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Perceived Competency and Resolution of Homelessness Among Women with Substance Abuse Problems

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Abstract

Using a metasynthesis approach, our aim was to articulate new insights relating to the most efficient and effective means of helping homeless women with substance abuse problems to enhance their well-being and become more stably housed. Distorted perceptions of competency, which are shaped by dysfunctional relationships and mental health problems, make it challenging for women with substance abuse problems to resolve homelessness. Women with particularly low or high levels of perceived competency tend to grapple with challenges related to structure and control, trust, and hopelessness. Therapeutic strategies for approaching these women include careful assessment, caring, personalized structure and control, development of interpersonal trust, instillation of hope, and the targeted use of psychotherapeutic agents and counseling. Framing care for homeless women within the context of perceived competency offers a new way of understanding their plight and shaping interventions to more expeditiously move them toward healthy and stable lives.

Keywords

addiction/substance use; homelessness; metasynthesis; poverty; women's health

Despite evidence of relative prosperity in some places, homelessness remains a problem in many locales. Homelessness in Canada is estimated to range from 150,000 to 300,000 (Intraspec.ca, 2010), and in Australia the numbers are thought to hover around 105,000 (Australian Bureau of Statistics, 2008). Over the course of a year, it is estimated that 1,593,150 individuals in the United States experience homelessness. Of that number, 605,397 (38%) are believed to be women (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). Reasons for homelessness among women include a lack of jobs and public assistance funds and a coinciding increase in poverty and home foreclosures. Other exacerbating problems among women include domestic violence, mental illness, substance abuse, and a commensurate lack of affordable treatment programs (Human Resources and Skills Development Canada [HRSDC], 2010; National Coalition for the Homeless [NCH], 2009).

Moving homeless women into stable housing can be challenging when substances of abuse such as alcohol, cocaine, and heroin are involved. Among a sample of homeless women from three Canadian cities, 82% (N = 193) were found to have at least one type of substance

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abuse disorder (Torchalla, Strehlau, Li, & Krausz, in press). In the United States, it is estimated that women comprise one-fifth of the homeless who are admitted to substance abuse treatment facilities. About half of these individuals report between 1 and 4 prior treatment episodes, and 20% report 5 or more treatment experiences (SAMHSA, 2004). Given these recidivism rates, efforts to systematically examine and fine-tune assistance programs for homeless women with substance abuse problems are needed (O'Campo et al., 2009).

We conducted the current metasynthesis following a prior investigation in which the process of becoming homeless, being homeless, and resolving homelessness among persistently homeless women was investigated. Based on findings from that study, it appears that becoming and being homeless are likely to involve maladaptive experiences of interpersonal abuse, neglect, and/or abandonment; all of which might be fueled by the psychic instability and/or immoral proclivities of close associates. Other contextually-permeating factors include circumstantial poverty and transience; and social service system barriers. These barriers appear to extend beyond mere problems of availability and accessibility. Of particular note are intangible impediments pertaining to trust and the overall integrity of the system (Finfgeld-Connett, 2010a).

Based on findings from this same metasynthesis (Finfgeld-Connett, 2010a), it was also concluded that resolving homelessness among a heterogeneous group of persistently homeless women involves cyclic stages. These women tend to seek assistance when crises occur, but they remain vulnerable to homelessness. It is not unusual for persistently homeless women to repeatedly engage-disengage-engage with the social service system prior to making sustained efforts to become stably housed. The cyclic nature of this process prolongs the resolution of homelessness and is attributable, at least in part, to substance abuse problems (Burlingham, Andrasik, Larimer, Marlatt, & Spigner, 2010; Finfgeld-Connett, 2010a). The specific purpose of this investigation was to articulate new insights relating to the cyclic process of resolving homelessness among adult women with substance abuse problems.

Methodology

Qualitative Metasynthesis

Qualitative metasynthesis, as outlined by Finfgeld-Connett (e.g., 2009a–b, 2010a), was used to conduct this investigation. This method was inspired by the work of Noblit and Hare (1988), Miles and Huberman (1994), and the grounded theory approaches of Corbin & Strauss (2008) and Strauss and Corbin (1990). Qualitative metasynthesis does not involve data aggregation or any other quantitative method. It is not a secondary analysis of raw qualitative data, nor is it a type of meta-analysis. Metasynthesis is a methodology in which qualitative findings from existing research reports are systematically acquired and qualitatively analyzed and synthesized (Finfgeld, 2003; Finfgeld-Connett 2010b). Qualitative metasynthesis results in novel interpretations of qualitative findings that cannot be identified in original research reports (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004).

Within the context of metasynthesis research, validity is not dependent on the logic of replication (Thorne et al., 2004); rather, it is based on trustworthiness (Lincoln & Guba, 1985). One way that trustworthiness is established is through transparent data collection, extraction, and analysis methods (Finfgeld, 2003). To this end, these iterative processes along with other ways of enhancing trustworthiness are described in the following paragraphs.

Sample

There is some overlap (n = 23) between the reports that comprise the database for this study (N = 60) and a prior investigation (N = 45; Finfgeld-Connett, 2010a), however, with the help of an expert reference librarian (third author E. Diane Johnson), the pool of potential research reports was greatly expanded for this study. In addition, unlike the prior investigation, research reports were excluded if substance abuse issues were not addressed.

Electronic databases that were searched included Cumulative Index to Nursing and Allied Health Literature (CINAHL), ETOH Archival Database, GenderWatch, Google Books, Ovid MedLine, ProQuest Dissertations, PsycINFO, Scopus, and Social Work Abstracts. Customized search strategies, such as the example in Table 1, were used to maximize the potential of each unique database and to exclude reports such as those that pertained solely to children, adolescents, and men, or those that were not conducted using qualitative methods. These tailored search strategies resulted in more than 5,500 English language citations, with unavoidable duplication across databases.

A cursory review of each citation title and abstract was conducted to further eliminate publications that were clearly not reports of qualitative research relating to homeless women. This resulted in the identification of 90 promising reports that were subsequently secured for further evaluation. Thirty of these were eliminated for one or more reasons. For example, findings relating to substance abuse could not be identified, or findings relating to women could not be separated from those pertaining to men, or findings relating strictly to homeless women could not be isolated from those associated with low income women. In total, 60 reports of qualitative research, dating from 1990 to mid 2010, comprised the sample for this investigation. This number consisted of 30 published peer-reviewed articles, 7 books, and 23 theses/dissertations.

Data Extraction, Analysis, and Synthesis

To avoid potential theoretical bias, grounded theory process concepts (e.g., antecedents, attributes, outcomes, and interrelationships among constructs; Corbin & Strauss, 2008) were the only theoretical foundations that were used for data analysis. Coding structures from a prior investigation (Finfgeld-Connett, 2010a) were not used to guide data analysis because the foci of this study and that one differ.

A data collection form that was adapted from Finfgeld-Connett (2010a) was used to gather information pertaining to each study such as aim/purpose, theoretical framework, methods, and sample. This information was used throughout the data analysis process to provide context. When available, information relating to substance abuse treatment strategies was also gathered, however, the utility of these data was limited because they were inconsistently reported across studies.

Each research report was carefully read, and the findings were highlighted. In keeping with metasynthesis methods, findings were limited to researcher interpretations rather than raw data such as quotations (Finfgeld, 2003; Finfgeld-Connett, 2010a). To avoid bias, all interpreted findings, regardless of how they compared with the researchers' preconceived ideas, were extracted from the original research reports and placed into data analysis matrices for coding and categorizing.

Concrete and in vivo codes were initially used to insure a firm grounding in the data. To further insure well-grounded results, metaphorical coding was carried out in small iterative and reflexive steps. Subsequently, memos were iteratively and reflexively composed and revised to clearly articulate singular codes, explicate abstract categories, and delineate links among concepts (Finfgeld-Connett, 2010a).

Memos were gradually translated into provisional lines of argument and continually evaluated against the original data to assess for truthfulness and fittingness with associated findings. This reflexive and iterative process continued until conceptual clarity was achieved and the core concept of perceived competency was fully articulated (Finfgeld-Connett, 2010a; Corbin & Strauss, 2008; Noblit & Hare, 1988).

Trustworthiness

In addition to using transparent and iterative data collection, extraction, and analysis methods; trustworthiness of the findings was enhanced in the following ways. First, instead of vetting research reports in their entirety for quality, each finding was evaluated based on its credibility and fittingness within the emergent findings (Pawson, 2006). This approach is consistent with the fact that no known valid method currently exists for establishing the overall quality of qualitative research based on written reports (Centre for Reviews and Dissemination, 2009).

In the end, only those findings that lacked support within the context of the current investigation were excluded from further consideration. This is in contrast to rejecting all findings from an entire research report based on the way that a study is presented or written. For example, because research reports as old as 20 years were included in the database, each finding was carefully vetted for currency. In large part, findings relating to the topic under investigation transcended time. Findings that did not were excluded from further analysis. These included time-sensitive findings pertaining to treatment funding and public policy initiatives.

In terms of trustworthiness, it is notable that several forms of triangulation are inherent to metasynthesis. This relates to the fact that findings from multiple qualitative investigations comprise the database. Forms of triangulation that were relevant to this investigation, included multiple research frameworks (i.e., phenomenology, ethnography, grounded theory, and so forth), sampling methods, data analysis methods, and researchers (Finfgeld, 2003; Finfgeld-Connett, 2010b).

In the case of this metasynthesis, trustworthiness was also enhanced by the fact that the second author, Tina Bloom, independently reviewed codes and memos at critical junctures in the data analysis process and provided feedback to the first author, Deborah Finfgeld-Connett. Her feedback was used to reflexively review coding, categorizing, and memoing; and to make adjustments that were congruent with the data.

Findings

Overview

The reports included in this investigation represent studies that were carried out in the United States (n = 51), Canada (n = 3), and Australia (n = 1). One was a multisite study (Canada and Scotland), and in four instances, the data collection locations were undisclosed. In light of contextual information, these four studies appear to have been carried out in the United States and Canada. The findings that comprised the sample for this metasynthesis represent data from 1,871 homeless women. This includes data from 674 Black women, 346 White women, 252 Hispanic women, 100 women who were classified as other, and 499 individuals whose race/ethnicity remain unknown. The study database also included findings generated from 251 staff and 74 members of the public. These numbers do not account for countless others who were included in the research process through observation and participant observation.

Moving beyond demographics, metasynthesis findings are presented next. Based on the results of this metasynthesis, distorted perceptions of competency, which are shaped by dysfunctional relationships and mental health problems, appear to make it challenging for women with substance abuse problems to resolve homelessness. Women with low and high levels of perceived competency grapple with challenges related to structure and control, trust, and hopelessness. Therapeutic strategies for approaching women with distorted perceptions of competency include careful assessment, caring, personalized structure and control, development of interpersonal trust, and instillation of hope. Targeted efforts to manage substance abuse and other exacerbating mental health problems are also consistent with optimal care.

Perceived Competency

Perceived competency is a concept that is inferred based on the findings of this metasynthesis. It is the personally-interpreted ability to make decisions, take action, and execute positive change in one's life. Perceived competency exists on a continuum and is based on individual insights and interpretations. Given the enduring personal and interpersonal challenges that many homeless women face (Marcus, 2001; Padgett, Hawkins, Abrams, & Davis, 2006), they tend to present with varying levels of perceived competency. Some homeless women project a high level of perceived competency whereas others project very little. Still others lie somewhere in the middle. Supporting references are used to explicate these ideas in the following paragraphs.

Low perceived competency—Women with low levels of perceived competency are likely to present as chronically-homeless owing to a sense of personal paralysis (Lineberger, 2009). They are apt to psychologically distance themselves from the reality of their situations (Acquaviva, 2000) and to disassociate from their mental and physical health care needs (Enriquez, 2005; Liebow, 1993). These women tend to see themselves as unable to effect positive change, and they attribute their gridlocked status to forces beyond their control such as the economy or the bureaucratic system (Williams, 2003). Using this mindset, fatalism tends to become a consoling way to explain a powerful and unjust world, and blame and loathing might be projected elsewhere (Acquaviva, 2000; Brink, 2001; Carroll & Trull, 2002; Lineberger, 2009; Williams, 2003). Although adaptive in some ways, this nihilistic worldview is apt to inhibit change by obfuscating links between personal behavior and negative consequences. It might also lead to acquiescence and behavioral inertia on the part of the individual (Acquaviva, 2000; Gelberg, Browner, Lejano, & Arangua, 2004).

High perceived competency—Women with high levels of perceived competency also tend to present as intransigently homeless, however, their affect might be notably different than those individuals with low levels of perceived competency. Freedom and the liberty to abide by one's own value system and rules are likely to take priority over getting help in a structured setting that functions based on conventional mores and regulations (Fogel, 1997; Patterson, 2003). These women might see the treatment environment as alien, and expectations of social service providers might exceed their willingness or ability to adapt. Instead of feeling more stable and secure in a structured environment (Fogel, 1997), they tend to feel out of control, and their behavior might be disruptive (Fogel, 1997; Grella, 1994).

Homeless women with high levels of perceived competency appear to overestimate their ability to independently execute change and improve their lives outside of therapeutic environments. Based on this vantage point, they might repress or deny injustices and assume personae of strength, toughness, and autonomy (Huey & Quirouette, 2010). These women

have been known to go so far as to believe that they are exceptionally lucky, skillful, strong, or manipulative. At this polarity of the continuum, homeless women might perceive that societal rules do not apply to them, which can lead to aggressive, antisocial, or criminal activities (Carroll & Trull, 2002; Gentry, 2003; Luhrmann, 2008). Consequently, they might habitually gravitate toward illegal and unsustainable activities such as drug sales and sex work (Geter, 1993; Greene, Ball, Belcher, & McAlpine, 2003; Marcus, 2001; Wheeler, 2006).

Perceived competency at mid-continuum—It is inferred that homeless women in the middle of the perceived competency continuum appear to have a relatively good grasp of their personal assets and limitations, and they tend to possess skills that are needed to effectively make decisions and resolve problems. These women are better equipped than those on the margins of the continuum to assertively approach social service providers, gain knowledge, build healthy supportive relationships; establish conventional daily routines, and pursue job and housing leads (Banyard, 1995; Gillette, 2001; Haydon, 2005; Sysko, 2002). They tend to be more adept at instituting creative coping strategies, and they are not as likely to rely on social services for extended periods of time (Grella, 1994). In keeping with the purpose of this metasynthesis, these women are not the focus of this investigation.

Factors That Shape Perceived Competency

Dysfunctional relationships—High and low perceptions of competency tend to emerge in the context of dysfunctional relationships. Many homeless women are likely to have been raised in unstable homes where there was a history of multi-generational dysfunction and loss (Trickett & Chung, 2007); it is not unusual for their parents to have been divorced, deceased, and/or substance abusers. As youth, many homeless women endured some form of neglect and physical and emotional abuse, and they might have been raised by relatives or placed in foster care at an early age (Acquaviva, 2000; Carroll & Trull, 1999, 2002; Haydon, 2005; Marcus, 2001).

As adults, homeless women frequently report that they have experienced familial abuse and/or alienation (Carroll & Trull, 2002; Lineberger, 2009; Trickett & Chung, 2007; Wheeler, 2006). Although they might seek refuge with sympathetic acquaintances and family members, these relationships are tenuous, tensions escalate over time, and eventually the women feel compelled to leave (Belcher, Greene, McAlpine, & Ball, 2001; Brink, 2001; Montgomery, McCauley, & Bailey, 2009; Williams, 2003). As a result of these types of experiences, many homeless women do not have the opportunity to develop healthy interpersonal relationships (Belcher et al., 2001), and their social support systems are, at best, fragile (Brink, 2001; Gillette, 2001; Williams, 2003).

Among individuals with low levels of perceived competency, it is inferred that innate needs to stay interpersonally connected might sometimes override needs to ensure one's own well-being and safety (D'Amico, Barnes, Gilbert, Ryan, & Wenzel, 2009; Urbanoski, 2001). In an attempt to create mutually fulfilling relationships, these women are apt to endure a number of different types of interpersonal abuse for the short term in hopes of satisfying their need for fulfilling relationships in the long run (Haydon, 2005; Liebow, 1993; Lineberger, 2009).

Among homeless women with high levels of perceived competency, it appears that they are also likely to engage in maladaptive interpersonal relationships, but they are apt to take a different form. These women might be less likely to become closely linked with men who will abuse them, but they remain highly vulnerable to ubiquitous violence and the negative consequences of activities such as serial monogamy and drug use with strangers (e.g.,

exposure to human immunodeficiency virus; Bourgois, Prince, & Moss 2004; Luhrmann, 2008).

Substance abuse and mental health problems—In some instances it is difficult to determine which comes first, substance abuse or homelessness. Many times there is a family history of substance abuse or, at the very least; it can be documented at an early age (Carroll & Trull, 1999, 2002; Lineberger, 2009; Schretzman, 1999). Foregoing that, it is not unusual for substance abuse to emerge once a woman becomes homeless. Homeless women might resort to using drugs and alcohol to belong, please a sexual partner, and/or to escape from painful realities (Brink, 2001; Enriquez, 2005; Padgett et al., 2006). No matter its inception, a self-perpetuating cycle of substance abuse and homelessness might take shape (Belcher et al., 2001). In addition, this problem might be fueled by other acute and chronic mental health conditions such as anxiety and personality, mood, and psychotic disorders (Hatton, Kleffel, Bennett, & Gaffrey, 2001; Magee & Huriaux, 2008; Sysko, 2002; Trickett & Chung, 2007).

It is inferred that substance abuse and/or mental health problems might exacerbate the misperceptions that women on each end of the perceived competency continuum experience. In severe cases, individuals might suffer from delusions of grandeur, which could significantly escalate problems related to high perceived competency. Conversely, delusional thinking could reduce a woman's already diminished sense of perceived competency and make it difficult for her to initiate positive changes (Acquaviva, 2000; Carroll & Trull, 1999, 2002; Gillette, 2001; Haydon, 2005; Marcus, 2001; Padgett et al., 2006; Trickett & Chung, 2007; Sysko, 2002; Williams, 2003; Woods-Brown, 2001).

Perceived Competency and Receptiveness to Assistance

Structure and control issues—The notion that many homeless women do not have well-developed adaptive skills that are needed to make long-term positive changes in their lives is supported by qualitative research findings (Carroll & Trull, 2002; Greene et al., 2003; Lineberger, 2009; Wheeler, 2006). In different ways, homeless women on each end of the perceived competency continuum appear to struggle with structure and control issues. Homeless women with low perceived competency tend to flounder and acquiesce when they are left to their own coping devices. They prefer to abdicate decision making to others, and they are apt to flourish within supportive environments that are highly controlling and structured (Hill, 1991; Lindsey, 1997). At times, they might unobtrusively adhere to unwarranted rules and regulations simply because they fear denial of services if they do not comply (Liebow, 1993; Luhrmann, 2008; Williams, 2003).

In contrast, the same structure and control that is comforting to women with low levels of perceived competency might be interpreted as oppressive to those on the opposite end of the competency continuum. Women with high levels of perceived competency tend to deeply resent structured and controlling environments. They dislike that activities such as eating, sleeping, and parenting are subject to focused scrutiny and regulation (Flores, 2006; Fogel, 1997; Geter, 1993; Gillette, 2001; Haydon, 2005; Marcus, 2001; Urbanoski, 2001; Wheeler, 2006). They are also highly critical of the fact that, because of restrictive rules and procedures, they are unable to make personal decisions (Connolly, 2000; Urbanoski, 2001; Wheeler, 2006). Consequently, women with elevated levels of perceived competency find it difficult to benefit from highly structured programs of assistance, and they are apt to leave prior to fully benefiting from the services that are available (Fogel, 1997; Patterson, 2003).

Trust v.s mistrust—Due, at least in part, to a history of non-normative developmental experiences such as abuse and neglect, persistently homeless women appear to have

difficulty making adaptive decisions and functioning with their own best interests in mind (Cook, 1995). One long-term repercussion includes difficulty forming adaptive interpersonal relationships with peers, significant others, and family members (Acquaviva, 2000; Carroll & Trull, 1999, 2002; Haydon, 2005; Lineberger, 2009; Marcus, 2001; Wheeler, 2006).

In an effort to protect themselves from additional victimization and trauma, homeless women might have difficulty forming adaptive interpersonal connections with beneficent social service personnel (Haydon, 2005). Homeless women do not always trust that the social service system works with their best interests in mind, and they do not necessarily take advantage of the help that is available to them (Sysko, 2002). For example, homeless women do not always believe that social service providers tell them the truth (Acquaviva, 2000; Connolly, 2000), or that the justice system will protect them (Brink, 2001). They might also fear that information they share with social service providers will be used against them when child custody decisions are at stake (Hatton et al., 2001; Woods-Brown, 2001).

Because of a lack of trust, homeless women on each end of the perceived competency continuum might find it difficult to benefit from the services that are available (Sysko, 2002). Individuals with low perceived competency might not feel confident disclosing and asserting themselves, and they are likely to behave in servile and obsequious ways. These women might shape their needs to fit the services that are available rather than forthrightly seeking out assistance that is designed to specifically meet their needs (Liebow, 1993; Luhrmann, 2008; Williams, 2003). For instance, to meet their need for food and shelter, women with substance abuse problems have been known to feign domestic abuse to receive assistance at a facility that specializes in intimate partner violence. This type of behavior tends to obfuscate their real problems and hinders rehabilitation efforts (Geter, 1993; Gillette, 2001). Alternatively, women with high levels of perceived competency who lack trust might be reluctant to enter or remain in the system unless a crisis occurs. Compassionate outreach efforts might be needed to recruit them into helping environments (Apfel, 2007; Gelberg et al., 2004), and once enrolled, they might be reluctant to disclose personal information (Liebow, 1993; Gillette, 2001; Marcus, 2001). To retain them in the system, considerable effort might be needed to establish and maintain trusting relationships.

Hopelessness—Creating a new life can be challenging, even under ideal circumstances. These challenges tend to be magnified when individuals are prone to distorted perceptions of competency, and the system they must work within is rife with imperfections. For instance, complex bureaucracy is a widespread problem that can make it difficult for women with relatively few interpersonal skills to benefit from the services that are available (Brink, 2001; Hatton, 2001; Marcus, 2001; Wheeler, 2006). It is these types of problems that might heighten frustration and lead to a sense of hopelessness among women with both low and high levels of perceived competency.

Given their proclivity to develop a sense of powerlessness and to assume an inactive stance (Acquaviva, 2000; Carroll & Trull, 2002; Lineberger, 2009; Williams, 2003), it is reasonable to infer that women with low levels of perceived competency might experience a sense of hopelessness. At first, they might attach this feeling strictly to themselves. Later, they might extend this same feeling to a system that they perceive to be inefficient and ineffective. Alternatively, women with high levels of perceived competency are thought to feel hopeless when they are forced to operate within a system that they view as overly restrictive and punitive (Fogel, 1997; Liebow, 1993; Marcus, 2001; Patterson, 2003; Williams, 2003). Among the latter group, their sense of hopelessness tends to immediately transcend personal attributions and be projected onto a bureaucratic system that is perceived to be oppressive. In effect, this defense mechanism might help women with high levels of perceived competency preserve their distorted perception of competency.

Provision of Services in the Context of Distorted Perceptions of Competency

Careful Assessment

For different reasons, women on each end of the perceived competency continuum might find it difficult to optimally benefit from social services. For this reason, careful assessment is recommended (Apfel, 2007; Bridgman, 2003; Flores, 2006; Lindsey, 1997; Magee & Huriaux, 2008; Urbanoski, 2001; Williams, 2003; Woods-Brown, 2001). Having a sense of each woman's position on the perceived competency continuum is anticipated to help social service providers create and implement the most effective and efficacious assistance possible.

Supplied with accurate assessment information, social service providers are better able to foresee how homeless women might present themselves, request assistance, and respond when assistance is offered. For instance, homeless women with high levels of perceived competency would be expected to present themselves as being more capable and less in need than those with low levels of perceived competency. In addition, substance abuse problems would be anticipated to further complicate attempts to resolve homelessness (Apfel, 2007; Bridgman, 2003; Flores, 2006; Lindsey, 1997; Magee & Huriaux, 2008; Urbanoski, 2001; Williams, 2003; Woods-Brown, 2001).

Caring

Based on evidence from this investigation, it cannot be assumed that social service providers will routinely provide assistance in a caring manner. This is despite the fact that caring is perceived to be an important attribute of therapeutic assistance (Gillette, 2001; Gelberg et al., 2004; Liebow, 1993). In particular, homeless women comment on the therapeutic benefits of compassion, kindness, empathy, support, and respect. Patient, nonjudgmental communication and collaboration are valued, and the women emphasize how non-caring approaches obfuscate attempts to assist (Apfel, 2007; Gelberg et al., 2004; Gillette, 2001; Magee & Huriaux, 2008; Urbanoski, 2001; Wenzel, D'Amico, Barnes, & Gilbert, 2009). Caring is perceived to be particularly important given that many homeless women are survivors of various forms of interpersonal trauma (Finfgeld-Connett, 2010a). It is also inferred that caring might help to diminish treatment barriers related to trust.

Development of Interpersonal Trust

Regardless of their position on the perceived competency continuum, distrust of the social service system might result in treatment barriers. Distrust is thought to stem from previous experiences in which homeless women put their trust in individuals who ultimately disappointed or failed them (Acquaviva, 2000; Carroll & Trull, 1999, 2002; Haydon, 2005; Marcus, 2001). Homeless women might also lose trust in the social service system because they were stigmatized, shamed, or blatantly mistreated by helping professionals (Acquaviva, 2000; Brink, 2001; Connolly, 2000; Gillette, 2001).

In addition to building trust through caring, a holistic approach is recommended (D'Amico et al., 2009; Gelberg et al., 2004; Williams, 2003; Woods-Brown, 2001). This is not meant to imply that all services are needed or appropriate for every individual. On the contrary, each woman enters the system with her own unique needs and requires customized care and assistance (Apfel, 2007; Bridgman, 2003; Flores, 2006; Magee & Huriaux, 2008; Urbanoski, 2001; Williams, 2003; Woods-Brown, 2001). Assistance programs that are not well-tailored to individual needs are inferred to promote distrust and alienation, because women might perceive that their problems are not being addressed or taken seriously.

Although homeless women build supportive relationships with social service personnel (Haydon, 2005), they cannot rely solely on these individuals for nurturance and support. For this reason, they might require assistance establishing trusting relationships with individuals outside of the helping professions. Prior to doing this, however, homeless women might need support to relinquish non-adaptive relationships (Sysko, 2002) that are characterized by interpersonal abuse and substance use (Greene et al., 2003; Schretzman, 1999; Sysko, 2002).

Care providers are encouraged to foster adaptive relationships among homeless women. Researchers indicate that homeless women can build healthy supportive relationships with other homeless women that cross race, ethnicity, and sexual orientation (Haydon, 2005; Gillette, 2001). Bonding occurs based on the fact that the women share similar backgrounds and challenges, and they do not judge each other (Urbanoski, 2001). These types of supportive relationships might be helpful in terms of maintaining abstinence from alcohol and drugs (Sysko, 2002), providing comfort, and enhancing financial stability (Acquaviva, 2000).

Personalized Structure and Control

In different ways, homeless women on each end of the perceived competency continuum struggle with structure and control issues. Women with low levels of perceived competency tend to thrive in more controlled and structured environments (Liebow, 1993; Luhrmann, 2008; Williams, 2003). Conversely, women with high levels of perceived competency are likely to resent these same types of milieus (Fogel, 1997; Geter, 1993; Gillette, 2001; Haydon, 2005; Marcus, 2001; Urbanoski, 2001; Wheeler, 2006). For these reasons, social service providers are encouraged to optimize assistance efforts by providing personalized structure and control (Apfel, 2007; Bridgman, 2003; Flores, 2006; Haydon, 2005; Magee & Huriaux, 2008; Urbanoski, 2001; Williams, 2003; Woods-Brown, 2001).

Most homeless women appear to understand the need for at least some structure and control to live safely and amicably among others. They might even express a sense of appreciation and relief when they know that beneficent staff are present to insure that behavioral expectations are clear and rules are judiciously applied (Bridgman, 2003; Sysko, 2002). For these individuals, fully explaining the ground rules and offering clear rationale if objections are raised might be enough to create a therapeutic milieu (Apfel, 2007).

There might also be times when personalized structure and control means letting women know what type of help is available and allowing them to decide whether they will accept and actively use the services that are offered (Bridgman, 2003). This also means allowing the women to deal with the consequences of their decisions, despite the fact that those consequences might be painful (Connolly, 2000). There are, of course, instances when this type of laissez-faire approach would not be appropriate, and priorities such as safety would take precedence.

Instillation of Hope

Homeless women on both ends of the perceived competency continuum might have difficulty formulating a realistic vision of what their lives could be like. As homeless individuals, they might not see their options as plentiful, and/or they might not see one option as being significantly better than another (Grella, 1994; Montgomery et al., 2009). When making choices, they might feel as if they face the classic dilemma of choosing the lesser of two or more evils (Lineberger, 2009). For these reasons, it is important for those who work with homeless women to instill the belief that they are worthy of a better life and to help them envision what their lives might realistically look like (Gillette, 2001; Haydon, 2005; Montgomery et al., 2009; Sysko, 2002). To avoid perpetual disappointment and lapses

into hopelessness, care providers are urged to acknowledge challenges and help homeless women envision small incremental improvements rather than the ideal (Apfel, 2007; D'Amico et al., 2009; Haydon, 2005; Liebow, 1993; Magee & Huriaux, 2008; Schretzman, 1999; Sysko, 2002).

To instill and sustain hopefulness, providers are urged to help homeless women on both ends of the perceived competency continuum develop new skill sets. Armed with new skills, individuals in each group have the potential to use them to suit their unique needs. For instance, newly acquired communication skills have the potential to enable individuals with low and high levels of perceived competency to interact more assertively rather than passively or aggressively (Banyard, 1995; Hatton et al., 2001). Other skill sets that could be honed include the art of compromise, collaborative goal setting, and decision making (Apfel, 2007; Barkley, 1996; Connolly, 2000; D'Amico et al., 2009; Flores, 2006; Gentry, 2003; Haydon, 2005; Magee & Huriaux, 2008). Homeless women could also benefit from learning basic living skills such as how to apply for benefits, manage money, and get and maintain a job (Marcus, 2001; Wheeler, 2006; Williams, 2003). Each of these is action oriented and has the potential to lead to immediate positive results and reinforcement, which might be desperately needed when individuals are experiencing hopelessness.

Another strategy that is recommended for dealing with hopelessness is spirituality. Spirituality is thought to provide homeless women with hope that their lives will improve and the supplemental nurturance that they need to see them through the process (Gillette, 2001; Greene et al., 2003; Sysko, 2002; Urbanoski, 2001). Spiritual sustenance is also associated with the intra-psychic and interpersonal support that they might require to overcome substance abuse problems (Greene et al., 2003).

Management of Substance Abuse and Mental Health Problems

It might be difficult for persistently homeless women to take steps in a positive direction given substance abuse and mental health problems (Banyard, 1995; Grella, 1994) that might exacerbate distorted perceptions of competency. Psychotherapeutic agents might be used to treat some acute and chronic problems (Apfel, 2007). In addition, individual, substance abuse, and trauma-informed therapy are frequently recommended (Apfel, 2007; Kissman, 1999; Williams, 2003; Woods-Brown, 2001). Careful assessment is needed to know when and what type of counseling is most appropriate. For instance, counseling might be eagerly accepted in crisis situations, but individuals might be less receptive as presenting problems are resolved. This might be particularly true for individuals with high levels of perceived competency, and flexibility might be required to capture therapeutic opportunities and effectively meet the targeted needs of recipients (Urbanoski, 2001).

Discussion

Perceived Competency and Related Concepts

Many factors contribute to persistent homelessness among women. They include substance abuse, economics, and mental illness (HRSDC, 2010; NCH, 2009). Results from this investigation also point to the role that contextual factors such as long-term dysfunctional interpersonal relationships play in the emergence of distorted perceptions of competency and homelessness among women.

It has been suggested that differences such as co-morbid mental health problems, culture and ethnicity, domestic abuse, motherhood, and even transgender issues should be accommodated to provide optimum care to homeless women (Apfel, 2007; Bridgman, 2003; Flores, 2006; Magee & Huriaux, 2008; Urbanoski, 2001; Williams, 2003; Woods-Brown, 2001). Although this might be true, evidence from this investigation supports the notion that

perceived competency could potentially transcend these differences. As such, service providers are urged to carefully determine where homeless women lie on the perceived competency continuum and accommodate their care accordingly.

Self-efficacy—Outside of grounded theory process concepts (Corbin & Strauss, 2008), which were used to guide the research methods, no other theoretical or conceptual frameworks were employed to carry out this investigation. To examine the findings further, a systematic comparison is recommended to evaluate the similarities and differences between concepts such as self-efficacy and perceived competency. A comprehensive comparison of these two concepts is beyond the scope of this report; however, a cursory review is offered.

Like perceived competency, self-efficacy is thought to exist on a continuum ranging from low to high, and individuals on the low end of the continuum are anticipated to require considerable assistance to make adaptive changes in their lives (Bandura, 2004). Aside from this similarity, differences between the two concepts abound. Unlike perceived competency, it is proffered that the more self-efficacy that individuals possess, the more likely it is that they will be able to make adaptive changes in their lives (Bandura, 2004). This is counter to findings from this investigation in which homeless women who lie in the middle of the perceived competency continuum are seen as better prepared to improve their living situations than those on the high end of the continuum.

It is noteworthy that the theorized correlation between high levels of self-efficacy and adaptive change among homeless women and women who have endured long-term abuse and trauma is not robust (Benight & Bandura, 2004; Epel, Bandura, & Zimbardo, 1999). For this reason, researchers are urged to further examine the value of concepts such as perceived competency to more fully explain the process of resolving homelessness among women.

Empowerment—Qualitative researchers do not begin research investigations devoid of information relating to their topic of interest. To manage this potential threat to trustworthiness, data analysis is conducted in a reflexive manner (Finlay, 2002). In the case of this investigation, it was tentatively hypothesized at the start of this investigation that empowerment would emerge as an important strategy for helping homeless women with substance abuse problems become stably housed. In fact, empowerment was a working code well into the latter stages of data categorizing and memoing. As data analysis and synthesis progressed, however, it became clear that empowerment does not fully capture the complexity involved in such things as personalizing structure and control, making collaborative decisions, and instilling hope among women with vastly different levels of perceived competency.

Autonomy—A similar conclusion can be inferred about autonomy, a concept that was identified by O'Campo et al. (2009) in their systematic review of homeless adults with substance abuse problems. It is averred that undifferentiated promotion of autonomy among women with high levels of competency might exacerbate existing distortions. Conversely, women with low levels of perceived competency, who prefer structure, might find unbridled autonomy to be overwhelming. For these reasons, it is recommended that careful assessment and tailored promotion of autonomy be instituted to meet the unique needs of each woman.

Limitations

All metasyntheses involve inherent limitations. Among the most serious is the researcher's distance from the original research participants. This limitation was minimized by conducting expansive sampling and carrying out careful and comprehensive data extraction.

This potential limitation was also minimized by staying close to the data and using in vivo codes and transparent metaphors throughout the data analysis and synthesis processes.

In keeping with O'Campo and colleagues' (2009) results from a qualitative synthesis related to homeless adults, clear guidelines for improving substance abuse outcomes could not be inferred from the data that were available for this investigation. In the case of this study, it has already been noted that data related to specific substance abuse treatment strategies were inconsistently reported across studies. In addition, although researchers were interested in substance abuse problems, immediate needs such as housing seemed to take precedence followed closely by a keen interest in the women's overall well-being rather than merely their status as a substance abuser. The latter most likely relates to the complexities involved in becoming and being homeless and resolving homelessness versus the more limited role that substance abuse might play as a coping mechanism (Burlingham et al., 2010).

Conclusion

Framing care for persistently homeless women within the context of perceived competency offers a new way of understanding the plight of these women and shaping interventions to assist them in establishing healthier and more stable lives. Social service providers are encouraged to carefully assess homeless women's receptiveness to assistance based on their level of perceived competency and to intervene accordingly. Suggested therapeutic strategies include development of trust, personalized structure and control, instillation of hope, and careful management of mental health problems that might exacerbate distorted perceptions of competency.

Based on the results of this investigation, social service providers are asked to reconsider blanket admonitions to enhance self-efficacy and promote empowerment and autonomy among homeless women with substance abuse problems. In addition, research is recommended to explore the similarities and differences between perceived competency and self-efficacy. Researchers are also urged to carefully examine the effectiveness of personalized structure and control versus undifferentiated efforts to promote empowerment and autonomy when working with homeless women who are on the margins of the perceived competency continuum.

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Table 1

PsycINFO Literature Search

Number	Searches	Results
1	homeless/ or homeless mentally ill/	3878
2	(homeless$ or street people or street person$1 or living on the street$1).mp.	5598
3	1 or 2	5598
4	human females/ or (women or woman or female$).mp.	335282
5	3 and 4	1192
6	drug abuse/ or alcohol abuse/ or alcoholism/ or binge drinking/	53587
7	drug dependency/ or drug addiction/ or heroin addiction/	16812
8	inhalant abuse/ or glue sniffing/ or polydrug abuse/	930
9	addiction/ or drug usage/ or alcohol drinking patterns/	26986
10	alcohol intoxication/ or acute alcohol intoxication/ or chronic alcohol intoxication/	1909
11	social drinking/	696
12	intravenous drug usage/	2268
13	drug abstinence/ or sobriety/	2309
14	drug rehabilitation/ or alcohol rehabilitation/ or alcoholics anonymous/	20789
15	methadone maintenance/	2434
16	twelve-step programs/	407
17	drug seeking/	126
18	or/6–17	94462
19	4 and 18 and 3	298
20	limit 19 to yr=“1980 -Current”	295

Note. “$” = replaces characters and will find all forms of a word root; .mp. = search multiple parameters (e.g., title, abstract, subject heading field) for a word