experiencing homelessness, have traditionally been seen as being at even greater risk, or more vulnerable, to poor health and health care outcomes, and therefore are categorized as vulnerable populations.[28,29]

Members of vulnerable populations often lack the necessary physical capabilities, educational backgrounds, or financial resources to adequately safeguard their own health.

Marginalization is a social process through which a person or group is peripheralized on the basis of identity, associations, experiences, or environment.[30] To marginalize someone is to treat them as if he or she is of little or no consequence, or is unimportant. The marginalization of certain groups conveys the idea that individuals in those groups do not matter or are of little concern to the rest of society. Often group differences, such as gender, ethnicity or race, education or income, geographic location, or sexual preference contribute to marginalization. Women, racial and ethnic minorities, and persons living in poverty are examples of groups who have a long history of marginalization within our society.[31]

Marginalization is exclusionary and isolating and denies a person his or her human rights. As a result, this process can lead to negative health outcomes and therefore contribute to vulnerability. It can limit an individual's or group's opportunities for establishing beneficial relationships necessary for accessing health care services. In addition, those who are marginalized can experience heightened levels of stress and despair related to their sense of powerlessness.[31] Historically, many if not all of the groups designated as vulnerable populations have been marginalized within larger society.

Stigma can be thought of as a characteristic of person or group of persons that is contrary to those characteristics of the larger group. Stigmatized individuals either possess, or are believed to possess, some attribute that is not valued in a particular social context.[29] For example, in many societies, mental illness is seen as a stigmatizing characteristic because it sets those individuals who have a mental illness apart from those who are perceived as being "normal."

Stigma can also be seen as a relationship between an attribute of a certain group and a stereotype. A stereotype is an exaggerated, usually negative, belief or image applied to an entire category of people. Members of vulnerable populations who are stigmatized experience loss of status within society, which can then result in discrimination. Discrimination is the differential and negative treatment of an individual based on their race, ethnicity, gender, socioeconomic status, or other group membership. This discriminatory treatment leads to further stigma and further loss of status, thus perpetuating a cycle that enhances vulnerability and marginalization, which is once again, beyond the control of the individual.

Stigma and discrimination are social processes that can impact the health and health care of vulnerable populations. A great deal of stress is associated with the constant threat of being stigmatized.[29] As a result of these forces, individuals and groups are also placed at a distinct social disadvantage with regard to resources such as knowledge, money, power, prestige, and social connections, thus adding to their risks and level of vulnerability to negative health and health care outcomes.[30,31] In addition, when people are seen as responsible for their life circumstances, such as in the case of individuals with substance use disorders, unwed mothers, or prisoners, there is less public compassion and the perception that these individuals contributed to their own vulnerability can result in further stigmatization for other members of these groups.[31] The extent to which a stigmatized person is denied access to the basic necessities of living, such as housing and food, has been posited as a source of chronic stress, with consequent negative effects on mental and physical health.

THEORETICAL FRAMEWORK

Cultural differences and commonalities about human care exist among all cultures and subcultures of the world and their discovery can be used to guide nurse care decisions and actions beneficial to clients' health.[4] The purpose of this study, conceptualized within

Leininger's *Theory of Culture Care: Diversity and Universality*, was to discover, describe, and systematically analyze universal and diverse care meanings and expressions of mothers caring for their children in an urban homeless shelter.

DESIGN

The goal of qualitative research is to document and interpret as fully as possible the totality of an experience and its particular context from the emic perspective of the people.[32] Therefore, a qualitative research design was selected to identify the care meanings and experiences of family homelessness and its relationship to health as expressed by Appalachian mothers. The ethnonursing research method was used to guide this exploration.

Ethnonursing research method

The ethnonursing research method was specifically designed by Leininger to facilitate the discovery of data focused on the theory of Culture Care Diversity and Universality.[33] The term *ethnonursing* was developed in relation to the Greek word *ethos,* which refers to "the people" or culture with their lifeways, and the word *nursing*, which reflects the focus of the research on nursing phenomena concerned primarily with the humanistic and scientific aspects of human care, wellbeing, and health in different environmental and cultural contexts.[34] The method focuses on naturalistic, open, and inductive modes of knowledge discovery. When conducting an ethnonursing study, the researcher's goal is to discover the worldview, attitudes, meanings, and experiences of the people so that truths and realities can be known. Emic or local information serves as a baseline of knowledge, in contrast with etic or more universal views and explanations of nursing, care, health, and illness phenomena.[32] By comparing emic and etic perspectives, universal and diverse care meanings can be discovered. In this study, emic perspectives were provided by key participants—the mothers experiencing homelessness. Etic perspectives were gained through interviews with general participants. Throughout this discovery, the researcher sought to uncover cultural and social structure factors that influenced the way that mothers experiencing homelessness view, provide, and expect care.

Several ethnonursing research guides[33] were used to enable the researcher to conduct the ethnonursing research in an organized, systematic, and effective manner. Leininger developed these guides to support researchers as they seek cultural knowledge. The Sunrise Enabler, a model depicting various areas influencing care expressions, patterns, and practices for a group of people, served as an overall guide for discovering the meanings, patterns, and practices of care of the mothers. These influencers include religious, philosophical, kinship, and social factors, along with the cultural values and beliefs. An inquiry guide, consisting of open-ended questions, was used by the researcher to give direction to the discussions with key participants and to gain information related to the domain of inquiry of the study.

Leininger's[34] Stranger to Trusted Friend Enabler was used to support the researcher's efforts to establish and maintain the trust of the Appalachian mothers staying at the shelter. When conducting a research study using the ethnonursing method, it is important that the researcher earn the trust of the group whom they wish to learn from to obtain authentic, credible, and dependable data.[33] In using this guide, the researcher assesses various indicators while moving from the role of stranger to that of a trusted person with whom the participant establishes a sharing relationship. During the period of observation, prior to initiation of interviews, the researcher spent time with the mothers to study their experiences in relation to nursing care phenomena in a systematic and reflective way.[34] Observations of the mothers and children were made at the day center of an urban homeless shelter and in the surrounding community because the researcher accompanied them on walks. She also traveled by bus with the families from the day center to and from area churches where the families and the researcher were provided food and beds each evening. The researcher also accompanied mothers as they took children to and from daycare, enrolled for various social services, and as they searched for housing and employment. Finally, the researcher spent time visiting with mothers after they left the shelter and moved into housing. According to Leininger,[34] the researcher develops skills in human care meanings, expressions, patterns, and general care experiences from the emic world of the people through participation in these experiences.

METHODS

Participants

Twelve mothers residing in an urban homeless shelter with their children were purposefully selected as key participants for the study. Mothers enrolled in the study self-identified as either African American (n = 6) or European American (n = 6) and were determined to be either a first- or second-generation Appalachian. Appalachian ethnicity for each mother was established using guidelines issued by the Appalachian Regional Commission[35] and was based on an Appalachian county of birth for the mother (first generation) or either of her parents (second generation).

Mothers who participated in the study ranged in age from 20 to 48 years of age, had an educational background from tenth grade to a 2-year college diploma, and had 1 to 5 children between the ages of 2 months to 15 years living with them in the shelter. Before entering the shelter, mothers lived with their children in their own apartment or house, "doubled-up" with family or friends, or in a car. Two of the mothers enrolled in the study were first-generation Appalachians. The remaining 10 mothers were second-generation Appalachians.

Twenty-three individuals familiar with family homelessness, but who were not currently experiencing homelessness, were enrolled as general participants. These participants included formerly homeless mothers, shelter staff and volunteers, nurses, and local and national experts on homelessness. According to the ethnonursing research method developed by Leininger,[33] general participants enhance the credibility of the findings and provide contextual information.

Setting

Research was conducted at the shelter day center of a faith-based program run by a nonprofit agency dedicated to providing shelter to families experiencing homelessness in a large Midwestern city. This program, 1 of only 2 in the area that allow families with men and older boys to remain together, enrolls families for an initial 30-day period. Once processed into the program, families attend mandatory classes, receive case management services, have access to laundry and shower facilities, and the use of a telephone and postal services. A transportation van is available during the day to take families to and from various appointments. At the end of the day, families board a bus that transports them to participating religious congregations across the metropolitan area. At these facilities, families are provided dinner, a sleeping area, and breakfast the following morning, after which they return on the bus to the day center to prepare children for school and daycare.

Data collection

Consistent with the ethnonursing method, the researcher became immersed within the culture of the participants to gain thick, rich, and credible data. This included spending time with mothers while they were at the day center playing with their children, doing laundry, eating, or attending classes. The researcher also spent time with the mothers outside the day center, riding in the shelter van as they took their children to and from school or daycare, riding the shelter bus to overnight accommodations at area churches, eating meals and sleeping at the churches, and accompanying them as they sought housing, jobs, health care, and social services. Key participants were interviewed individually from 2 to 4 times, for a period of 1 to 2 hours per interview. Digitally recorded interviews were held at times that were convenient for the mothers and took place in a private office at the day center or in private locations during overnight stays at various churches.

General participants were interviewed once each for approximately 1 hour. Some of these interviews took place at offices of local and national experts on homelessness, on shelter transportation vans and buses not in use, in restaurants, at the day center, and in homes of mothers who were formerly homeless.

At the conclusion of each interview session, field notes and digital recordings were transcribed verbatim into narratives by a professional transcriber who signed a confidentiality agreement prior to transcription of the data. All personal identifiers were removed from the data and a participant code was assigned to protect confidentiality, yet allow for follow-up interviews.

Ethics

Approval for the study was obtained from the university institutional review board. Considering the vulnerability of this population, strategies were developed to minimize any potential harm, specifically in the area of coercion and confidentiality. Enrollment in the study was completely voluntary. Mothers were provided a small monetary compensation for their time, with the compensation amount determined on the basis of conversations with the shelter director and a group of mothers staying at the shelter who assisted the researcher during the planning phase of the study. The identity of mothers choosing to participate was kept confidential from shelter staff to reduce the potential for staff coercion to enroll or enrollment due to perceived advantages in access to program resources.

DATA ANALYSIS

Data analysis proceeded through Leininger's[34] phases of ethnonursing qualitative data analysis (*a*) collecting, describing, and documenting the raw data; (*b*) identifying and categorizing descriptors; (*c*) identifying patterns and contextual analysis; and (*d*) identifying major themes and theoretical formulations.

Separate analyses of the African American and European American participants' transcripts were conducted through the first 3 phases of the analysis process. Once these analyses were completed, the identified patterns and contextual analysis for each group were compared, resulting in identification of 3 universal care themes and 2 diverse themes. This systematic analysis process allowed the researcher to tease out the patterns and themes that reflected culture care beliefs of mothers caring for their children within the context of family homelessness.

Evaluation of data was completed throughout the study using Leininger's[34] criteria for ethnonursing qualitative research, which are as follows: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. By adhering to these criteria, the researcher was able to arrive at more accurate and credible findings, thus allowing the findings presented in the next section to contribute to the body of transcultural nursing knowledge related to the domain of inquiry.

FINDINGS

Three universal themes were discovered during this ethnonursing exploration. Universal themes were identified on the basis of the recurrent, observed, and expressed similarities or commonalities between each of the African American Appalachian and European American Appalachian mothers experiencing homelessness. Within each of these themes is embedded cultural knowledge illustrating the intersection of health, human rights, and the experience of homelessness.

Enduring threatening lifeways before coming to the shelter . . .

Each of the mothers spoke of struggling through threatening lifeways while attempting to provide care for their children in the days before coming to the shelter. These challenges included job loss due to illnesses and the instability of caring and noncaring relationships with family and friends with whom they sought housing. For many of the families, the downward spiral toward homelessness often began with a family illness—either for the mother or for one of her children. One mother of 3 teenage children was working 2 jobs to keep her family housed when her 14-year-old son developed significant mental health issues. Not having any sick leave available, she was forced to choose between taking her son to counseling appointments and going to work. In her words, "I made the only choice any good mother could make." Because of this mother's choice to seek care for her son, she lost both jobs and the family was unable to pay their rent. Eviction from a home that was "an important part of our family's identity" soon followed.

Caring for one's family is an expectation within the Appalachian culture. Extended family members provide caring when mothers or fathers are unable or unwilling to do so. Each of the mothers interviewed described childhood memories associated with this familial caring "Growin' up, that's how we tell each other . . . that's all we got. When times get rough, family got your back."

Because of this expectation of care, mothers felt betrayed when they were unable to count on family and friends to provide caring and support to them and their children during the period of homelessness. Being turned out by family members represented an almost unbearable injustice. Painful memories of these events remained with them months after entering the shelter:

> It's really hard, 'cause obviously it hurts more since it was my niece who put us out. She put us out in that really bad snowstorm last month. There was so much snow and it was so cold. It's not so much that she put me out, but it's like 'how could you do that to my child?'

Struggling to earn the respect of self and others . . .

For the mothers participating in this study, the experience of homelessness represented a temporary loss of self and a challenge to her human dignity. Mothers struggled to maintain self-respect and a sense of identity apart from the experience of homelessness. Coming to the realization that she was experiencing homelessness, but was not defined by that experience, and that she was a person of value, was an important step in a mother's adjustment to her situation.

> I never thought I'd be in a shelter, but it happens. I tried my best to work it out on my own, but I wasn't getting nowhere, so I decided I had to ask for help. That doesn't make me less of a person.

Each of these women insisted that she and her children were not homeless; that they had somewhere to sleep, food to eat, and a "place to be together as a family"—their definition of a home.

A person's sense of self-respect is influenced through interactions with others, and the respect, or disrespect, communicated during those encounters. A fundamental culture care need expressed by all mothers was the need for respect: "The way I want people to treat me and the way I should treat myself is with respect. People need to give the gift of respect to themselves and to others."

Our sense of self-respect is also shaped through the successes and failures in our daily lives. The roles in which a person feels competent and successful can increase feelings of self-worth, whereas the ones in which they feel less competent lead them to question themselves. The source of self-respect most often discussed by all of the women participating in this study was through their role as mothers. One mother stated, "My child is the best thing about me, he is my reason for being here. Being his mother makes me want to do better by myself so that I can do better by him."

Being respected in their mothering role by all those with whom they interacted was also seen as an important part of care for these women. Any challenge to a mother's perception of self as a "good mother" was viewed as noncaring and nonsupportive to the health and well-being of her family. When a mother felt that she had somehow been shown or seen by others as unable to care for her children properly, she suffered a loss of self-respect.

Earlier experiences of disrespect and discrimination related to their lack of economic resources had left an impression in the lives of these mothers who were struggling to overcome their current situation of homelessness. Several mothers spoke of previous noncaring, judgmental encounters with health care providers:

> There were incidents when I was pregnant with him, where, you know the fact being pregnant at my age, "You're 17 and you're havin' a kid, what's wrong with you? Where did you go wrong? Do you want to be a welfare mom all your life?"

Accessing prenatal care, even in an area known for high infant mortality rates, revealed judgment:

> This one doctor, he comes in to check me, and he's looking at me, and he notices the tattoos I have on either side of my lower stomach, and he says to me "maybe if you wouldn't decorate yourself like that, you wouldn't be in this situation."

Mothers reflected concerns that they would be judged by others and face additional discrimination and stereotyping because of their current situation of homelessness:

> Sometimes, it gets real hard to accept help. It just is getting' harder and harder, 'cause I shouldn't have to feel like I'm lesser than a person because I'm in here. People look at me like, "Well you're just lazy, you're just making up an excuse to get out of workin."

> Some people we deal with, they look at us with their nose stuck up in the air like, "ooh, these homeless people, they are just so dirty and we just don't want to touch them." It puts you in a real awkward situation, 'cause you be needin' help, but you sure don't want to accept help from people who are lookin' down on you.

Each mother went to great lengths to explain to the researcher all the reasons they should not be classified as homeless. This passionate defense of their status was related to knowledge of the societal stigma associated with homelessness and those experiencing it, and their fears of being seen as incapable of caring for their children, placing them at risk of losing the very source of their identity:

> None of us are homeless. I don't like that word because that is not who we are. We can take care of our children. We have somewhere to be. We have enough strength in us to come in and do what we needed to do, so we weren't out there under a bridge. We came in here so that we could maintain our lives, and our children's lives, in the best way that we could.

> Our kids, they are all in day care and school. They still go to school. It's not, I mean, when you hear the word "homeless," you picture your kids being taken away and being awarded to the state.

Remaining emotionally and spiritually strong while facing challenges of shelter living and an uncertain future . . .

Although mothers entering the shelter no longer faced the threatening lifeways associated with finding housing and food for their children, they were left to face new challenges associated with shelter living and the search for stable housing and jobs. Remaining strong was seen as crucial in providing the support their children needed during this difficult time and in teaching their children the meaning of strength:

> This is a lesson I am teaching my children—a lesson in how to survive and be strong. As they see me fall, and we all do fall, they also see me stand back up, and work to make it better than it was before. They see that I never stay down, I never give up.

An important source of strength for this group of Appalachian mothers was their belief in God. Through their spiritual beliefs, mothers found meaning in their current situation, seeing this experience as yet another of life's lessons. Through their faith, mothers found a sense of hope that allowed them to endure daily challenges while looking toward the future:

> I believe that everything happens for a reason, to teach you life lessons, and in the end, this is just a big lesson that I have to learn. I believe that, you know, there is a God, and He will do what He has to do to make sure that you make it through things like this.

DISCUSSION

Mothers face challenges and cultural incongruence when providing care for their children within the context of family homelessness. Threatening lifeways experienced during the period before entering a shelter can have lasting impacts on the health and well-being of all family members. Supporting families during this vulnerable transition period through delivery of respectful care informed by recognition of the inherent dignity of each mother and child is vital.

IMPLICATIONS FOR RESEARCH AND PRACTICE

The interaction between the nurse and client occurs within the context of the values, beliefs, and experiences of each. Professional nursing has a contract with society to provide culturally competent, individualized care for patients of all ages who have varied cultural, ethnic, and religious orientations.[36] Providing this type of care requires an understanding of each person's unique social context, such as the experience of family homelessness.

In planning interventions targeting identified needs of various vulnerable populations, it is imperative that health care providers understand their needs and perspectives rather than imposing our own interpretation. Nurse researchers are uniquely positioned to partner with vulnerable populations through scholarly inquiry to (*a*) determine needs; (*b*) identify resources available for meeting health needs; (*c*) plan effective interventions aimed at improving health outcomes; and (*d*) evaluate both the processes and outcomes associated with existing programs.

The American Nurses Association Code of Ethics[37] calls on all nurses to fulfill the role of advocate on behalf of those for whom we provide care. None are more in need of our advocacy than those who are vulnerable. Members of vulnerable populations have few resources, so they are uniquely dependent on social and public policy to develop and implement programs that meet their basic needs. Through their direct contact with vulnerable groups, nurses are in a position not only to be aware of the needs of vulnerable populations, but also to take action through advocacy efforts on behalf of those individuals and populations. Nurses function in the role of advocate through communication with those who create such policy, at both the local, state, and national levels.

All those who work with families experiencing homelessness must examine and repattern their own practices to reflect an understanding that these individuals are not defined by their experience. As reflected in the words of the mothers participating in this study, treating them in this manner is viewed as a noncaring expression that diminishes their self-worth and human dignity; therefore, such care will not have the desired outcome of promoting their health and well-being.

When asked how they would define health, each of the mothers participating in the study described health as a holistic way of being that included having a place to live. According to Noddings,[38] what individuals who are homeless need most are homes, not halfway measures. She goes on to state that "increasing numbers of people in our country have become specialists in dealing with the homeless."[38(445)] Although nurses and other health care providers should continue delivering health care services to families and individuals who are homeless, they also must move their advocacy efforts beyond the traditional scope of service provision and into the arena of public policy related to housing and employment reform. From this perspective, culture care for mothers who are homeless, and all mothers living in the United States, means (*a*) having access to safe, affordable housing; (*b*) having access to employment opportunities that provide a living wage; and (*c*) having access to affordable, quality childcare for working families.

CONCLUSION

The universal care need for respect and recognition of their worth as human beings was expressed by Appalachian mothers in this study and embedded as a pattern within each of the universal themes. Each of these mothers faced experiences of discrimination and prejudice, both before and during the event of homelessness, which went on to cloud their vision of the future. These experiences had denied them their inalienable human rights.

Care provided for families who are homeless must be based on an understanding of their unique situation and the contextual factors that contribute to their experience. Women who are guiding their families as they navigate homelessness need to be respected and supported in their roles as mothers and valued for the strength and dignity they have shown while enduring challenging life experiences.

REFERENCES

1. National Alliance to End Homelessness, State of Homelessness in America 2011. http://www.endhomelessness.org/content/article/detail/3668. Published January 2011. Accessed September 12, 2011.
2. US Conference of Mayors. Hunger and Homelessness Survey. http://www.usmayors.org/. Published December 2010. Accessed June 15, 2011.
3. Obermiller P, Wagner T, Tucker B. *Appalachian Odyssey: Historical Perspectives on the Great Migration*. Westport, CT: Praeger; 2000.
4. Leininger M, McFarland MR. *Culture Care Diversity and Universality: A Worldwide Nursing Theory*. 2nd ed. Sudbury, MA: Jones and Bartlett Publishers; 2006.
5. Rog D, Buckner J. Homeless families and children. In: Dennis D, Locke G, Khadduri J, eds. *National Symposium on Homelessness Research*. Washington, DC: US Department of Health and Human Services. http://aspe.hhs.gov/hsp/homelessness/symposium07/rog/index.htm. Published March 2007. Accessed July 20, 2008.
6. Toro PA, Trcikett EJ, Wall DD, Salem DA. Homelessness in the United States. *Am Psychol*. 1991;46:1208-1218.
7. National Center on Family Homelessness. The characteristics and needs of families experiencing homelessness. http://www.familyhomelessness.org/media/278.pdf. Published June 2011. Accessed July 5, 2011.
8. Nichols L, Gault B. The implications of welfare reform for housing and school instability. *J Negro Educ*. 2003;7(2):104-116.
9. US Census Bureau. Income, poverty, and health insurance in the United States: 2010. http://www.census.gov/hhes/www/poverty/data/incpovhlth/2010/index.html. Published September 13, 2011. Accessed October 1, 2011.
10. Kilty KM, Segal EA. *The Promise of Welfare Reform: Political Rhetoric and the Reality of Poverty in the Twenty-first Century*. New York, NY: Haworth Press Inc; 2006.
11. Hilfiker D. *Urban Injustice: How Ghettos Happen*. New York, NY: Seven Stories Press; 2002.
12. Massey DS, Denton NA. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge, MA: Harvard University Press; 1993.
13. Sugrue TJ. *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit*. Princeton, NJ: Princeton University Press; 1996/2005.
14. Bassuk EL, Buckner JC, Weinreb LF, et al. Homelessness in female-headed families: childhood and adult risk and protective factors. *Am J Public Health*. 1997;87:241-248.
15. National Child Traumatic Stress Network. Facts on trauma and homeless children. http://www.nctsnet.org/sites/default/files/assets/pdfs/Facts_on_Trauma_and_Homeless_Children.pdf. Published 2005. Accessed July 10, 2008.
16. Davey TL. Homeless children and stress: an empirical study. *J Soc Distr Homeless*. 1998;7(1):29-40.
17. Harpaz-Rotem I, Rosenheck RA, Desai R. The mental health of children exposed to maternal mental illness and homelessness. *Community Ment Health J*. 2006;42(5):437-448.
18. Bassuk E, Weinreb L, Buckner J, Browne A, Solomon A, Bassuk S. The characteristics and needs of sheltered homeless and low-income housed mothers. *J Am Med Assoc*. 1996;276(8):640-646.

19. Weinreb LF, Buckner JC, Williams V, Nicholson J. A comparison of the health and mental health status of homeless mothers in Worcester, Mass: 1993 and 2003. *Am J Public Health*. 2006;96(8):1444-1448.
20. Appalachian Regional Commission (ARC). The Appalachian region. http://www.arc.gov/appalachian_region/TheAppalachianRegion.asp. 2011.
21. Obermiller PJ. Introduction. In: *Down home, downtown: Urban Appalachians today*. Dubuque, IA: Kendall/Hunt Publishing Co; 1996:1-10.
22. Denham SA. The definition and practice of family health. *J Fam Nurs*. 1999;5:133-159.
23. Denham SA. Family health: during and after death of a family member. *J Fam Nurs*. 1999;5:160-183.
24. Denham SA. Family health in an economically disadvantaged population. *J Fam Nurs*. 1999;5:184-213.
25. United Nations. Human rights. http://www.un.org/en/rights/. Published September 2011. Accessed October 3, 2011.
26. vulnus. In: *Oxford Latin Dictionary*. Oxford, UK: Oxford University Press; 2004.
27. vulnerability. In: *Merriam-Webster Online Dictionary*. http://www.merriam-webster.com/dictionary/vulnerability. Published 2010. Accessed July 20, 2010.
28. Blackshier E. On being poor and feeling poor: low socioeconomic status and the moral self. *Theoret Med.* 2002;23:455-470.
29. Link BG, Phelan JC. Stigma and its public health implications. *Lancet*. 2006;367:528-529.
30. Shi L, Stevens GD. Vulnerability and unmet health care needs: the influence of multiple risk factors. *J Gen Intern Med*. 2005;20:148-154.
31. Aday LA. *At risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States*. 2nd ed. San Francisco, CA: Jossey-Bass; 2001.
32. Leininger M. *Qualitative Research Methods in Nursing*. Philadelphia, PA: WB Saunders Co; 1984.
33. Leininger M, McFarland MR. *Transcultural Nursing: Concepts, Theories, Research, and Practice*. 3rd ed. New York, NY: McGraw-Hill; 2002.
34. Leininger M. *Culture Care Diversity and Universality: A Theory for Nursing*. New York, NY: National League for Nursing Press; 1991.
35. Appalachian Regional Commission. Counties in Appalachia. http://www.arc.gov/counties. Published 2011. Accessed September 4, 2011.
36. American Nurses Association. *Nursing's Social Policy Statement*. 2nd ed. Maryland, MA: American Nurses Association; 2003.
37. American Nurses Association. *Guide to the Code of Ethics for Nurses: Interpretation and Application*. Maryland: American Nurses Association; 2008.
38. Noddings N. Caring, social policy, and homelessness. *Theoret Med*. 2002;23:441-454.