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Understanding context, agency and process in the health of homeless young women in Glasgow: a qualitative study

Thesis submitted for the degree Doctor of Philosophy (Ph.D.)

Dawn Eunice Stephen
September 1998

Abstract

The health experiences, and the lived experiences in general, of homeless young women have largely been overlooked. In seeking to redress this situation, the research findings presented in this thesis support those from other homelessness studies; the sample's health was poor. However, drawing upon a wider range of research traditions than is normally the case, conceiving health in terms of physical, mental and social well-being, and employing qualitative methods to facilitate *verstehen* of the epiphanies and processes involved in the outcome of 'homelessness', the meanings these lived experiences had engendered, and the *lifeworld* of 'homeless' young women, this study problematises the rather biomedical orientation of most homelessness and ill-health studies. The fundamental argument presented is that homelessness and poor health outcomes are products of the same iniquitous structures that affect a much greater population, yet the medicalisation of homelessness has served to obscure this and reinforce difference. Accordingly, the concepts of social exclusion, youth transitions and identity in late modernity provide a normative 'way of seeing' the experience of homelessness and its relationship with health. By simply conceiving the subjects of research as cognisant and purposive agents whose lived experiences are rooted in the structures and processes of exclusion inherent in late modernity, yet mediated by the affective body, the importance of acknowledging relativity, as a social concept in homelessness research is demonstrated. This is accomplished by exploring the sample's lived experiences as the contexts within which their health meanings and actions are informed and effected. It is shown that 'homelessness', portrayed by the sample as a stage of transition between the structured limitations of the past and their aspirations for the future, does not only produce negative health outcomes.

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Introduction

As the title suggests, this thesis is concerned with the health of homeless young women. Yet, as also indicated, the qualitative purpose if this study is rather different to more usual approaches to the subject where lists of health problems are often collated as a means of demonstrating that homelessness is detrimental to health. It is also different in choosing to look at young women for, as will be shown in Chapter 1, their lived experiences, in terms of homelessness, have largely been overlooked. Whilst possible reasons for this will be offered, it is an anomalous situation since the ideology of 'home', and health and ill-health experiences are firmly rooted in highly gendered discourses and structures. This introduction and the two chapters that follow reveal that the terms 'homeless' and 'health' are not easily defined and, indeed, unpacking what is meant by 'health' requires the whole of Chapter 2. These introductory chapters will demonstrate why, as 'some of the most unrecognised of all homeless people' (Dibblin 1991: 9), qualitative research into young women's experiences, and the meanings they ascribe to these experiences is overdue.

This introduction provides an overview of the existing literature on homelessness and health, and Chapter 1 considers the literature in regard to homelessness. By structuring the beginning of the thesis in this manner, the main intention is to establish the fundamental argument which underpins this thesis: homeless young women's health experiences cannot be understood without acknowledging the social, material and political processes which give rise to, and continue to maintain their homelessness. This lays the foundations for Chapter 2 which highlights the importance of these very same structures and processes in shaping health outcomes.

In the review of the main themes in the homelessness and health literature three main factors become immediately apparent. Firstly, 'health' is, inexplicably,

taken to mean 'ill-health', and this is returned to in Chapter 2. Secondly, most studies are gender-blind; gender only becomes a factor to be considered in specific circumstances, outlined below. Thirdly, the main focus of most studies appears to be to try to establish some kind of cause and effect relationship in terms of demonstrating the extent to which health problems may predispose individuals to homelessness, or identifying the effects of homelessness upon health. This is by no means a critique of individual studies themselves, but represents the beginning of a problematisation of the hegemony of biomedical conceptions and portrayals of health.

In regard to themes of causality, the literature on the 'health selectivity' of housing is an appropriate place to start. Health status is considered to impact on housing opportunities (Smith 1990) and the homeless legislation and the medical priority system should ensure that individuals with health problems have a status of high priority for rehousing according to identified need. It has been shown that physical or mental ill-health or disability can be included within the 'vulnerability' criterion of the homelessness legislation (Watchman and Robson 1989). These criteria are discussed later. Within the social rented sector the housing route allowed for by the 'medical priority for rehousing' (Smith *et al.* 1991; Smith *et al.* 1993) should ensure that any homeless person with an illness will be rehoused into 'special projects' or into mainstream social rented stock (Smith 1991). Yet, it is shown that this is mediated by wide variations in interpretation in practice (Evans and Duncan 1989), the extent to which an individual is able to 'play the system' (Robinson, forthcoming), and a decline in social housing stock outlined in Chapter 1. There is increasing evidence to suggest that individuals with poor health do not receive housing that meets their needs and are at risk of homelessness (Smith 1990; Connelly *et al.* 1991; Smith *et al.* 1991; Shanks and Smith 1992; Connelly and Crown 1994; SCOPH 1994).

An acknowledgement that ill-health may predispose people to homelessness is explicit in this context, but as will be shown later, tacit inferences of this kind are also made in regard to studies which focus upon 'behavioural' matters. Most studies, however, focus upon identifying and enumerating the ill-health outcomes of homelessness and two extensive reviews of the literature on homelessness and ill-health exist (Smith 1989; Connelly and Crown 1994). Connelly and Crown, who do employ the term 'ill-health', highlight methodological problems in the existing literature. These are demonstrated to include: the generally small scale nature of most studies; the variety of sampling methods, data gathering procedures and classifications employed; how the data has been analysed and presented; and, the differing and changing material characteristics of respondents (*Ibid.*). Undoubtedly, this project must be considered in light of these caveats and this is discussed in Chapter 3.

One notable study of the 'health' of single homeless people (Bines 1994) stands out for its scale, and therefore some of the criticisms outlined by Connelly and Crown (1994), and for the way in which it represents a qualitative break from the rather positivistic orientation of the majority of studies. This comparative study is based on secondary analysis of two data sources of self-reported health: a large scale survey involving structured interviews with three representative samples of single homeless people - 1280 people living in hostels and bed and breakfast accommodation and 507 people who were sleeping rough and using day centres or soup runs, conducted in 1991 (*cf.* Anderson *et al.* 1994) and the first wave of the British Household Panel Study conducted in the same year. In both surveys respondents had been asked about similar health problems.

Whilst one-quarter (24%) of the general population reported experiencing more than one health problem, over one-third (38%) of those living in bed and breakfast and hostel accommodation reported multiple health problems (*Ibid.*: 3). Specific health problems included musculo-skeletal problems, difficulties

with seeing and hearing, wounds, skin problems, chronic chest or breathing problems, heart problems, digestive problems, depression, anxiety or nerves, fits or loss of consciousness and frequent headaches (*Ibid.*: 5). Apart from 'heart disease', the figures for homeless people are consistently greater than those for the general population and amongst homeless respondents themselves, the figures for those sleeping rough are highest of all.

In a later paper (Bines 1995), some important age-related differentials were identified in terms of the greater propensity of homeless 16 and 17 year olds to have health problems than their older counterparts (77% and 54% respectively). Between the ages of 16 and 24 years, homeless young people were also found to have a greater likelihood of health problems when compared to their peers in the general population. Among the latter, 41 per cent claimed to experience health problems compared with 58 per cent of young people living in hostels or bed and breakfast accommodation and 97 per cent of those sleeping rough (*Ibid.*).

Age and gender-related differentials are particularly evident in figures for mental health problems. The average number of all homeless women reporting mental health problems is 44 per cent as opposed to 7 per cent for women in the general population (for men this is 33% and 3% respectively) and amongst those aged 16 to 24 years, an average of 33 per cent compares badly with 3 per cent for the general population (Bines 1994: 14). This report is important for its comparison between homeless people and the general population, and between homeless people themselves, and for the way in which it reaffirms the multiple health problems experienced by homeless single people which most of the studies considered below have demonstrated. Bines' study is especially important because it identifies some gender differences which, as will be shown, most general homelessness and health studies ignore.

When examining the general literature on homelessness and health there are significant consistencies between national and international studies (*cf.* Connelly and Crown 1994) which demonstrate the poor health of homeless people. From earlier studies (*for example*, Marsh 1957; Tattersall 1957; Elwood 1961; Scott *et al.* 1966; Edwards *et al.* 1968; Gaskell 1969; Lodge-Patch 1971; Tidmarsh and Woods 1972; Alstrom 1975; Priest 1976) of 'common lodging house inmates'(*sic*) and surveys of people using peripatetic GP surgeries to more contemporary studies of coroners' records, high mortality (Shanks 1984; Keyes and Kennedy 1992; Grenier 1996) and morbidity rates are recorded. Among the factors contributing to high morbidity rates, respiratory disorders rank highly, ranging from upper respiratory infections to bronchitis, chronic obstructive airways disease, emphysema, pneumonia and tuberculosis (*cf.* Shanks and Carroll 1982; Shanks 1983; Patel 1985; Powell 1987a; Toon *et al.* 1987; Featherstone and Ashmore 1988; Ramsden *et al.* 1988, 1989; Braddick and Thompson 1989; Balazs and Burnett 1990; Stephens *et al.* 1991; Balazs 1993).

Homelessness is associated with other specific health problems and studies report a high incidence of musculo-skeletal problems (*cf.* Shanks 1984; Powell 1987a; Toon *et al.* 1987; Ramsden *et al.* 1989; Wrenn 1990) and dermatological problems, including infestations, skin disease, leg ulcers and wounds (*cf.* Shanks 1984, 1988; Powell 1987a; Toon *et al.* 1987; Featherstone and Ashmore 1988; Ramsden *et al.* 1988, 1989; Balazs and Burnett 1990; Balazs 1993). Gastrointestinal problems, including nutritional deficiencies and digestive complaints are also commonly reported (*cf.* El Kabir 1982; Shanks 1984, 1989; Bayliss and Logan 1987; Toon *et al.* 1987; Featherstone and Ashmore 1988; Balazs 1993) and neurological problems, particularly high incidences of epilepsy (*cf.* Powell 1987a; Toon *et al.* 1987; Featherstone and Ashmore 1988; Ramsden *et al.* 1989). Although the literature is less extensive, dental health problems are also highlighted (*cf.* Hopes 1985; Toon *et al.* 1987; Featherstone and Ashmore 1988; Balazs and Burnett 1990; Balazs 1993).

Many studies report higher incidences of mental health problems, including depression, anxiety and stress, alongside histories of admissions to mental hospitals amongst homeless respondents than levels found within the general population (*cf.* Timms and Fry 1989; Hamid and McCarthy 1989; Marshall 1989; Balazs and Burnett 1990; Marshall and Reed 1992; Geddes *et al.* 1994; Westlake and George 1994). Gender differences have been considered in terms of mental health problems. Supporting Bines' (1994) findings women have been found to experience more severe mental health problems than men; these being reported as three times higher (Balazs 1993).

Implicit in many of these studies is the concern to show that mental health problems may contribute to homelessness, for example, in light of the failure of Care in the Community policies (*cf.* Craig and Timms 1992). Such types of study are criticised for failing to acknowledge the part that homelessness plays in magnifying and creating mental health problems (*cf.* Bean *et al.* 1987; Daly 1989; Pleace and Quilgars 1996). In this manner, those latter authors are underlining their objection to early homelessness and health studies which tended to infer individual psychopathology to be 'the cause' of homelessness, but they are still reproducing the preoccupation with cause and effect. Nevertheless their critiques are important because such cause and effect arguments are no more evident than in the focus upon the 'alcoholic' imagery of homeless people over time (*cf.* Stark 1987), imagery which has now been amended to include homeless young people's 'health risk' behaviour.

The focus on behavioural factors is revealed in a host of studies which have long highlighted the extent of alcohol dependency among homeless people (*cf.* Shanks 1983, 1988; Featherstone and Ashmore 1988; Ramsden *et al.* 1988, 1989; Braddick and Thompson 1989; Balazs and Burnett 1990; Marshall and Reed 1992; Geddes *et al.* 1994; Westlake and George 1994) and this is shown to be a 'risk factor' for a number of health problems (*for example*, Vredevoe *et*

al. 1992; Arblaster and Hawtin 1993). The literature on drug use amongst homeless people is less extensive, though growing, than that for alcohol and is reflective of the changing age composition of homeless people, discussed in Chapter 1. Studies indicate an 'experimental use' of drugs ranging from 38 to 64 per cent of their samples (respectively. Reed *et al.* 1992; Randall 1988) or a level of drug dependency of one in ten of those sampled (George *et al.* 1991). Most studies describe 'chaotic use' of available and affordable illegal drugs and highlight associated health problems, ranging from overdoses and abscesses, to hepatitis and HIV infections (Daly 1989a; Randall 1989; Balazs 1993; Boulton 1993). High levels of cigarette consumption are also demonstrated (Balazs and Burnett 1990) with rates as high as 93 per cent of respondents identified (Collett 1992), though the figure for women has been found to be less at 73 per cent (Balazs 1993). In addition to such health risk behaviour, the vulnerability of young people, and especially young women, is often stressed.

Some specific problems associated with rough sleeping among young people are considered in the literature. Assaults are described (Boulton 1993) and, in one study of female residents of the Children's Society Central London Teenage Project, 7 percent of respondents said they had been raped when sleeping rough (YHG 1992). Amongst young people, involvement in prostitution is presented as an additional hazard to health, especially through factors associated with unprotected sex (Dibblin 1991; Boulton 1993). A link has been found between prostitution and earlier sexual abuse (McMullin 1988) and problems associated with such earlier abuse are described as 'low self-esteem', 'lack of confidence', 'mood disturbance' and suicide behaviour (Hendessi 1992). This, alongside relative economic weakness and the shortfall in facilities for homeless young women is implicated in predisposing this group to prostitution (Randall 1989; Akilu 1991). An essential question is beginning to be formulated: why does gender emerge as a factor for consideration only in areas pertaining to mental health, or in active participation in, or vulnerability

to health risk behaviour? There is one final area where gender is a factor and this relates to women's role for, as will now be shown. aspects of motherhood when homeless are well documented.

Whilst various homeless situations are shown to produce physical and psychological stresses associated with such factors as sleep deprivation, overcrowded environments and 'chaotic lifestyles' (Daly 1989b), the greatest attention has been directed at conditions within temporary accommodation and the health problems these produce, especially for families. The inferior quality of the fabric of many buildings used in regard to fire safety, overcrowding, hygiene problems, poor facilities for food storage and preparation, the lack of basic amenities, and the high incidence of reported accidents are frequent themes (*for example*, Drennan and Stearn 1986; BHHP 1987; Maternity Alliance/ Shelter 1987; BABIE 1989; Thomas and Niner 1989). However, such studies have been criticised because much of the 'evidence' is anecdotal and assessment of the interrelationship is problematic (Smith 1989; Connelly *et al.* 1991; Mant 1993).

A study of acute medical admissions of children from bed and breakfast accommodation in London identifies the mothers' reported difficulties in such conditions, which include lack of space and privacy, isolation and noise (Lissauer *et al.* 1993). The large number of studies of temporary accommodation, predominantly by health professionals (Boyer 1986; Drennan and Stearn 1986; Lovell 1986; Stern 1986; HVA/ GMSC 1989; Lowry 1989, 1990; Patterson and Roderick 1990; Parsons 1991) point to factorial commonalities associated with the living environment. These include, high incidences of infectious diseases and infestations, gastro-enteritis, weight loss and malnourishment, and 'emotional' problems and depression. These lend support to findings from a notable, questionnaire-based study of the more qualitative health experiences of 56 mothers living in bed and breakfast accommodation (Conway 1988). Headaches, migraines, diarrhoea, vomiting,

chest infections, feeling 'run down' and tired, and increased susceptibility to coughs and colds were the most common ailments reported. Other problems included urinary tract infections and anaemia. Over half of the respondents believed their health had worsened as a result of living in this accommodation and expressions of boredom, isolation and loneliness were high (*Ibid.*).

Over and above their own health problems, mothers are also shown to have to cope with their children's ill-health. As supported in the study referred to above (Lissauer *et al.* 1993), children appear to be particularly affected by living in temporary accommodation. Research indicates that they experience higher incidences of respiratory infections and other childhood infections, a high rate of hospital admissions, depression, sleep disturbance, poor eating habits, overactivity, bedwetting and soiling, toilet training problems, aggression, poor speech and motor development, and lack of concentration have been reported (Boyer 1986; Drennan and Stearn 1986; Stern 1987; Parsons 1991). Lower levels of childhood immunisations are recorded (Victor 1992).

Further examples of the adverse effect of homelessness upon women's health relate to pregnancy. Studies indicate that, when compared to pregnant women in the general population, homeless women tend to be at increased obstetric risk with later booking dates, to smoke more, to be younger, to have a higher history of stillbirths and their babies, when born, have a higher risk of prematurity and difficulties with spontaneous breathing (Patterson and Roderick 1990). Homeless women are shown to be twice as likely to experience problems in pregnancy, and three times more likely to be admitted to hospital when pregnant (Lowry 1989). Among these problems are higher levels of anaemia, genito-urinary infections and antepartum haemorrhage (Shank 1991). They are also shown to experience higher incidences of postnatal and clinical depression than their housed counterparts (Drennan and Stearn 1986).

The final area to consider relates to what seems to be taken as a measure of homeless people's agency, or lack of agency in terms of health. A considerable body of literature exists on the utilisation of health services by homeless people. Concerns have long been expressed about their 'low registration' and 'differential utilisation' of primary health care services when compared to the general population (*for example*, MacGregor-Wood 1976; Shanks 1983; Powell 1987; Connelly *et al.* 1991; Fisher and Collins 1993; Pleace and Quilgars 1997). Difficulties associated with GP registration are identified (Cumming 1986; Stern *et al.* 1989; Williams and Allen 1989) and homeless people are reputed to be reluctant to use primary health services for a variety of reasons, such as 'low expectations' of the services available, and to express difficulties when they do seek medical assistance, including reported negative attitudes of health professionals or the inaccessibility or inflexibility of services (Stern *et al.* 1988; BHHP 1989). One description of the scenario facing homeless people is 'the cycle of reluctance' (Fisher 1989). In this cycle, the reported unwillingness of GPs to register a homeless person is believed to be compounded by the homeless person's 'expectation of refusal', their perception of health as a 'low priority concern', and a mix of their 'powerlessness', 'stigmatisation', and 'poor self esteem'. Thus health problems are said to be presented for treatment only at an advanced stage (Fisher and Collins 1993). Moreover, there is conflicting evidence to suggest that homeless people may use hospital accident and emergency services for treatment of their health problems to a greater extent than the general population (*cf.* Powell 1987a; Victor *et al.* 1989; SHIL 1990).

The solution to the difficulties faced by homeless people in securing primary health care led to the establishment of a variety of schemes which have tried to make services more accessible. The have included 'House Doctor' schemes (*cf.* Holden 1975; Weir 1977; Powell 1987b), mobile surgeries (Ramsden *et al.* 1988, 1989), the appointment of specialist GPs (Stern 1987) or inducement practice payments (Powell 1988), peripatetic nursing services (Featherstone

and Ashmore 1988) or flexible multi-agency approaches which combine mainstream and specialist services (Balazs 1993). The debate over such specialist services for homeless people versus their full integration into mainstream services continues (*for example*, Stern and Stilwell 1991; Bayliss 1993; Rosengard 1997). It has, however, been said that the current NHS system particularly 'fails' homeless women since many health schemes look after 'traditional, white, male street drinkers' and because women, by the 'different' nature of their homelessness, are more difficult to target and follow up (Balazs 1996).

This latter sentence provides *the* important link with Chapters 1 and 2. Although notable studies have been conducted with women (*cf.* Watson with Austerberry 1986; Webb 1994; Tomas and Dittmar 1995) homelessness among young women is a subject which neither the homelessness nor, as illustrated here, the homelessness and health literature have fully addressed. Despite evidence of rising consultations to specialist health services by homeless young women (Balazs 1993), very little is actually known about their health needs and concerns. With the exception of Bines' (1994) study, young women are largely invisible. Accessing information on homeless young women's health has been through their role as actual or potential mothers, or studies which highlight 'risks' to the person, or 'health risk behaviour'. They have not been studied holistically in their own right.

There are several factors which appear to have contributed to this situation and these include, the division in the literature between statutory and non-statutory conceptions of homelessness, between single people and families, between academic or professional quantitative research and campaigners' anecdotal reportage, and, historically, the over-riding focus upon males. Nevertheless, this introduction has demonstrated that all studies pronounce the health of homeless people to be poor. Although the literature has advanced from 'pathological' approaches to health and homelessness issues to a consideration

of various environmental factors which contribute to poor health, the acknowledgement of all processes involved in producing health outcomes remains under-developed (*cf.* Pleace and Quilgars 1997).

The influence of biomedical approaches to homelessness and health must be problematised for, by transforming 'health' into 'ill-health', the hegemony of biomedical conceptions is not challenged and 'health' and 'ill-health' cannot then be conceived as social products. Without such a problematisation, homeless people will continue to be portrayed as 'different', either as 'victims' of circumstance, or as deviant by virtue of their 'health risk' behaviour. Such imagery must be challenged for, when located within the structures and processes of late modernity, considered in Chapters 1 and 9, homeless people's lived experiences are different only by degree, this being the intensity of their social exclusion, not of kind.

This research project was not intended to be maverick and, indeed, was initially conceived, somewhat naively, as a straight-forward qualitative investigation into the health experiences of homeless young women whom, to this point, had not been researched in their own right. Having studied homelessness issues at undergraduate level, and furnished with some experience of providing health care to homeless people, there was little doubt that homelessness and health problems are inter-related. However, coming from a sociological perspective, questions arising from an extensive review of the existing literature and the subsequent fieldwork soon served to problematise the basis of the many associations and assumptions made concerning homelessness, health outcomes and, especially, health agency.

This interest in a qualitative understanding of homeless people's intentional agency was kindled through a much earlier encounter. One night, an elderly man who had slept rough for many years was brought into the Accident and Emergency Department where this author was on secondment. Unkempt and

filthy, his health was very poor. As the junior student this author was dispatched to undress him. Whilst peeling off the layers of his sticky clothing, lumps were felt in his overcoat; carefully sewn into the lining, these lumps were found to amount to several hundreds of pounds. This man had neither family, nor worldly possessions and his greatest fear was that he would be subjected to, what he termed, a 'paupers' burial; these life-savings were intended to ensure he would receive a 'decent' funeral. He desired neither pity nor condemnation for his situation, merely the guarantee that he would be accorded dignity in death.

Objectively, this man represented a classic image of a 'Down and Out', and all the pejorative notions this arouses, but, subjectively, his concerns about and actions in regard to funeral provision were no different to most impoverished people of his age group. Yet, societal response to the existence of homelessness has been the objectification of homeless people through stereotypes which deny them the essential reflexivity and the intentionality inherent in all human beings. They are made different. Homelessness is portrayed, explained and responded to simplistically, and homeless people's 'otherness' consolidated. The 'medicalisation' of homelessness has served to reinforce and reproduce such conceptions.

Within this scenario young women are less visible, for the existence of homelessness amongst this section of society threatens, not only the archetypes upon which such difference is sustained, but the very values upon which contemporary notions of 'home' and social divisions are founded. Where young women are made visible they are presented as 'vulnerable' or 'damaged'(*sic*), child-like in their needs, or they are presented as conniving exploiters of their sexuality to obtain a house. Such dichotomous imagery is a long-standing reaction to young women who do not conform to gendered expectations, but what is new are the conflicting messages in contemporary society where women 'can have it all' in terms of career, material success,

marriage and motherhood. Accordingly, how young women, subjected to cumulative processes of social exclusion, construct their own identity must be an integral part of understanding their overall well-being. By qualitatively exploring health as a holistic and affective concept in this thesis, incorporating physical, mental and social well-being, 'homeless' young women are afforded the opportunity to contribute their own accounts and evaluations of their experiences to the research process.

Chapter 1, *Challenging 'difference'*, reviews the existing homelessness literature and contextualises homelessness within developments in the political economy. By focusing upon youth transitions and relating these to processes of social exclusion this chapter provides the foundations for a normative understanding of homelessness amongst young women and thus highlights the need to locate their health and ill-health experiences within wider structures and processes. Chapter 2, *A different challenge,* develops this argument by problematising cause and effect type approaches and the gender-blind, quantitative and biomedical orientation of most homelessness and health studies through challenging the notion that self-reports of 'health' and 'ill-health' are objective categories. Instead, by reviewing a rich and diverse range of sociological literature on health and ill-health, health meanings and actions, a holistic model of health is advocated and the case for an understanding of the mediating effects of the affective body is made. Chapter 3, *The bricolage*, explains the rationales underpinning, and the chronological development of the eclectic, yet complementary blend of methodological imperatives and inductive methods employed throughout this project. Chapter 4 provides a descriptive overview of the institutional context for this study.

Consistent with the themes identified in the earlier chapters the remainder of the thesis presents an interpretation of the data collated from the main interviews. Deliberately adopting a style akin to most homelessness and health studies, Chapter 5 *Problematising associations between homelessness and*

health, provides the basis for highlighting the importance of going beyond the reported health problems themselves to an employment of these for engendering understanding of the social and material circumstances within which they were produced. As implied, Chapter 6, *Establishing the need for context, not 'causes'*, explores the cumulative material, gendered and psychosocial processes through which the sample became 'homeless' and lays the foundations for an appreciation of the argument that, for this sample, 'homelessness' cannot be conceived as a new or aberrant state of being. This argument cannot be understood without exploring how the sample defined themselves and their situations, so Chapter 7 *Lifeworld and identity*, by exploring these meanings in terms of well-being, problematises the commonly held view that 'homelessness' is experienced as a progressive downward spiral and, therefore, only produces negative health outcomes. The complexity of the sample's conceptions of health, initiated in Chapter 5, is developed in Chapter 8, *Health Agency*, whereupon these and the sample's actions in regard to health are contrasted with existing pronouncements about homeless people's motivations towards health. Finally, Chapter 9, *The paucity of theory: some directions*, draws the thesis to a conclusion by offering a means of conceptualising this sample's homelessness and health experiences as symptomatic of the risks inherent in late modernity and underlines the need for much more collaborative, inter-disciplinary research in this area.

Several theses could have been written from the rich data collated throughout this project, yet from the relatively small portion presented in the chapters that follow it is hoped that a full appreciation of the basis for these arguments can be engendered. Although the findings from this research offer a challenge to conventional wisdom on homelessness and health issues, they do not appear to stand alone. A wind of change is beginning to blow, whether in the developing qualitative orientation of homelessness studies with young people and women, which shall be outlined, in the collectivity of *Speakout*, the campaigning organisation by and for homeless people, or in television programmes, such as

Beg to Differ, (Channel 4, June-July 1998). It is hoped that the conclusions reached in this thesis will spur debate on the real issues underpinning homelessness and health outcomes. This thesis makes no great claims other than, by providing a different way of researching homelessness and health, by problematising taken-for-granted associations and assumptions and, simply, by going beyond the apparent, it is hoped that this study will contribute to these emerging changes through providing a more normative way of understanding and conceptualising homelessness experiences and related health outcomes.

Chapter 1

Challenging 'difference'

This chapter problematises the widespread impression that homelessness represents a state of otherness, that it is an objective category to be quantified and explained without due acknowledgement of the social, material and political processes which give rise to its existence. The first section considers how homelessness has come to be defined. By highlighting difficulties with the many definitions offered, it is argued that the most important sources of definitions, homeless people themselves, have rarely been consulted. It also introduces the actuality that statutory definitions and counts are of little benefit in studies of youth homelessness, and especially young women's homelessness. Moreover, as a corollary of looking at definitions of homelessness, the failure to consider the gender-specific meanings of 'home' in most homelessness studies (*cf.* Watson with Austerberry 1986; Tomas and Dittmar 1995) ignores findings from notable studies that 'home' does not necessarily correspond with the physical structure of 'house'. As a social construct 'home' is imbued with a host of psychosocial inferences and it follows that homelessness cannot be explained by reference to inadequate housing provision alone. These issues are pursued in subsequent sections which focus upon the importance of contextualising homelessness and conceiving homelessness among young women within a framework of factors associated with 'youth transitions' in late modernity. This provides the basis for arguing that there exists an ideological imperative for locating homelessness within a normative framework. The latter sections, therefore, provide a means of understanding the social structuring of homelessness among young women. Finally, the concluding section provides an overview of the local context.

Defining the 'problem'

In Britain homelessness is not a new matter of public concern, but by the early 1970s it had re-emerged as a major social and political issue and the historical context for the development of policy and provision is recorded elsewhere (Donnison and Ungerson 1982; Ball 1983; Watchman and Robson 1983; Malpass 1986; Rose 1988; Karn 1990; Clapham *et al.* 1992; Malpass and Murie 1994; Sommerville 1994). Before 1977 the statutory responsibility for homelessness provision lay between the Department of Health and Social Security (DHSS), at the national level, and local social services departments. The major shift in government policy towards homelessness came in the Housing (Homeless Persons) Act of 1977 which codified homelessness as a housing problem and from this date statutory responsibility has remained with local housing authorities, with the Department of the Environment, in England and Wales, and the Scottish Office as overseers of this policy. The previous focus upon homelessness being a welfare issue is found in local social services departments retaining residual responsibility for housing those with 'special needs'. For young people this now comes under the provisions of the Children Act (1989) in England and Wales, and the Children (Scotland) Act 1995. The 1977 Act was then incorporated within Part III of the Housing Act 1985, in England and Wales, and Part II of the Housing (Scotland) Act 1987. Although this has now been superseded by Part VII of the Housing Act 1996 in England and Wales (*cf.* Lowe 1997), and in Scotland a new Code of Guidance (Scottish Office 1997) came into effect on 1 December 1997, the Housing (Scotland) Act 1987, hereinforth termed 'the Act', continues to be applicable. Under the Act the obligations for local authorities include giving reasonable preference to homeless people, providing appropriate advice and temporary assistance, taking reasonable steps to avoid homelessness, and providing permanent accommodation. Applicants are deemed to be homeless if they:

* have no accommodation which they are entitled to occupy by virtue of an interest in it, a right or permission, or by virtue of protection in law;

* have accommodation but are unable to secure entry to it, or are at risk of violence or threats of violence from another resident, or someone who used to stay with the applicant, or unable to park a mobile home or moor a houseboat; or
* have accommodation which is overcrowded and which may endanger the health of the occupants, or which it is unreasonable for them to continue to occupy.

Applicants are deemed to be threatened with homelessness if they are likely to fall into one of these categories within twenty-eight days. If the authority is satisfied then it must make further enquiries to decide if the applicant comes into one of the categories of 'priority need':

* with dependent children;
* pregnant women;
* made homeless because of fire, flood or similar emergency; or,
* are vulnerable because of old age, mental illness or handicap, physical disability or other special reason.

If an applicant meets one of these conditions the local authority must then decide if they have become homeless 'intentionally'. This is deemed to have arisen if actions deliberately caused the loss of accommodation which it would have been reasonable to continue to occupy. If this is so, then the local authority only has a limited duty towards them through the provision of temporary accommodation for a limited time, and advice and assistance in finding housing. Finally, if the applicant does not satisfy the 'local connection' criterion, referral can be made to another local authority where a connection exists. Only where all of these conditions are satisfied does the local authority have a statutory duty to secure permanent accommodation for the applicant. If the applicant fails to meet these criteria the local authority only has a duty to provide advice and assistance.

Young single people over the age of sixteen are accommodated under the Act only if local councils deem them to be 'vulnerable', and in 'priority need' (DoE 1989). Age alone does not qualify for inclusion (DoE 1991). However, degrees of discretion are allowed in the interpretation of 'other special reason' and

examples of these in the recent Scottish Code of Guidance include: young people of 16 or 17 years who may be at risk of sexual or financial exploitation or involvement in drug or solvent abuse, if they have left home without moving to stable accommodation; young people under 19 who have been in care; chronically sick people or those recently discharged from hospital or prison: women suffering, or in fear of violence; or, people at risk of racial harassment (Scottish Office 1997: 40). From 1 January 1998 the Homeless Persons (Priority Need) Order secured the rights to accommodation of young people under twenty-one years previously looked after by local authorities by codifying those young people as a priority group, if unintentionally homeless (Scottish Office, December 1997).

Within the bounds of the law, local authorities can exercise discretion of interpretation and in the types of accommodation provided and these have been said to favour families with children and elderly people (Niner 1989a; Butler *et al.* 1994). Whilst the statutory definition of 'homelessness' has attempted to safeguard the rights of eligible households, it has also been presented as a rationing device (Johnson *et al.* 1991) and the difficulties experienced by single people or childless couples in securing accommodation are recorded (Watson 1986a; O'Mahony 1988; Thomas and Niner 1989; Thornton 1990; Anderson 1993; Jones 1993). An example of such 'rationing' can be found in recent Scottish Office statistics which reveal that of 41,000 homeless applications in 1995-96, just under three-quarters (74%) were assessed as homeless or potentially homeless (Scottish Office 1998). Moreover, as a result of additional factors outlined shortly, it is believed that the numbers of people falling outwith the specified categories may equal, or be greater than those included (Greve with Currie 1991).

There is no absolute consensus of how 'homelessness' should be defined, but one factor upon which most commentators agree is that the terms of the statutory definition are too narrow and most authors include a broader number

of housing situations and categories of housing 'need' in their definitions (*for example,* Brandon 1974; Watson 1984; Watson with Austerberry 1986; Murie and Jeffries 1987; Spafford 1991; Hutson and Liddiard 1994; Pleace *et al.* 1997). The variety of definitions incorporating rooflessness, houselessness, long-term institutions, bed and breakfast accommodation, or intolerable housing conditions (Watchman and Robson 1983) pose a fundamental problem when trying to quantify the population who are homeless, as demonstrated shortly. Among the many definitions offered, however, those from 'the defined' themselves have tended to be neglected, although notable authors have begun to address this by exploring individuals' own interpretations and experiences of their situation (Watson with Austerberry 1986; Canter *et al.* 1990; Hutson and Liddiard 1994; Tomas and Dittmar 1995; Downing-Orr 1996).

A necessary precursor to arriving at a working definition of homelessness is to address how 'home' has come to be defined. There is a twofold basis for this exigency since by exploring the tenets of this social construct it becomes possible to recognise what is 'absent' when people become 'homeless', and because women's status has been linked inextricably to this construct since the separation of home and workplace in the late eighteenth and early nineteenth century, which provided the foundations for the privileging of 'the home' and women's place therein. The production of this 'ideal' has had distinct gender-specific connotations and outcomes considered elsewhere (*for example,* Vicinus 1977; Foucault 1978; Smart and Smart 1978; Davidoff 1979; Watson with Austerberry 1986; Weeks 1989). Notable amongst these are gender differences in the meaning of home (*cf.* Munro and Madigan 1993), and especially, the consolidation of a dichotomous classification of women (*cf.* Walcowitz 1977; Mahood 1990). Accordingly today, the existence of homelessness in a 'home based society' (Marcuse 1988) and especially homelessness among women serves to question the presuppositions upon which notions of the 'home', and women's roles and identity are constructed.

The 'home' is considered the basic unit of social and economic organisation (Pahl 1984) but, as suggested above, the social and personal significance of housing exemplified in the 'home' which, as a socio-spatial unit providing a base for social interactions (Giddens 1984), epitomises far more than a utilitarian place of physical shelter. This positively ascribed notion provides the context for a complex of processes and meanings that engender a sense of personal autonomy and 'ontological security' (Saunders and Williams 1988; Saunders, 1990). Moreover, when considering the variety of socio-psychological inferences (*cf.* Tognoli and Horwitz 1982; Sixsmith, 1986; Rybczynski 1988; Doyle 1992) the 'home' is representative of personal comfort, protection, privacy, support, and stability. Accordingly, the symbolism imbued in the 'home' has essential personal and social dimensions. On the personal level it provides a stable context for the production of meanings and identity and it also provides a base for the individual's interaction with, and participation in wider social, economic, political and cultural processes. The fundamental factor to acknowledge here is that these socio-psychological constituents of the meaning of 'home' are not always synonymous with physical structure (Tomas and Dittmar 1995) and this has a bearing on whether individuals regard themselves as 'homeless', even if they appear to be, or have been accepted officially as such (Hutson and Liddiard 1994).

Any working definition of 'homelessness' should, therefore, facilitate an appreciation of not only the physical framework or fabric of housing in terms of shelter, warmth, adequate facilities, space and privacy, but also to allow for an exploration of the individual's own self-identity, their own sense of physical and emotional security, their opportunities for personal development, for social, cultural and economic exchange, for full participation in society, and allow for a grasp of process. This research employs that proposed as:

> Individuals or families socially excluded from lasting occupancy of a suitable, i.e. *subjectively* and *socially* acceptable, personal abode and who:
> a. are without shelter and have nowhere to live but the street;
> b. find shelter through temporary accommodation:
> i. in an institution: establishments, care centres and hostels of various kinds set up and managed by the public authorities or the non-profit making sector;
> ii. in the private sector constituted by cheap hostels, casual furnished lodgings, and other private night shelters;
> iii. with relatives or friends whose home they share (involuntary cohabitation);
> c. or are subject to unacceptable housing conditions on the housing market or elsewhere (unsuitably housed). (CDPS 1993; 24 emphasis added)

By accepting the term 'socially excluded' it is possible to explore 'society's role in excluding certain people from full participation' in society (Walker 1997: 49). This exclusion refers not only to fundamental material goods, such as housing or possessions, but has been defined elsewhere to include a range of basic human needs, from the absence of employment, to the more emotional aspects of the absence of family relationships, friendships and sexual relationships (Dant and Deacon 1989). Accordingly, the term 'social exclusion' is employed in this thesis to encompass a lack of material resources alongside the inability to participate effectively in the economic, social, cultural and political life of mainstream society (*cf.* Duffy 1995). Yet, as a corollary of this process of exclusion, recent research among young people has indicated that there is also a process of inclusion to be considered (Downing-Orr 1996) and this is pursued in Chapter 7.

The weakness in this definition of 'homelessness' is that by accepting such breadth the actual term 'homeless' has the potential to become meaningless and impossible to measure. This problem is insoluble and will not be rectified in this research which instead will illuminate its strength. This loose framework allows for an exploration of individuals' perceptions of their situation whilst

locating these perceptions within a social and material framework. Homelessness is proposed to be an absolute and a relative category which cannot be understood without reference to 'homeless' people's own accounts and definitions. Moreover, it will be possible to explore process by tracing the various accommodation strategies employed throughout the interviewee's housing 'careers'(Banks *et al.* 1992; Coles 1995), their own accounts of these, and especially, the contexts for the production of their own definitions.

The extent of the problem

Having presented the main difficulties associated with definitions of homelessness, the foundations for an appreciation of related measurement problems have been laid. As a result of various difficulties associated with quantification it is generally accepted that exact figures are not known (*for example*, Drake 1989; Randall 1989; Anderson *et al.* 1993; Hutson and Liddiard 1994; Pleace and Quilgars 1996; Pleace *et al.* 1997). In Scotland between 1995-96, of 41,000 applications by households to local authorities under the homeless legislation, some 30,300 were accepted as homeless or potentially homeless (Scottish Office 1998). Yet, it has been indicated that many people do not apply at all (Greve with Currie 1991). Such difficulties are shown to be further compounded by the differential policies and practices of local authorities (Duguid 1990; Liddiard and Hutson 1991; Butler *et al.* 1994).

One estimate of young people calculated that at least 246,000 *may be* homeless in the United Kingdom (Evans 1996: Appendix 2) though this figure is based upon a multiplication of actual and estimated numbers of homeless applications. Attempts to quantify the extent of homelessness are fraught with difficulties, but these problems appear to be particularly acute in assessing the extent of homelessness among young people, and especially young women. The first of these relates to the difficulties young people are said to experience in being accepted as statutorily homeless. The earlier outline indicated that age

alone does not qualify young people for inclusion in the 'vulnerability' or 'in priority need' criteria, and since 1991 the Department of the Environment has collated statistics only from those accepted as homeless, rather than all those who have applied, although in Scotland figures continue to relate to applications (Evans 1996; Yanetta and Edwards 1996). Research into homelessness among single people in England indicates that only around two-fifths of young people had actually applied to their local authorities (Anderson *et al.* 1993). A variety of possible reasons are offered as to why there is a reluctance for young people to apply which include: they are deterred from doing so because they are not accorded 'priority need' status; discouragement arising from length of waiting lists; the shortage of housing for single person households; and, allocation policies favouring the 'traditional' family (SCSH 1993). Further confusion is found to exist among the agencies who present 'youth homelessness' figures, since the differential boundaries used for the term produce variable results.

Without minimising the problems associated with quantification, actual measurement is not the purpose of this project. Rather what must be established are the reasons why young women have been chosen as subjects for research. The literature indicates rising trends among two main groups: young people (Randall 1988; Thornton 1990; Mann and Smith 1993; Hutson and Liddiard 1994; Bales and Cooper 1995; Burrows 1997) and women, either single or with dependants (Warlow and Spellacy 1985; Drake 1989; Greve with Currie 1991; Scott 1993; Webb 1994). Furthermore, in Anderson *et al.*'s study (1993) it is shown that young people under 25 years were over-represented in their sample, with females, although representing lesser numbers for their sample as a whole, outnumbering males in the younger age group. About half of sixteen to seventeen year olds who were sleeping rough were female, compared with about a quarter of those in the wider age group of sixteen to twenty-four years and, of those interviewed in hostels and bed and breakfast facilities, half of all female respondents were under 25 years compared to a quarter of males (*Ibid.*).

These findings appear to concur with other work (Jones and Stevens 1993) which indicates that the mean age of the female 'homeless' population has been falling (George *et al.* 1991).

It is argued that, alongside people from minority ethnic groups (Cowen and Lording 1982) women adopt different housing strategies from their male counterparts which makes their homelessness 'less visible' and this creates further enumeration difficulties (Austerberry and Watson 1983; Watson with Austerberry 1986; Oldman 1991; Webb 1994). This, however, could be an artefact of two historical factors associated with lesser hostel provision for women than for men and, regarding the fabric or atmosphere of facilities, it is said that women have been reluctant to utilise the facilities that do exist (Gosling 1990; Harrison *et al.* 1991). Whilst this may be applicable to the wider homeless female population, the research referred to above suggests that among young women this may not be the case and this appears to be supported elsewhere for both women, and those from minority ethnic groups (Randall and Brown 1993; Vincent *et al.* 1994). This change could also be an artefact of increasing provision for young women (Watson and Cooper 1992). Fundamentally, the root of enumeration difficulties lies in there having been no systematic research into homelessness among young women despite their providing a significant point of intersection for both sets of trends.

Youth homelessness defined

Homelessness among young people has been described as an 'unsuccessful and incomplete transition from youth to independence' (Doogan 1988: 89). In wider youth studies the concepts of 'extended', 'protracted', 'accelerated', 'fractured' or 'de-sequenced' transitions are well considered (Willis 1984; Wallace 1987; Jones 1987, 1993 (3), 1995; Banks *et al.* 1992; Jones and Wallace 1992; Coles 1995; Furlong and Cartmel 1997). The term 'transition' is adopted as an essential defining feature in this research and its relevance to health is demonstrated in Chapter 2. However, because the population to be

studied are 'young' the 'youth to independence' definition cannot be accepted, simply because a term cannot define itself. Thus far the terms 'young' and 'youth' have been used without either definition or justification for their usage and it is now time to rectify this.

In homelessness research the term 'youth homelessness' is presented in a variety of ways to refer to persons between the ages of 16 and 21 years (Downing-Orr 1996) or between 16 to 24 years (Anderson *et al.* 1993), but this research adopts that which is more generally accepted as referring to those young people between the ages of 16 and 25 years (Hutson and Liddiard 1994), such as the work of Stockley and Bishopp (1993) considered later. Moreover in wider 'youth' studies where the term is acknowledged as a social construct this looser choice of age group is supported (*cf.* Springhall 1986; Furlong and Cartmel 1997).

Youth has been defined as an intermediate phase in the life course between childhood and adulthood (Jones and Wallace 1992). Whilst the fundamental problems in attempting to define both of these latter concepts are acknowledged this discussion must necessarily focus upon the constituents of this 'intermediate phase'. This phase has no clear beginning nor end and covers a period wherein individuals are accorded staged rights and responsibilities, and acquire a status of 'semi-dependency and semi-independence', childhood being accepted as a state of dependence on parents or 'surrogate' parents (Coles 1995: 7, 4). In the context of homelessness research it is important to consider two main statutory factors which appear to set limits to this phase. Firstly, as stated earlier, young people aged sixteen and above are not required to be accepted automatically as statutorily homeless by virtue of their age alone and secondly, as addressed later, full rights to Income Support at the adult rate are not granted until the age of 25 years because of an assumption that young people would remain within the parental home until this age (Harris 1989).

Accordingly it is necessary to indicate possible reasons why this state of 'semi-dependency and semi-independence' appear to be implicit in statutory considerations by identifying what has been posited as transitionary markers and processes through which individuals move from perceived 'dependency' to the rights and obligations implicit in conceptions of 'adulthood'. Three key constituents of this intermediate phase have been described: the education to employment transition; the domestic transition; and, the housing transition (Coles 1995; Furlong and Cartmel 1997). By incorporating these three key transitions in this research it is the intention to provide a tentative conceptual framework for the study of homelessness among young women as arising from the unsuccessful passage from 'dependency' to 'independence', the outcomes of which are set within the socio-spatial framework of the definition of homelessness offered earlier.

Presenting the problem

This section provides an overview of the way in which homelessness is usually presented in the literature. Before this commences there is an important point to raise concerning terminology: 'the homeless', including its variants, must be unveiled. This term continues to be employed by the media and by campaigning organisations, but it is also reproduced in the homelessness literature, disappointingly even amongst the most creditable texts (*for example*, Bevan and Rhodes 1997: 190) and especially in the homelessness and health literature (*for example*, Lowry 1991: 88; Connelly *et al.* 1991; Widgery 1993: Foreword; SCOPH 1994). By applying the fundamental tenets of labelling theory (Becker 1963) to this socially defined category the problems of its usage become apparent and this bears relevance to the subsequent discussion. Although the heterogeneity of this population is stressed (Garside *et al.* 1990; Anderson *et al.* 1993; Evans 1996; Burrows 1997; Kemp 1997), the continued use of this label in much of the literature serves to objectify individuals and reinforce stereotypes.

The existence of homeless people whose circumstances and experiences stand opposed to privileged societal mores, particularly the notions of 'family' and 'home', disturbs these privileged ideals. It is here that 'the label' plays its part by simplifying conceptions so that the stereotyping and essentialising effect this produces helps to order how those individuals are perceived by the wider society. By objectifying people as 'the homeless' the label is no longer applicable to the circumstances within which individuals are living, it comes to represent their whole being and the individuals, their experiences and meanings ascribed to, and arising from, these experiences become lost. In considering such matters it is clear that there is much room for work into the effects of the label itself on the individuals' sense of self and of their well-being, and the ways through which stigma is experienced and handled, particularly since it has been postulated that there is a greater stigma attached to young women's homelessness in their inclusion in the popular 'fallen' women imagery (Dibblin 1991).

Baldly stated 'explanations' of homelessness have tended to fall into one of two categories which are individually or structurally based and these divisions are considered elsewhere (*for example*, Thorns 1989; Thornton 1990; Johnson *et al.* 1991; Hutson and Liddiard 1994; Tomas and Dittmar 1995). This dichotomy persists despite the fact that the combination of circumstances and the complexity of factors which give rise to the outcome of homelessness are documented (*for example*, Thomas and Niner 1989; Anderson *et al.* 1993; Jones 1993; Burrows *et al.* 1997). By focusing upon either 'individual failure' or 'system inadequacy' (Thorns 1989: 253) at the crudest level homeless people are presented as somehow culpable of, or as having a pathology which has predisposed them to homelessness, or they are presented as almost passive victims of structure, and these constructs are particularly relevant to media representations (*cf.* Hutson and Liddiard 1994). Moreover, young women have been particularly subjected to stereotyping in their frequent depiction of using pregnancy as a deliberate housing strategy despite no evidence being found

(Greve with Currie *op cit.* 1991; Jones 1993 (4); Ermisch *et al.* 1995; Speak *et al.* 1995; Lowe 1997). The theoretical problems this dichotomous quagmire poses have been highlighted recently (Neale 1997a, 1997b), and these are pursued in Chapters 3 and 9.

Processes contributing to homelessness among young women

In light of such types of portrayal the following sections endeavour to break away from the practice of presenting the 'causes' of homelessness by structural and individual factors. Earlier work provides some impetus for this (Thomas and Niner 1989) where the problems in trying to find any one specific reason for homelessness among the residents of temporary accommodation are highlighted and accordingly 'becoming homeless' is described as arising from a sequence of events and circumstances. Homelessness among young people has been described as the product of a 'fractured transition' (Jones and Wallace 1992; Williamson 1993). Correspondingly, the following sections present factors which are identified as predisposing young women to homelessness in a manner which explores these 'causes' as constituents of a process, or processes which impede the successful conclusion of the main transitions, outlined above. These transitions are not mutually exclusive and as will be shown there is a strong inter-relationship between the factors which can impede all three.

Adopting this approach is necessary, for as has been shown above homelessness is codified as a 'housing problem' and most of the literature reinforces this categorisation. For all people, but especially young people, 'homelessness' is said to lie in the shortage of affordable provision in areas where they seek to live (*for example*, Thornton 1990; Gosling 1990; Hutson and Liddiard 1991). Yet as will be shown, young people, and especially young women, as a result of differential employment, unemployment and income levels, are placed in a precarious position socially and economically and this bears directly on their housing opportunities, a position further augmented

where families are unable or unwilling to provide forms of material and social support.

The housing transition

This section considers factors which are proffered as contributing to the failure of the 'housing transition'. In housing literature it is stressed that the housing needs of single people as a whole have been overlooked in policy terms throughout this century, with a few exceptions where the needs of families are thought to have been met and this has often taken the form of 'special needs' (*for example*, Clapham and Smith 1990; Garside 1993). A full exploration of British housing policy and practice throughout this century is clearly presented elsewhere (*for example,* Balchin 1989; Clapham *et al.* 1992; Malpass and Means 1993; Malpass and Murie 1994; Currie and Murie 1996). This section presents an outline of key factors which are said to contribute to what has been termed a 'housing crisis' (Malpass 1986) or an 'access-crisis' (Kleinman and Whitehead 1988) and which are implicated in the production of homelessness among young women.

The focus of policy upon the needs of 'conventional families' is a central concern among feminist authors who argue that the patriarchal operation of housing systems have worked to marginalise women and they emphasise the difficulties experienced by women in obtaining housing in their own right, particularly in regard to allocation practices (Austerberry with Watson 1986; Brailey 1986; Watson 1986a, 1986b; Webb 1994). However, as examined elsewhere there is a need to explore the processes through which housing attainment is in itself an expression of wider social inequalities and relations (Munro and Smith 1989) and is a product of the structures of housing provision (Ball 1986). The inherent weaknesses of focusing upon a single theoretical paradigm is emphasised (Pugh 1990). As will be shown, the limited nature of employment opportunities available to many young women are themselves the product of a number of processes, yet it is the ability to afford housing through

remuneration from paid employment which has been shown to be the key feature in determining housing opportunities and choice (Murphy and Sullivan 1986).

The literature indicates that generally lower income levels among certain social groups produces specific tenure outcomes. Alongside people from minority ethnic groups, single women and lone mothers are shown to be more likely to live in social rented housing than other groups (Mason 1995; Wilcox 1996). Yet, because young single people have generally not had access to council housing and home ownership is rarely possible, the private rented sector has tended to provide first-stage accommodation for this group as a whole (Hutson and Liddiard 1994). Accordingly the policies which have contributed to a decline in the private and public rented sectors and a rise in rents and which have been implicated in the reduction of available and affordable rented housing must be identified.

The structuring and restructuring of the tenure system has been directly related to government policy. The baldest essence of housing policy objectives since the 1960s has been the positive support of owner-occupation, the progressive decontrol of privately rented housing since the 1980s and the encouragement of social housing through organisations other than local authorities. These historical factors are presented as providing the basis for contemporary shortfalls in housing for young people and women (Thornton 1990; Watson with Austerberry 1986). The Conservative government's systematic pursuit of these objectives through interventionist policies, underlined by taxation and public expenditure considerations, which promoted privatisation and demunicipalisation, is cited in the homelessness literature as specific factors which contributed to the problems of accessing and securing affordable housing.

Despite only a minority of young people being likely to secure accommodation in local authority housing (Hutson and Liddiard 1994), this being under the terms of the homeless legislation or The Children Act 1989, and The Children (Scotland) Act 1995, a study of local authority waiting lists identified a large increase in the numbers of young people applying to local authorities between 1986 and 1991(Prescott-Clarke *et al.* 1994), yet this was set against a background of a marked decline in the quality and quantity of stock in this sector. The Housing Act 1980 and The Tenants Rights Etc. (Scotland) Act 1980 introduced the 'Right to Buy' and by 1995 almost 1.7 million of the better quality social housing stock had been sold (Ginsburg 1997). A number of restrictions were placed upon local authorities which prevented them from using receipts from sales for new build replacements and this has accompanied cuts in bricks and mortar subsidies and investment in England and Wales (Ginsburg 1989). It must be stated, however, that these sales have tended not to be of properties traditionally occupied by young people, but are key to understanding the overall decline in this sector. It is this shortfall in supply and availability which has been implicated as the main factor in determining the rate at which people are rehoused from waiting lists (Bales and Cooper 1995). It is argued that as a result of this policy local authority housing would increasingly become 'residualised' to providing poor quality housing for those on low incomes (Forrest and Murie 1983). This earlier prognosis appears to have some merit with about 65 per cent of tenants living in social housing in 1994 being found to be in receipt of housing benefit (Newton 1994).

More notably for young people, changes arising from The Housing Act 1988, and the Housing (Scotland) Act 1988 are particularly highlighted as contributing to the decline of affordable accommodation to rent. This was introduced to increase the supply of privately rented accommodation by removing statutory rent controls. These enabled landlords to charge 'market rents' instead of 'fair rents', and under the 'assured' or 'assured shorthold', or 'short assured' in Scotland, leases permitted by these Acts there has also been

less security of tenure for tenants. Secondly, housing associations, which have traditionally been a source of housing for people on low incomes (Newton 1994) were also affected by these Acts with the introduction of mixed-funding and this is shown to have led to an increase in rents. Accordingly it is argued that people on low incomes, especially young people have been disadvantaged by these changes. Moreover, single people have generally not been entitled to assistance with deposits and rent-in-advance payments for private rented accommodation since the introduction of the Social Security Act 1988 (Pollitt *et al.* 1989; Thornton 1990; Hutson and Liddiard 1991; Spafford 1991; Evans 1996). Others assert that within this 'disadvantaged' group, women (Brailey 1986) and lone parents (CIH/One Plus 1994) are subjected to additional problems in securing rented accommodation by virtue of their weaker socio-economic position, and because of discriminatory practices, this latter issue being said to be particularly germane for those from minority ethnic groups (Bowes and Sim 1991) or lesbians and gay men (Anlin 1989; Evans 1996).

Some commentators focus upon the increased use of temporary accommodation by local authorities, such as hostels, bed and breakfast establishments and short life housing, and this has long been criticised as expensive and unsuitable (Conway and Kemp 1985). These accommodation types are often criticised as sub-standard (Greve with Currie 1991; Liddiard and Hutson 1991; Hendessi 1992; Anderson 1993) and are implicated in the poor health of residents. This sector has also been subject to revised social security regulations whereby the system of direct payments to cover lodging costs was replaced by the payment of housing benefit with the remainder being met from the residents' income (Scottish Homes 1995). Given that young people have been found to be over-represented in hostels and bed and breakfast accommodation (Thomas and Niner 1989; Anderson *et al.* 1993; Kemp 1997) this change impacts upon the reduced incomes arising from the other benefit changes to be identified.

Without minimising the consequences of these housing factors, they only partly explain the outcome of homelessness. The processes which render young women unable to afford and maintain housing in their own right are more fundamental. Moreover, by problematising the creed that homelessness is basically a housing concern, weaknesses in other explanations for homelessness can be shown. This is key to understanding why relationships between homelessness and health are problematised in Chapter 2.

The education to employment transition

The successful conclusion of the education to employment transition is a marker of having acquired adult status, and provides the economic resources for young people to be able to live as self-supporting individuals. Unemployment is, therefore presented in the literature as a major cause of youth homelessness (Randall 1988; Thornton 1990; Hutson and Liddiard 1994; Evans 1996; Quilgars and Anderson 1997) and these authors also underline the tautological problems of the no home, no job cycle. It is also shown that homeless young people are more likely to have truanted and to have left school earlier without qualifications, and to have been more likely to have been on youth training, to have left before completion, and to be unemployed than their housed counterparts (Jones 1993). However, not all homeless young people lack academic qualifications (*cf.* St Mungo Association 1996).

Figures (*for example*, OPCS 1995) indicate that young people as a whole experienced disproportionally the negative consequences of the economic restructuring in the 1980s and early 1990s, explained later. However, as with all statistics there are inherent caveats, particularly those pertaining to the subjects of this research since official statistics include only those who are unemployed and receiving benefits, and this skews the results particularly for sixteen and seventeen year olds who are able to claim only if they have a Youth Training place or are accepted under one of the strictly defined categories of 'severe hardship' (Oppenheim and Harker 1996); it is suggested that almost

nine tenths of unemployed sixteen and seventeen year olds have no form of income (Chatrick and Convery 1997).

Additional difficulties arise when looking at figures for women who may not be eligible for benefits since they are less likely to secure these in their own right and have also been shown to be more dependent on means-tested, non-contributory benefits than men (Lister 1992). In support of the female under-estimation thesis, one study proposes that although women comprised forty-seven per cent of those actively seeking work, they constituted only twenty-four per cent of those eligible to claim benefits (Muir and Ross 1993). This type of disparity appears to be consistent with other work, such as analysis of the 1991 Census in Scotland where, although official accounts indicated that female unemployment was just under half (5.2%) of that for males (10.7%), when the levels of 'non-employment' in terms of all those of working age who could work, but are not in employment are considered, women's 'non-employment' rate was calculated as being more than twice as high (28%) than men's (13%) (Tennant 1995: 25). These difficulties demonstrate caveats which must accompany any numerical presentations. Nevertheless, the official unemployment rate for young people aged 16 to 24 who were unemployed and claiming benefit at point of start of the interviews for this research was around 15 per cent, representing almost twice the national average (DoE Spring 1996).

Unemployment, although a factor in explaining homelessness, is itself an outcome of wider forces and processes which must be considered and, as this section is concerned with the education to employment transition, the factors which limit the potential for employment are explored. Among the factors shown to predispose individuals to unemployment are poor qualifications, lack of skills, youth and inexperience, and poor health or disability (Convery 1997). When looking at the first of these factors it would appear that young people who have already experienced homelessness with their parent(s) have considerable potential to be disadvantaged in this area. One study of children

living in temporary accommodation identifies the detrimental effect of homelessness upon their schooling and this was found to be related to a combination of factors, including difficulties associated with the reasons for their homelessness, stigmatisation by fellow pupils, late or missed attendances, and difficulties associated with ability to perform homework in their living environment (Power *et al.* 1995).

Qualifications or skills are essential to the successful progress of young people's move towards independence, yet various research reports point to a widening gap in opportunities for young people with one aspect of this being the record numbers who are entering further or higher education. Analysis of the National Child Development cohort study found some 33 per cent of 18 year olds in full-time education compared with 15 per cent in 1979 (Ermisch *et al.* 1995). Other work based on the 1988 School-Leavers study has shown this rise to be related to parental social class with young people from social classes I and II being twice as likely to stay on at school beyond school-leaving age (76%) than those from social classes VI and V (38%), and those from the former classes being five times more likely to enter further or higher education (40%) than the latter (8%) (MacGuiness 1992: 11).

This has been accompanied by a decline of the youth labour market (Courtnay and McAleese 1993) and the segmentation of occupations available to young people particularly by sex (Ashton *et al.* 1990). Various youth training initiatives were introduced to provide work experience and training for young people unable to secure employment, but these have been criticised for their failure to guarantee a training place for all eligible young people, inappropriate placements, and for providing insufficient income levels (Spafford 1991). These have also been shown to reinforce practices of segmentation by sex. One cohort study, explained below, reveals that the majority of young women on youth training were placed in 'traditionally female' schemes of clerical, cleaning, catering or sales (Courtnay and McAleese 1993). Moreover, further

analysis of this study also demonstrates the lesser propensity of young women to find employment in actual jobs at point of leaving school (14%) compared to their male counterparts (22%) and, where employed, over three-quarters of young women were found to be working in the predominantly 'female' areas outlined above, and personal services (Coles 1995: 42).

Work exploring 'youth trajectories' (Roberts 1993) provides an insight into the widening gap of opportunities available to young people. Using findings from the ESRC 16-19 Initiative cohort study (Banks *et al.* 1992) Roberts asserts that young people's life chances are pre-determined by their parents' social class and locality, this latter factor being of particular relevance in circumscribing labour market opportunities. In the context of homelessness, this has been suggested to be a particular difficulty faced by young people arising from the 'extension' of youth 'dependency' (Evans 1996) a matter expanded upon shortly. Roberts' work indicates that 70 per cent of young people from middle class backgrounds entered the 'successful trajectory', these 'trajectories' being: 'successful' resulting in the acquisition of good jobs; 'less successful' resulting in 'respectable' working class jobs; and, those resulting in insecure employment, youth training and episodes of unemployment. In contrast young people from working class backgrounds experienced 'failure' at one of three levels of transition: pre-sixteen years education; sixteen to eighteen years education, training and employment experience; and, post-eighteen years careers. For Roberts the pre-sixteen phase, and particularly educational attainment therein, is the most important since it determines the progress and outcomes of subsequent stages. Accordingly class background and locality are presented as the main determinants of a young person's career, but sex and ethnicity are also considered to further sub-divide these 'trajectories' (Roberts 1993).

This study further highlights factors which other authors have considered as affecting education to work transitions. These include, class background

(Willis 1977; Courtnay 1988; Banks *et al.* 1992; Furlong 1992); government policy on the relationship between poverty and schooling (Smith *et al.* 1997); locality (Ashton and Maguire 1986; Garner *et al.* 1987; Roberts *et. al.* 1987; MacDonald 1988), gender (Pollert 1981; Griffin 1985; Raffe and Courtnay 1988; Skeggs 1990) and ethnicity (Sillitoe and Melzer 1986; Banks and Ullah 1987; Mirza 1992). Coles (1995) considers additional factors which add further dimensions to the understanding of potential 'fractured transitions' and these are: experience of 'care', this being especially pertinent since research found that three-quarters of the care-leavers studied had left school without qualifications (AAC 1996); disability, ill-health or having 'special needs'; and, involvement with the criminal justice system (Coles 1995) all of which are also shown to have a bearing upon young people's propensity to become homeless and are considered in appropriate sections below.

Income and welfare benefits

Income levels arising from employment, training or unemployment benefits are key to understanding young people's ability to afford housing in their own right. For those young people in employment remuneration is proportionally lower than for older workers and within the category of youth itself levels are mediated by age and gender. This latter point is consistent with incomes for women as a whole who tend to earn just over 70 per cent of the full-time male wage (*cf.* DoE 1995). This weaker economic position impinges on their abilities to participate in the market as consumers (Jones 1993 (2)). Unemployment, however, may produce a more levelling effect between males and females, but this conclusion carries with it consideration of the gender-specific differentials already presented. When the interviews for this research were conducted contributory Unemployment Benefit and means-tested Income Support were the welfare benefits in force, but these were replaced by the Jobseekers Allowance in October 1996. The reduction in welfare benefits to young people under the age of 25 years is cited as another major factor in

contributing to homelessness (Thornton 1990; YHG 1990; Hutson and Liddiard 1991; Spafford 1991; Evans 1996).

The Social Security Acts of 1986 and 1988 introduced age-related cuts in benefit for young people who are now treated as 'non-householders' for benefit purposes, unless they have children, and throughout the period in which the interviews were conducted young people aged 18 to 24 years were receiving Income Support of £37.90 per week, compared with £47.90 for those aged 25 years and over. Sixteen and 17 year olds eligible for the discretionary income support benefit 'severe hardship payments' received a lower rate of £28.85 (CPAG 1995). Despite the difficulties associated with meeting the 'severe hardship' criteria, awards for these latter payments is shown to have risen sixfold between 1990 and 1996 (Evans 1996: 35) and, although these payments were originally intended to provide 'temporary cover' in 1993 repeat and continuous claims comprised just under three-quarters of all awards (CPRU 1993).

Other pertinent changes arising from the Social Security Acts are implicated in affecting young people's ability to afford housing. Housing Benefit is also paid on a sliding scale according to age, and this is evinced as further disadvantaging those under the age of twenty-five (Spafford 1991). Changes to Housing Benefit were introduced in October 1996 for single people under the age of 25 years and benefit is now based on shared and not self-contained accommodation. Another inculpated shift has been the introduction of the payment of benefits fortnightly in arrears and this is said to contribute to debt acquisition in the intervening period (Gosling 1990). The introduction of the Social Fund created a situation where any loans require to be repaid from benefits and this has been shown to produce financial difficulties (Huby and Dix 1992; Walker *et al.* 1992).

Wider social changes

The impact of these legislative changes, however, do not explain why they can lead to the outcome of homelessness. They need to be contextualised in reported wider trends of rising poverty and inequality (*cf.* Oppenheim and Harker 1996; Oppenheim, 1997), insecurity of employment (*cf.* Convery 1997) and greater incidences of low pay (*cf.* Webb *et al.* 1996) accompanying the growth in temporary and part-time work and a reduction in employment rights (*cf.* Pile and O'Donnell 1997) all of which are said to have produced an increasing polarisation between 'work-rich' and 'work-poor' households (Gregg and Wadsworth 1994). Official figures indicate that, in 1992, 13.7 million or almost a quarter of the UK population were living at or below the level of Income Support compared with just over a tenth in 1979. Whilst average incomes, after deductions for housing costs, had risen by 37 per cent between 1979 and 1992/3, the incomes of the lowest decile had fallen by 18 per cent whilst those in the highest rose by 61 per cent (DSS 1995; Social Security Committee 1995). Moreover, if defining poverty as below 50 per cent of average incomes after housing costs, these findings further indicate that one third of all children were growing up in poverty compared with a tenth in 1979 (*cf.* DSS 1995).

By means of conceptualising these changes to the lower strata, as defined earlier, the term 'social exclusion' (*cf.* Duffy 1995) is employed in this thesis. The key notion in the literature on social exclusion is its compound nature (*for example*, Lee *et al.* 1995) whereupon one disadvantage is said to build upon another. It is proposed that this composite process of exclusion is framed within and reproduced by the 'Risk Society',

> Like wealth, risks adhere to the class pattern, only inversely: wealth accumulates at the top, risks at the bottom. To that extent, risks seem to strengthen, not abolish class society. Poverty attracts an unfortunate

abundance of risks. By contrast, the wealthy can purchase safety and freedom from risk. (Beck 1992: 35)

Beck argues that in late modernity, whilst there has been an individualisation of identities, lifestyles and social ties, individual life chances continue to be highly structured and 'remain relatively unchanged' (*Ibid.*: 92). Although this project must necessarily utilise findings from research alluding to social class it is submitted here that the changes over the past couple of decades associated with the development of that symptom of late modernity, the 'Risk Society', returned to in Chapter 9, has produced a new picture of socio-economic cleavages which no longer fit neatly with these older classifications.

Hutton's (1995) treatise on the 'Thirty, Thirty, Forty Society' provides a useful illustration of the new stratification. In this, the lowest status 30 per cent of the population are those individuals who are unemployed or economically inactive and who are said to be living 'at the edge'. The second 30 per cent are characterised by their insecure or marginal relation to the labour market, poor workplace protection and few benefits. This group includes some 5 million part-time workers, of whom over eighty per cent are women, some self-employed persons, and fixed-term contract workers. The final forty per cent are characterised by full-time employees and self-employed persons who have held their jobs for over two years (*Ibid.*: 105).

Hutton argues that the insecure conditions these new cleavages have produced have impacted, not only upon society as a whole, but upon family life, in terms of family-building, the ability of families to support themselves, maintaining marriages, and successful parenting (*Ibid.*) This, therefore, is not merely the society into which young people are attempting to establish a foothold (*cf.* Furlong and Cartmel 1997), it is the society within which they have been reared and may have already experienced the tensions these conditions have been found to place upon their parent(s) and the sense of exclusion that

poverty is shown to produce (*cf.* Cohen *et al.* 1992). Indeed, family conflict is cited as the most frequently reported cause of homelessness among young people (O'Mahony 1988; Hutson and Liddiard 1995). Evidence submitted to the Inquiry into Youth Homelessness suggests that the prolonged period of youth dependency created by contemporary socio-economic conditions and by the Social Security legislation has produced increasing tensions between young people and their parents (Evans 1996).

In wider 'youth studies', a rich body of literature exists on the effects of family life upon young people's social well-being and this is shown to be associated with their current lifestyle and future life chances (*for example,* Furstenberg 1990; Lamborn *et al.* 1991; Shucksmith *et al.* 1995; Sweeting *et al.* 1997). In terms of structure, lone-mother households are implicated in 'adolescent deviance', including running away from home and school truancy (Dornbusch *et al.* 1985). Parental marital breakdown is associated with lower educational attainment, higher school drop out rates (Zimiles and Lee 1991) and an increased possibility of unemployment or work in low status occupations (Kiernan 1996), although other work indicates only small differences between such families and 'intact' families (Amato 1993) and highlights the potential benefits of parental separation in conflict situations (Edwards 1987). Young women are shown to be particularly affected by parental marital breakdown with early child-bearing, cohabitation or marriage demonstrated (Kiernan 1996). As recorded above, family conflict is a major reason for leaving the family home (Noller and Callan 1991). It is shown to be associated with problems at school (Kurdeck and Sinclair 1988) and exposure to conflict is shown to be more associated with reconstituted families than other family forms (Hanson *et al.* 1996). Correspondingly, family process in terms of cohesion or high levels of support are associated with positive social outcomes (Olson and McCubbin 1983; Farrell and Barnes 1993). Further work, considered in greater detail in Chapter 2, considers the effect of parenting style, in terms of restrictiveness and monitoring, with high 'restrictiveness' and

'monitoring' associated with increased 'family-centredness' and a higher degree of conformity to parental expectations (Brannen *et al.* 1994), however 'over-protection' is shown to be related to depression in young people (MacFarlane *et al.* 1995). The influences exerted by family structure and process upon young people's health are considered in Chapter 2.

The domestic transition

These latter considerations help to introduce factors which the literature on homelessness attribute to what can be taken as the failure of the 'domestic transition', but which also can be seen to be related to, and impinge upon all three transitions within which this overview is framed. Leaving home is another marker of adult status, but it has been shown that patterns of leaving home tend to vary by social class and gender. Young people from working class backgrounds have been found to leave home later, but become economically independent from their parents earlier than middle class counterparts, who tend to leave home earlier for educational purposes, but are also more likely to return periodically prior to permanent departure. Young women tend to leave home around a median age of 20 to 21 years, which is just under two years earlier than males (Jones 1987, 1993; Jones and Wallace 1992; Ermisch *et al.* 1995). The literature on homelessness provides a number of familial factors which spur young people's 'premature' departure from the parental home and, in the context of the trends outlined above, it is suggested that lack of support from families after departure is a major contributory factor in producing an unsuccessful transition (Jones 1994, 1995).

Research into the processes of leaving home among a sample of four hundred 16 to 25 years olds provides a broad picture of their experiences (Stockley and Bishop 1993). Respondents reported high levels of truancy and low levels of scholastic encouragement from parents, social services or teachers. Nearly 70 per cent were unemployed and 13 per cent were in further education and, among those who were in employment, 40 per cent had been on some type of

youth training scheme and 10 per cent had been rejected for these. Over half had experienced some form of family breakdown, such as parental separation, divorce or death. Just over half of the sample had experienced social services care. Just over four in ten (41%) had spent time living on the street before the age of 16, this rising to 55 per cent after 16 years. Most of the young people cited 'arguments' as the reason for leaving the parental home, though this was found to conceal other factors, such as physical or sexual abuse. Over a quarter had left because of violence and 13 per cent indicated that they had been sexually abused. Over 80 per cent of the sample stated that they would or could not return home (*Ibid.*).

Personal reasons for 'leaving home' are shown to be multifarious, but as the above research demonstrates there are factorial commonalties which should be acknowledged. These factors, however, should be viewed not as single events, but as part of a cumulative process which contributes to what has been termed as 'youth-parental alienation' (Rutter 1990: 98). In a survey of 7,500 homeless young people across Britain 86 per cent reported that they had been forced to leave home (Nassor and Simms 1996) and other research demonstrates that the majority of homeless young people have reported their inability to return home (Randall 1989; Hutson and Liddiard 1991). Reasons for this are shown to include youth-parental disagreements, eviction by family, overcrowding in the family home, parents being unable to support young people financially, lack of employment in the 'home' area, or contact had been lost (Jones 1993 (2)).

A number of studies reveal strong consistencies in the main factors associated with 'leaving home'. These are: 'dysfunctioning' families or parents (Downing-Orr 1996; Evans 1996); problems associated with family disruption in terms of parental separation, divorce and reconstituted families or bereavement, or household moves (Drake 1989; Webb 1994; Jones 1994; Tomas and Dittmar 1995); physical and sexual abuse (Watson with Austerberry 1986; Killeen, 1988; Thornton 1990; Hendessi 1992; Tomas and Dittmar 1995;

Downing-Orr 1996); and, sexuality, if parents cannot accept this (Anlin 1989; Evans 1996).

Moreover, and as a corollary of most of these other factors, studies demonstrate the much greater propensity for those with previous experience of social services care to become homeless because, it is proposed, the direct lack of support networks, superimposed upon problems experienced earlier in life, serves to magnify the problems of independent living on discharge since those young people are expected to cope on their own from an earlier age than their contemporaries. Despite only 1 per cent of British children being placed in care, studies have found between 23 to 40 per cent of homeless young people with this history (O'Mahony 1988; Watson 1988; Randall 1989; Anderson *et al.* 1993; Gilliland 1994; West 1995).

Experience of social services care has also been found to be related to involvement with the criminal justice system and research indicates that care leavers are over-represented among this population (Walmsley *et al.* 1992). Correspondingly such involvement is shown to predispose young people to homelessness (Watson 1988; Carlisle 1997). However it is also shown that homelessness can increase the potential for involvement in crime as a means of 'survival' which further poses problems for future housing opportunities (Liddiard and Hutson 1990; Thornton 1990). Young women leaving prison and detention centres are found to be more predisposed to homelessness if they do not have a family or friendship support network to rely on (Gosling 1990). In Scotland the problems associated with lack of provision for women on release from prison are shown to be particularly acute (McAteer 1994).

This list is not exhaustive, but it does provide an outline of the main factors which are shown to spur young women into homelessness. However, young women who do make the domestic transition can face problems subsequently which prevent this stage from being consolidated and these can contribute to

the outcome of homelessness. The main factors identified include: relationship breakdown (Thomas and Niner 1989; Sexty 1990), especially since it is demonstrated that young women are more reliant on partners to meet housing costs (Munro and Smith 1989; Muir and Ross 1993); domestic violence (Warlow and Spellacy 1985; Charles 1994); violence or harassment from others in the locality (Speak *et al.* 1995); lone parenthood (Friedman and Pawson 1989; Greve with Currie 1991); and problems associated with debt (Oppenheim and Harker 1996). These factors should be regarded as life course changes, in terms of economic or family status, and such changes are shown to have the potential to act as triggers for spells of poverty (Walker 1997).

Illustrative abridgement

By contextualising young women's homelessness within 'normal' youth transitions it is possible to identify social and material processes which contribute to the outcome of homelessness. Homelessness amongst young women is, therefore, conceived as an end product of cumulative processes of social exclusion. Nevertheless, they are not conceived as 'passive victims' of this process. The presupposition upon which this thesis is predicated is that these processes do not merely 'happen' to individuals; they provide the context for an ongoing interaction between the social, material and cultural circumstances of their being and the production of cognisant and purposive actions. The weight of this point is reinforced in Chapters 2 and 3. Moreover, in outlining key elements of these processes, the futility of the search for cause and effect type associations between homelessness and health is shown. For the social and material constituents of this exclusion also exert strong influences upon health and ill-health experiences.

An overview of the local context now illustrates this argument. This is not to be parochial, but by identifying the social and material circumstances within which most of the young women in this study were reportedly reared, the importance of contextualising wider influences upon health will be recognised.

For, a person's health state at any given time cannot be adequately understood without an appreciation of overall health status, or 'stock of health', defined in Chapter 2, acquired throughout the lifecourse.

Scotland has generally had higher official rates of unemployment than the UK average and this has had distinct regional dimensions especially relevant when looking at Glasgow. With reference to the socio-economic changes outlined above, it has been argued that Scotland is increasingly becoming a 'low wage economy' (Tennant 1995). This appears to be supported in figures demonstrating lower average weekly household incomes in Scotland when compared to the rest of the UK (SLPU 1994). The effects of unemployment and low pay are reflected in the higher figures for child poverty, when defined as below 50 per cent of average income. This has been shown to affect 38 per cent of Scottish children under the age of 18 years, higher than the UK rate of 31 per cent (DoE 1993). One indicator of increasing economic hardship among young people can be implied from increasing 'severe hardship' claims, from 6,915 to 28,041 between 1989-93, and although this may be reflective of increasing awareness among young people, the corresponding decline in refusal rates (28.3% to 16.2%) (Tennant 1995: 31-3) suggests that greater numbers of Scottish young people are being considered officially to merit this.

Poverty is acicular in some areas of Glasgow. Some 79 per cent of the council's tenants have been shown to be in receipt of some form of housing benefit (GCH 1994b), and in some areas of the city, 76 per cent of children have been found to be living in families dependent on Income Support (CPRU 1993). Evidence of a rising concentration of childhood poverty can be implied from the figures for lone parenthood: in 1981 Glasgow housed 18 per cent of Scotland's total of lone parents, by 1991 this had risen to 22 per cent (GCH 1994a). Over nine in ten (93%) of such households were headed by a women (Wainwright 1996). The most notable figures, however, relate to the uptake of child-related benefits with some 42 per cent of all primary school children in

Glasgow receiving free school meals and 53 per cent being in receipt of clothing grants (GCH 1994a).

In Scotland the number of public sector houses has been historically higher than elsewhere in the UK, shown in brackets, but these too have declined to 33 per cent (18.9%) (Shelter (Scotland) 1995; Ginsburg 1987). As throughout the UK, this has been accompanied by a decline in capital investment in this area (Robertson 1994). The Scottish House Condition Survey of 1991 demonstrates the high numbers of low income heads of households, just under two-thirds (64.2%) of unemployed and long term sick people and seven in ten (69.4%) lone parents residing in this sector. It also demonstrates the greater propensity of those groups to be living in dwellings of Below Tolerable Standard (Scottish Homes 1993a).

Glasgow continues to have a higher proportion of local authority houses (56.4%), although this too represents a decline of just over 14 per cent since 1981 (GCH 1994a). It is suggested that the effect of stock transfers and 'Right to Buy' 'have concentrated large pockets of deprivation' in 'unpopular' council estates throughout the city (*Ibid.*: 11). Moreover, the housing stock in Glasgow is much older than Scotland as a whole (GCH 1994a) and, for a variety of reasons, much of this stock has been unable to withstand the combined effects of the vagaries of the climate in the West of Scotland and the extent of 'fuel poverty' (Boardman 1991, 1993) among the population. Almost half (49%) of this stock has been shown to be affected by condensation, dampness and mould which compares badly with Scotland as a whole (36%) (Scottish Homes 1993a). Overcrowding is a further problem facing around one tenth of households in the city; figures from the 1991 Census suggest that the level of overcrowding was over twice that for Scotland with around 9 per cent of households in Glasgow having one room less than required by the 'bedroom standard' (GCH 1994a). Whilst these are clearly 'housing problems', it is

poverty which provides the context for such housing outcomes and this is the most important factor in the poor health of the city's population (GGHB 1992).

Using measures based on six indicators from the Registrar General: unemployed head of household; low socio-economic group of the head of household; overcrowded households; large family - four or more dependent children; single head of household; and all elderly households, Glasgow has been found to contain a population with a higher level of deprivation than elsewhere in Scotland (Carstairs and Morris 1991). There is, however, considerable more socio-economic diversity in Glasgow than is afforded here, therefore, using a contrast between the deprivation scores of affluent suburbs and the city these differentials can be appreciated. Whilst the city of Glasgow has been shown to have 29 per cent of households 'multiply deprived' according to these measures, this contrasts with 6 per cent for the two districts of Eastwood, and Bearsden and Milngavie (*Ibid.*: 26). Such differentials are shown to exert strong influences upon educational attainment (*cf.* Garner 1989) and health.

The city of Glasgow has the highest Standardised Mortality Rate for all ages in Scotland (Carstairs and Morris 1991; NHS 1993). In terms of morbidity, analysis of the 1991 Census indicates that one-fifth (19%) of Glasgow's population has a limiting long-standing illness as opposed to 14 per cent for Scotland as a whole (GCH 1994b: 13). Amongst women aged 35 to 64 years in Glasgow, the figures for premature death rates when compared to all Scottish women, in brackets, reveal strong differences. The three highest cause of death among women in Glasgow are shown to be ischaemic heart disease, with a rate of 128.1/100,00 (99), stroke 50.3/100,000 (39) and lung cancer 71/100,000 (45.6) with differences in death rates from all causes being marked at 627.9/100,000 (503.9) (NHS 1993).

This thumb-nail sketch is important, for the ill-health experiences of the subjects of this research cannot be understood without considering the wider social and material contexts within which they were reared. It is, therefore, argued that the health and ill-health experiences of homeless young women in Glasgow must be placed on the same continuum as those of all women in the city. Chapter 2 will now assert why a different approach to the study of homelessness and health is required.

Chapter 2

A different challenge

Building upon the previous chapter, this chapter, through reference to a wide range of sociological literature on gender, youth and youth transitions as related to health, will demonstrate why a qualitative approach to young women's homelessness and health is employed in this study. The *Introduction* revealed that the health of homeless people is a popular subject for research and it has been posited that this is an attempt to 'medicalise' an essentially housing problem (Shanks and Smith 1992). However, as argued in Chapter 1, 'housing problems' are themselves a product of wider structural disparities. Consequently, any potential connections between housing and health, and homelessness and health cannot be made without acknowledging the various factors which contribute to differential outcomes. Moreover, and however much connections between homelessness and health are demonstrated, there are two main exigencies this chapter must address.

The first is to illustrate the need for an approach that incorporates the many material, environmental and psychosocial processes which produce this relationship (*cf.* Macintyre 1994). By locating the ill-health outcomes of homelessness within the wider structures and processes of society, homeless individuals are no longer marked as 'different' by virtue of their social, material and health status's; their ill-health experiences are contextualised within a much wider population who are subject to similar material and social disadvantages and processes of exclusion. This is necessary because the complex inter-relationship between the factors associated with homelessness which pose a risk to health are not fully understood (*cf.* Taylor and Bloor 1994) and frequently homelessness and health studies have been biased by an assumption that homelessness alone causes ill-health (*cf.* Pleace and Quilgars 1997). Homelessness and health, therefore, tend to be presented as phenomena

that 'happen' to individuals and the only apparent acknowledgement of process is one of a 'progressive downward spiral' (*cf.* Hutson and Liddiard 1994). The consequences of this are that agency is presented in a largely negative sense as in the 'health is a low priority concern' or 'poor motivation' theses (*for example*, Fisher and Collins 1993; SCOPH 1994). This is important for the terms 'homelessness' and 'health' tend to be taken as self-evident truths without consideration of the possibility that the subjects of research might have their own definitions of these terms which might exert contrary influences upon their sense of well-being to those assumed by researchers.

The second exigency relates to the term 'health'. In most homelessness and 'health' studies, two fundamental weaknesses exist. Firstly, based upon the assumptions outlined above, health is immediately transformed into 'ill-health' without any justification for this substitution. Secondly, 'health', or rather 'ill-health' is taken as a readily identifiable and accessible category. Those studies appear to have overlooked the wider implications of this assumption; the dominant conceptions of 'health' and 'ill-health' as objective and measurable must be challenged for these are not unproblematic categories. They are reflections of the hegemonic influence of the scientific paradigm and its penchant for counts, classifications and causation. This hegemony has been sustained through discourses which serve to undermine differing epistemological approaches by reinforcing dichotomies between those qualities associated with 'hard research' and the 'strengths' of 'objectivity', quantification, 'reason', 'knowledge' and 'facts', as opposed to 'soft research', portrayed as 'subjective', qualitative and preoccupied with 'emotion', 'experience' and 'values' (*cf.* Oakley 1992: 15). Two important outcomes of this dichotomy have been the undermining of non-medical conceptions of health, and the reinforcement of gendered assumptions concerning health and ill-health experiences. This chapter will demonstrate that conceptions of health and reported health experiences cannot be understood without reference to the

social, cultural and material resources within which these experiences are framed and upon which individuals draw for their own meanings and actions.

A few noteworthy housing/ homelessness and health studies do, however, provide a direction for a qualitative evaluation of a relationship between housing circumstances and health. The benefits of including qualitative data and context when exploring health outcomes is demonstrated in Conway's (1988) investigation of the health of homeless families living in bed and breakfast accommodation, and in Bines (1994) comparative health study, not only between people who are homeless with people in the general population, but which identifies the differentials among different accommodation-based groups of homeless people. The need to include the context for the production of health outcomes is further reinforced in notable studies among women (Tomas and Dittmar 1995) and young people (Downing-Orr 1996). In demonstrating the need to research the experience of homelessness and the meanings homeless people ascribe to their situation., those authors provide strong evidence which problematises the 'progressive decline' thesis, especially in terms of well-being, a term explicated shortly. Linking the need for context and the meanings individuals ascribe to their circumstances is the imperative to consider the connections subjects of research make between their housing circumstances and health outcomes. This is well-illustrated in Ambrose (1996), discussed later. The importance of these factors, however, cannot be recognised without full consideration of this term 'health'.

Defining health

Given that much of the literature on homelessness and health issues record the 'low priority' accorded to health by homeless people (*for example*, Stern *et al.* 1989; Williams and Allen 1989) and although, as identified in the *Introduction*, some have tried to explain why this may be so (Fisher and Collins 1993) the approach adopted in this project may appear rather contrary:

> It starts from the assumption that people are concerned, in their everyday lives, to maintain their health and in doing so they carry out health work and make decisions about and choices between the available services. It also recognises that members are using their own social definitions of health and illness, and their own knowledge of how to promote, maintain and restore health. They do so within a material framework that not only constrains and limits the choices available to them, but is a major factor in shaping their health status. (Abbott and Payne 1990: 6)

Herein lies a difficulty with most of the existing homelessness and (ill)health studies. Despite notable studies utilising self-reports of illness (*for example*, Conway 1988; George *et al.* 1991; Whynes and Giggs 1992; Bines 1994; Westlake and George 1994), the issue of what 'health' itself means to homeless people has been overlooked. This has had two main consequences in that the person and their circumstances continue to be pathologised and, the individual's own knowledge, understandings and health behaviours tend to remain subsumed within biomedical models of health and illness. 'Biomedical' is employed here to refer to the knowledge systems which focus upon the body as a biological organism and which is associated with the various aspects of 'scientific medicine' (*cf.* Kleinman 1978; Stacey 1993). The difficulties associated with self-report studies are considered elsewhere (Connelly and Crown 1994; Pleace and Quilgars 1996) and expanded upon in Chapter 3, but one essential point remains; without an understanding of what 'health' means to individuals, self-reports of 'ill-health' cannot fully be appreciated.

This has further implications, and baldly stated, the individual is presented passively and their cognisant and purposive health work is denied. 'Health work' is taken to refer to those activities involved in the production and maintenance of health, the restoration of health, the amelioration of conditions, the control of reproduction, and, the care of dependants (*cf.* Stacey 1993). Being a guardian of the family's health (Graham 1984) or 'health worker' is women's paramount socialised role, a role which encompasses all aspects

pertaining to the physical and emotional needs of other household members through a host of activities simply labelled as 'housework'.

A useful example of 'health work' lies in diet. Diet, as a fundamental constituent of health, can be studied as a reflection of material circumstances, or social and cultural customs and mores, since these wider structures and forces inform knowledge and attitudes about food, and set limits upon what can be consumed (*cf.* Thorogood and Coulter 1992). Diet is also a useful means of understanding domestic relationships, since food production and consumption also reflect the balance of power within households (*cf.* Delphy 1979; Charles and Kerr 1988). Yet, and however much diet is subject to material constraints or power imbalances, dietary planning, purchase and preparation are creative activities. Studies indicate that women are not only the main providers of diet, but to a greater extent than men, emphasise the importance of food to health (*cf.* Coulter 1987; Blaxter 1990) and these gender differences are shown to start at an early age (Wenlock *et al.* 1986). Women are also shown to limit their own diets in order to provide for their children (Lang *et al.* 1984; Milburn *et al.* 1987; NCH 1991; Dowler and Calvert 1995).

Thus, by looking at the decisions made and the strategies employed in regard to this basic constituent for life, the ways in which structure and agency interact can be analysed. Moreover, by studying these as intentional activities undertaken by individuals in the context of 'health work' it is possible to move beyond the 'passivity' implicit in a focus only on the constraints of circumstances and the belief that health work is some kind of professionalised speciality. For without acknowledging these as intentional activities, women's key health role is undermined and the hegemonic imagery of medical professionals as being *the* providers of health-care is sustained (*cf.* Oakley 1991). In the context of homelessness studies, this is important since GP registration and consultations are generally presented as a 'measure' of 'motivation towards health'. This exposes a remarkable similarity between

long-standing biomedical portrayals of women as 'weak' and 'victims' of their physiology, especially their reproductive organs, and those of homeless people as 'vulnerable' and 'victims' of their circumstances. There is a need to surmount such assumptions. Accordingly, the thesis that 'health work' is an integral part of daily life experience provides the analytic foundation for Chapter 8.

Arriving at a definition of 'health' is, however, fraught with difficulties for no agreed meaning exists. 'Biomedical' and 'alternative holistic' conceptions are often portrayed as standing in opposition to each other and critiques of each have been long-standing (*for example*, respectively, McKeown 1965, 1971, 1976; Dubos 1979 or Armstrong 1986). Furthermore, in medical-anthropology and medical-sociology different 'lay' concepts have been demonstrated (*for example*, Helman 1981; Blaxter and Paterson 1982; Blaxter 1990) and this is exemplified shortly. This section will present the case for an inclusive conception of health which is sufficiently broad to allow for an incorporation of all 'traditions', and which locates the production of this definition within a material and cultural framework. The World Health Organisation has long promoted a form of inclusive conception by emphasising the complete interdependence of physical, mental and social welfare in their definition of health as *a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity* (WHO 1948). Although adopted in this research, the inherent weakness arising from the lack of definition of 'well-being' is acknowledged and it is for this reason that the work of Blaxter (1990) is considered.

Whilst Blaxter's work recognises the 'moral responsibility ethos' for illness identified in 'lay beliefs' or 'folk models' described elsewhere (*for example*, Herzlich 1973; Helman 1981) and appears to build upon the tripartite conceptions of health identified in earlier work: 'health-in-a-vacuum'; 'reserve of health'; and, as 'a condition of equilibrium' (Herzlich 1973), her findings

indicate a wider variety of 'lay' conceptions of health which are shown to include references to the 'biomedical' and the 'social'(*cf.* Crawford 1980; Helman 1981; Blaxter 1983; Cornwell 1984). Blaxter further demonstrates how conceptions of health vary between the sexes, and over the life course. Based upon a 10 per cent random sample of 9010 people interviewed for the Health and Lifestyle Survey (*cf.* Cox *et al.* 1987) Blaxter describes ten different categories of response: 'negative answers', those who claimed not to think about their health; health as 'not ill'; health as either the 'absence of disease' or health 'despite disease'; health as 'reserve'; 'health as behaviour' in terms of 'the healthy life'; health as physical fitness'; health as 'energy and vitality'; health as 'a social relationship'; health as a 'function'; and, health as 'psychosocial well-being' (*Ibid.*: 19-30).

The immediate point to note from this study is the extent to which women as a whole appeared more likely to regard health in largely 'negative' and passive terms of the absence of illness or disease and included 'social relationships' in their definitions, whilst men were more likely to offer positive and active descriptions involving fitness and physical strength, this being particularly relevant to young men's accounts. Young women tended to speak of energy and the ability to cope mentally and physically in their accounts Gender was further reflected in respondents' perceptions of 'a healthy person' with females and males tending to identify males. In personal analysis of their own health status men tended to offer healthier accounts than women. Middle aged people emphasised more holistic accounts in terms of physical and mental well-being, whilst older people tended to highlight more functional aspects (*Ibid.*). 'Lay' conceptions of 'health' should, therefore, be recognised as grounded in a complex of knowledge, attitudes, beliefs and behaviour grounded in time and place. These are multifarious conceptions which cannot be understood without reference to the defining individual's gender, stage in the life course, and material and cultural circumstances (*cf.* Herzlich and Pierret 1986).

Accordingly, 'well-being' is conceived of, in this project, as *relative* to the individuals own life experiences.

'Lay' conceptions are considered a valuable source material for the understanding of the individual and their circumstances and, as a research active field, the literature on women's conceptions demonstrate strong consistencies (*cf.* Stacey 1977; Blaxter and Patterson 1982; Pill and Stott 1986; Blaxter 1983; Cornwell 1984; Calnan and Johnson 1985; Currer and Stacey 1986; Calnan 1987; Miles 1993; Stacey 1993). Paramount among these are class differences. For example, class-specific 'lay' concepts of health are presented as lying along a continuum, represented at the poles by working class imagery of health in rather Parsonian terms (Parsons 1958) associated with the functional and the collective, and the more hedonistic imagery of the individual and the personal is expressed by higher class respondents (d'Houtaud and Field 1984, 1986).

Strong class-related differences are also found in descriptions of respondents' own health. In the *Health and Lifestyle Survey* just under three-quarters (71%) of respondents described their health as 'at least good' (Blaxter 1990: 32) despite the presence of illness or disability, suggesting the relativity of respondents' self-assessments. However, Blaxter found 'steep and regular' differences in self-assessed health by all measures of social advantage and disadvantage with those in lower classes being more likely to say their health was 'fair' or 'poor', and lone parents, unemployed people, those living in inner cites or industrial areas being more likely to provide a poor view of their health. Regional variations were also found thus reinforcing the argument at the end of Chapter 1 of the need to understand the social and material contexts within which these pronouncements were formulated. In Scotland around one-third of men and women reported their health as 'less than good' (respectively, 31% and 33%), compared with just under a quarter of those living in the South East of England (respectively, 23% and 24%) (*Ibid.*).

The large literature on 'adults', and on children, especially in terms of cognitive-developmental studies (*for example*, Campbell 1975; Natapoff 1978; Dielman *et al.* 1980; Burbach and Peterson 1986; Santrock 1990; Millstein 1991) contrasts with the relative scarcity of information on young peoples' conceptions of health. Few studies have focused on their health beliefs (*cf.* Hein 1988; Brannen *et al.* 1994). In their integrated questionnaire research of 843 young people aged 15 and 17 years and a follow-up qualitative study with a smaller sample and their parents, Brannen *et al.* found definitions of 'health' to be akin to those identified in Blaxter's (1990) work, incorporating 'not ill', fitness, healthy lifestyle, emotional well-being and having energy. Young women were found especially to emphasise healthy lifestyles and fitness. Yet despite this, lesser numbers of young women believed they could exercise 'control' over their health. One-fifth of young women believed that health was a matter of 'luck', although just under one-third believed it was a matter of individual 'control' (32%) and just under half (48%) believed it to be reliant on a mix of both. This compared with more than half (52%) of young men responding health to be a matter of individual 'control' or both (45%) (*Ibid.*: 74). In terms of the importance of health the young women accorded this a third position behind 'love' and 'happy family relationships' in a list of choices including the additional factors of future job security, happiness, peace of mind, success, money and friends. Two conclusions are of particular relevance: firstly, and as found in Blaxter's (1990) study, perceiving oneself to be 'healthy' is compatible with having health problems and secondly, an evaluation of health as important does not necessarily mean that a 'healthy lifestyle' is always adopted.

In presenting these various aspects of health belief it is possible to see that 'health' is not an objective category, it is actively constituted by individuals through the knowledge derived from, and meanings ascribed to their lived experiences. The paramount influences upon these lived experiences are those

arising from an individual's gender and class. In demonstrating the need to conceptualise health as relative to an individual's own lived experiences it is possible to recognise the importance of conceiving individuals as more than physiological entities who experience ill-health passively. For this physiological body cannot be extricated from the affective body, since 'the "felt world" combines feelings, thoughts and bodily processes into a single vital structure' (Hughes and Patterson 1997: 336). Thus, by incorporating this conceptualisation, the 'lived body' is presented as simultaneously physiological, psychological and social. The need for an acknowledgement of the interplay of the multifarious factors which have the potential to exert an influence upon young women's health is now illustrated.

'Adolescence as a period of latency'?

Having argued in Chapter 1 that the period of youth should be conceived as a stage of transitions, this section considers aspects of these transitions which studies have shown exert influences upon young people's health in general and young women's health in particular. Despite a number of predominantly psychological works distinguishing the period of adolescence as being of fundamental importance to later emotional development (*for example*, Furnum and Gunter 1989; Furnum and Stacey 1991; Heaven 1994, 1996) and in so far as young peoples' understandings of health provide a potentially rich research field, when compared to other age-groups information on young people's general health remains a relatively small portion of the literature. Indices of mortality rates reveal the low rates for young people between the ages of 15-24 years, especially young women as a result of their lesser propensity for death from violence or accidents when compared to young men. From these, it is posited that young people comprise one of the healthiest social groups in most developed countries (WHO 1989). Whilst recorded health problems, associated with youth, are outlined at the end of this section the difficulties with this proposition must be recognised.

Mortality rates are often used as measures of health and although such rates indicate social differentiation in terms of specific diseases as cause of death, they contribute little to a calculation of the prevalence of non-threatening conditions (Wilkinson 1996). However, research does indicate the existence of a relationship between differences in mortality rates and differences in self-reported measures of illness (Arber 1987; Wilkinson 1996) and the use of mortality statistics as a demonstration of inequalities in health over the life course has been invaluable (*cf.* Townsend and Davidson 1982; Hart 1986; Whitehead 1987), but in terms of their applicability to young people, the age bands employed are too broad to allow for a specific consideration of the period of youth (West 1997). This question of age-bands also applies to studies of young people's health. For the discussion that follows texts which employ the terms 'teenagers', 'adolescence', 'youth', 'young people' and 'young adults' have been referred to in order to incorporate all aspects of the sixteen to twenty-five years stage in the lifecourse.

Chapter 1 stressed the importance of a processual approach to the study of youth homelessness and this theme underpins this section. Youth, already defined as an 'intermediate stage' is a time of psychosocial, material and cultural change. In the literature it also appears to be a time in which certain taken-for-granted sociological assumptions about health must be reconsidered, suggesting that this project's sample population provides fertile ground for study. Despite strong evidence indicating that material circumstances in childhood and adolescence exert an influence on adult health status (*cf.* Power 1991) adolescence is described 'as a latency period', a time when class-based inequalities in both mortality and morbidity rates diminish and then begin to re-emerge in late adolescence and early adulthood (West 1988). This matter is further pursued in a research review which draws upon a number of findings from the *West of Scotland Twenty-07 Study: Health in the Community*, (*cf.* Macintyre *et al.* 1989) a longitudinal investigation of three cohorts, the youngest being a sample of around one thousand fifteen year olds in 1987

(West 1997). Several reports from this study are drawn upon because many of the local considerations are of relevance.

Although the apparent absence of class gradients in mortality during youth is said to be an artefact of the 'high levels of health enjoyed in this age group' (Blane *et al.* 1994: 361), West's (1988) proposition is partly supported in this report which is based upon an analysis of measures of social class and mortality using data from the *OPCS* longitudinal study (*cf.* Goldblatt 1990). Among males aged 0-9 years a 'classic gradient' was found, but by the ages of 10-14 years this had disappeared and re-emerged among those aged 15-29 years. The findings among females were quite different; there was no evidence of class patterning either between the ages of 0-9 years, or 10-14 years, but subsequently there was a reverse class gradient among those aged 15-29 years (Blane *et al.* 1994). Further evidence of qualified support for the 'latency period' thesis appears to be found in analyses of measures of chronic illness in which little or no class differentiation is recorded (Foster *et al.* 1990; Rahkonen 1992; Glendinning *et al.* 1992). However, the difficulties of arriving at concrete conclusions regarding the period of youth, as suggested above (*cf.* Blane *et al.* 1994), are compounded by research indicating that young people from higher class homes report more ill-health than their lower class counterparts (Brannen *et al.* 1994) and similarly, although differences between social classes, at the start of adult life, are found they are shown to be small and irregular (Blaxter 1990).

Furthermore, although assessments of mental health problems in youth are fraught with methodological and diagnostic difficulties, with figures for depression alone ranging from under 1 per cent to almost half of those studied (*cf.* Angold 1988) the sociological literature on young people's mental health problems also indicate little class difference (*cf.* Glendinning *et al.* 1992) and suggest a lack of differentiation among 15 year olds followed by the emergence of a class gradient among 18 year olds (Ford *et al.* 1994). The *Health and*

Lifestyle Survey indicates the increased likelihood of poorer psychosocial health among young women, aged 18 to 39, as the only group where 'modest, but significant' measured effects of the inter-relationship between social class and low income was found (Blaxter 1990). It is only in 'behavioural analysis', where 'conduct disorders' or 'anti-social behaviour' are examined that any continuation of class differences in childhood through adolescence are described (Rutter and Smith 1995), this suggesting that young people's 'lifestyles' may retain a degree of class association (*cf.* West and Sweeting 1996c). In adopting a more holistic conception of health, therefore, it is possible to identify the need for an inclusion of such 'lifestyle' factors in health research.

The implications of such ostensible changing class-based health problems, between childhood and youth, thence youth and adulthood indicate that processes other than material may exert stronger influences on young people's health. Some authors have suggested that this is related to 'behavioural-cultural lifestyle factors' such as the formation of identity, and to definitions of norms and values associated with the diminishing effects of the family, home background and neighbourhood through the effects of progressive detachment from parents, the effects of school, peer group lifestyles, and youth culture (*cf.* Glendinning *et al.* 1995; West and Sweeting 1996a; West 1997) which, with the exception of smoking and alcohol and drug consumption, tend to be independent of class of origin (*cf.* West and Sweeting 1996c). Thereafter, changes associated with the material aspects of the youth-adult transition are believed to exert influences upon health, and class-based differences begin to re-emerge.

These factors are shown to exert an influence on the young person's future inasmuch as a relationship between the 'way of life' (Herzlich 1973), to wit the attitudes, values, behaviour and lifestyles adopted in adolescence, later labour market position and overall adult health status are also demonstrated to be

products of the wider material and environmental contexts of young people's lives (Macintyre *et al.* 1989; Blaxter 1990; Power *et al.* 1991; Glendinning *et al.* 1995). Moreover, as with issues of 'health selection into homelessness' the relationship between material status and health is not a simple one since young people with health problems are likely to be 'downwardly mobile' or excluded from employment (Power *et al.* 1991; Glendinning *et al.* 1992; West 1994). This concept of 'health selection', referring to the accumulation of advantage or disadvantage throughout the earlier stages of childhood and adolescence (*cf.* Blane *et al.* 1993) provides an additional means of comprehending factors which contribute to both health and social status in adulthood and these are considered in Chapter 5.

Research exploring health inequalities in early adulthood has produced additional and complementary factors for deliberation. In their comparative study of British and Finnish data sets from the *General Household Survey* for 1988 and 1989, and the 1986 *Level of Living Survey,* Rahkonen *et al.* (1995) record that there is no specific age at which these emerge, although compatible with other work (West 1988; Power *et al.* 1991; Glendinning 1992) 'modest' social class differences by own occupation are shown to emanate soon after the age of 20 years. There is also a weaker, though consistent association with class of origin among young people in both countries, and in Britain the association between parental social class and young people's health was found to strengthen with age. Moreover, using two health indicators, these being limiting long-standing illness, a rather dubious measure for young people, and self-assessed health, the main discriminator of differences in ill-health was found to be educational attainment, as a proxy for social position. This, as outlined in Chapter 1, is associated with wider structural and environmental factors. This study provides two additional noteworthy ingredients. Concordant with studies identified later, females reported poorer health than males and, housing tenure was especially associated with parental social class among those aged 16 to 19 years and when health is considered, in Britain, a strong

association was statistically significant after the age of 20 years (Rahkonen *et al.* 1995).

Chapter 1 highlighted the importance of family background to understanding homelessness among young people and this appears the best arena in which the complex interaction between material and cultural factors and their effects upon present and future well-being can be illustrated. The research active field on family life has focused considerable attention upon youth 'behaviours'. Although, associations between material circumstances to family structure are shown (*cf.* Edwards 1987; Burghes 1994; Sweeting *et al.* 1997), studies indicate the effect on behaviour of different family forms and the mediating effects of perceived parental support, control, cohesiveness and conflict (*for example*, Conrad *et al.* 1992; Brannen *et al.* 1994; Foxcroft and Lowe 1995; Glendinning *et al.* 1997; Shucksmith *et al.* 1997; Sweeting *et al.* 1997), with young people from 'traditional' two-parent families being found less likely to be regular drinkers, smokers or drug users (Dornbusch *et al.* 1985; Furstenberg 1990; Green *et al.* 1991; Brannen *et al.* 1994; Shucksmith *et al.* 1997; Glendinning *et al.* 1997) or to experience early sexual intercourse (West *et al.* 1993). Among young women, aspects of family disruption, especially death of a parent is associated with smoking, drinking, drug use, earlier sexual intercourse and pregnancy (Sweeting and West 1995b; Sweeting *et al.* 1997).

To exemplify the complexity of such interactions, Sweeting and West (1995a) furnish a means of grasping the ways in which family structure, functioning and conflict can exert an influence on current and future physical and psychological well-being, and later labour market position. Furthermore, they demonstrate that females are more affected by these factors which, they speculate, could be associated with a 'clash of cultural expectations' between the family and the wider society during mid- to late-adolescence. Using data from the *West of Scotland Twenty-07 Study*, Sweeting and West consider ten variables: family structure; family culture, measured by family-centredness,

parental strictness and household tasks; family conflict; household material deprivation; parental social class; personal labour market position at eighteen years; 'self-esteem'; psychological well-being; physical symptoms; and, limiting long-standing illness. The initial conspicuous result is that, although finding a strong association between family structure and deprivation, thence deprivation and labour-market position at eighteen years, young people from all family types: intact, reconstituted and single parent, were largely undifferentiated in terms of physical or psychological health, although lower 'self-esteem' was found among 15 year old females from reconstituted families, but this was not found on follow up three years later.

Sweeting and West, however, report that family structure was found to exert a strong, and gendered, influence on labour market position at 18 years, with non-employment being found among just under one-third (31.6%) of females from single-parent families, a percentage higher than their male counterparts (12.2%) whose highest rate for non-employment was found among those from reconstituted families (23.5% *vs*. 18.5% for females). In the analysis of aspects of 'family functioning' additional gender differences emerged. Among female respondents, poor relationships with parents and family conflict were associated with lower 'self-esteem', poorer psychological well-being and increased physical symptoms at 15, and later at 18 years. Moreover, among females, associations between low 'self-esteem' measures and high levels of participation in household tasks, and between low 'self-esteem' at 15 and non-employment at 18 years are reported. The authors suggest that, in adolescence, family life may exert a greater influence on health than material factors and this may be linked indirectly to later health inequalities (*Ibid.*). Family life is considered in Chapter 6 and, in a health context, in Chapter 5.

Before closing this section a synopsis of morbidity among young people should be presented. The *General Household Survey* records around 20 per cent of young people between the ages of 12 and 20 reporting a long-standing illness,

disability or infirmity (OPCS 1995). This figure is compatible with West and Sweeting's (1996a) study of 15 year olds where a tenth of the sample reported this as limiting their activities, but is somewhat lower than the self-reports of long-term or recurrent illness (39%) found among the 15 to 17 years age-group in the study by Brannen *et al.* (1994), although the latter study incorporates aspects of what has been taken elsewhere as 'acute' health problems, such as headaches. In terms of acute health problems, studies indicate that young people report abdominal problems, fainting and dizziness, headaches and migraine, musculo-skeletal disorders, respiratory problems such as asthma, skin problems, worries about body weight and mental health problems, including sleeping problems, anxiety and depression (*For example*, Macfarlane *et al.* 1987; Brannen *et al.* 1994; Currie *et al.* 1994; West and Sweeting 1996a).

Young women are shown to report more mental health problems (West and Sweeting 1996a). Within much of the psychological literature answers as to why this may be so are conflicting and these tend to reinforce the imagery of women being 'victims of their physiology'. Such explanations include 'hormonal activity' or 'a negative cognitive set' (Rutter 1986), differential reporting of depressive symptoms between males and females (Fleming *et al.* 1989), or, young women have a differential 'focus upon symptoms' than their male counterparts (Nolen-Hoeksema 1991; Compass *et al.* 1993). Sociological explanations for such differential reporting are considered shortly. Major depressive disorders have also been found in around one in twenty adolescents and teenage parasuicide among slightly lower numbers (3%) (NHSHAS 1995) and authors, using five 'disorders' as indicators: alcohol and drug use, crime, depression, eating disorders, and, suicide behaviour, suggest that adolescent mental health has been deteriorating (*cf.* Rutter and Smith 1995). Stress is also linked to depression among adolescents and this is associated with the biological changes, social changes and gender-role expectations (Gore *et al.* 1992) throughout this period.

The lack of attention paid here to issues related to congenital conditions or limiting conditions arising in the perinatal period and early childhood, and functional impairments which have been shown to be strong indicators of health inequalities in youth, and subsequently in adulthood (*cf.* Blane *et al.* 1994; Davey Smith *et al.* 1994), is intentional. The objective has been to illustrate firstly, although an indispensable part of the health equation, the necessity of an approach to health that encompasses a greater range of variables than those only pertaining to biomedical models of health and ill-health. Secondly, it has been requisite to demonstrate the need to consider young people's health as a product of multifarious, inter-related and interacting factors. Lastly, it has been crucial to make clear the point that, although connections are made, there is a scarcity of concrete answers why health inequalities exist (*cf.* Macintyre 1986, 1994). These aims are upheld on contrasting the findings presented in this and the previous section where an immediate anomaly manifests, in that there appears to be a class-based relationship between young people's conceptions of, and attitudes towards health, yet measures of self-reported health seem to show little variation. This appears to underline the arguments that, in youth, health and ill-health, actual or perceived, are subject to a wider range of influences than allowed for by potentially reductionist paradigms. The consistencies in gender-related differentials of conceptions, attitudes and self-reports further appear to substantiate this thesis.

Further potential influences.

A strong objection to the labelling of people who are homeless was presented in Chapter 1 and this matter must now be expanded. Being with or without a home is but one aspect of any individual's life-situation and identity, yet most homelessness studies tend not to avow other factors which could influence a homeless person's health and this undermines 'connections' made. This is not an attempt to belittle demonstrable health consequences of homelessness upon people's lives, but rather to look beyond the apparent to wider factors and

processes which are shown to shape 'health status', or general 'stock of health' and 'health state', referring to current health (*cf.* Blaxter 1985; Arber 1990a). The relevance of distinguishing between these concepts is identified in Chapter 5.

Having conceived the period of youth as a stage of transitions it is now time to consider specific aspects of this period and how these might exert an influence upon young women's health. The fundamental transition interviewees within this research project are making is that of becoming adult women. As consistently illustrated above health beliefs and experiences are gendered, but too often homelessness and health studies have suffered from gender-blindness in that, even where gender differences are indicated, these overlook a basic methodological implication: women and men do not conceive and report health in the same manner. This is expanded shortly. As outlined in Chapter 1, the foundations for these health-related differences are located within women's different social, material and cultural experiences from those of men. The following section, therefore, presents an overview of the main factors identified in the literature on women's health which are considered germane to the study of homeless young women's health.

Gender

Thus far it has been shown that gender exerts an influence upon health conceptions, attitudes and experiences. Brannen *et al.* (1994: 84) record that the respondent's sex is the 'main factor associated with differential reports of illness' in their study where one in ten females reported long-term illnesses and 38 per cent, recurrent illness, both marginally higher than male respondents (7% and 36%). Females were also more likely to have visited their GP five or more times in the previous year than males (14% *vs.* 6%). Additionally, more females than males reported their health as 'not good' (14% vs. 8%) and more females reported worrying 'a great deal' about their health when compared with their male counterparts (14% *vs.* 10%). A notable difference was found in

the use of prescribed medication with significantly higher levels found among females (20% *vs.* 8% for males). Reported illness was found disproportionally among those who expressed dissatisfaction with life (52% female and 37% male respondents) and among those who expressed a desire for more information on stress and depression where this was found to be statistically significant for females (*Ibid.*: 84-86). One final finding of relevance to the discussion in Chapter 8 is that higher numbers of females than males reported the use of analgesia in the previous week (48% *vs.* 39%), and that among females an association between this and cigarette and alcohol use was found (*Ibid.*).

Brannen *et al's.* study also reinforces the different parenting of young people and the different roles adopted by parents in the rearing of their children, with parents also demonstrating divergent attitudes and behaviour towards health and health work. Although the authors tend to intermix the terms 'sex' and 'gender', this study appears to suggest that gender differences in health reporting are consolidated by early youth. 'Sex' can be taken as something physiologically determined (Szreter 1985), yet 'gender', either taken as an 'explanatory variable' or for 'descriptive documentation' purposes (Morgan 1986) involves the recognition of more subtle distinctions and dichotomies between the biological and the social (*cf.* Oakley 1981). Underlying this distinction are assumptions of differentiation, socially and culturally produced, with an accompanying unequal distribution of, and access to various positions and resources, as shown in Chapter 1 in the exemplars of employment and housing.

There is indeed a biological basis for some differentials in health and fundamental 'sex' differences do exert a strong influence in the early stages of life (*cf.* Macintyre 1986). However, in a world where all infants are 'colour-coded' according to their genital formations at birth, any biological differences which may exert an influence upon health, with the exception of inherited sex-

linked conditions or diseases with a proclivity towards one sex (*cf.* Roberts 1976), become subsumed under an ever increasing number of determining material and cultural factors as the life-course progresses (*cf.* Macintyre *et al.* 1989). Nevertheless, the biological cannot be extricated completely from the social since humans are simultaneously biological and social (*cf.* Rose *et al.* 1984) and both are inter-dependent variables in the structuring of status and identity, as considered in Chapter 7.

Reports of morbidity and mortality rate differences between males and females are omnipresent in the literature. Studies consistently demonstrate that males experience higher mortality rates in all age groups, and have a lower life-expectancy than females and women give poorer evaluations of their health and report higher levels of psychosocial malaise, illness symptoms, medical consultations, use of prescribed and non-prescribed medication, and more, but less severe, chronic conditions than men (*for example,* Clarke 1983; Whitehead 1984; Townsend *et al.* 1984; Annandale and Hunt 1990; Blaxter 1990; Miles 1993; Macintyre 1993; Stacey 1993; Sweeting 1994). The reasons offered for such differences are long shown to include: different behaviours, including male tendency towards 'riskier lifestyles'; differential use of health services; role-based distinctions in self-assessment and reporting of ill-health; and the different meanings attached to health and illness by men and women (*cf.* Nathanson 1975, 1977; Clarke 1983). However, research also indicates that, if women's consultations for reproductive or genito-urinary tract problems are accounted for, female excess virtually disappears (Macfarlane 1990).

Nevertheless, such accepted illations have recently been criticised as 'over-simplistic' and 'over-generalised' (Macintyre *et al.* 1996). In their analysis of two large data sets, the *West of Scotland Twenty-07 Study* and the *Health and Lifestyle Survey* (Blaxter 1990) Macintyre *et al.* demonstrate that gender differences vary by the type of morbidity measure used, the social context and stage in the life-course. Female excess across the life-course was only found in

'psychological distress' and was less apparent, and at times reversed, for a number of physical conditions and symptoms. The authors propose that, by locating their work in the research on gendered health-differences to date, this suggests that these differences are rooted in social roles, which as a result of ongoing changes could have produced findings contrary to earlier works.

Such considerations are further complicated by the introduction of 'social class' to the gender equation. As indicated earlier, conceptions of, and attitudes towards health vary among women according to social class and this corresponds with findings showing mortality rates for women in social class V to be twice those for women in social class I, and where the gradients among women themselves are shown to be steeper than those for men (Blaxter 1987b). Moreover strong health differences between women who undertake paid employment, are 'housewives' and are unemployed have been recorded (Waldron 1980; Warr and Parry 1982). However, when looking at the effects of such paid work, balancing multiple-role expectations appears to be detrimental to health.

In their analysis of data from 14,000 households for the *General Household Survey,* Arber *et al.* (1985) found women working in full-time manual occupations, or at low-level non-manual jobs, with dependent children at home to report more ill-health and stress than comparable women in managerial or professional positions, or housewives. Correspondingly, part-time work for working class mothers is shown to have beneficial effects and the authors suggest this results from work engendering 'self-esteem', promoting wider social contacts alongside the financial rewards. Social contacts, social support and 'self-esteem' appear to be key 'gains' of paid employment for women, especially for those with few avenues to these elsewhere (Brown and Harris 1978; Nathanson 1980). Because of the importance of social support to women's well-being, this is further explored later. Arber *et al.*'s work is important for the way in which it bases analysis on the women's 'own class'

since the use of social class for women is inherently problematic and reports which utilises the 'male head of household' as a measure have been criticised for their failure to conceptualise adequately the position of women (*cf.* Arber 1990a, 1990b; Pugh and Moser 1990). In what appears to link with Macintyre *et al's* (1996) work, Arber (1990a, 1991) further demonstrates the need to conceptualise women's various roles and consider how they influence health within a structural context. The potential health effects of young women's 'roles' are considered shortly.

As this research project will be reliant upon self-reports of health and ill-health it is necessary to devote some attention to this subject. As stated above, women are consistently more likely to report more ill-health than men, but unlike the psychological studies recorded earlier, sociological studies indicate that this difference has a social base. However, there has been long-standing disagreement over what the social basis actually is. For example, some earlier studies have focused upon women's greater propensity to report and act upon symptoms (*cf.* Gove and Hughes 1979), although no evidence was found in this review to substantiate such claims. Other authors make associations between the 'flexibility' in women's social roles and reporting of symptoms (*cf.* Verbrugge and Wingard 1987). Because such confusions exist, one particular study will be illuminated for the way in which it explores the meanings people attach to their experiences and the way in which social structures and processes shape these meanings.

Popay's (1992) study combines secondary analysis of existing large data sets from the Health and Lifestyles Survey (*cf.* Cox *et al.* 1987) and the OPCS General Household Survey alongside case studies of a year in the life of women and men in eighteen London households. This study refutes the ideas that women are more likely to perceive themselves to be ill or to have more 'freedom' to be ill. Instead using the example of reports of tiredness, she demonstrates the need to explore the inter-relationship between subjective

measures of health and the differences in women and men's experiences of health and ill-health through the mediation of socialised expectations and material circumstances. In short, Popay encourages researchers to go beyond the concerns embodied in the earlier debate towards a study of the social and material context for the meanings imbued in women's accounts of their health and ill-health.

Instead of clarifying matters this section has continued to problematise the notion of 'health' as an objective and measurable category, and that differences in health experiences or reports can be explained in any concrete manner. The only certainty is that gender differences do exist. As has been shown, gender socialisation from birth provides the context for a subsequent process of differentiation, socially, culturally and materially. This process is experienced, and expressed in terms of health. By acknowledging this inter-relationship, Popay's (1992) exhortation provides a means of accessing homeless young women's lived experiences, for the imperative to conceive health and ill-health accounts as meaningful expressions of the social and material circumstances of individuals underpins every chapter that follows.

Transitional thoughts

The conceptualisation of 'youth' as representing a series of transitions continues to provide the framework for the following sections. Underlying these transitions are the unifying goals of establishing independent status and identity, but as already considered homelessness among young women is conceived as the product of 'fractured' transitions (*cf.* Jones and Wallace 1992; Williamson 1993). By utilising examples of the three main groups of influences upon health: environmental, material and psychosocial (*cf.* Macintyre 1994) as a guide, the following sections consider specific examples, implicit in social well-being, which may exert an influence upon physical and mental well-being, and which are inextricably linked to homelessness

experiences. The overarching influence of gender will continue to be demonstrated.

Some environmental influences

It would appear a self-evident truth that a relationship exists between poor housing conditions and poor health, but the relationship is not so simple (Lowry 1991) since, as shown above, those who occupy poor housing also tend to be disadvantaged in other ways which exert a detrimental influence upon health (Mant 1993; Ambrose 1996; Wilkinson 1996). However, it has been shown that historical improvements in housing have been accompanied by improvements in health (Byrne *et al.* 1986).

A large literature exists on the relationship between housing conditions and health and noteworthy examples provide extensive literature reviews (Byrne *et al.* 1986; Smith 1989; Smith *et al.* 1991; Connelly *et al.* 1991; Lowry 1991; Arblaster and Hawtin 1993; Burridge and Ormandy 1993; Ineichen 1993; Leather *et al.* 1994; SCOPH 1994). The *Introduction* to this thesis sketched the established relationship between poor health status and housing opportunities and this should be borne in mind when considering the following 'health effects' of housing. Nevertheless, various environmental conditions are associated with risks to health and those which may have a bearing on the health of 'homeless' young women, either during their formative years, or as they undertake their own housing transitions are considered.

Various aspects of housing are linked with the production of poorer health among occupants. Risks associated with building insulation (PAAC 1987) hazards identified with domestic appliances (Ware 1984), and accidents in the home arising from poor maintenance of buildings, faulty wiring, lack of space, poorly maintained appliances or poor lighting (Lowry 1991; Mood 1993). Damp, cold and mouldy conditions are connected with incidences of childhood pneumonia, bronchitis and asthma and these are strongly implicated in excess

adult morbidity and mortality rates (Folmer-Anderson 1984; Barker and Osmond 1987). Noise pollution is associated with raised anxiety levels (Arblaster and Hawtin 1994). Additional symptomatic outcomes of such measurable poor housing conditions are shown to include, in children, headaches, diarrhoea, aches and pains, and respiratory disease particularly sore throats, nasal problems, coughs and wheezing, alongside vomiting, irritability, tiredness, unhappiness and poor appetite, and among adults, breathlessness, nausea, constipation, aching joints and 'bad nerves' (Hunt *et al.* 1986a, 1986b; Martin *et al.* 1987; Hunt *et al.* 1988; Platt *et al.* 1989).

Environments which lack the opportunity for the hygienic preparation and storage of foods are linked with the spread of gastrointestinal pathogens and impacts upon individuals nutritional status, and ability to resist disease, since the quality of facilities determines dietary intake (Conway 1988, 1991, 1993). Overcrowding is associated with the spread of infectious diseases, ranging from influenza to tuberculosis (Mant 1993), to shortened adult stature and respiratory disorders as an effect of previous overcrowding in childhood (Britten *et al.* 1987), to increase the likelihood of accidents, especially fire (IEHO 1984). Overcrowding and poor housing situations are considered factors that may bear on domestic violence (Ambrose 1996).

Older studies report the effect of environment upon women's mental health. Lack of 'defensible' space (Newman 1972), with an associated lack of privacy is implicated in poorer mental health, and a relationship between crowding in the home and 'psychological distress' is reported (Gabe and Williams 1987, 1993). Such problems have long been attributed to difficulties in controlling the desired amount of social interaction with other members of the household (Stockols 1976) and maintaining a desired level of privacy (Altman 1975; Ineichan 1993) alongside problems arising from the lack of demarcation between domestic roles and leisure time (Brittan and Maynard 1984).

Correspondingly, the isolation of living alone is implicated in the production of poorer mental health among women (Gabe and Williams 1986a, 1986b, 1987).

The general environment of the locality is also associated with 'psychosocial malaise', employed here in opposition to the concept of 'well-being' (Blaxter 1990). Reinforcing the caveat for the potential of health-selectivity into such housing, people in high flats of poor repair are shown to have more mental health problems than people living in houses (Hannay 1981). The anxiety produced by fear of crime is demonstrated (*cf.* Smith 1987, 1988) with high levels of stress found among people wishing to move out of the area in which they are living, or who have experienced crime directly (Blackman *et al.* 1993) and it is shown that poorer people experience crime and associated anxiety disproportionally (Kinsey 1984). Moreover, the stigma associated with living in certain areas, and the consequential effects upon employment and credit opportunities is shown to create various mental health problems (Freeman 1985).

A qualitative study of 107 sample households in two social housing estates in London lists the five most common categories of symptoms reported: coughs and colds, aches and pains, asthma and bronchial disorders, digestive disorders, and stress and depression (Ambrose 1996). This study is particularly useful in identifying differential reporting of symptoms. Younger people reported experiencing more coughs, colds, asthma and bronchial complaints, whilst older residents reported more aches and pains, stress and depression. Those in work reported fewer symptoms than unemployed or non-employed respondents, a subject illuminated in the next section. Moreover, by focusing upon residents own judgements of the relationship between their housing conditions and their health experiences, over 60 per cent believed the two were 'very closely related' and a further 13 per cent said the conditions 'had a lot to do with it' (*Ibid.*: 78-79). This latter consideration is important since it is shown that those living in poorer conditions often attribute their ill health to

their circumstances more so than those who live in better conditions (McCarthy *et al.* 1985; Coulter 1987).

In this brief overview it is possible to see that poor environmental conditions exert influences upon individuals' physical and mental health. Moreover, the effects of such conditions are mediated by the individual's own experiences and perceptions of their environment and, as demonstrated, these also produce demonstrable levels of physical and, especially psychosocial malaise. Housing circumstances are, however, associated with an individual's level of ability to afford and accordingly choose, or alter the environment in which they live.

Unemployment

For young people the key to obtaining independent status is the acquisition of employment, but as affirmed in the literature on 'the causes' of homelessness, unemployment renders individuals unable to afford and maintain housing in their own right. Yet, as discussed in this and the previous chapter, unemployment is the result of a number of factors. Studies attest that unemployment is a paramount concern for young people (*cf.* Brannen *et al.* 1994; Barnardos 1995), especially for young women, those from manual backgrounds, and those not staying on at school, with those anticipating unemployment being found to rate their health worse and showing a higher malaise symptom score than their peers (West and Sweeting 1996a, 1996b). Such findings provide a means of understanding potential health effects of the uncertainties produced by the 'Risk Society' as outlined in Chapter 1. The social support received from family, peers or the community, however, is shown to ameliorate some of the detrimental effects of unemployment (Jackson and Warr 1984; Ullah *et al.* 1985) and this is explored in the next section.

Looking at the potential 'roles' of the subjects of this research: daughters, partners, mothers and autonomous individuals, when considering the health effects of unemployment, it is important not only to consider the potential

effects of their own unemployment, but also possible prior effects of parental and partners' unemployment. As individuals and mothers, existing homelessness research highlights unemployment as a 'cause' of homelessness. As daughters, and as will be shown, many interviewees in this study reported having experienced the effects of their mothers' unemployment. Studies of 'housewives' and unemployed women over the age of thirty years indicate their poorer health than working women with higher levels of limiting long-standing illness being found among women in previously manual jobs (Arber 1987, 1990a). Moreover, previously married women and women without children, especially if unemployed and living in social housing, are shown to have a particularly poor health status (Arber 1990a, 1991) and this is related to their poorer material circumstances (*cf.* Glendinning and Millar 1987).

As will also be shown, many interviewees had already experienced the consequences of their fathers' or partners' unemployment. Studies of unemployed men demonstrate high mortality rates and reports of long-standing illness (Cooke *et al.* 1982; Moser *et al.* 1986; Blaxter 1990), a relationship between unemployment and psychosocial malaise (Banks and Jackson 1982; Beale and Nethercote 1985; Warr 1984, 1985; Blaxter 1990), suicide behaviour (Kreitman and Platt 1984; Platt and Kreitman 1984; Hawton and Rose, 1986) and conflicting work suggests there may be an association with increased alcohol consumption (*cf.* Kandel 1980). The health of the families of unemployed men is shown to be affected (*cf.* Durward 1985; Blaxter 1990) with wives experiencing increased mortality and morbidity rates (Moser *et al.* 1986) and psychosocial malaise (Penkower *et al.* 1988) and children showing poorer health and development (Maclure and Stewart 1984; Macfarlane and Cole 1985). Male unemployment is also said to be a predictor of severity of child abuse (Rosenthal 1988) and may be a factor in domestic violence (Hammerstrom 1994).

Unemployment among young people is shown to increase tensions within the family (Roberts *et al.* 1982) and to produce higher levels of psychosocial malaise, dissatisfaction with life and lowered 'self-esteem' (Warr 1987; Kieselbach 1988) and although connections are made between unemployment and physical illness (Fryer and Payne 1986; Bartley 1987), other work suggests little or no connection (McPherson and Wayne 1983). Unemployment is shown to have some association with young people's consumption of cigarettes, especially young women (Hammerstrom 1994), alcohol (Power and Estaugh 1990), and drugs (Peck and Plant 1986; Hammerstrom *et al.* 1988), although such 'behaviours' are also associated with parental class (*for example*, Conrad *et al.* 1992) and perceptions of parental support and control (Foxcroft and Lowe 1995) which, as outlined earlier, are implicated in educational and employment opportunities. The full significance of these considerations is found in the chapters that follow.

Among young women connections appear to be clearer with higher levels of physical health problems and psychosocial malaise, including suicide ideation, reported during periods of unemployment which then recede with employment (Hammerstrom 1994). This work, which incorporates a thorough literature review alongside the reporting of findings from Hammerstrom's analysis of follow-up studies of a cohort of 16 year old school-leavers in Sweden (*cf.* Hammerstrom *et al.* 1988), reveals gender differences in strategies to overcome unemployment. Although female respondents were found to report more psychological problems as a result of unemployment than males, they were also found to be more active in moving to areas where employment could be secured, to undertake any available work, commence studies, or to have a child (Hammerstrom 1994). In this latter respect, marriage or motherhood are said to be 'socially acceptable' alternatives to long-term unemployment for young women (Furlong and Cartmel 1997). This matter is examined in Chapter 8.

Locally, in their comparative analysis of the youngest cohort in the *West of Scotland Twenty-07 Study* at 15, 18 and 21 years West and Sweeting (1996a) report the overall high levels of mental health problems in the post-school period, at age of 18 years. Mainly attributable to anxiety, the percentage exhibiting 'psychological morbidity of potential clinical significance' had doubled over the three years and now involved around one-third of males and two in five females. Additionally, one fifth reported suicidal feelings and 3 per cent an episode of deliberate self-harm (*Ibid.*: 60). However, among those who were unemployed at 18 years higher levels of mental health problems were found, including suicide ideation among one in five males, and over half of females, and suicidal behaviour, with just under 9 per cent of males and 7 per cent of females having reported this, though this latter figure was considerably lower than the much higher rate (17.4%) for 'at home' females (*Ibid.*: 57), that is not in paid work, or any form of training or education. By the age of 21 years there was also evidence of a direct relationship between psychological morbidity and a number of periods of unemployment, and among those, predominantly females, 'at home'.

These effects of either anticipated unemployment and indirect or direct experiences of unemployment or non-employment upon individuals' health and well-being cannot be explained by reference to the tangible material aspects of employment alone (*cf.* Arber *et al.* 1985; Hammerstrom 1994). Accordingly, in order to understand these wider aspects Jahoda's (1979) conceptualisation of the 'latent functions' of employment provides a useful tool. Employment, she suggests imposes a time structure on the day, and enforces activity, it implies shared experiences and contact with others, it links the individual to objectives that transcend their own and, as stated above, it defines aspects of personal status and identity. The introduction of this model here is to emphasise why the meanings, norms and values imbued in any given situation should be identified, analysed and understood. This provides an essential framework for the crucial explorations and interpretations presented in Chapter 7 for, without

an understanding of such matters the arguments presented throughout this thesis are potentially meaningless.

Psychosocial aspects of health and ill-health

This chapter, through examples, has emphasised the need for a model of health that encapsulates the various inter-related and inter-dependent biological, material, cultural and psychosocial factors which can exert influences upon experiences, understandings and reports of health and ill-health. Until now the psychosocial constituents of health have only been acknowledged implicitly. A persuasive case for an investigation of the various psychosocial elements which mediate between material and health factors has been produced in which the author illustrates his thesis that, when looking at health inequalities in developed countries, of all the determinants of health the psychosocial influences, notably social cohesion, may be pre-eminent and, above all the need for an appreciation of 'relativity' as a social concept is stressed (Wilkinson 1996). As particularly evident in the examples of gender, housing conditions, and unemployment, two over-riding factors are shown to magnify or ameliorate the effects of these variables: an individual's own perspicacity of their situation, and the absence or presence of social support.

When considering perspicacity, the initial factor to illuminate is control or the extent to which any individual may perceive control of a situation to be within their sway. As shown earlier feelings of control over health are subject to strong age, gender and class variations (*cf.* Blaxter 1990; Brannen *et al.* 1994). Accordingly, the notion of 'empowerment' (Wallerstein 1992) or sense of control, must necessarily be explored since it has been shown that those who feel empowered are also likely to be self-efficacious and to experience lower levels of psychosocial malaise (Myers 1989). Whilst there exists a material basis for the extent of control which can be exerted over many situations, to focus only on limitations would be to deny the 'strategies' (*cf.* Blaxter 1990; Hammerstrom 1994) individuals employ. Housing strategies are considered in

Chapter 6, and later chapters identify those in relation to health. The significance of perceptions of control is underlined in chapters 6 and 7.

The protective health effects of social contacts and support relationships is recorded and studies indicate that the presence or absence of such support can cushion or intensify individuals' responses to stressful situations and events (*cf.* House *et al.* 1988; Whelan 1993; Rosengren *et al.* 1993; Berkman 1995). However, research among women with mental health problems reveals the high extent to which they felt they received little or no support from family and friends (Ginsberg and Brown 1982; Miles 1988). The connection between social support relationships, material and environmental circumstances and gender has long been recognised (*cf.* Brown and Harris 1978). In their seminal study which illustrated the difficulties experienced by women with children in poverty, Brown and Harris demonstrated the connection between depression and such social and economic conditions. Amounting to one-third of respondents, this study identified the highest rates of clinical depression among working class women, with three or more children under the age of five years, who did not have a confiding relationship with their husband or partner. More recent support for an association between ill-health and feelings of social isolation (Blaxter 1990) suggests a close relationship between measures of stress and social isolation and other forms of social disadvantage. Low incomes and lack of social support were found generally to be associated with high reports of illness. Moreover, those with fewest family and friendship ties, and working and community roles, were found to report the lowest psychosocial well-being. As will be made manifest in subsequent chapters, interviewees accorded great prominence to these inter-relationships in their accounts of their own well-being, and especially in their narratives about their mothers' lives.

In her qualitative study of 200 homeless young people, aged 16 to 21 years, in London and Sydney, Downing-Orr (1996) illuminates the importance of studying these factors in homelessness research. By focusing on 'the homeless

community' Downing-Orr found that, despite the difficulties and hazards associated with the 'homeless lifestyle', when compared to their previous experiences of childhood institutions, 'the homeless community' was regarded by respondents as welcoming, supportive, protective and engendering a sense of belonging and these components helped to 'countervail the process of alienation experienced during childhood' (*Ibid.*: 56). This support is also shown to ameliorate the experiences associated with homelessness through the sharing of goods or the companionship and empathy found among others with similar histories. In the context of general women's health studies this latter point is a particularly germane feature since most women who seek support regard others with similar experiences to be a preferred source of emotional support (*cf.* Miles 1993).

Concluding remarks

This chapter has problematised the notion that health and ill-health are objective and measurable categories which refer only to the biomedical paradigm. It has also questioned the notion that actions in terms of health must necessarily have recourse to professional health services. Moreover, by accentuating consistently that reports of health and ill-health experiences are subject to the meanings derived from individuals' lived experience it has been argued that health reports should be treated as relative to, and expressions of these experiences. In this manner, however insightful self-reports of ill-health may be, they are not an end in themselves, but the starting point for accessing and analysing the interaction between objective social, material and cultural circumstances and reported health outcomes, as mediated by the affective body.

Moreover, by going beyond the desire to demonstrate associations between homelessness and ill-health to the processes contributing to reported health outcomes it is possible to recognise that, as much as homelessness should be recognised as one, albeit consummate, product of the iniquitous structures and forces which affect a much wider population, so too should homeless peoples'

health experiences be contextualised within this much broader population. This shift is fundamental to challenging the codification of homelessness as a 'housing problem' and problematising the biomedical orientation of most homelessness and health studies. No research project can be value-free, but by conceiving health as a state of complete physical, mental and social well-being, by exploring the inter-relationship between structure and agency, and by treating self-reports as expressions of the interviewees' lived experiences, this project resolves to provide a more holistic understanding. Chapter 3 will now explain the influential methodologies and the methods employed in the pursuit of this objective.

Chapter 3

The bricolage

In focusing upon key features of youth transitions, the previous chapters were framed in a rather structuralist manner, yet they also appealed for an understanding of the meanings individuals ascribe to their situation and an appreciation of the agency these meanings inform. This raises the difficult problem in social theory which has both theoretical and methodological implications for the conduct and analysis of this research: how to adequately conceptualise structure and agency in a single explanatory framework? This chapter must, therefore, begin by outlining the influences upon which this project was founded.

Background influences

The previous chapter argued for an appreciation of the 'lived body' as simultaneously physiological, psychological and social and concluded with an appeal for a conceptualisation and incorporation of 'lived experience' in homelessness research. As the paramount theoretical predilection brought to this research, the basis for such reasoning was formulated in an earlier dissertation which argued that the theoretical difficulties imbued in connecting the notion of human agency with a structural explanation had been overcome by the role assigned to the category of 'experience' in E.P.Thompson's historiography (Stephen 1994). In his works (*for example,* 1968, 1980, 1991) Thompson demonstrates the means through which it is possible to conceptualise social process through accepting the autonomy of human consciousness whilst acknowledging the influence of social being. However, the concepts of structure and agency are generally taken as oppositional and mutually exclusive (*cf.* Giddens 1993) and the implications of this dichotomy

to homelessness research was outlined in Chapter 1. It is precisely because of these weaknesses that the considerations by Neale (1997a, b) were welcomed.

The main weaknesses identified by Neale surround the simplistic and atheoretical presentations of homelessness as a result of structural or individual factors and, by providing a brief historical overview she highlights how such conceptions have influenced policy responses and how homeless people are perceived and portrayed. Succinctly offering a number of possible theoretical approaches, Neale appeals for a union of structure and agency in homelessness research. With reference to the data presented throughout the chapters that follow, this vital, yet missing ingredient in homelessness and homelessness and health studies is considered in Chapter 9.

Neale's considerations were, however, pre-empted by this research, for the employment of Thompson's conceptualisation here has had both theoretical and practical bases. In presenting history as an active process shaped by agency, Thompson (*for example*, 1968, 1991) reinforces his thesis that human beings make their own history as much as they are made by it; all historical subjects are conceived of as conscious, goal-directed agents and, although their activities are inscribed within existing social relations, they remain intentional activities. Through his concept of 'experience' Thompson provides an efficacious means of connecting human agents, and the conditions and consequences of their autonomous action, with the structured causes and consequences of the conditions of their existence (*cf.* Thompson 1980, 1981) and this provides a clear direction for an exploration of the ways through which structure and agency can be appreciated and analysed as inter-dependent variables in homelessness research.

Methodologically, this conceptualisation of 'experience' enables an understanding of research traditions which inspired this project. A main example is found in McRobbie's studies with young women and by

acknowledging this influence, the doubly significant link with Thompson's work is revealed through the incorporation of his practice of writing 'history from below'(McRobbie 1982, 1991). By contextualising the character of human activity, the object of 'real history', for Thompson is to recover the history of those whom history has overlooked, those whose agency has been denied or portrayed as torpid (*for example*, Thompson 1991). In the context of homelessness research the notable studies by Tomas and Dittmar (1995) and Downing-Orr (1996), published in the course of this project, underline the need for an approach which 'listens' to the accounts of 'the defined' and contextualises meanings and agency.

It is a measure of the invisibility of young women and the under-development of qualitative methodology in homelessness research that the principal research aims of raising the visibility of young women and attempting to discern their lived experiences are akin to those outlined in McRobbie's early works (*respectively*, McRobbie and Garber 1978; McRobbie 1977). With direct reference to factors outlined in preceding chapters, and with pre-stated exceptions, the overall knowledge base of homelessness studies, and especially those pertaining to (ill)health, has three weaknesses. The first is the tendency for an objectification of homeless people and a related focus upon causation and quantification. The second is the failure to include a conceptualisation of the 'affective body' and, thirdly, the paucity of investigations into how 'homeless' people themselves explain and give meaning to their experiences. Accordingly, on the basis of these critiques and the conceptualisation that human activity embodies both social action and social structure simultaneously, a further methodological predilection brought to this research was the desire to employ qualitative methods. Goffman's systematic approach to the study of human life provided a definitive archetype because,

> Any group of persons ... develop a life of their own that becomes meaningful, reasonable and normal once you get close to it (Goffman 1961: ix-x)

From the outset of the research process the founding aim was to discern context by 'getting close' to homeless young women's material and social lifeworld, or *Lebenswelt* (Husserl 1970), the intersubjective world of human experience and social action as constituted by the thoughts and acts of the subjects, through the employment of methods conducive to the pursuit of *Verstehen* (Dilthey 1976) in its contemporary derivative forms. The methodological tools and the justification for their usage are explained shortly. This desire to 'get close' was believed prerequisite to exploring homeless young women's social and material life experiences, the meanings, values and ideas they associate with these experiences, and ways through which they negotiate their social life.

Accordingly, this research necessarily represents a fusion of assumptions drawn from symbolic interactionism (*cf.* Denzin 1992), phenomenology (*cf.* Schutz 1967) and ethnomethodology (*cf.* Garfinkel 1967). In the conception of human subjects as purposive agents who confront a world that must be interpreted, symbolic interactionism allows for an investigation of how individuals make sense of their world and how, in turn, these meanings are employed as instruments for guiding and forming action. This tradition also engenders a focus upon the ways in which social roles and identities are constructed through interaction. This research project's concern for an appreciation of lived experience unquestionably points, in a complementary fashion, to phenomenology, as exemplified in the social constructionism of Berger and Luckman (1967), since this allows for an investigation of how the lifeworld is produced and experienced by individuals through the description of the experiences of everyday life. The complementary influences of both traditions are illustrated in Chapter 7 in the necessarily intertwining considerations of lifeworld and identity. Moreover, the phenomenological encouragement of an understanding of the social given meaning of an act in context underpinned the direction of analysis of which Chapter 8 on health agency became a product. Lastly, continuing with the theme that meanings are

indexical or context bound, ethnomethodology encourages a focus upon the meanings and understandings that people use to make sense of their everyday lives and how individuals construct their own definitions of a social setting. The significance of this tradition to this project lies in Garfinkel's (1967) focus upon the essential reflexivity, as evident in the contextual nature of meaning, built into social action and with a concern for identifying the nature of the process. In this manner the everyday processes of social life are conceived as skilful accomplishments of actors. The influence of this tradition can, firstly, be illustrated in analysis of the interviewees' definitions of 'home', 'homelessness' and 'health', and, secondly, in Chapters 5 and 6 which are underpinned by the concepts of processes and careers.

These latter paragraphs indicate this project's indebtedness to Verstehende sociology, but it does not aspire to be part of that tradition for the fact that this tradition confines itself to the study of subjective meanings and, therefore, does not fully conceptualise the underlying structures of these meanings. Accordingly, in using as a standard the seminal studies produced by the Centre for Contemporary Cultural Studies which drew upon a multicultural heritage (*cf.* McRobbie 1991), and because of the inductive nature of this project with its concern for grounded theory, this thesis adopts a necessary theoretical pluralism founded in the aspiration to provide an understanding of context, agency and process in the health of the subjects of research.

Adopting such a fragmentary and pluralist approach is not without its problems for, in formulating this eclectic bricolage, this research would appear to be representative of some kind of disorderly postmodernist thinking. Indeed this project is driven by a 'distrust of universal or totalising discourses' (Eagleton 1987) and a scepticism towards the essentialist modes of binary opposite representations of reality (*cf.* Derrida 1991) characteristic of the modernist project and its claims for truth. Modernist modes of thought in homelessness and homelessness and health research have resulted in explanations which do

not question the hegemony of the scientific paradigm's privileging of cause and effect and, by not challenging 'difference' in the prioritisation of either structure or agency, reinforce the 'victim/ guilty' dichotomies perpetuated by the wider society. As this thesis asseverates throughout, the actuality is not so simple. All representations are merely how commentators have constructed and represented it according to their worldview, and this thesis cannot be exempt from this charge. However, as argued in the previous chapters, the context for both homelessness and health outcomes is not representative of any radical break from the social conditions of the past. They are symptomatic of an underlying continuity and, in fact, an intensification of exclusion and marginalisation (*cf.* Giddens 1991) for those who, by virtue of their income, status or education, cannot be full shareholders in society; cumulative inequalities that continue to adhere to the key anchor lines of class, gender and ethnicity.

In drawing upon the aforementioned methodologies and upon socialist humanistic influences, this research cannot deny its roots in modernist modes of thought, but, as argued in Chapter 1, the contemporary conditions of social life are no longer readily identifiable with classical modernist explanations and in this regard the 'Risk Society' (Beck 1992), as symptomatic of late modernity, is advanced as the most useful means of conceptualising these changes. Social researchers must, correspondingly, adapt to these changes, adopting a necessary pluralism grounded in 'methodological pragmatism' (*cf.* Morrow with Brown 1994) which breaks from modernist thought by problematising such ways of knowing the world, yet demonstrates continuity through drawing upon the applicable strengths of such traditions. Moreover, the inductive nature of this research process means that there is not only an interactive flow between the subject-subject research relationships, but between the researcher and the data and this interaction necessitates the employment of grounded theory, defined shortly. Undoubtedly biased, firstly, by the desire to transcend the structuralist/ culturalist divide, secondly, the conjecture that there

is 'no such thing as a general universal methodology' (Galtung 1977: 40) which can provide definitive truth, and, thirdly, that the choice of methodology is an 'ideological act' (*Ibid.*) the holistic intentions of this research are concerned with using the appropriate tools for the task in hand rather than trying to make the research process 'fit' dogmatically around a particular methodology. The precedent for innovation in advancing forms of 'interpretive structuralism' (Morrow with Brown 1994) has been established (*for example*, Giddens 1976, 1979, 1984; Habermas 1984, 1987, 1988) and, although this research makes no such grand claims, it will advance a fairly straight-forward way of seeing how structure and agency can be understood from analyses of the data generated.

By means of providing a framework for these explorations, a final predilection brought to this research from earlier undergraduate study, was translated into a straight-forward hypothesis: *As a particularly disadvantaged group, homeless young women are especially vulnerable health-wise*. However, the aims of this research have not been to try to prove this hypothesis, rather by problematising what is a common-sense assumption the following founding research questions were formulated:

1. Why do young women become homeless?
2. How do young women experience homelessness?
3. Is there a relationship between these experiences and health?
4. If so, what is the nature of that relationship?

These simple questions reveal the nature of this project to be both exploratory and interpretative through the employment of appropriate qualitative research strategies, and grounded theory, taken here in the more general use of the term to refer to the development of theoretical ideas that begin with the data, and through experience of the data the generation of insights and further questions to be pursued (*cf.* Strauss and Corbin 1990). The over-riding intention was to collate rich narratives of young women's' lived experiences. Given that most existing research offer 'causes' of homelessness, the concept of 'epiphanies'

(Denzin 1994) would provide a useful heuristic framework for the investigation of these as constituents of process:

> The focus of the research is on those life experiences (epiphanies) that radically alter and shape the meanings persons give to themselves and their life projects. In epiphanies, personal character is manifested and made known. By recording these experiences in detail and by listening to the stories people tell about them, the researcher is able to illuminate the moments of crisis that occurs in a person's life. (Denzin 1994: 510)

As argued in the previous chapters, too often 'homelessness' and 'health', and the 'links' between both have been taken as objective phenomena that are readily available to the researcher. By problematising such notions, particularly those of causality, by going beyond 'sheer association' (Miles and Huberman 1994) assumptions of straight-forward cause and effect mechanisms are quickly dissolved. The notion of 'epiphanies' therefore facilitates an investigation into how these are experienced and highlights their potential for action. The means through which common-sense assumptions were translated and transformed into a methodological framework are now considered. Because the research process was lengthy and involved a number of methods, Appendix A provides a diagrammatic overview of the research schemata which the remainder of this chapter now explains.

Review of the literature

Although ongoing, the main review of the literature was undertaken in the early months of this research. The themes presented in the *Introduction* and Chapter 1 were largely the product of this stage. This initial literature review also revealed contextual difficulties which Chapters 1 and 2 have attempted to redress. As shown in these chapters, the subsequent and ongoing literature review tapped into rich, research-active fields which provided invaluable resources to the progress of the project and, importantly, a more normative context for the study of 'homeless' young women's health.

The main contextual difficulty related to the research tradition itself. Unlike, for example, youth cultural studies or women's health studies, with exceptions noted in previous chapters, there is no consolidated qualitative tradition in the field of homelessness and health to draw upon for methodological guidance. Consequently an eclectic blend of methodological influences and tools considered appropriate to the aim of 'getting close' were drawn upon and employed. However, because the population to be studied is a marginalised one and much of the research explorations were to be of a 'sensitive' (Lee 1993) nature, methodological strategies refined within social research on HIV and AIDS (*cf.* Boulton 1994) proved indispensable. To ensure the research process had an internal coherence, the concept of 'bricoleur' (Levi-Strauss 1966), as redefined by Denzin and Lincoln (1994), provided a useful metaphor for the production and evaluation of the research process as a coherent and reasoned 'bricolage'.

Establishing contacts

From the outset of the research process it had been a primary aim to become familiarised with the homeless situation in Glasgow by establishing contact with representatives from the statutory and voluntary housing, health and welfare organisations who work directly or indirectly with homeless young women throughout the city. It was hoped that by speaking with those who have experience in this area 'prototypical portrayals'(Sudnow 1965), in terms of the social characteristics, experiences, needs and concerns, of homeless young women could be elicited. This was deemed essential to a general identification and understanding of the pertinent issues and to the informed and sensitive planning of subsequent interactions with the subjects of study. Moreover, it would allow for an evaluation of the most appropriate venue for conducting participant-observation and for sampling, discussed later. Early discussions with academics knowledgeable of the main figures, and structures of homelessness provision within the city, and an interview with an agency-based researcher studying homelessness and health issues generated a comprehensive

list of possible contacts. In order to provide as broad a picture as possible, all statutory and voluntary housing, homelessness and social welfare agencies, and specialist health and outreach projects with a remit for homeless young women were contacted.

A total of thirty-four introductory letters were sent to senior staff within these organisations explaining the nature of the research, requesting information about their organisations and possible meetings were sent at the beginning of April 1995. Responses took on average one month, although ten follow-up letters required to be posted in July. Despite this, six organisations never replied. Two were national bodies where information was not essential as it could be gathered tangetially elsewhere, but four were small-scale projects and the shortfall of local specialised information, especially relating to domestic violence, was disappointing. Twenty-eight favourable responses were received. Relevant information was received from eight organisations and twenty-three interviews were arranged by telephone, and, as contacts were established, a further nine interviews with others recommended by those primary contacts as useful to the research were held. Most interviews were held between April and August 1995. This period is characterised by overwhelming generosity on the part of those professionals in terms of time, the average duration being two hours, and in the information conveyed.

Because of the inductive nature of this stage of the research process the term 'meeting' was employed, with the professionals, to convey a less formal and less structured interaction unlike 'interview' which implies a more formal, pre-structured agenda. Given the limited information on homeless young women it was imperative that the professionals be allowed to provide as rich a picture as possible of their clientele free from the confines of a potentially uninformed question format. In the initial letters and during interview, those professionals were asked if they would provide information on the nature of the organisation and its work, detailed accounts of the numbers, ages and types of background

of their client-group, and information about their clients' health and support needs. Where different ages and sexes were catered for any age-, or sex-related differentials were requested. To reinforce the relatively informality of these interviews no tape recordings were taken, notes were taken and written up immediately afterwards. Consideration had been given to the possibility that the professionals might be constrained in their accounts by the presence of a tape recorder and it was hoped that, by not recording the interviews, their own knowledge and experiences, rather than the mission-statements of the agencies, would be imparted more readily. This was substantiated when, occasionally, 'official' policy was contrasted with the 'realities' of practice through anecdotally-rich illustrations.

With the exception of those organisations catering for homeless mothers, discussed later, it was held that all avenues had been exhausted on noting that latter interviews were not generating new professionally-based insights into homelessness among young women. Fairly consistent 'prototypical portrayals' had been presented. In these, the term 'chaotic' was omnipresent in the context of 'you have chosen the most chaotic homeless group to study'. Such statements tended to be qualified by reference to two other key terms 'vulnerable' or 'damaged'. Homeless young women were characterised as coming from abusive, unsupportive and disruptive backgrounds, with high levels of care experiences who had become 'detached' from support networks, who 'lacked' the necessary life-skills required for independent living and who required high levels of emotional support. High levels of self-harming and parasuicide were reported. Physical health needs were perceived in terms of basic factors such as poor diet or 'health risks' such as smoking, alcohol and drug use, or sexual behaviour. 'They have a poor motivation towards health' was frequently stressed, although some professionals qualified this by explanations of 'poor motivation' as an effect of the young women's poor emotional health or problems associated with General Practitioner registration. Nevertheless, health was portrayed as very much a 'low priority concern'.

Problems associated with 'behavioural difficulties' were mentioned. However, many professionals underlined 'the resilience' of the young women in terms of their ability to cope with their experiences and this was often illustrated by anecdotes of individuals who had made successful transitions to independent living. Undoubtedly, two factors underpinned future planning: a high level of sensitivity towards the subjects of research and the need for a greater insight into homeless young women's lifeworld, especially by means of unpacking these terms 'chaotic', 'vulnerable', 'detachment from support networks', 'poor social skills' and 'poor motivation'. Before explaining the method by which this was achieved the other main contacts made should be mentioned.

The extent of emerging ideas necessitated an active and evaluative engagement with other researchers with a local interest in this field, and more experienced researchers who have confronted the various methodological issues associated with studying marginalised groups. Contact with other homelessness researchers, sociologists, anthropologists and social psychologists was either direct or arose following conversations with third parties. Such encounters generated a useful gathering, exchange or imparting of information, however, their greatest benefit lay in the need to conceptualise the research issues, aims and directions succinctly to those in a position to evaluate critically. Furthermore, the shared interests and mutual support generated provided valued opportunities to discuss emergent ideas which helped to reduce the sense of isolation engendered by individual research. Ongoing attendance at relevant conferences and participation in seminars provided additional and complementary avenues for advancement of the apprenticeship of becoming a 'reflective practitioner' (Schon 1983).

Participant-observation

Thus far this chapter has concentrated upon a description on those facets of the research process related to what can be taken as representative of main 'frontstage regions' (Goffman 1959). Equipped with a confident familiarisation

with the academic issues, the structure and nature of homelessness provision within the city and a tentative appreciation of 'prototypical portrayals', it was time to negotiate access to the 'backstage regions' (*Ibid.*). Textbooks explaining the practice of observational methods (*For example*, Fielding 1993; Robson 1993; Yin 1994; Hammersley and Atkinson 1995) record the difficulties associated with gaining access, yet finding a suitable avenue for participant-observation proved the most straight-forward part of the research process.

In August 1995 an interview was arranged with a Missionary who, with her husband, held responsibility for the running of facilities operated by a charitable Christian organisation which provided a range of practical, emotional and spiritual support, each weekday night, to homeless people, drug users and women who work as prostitutes. Moreover, the Health Board operated medical, dental and chiropody services in one of the premises. The women's facility catered for up to sixty women per night, of all ages and from the whole gamut of homeless situations. During this interview, an invitation was extended to visit again to speak with anyone willing to participate in this research. After explaining the principles of participant-observation, the position of 'volunteer' was secured subject to completion of an application form, two references, and a course of Hepatitis B vaccinations.

This method was decided the most appropriate initial means to develop an appreciation of the lifeworld of homeless young women, their lived experiences and the meanings they ascribe to these experiences, the ways through which they negotiate their social life, and their health views and practices. It would have been an empty gesture to spend some time living in a homeless situation, so having been inspired by the example of others who adopted a 'useful role' as an integral part of their research (*For example*, McRobbie 1977, 1991; McKeganey and Barnard 1992) the position of volunteer would allow for the gathering of information as an 'accepted

outsider' (Bloor *et al.* 1990; Grund *et al.* 1991). 'Acceptance' had been an initial consideration and there was some concern that there might be adverse effect from, or some opposition to the presence of a researcher, but after a couple of weeks the new recruit became just another volunteer who cooked, served, cleaned and chatted. No fieldnotes were taken on the premises because there would not be the time to do so, and there was no 'private space'. To write up notes in the presence of the women was not regarded as conducive to normal interaction. These were written in note form immediately on arriving home and written up the next day. This ongoing diary is expanded upon shortly.

Throughout the research process ethical concerns were paramount. Researchers within, for example, medical sociology are subjected to ethic committee scrutiny. Yet, despite the highly sensitive nature of this research and the marginal position of the population being studied, the ethical conduct of this project has only been subject to rigorous self-monitoring. Undoubtedly rooted in the belief that homelessness is a 'housing problem', this profoundly important oversight must be recognised by any researcher who seeks to repeat this study. The first ethical issue to address was that of consent.

The British Sociological Association (1991) stipulates that informed consent requires the sociologist to explain fully to all participants the research in terms of its aims, why it is being done, who is financing it and what use will be made of it. This code is sufficiently flexible to recognise that consent in such a fieldwork situation is a process to be negotiated and renegotiated over time. Every women who came in during the first couple of weeks was aware of the presence of a researcher, but to inform each and every subsequent woman was rejected as impractical since it would hinder genuine interaction and observational opportunities. Reassured by Hammersley and Atkinson's thesis that 'within the same piece of research the degree of openness may vary considerably across the different people in the field' (1993: 266), the criteria

upon which consent would be sought were determined. Whilst there was no deliberate attempt to be covert - on the contrary, the research was discussed at every available opportunity - a two-pronged process of participant-observation was decided upon.

The first relates to the more general observation matters, what Robson (1993) terms 'descriptive observation' using Spradley's (1980) nine dimensions upon which descriptions can be collated: physical space, physical elements within that space, details of the actors, their activities, specific actions, events, sequences of events, actors' goals, and, emotions in particular contexts. The amassing of such general descriptive data would not require individual consent from those being observed since these were to be anonymous descriptive accounts upon which generalised interpretations and grounded theories could be developed. The first couple of months were spent creating this background narrative. The framework provided by Lofland and Lofland (1984) provided a useful recording guide and notes were written according to running descriptions, interpretative ideas, personal impressions, recalls of forgotten materials, and, reminders to look for specific information. With this narrative in place it was possible to identify where more observation was required and attention would then focus upon specific 'sub-groups', such as those living in specific accommodation situations, drug users, or those with mental health problems. This produced a deeper understanding of specific issues and supported or invalidated tentative ideas generated earlier. Strict adherence to confidentiality, data protection (Lee 1995), ethical guidelines (BSA 1991) and ongoing contemplation of the potential consequences for the subjects (Punch 1986) were decided the best means to regulate this process in an ethical manner.

The second process was where individual informed consent was always secured. As knowledge of the women and their situations developed, alongside their trust of this now familiar face it was necessary to understand their past

and present individual and shared experiences. Directly, individuals or friendship groups were asked if they would be willing to discuss a matter and it was made clear that this information may be used in the project. Complete confidentiality was assured. No-one refused to participate in this 'on-the-record' approach. There was great support for this project and a high degree of willingness to explain matters to one deemed unfamiliar with their lifeworld, for example, whether living or working on the street, within the drug scene or within hostels. An early example of the ongoing experience of 'being taught' demonstrates this well:

> A young woman whom I did not know threw herself down beside me, she appeared semi-conscious and, unable to sit up straight, lay across my lap... Checking her vital signs I tried to rouse her, but there was little response... After about ten minutes her state of consciousness began to improve, but she was neither coherent nor weight bearing well...I decided she ought to see a doctor. (Another young woman), with whom I had spoken about my research earlier, volunteered to come with me 'for protection', but on recognising the 'patient' from the hostel, informed me that 'the patient' smokes heroin and uses valium and looking closely at her "She's only gouching" was the diagnosis offered in matter-of-fact tones. (Fieldnotes 20.9.95: 16)

The diagnosis proved correct and the young woman who had come to assist later sat down and explained 'gouching' (flaccid physical and mental state after heroin consumption), and itemised useful 'do's and don'ts'. Two important, inter-related lessons were learned from this early experience. It reaffirmed the usefulness of participant-observation in generating a qualitative understanding, especially in terms of language and behaviour. It also reinforced the need for academic researchers to be open to all knowledge systems (*cf.* Thompson 1993). Correspondingly, being perceived as one with 'formal' knowledge had its merits. Frequently, an approach was made along the lines of 'Are you the one who's doing research into homelessness?' and an individual's own experiences would be recounted as a contribution to the research. Sometimes, advice was sought on a matter related to the individual's situation. Whilst it was made clear that any intervention would be limited by lack of power or

position, using derived knowledge it was possible to provide appropriate information or advice. Offering such help, commonly defined as 'reciprocity and exchange' (Johnson 1975) is explained as a desire by the researcher not to be parasitic (Power 1989), and this was true, but underlined by wider ideological concerns.

A further, and complementary ethos inspiring this research is revealed in the context of the decision to undertake participant-observation, and as explained later, in the use of focus groups. Collaborative Research (*cf.* Lee 1993) is orientated towards co-operation and collaboration between the researcher and other participants in problem definition, knowledge production, and the choice of suitable methods. This type of approach has been shown invaluable to researching 'sensitive issues', such as HIV and AIDS (Melton *et al.* 1988). Paying due consideration to the potential for exploitation and objectification of participants in the research process (*cf.* Holland *et al.* 1994), in encouraging individuals to contribute actively to the progress of the research process, rather than be objectified or portrayed as 'passive' both of which are implicit in the terms 'observation' or 'respondent', individuals and groups could be conceived of as 'informed insiders'(*cf.* Whyte 1955) or 'consultants' (Bowser and Sieber 1992) able to provide 'insider accounts' (Hammersley and Atkinson 1995) of information which would otherwise be concealed from observation alone (*cf.* Power 1994). This appeared the best way to overcome the main expressed difficulties associated with 'women researching women' (*For example,* Roberts 1981; Bell and Roberts 1984; Finch 1984; Ramazanoglu 1989), and it surmounts the pitfalls imbued in the proposition that social, and therefore 'power' differentials (*cf.* Wise 1987) between researcher and the subjects of research can be overcome by some specious commonality of gender (*cf.* Oakley 1981).

Space does not allow for an appreciation of the copious and rich fieldnotes recorded over fourteen months, but this had never been the intention of this

stage; it was purely a means of 'getting close'. Although some relevant information derived is presented in subsequent chapters, the greatest benefit of participant-observation was the way in which it completely demystified homelessness and homeless people's experiences and transformed any remaining paternalistic notions into realistic appraisals and goals. Participant-observation provided a foundation for the construction of tentative typologies of the processes through which young women become homeless, their experiences, especially those related to health, when homeless, the decisions they make and the strategies they employ as they negotiate their lives, their observed and expressed health needs and concerns and, their life-goals and aspirations. These factors superimposed upon an appreciation of terminology, unspoken practices in terms of 'health behaviours' and lifestyles. Moreover, new factors for consideration arose especially in terms of the inclusion and exclusion bases for the friendship relations observed.

When compared with the 'prototypical portrayals' engendered by the professionals two key differences emerged. When viewed from the perspective of the subjects rather than being 'chaotic', lifestyles were presented as rather mundane. This was especially apparent among those who were drug users where daily lives were highly structured around securing money for drugs and buying drugs. Furthermore, 'motivations towards health', instead of being 'poor' were directly related to the extent to which individuals believed they were able to maintain and improve their health in their circumstances. So, for many, the act of coming to this facility each evening for hot food, despite their being fearful of entering this 'red light' area, was presented as an essential aspect of health maintenance. Moreover, food was directly related to well-being. For example, by observing what individuals ate on a weekly basis, mood changes could be surmised, those experiencing colds would ask for fresh fruit, fruit juice or vitamin C enriched sweets, or those with heroin habits could be identified by taking, almost invariably, three teaspoons of sugar in their tea and

opting for sweet rather than savoury foodstuffs. Such fundamental and simple observations provided a basis for Chapter 8.

The main drawbacks to this method of were twofold. The first lay in the lack of time to devote to exploring a specific range of emerging issues at one time. The second lay in queries about the representativeness of the young women who came to this organisation, especially in regard to the extent of reported territoriality within the city by professionals and the young women themselves. The imperative to explore emerging ideas with 'purposive' sampled groups of homeless young women led to the decision to undertake focus group work.

Focus groups

In HIV and AIDS research, focus groups, as a means of establishing collaborative research relations, are shown to be a useful method for developing insights into community concerns (Bowser and Sieber 1992; Singer 1992) by exploring understandings and experiences, 'providing insights into how and why people think as they do, locating their sources of information, identifying their explanatory frameworks and highlighting different forms and levels of 'knowing''(Kitzinger 1994: 159). Focus groups were decided upon, for two main reasons. Firstly, they would allow for a furtherance of the inductive aims of the project through 'negotiated outcomes' (Lincoln and Guba 1985), that is, an exploration thence identification of key issues raised by the participants. Secondly, group interaction itself was to be an integral part of the data to be collected, for as emerging from participant-observation 'the homeless community' was neither fixed nor singular, it was actively constituted through shared meanings, experience and language which appeared to delineate boundaries of inclusion or exclusion, as explained in Chapter 7.

The merits and disadvantages of using existing or specifically-created groups were considered (*cf.* Hedges 1995). Despite the potential difficulties associated with using pre-existing groups, for example, the effect of an already pre-

established hierarchy in which one person might dominate, these were chosen as the preferred form. In practice, this perceived difficulty worked to great advantage during the course of one focus group where a participant was openly ostracised by the other members of the group. A combination of focus group observations and subsequent interviews with the participants produced important insights into how group hegemony is exerted and maintained, and the positive and negative effects this exerts upon health, a matter pursued in Chapter 7. Pragmatism was the overwhelming reason for choosing pre-existing groups. The interviews with professionals had elicited the centrality of groupwork sessions to the support provided and, accordingly, this prior experience of participation in a group setting was considered a means of reducing any awkwardness engendered by such a forced activity and would facilitate smoother interaction. Moreover, as marginalised young women it was important that participants would feel comfortable amongst those with whom they were already familiar, in a location of their own choosing.

Having developed a tentative typology of homelessness provision (*cf.* Jones 1993) in Glasgow the decision was taken to select the groups from the three general levels of support offered: 'intensive', for those categorised as 'highly vulnerable', that is those who had been assessed by professionals to be in greatest social or emotional need; 'medium', for those perceived to require less intensive support, for example, on a practical level in terms of budgeting, or on an emotional level; and 'light' support as found in local authority 'adult' (18 years and over) provision, for example housing advice. Two voluntary projects were selected as representative of the former groups and, with permission secured by meetings with managers and subsequent letters to residents, two group sessions were arranged. A third group session was organised with an established friendship group of local authority hostel residents encountered during participant-observation. Only two were actually conducted at this point. A group of five young women from the 'medium' support project and a group of four from the local authority hostel were held, respectively, in a quiet room

within the project chosen by themselves and the staff for the occasion, and by choice of the participants in the 'refuge' on a pre-agreed night when there was no possibility of being disturbed.

In the third case, two days prior to the pre-arranged session the manager decided that only one resident would be 'suitable', the others being deemed 'too vulnerable', a 'gatekeeper' factor which appears to impede research on 'sensitive matters' with young women (*cf.* Holland *et al.* 1994) and may provide a further insight into why young women have been largely neglected thus far in homelessness and health studies. This young woman was said to be 'very keen to participate' so an insightful 'focused interview' (Merton *et al.* 1956) took place helping to compensate for this disappointing development which was also, in part overcome, by conducting a final focus group with a group of six homeless young mothers at a later point, and explained shortly. Because of the specialised provision offered by this particular project there was no equivalent from which to attempt work with a similar group, and this was largely an effect of the poor response from similar projects highlighted above. As would emerge, however, the desire to 'sample' from professionally-assessed levels of 'need' was imprecise since levels of 'expressed need' as related by group participants to their past and present lived experiences bore little correlation to their accommodation-type. Age alone appeared the main criterion of 'vulnerability'. This important implication for policy and practice is returned to in Chapter 9. Participants' ages ranged from sixteen to twenty-five years. One was attending college, another was at school, studying SCE Higher grades and the remainder were unemployed, though two were involved in voluntary work. One young woman was pregnant and two were lesbians.

As highlighted in the *Introduction*, one of the main factors identified in existing research, and in the meetings with professionals in the field is that homeless people have a 'poor motivation towards health', and, among young women, many professionals presented this as being particularly acute.

However, research observations were providing contrary evidence to this thesis, when considered from the point of view of the research subjects. Consequently, the aims of the focus group work were threefold. In order to generate context it was imperative to elicit understandings of, and attitudes towards the experience of 'homelessness', since observational methods were supporting Tomas and Dittmar's (1995) proposition that many 'homeless' young women do not regard themselves as such. Secondly it was imperative to discover understandings of, and attitudes towards their health and ill-health experiences, and to identify the experiences and factors which the participants perceived had a bearing on these ill-health and health experiences. Finally, it was necessary to explore attitudes and experiences in regard to formal health services, including 'health education'. The topics covered over a two hour period are listed in Appendix B.

These sessions were taped and whilst there was initial nervousness about the presence of a tape recorder, it was quickly forgotten. Assurances that 'staff' would not have access to the tapes was the paramount stipulation here, a factor which emerged strongly in many of the individual interviews later. Recordings were transcribed as soon as possible afterwards and matched with notes made concerning unspoken practices observed during the sessions, such as the sharing of a single cigarette and the order it was passed round. The most useful aspect of this method related to the overall dynamics of the group. The participants interacted well and acted almost as 'co-researchers'(*cf.* Kitzinger 1994) by prompting each other to recite experiences regarding a specific matter or event, referring to known shared experiences or questioning each other about a statement made. Moreover, because the participants were already known to each other, in most cases as friends, there was little hesitancy to discuss various health issues, including contraceptive matters and drug use.

The findings from these sessions were instructive, confirming tentative thoughts derived from participant-observation and yielding new factors for

exploration, discussed shortly. A good sense of interaction was emerging between existing knowledge and data derived at earlier points in the research process, this new data, and existing and new ideas. As with participant-observation it had never been the intention to include a full account of the data generated here since this was a further means of 'getting close' to 'homeless' young women. Although some relevant findings are included in subsequent chapters, this stage, as intended, was vital to the planning of the individual interviews. Moreover, a significant revelation should be explained. This was the point in the research process where the notion of 'abductive reasoning' (Peirce 1979; Kelle 1995) was revealed as a heuristic device to be developed for the generation of new ideas through ongoing and repeated interaction with existing ideas derived from participant-observation-based data and those emerging from this new data source (*cf.* Coffey and Atkinson 1996). This praxis-friendly tool would prove more applicable to the ongoing analysis and development of a research focus than a potentially unending inductive quest.

Reflection and direction

The final weeks of 1995 afforded an opportunity for critical reflection upon the data collated thus far, a process enhanced by having been writing up and analysing from the beginning of the project. Although presented here as stages to facilitate understanding of how the project progressed, the emergence of the design as related to the emergent research problems, the data collection methods and the analytic tools employed, and the tentative theories formulated were all inter-connected and pervasive activities throughout. Homeless young women were indeed being found to be 'vulnerable' health-wise and the relationship between their 'homeless' situation and their overall health was not straight-forward as much of the literature suggests. The pressing need for research which goes beyond 'cause and effect' explanations to explore the actual 'mechanisms' (Miles and Huberman 1994), the network of events or 'epiphanies' (Denzin 1994) and processes which gives rise to the health outcomes reported was magnified. Through systematic sorting and coding of

the data according to the temporal and processual features of epiphanies and their antecedents and consequential associations, in terms of human action and reported health ramifications, tentative 'ideal types' in terms of key processual patterns and elements were constructed. Influentially, by employing the method of 'triangulation' (Denzin 1989; Yin 1994; Hammersley and Atkinson 1995) the integrity of these ideas could be checked continuously. This formed the basis of the model presented below which illustrates key areas for a holistic investigation of 'homeless' young women's well-being.

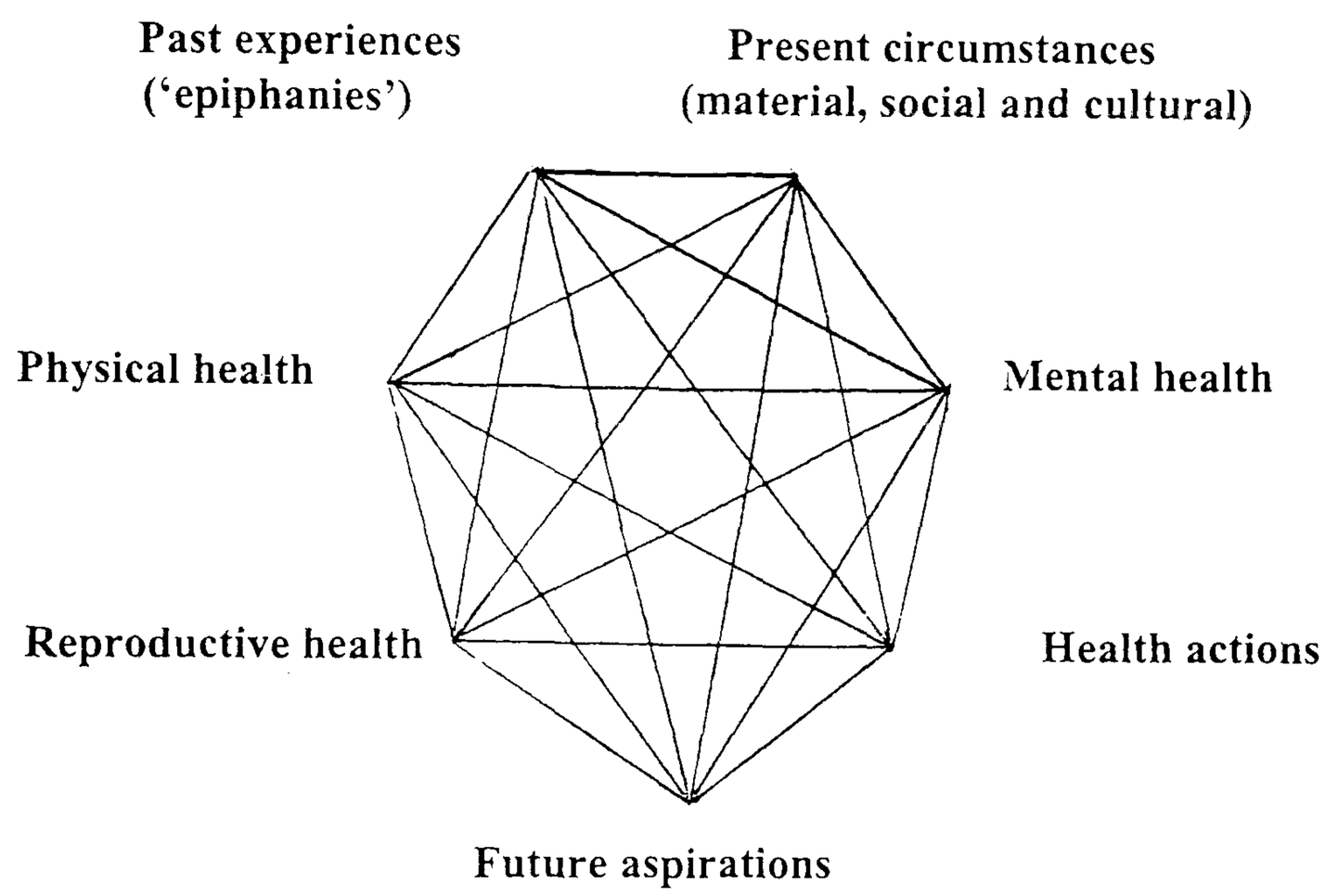

Figure 3.1. ***The inter-related web of factors exerting influences on the well-being of 'homeless' young women***

As a heuristic framework for empirical investigation, the model was well-received by 'homeless' young women, and professionals in the field, with feedback being rather matter-of-fact, 'it's common-sense', by those who could relate their own lived experiences to it. From these remarks, the desire to 'get close' to the lived experiences of 'homeless' young women seemed to have been realised. It was now time to 'get even closer' in a more holistic manner to individuals themselves.

Main interviews

The desire for an investigative approach that would generate 'thick descriptions' (Geertz 1973) of individual young women's lived experiences,

the *meaningful* characteristics of life-events in terms of the contextual factors and processes contributing to the known outcome of 'homelessness', their strategies and motivations and their perceptions of their lifeworld, as they relate to their health led to the decision to conduct individual interviews as a basis for the construction of 'case studies' (Ragin and Becker 1992; Yin 1994; Stake 1995). Questionnaires, structured and semi-structured interviews are commonplace in homelessness and health research, but the decision to opt for 'focused interviews' (Merton *et al.* 1956) as a necessary constituent of the emergent 'bricolage' was unequivocal. The ongoing process of 'abductive reasoning' (Peirce 1979; Kelle 1995), that is the ongoing interaction between existing knowledge, empirically-based data and emergent ideas grounded in this data had led to the formulation of the above model as a framework for further focused inquiry into the key areas identified. What was now required was an understanding of 'why' and 'how' (Yin 1994) individual young women experience homelessness as related to health. The 'interview guide' (Fielding 1993; Robson 1993), included in Appendix C, was designed to focus upon these experiences and their meanings to the subjects of study.

As with all preceding stages of the research process openness and flexibility were central to the construction of the interview guide which was drafted using the pre-determined headings shown in the model. The value of this interview form to the project cannot be understated, although without the aid of QSR NUD.IST, the volume of data this engendered would have been a daunting data-management prospect. This format allowed for great situational freedom, in terms of the terminology employed, the variable sequencing of topics and questions according to the prioritisation and degrees of importance in the attention ascribed to different areas by the young women, and in the ability to explore new issues as they emerged.

The aim was to engender knowledge of the particular by discerning and pursuing understanding of issues intrinsic to 'the case' itself (Stake 1995)

thence moving from particular cases through 'theoretical elaboration' (Geertz 1973) or 'analytic generalisation' (Yin 1994) to tease out associations between homelessness and health. The practical efficacy of the case study lies in the ability to incorporate contextual conditions by focusing on 'antecedents, contextual factors, perceptions and attitudes preceding a known outcome' (Robson 1993: 147). The merits of this approach when tracing young people's careers as they negotiate the housing market is attested to in Jones' (1993) study which explored family background and circumstances, education and un/employment. The choice of case study approach, rather than a more general life-history, or biographical approach, therefore, meant that interviews could focus attention upon the 'epiphanies' (Denzin 1994), the meanings individuals attribute to these and their consequences for action.

The first few weeks of 1996 were spent arranging, conducting and transcribing the pilot studies. Aware of the distinction between 'pilot test' and 'pretest' (Yin 1994: 74) this exercise was to incorporate both aspects. Theoretically and methodologically this was a means to test and develop relevant lines of inquiry and seek conceptual clarification for the research design. This was also a means to practise this technique prior to the main studies. Four of the most articulate members of the focus groups were selected on the grounds that they had shown intense interest in the research and were known to be well able to express their opinions. Only two, however, could be contacted since the others had moved on and could not be traced. A further two were interviewed through participant-observation. Although small, the equal balance between those who had contributed before and new participants in the research was useful in so far as the former two were more at ease to discuss their feelings about the interview afterwards whilst the new recruits provided a measure of how the interviews would be received by an audience fresh to the format. Aside from the need to clarify approaches to more conceptual issues, such as how to ask unambiguously for definitions of 'home' and 'health', feedback was encouraging. The subject-matter of the interview guide was believed to be

comprehensive, informed and relevant, participants reported being happy with the presence of a tape recorder, in terms of assurances of confidentiality, and with the length of time of the interviews, being around one and a half hours, and all felt they had been able to speak openly and 'comfortably'. Moreover, participants stressed the importance of knowing about the research and the part they were playing in its development prior to the interview, and of the 'debriefing' session afterwards, explained shortly.

Evaluation of these interviews revealed just how beneficial the background work of participant-observation and focus group work had been, and how many skills had been drawn upon and refined here. These included, the ability to probe, prompt and use language appropriate to the apperceived level of understanding, to listen to context as well as the words being spoken, to store information to be recalled at a later point in the interview, to be adaptable and flexible throughout without losing sight of the core areas to be explored and, the need to interpret information during the interview and to pursue new factors, omissions or contradictions. There was a new confidence in the sense that the apprenticeship as a 'reflective practitioner' was progressing fruitfully.

Selecting the sample

In considering the practicalities of whom, and from where the sample, should be selected for this main stage of the research 'representativeness' was a key concern. But, for the reasons outlined in Chapter 1, a 'representative sample' in quantitative terms (*cf.* Bines 1994) was not the purpose of this inquiry. Three over-riding factors made 'traditional' sampling methods inappropriate. Firstly, representative sampling of all the homeless young women in the city was unworkable since this is an unquantifiable population and it would be unrealisable to construct a sampling frame and sample with any accuracy. Secondly, homelessness is not a static phenomenon and, as such, makes for a fluid and unmanageable situation. Thirdly, it would be necessary to find

sufficient young women willing to talk in some detail about their lives which would immediately restrict the response rate.

A 'purposive sample' (Holland *et al.* 1994) was required, on the basis of age since this was a main statutory criterion of 'vulnerability' and, accordingly, accommodation-type. Notable qualitative research with homeless young people (Hutson and Liddiard 1991; Jones 1993) and studies emerging during the course of this project (Tomas and Dittmar 1995; Robinson forthcoming) revealed the strengths in terms of rich accounts to be derived from small-scale studies. On the basis of seeking a sample sufficiently large to represent a diverse range of experiences, processes and outcomes, and small enough to allow for the generation of thick knowledge of the particular (Stake 1995) through the collation and detailed analysis of multiple case studies, a sample of forty was decided, though forty-one were accomplished, explained shortly.

A study of the methodologies employed in existing homelessness research revealed the practical necessity of selecting individuals through 'outcropping' (Lee 1993), that is, the opportunistic utilisation of 'data points' which are readily available to the researcher. Homelessness services in Glasgow are managed centrally through the Hamish Allen Centre and young women's immediate placements, prior to assessment and selection into subsequent accommodation-types, tend to be in local authority facilities and a voluntary sector project. Chapter 4 provides an overview of this structure of provision for young women in Glasgow. According to this schemata it was decided that young women living in these should be selected because, of all the organisations operating in the city, lesser degrees of 'selectivity' should have occurred prior to placement. There are, however, inherent weaknesses in this choice. By opting to conduct interviews with those who have been accepted officially as homeless, there is a reliance on statutory definitions and assessments and there would be no representation from those who 'choose' not to use formal homelessness services or those barred from statutory provision.

Furthermore, by having to negotiate access through a host of gatekeepers, progress would rely on their benevolence. From the residents' viewpoint, this may suggest an association with figures of authority. Nevertheless, the ongoing process of 'triangulation' with other data sources would help to check levels of 'representativeness'.

Negotiating access through meetings with managers was unproblematic, and in the case of the voluntary sector project the decision was taken by the Care Team on the basis of a presentation on the substance of the project. Although doubtful of the success of the first sampling method employed, the initial means to contact residents was by letter. Lists of residents, and their ages had been supplied by the Hostels Co-ordinator, who had provided initial consent in February 1996 for access to the local authority facilities, and letters providing details and enclosing pre-prepared forms to tick and stamped addressed envelopes were posted to all residents. Only three replies were received, the day after those residents had been interviewed. On pursuing this subsequently with staff, and residents coming forward for interview, it was found that an aggregation of moving on, suspicion and disinterest were the main reasons provided. Discussions with managers and young women met during participant-observation led to the decision to use a combination of methods.

In the 'supported' hostels and projects staff greatly facilitated progress through the distribution of letters and flyers to residents, making posters visible in common areas and ensuring interviewees were available at pre-arranged times. In the 'adult' hostels, however, daily negotiations with minor gatekeepers made for a protracted and frustrating endeavour to attract interest amongst residents primarily, as related later by interviewees, because of the association, in their minds, between the research and officialdom. Accordingly, two main means of securing interviewees were employed. In the statutory and voluntary 'supported' projects letters or flyers explaining the nature and purpose of the research were handed out to residents by staff. In the local authority 'adult'

hostels posters and flyers were employed, though with little success, opportunistic contact through sitting in common rooms and approaching individuals produced 'snowball' sampling (Hedges 1979) where one member of a friendship network would come forward and then vouch to her friends that the research was 'sound'. This latter method engendered a total of twelve interviews, out of a total of sixteen, through four initial individuals in two 'adult' hostels.

By means of assessing the response rates in the various facilities, numbers of potential residents were gathered on visits and this revealed stark contrasts. In 'supported' projects, where, through their interest, positive remarks and efforts to secure research participants, the staff were found to be openly sympathetic to the research, a response rate of sixteen out of a possible seventeen residents were interviewed during main visits of two to three days over a three month period to the same facility, and, later, in another, over the period of a week all of the young mothers who were approached participated, as explained shortly. Yet, in the 'emergency-access adult' hostel only one interview could be secured over a three month period, despite fluctuating numbers of up to seven potential residents at a time. This suggests that attempts to interview those who have just been processed by housing and social services staff, and placed in a hostel which all of those who had reported being placed here at one point in their housing career had termed 'the worst', are not amenable to participating in further inquiries into their lives. The general response rate within the remaining 'adult' hostels, by comparing mean numbers of potential interviewees (n = 33) over the 'interview periods' with actual interviews conducted (n = 16) revealed an overall average response of just under fifty percent. This was an important check to make since, in one such hostel a Hostel Assistant claimed that all possible residents had been interviewed, but when checked, only half of those who could have been approached had been.

There are weaknesses in the methods employed. Firstly, interviewees were all self-selected and there is little objective evidence as to why other residents in the 'adult' hostels would or could not participate, although anecdotal evidence from those who did participate in this research suggests a combination of factors. The main factor relates to the discussion above and the suspicion that, despite the explanations on the posters or flyers, the research was somehow connected with 'the housing' or 'the social' and residents did not wish to 'collaborate' with such structures of authority. Residents also emphasised being 'fed up' with questions about themselves with little benefit to be derived in terms of progress with their housing applications or benefits. Strong concerns were also expressed about the possible conduct of the interview, especially the types of questions that might be asked which many just did not wish to answer. Finally, it was said that many simply 'could not be bothered'. Furthermore, there were no interviews with young women from minority ethnic groups. When this was pursued with managers it emerged that, generally, they would only expect one or two residents with this background per year and during the course of this study all residents were white. English research (*for example*, O'Callaghan *et al.* 1996) highlights the over-representation of homeless applications by individuals from minority ethnic groups, although studies do indicate that they employ different strategies when homeless (*cf.* Evans 1996). A specific study in Glasgow is required to explore and explain this void.

The anecdotal reports suggest that the true worth of 'snowball' sampling lies in the researcher's ability to overcome such assumptions through the mediation of a single individual, sufficiently brave to come forward initially. However, herein lies the second weakness in that it is self-limiting to members of a specific network and, as illustrated in Chapter 7, this emerged a highly influential factor in terms of well-being. Correspondingly, the third deficiency lies in the very small number of 'hard' drug users, despite claims of the 'widespread' nature of this by other interviewees and as witnessed during

participant-observation. Superimposed upon the above anecdotal factors lay the reported structured lifestyle, so interviews did not fit readily within such schedules. Moreover, on occasions where interviews had been arranged personally with suspected users, three young women did not appear and two were not interviewed because it was deemed unethical to proceed because they had just injected heroin.

Pregnancy and motherhood issues were emerging as a major part of young women's experiences, well-being and life plans. Examples of this were found in all fieldwork situations whether during a focus group where a participant had been pregnant, or during participant-observation where contraception, pregnancy, miscarriage, children being placed in care, and lone parenthood were frequent topics. These factors were to be supported in the course of the interviews where two interviewees were in an advanced state of pregnancy, yet living in an 'adult' hostel, three interviewees had reported miscarriages and one, the death of her infant, and two further interviewees reported their children to be in social services care. Accordingly, in July 1996 the decision was taken to negotiate access to two direct-access facilities catering for young women who are pregnant or mothers. From this point the term 'mother' is employed to refer exclusively to the young women living in these facilities with their children.

The managers were sympathetic to the research and an exploratory focus group, as reported earlier, was arranged by the manager within one of the projects. In addition to the factors outlined earlier the purpose of this was to explore their lifeworld as 'homeless' lone parents, their experiences and the meanings imbued in these experiences. The strongest points to emerge related to almost indistinguishable consistencies with findings from the previous focus groups, such as familial or neighbourhood histories. The main determinable differences were embodied in their motherhood experiences, notably the sense of shared stigma reported and the shift in focus of aspirations from themselves

to those being invested in their children. Moreover, when analysing their narratives it was possible to begin to recognise why attitudes towards contraception and pregnancy were expressed so strongly in the interviews with the 'single' interviewees, and this is developed in Chapter 8.

At the end of the focus group, four participants were asked if they would agree to individual interviews and all did so. The remaining two were not asked for ethical reasons, one being at her expected date of delivery and it was felt she had enough to contend with, and with the second young mother it was not appropriate to do so, for reasons discussed with the manager. A fifth young mother, who had been unable to join the group later volunteered for interview. In the second project two further interviews were conducted as a result of the manager's direct involvement in distributing pre-discussed, detailed letters to residents. Although small in number, the seven interviews here added crucial dimensions considered in subsequent chapters.

Key characteristics of the sample

The descriptive information contained in this short section provides a brief introduction to the sample by representing a summary of more detailed and explicated information presented in subsequent chapters. As will be explained in Chapter 6, most of the forty-one interviewees came from in and around Glasgow. Their ages ranged from sixteen to twenty-five years, with a mean age of nineteen years which is reflective of the wider distribution of those aged eighteen years and over. The median age is eighteen years and this proved important in terms of institutional provision, as explained in Chapter 4, and related accounts of hostel life, as considered in Chapters 7 and 8. In terms of marital status, all were single at point of interview, though sixteen reported having boyfriends. Two had been married and a further ten had experience of cohabiting relationships which had broken down. Ten interviewees had experience of motherhood, although three did not have custody of children at

point of interview, and one interviewee had experienced the death of her only infant. A further two were pregnant and one mother believed she might be pregnant again. One interviewee was a lesbian. Nine of the young women had experienced social services care and this is considered in Chapter 6. Two had been in prison. Six interviewees reported paid employment, one sold *The Big Issue*, one was at college and two worked as prostitutes. Seven were in receipt of Incapacity Benefit. Thirty-one smoked cigarettes, three believed they had a problem with alcohol, three were on methadone programmes, one interviewee attended a drug-recovery project daily and two reported use of hard drugs. Individual key characteristics of the young women who participated in the main interviews can be found in Appendix D.

Conducting the interviews

Interviews were conducted between mid-March to late August. Despite the reticence of many to come forward, individual responses to the interviews were positive. The duration of these tape-recorded interviews ranged from one of only thirty minutes to lengthy sessions of over two and a half hours. The average duration, however, tended to be around one and a half hours. These time-scales were for actual interview length and do not include time spent prior to the interview in terms of explanation or afterwards in 'debriefing' and conversation which added between one to two further hours to the encounter.

Such ethical considerations were essential to the conduct of the interview since, now furnished with an awareness of the types of traumatic experiences that could be recalled, the desire to limit possible adverse effects of this interaction was paramount. Moreover, because interviews would be conducted in an empathic manner there was concern that this might encourage interviewees to disclose more than they wished and there was no desire to exploit this for the sake of a thesis (*cf.* Finch 1984; Holland *et al.* 1994). One example of this in practice arose where interviewees mentioned or alluded to previous abuse in

childhood and this was only pursued if they elaborated upon, or returned to the matter. Where they did not refer to it again it was not raised.

Explanations about the research comprised a description of the background to, and general aims of the research, an explanation of the 'independence' of the research, and the status of the researcher, details of funding and dissemination, a guarantee of confidentiality, especially mentioning that all transcriptions would have any identifying information removed, assurances that the interviewees had the power to terminate the interview at any point and to refuse to answer questions, and assurances that they would not be pressed for information on any subject that they did not wish to discuss. These matters were considered essential to accepting the interviewees' informed consent and, as would emerge in the course of the interviews was something they reported having limited experience of.

It is important to mention small examples of ways in which it was emphasised that the interview was intended to be as 'non-hierarchical' as possible. Where a room had not been set aside by staff for the occasion, interviewees were asked where they would like to go. Where such choice was made, either in their own rooms (personal space) or in a sitting room (neutral space), these tended to engender more ease at the commencement of the interview than those held in a room where they were in the habit of meeting housing or social services staff (hierarchical space). Interviews conducted in their bedrooms produced highly animated interviews since interviewees drew upon letters in support of statements made, showed photographs of loved ones or stressed, by reference to the fabric of their room, their ornaments and other personal items, why this was or was not their 'home'. To reduce associations with the 'formal' rooms, and to symbolise their position within the interview setting, small matters such as offering interviewees the chair normally occupied by staff promoted amusement and reduced initial nervousness. However, the one factor which promoted a more relaxed atmosphere related to smoking. Being aware that

there might be a high level of smoking amongst interviewees, the ability to smoke during an interview on 'health' was treated with surprise, but was a symbolic means of demonstrating that any health practices reported would not be judged.

Interviews commenced with loose opening questions as to how long interviewees had lived in the facility and how they felt about living there. These questions then tended to lead to a spontaneous offering of either their 'housing career' or the positive or negative effects upon their well-being of their present situation as compared to previously which then led on to other areas of interest. In all but two interviews a normative sequential flow developed encapsulating all themes on the interview guide through the 'guiding' of interviewees by questions conducive to this flow. No notes were taken since this would have fragmented this 'natural' conversational approach and could have introduced an aspect of formality. The exceptions to this style related to interviewees portrayed as 'Eremites', in Chapter 7, where the interviews necessarily proceeded on a question and answer type format and where their body language revealed as much about their well-being as the spoken word.

At the conclusion of each interview there followed a period of 'debriefing'. During this time each interviewee was encouraged to speak about any matters raised and which might have made her think about things she would rather forget. It was hoped that this informal session would help to purge any negative feelings arising from participation in the interview. On several occasions details of appropriate contacts for their stated needs were supplied, for example, two interviewees who had spoken of ongoing 'depression' from miscarriages were provided with details of local support groups. Small pieces of 'medical' advice were also imparted, such as the recommendation of 'common-sense' palliatives for cystitis or a chesty cough where GPs were not going to be consulted. More usually, information tended to be on a more

pragmatic level in terms of where to go for specific advice, on the workings of the housing system in the city, or on their 'rights', although such latter information was only requested by interviewees in the 'adult' hostels since interviewees elsewhere were knowledgeable on such matters. These interventions were not believed to compromise the research as they occurred after the interview and any information provided is readily available in the public domain to those in a position to know where to look (*cf.* Robinson, forthcoming). All interviews were followed up by thank-you letters and a contact number provided should anyone wish to keep in touch. No-one did by this means, though two wish to receive copies of any reports produced. Contact was maintained with some through chance encounters or their specifically approaching for a chat during later visits to their hostel, through mutual acquaintances, or during participant-observation.

Considering the research interview

In this thesis the term 'reflexivity' is omnipresent so it is important to consider the potential consequences of this to the interview setting. Consideration of a variety of interactions in the field indicated that, for the interviewees, the interview represented more than a straight-forward encounter where they imparted information to an enquiring researcher. For example, when asked what would help to improve their present health the main factor mentioned by interviewees was 'someone like you to talk to', so this could help to explain a benefit to be derived from the interview interaction. Moreover, it was apparent from the snowball samples that a status of credibility had been required to encourage individuals to come forward. Accordingly, fundamental questions about the interview encounter must be considered for, regardless of how free-flowing the conversational approach in an interview appears, interviewees are aware that this is an interview environment and they will, therefore, have formulated their own assessments of the researcher and the research before and during the interview, and will have brought their own agendas to the encounter.

Essentially, however empathic a researcher can be towards marginalised individuals, there must be a sense of realism that the academic researcher can only ever be accorded tentative acceptance, as a transitory 'limbo member' (*cf.* Weinberg and Williams 1972) of the social world they are attempting to understand.

Throughout the interview, both researcher and interviewee 'collaboratively construct the meaning of interview narratives' (Holstein and Gubrium 1995: 59); it is an active process where words are the principal instrument for the accomplishment of social action. As depicted below, the interview setting does not constitute neutral territory in which value-free data are generated, it constitutes a dynamic process of self-presentation and narrative production:

> The social milieu in which communication takes place (during interviews) modifies not only what a person dares to say but even what he thinks he chooses to say. And these variations in expression cannot be viewed as mere deviations from some underlying "true" opinion, for there is no neutral, non-social, uninfluenced situation to provide that baseline. (Pool 1957: 192)

Accordingly, the interview itself is not merely an opportunity to probe for information from the subject, it is also an arena for meaning-production. As the chapters that follow will demonstrate, such a conception of the interview, and the data generated therein, enabled analysis to go beyond the health data presented by interviewees to an understanding of these, not simply as objective categories to be quantified, but as expressions of their past and present social and material circumstances, their lifeworld, their aspirations and their self-identity, and, as particularly evident, their normative self-presentations as competent social actors. But, to what extent was this how interviewees wished to present themselves and be represented? When providing an introduction to the interview, the researcher must be aware that the interviewee will probably be looking for 'reference points' (Holstein and Gubrium 1995) as to the kinds of answers the researcher might be seeking and, in the case of the 'snowball

samples' there was a much greater likelihood of their being aware of the kinds of topics and linkages that might arise. An example of the ways in which all attempts were made to counteract such possibilities, can be found in the avoidance of the term 'homeless'. It was vital that this term was never used in the introduction to allow interviewees to define their situation later and even then the researcher could not allow her own evaluation to be known for fear of contaminating any subsequent data on this subject. Moreover, during the interview the interviewee may also be looking for clues, or even testing the researcher's leanings on a particular subject. This can be exemplified in the course of one interview where an interviewee described membership of a sectarian organisation. Given the sensitivity of such an admission in Glasgow, had she assessed that it was 'safe' to talk openly about this to a stranger, or was she testing the researcher's own colours?

Furthermore, as an active and complex social interaction, the interview process also involves personal investment and feelings (*cf.* Oakley 1981, 1993) which taps into 'emotional wellsprings' (Douglas 1985), and arguably in light of the traumatic histories narrated in this project, not only of the interviewee, but of the researcher herself. The extract below introduces examples of abuse, the intensity, duration and range of which, despite having become 'sensitive to context' (*cf.* Holstein and Gubrium 1995) in the background stages of this project, this researcher only felt partially prepared:

> **Interviewee**: He sexually abused me, he sexually abused my wee sister and aw and I can still remember trying to protect her and saying 'Da come to me' so's he wouldnae hurt her 'Come wi' me, come wi' me', things like that. And my ma would be there and I can still see her, she was like doing nothing and I would be drifting in and out of consciousness. That was the start of it, so it was, that's when I realised adults couldnae be trusted (pause)...
> **Researcher**: How do you feel talking about this?
> **Interviewee**: Sometimes I find it helps. You know when something really bad happens to you it can hurt so much that you just block out what you feel so's you cannae feel, you just don't feel. Sometimes it's good to talk, but sometimes you cannae. (Interview 40)

Excepting the offer of a comforting arm and an empathic demeanour the researcher is impotent, for such events and their consequences cannot be altered. Assured by the interviewee that she does not 'mind' talking about such matters, there can be no probing for useful data, the interviewee can only be left to say what she feels she must say on the subject, no more, no less. As shown in this extract, when reading through the interview transcriptions one ubiquitous question-form stands out 'How did/ do you feel about that/ this?'. The interviewees' reflexivity was encouraged throughout; this was not merely a means of accessing how the interviewee apperceived a particular event or situation, but was a means of providing a basis for analysing why narratives had been recounted as they had through the evaluations offered. This, as will be indicated in Chapters 6, 7 and 8 was important for it enables the researcher to go beyond the, often very strong and orderly, self-presentations to the more spontaneous and less guarded realms of the 'emotional wellsprings'.

The use of a natural conversational approach engendered an interactive and dynamic dialogue. In this, however, the researcher must pay attention to important caveats whether in terms of interviewees' assessment of the status of the researcher and the research, or in terms of the problems of 'self-presentation', especially at the commencement of interview, and 'fleeting encounters' where interviewees may feel little, if no, investment in the research and this may even involve fabrication (*cf.* Denzin 1970). Accordingly, in acknowledging the interview as an interactive and dynamic process of story-making, the qualitative researcher must pay regard to the ways in which the interviewee is presenting her story with specific objectives in mind (*cf.* Bauman 1986), often saying what she believes the researcher might wish to hear (*cf.* Gubrium and Buckholdt 1982) and the researcher can never by truly certain of the extent to which they help to produce meanings which should rest with interviewees (*cf.* Cicourel 1974).

Given that interview accounts are imbued with such problems, the best way to approach these in the analysis was to conceive these, not as 'facts', but as 'speech acts' (*cf.* Coffey and Atkinson 1996). The importance of this conceptualisation will be demonstrated in the chapters that follow. For example, Chapter 5 identifies how the health problems recounted by the interviewees should be regarded as expressions of their social and material environment through the changed focus in the reporting and prioritisation of these, depending on how they appeared to wish to underline their feelings about a particular situation. Another example of the usefulness of the concept of 'speech acts' is found in Chapter 6 where the specific ways in which interviewees recounted the context for their 'homelessness' indicated that, in these accounts, they were laying foundations for an understanding of their experience of 'homelessness' and its perceived relationship with health. The strongest example of 'speech acts' is, however, found in Chapter 7 where, through exemplars of 'contrastive rhetoric' (Hargreaves 1984), past events, the self and future aspirations were presented in a normative light, despite interviewees relating their experiences of stigmatisation by the wider society. Said chapter, therefore, necessarily proceeds with an exploration of how the interviewees reconciled these conflicting images. Nevertheless, whilst being assured from the research relationships established that it is possible for an academic researcher to 'get close' to the individuals and the social world she is attempting to understand, in analysing both content and form of the interviews, this research is predicated pragmatically on the principal that absolute truth cannot be known and as such the interpretations offered in this thesis can only ever be regarded as one representation of the data derived.

With the interviews concluded by September 1996, the remaining months of the 1996 were devoted to the laborious transcriptions. Context for accurate representation of the accounts was important, so verbatim transcriptions incorporating phonetic spelling of interviewees' own grammar and pronunciations, alongside such points as accentuations, pregnant pauses and

laughter were all included in the text as markers for subsequent narrative analysis. Regardless of the fatuous nature of the physical process, typing almost four hundred thousand words has distinct advantages, in allowing for a deeper familiarity with the data and facilitating a consideration of tentative frameworks for initial analyses.

Analysis

The presentation of this as a stage in the research process produces a rather flat picture of what was, in reality, an ongoing process of interaction with the data throughout the project. Without continuous collation and organisation of the data, abductive reasoning and checking the internal coherence of the research process by triangulation, this stage of the research process could not have been reached. However, what marks this stage as distinct from the ongoing process are the systematic methods employed to reduce, organise and explore the data and create codes, categories and concepts, as a basis for the identification of themes and patterns and theorising their relationships. Thus, although descriptions of the mechanisms by which this was achieved are presented, these were 'heuristic devices for discovery' (Seidel and Kelle 1995: 58) engendering an ability to get close to and 'transcend' the data.

Although concerned about the possibility of 'technological determinism' (Lonkila 1995), any doubts about the practical efficacy of using a computer software package for the sorting and coding of the data were quickly eradicated. Discussions with other researchers who had used these led to the decision to use QSR. NUD.IST version 3 (Richards and Richards 1994) which was the most up-to-date qualitative package available at the time. With the transcribed texts amended for incorporation into NUD.IST the coding process commenced.

The primary coding structure was developed to facilitate the key processes of data simplification, that is breaking the data down into their constituent parts as

a means of identifying relevant phenomena and analysing these to find commonalities and differences, patterns and deviations (*cf.* Delamont 1992). Accordingly, the initial structure of the index system was based upon both the preconceived and 'in vivo' (Strauss 1987) themes, and their sub-divisions, explored during the interviews. The merits of NUD.IST here lay in its flexibility; the ability to re-order and re-create nodes as new ideas arising from the data emerged, and to create summarised reports for ease of recognition in later analysis and in the writing up process. The aims of this stage were to produce a framework upon which the basic descriptive and conceptual material could be organised and explored, and to establish processual links by 'programme logic models' (Yin 1994: 118), that is combinations of pattern-matching and simple time-series analysis, in terms of chronologies, within individual cases and across all cases, as a basis for tentative theories and interpretations. This primary strategy produced outcomes which indicated both internal, through triangulation with other data sources, and external 'dependability' (Guba 1981) of the data, in that key processual elements contributing to homelessness among young women corresponded to findings for young people as a whole, as outlined in Chapter 1, and that their health was indeed poor. Chapter 5 which explains the sample's health problems and Chapter 6 which provides the context for an appreciation of the sample's homelessness are examples of this primary approach.

The second analytic process was 'data complication' (Coffey and Atkinson 1996) as a basis for the 'transcendence' (Wolcott 1994) of the data and represented a shift from the substantive to the formal levels of thinking about the data. This involved a complete reconstruction of the analytic framework in order to tease out answers to the questions being raised and the most pertinent of these are included in the text of Chapters 6 and 7, and formalised in Chapter 9. A strong example of the usefulness of 'transcendence' lay in the move to narrative analysis, notably the ways in which social action is accomplished through the use of language (*cf.* Garfinkel 1967). In initially seeking to

examine how interviewees constructed their lives and their lived experiences (*cf.* Denzin 1989), the many contextual explanations, justifications, 'contrastive rhetoric' (Hargreaves 1984) and the essential 'normality' of self-conceptions found in the accounts, it was possible to see that interviewees had, reflexively, been presenting coherent and cogent accounts of themselves and their social world through these narratives. Thus, by treating the accounts as 'speech acts' (Coffey and Atkinson 1996) a conceptual framework was developed for exploring why these 'linguistic repertoires' (Halliday 1978) were employed. Thence, the conclusions drawn here provided the tools for further investigation of the data relating to social and cultural influences within which these were produced and, through subsequent 'domain analysis' (Spradley 1979), of the symbols denoting shared meanings, understandings and relationships, it was possible to tease out processes of inclusion into, or exclusion from the hegemonic hostel culture. This ongoing, interactive and cumulative approach eventually terminated when a strong relationship with psychosocial well-being could be inferred. This process is exemplified in the substance of Chapter 7.

Writing this thesis has been considered an essential constituent of the process of analysis. Continuous planning of presentation, writing, reworking, reducing and scrutiny of the text, checking all the available evidence in the analysed data, reviewing findings and ensuring their accurate representation, and relating all of these externally to existing studies, and internally to ensure that the initial and emergent research questions have been addressed, provided new ways of reflecting upon and interpreting the data and its presentation. An example of this relates to the decision to include verbatim interview extracts in the text of Chapters 6 to 8. Having argued consistently for the need to 'listen' to the accounts of 'the defined' on a fundamental level this underlined such a commitment. However, rather than serving as anecdotal examples, these extracts are employed as visual supports for conclusions presented in the text. In this manner, whilst serving as a check on the contents of the text, they also provide as a means for the reader to have access to the interviewees

themselves, their experiences, and how they explain and give meaning to these experiences. Accordingly, the reading of this thesis is intended to be an integral part of the qualitative process. Yet, in true hermeneutic fashion, the interpretation of meaning by interviewees, researcher and reader is ontologically and epistemologically bound up in the circularity of interpretation (*cf.* Bleicher 1980) and this thesis must be accepted as one representation arrived at through the means described in this chapter. After providing an overview of the institutional context for this study in Chapter 4, the remainder of the thesis is the assay of whether this 'bricolage' was justified.

Chapter 4

Overview of provision for homeless young women (aged 16 to 25 years) in Glasgow

This short chapter provides an overview of the institutional context within which this research was conducted. After presenting figures for the number and type of provision for homeless young women in the city and a short explanation of the Youth Housing Strategy, this chapter provides a descriptive outline of the facilities in which the main interviews were conducted in order to provide some context for this research.

As with all figures pertaining to homeless, it was difficult to find exact figures for the provision for homeless young women in Glasgow. Prior to the commencement of interviews information was requested on the number of hostel places available in Glasgow for homeless people in general and homeless young women in particular (GCSH 1996). The total number of beds available for *all* homeless people in the city was 2394, representing 1184 voluntary sector beds and 1270 local authority beds. Breakdown of these beds according to age was problematic since over-18 year olds are accommodated in adult local authority and voluntary sector hostels. Accordingly, the number of beds in the city open *only* to young people amounted to 366 beds for 16 to 25 year olds, with 316 of these being in the voluntary sector and 50 in local authority hostels. This figure does not include the 100 temporary furnished flats provided by Glasgow City Housing for 16 and 17 year old homeless applicants at that time. It was also difficult to find gender-specific figures. Glasgow Council for the Single Homeless estimated that in mixed hostels the ratio of male to female beds was around 70: 30, though this was a very fluid situation. The number of mixed provision in the city was 591 and, based on the above ratio, this would make for a breakdown of 413 male places to 178 female. However, the number of female-only beds in the city was 205 which

represents 65 voluntary sector and 140 local authority beds. Accordingly, GSCH estimates that there were 2011 places for homeless males compared to 383 places for women. In the youth sector there were 34 female-only beds and 330 mixed beds. Using the 70: 30 ratio, therefore, it was estimated that there were 233 homeless young men and 133 homeless females accommodated in early 1996.

As recorded in Chapter 3, having developed a tentative typology of homelessness provision in Glasgow it was apparent that there are three general levels of support offered by the homeless facilities for young women: 'intensive', for those categorised as 'highly vulnerable', that is those who had been assessed by professionals to be in greatest social or emotional need; 'medium', for those perceived to require less intensive support, for example, on a practical level in terms of budgeting, or on an emotional level; and 'light' support as found in local authority adult provision, for example housing advice. Accepting that these are not official terms, they do best describe the type of support offered. As also mentioned in Chapter 3, homelessness services in Glasgow are managed centrally through the Hamish Allen Centre and young women's immediate placements, prior to assessment and placement into subsequent accommodation-types, tend to be in local authority facilities and a voluntary sector project. There are also two voluntary facilities for mothers and their children and another was being planned by another voluntary organisation during this research. According to this schemata it was decided that young women living in these immediate access facilities, from the major gatekeeper, should be selected because, of all the organisations operating in the city, lesser degrees of selectivity should have occurred prior to placement. The next paragraph will explain the Youth Housing Strategy operating in the city and the remainder of this chapter will provide a description of the facilities where interviews were conducted.

With its Youth Housing Strategy (*cf.* Irvine 1995), Glasgow is more advanced in its provision for young people than is found in other parts of the country (*cf.* HAHP 1997). The stated aim of Glasgow City Housing's policy response to youth homelessness was 'to provide a sensitive housing service for all young people, preferably before they become homeless' (Brooke 1994). Under its interpretation of the 'vulnerability' criterion in the homeless legislation, the local authority has accorded immediate priority to 16 and 17 year olds. At its inception in January 1992 the Youth Housing Strategy was to be based on a 5-tier system based on young persons' needs and was to be flexible enough to allow young people to move from one type of accommodation to another according to changing needs. This comprises: mainstream housing, including furnished accommodation; lightly supported scatter flats; emergency furnished flats for young people who would normally be accommodated within adult hostels; short stay emergency access hostel accommodation; and, medium stay planned entry hostels. Access to this system can be made at three points: District Offices, where young people between the ages of 16 and 25 years are interviewed by a dedicated Youth Support Worker; referral from the Social Work Department; or, through the Hamish Allen Centre where homelessness is managed centrally. Emergency access bed-sits are available at the Hamish Allen Centre, but during the interview stage of this project places were limited as a result of a fire in the accommodation area. Permission to interview residents in the local authority facilities came from the Hostels Co-ordinator and, thereafter, after meetings with respective hostel managers.

When asked, the 16 and 17 year olds felt that this system worked well for them and very often they expressed feelings that they had received special treatment because of their age. For example,

> I went in and I was kept waiting. A woman said 'We're quite busy so you might have to wait a wee while' and then this other woman came over to and she said 'What age are you?' 'Sixteen and you've been kept waiting!' She was awright, took me straight away, showed me to

my room, nice rooms and aw that and I moved in. I liked it there. (Interview 34)

Supported facilities for 16 to 21 year olds

Under the terms of the Youth Housing Strategy, the local authority short-stay, emergency access hostel provides 16 places for homeless 16 to 18 year olds of both sexes. This project aims to provide safe accommodation for young people who present as homeless at the Hamish Allen Centre. The accommodation comprises individual fully furnished bedsits, with shared well-stocked kitchen, toilet and shower facilities, sitting room, laundry and games room. The project provides a high level of support through groupwork sessions, practical living skills, organised outings, and individual support through personal keyworkers and Social Workers or members of the Homeless Young Persons Team. During their stay residents are assessed according to their needs and are moved on to a more appropriate level of accommodation and support once this is complete. No interviewee had been in this project for more than 10 weeks. On all visits staff and residents were found to be interacting well in common rooms and the staff office where the door was always open.

The voluntary sector project was a short-term mixed hostel which provides advice, counselling, practical assistance and support to fourteen 16 to 21 year olds. Residents have individual rooms, with fridges, and share the kitchen - where a special group breakfast is cooked on Sundays, sitting room, bathrooms and laundry facilities. As with the above project assessment takes place during the residents' stay and they are then moved on to appropriate accommodation, for example, mainstream tenancies, longer term hostels, scatter flats, supported accommodation, private bed-sits or they may return to the parental home. Most referrals come from the Hamish Allan Centre or the Social Work Department. All residents are provided with a high level of support through their own choice of individual members of the Care Team and may have additional extraneous support, such as Social Workers, drug counsellors or

mental health support. Residents are also encouraged to participate in groupwork sessions, acquiring practical living skills and have organised outings. The relationships between staff and residents appeared to be based on high levels of mutual trust and respect. The staff seemed very keen to protect their residents and access only followed a formal presentation on the substance of the research to the entire Care Team who then took a vote on whether access should be granted.

Local authority adult hostels

The support available to young women in the two facilities described above contrasts with that for those aged 18 and over who are placed in 'adult' hostels. The first of these to mention is that which residents termed as 'the best' adult hostel providing 61 places for women aged 18 years and over. The hostel is bright, fresh and airy and situated in a relatively safe part of the city. Each resident has a room of their own which they are able to decorate as they wish. All facilities are communal including a kitchen and dining room, where breakfast is provided as part of their board, bathrooms, shower rooms and toilets, a sitting room and laundry facilities. Residents have to supply their own cooking utensils. There is no time limit here. There is one Housing Caseworker for the hostel, who also shared duties with a voluntary sector organisation. Additional support may exist where residents have previous contact with social services, drug counsellors or probation officers. There are no structured groupwork sessions or formally organised activities. Interaction between staff and residents was found to be mixed on visits and the staff offices always remained locked.

The second adult hostel provides 48 places for women aged 18 years and over. Located in the city centre, the fabric of the building was rather run-down and the building was closed for renovation shortly after interviews here were completed. The accommodation comprised single, double and triple rooms and

a hierarchy seemed to exist for the acquisition of single rooms, apparently based on merit and length of stay. Breakfast was not provided and residents must supply own their cooking utensils. Communal facilities included bathrooms, sitting room, games room and laundry. There is no time limit here. There is one Housing Caseworker for the hostel. Additional support may exist where residents have previous contact with social services, drug counsellors or probation officers. There are no structured groupwork sessions or formally organised activities. Interaction between staff and residents was found to be limited on visits and the staff offices always remained locked. On one visit two residents commented that the only difference between this hostel and prison was that here it was the staff who locked themselves in.

The final adult hostel was located in a run down industrial estate in the east end of Glasgow and was really a collection of joined portacabins which had been intended as a temporary measure in the 1977. As a hostel for those aged 18 years and over, there are 31 beds for women and 70 for men. Surrounded by barbed-wire topped fencing to the sides and rear, the accommodation was bleak. Breakfast was provided as part of the board in a communal kitchen and dining room and other communal facilities included bathrooms, sitting room, and laundry. Residents have to supply their own cooking utensils. There is no time limit here. There is one Housing Caseworker for the hostel. Additional support may exist where residents have previous contact with social services, drug counsellors or probation officers. There are no structured groupwork sessions or formally organised activities, though some staff were trying to organise football matches with other hostels. Interaction between staff and residents was found to be limited on visits and the staff offices always remained locked. The young women here were all 'emergency access' and accounts from a large number of homeless young women during participant-observation, the focus groups and the main interviews indicated that this was deemed 'the worst' hostel where individuals would stay for one night only

before appealing for a move to another hostel. A few reported returning to rough sleeping rather than staying here.

Regardless of the highly variable support differences between younger and older young women, overall most interviewees expressed a belief that this centralised system worked, but there is a major problem which arose occasionally during participant-observation and in a couple of the main interviews. Only the Salvation Army's mixed, Hope House accepted immediate self-referrals of young women or, uniquely, couples presenting at the door as homeless, if there was an available bed, all other hostels require prior assessment by a social worker or by support staff in the referring hostel or Hamish Allan Centre. This is, however, problematic for those whose files have been labelled DNA (Do Not Accommodate) for a variety of reasons, such as rent arrears, or who have been expelled from hostels previously for problems arising from breaking hostel rules, for example, fighting, alcohol or drug use. The following extract from participant-observation fieldnotes demonstrates this:

> A young woman with whom I had spent some time during the course of the evening because she had been 'gouching' after, reportedly, her "first" experience of injecting heroin (she usually smoked it) told me at 11pm that she had nowhere to go (her family had thrown her out because of drug use). I asked her if she had any friends to go to, but because, she said, "they are all junkies" she was not keen to stay with them for fear of being drawn further into the drug scene. I told her to try the Hamish Allan Centre and she told me she had been "DNA'd because of rent arrears". I telephoned Hope House, but there were no beds available. I suggested that she return to the Hamish Allan Centre to see if some arrangements could be made since there were no places at Hope House for her tonight. Rather resolutely, she replied that she would go "up to the hospital for a bed" until the morning (Summarised from fieldnotes 4.10.95).

Facilities for mothers

Somewhat on the fringes of the kind of provision described above, the young mothers were found in voluntary sector projects, having been referred

predominantly by social services, though occasionally from the Hamish Allen Centre. For security reasons their locations are not given here. Both organisations offered supported accommodation to pregnant young women and mothers and babies in a small number of places in centralised facilities. The first comprised a house with accommodation for five pregnant women and a second house containing five furnished flats for ten mothers and babies, residents eventually moved on to independent tenancies. The second provided seven self-contained one room flats within a complex that includes a 'family centre', the women can move on to supported flats and thereafter to their own tenancies. Though practical lifeskill support was provided, it was in the context of psychosocial needs that the greatest support appeared to be directed and this revolved around addressing problems arising from the young women's backgrounds. Both organisations sought to provide 'a safe environment in which to acquire the skills necessary for living independently as the head of their own households' (One project's handbook) This safety aspects appeared to be of paramount importance to both projects in regard to the young women, in terms of their personal development, and their children, through the acquisition of wide ranging parenting skills. Both organisations required a great deal of assurance, in the form of meetings, correspondence and phone calls to ensure that their residents would be protected at all times.

This chapter has provided an overview of the institutional context for this study. As will be demonstrated in the chapters that follow, this context proved important to an understanding of the young women's accounts. It is now time to begin to explore these.

Chapter 5

Problematising associations between homelessness and health

This chapter examines the relationship between homelessness and ill-health. As shown in their wide review if the literature, Connelly and Crown (1994) indicate how this relationship is usually explained in one of the following ways: by ill-health contributing to, being exacerbated by, as outcome of, or by 'behaviour' associated with homelessness. Moreover, much of the literature on homelessness, or housing and health generally focus upon the ill-health associated with specific physical environments. For example, commonly posited sentiments include 'there is a demonstrable link between bad housing and poor physical and mental health' (SCOPH 1994: 7) or there is an employment of mortality rates for people sleeping rough to stress that homelessness 'contributes to a much shorter life expectancy' (Grenier 1996: 5). At the crudest level it is reported that 'homelessness can be both a cause of illness and can itself be caused by illness' (Connelly *et al.* 1991: 79). The quest to demonstrate such causal relationships is increasingly being criticised for the way in which 'the relationship between poor health and homelessness' is 'misrepresented' (Pleace and Quilgars 1997: 153) by failing to consider the wider context within which poor health outcomes are produced. Furthermore, in terms of causality, such a relationship is 'impossible to prove scientifically' (Lowry 1991: 13).

Given that Chapter 2 outlined the difficulties in accepting accounts of ill-health at face value, it was, therefore, necessary to problematise the notion that a straight-forward causal-type relationship exists and that reports of ill-health can be accepted without question. Furnished with Popay's (1992) exhortation, reports of ill-health are conceived as meaningful expressions of the interviewees' social and material circumstances. Moreover, consistent with the desire for a meaningful understanding of their lived experiences, it was

important to discover what the interviewees themselves perceived the nature of this relationship to be (*cf.* Ambrose 1996). Thus, with reference to the distinction between 'health status' and 'health state' (*cf.* Blaxter 1985; Arber 1990a), this chapter identifies general commonalities which the interviewees perceived as having structured their overall health status and specific factors contributing to their health state at specified points in their histories.

Examining the premise that ill-health contributes to homelessness, the first section outlines the interviewees' health as juveniles - this term denoting the period from birth to age at which they left the parental home or social services' care, this marking the physical departure from family or 'surrogate family' dependency (*cf.* Coles 1995). By utilising this basic constituent of the 'housing transition' as a watershed interviewees had a marker from which to recall past events. This time proved more appropriate than other markers, such as: age at leaving school, since many remained in the parental home in the post-school period and the family was implicated in much of the poor health reported; the 'school to employment' transition, since only eleven entered genuine employment or further education on leaving school; and the 'domestic transition' because only one moved directly from the parental home to the marital home. Thereafter, the middle section explores the interviewees' health throughout their housing careers and the final section considers their health as they related to present circumstances.

This descriptively dense chapter marks a deliberate change in presentational style from the qualitative claims made in the previous chapter and in the presentation of the chapters that follow which must be explained. The narratives upon which the exploratory and descriptive analyses were based are immense and fragmented and do not lend themselves to succinct representation in the text. These anecdotes necessitated exacting collation and categorisation to ensure that the health problems and the contexts for their production were accounted for which, in turn, engenders a rather quantitative style of

presentation. Moreover, because of the interviewees' emphasis on the ongoing and cumulative nature of the development of the health problems reported, it is only by breaking the data down to its constituent parts, and representing these components that the main themes and arguments could be supported in the text. Although this might indicate a weakness in qualitative terms, by representing the data somewhat akin to the manner in which most homelessness and (ill)health studies are written, it is possible to show that established 'associations' between homelessness and health are tenuous. Most importantly, as will be shown in subsequent chapters, it is not the health problems themselves that proved meaningful to the interviewees, but the social, material and cultural context within which they were produced. Accordingly the chapters that follow provide the qualitative substantiation for the findings here.

Before these data can be considered there is an essential caveat to address. It must be accepted that such narratives are fraught with potential errors of recall and representation. Accordingly they cannot be accepted without questioning the underlying motivations that governed their recounting. Fundamentally, why did the interviewees recall the health problems that they did? Conceiving these narratives as 'speech acts' (Coffey and Atkinson 1996) and looking beyond the data itself to possible motivations, the underlying aim of this chapter is to identify unspoken themes that will facilitate interpretation of how interviewees constructed their lived experiences in terms of health. Furthermore, as a corollary of asking the interviewees for accounts of their 'health problems', it is possible to begin to understand their conceptions of 'health' as a precursor to the themes outlined in Chapters 7 and 8.

Juvenile health considered

This section presents findings from analysis of the data by pursuing four questions:

1. What overall 'stock of health' had been achieved by the onset of the 'housing transition'?

2. What did the interviewees perceive as factors contributing to their overall 'stock of health' as juveniles?
3. Can any 'associations' be made between reported juvenile health and the 'fracture' of the transition to 'independence'?
4. Can any tentative conclusions be drawn regarding meanings of 'health' at this stage.

As shown in Chapter 2, juvenile health and health behaviour have a bearing on adult health and social status and there exists evidence to support the 'health selection' thesis (*for example,* Power *et al.* 1991; Glendinning *et al.* 1992; Blane *et al.* 1993; West 1994). Yet, as already evinced, these are shaped by a host of material, environmental, cultural and psychosocial factors. Unlike later aspects of health reported in subsequent sections, in their accounts of juvenility interviewees focused predominantly upon the psychosocial aspects of health and cited matters associated with the structure, functioning and conflict within their families (*cf.* Sweeting and West 1995a; Sweeting *et al.* 1997) as main contributory factors. The significance of this is discussed later. It is now time to address the first question raised above: what overall 'stock of health' had been achieved by the onset of the housing transition? Table 5.1, over, itemises the types and extent of health problems reported. Because of the variety of terms employed by the sample these groupings were post-coded by the given terms to facilitate collation, categorisation and presentation of the data.

Four interviewees stated they had experienced no health problems as juveniles other than what all considered 'usual' or 'normal things', that is, coughs, colds, influenza, vomiting or diarrhoea, which were not considered 'health problems' because 'everybody gets them'. The accounts of those four interviewees contrast with the majority who reported one or more health problem. To discover what, if any factors, differentiated those four from the remainder of the sample only one association was found: representations of their present circumstances were wholly negative and these were contrasted with highly positive recollections of their childhood.

Table 5.1. Reported health problems as juveniles

Health problem	Number
Psychosocial malaise	12
Headaches and migraines	11
Problems associated with drugs or alcohol	11
Suicide and self-harming behaviour	10
Respiratory tract problems	8
Abdominal problems	6
Fractures	6
Problems associated with eating	6
Anaemia	5
Childhood inflammations	5
Menstrual problems	4
Skin problems	4
Problems associated with abusive sex	3
Urinary tract problems	2
Congenital abnormalities	2
Epilepsy	1
Meningitis	1
N=37	

Reported aspects of psychosocial malaise

Although self-harming may be considered the most evident expression of psychosocial malaise, twelve interviewees explicitly reported experiencing feeling 'really, really low', 'depressed', 'stressed' or having 'panic attacks' sufficiently marked to have impinged upon their sense of well-being for 'months' or 'years' as juveniles and to have encroached upon their activities through additional and related sleep problems and lethargy, poor self-confidence or feelings of difference from peers, alongside physical symptoms of anxiety, such as 'stomach churning' or suicide ideation 'but didnae have the nerve'.

Accepting this as a category in its own right is problematic since a number of reported health problems can be interpreted as manifestations of psychosocial malaise. Accordingly, this refers only to those who explicitly mentioned having experienced such feelings and who had not reported any suicide or self-harming behaviour. All were asked why they had felt this way and this was reported as having been connected to difficulties associated with relationships

with their parent(s). Firstly, parents were believed to have tried to exercise 'too much control'. This was associated with restrictions on activities which interviewees believed applied to them more than their brothers (*cf.* Brannen *et al.* 1994), being primarily related to stated parental fears of teenage pregnancy, and domestic responsibilities as their examples of the gender-role expectations reported (*cf.* Gore *et al.* 1992). Secondly, parents were also perceived as not having 'cared enough' (*cf.* Downing-Orr 1996). Finally, aspects of family functioning, structure and conflict, related to difficulties with the parent's partner, family breakdown or upheaval, parental alcohol problems, and arguments or violence within the home, were associated with reported high levels of stress and depression.

Over and above these reported aspects of psychosocial malaise, just under a quarter of the sample recounted suicide and self-harming behaviour as juveniles. Although the sample is small this suggests higher levels than found among comparable age groups (*For example*, NHSHAS 1995; West and Sweeting 1996). For these suicide attempts interviewees reported having cut their wrists or employed combinations of non-prescription analgesics and/ or benzodiazepines prescribed to their mothers, an interesting finding in light of accounts of family life to be presented in Chapter 6. Two-thirds of those interviewees also recounted episodes of self-harming, predominantly cutting of arms or legs with razor blades, knives, scissors or broken glass. Congruous with analogous research (*cf.* Spandler 1996) interviewees spoke of the sense of release of 'pain inside' or 'anger', feelings of being 'in control', and the increasing compulsion to do this when events became 'too much to handle'.

These practices were contextualised by reference to reported psychosocial stressors, most notably a variety of abusive events and, to a lesser degree, household responsibilities. The main commonalities reported were feelings of isolation 'felt I had naebody', and impotence where suicide was a perceived 'way out' whilst 'cutting helped me cope'. This latter point was relevant to

accounts of those who had required medical treatment where Accident and Emergency staff were generally said to have been unsupportive, 'made me feel like a daft wee lassie', and subsequent psychiatric support was believed to have been ineffectual. The main expressed frustration related to the failure of others to recognise that, at the time, these practices were not only a manifestation of how interviewees had been feeling, but also a means of coping with these feelings (*cf.* Spandler 1996). Finally, despite denying any religious affiliations, two interviewees introduced a spiritual dimension to their accounts of failed suicide attempts by stating their belief they had been 'saved' or 'it hadn't meant to be' and for this reason reported not having tried again.

There was some affinity between expressions of psychosocial malaise considered above and reported problems associated with alcohol and drug use (*cf.* Marlatt *et al.* 1988; Rutter and Smith 1995), with just over half of the interviewees who mentioned this recounting aspects of psychosocial malaise. Furthermore, all recalled additional physical and social problems which they associated with their habit. These included disturbed eating patterns and consequential weight loss, secondary amenorrhoea, disregard for school or in future aspirations, loss of contact with non-using friends and involvement in shop-lifting, or stealing from families.

From their early teenage years, six reported drinking to the extent that they were unable, or unwilling to attend school on the days following drinking sessions because of 'hangovers', staying out or running away and 'getting into trouble', such as fighting or shoplifting alcohol. All held they did have an alcohol problem as juveniles which, they reported, had started as an 'escape' from environment or circumstances, or was just part of the activities of the peer group with whom they had been associating.

Those who reported a drug habit, either amphetamines or heroin, prior to the age of seventeen recounted having been living at home when this had

developed, although two were subsequently placed in care. A significant point to mention here which generally emerged in the context of smoking was that one interviewee's mother, reportedly a drug user, was said to have given the interviewee her first 'joint' when deemed 'old enough' at fourteen. Interviewees reported having sampled a variety of drugs from their early teenage years and attributed this to a mix of 'curiosity', desire for 'escape', or to provide 'energy' to cope with combined domestic responsibilities and schoolwork. Although all spoke of how 'easily available' drugs had been in their locales and that they had generally obtained supplies through 'pals', all denied any peer pressure as a contributory factor. As if to support this latter point, those interviewees who reported heroin use referred to progressive detachment from existing friendship networks, unless those friends were users themselves, and increasing involvement with other drug users. Further consideration of such status and 'lifestyle' aspects is found in Chapter 7.

This section has identified that the most common health problems reported were associated with aspects of psychosocial malaise which, in turn, were believed to have had consequences for the interviewees physical health, and cases of drug and alcohol use. Moreover, interviewees attributed these health problems to social factors and yet, these health problems were represented as also having social implications. The social origins and outcomes of an inter-relationship between 'the mind' and 'the body' continued to be emphasised and the next section illustrates this further.

Mind-body associations

This section considers those mind-body associations elucidated by the interviewees. The numbers reporting headaches and migraines sufficiently severe as to have impinged upon activities, including absences from school, reveals the extent to which interviewees underlined an interaction between the physical and psychosocial components of health. Although a small number provided explanations for the emergence of their headaches and these included

skull injuries arising from violence or accidents in the home or locale, with the benefit of hindsight, most attributed the incipience of these problems to domestic tensions and difficulties, since consultations with doctors or ophthalmologists had, reportedly, excluded pathology.

Such associations were further made in the accounts of those interviewees who reported having experienced eating problems, or medically-diagnosed anorexia nervosa and bulimia. This was cited as a health problem developed in juvenility and was implicated in episodes of secondary amenorrhoea and reflections of the poor condition of their skin and hair. Among those who stated that GPs had diagnosed anorexia or bulimia, by the age of fifteen years, one still refused to accept this label because 'I know I'm too skinny and if I was anorexic I would think I was fat'. Other eating problems without such formal labels which encompassed the practice of regularly 'stopping eating for days', or swallowing problems associated with accounts of regular 'starvation' by parents. Interviewees attributed these problems to domestic difficulties. For those with experience of 'care', this was said to have developed prior to entry and had been exacerbated by periodic returns to parents. Those who had been living in the parental home related this to problems with a parent's partner. In two cases there was also a history of suicide and self-harming behaviour and the connection is interesting, since such 'dieting' was said to have made the interviewees 'feel good' about themselves and 'in control', or as a form of self-punishment 'Ah thought Ah was a terrible person cause she kept telling me Ah was'. Such expressions concur with findings elsewhere (*for example*, Garfinkel and Garner 1982; Brannen *et al.* 1994).

The inter-relationship between physical and psychosocial well-being is further demonstrated in the recounted outcomes of abusive sexual encounters by those interviewees who recounted these experiences which were reported to have been perpetrated by persons known to them when young teenagers whilst living in the parental home, or during home visits from 'care'. As with those who

referred to sexual abuse by fathers, both had a history of suicide and self-harming behaviour and itemised health problems arising from these events including a spontaneously aborted pregnancy accompanied by 'complications' with unknown long-term consequences. Both stressed the psychosocial aspects of these, particularly being unsure as to their ability to enter into future heterosexual relationships. A further interviewee detailed her participation in prostitution from the age of fourteen as a means of 'survival' (*cf.* Akilu 1991) when 'on the run from the children's home' and reported having developed pelvic inflammatory disease which has, reportedly, also impacted on her future reproductive capacity and ability to have full sexual relations.

Final mind-body examples are found in accounts of abdominal and skin problems. In regard to the former, interviewees reported often lengthy absences from school and recounted experiencing a range of problems including recurrent and severe abdominal pains with no obvious pathology diagnosed on investigation, diagnosed 'abdominal migraines', and diagnosed irritable bowel syndrome. There was a twofold commonality between the associations offered: diet and stress. Experience was said to have taught that certain foodstuffs and levels of stress tended to ameliorate or magnify these conditions. These conclusions were also found to be applicable in the accounts of those who itemised skin problems, either excema or 'bad spots', as having posed difficulties and which had required treatment by topical ointments and creams. Interviewees stressed a relationship with these skin problems and psychosocial well-being by underlying that these had worsened when they had felt 'stressed'. Correspondingly, these were also said to have created stress because of the effect on appearance.

The data presented in this section has reinforced the importance, to the interviewees, of reporting past health problems with reference to a connection between the psychosocial and the physical which they grounded in their social relationships. The social production of poor health outcomes continued to be

demonstrated in most of the physical health problems reported. Moreover, interviewees continued to indicate the social consequences of the health problems reported by reference to their impact on schooling.

Reported physical health problems

With the exception of differences in musculo-skeletal problems, and the relatively high number of reports of anaemia, the types of reported physical health problems tend to correspond with those found in other studies (*For example*, MacFarlane *et al.* 1987; Brannen *et al.* 1994; Currie *et al.* 1994; West and Sweeting 1996a). Of the physical health problems, respiratory tract problems represented the largest grouping with eight reporting having had asthma and/or bronchitis from early childhood. These were said to have been sufficiently severe as to warrant daily use of inhalers, occasional home visits from GPs, and periods of hospitalisation. All mentioned absences from school. Only one interviewee mentioned dampness in the home as a possible cause of her bronchitis, the remainder citing family histories, parental smoking or allergies as potential contributors.

Five interviewees reported that, between the ages of thirteen and sixteen, blood tests conducted by GPs whom they had consulted because of combinations of: 'feeling run down', dizziness or fainting episodes, lethargy, pallor, or headaches, had detected anaemia for which iron tablets had been prescribed. Those interviewees attributed anaemia to their 'eating problems' or to variable levels of food availability within the parental home because family budgets fluctuated, especially with parental alcohol consumption. All were united by a common belief that anaemia had exerted a detrimental influence on their education through poor concentration and stamina arising from these symptoms.

Aside from reports of tonsillitis, appendicitis, peritonitis and meningitis, additional absences from school were reported to have resulted from fractures

arising from 'accidents' outwith the home, or as a result of physical assaults within the home. Urinary tract problems, now diagnosed as cystitis, developed in the early teenage years and which continued to affect well-being, were also implicated in lost school time. Two further interviewees reported congenital abnormalities which were said to have required surgery and impeded activities, especially sport. Finally, where epilepsy was said to have been diagnosed this also resulted in frequent absences from school, the interviewee believed this, alongside deafness in one ear, had arisen from physical assaults sustained in early childhood.

Tentative remarks

Referring to the questions posed at the beginning of this section, the findings presented indicate that many of the interviewees' overall stock of health by the onset of the 'housing transition' was not favourable with psychosocial aspects of health being the paramount 'problems' expressed. These were linked inexorably to familial factors. The findings, therefore, indicate support for Sweeting and West's (1995a) proposition that family life may exert a greater influence on health than material factors in youth. However, as will be shown in Chapter 6, such familial factors were almost invariably explained by reference to social and material conditions.

From the accounts, it is possible to begin to appreciate the development of overall 'health status' as an ongoing and cumulative process. Moreover, interviewees believed these processual aspects to have affected adversely their overall well-being as juveniles and, albeit to a lesser extent the specific physical health problems reported, were held to have impacted on their schooling and subsequent qualifications which, in turn, had implications for employment opportunities. Thus, from the anecdotal evidence provided, 'health problems' can be considered as contributing to the interviewees' homelessness, but not in a manner suggested by straight-forward explanations. Health, as emerging from the accounts encapsulates aspects of the physical, mental and

the social, simultaneously, it is reported as manifestation of, and contributor to wider social and material processes.

Reported intermediate health

This section presents findings from analysis of the health problems reported by the interviewees which they associated with experiences arising from the various strategies employed or relationships developed throughout the period from the onset of the 'housing transition' to point of entry to present accommodation. This is referred to as 'the intermediate period' throughout. Beginning to explore the premises that ill-health is produced or exacerbated by homelessness, or 'behaviour' associated with homelessness, questions addressed in this section are:

1. How did interviewees recall their health state in this intermediate period?
2. What particular aspects of the intermediate period did interviewees perceive as having an impact on their health state?
3. Are there any differences in the accounts of those who became 'homeless' immediately and those who became 'homeless' after having made a 'home' or 'housing transition'?
4. Can further conclusions be drawn concerning the relationship between 'homelessness' and health, and the meaning of 'health' at this stage?

The narratives of seven interviewees who moved directly from the parental home to the present accommodation, five who recounted 'no change' in their health during this time, and a further four, who had reported high levels of psychosocial malaise as juveniles and who, recalled this period in a relatively positive light are not included. The latter nine reported having been 'homeless' for a few weeks at most where they had moved between friends and relatives prior to presenting as 'homeless' and, although referring to difficulties associated with these housing strategies they reported no change in their health, or said it had seemed 'better'. Such relatively, and particularly the meanings attached to 'health, discussed in Chapter 8, will engender an appreciation of how these analogues came to be constructed. To exemplify some positive

health aspects of this period the accounts of those who, despite reporting additional 'health problems', emphasised specific 'health gains' made during this time are considered shortly.

Two main factors made disentangling recollections of this period difficult. If health had been reported as poor when juveniles, interviewees spoke of how these problems had continued to 'trouble' them when moving around, so only new or tangential health problems are identified, or those who regarded their present health as 'poor' recalled the intermediate period as a time when their health had been 'better', even if they reported health problems. Furthermore, interviewees tended to recall specific health events in the context of other health problems and the most common phraseology was 'I still had as many (colds/ headaches/ sore stomachs/ asthma attacks/ dizziness) as I ever had, but...' and then a specific health problem would be recounted. Implicitly, interviewees can be seen as underlining what they considered to be the main health outcomes of their circumstances at the time.

Six interviewees reported discharge from hospital to the present accommodation and for one, the hospital was the single intermediate stage after leaving 'home'. Such histories are reported elsewhere (*for example*, Anderson *et al.* 1993). This lends convincing support to the proposition of health problems contributing to homelessness. Moreover, underlining the ill-health as a cumulative process thesis, five linked these admissions to health problems initiated in juvenility, but which were said to have been exacerbated by subsequent circumstances. These cases are defined to demonstrate this connectivity.

Hospital admissions

The most evident support of the complexity of the relationship between homelessness and ill-health was found in the history presented by one

interviewee, who reported combinations of sleeping rough and staying with friends between unsuccessful returns to reportedly alcoholic parents. She recounted nineteen admissions to hospital over a two year period with multiple health problems including, meningitis, fractures, abdominal problems, and overdoses, which she believed had arisen from various physical and psychosocial stresses. Psychosocial malaise continued to underline accounts. Three reported having been discharged after treatment in psychiatric units, two following recounted suicide attempts whilst in the parental home or when moving between friends who had emphasised 'knowing you'd outstayed your welcome', but 'didnae know where else to go or what to dae'. Both had reported histories of suicide and self-harming behaviour. A third, who had accentuated her inability to 'cope' on her own on leaving 'care', recited lengthy admissions for 'severe depression' and drug withdrawal. The interviewee with the longest history of 'homelessness', briefly interrupted by an unsuccessful stay in her own tenancy, recalled 'collapsing' when sleeping rough and, on admission, Crohn's Disease, 'bad anaemia' and 'depression' were reportedly diagnosed. Finally, one interviewee had just been discharged from hospital following heart surgery, where she had been commenced on a methadone programme, and iron tablets for anaemia.

These cases represent the clearest examples of an association between ill-health and admission to 'homeless' facilities. From the remaining accounts, however, there continues to be efficacious support for a less direct relationship. By addressing questions 1 and 2 above regarding how interviewees recalled their health state in the intermediate period, and the particular aspects of this period that interviewees perceived as impacting on this state, analysis quickly revealed that interviewees tended to offer two groupings of explanatory variables: the effects of physical environment, and the effects of relationships developed or 'lost' during this time. In respect of environment the types of health problems reported, with the major exceptions of musculo-skeletal problems, 'fits or loss of consciousness' or 'difficulties with seeing or hearing' tend to concur with

notable studies outlined in Chapter 1 (*for example*, Daly 1989b, Balazs and Burnett 1990; Anderson *et al.* 1993; Balazs 1993; Bines 1994). The absence of the aforementioned health problems in the accounts is probably a reflection of the young age of the sample. There were also additional reported 'health problems' associated with 'physical environment' and 'relationships'.

Effects of physical environment

Lending support to differences recorded in Bines' (1994) study and as witnessed in the high numbers of reported colds, chest infections, abdominal problems and fatigue during participant-observation, all interviewees who reported having experienced rough sleeping emphasised how their physical health had 'been at its worst' during this time. Those interviewees who recalled numerous respiratory infections tended to have reported sleeping rough for long periods. All spoke of how 'run down' they had felt and this was associated with ongoing and recurrent infections, inability to keep themselves and their belongings warm and dry, and being unable to eat 'properly'. Foodstuffs were said to have comprised chip-shop left-overs, soup, sandwiches and cakes from charitable organisations, or whatever could be 'shoplifted', such as crisps, chocolate or biscuits.

Sleeping difficulties when sleeping rough were also said to have compounded feeling 'run down' and these were related to the cold and discomfort experienced, or general fears. Weight loss and increased asthmatic episodes, reportedly necessitating hospitalisation, were cited as main exemplars of interviewees' general poor health whilst sleeping rough. Although Accident and Emergency facilities were reportedly the only source of primary health-care for a few when sleeping rough (*cf.* Fisher and Collins 1993), most had continued to consult their own GPs. Most of those latter interviewees had not informed GPs of their changed circumstances 'in case I'd be struck off'. Consultations were said to have been for antibiotics and bronchodilators.

However, accounts of street life were not wholly negative and this is expanded in Chapter 6.

In their accounts of sleeping rough or, less rarely when moving between friends and relatives, interviewees recounted having developed abdominal problems, notably episodes of spontaneous vomiting on food ingestion if they had not eaten for a while, abdominal 'swelling' and pains, and 'heartburn'. Those who had been sleeping rough attributed these to infrequent eating habits and constipation whilst the others related these problems to the tensions associated with moves. None reported having consulted a doctor and when asked why, it was said there had been 'no point' because it was a 'part of skippering' (sleeping rough) or 'the doctor couldnae dae anything for me'. Such discernments are explored in Chapter 8.

Although many mentioned fluctuating body weight throughout this period, relating this to 'ma stomach problems', 'not eating right' or 'the drugs', only five specifically named this as a 'health problem', two of whom reported having been diagnosed as 'anorexic' when moving between friends and relatives. This would appear to be because interviewees could not impugn a single factor for this, syncopated here as 'S'pose it wis the way Ah wis feeling'. In these accounts food intake was associated with well-being with reported weight loss, or 'bingeing' analogous with stressful points in time, such as tensions prior to moves, or when 'just thinking too much about things'. This association with food, weight and well-being was reinforced at interview when two interviewees exhibited 'fat folds' as a means of underlining how 'well' they were feeling now.

Dizziness and fainting were also attributed to feeling physically 'run down' and poor eating habits when sleeping rough. One of the four who mentioned menstrual changes during this time, further associated her being 'run down' and fainting to dysmenorrhoea and heavy bleeding for which she had consulted

her GP who had prescribed analgesia. The others related the varying frequency and extent, thence the onset of secondary amenorrhoea, to drug habits or anorexia. In these latter cases the onset of secondary amenorrhoea was described as one less factor to 'worry about' or 'spend money on'. Discussed later, over a third of the sample recounted problems associated with menstruation which were said to have impinged on their well-being throughout this time.

One physical environment to which two interviewees attributed blame concerned the reported acquisition of scabies, by themselves and their children, in the same bed and breakfast hotel where they had been accommodated upon leaving partners. Both had consulted their GPs for treatment. Although successful, one child was said to continue experiencing 'sensitive skin' some months later and the ongoing practical and mental stress, for the child and mother, associated with daily topical treatments was described.

Risky strategies

Whilst most of the interviewees who reported having become 'homeless' on leaving the parental home or care focused upon such general health outcomes of the physical environments as recorded above, a few mentioned specific, additional health outcomes of housing strategies undertaken notably, abusive sexual encounters, involvement in prostitution and drug use. Two interviewees reported having been 'raped' when sleeping rough and when staying with a friend. Neither had reported these incidents either because it was perceived that authorities would not take a rough sleeper seriously 'they'd think I'd asked for it' or the reputed perpetrator had been a brother of the friend with whom the interviewee had been living. Two others related accounts of the implications of 'new relationships' formed when sleeping rough and when living in a hostel, a factor indicated in other studies where a connection between homelessness and actual or potential involvement in prostitution has been made (*cf.* McMullin 1988; Dibblin 1991; Hendessi 1992; YHG 1992), and as witnessed during

participant-observation where prostitution provided a means of economic survival when sleeping rough, or provided the means for securing a deposit for and then maintaining private rented accommodation. Both interviewees reported having become involved in prostitution, to support themselves financially, through the example of new friends and this, in turn, was implicated in their increased consumption of drugs. Two further interviewees reported having become involved in drugs when staying with friends. Having gone to stay with a reputed drug dealer one interviewee recounted becoming involved in 'dealing' as a means of financial support and later using heroin herself. The second interviewee, who attributed being previously overweight to 'comfort eating' as a child, described the formation of her addiction to her belief that amphetamines were the 'easiest way to diet' because she had seen the positive effects on her friend whose flat she shared.

Effects of relationships

Among those interviewees who recounted having developed drug habits (*cf.* Daly 1989a; Randall 1989; Balazs 1993; Boulton 1993) during the intermediate period, unlike previous accounts of 'curiosity' or 'boredom', six described this in terms of a 'reaction' to specific life-events or compounded circumstances which they 'needed help to cope' with, or had wished to 'blank out'. There continued to be one commonality in the accounts in that friends or partners were said to have been the primary source of substances used: heroin, temgesics, DF118, LSD, amphetamines, diazepam and temazepam. 'Reactive' accounts encompassed the reported effects of 'rape' and 'miscarriage'. Those interviewees reported having been able 'to cope' with previous circumstances and events including factors associated with admittance to and experience of care, and death of a parent, but this event was described as a 'last straw'. Remaining accounts focused on the compound effects of previous circumstances, superimposed by relationships developed during this period where drug use was explained simply as another factor in their chronology of life experiences.

There were similarities in the accounts of those interviewees who reported having developed drug habits when in cohabiting relationships. All three had experienced 'care' and spoke of having had 'no-one to turn to'. Initially the partners were said to have taken drugs (*cf.* Peck and Plant 1986; Hammerstrom *et al.* 1988) as a reported consequence of 'depression' arising from unemployment (*cf.* Banks and Jackson 1982; Beale and Nethercote 1984; Warr 1984, 1985; Hawton and Rose 1986). All cited problems with their partners' worsening behaviour, including various aspects of mental and physical abuse (*cf.* Hammerstrom 1994). All spoke of the increasing stress arising from rent and mortgage arrears and, two, external threats associated with drug debts, the given reason why one husband reportedly 'forced', with violence, one interviewee into prostitution. In two cases these factors were said to have coincided with 'post-natal depression' which is further considered shortly. All three cited 'to help me cope' as the primary reason for their own subsequent use of cannabis, prescribed benzodiazepines, and illicitly procured narcotic analgesics.

Further evidence to suggest a relationship between a partner's unemployment and the interviewees' psychosocial well-being (*cf.* Penkower *et al.* 1988) was found. 'Heavy depression' and 'stress' were cited as the main health problems experienced by three interviewees who related the breakdown of their relationships to physical and mental abuse from partners, including reported 'stabbing' and skeletal injuries following beatings. In one of these cases an interviewee reported temporarily losing custody of her child to her husband whilst his claims of 'neglect', after separation, were investigated, and this was said to have made her 'completely lose control' of herself for a while. Alcohol (*cf.* Kandel 1980; Power and Estaugh 1990) and drugs were implicated in the reported 'violence' and 'paranoia', with two interviewees reflecting upon the partner's worsened moods following unemployment.

Three interviewees, with no reported histories of suicide behaviour or ideation, explained common reasons for their single suicide attempt with prescribed benzodiazepines, during the intermediate period. This was attributed to inability to 'come to terms' with 'miscarriage' or death of a neonate. Two others also reported 'miscarried' pregnancies at this time, but explained 'relief' because 'I wasn't ready to be a mother'. Pregnant again, one of those latter interviewees recounted suicide behaviour with this second pregnancy. Only one interviewee reported having been provided with a reason for her 'miscarriage', 'the amphetamines' and, other than all recalling having received prescriptions of benzodiazepines, she was also the only interviewee to report having received follow-up support, which she described as 'useless'. None could recall receiving advice about future pregnancies.

In addition to the case indicated above, a further three interviewees reported losing custody of their children and, although one had since regained custody, the ongoing effects of this separation were implicated in their present levels of psychosocial malaise. All attributed losing custody to past drug habits. Of those who reported still not having custody, one child was with foster parents with whom there was no contact. The second interviewee cited convictions for 'possession' and 'soliciting' and, on separation, custody had been awarded to her husband 'cause he'd never been charged'. She expressed combined 'worry' and 'relief' in terms of fears for the children's safety, but also, relating her own history of abuse, stated this had removed any opportunity for 'history to repeat itself' through her, a crucial point returned to in Chapter 8.

Problems associated with reproduction

This short section considers additional factors associated with reproduction which were cited by those interviewees denoted as 'mothers', that is those interviewees who were living in the supported projects for young women and their children, which they believed had exerted, or continued to exert a negative influence on their own or their children's health. Despite reporting

combinations of morning sickness, fatigue, anaemia, backache, heartburn, hypertension, oedema, general weakness and vaginal infection, in contrast to labour experiences, pregnancies were considered to have been uneventful with the exception of those who mentioned post-natal back-ache and anaemia continuing to be problematic. In contrast, reflections tended to focus upon 'strains' associated with lack of support, even where partners had been present (*cf.* Sharpe 1987). Four of the seven mothers had experience of 'care'. Those interviewees who had not been in a cohabiting relationship with the baby's father recounted how boyfriends had departed either during the pregnancy, or soon after the birth. Only two of the mothers reported continuing supportive relationships with parents.

Studies have shown a relationship between 'homelessness' and problems, for mothers and their infants, associated with pregnancy, childbirth and the post-natal period (Drennan and Stearn 1986; Lowry 1989; Patterson and Roderick 1990; Shanks 1991). Most of the problems reported below occurred prior to homelessness and were said to have impinged upon the interviewees sense of well-being at the time. Only half of the births of their children were said to have been 'normal' (*cf.* Oakley 1993), the remainder being by emergency caesarean section for fetal distress and forceps deliveries. Four of the infants were said to have required Special Care Baby Unit treatment as a result of 'heart defects', low birth-weight, 'breathing problems', and a congenital 'swallowing problem'. Two additional infants were reported to have been diagnosed with congenital problems soon after birth which did not require special care, but necessitated subsequent surgery and long-term outpatient attendance.

Among the interviewees, 'bleeding problems' were reported, in one case requiring several days in an Intensive Care Unit after the birth of both children. A further four recounted post-natal 'bleeding', again, one following both of her labours. Two recounted subsequently developing uterine infections and another

continued to take antibiotics for a section wound infection. Three reported later diagnosed post-natal depression which they claimed not to have noticed until it was 'really bad', having attributed these feelings to the problems with their partner prior to their 'homelessness'. Generally, their own, or their infant's physical debilitation in light of above and recurrent 'chest infections', in the post-natal period were said to have compounded and been compounded by the psychosocial stressors in the home.

Health gains

This section considers some emphasised 'health gains' during this time. As will be shown in Chapter 6, two recalled periods of imprisonment favourably. With long histories of 'homelessness' both expressed a belief that these spells had improved their health and related this to regular mealtimes, having warm surroundings and a dry bed, and feelings of safety and support. Moreover, although drugs were said to have been 'easy to get' in prison, both recalled having used this time to reduce their habit. Prison was recalled as a place where 'ma body could get a rest'.

Three interviewees who had reported earlier drug habits stated they had stopped using during this time having sought treatment in detoxification and rehabilitation centres and one reported having been 'kidnapped' by a friend's parents and remaining there until 'getting sorted out' prior to presenting as 'homeless'. Although receiving a positive diagnosis of Hepatitis C, the detoxification centre was said to have been successful, but subsequently the interviewee reported being discharged into the care of relatives, reputedly, drug dealers. She then recounted sleeping rough for several months to avoid contact with anyone connected with her previous lifestyle. The third interviewee claimed the birth of her first child to have spurred her to 'stop using', however soon after discharge from 'rehabilitation' on methadone, she explained 'needing to top this up' with heroin. Reported parental intervention and support later enabled her to withdraw, and 'stay clean'.

Tentative remarks

As indicated recollections of this period in terms of health were mixed and for some this was a time when interviewees recalled having experienced 'no change' or an 'improvement' health-wise. These cases begin to contribute to a problematisation of the 'progressive decline' thesis (*cf.* Hutson and Liddiard 1994). Nevertheless, the majority recounted health problems during this period and two main groupings of explanatory variables were found and this division is illuminating. Generally, those who had become 'homeless' immediately upon the onset of the 'housing transition' tended to focus upon the negative aspects of physical environment, especially in terms of the physical health problems associated with rough sleeping. Moreover, and regardless of the negative health outcomes of some housing strategies undertaken during this time, those interviewees recalled relationships in a neutral light, such as those friends or relatives whose house they had shared, or positively, especially among those with experience of sleeping rough or prison. In contrast those who became 'homeless' after having undertaken 'housing' and 'home' transitions to be with partners tended to focus upon the adverse psychosocial effects of these relationships rather than the physical outcomes. Yet, subsequent accounts, for example the reports of scabies, primarily focused upon the physical health aspects of environment akin to those with a 'longer history' of 'homelessness'.

When superimposed upon the conclusions drawn at the end of the first section the interviewees were continuing to present the development of their health problems in a cumulative manner and were associating physical and psychological health problems with the social and material conditions of their being. Moreover, they appeared to be underlining the primacy of psychosocial malaise experiences prior to their 'homelessness'. Afterwards, an effect of having removed themselves from those specific psychosocial stressors, primacy is accorded to more tangible material and physical environmental factors and their physical outcomes. Yet, just as physical health problems are

largely explained as outcomes of psychosocial malaise initially, and psychosocial malaise as an outcome of physical health problems thereafter these focal changes cannot be taken as absolute, but relative, and this is developed in Chapters 7 and 8. This relativity is particularly exemplified in the accounts of reproductive problems where potentially life-threatening events, such as haemorrhaging, were accorded only brief mentions compared to lengthy narratives of the psychosocial stressors in the home at that time. This shift in focus does not mean that the effects of these original factors had disappeared for, as will be shown, they weighed heavily in many subsequent accounts. What this shift does make all the more necessary is to employ these as a means for accessing and understanding the social and material circumstances within which the accounts were produced. This will follow in Chapter 6.

Acknowledging that the sample here is too small to make any generalisations and accepting that such retrospective accounts are infused with difficulties these findings do have a methodological implication for future research, especially comparative studies of different groups of homeless people. These data indicate that there is a change in focus in the reporting of health problems according to space and time and as such, dependent on the reasons offered for their homelessness and the length of time individuals have been homeless, interviewees may over- or under-report what they perceive the health effects of their circumstances to be. In this manner, interviewees' accounts of their ill-health experiences are clearly emerging as meaningful expressions of their social and material circumstances during these specified times and this is particularly significant in the reports of their health experiences in their present circumstances.

Present health

More evidence is required to support these emerging propositions. Thus, continuing with the exploratory and descriptive remit of this chapter this final

section represents the data pertaining to the interviewees' health as they related to their present circumstances. Four key questions, derived from analysis of the data from the focus groups, influenced the analysis here:

1. How did interviewees describe their present health state?
2. What types of health problems did the interviewees experience whilst living in their present accommodation?
3. What factors did the interviewees perceive as contributing to their health state?
4. To what extent were 'formal' health services used?

As a prelude to exploring specific health problems an introductory question, generally posed as 'How would you describe your health at the moment?' was asked. One, a previous heroin user, expressed her belief it was 'the best its ever been', twenty-three replied 'okay' as the most common term used, 'fine', or 'good', one said it was 'not good or bad', and sixteen believed their health to be 'bad', 'the worst', 'it's deteriorated', 'drastic' or 'rubbish'. Consistent with general health studies (*cf.* Blaxter and Paterson 1982; Blaxter 1990; Brannen *et al.* 1994) there existed contradictions between these initial positive descriptions and the health problems reported and this is investigated in Chapter 7. Suggesting higher levels than findings from work with a similar age group (*cf.* Bines 1994) all reported health problems and most reported multiple, inter-related problems which, as they described, encroached upon their sense of well-being. These multiple problems, however, supported high numbers of reported health problems found from focus group work and participant-observation. These, having been post-coded, are presented in Table 5.2 over.

Table 5.2. Reported physical health problems

Health problem	Number
General lethargy	33
Upper respiratory tract infections	30
Dizziness or fainting	25
Headaches and migraines	23
Sleeping problems	21
Dental problems	20
Skin problems	20
Abdominal problems	13
Anaemia	12
Eating problems	12
Lower respiratory tract infections	12
Musculo-skeletal problems	12
Other respiratory problems	12
Genito-urinary problems	11
Problems with a vital organ	4
Eye infection	1
N=41	

This table provides an overview for the discussion that follows, but it does not reveal the extent to which individuals reported multiple and inter-related health problems, though this point is demonstrated throughout the text that follows. Providing an outline of the range of health problems in this manner is necessary, for no such collation exists and it provides a baseline for future comparison. However, in order to indicate differences in the reporting of health problems it is important to consider the distribution of the reported problems, particularly because analysis of these was to suggest that interviewees did not accord similar weight of importance to the health problems reported, nor to the sources of these problems. As will be shown in Chapter 7, the interviewees' accounts of whether they regarded themselves as homeless or not and, more significantly, the factors offered for these self-conceptions supports the proposition that health problems should be regarded as expressions of an individual's social and material environment (*cf.* Popay 1992). The basis for this assertion is now introduced.

Only two interviewees reported one health problem each; one reported a cough which she associated with her smoking, the other anaemia, despite having

recently being discharged from hospital following heart surgery and being on a methadone programme. Objectively, however, both interviewees did not look at all well, appearing rather gaunt, and their manner and body language exuded apathy. At the opposite pole lay a number of accounts which reported the highest number of multiple and inter-related health problems including constant tiredness, sleeping and eating problems, abdominal problems, ranging from vomiting, diarrhoea, constipation to diagnosed bowel disease, recurrent colds and chest infections, anaemia, light-headedness and episodes of fainting, and headaches or migraines. Those interviewees tended to emphasise these as products of their present social and material environment and underlined this by referring to increasing suicide ideation, self-harming or parasuicide practices, or an increasing desire to return to drug use. The majority of the sample, however, tended to simply recount a list their health problems and frequently referred to these, for example, tiredness, sleeping problems, coughs and colds, or dizziness in the context of what they appeared to accept as a part of shared living and or unemployment. These physical health problems were largely presented in two main types of manner: those who recounted these as secondary to the benefits of hostel life, particularly in terms of psychosocial well-being, or those who explained these as matters which were to be tolerated until their housing situation was resolved. Moreover, this largest grouping tended to include skin problems and spots in their accounts, according these, at least, an equal status with more serious problems outstanding from previous epiphanies, such as renal and hepatic failure, skeletal or genito-urinary problems. Finally, although reporting multiple and serious health problems, including hepatitis C and suspected HIV infection, neither of the two interviewees who used hard drugs and worked as prostitutes attributed their health problems to living in a hostel, these were presented as side-effects of the drugs used, their work and past experiences. The context for such variable reporting is considered in Chapter 7.

Returning to Table 5.2, the high number of types of 'health problems' recorded here would appear to indicate a strong relationship between present circumstances and health. To arrive at such a conclusion at this point would be erroneous for, as indicated in the preceding paragraph and as will be shown, and although these problems were said to impinge upon the interviewees' present well-being, most were rooted in the past. The inter-relationship between many of these categories continues to be demonstrated in the accounts and interviewees provided a variety of factors which they believed had impacted upon their health state. One way in which this can be exemplified is with reference to the most commonly reported 'health problem' in the narratives of those included under the heading 'general lethargy', that is reports of tiredness 'all' or 'most of the time', and expressions of 'nae energy' or motivation. Giving 'lethargy' as the most frequently reported 'health problem' is interesting because, in contrast to more tangible 'health problems', this alongside other 'basic' health issues of sleeping and eating were accorded considerable attention in the accounts.

Given the high numbers who reported aspects of 'lethargy', it was necessary to analyse the accounts of those who had *not* mentioned this in an attempt to elucidate any commonalities and these were found. The largest grouping here related to those who spoke of daily activities enthusiastically: employment, motherhood, attendance at college or a sports-based drug rehabilitation programme, who expressed, to varying degrees a belief they were living full and active lives. The remaining two who did not mention this as 'a problem' contrasted markedly with this first group and are depicted as 'Eremites' in Chapter 7.

Combinations of principal groupings of reasons were offered as a cause of lethargy: not sleeping at night, 'nothing to do', 'not getting enough breaks' from motherhood, or, generally feeling 'run down' as a result of other health problems, including anaemia, recurrent infections, abdominal problems. As

will be shown in Chapter 8, among the 'single' interviewees the omnipresence of words associated with 'laziness' arising from boredom were the most common expression and this tended to be contrasted with earlier periods where interviewees had not felt this way. It was also implicated in additional factors, particularly the break-down of existing relationships with friends outwith the hostel, because they 'couldnae be bothered' with the 'effort' involved which, in turn was said to reduce motivation further. Overwhelmingly lethargy was not regarded a problem for which a doctor would be consulted and this is considered in Chapter 8.

As identified in other studies (*cf.* Conway 1988; Lissauer *et al.* 1993) some mothers, however, reported contrasting problems of having 'too much to do' which tended to incorporate disturbed sleep relating to infants' needs, or sharing a bed with older children, the lack of personal space associated with sharing the bedroom with children and being 'on call twenty-four hours a day'. Most, however, stressed they were 'coping', and mentioned the benefits of having staff and friends within the facility upon whom they could call when help was required.

Whether 'too little' or 'too much' to do were cited all included aspects of the physical and psychological in their accounts. Both aspects of health, with reference to material, environmental and psychosocial contributory factors were demonstrated time and again and the complexity of associations in the narratives is exemplified throughout. Two basic health matters continue to exemplify factorial inter-relatedness.

As indicated, 'sleeping problems' were allied to aspects of 'lethargy'. Less than half reported they usually 'slept well' at night, but even among those six reported taking combinations of prescribed and non-prescription medications to facilitate sleep. Lack of activity during the day, noise disturbance, sharing of rooms and 'hostel hours don't suit working people' were the most commonly

reported factors impeding sleep. However, sleeping problems were also associated with past events where interviewees reported either being unable to 'fall asleep' because 'Ah just think o' things when Ah'm in ma bed' or 'night-time's when the worries really start', or waking through the night because of 'nightmares' relating to previous experiences. All expressed frustrations arising from these sleeping problems and consequential tiredness and irritability. These problems were further implicated in numerous additional physical and mental health problems.

Only two reported having considered consulting their GPs, but believed previous suicide behaviour would militate against being prescribed any night sedation. For three, however, sleeping problems were said to create specific difficulties associated with their employment. Those interviewees believed that, because of noise disturbance in the hostel, they were not 'getting enough sleep' and this was reported to create difficulties with tiredness and poor concentration at work. Additionally those whose days off were during the week, expressed annoyance at being unable to have a 'lie-in' on these days because all residents reportedly received an 'early wake-up call' on week days whether working or not and were expected to rise at this time. These 'wake-up calls' were also a source of resentment among unemployed interviewees. Having little to do throughout the day was cited the main source of inability to fall asleep on going to bed and those interviewees expressed a desire to 'sleep on' in the morning because they saw little reason to rise this early.

As emphasised during participant-observation and the focus groups, diet was a major factor in the accounts and, accordingly, requires full consideration in Chapter 8. Among those who reported 'eating problems', most of these were reported to have arisen at previous points in their lives with the exception of three who reported that since entering the hostel they had not 'felt like' cooking or eating, because of concerns about 'weight' or problems associated with 'threats' that food would be 'poisoned'. Only two, without a previous diagnosis

of 'anorexia' or 'bulimia' reported having consulted their GPs as a result of these concerns and expressed bewilderment at the advice reportedly offered: 'I was told to "go away and eat a healthy diet', but he didn't tell me what that was' and 'he tellt me my diet seemed quite normal and not to worry'. Both stated they believed there was something wrong, but were reluctant to seek further advice. Those with long-standing 'eating problems' reported fluctuations, generally depending on their 'mood'. Several recounted 'going hungry' regularly and eating only when additional physical symptoms, such as shaking or dizziness, became marked. Furthermore, this was related to a common theme of 'habit' and to varying degrees those interviewees believed they had lost the habit of 'eating properly' whether as juveniles, or in the intermediate period.

These eating problems were implicated in many of the additional health problems outlined below, including: anaemia, dizziness or fainting, skin problems, nausea or vomiting, abdominal problems and headaches. In addition to these 'basic' health concerns, as shown in Table 5.2, high numbers of physical health problems were disclosed. As indicated, the reasons provided for lethargy, and sleeping and eating problems were complex and there is no straight-forward 'cause and effect' relationship to exhibit. Most of these problems were rooted in the past which had implications for a multiplicity of related health problems in the present. However, there was only one area of health where 'causation' could be demonstrated more persuasively.

Clearer associations

Consistent with homelessness studies cited in Chapter 1, participant-observation and the focus groups, respiratory problems ranked highly in the health problems reported. Interviewees who did not report such problems were found to be recent arrivals from the parental 'home'. Among those living in the 'adult' hostels, colds and influenza were regarded to be particularly problematic, especially for those who had been living here for several months

or more who reported catching 'everything going' and this was strongly implicated in feeling 'run down', although it was believed that 'being run down' through other health problems predisposed them to recurrent infections. Primarily accounts focused upon the environment of the hostel where 'living wi' aw other folk is bound to make you catch things' since 'there's always somebody with a cold in here'.

Chest infections were said to be particularly troublesome and they were associated with 'bad' upper respiratory infections. Hoarse, productive coughs and breathlessness on mild to moderate exertion 'going up stairs' or 'running to the shops' were main symptoms reported. All who had experienced chest infections were smokers and rather than focusing on external factors, as with other health problems mentioned, all blamed their smoking for these infections and, although five recalled two or more chest infections, they had not reduced or stopped smoking. This is pursued in Chapter 7. All reported having consulted GPs for antibiotics for chest infections and said they had completed courses of treatment.

Respiratory problems might suggest a relationship between present circumstances and health, but even in these accounts questions begin to emerge insofar as the extent to which the interviewees health status predisposed them to such infections, given that their overall 'stock of health' does not appear to have been good on admission, and, especially, since respiratory infections had been described as a main health problem when sleeping rough and were said to have continued after entry to the hostel. Furthermore, the reported association between smoking and chest infections indicates that 'behaviours' adopted at an earlier point may exert an influence upon present health state. The context for such 'behaviours' is considered in Chapter 7. The data presented below confirm that, without acknowledging that ill-health is a cumulative process, any inferences of the existence of a relationship between circumstances and health are potentially facile.

Further problems with associations

Smoking and stress were blamed for exacerbations of other respiratory problems among those who had developed asthma and bronchitis as juveniles or in the intervening period. Here reports of chest tightness, wheezing and non-productive coughs were omnipresent. Only one interviewee, who associated this with her smoking and 'panic attacks', reported having developed asthma when living in the hostel. Most were using bronchodilators prescribed by their GPs and one, oral steroids having experienced an asthmatic episode three nights previously for which a doctor was said to have attended. Two of the interviewees who reported asthma were non-smokers and both complained about the extent of smoking in hostel common rooms and tended to avoid these as much as possible. This, however, was said to have posed additional problems since this marked them as 'different', a matter pursued in Chapter 7.

Over half reported episodes of dizziness or fainting which they related to other factors, including anaemia, poor diet, feeling 'run down', period problems, drug use or previous head injuries. Twelve interviewees reported anaemia as a present health problem, three of whom stated this had been diagnosed since entering the hostel. All reported having been prescribed iron tablets, but only three of the mothers and one 'single' interviewee, recently discharged from hospital, were following treatment. This is further considered in Chapter 8. Diet was blamed primarily for anaemia-related problems, but it was also cited by all as a causative factor for episodes of dizziness or fainting where this diagnosis was not present. For those who cited 'feeling run down' a combination of factors were offered, including recurrent infections, poor sleeping or eating habits, and the heat or 'stuffiness' in bedrooms were all proffered as potential causes. Among those who associated this with 'period problems' these tended to focus upon 'heavy' flow, or dysmenorrhoea.

In Blaxter's (1990) study eighteen per cent of female respondents, aged eighteen to twenty-four, reported 'trouble with periods' (*Ibid.*: 47) and using this for comparison the numbers of interviewees reporting such problems appears high. Fifteen reported experiencing 'period-related problems', including one or more of the following symptoms: pre-menstrual tension, fluid retention, cramps, irregularity, heavy flow, dizziness or fainting, and tiredness. This figure, however, belies other menstrual irregularities reported. Only nine, who were not using any pharmacological contraception, recounted no menstrual problems whatsoever. Similarly five who reported being 'on the pill' claimed menstruation to be regular, light and pain-free. A further four who reported using *Depo-Provera*, 'on the jag' were not menstruating. Among those latter nine, four reported having been prescribed either the contraceptive pill or *Depo-Provera* for problems associated with dysmenorrhoea, irregularity or heavy flows. Four interviewees recalled having experienced secondary amenorrhoea for between two and seven years as a result of drug use, and two others because of anorexia. Most could proffer reasons for their menstrual problems: an effect of contraceptive cessation; menstrual cycle was just re-establishing on recovery from previous drug use or 'eating problems'; or difficulties had arisen following 'miscarriages' or recent child-birth. Although a few had spoken to their GP as an aside to other matters, three who could not offer a reason for their problems were the only interviewees to report having consulted a GP specifically in regard to these problems and they reported taking prescribed analgesia as required.

Among those who reported headaches and migraines, most recalled these as having arisen when younger, although four mentioned these were not so frequent nor intense now, believing this to be because they were relatively 'happy' with their present circumstances. However, nine reported headaches or migraines as 'recent problems' arising from epidural anaesthesia during childbirth, or in the present accommodation and they associated this with lighting in the hostels, and to feelings of 'stress' or 'tension' arising from their

circumstances. Only one interviewee reported having consulted her GP concerning the headaches and a diagnosis of 'tension' was said to have been offered and 'relaxation exercises' recommended. This interviewee reported having 'no idea' where to go for these and instead was treating herself with aromatherapy oils. Most reported treating headaches with non-prescription analgesia.

Continuing manifestations of previous health problems were found in the accounts of those who reported abdominal problems. Interviewees with previously diagnosed conditions expressed frustration at being unable to adhere to recommended diets in the present environment. The pain allied with these conditions was said to be the principal factor contributing to their feeling 'run down'. Amongst the others who reported combinations of constipation. abdominal 'swelling' or recurrent 'diarrhoea' these problems were attributed to the present circumstances or drug habits. Explanations included: diet-related issues, 'not enough fruit and veg' or 'too many take-aways', inactivity 'bowels have got lazy too', or 'the smack (heroin) makes you constipated'. Two, who could not provide reasons for their abdominal pains and distension, reported having consulted GPs, one of whom was waiting for an appointment with a 'specialist' and the other was taking a third course of tablets, but did not know what they were for.

Among those interviewees who reported problems associated with genito-urinary infections, cystitis, an abscess, problems with previous pelvic inflammatory disease and vaginismus, only half of these problems had arisen since entering the hostel, but all were said to continue contributing to their feeling 'run down'. Six reported presently taking antibiotics. The first group being three who had contracted infections through sexual intercourse, reportedly from previous boyfriends and from a 'client'. This latter interviewee also believed she might have acquired a positive HIV status. Those interviewees who had contracted urinary tract infections attributed these to 'not

drinking enough' or 'dirty toilet seats' in the hostel. Two interviewees reported problems discovered with cervical smears: one who was attending a colposcopy clinic attributed this to a previous amphetamine addiction since someone had told her in the past that they 'rot your insides', and a second recounted how 'vaginismus' had been discovered at her first cervical smear test. Although she could offer no reason for this, both she and her boyfriend were said to be attending counselling.

Reported skin problems rank highly in half of the accounts and for the interviewees who reported these this was a pressing problem deemed sufficiently serious for all, but four who associated their 'bad skin' to diet alone, to recount having consulted GPs for topical treatments or medication, making this the second highest reason for GP consultations after antibiotics. Primarily 'spots', 'blotches' or 'dry skin' were cited, and pointed out, as the 'health problem' reported and combinations of stress, 'greasy' diet, periods and the central heating systems in the hostels were blamed. Those who had developed excema or dermatitis in juvenility, and two who had developed dermatitis when working as hairdressing 'juniors', expressed a belief that 'stress' and central heating exacerbated these conditions.

Only three of the twelve reports of musculo-skeletal problems reported had commenced in the present accommodation since most had arisen prior to entry, yet continued to pose problems. These included congenital abnormalities, post-fracture skeletal pains, muscular pains associated with employment undertaken prior to entry, or post epidural backache. Those who reported general aches and pains after drug withdrawal said this was 'aw part o' it' and 'a price worth paying'.

Finally, none of the labelled reported 'problems associated with a vital organ': renal and liver failure, recent heart surgery, hepatitis C and a heart murmur were connected with the present. All were attributed to drug habits or previous

suicide attempt overdoses. Two of those interviewees were on methadone programmes, but in one case this was reportedly being 'topped up' with heroin because the interviewee believed the prescription to be 'too low'. Although all appeared to recognise the gravity of these conditions 'the doctor told me I'll need a transplant' there was little awareness of what symptoms to expect 'when something's wrang wi' me I think "it must be the hep"'. Despite having stressed aspects of 'feeling run down', the interviewees found difficulty pinpointing specific outcomes of these problems among the others reported, including anaemia, asthma, eating and recurrent respiratory problems, and palpitations.

Quantitatively and qualitatively this section has shown that the overall health of the sample was found to be poor. Even allowing for consideration of the possible motivations which spurred such reporting and, referring to the studies outlined in Chapter 2, in regard to the possibility that gender exerts an influence upon women's propensity to report more health problems, to give poorer evaluations of and worry about their health to a greater extent than males, the high number of health problems identified cannot be denied. Nevertheless, any assumptions of straight-forward relationships between homelessness and health must be refuted. As consistently demonstrated in these outlines, present physical health state cannot be understood without acknowledging overall health status. The most convincing support of this is found in the accounts pertaining to 'psychosocial well-being'.

Psychosocial well-being considered

Mental health problems are shown to be higher amongst homeless people than the general population (*for example*, Bines 1994) and most researchers direct attention towards establishing whether mental health problems contributed to, were exacerbated by, or were created by homelessness (*cf.* Connelly and Crown 1994). As with physical health problems, some commentators argue there is a 'demonstrable link' (*for example*, SCOPH 1994) despite notable critiques to

the contrary (*cf.* Pleace and Quilgars 1997). As indicated throughout, the ubiquitous references to aspects of psychosocial malaise necessitated elicitation of what interviewees perceived the source of such feelings to be. These proved to be multifarious and as such any numerical presentation would be meaningless.

Although described sources of 'stress' and 'depression' tended to overlap in the accounts, distinct groupings can be identified. Reported sources of stress can be categorised under five headings: insecurity and uncertainty associated with the present situation; inability to 'fit in' with fellow residents; problems 'coming to terms' with past experiences; trying to resolve difficulties with family; and, worries about the future. Reported sources of depression can be summarised in seven categories: 'diagnosed depression', being treated; insecurity and uncertainty of present situation; sense of loss; loneliness; sense of stigma; dwelling on past circumstances; and fears for the future.

Indicating higher levels than comparable homeless groups (*cf.* Bines 1994), once more a possible artefact of gender, most of the interviewees reported aspects of psychosocial malaise and, although accounts could be placed in one of the categories offered above, the ways in which these were experienced was rather more composite. To be able to explain the extent to which such feelings can be related to present circumstance it is necessary to consider some vital sources of evidence. The first relates to whether interviewees felt their health had altered and, in contrast to the question posed in the introduction to this section, all were asked, after they had recounted their present health experiences, whether they considered their health to have improved or worsened whilst in their present accommodation. Generally associated with material and environmental factors, twenty-three believed their physical health to have worsened, fourteen perceived 'no' or 'little' change, and four thought their physical health to have improved greatly. However, on inspection of changes in mental health such divisions are rather different: twenty-two

believed their mental health had improved, thirteen considered it had worsened, and six perceived 'little' or 'no change'.

The second area to consider relates to reported self-harming or suicide behaviour. Four interviewees recounted suicide behaviour whilst in the present accommodation, two of whom, plus another recounted recent 'cutting' episodes. Four had recalled such behaviour in the past and for similar reasons to those previously offered, these behaviours were said to have 'felt the only way out' or 'helped me cope' through 'low' periods. In contrast, others who had reported such behaviours in the past provided two inter-related reasons why they no longer felt 'the need': firstly, they had removed themselves from the circumstances which had engendered the feelings behind these practices; and secondly, they looked upon their present circumstances as a largely positive action on their part to obtaining independence and security and claimed to be 'making the most' of their new circumstances. 'Independence' and 'security', as symbolised in their conceptions of 'home', are illuminated in Chapter 7.

The third area to consider relates to those interviewees who reported changes in their 'personalities'. All thirteen who believed their mental health to have worsened reflected upon how 'quick-tempered' or 'moody' they had become and recounted behaviours which, they said, they would not have considered previously. Crying outbursts and suicide ideation, with or without a previous history, were commonly reported. Five who claimed to have been 'outgoing' in the past related how they did not wish to interact with others and tended to attribute this to feelings of 'not belonging' or reported 'threats' from fellow residents. Three reported having become more argumentative, and a further three reported physical fights with other residents. All contrasted this with anecdotes of how 'quiet' they had been previously and attributed this to combinations of 'feeling stressed out', the strains of communal living among others with whom they felt they had little in common or who 'annoyed' them,

and 'pre-menstrual tension'. All expressed concern about these changes, but felt there was little they could do to change matters presently.

Finally, whilst pregnancy and motherhood were not described as 'health problems' the expressed psychosocial strains of these status's were consistent. Whilst the two pregnant interviewees reported multiple physical health problems (*cf.* Lowry 1989; Shanks 1991) including sleep disturbances, poor dietary intake, anaemia, backache, weight-loss, hypertension, dizziness and constant fatigue, both related how their mental state worried them more than any physical problem. Both were advanced in the third trimester of pregnancy and expressed concern about the possibility of 'going into labour' whilst still in a hostel and having 'no home' for the baby thereafter. Accounts of increasing stress and bouts of depression were imparted. All, but two, of the mothers reported 'stress' and 'depression' as 'health problems' (*cf.* Conway 1988) and, over and above those categories outlined above, they related these to feelings of detachment from the wider society and not being able to take a break from daily routines. However most mothers felt the present circumstances to be 'better' than previous situations.

Concluding remarks

Immediate inspection of Table 5.2 indicates that the overall state of the interviewees' health was poor and it could be surmised that this provides 'evidence' of the detrimental effect of 'hostel-life' upon health. Additionally, initial descriptions of interviewees' health state found sixteen providing negative assessments and, later, twenty-three expressing a belief that their physical health, and thirteen their mental health had worsened. Yet, as shown these figures are not representative of the sample as a whole since the remainder reported little or no change, and even improvements in their health, despite imparting multiple health problems (*cf.* Blaxter 1990; Brannen *et al.* 1994).

As outlined, interviewees generally provided explanations for the health problems reported, and these tended to focus upon environmental or psychosocial factors which interviewees associated with their present situation, but which, in almost every instance, were inextricably linked to their overall health status, and more so the factors which, they believed, had contributed to this status. However, and as will be demonstrated in Chapter 8, unlike accounts of previous health problems, these environmental and psychosocial aspects were set in the context of their present material circumstances to a far greater extent than previously. As meaningful expressions of their social and material circumstances, this further shift in focus, and the processes behind it, warrant full investigation for this would appear to provide the key for understanding the variable, and apparently contradictory, self-assessments presented above.

Furthermore, with the exception of visits to GPs for antibiotics, bronchodilators and skin ointments or creams, use of formal medical services was found to be variable. There also appeared little association between the number, or severity of symptoms and medical consultations. Unlike homelessness studies identified in the *Introduction*, GP registration was found to be high with thirty-eight reporting current registration. Further questioning into the location of these practices, however, revealed that only nineteen were registered with practices whose catchment covered the homeless facility. Seventeen were still registered with GPs in their 'home' area and had not reported their change of address even if they had left this area some months previously. Attendance, although exerting a stated cost burden, generally was not found to be a matter of distance since interviewees reported attending these practices, often two or three bus routes away. This question of why formal health services were used for some 'health problems' and not for others is examined in Chapter 8, but the findings presented thus far would appear to offer some indication that interviewees' perceptions, firstly, of the relationship between their health and their circumstances and, secondly, of whether GPs could offer some assistance, may provide the context for either seeking or not seeking medical help. The nature

of the relationship between such perceptions, social, material, cultural and psychosocial processes, health status and health state, and agency requires to be investigated and this provides the essential framework for the remainder of this thesis. Chapter 6 will now provide the foundations for an appreciation of why such context is vital to a meaningful understanding of health as related to homelessness.

Chapter 6

Establishing the need for context, not 'causes'.

The previous chapter indicated the overwhelming extent to which interviewees related their health problems to the social and material conditions of their existence; their social being. The context for the production of such meaningful expressions must, therefore, be examined. Accordingly, this chapter addresses the fundamental question of why the interviewees became homeless as a basis for understanding how they reported the experience of 'homelessness'. Grounded in the arguments presented in Chapter 1 which are underpinned with concerns about the listing of 'causes' of homelessness, this chapter considers components of the interviewees' general preparedness for independent life in light of their family background and experience of social services care, educational attainment and initial post-school employment, the process of leaving home and their housing careers. In considering these constituents of 'youth transitions' (Banks *et al.* 1992; Jones and Wallace 1992; Coles 1995; Furlong and Cartmel 1997) the factors which contributed to the 'fractures' (Jones and Wallace 1992 Williamson 1993) are identified. These factors, however, do not stand in isolation, they are cumulative and contingent upon each other. Accordingly, it is demonstrated that these 'fractures' are products of various intersecting and interacting factors throughout the interviewees' histories which led to the outcome of 'homelessness'. Furthermore, these processes did not merely 'happen to' the interviewees and the extent to which they provided the context for purposive action is underlined. It is important to contemplate, however, that the interviewees were not only active participants in their histories, but also in the reconstruction of these through their narratives as attested to in Chapter 5 in the context of their accounts of ill-health. In providing the recounted context for their 'homelessness' they were laying the foundations for an understanding of their experience of 'homelessness' and its relationship with health.

Family background

The first component considered is family background. The family can be regarded as the foremost institution for the preparation of young people for adulthood. Rutter (1990) proposes that having a secure family home life has crucial founding elements for young people's well-being, to their support in times of anxiety and stress, and to their future relationships. As will be shown in Chapter 7 this term 'secure' was accorded primacy in the interviewees' definitions of 'home' and this section provides an understanding of why the notions imbued by this term were so omnipresent. Supporting data derived from the interviews with professionals in the field and participant-observation, elements of insecurity or instability of parental relationships, of youth-parent relationships, of economic circumstances, of residence and residential area, and of the person, emotionally and physically peppered the histories recounted.

Table 6.1. Type of family background.

FAMILY TYPE	NUMBER
Lone mother -no contact with father	13
Mother and father	11
Lone mother - contact with father	5
Mother and partner - no contact with father	4
Mother and partner - contact with father	2
Lone mother - father dead	1
Lone father - mother dead	1
Lone father - contact with mother	1
Lone father - no contact with mother	1
Father and partner - no contact with mother	1
No support from either parent	1
N = 41	

Almost all interviewees spoke freely about their family background. The most common type of family arrangement in which the interviewees had been raised was that of a lone mother as head of household with no paternal contact, and as shown in Table 6.1 this applied to around one-third of the sample, a figure corresponding to the overall Scottish level (Wainwright 1996). When taking all

of the varieties of 'lone mother' household into account it was found that just under half of the sample had been reared in this family form, compared with just over a quarter in what is taken as a 'traditional' two-parent family. These categories, however, had not been completely static throughout the interviewees' childhood and adolescence and relate only to that which 'best describes' their families in these years.

Reported experiences of family disruption lend support to findings from other research with homeless young people and women (Jones 1993; Stockley and Bishop 1993; Tomas and Dittmar 1995; Downing-Orr 1996). Whichever family form they were reared in, a notable commonality was found in most cases where the interviewees illustrated accounts of family life with anecdotes of the state of flux of parental relationships and the way in which they had felt obliged to comply with each new situation:

> Ma dad is violent whenever he drinks. So he was battering my ma. I've watched it all my life. Me and my ma moved oot, we got a flat of our own for two weeks, she told me everything would be fine, we would have our own wee place, she wasnae going back to him this time. But I knew she would and one night she left me sitting in the flat and I phoned up my da and says to my sister (who answered) "Where's my ma?", cause I was worried about her, told her to get a haud a her and my sister says "She's in bed wi' your da". After everything he put us through! And he still drinks and he still hits her. (Interview 16)

As illustrated here the interviewees often included remarks which implied a form of role-reversal, that is they would present themselves as the 'responsible' individual within the parent-child relationships and this, as shown later, weighs heavily in the many of the factors offered for their homelessness and in their aspirations, presented in Chapter 7. Moreover, interviewees tended to provide justificatory contexts and, in almost every occasion alcohol tended to be cited as the root of domestic turmoil or violence (*cf.* Downing-Orr 1996), and where this could not be imputed, explanations encompassed some kind of pathological weakness:

> Like half of my family have been in jail, my dad's one of the hardest men in (named area). He liked to hit, he sure liked to hit, he's a very brutal man. He used to batter my maw something terrible when he got out of the jail, he's a sick man, a very sick man indeed. (Interview 40)

Since the domestic relations within which many of the interviewees were reared were not fixed, paying attention to issues of parental income and status would be hollow inasmuch as financial resources were reported to have changed according to several factors: the father being absent for any length of time; mothers finding new partners, or fathers returning; relatives providing support to the family income; whether parent(s) could work because of health problems; periods of parental employment and unemployment; or, whether, if at all, mothers could work because of child-care responsibilities, being the most commonly expressed variables. Nevertheless, the extent to which financial resources were said to fluctuate can be interpreted as a measure of the precarious nature of family income levels and this was supported by accounts of arguments over money in the home (*cf.* Downing Orr 1996). This is further sustained later when looking at the factors contributing to the interviewees' homelessness. Such variability means that more tangible dimensions must be used and on the basis of work on characteristics of locality (Banks *et al.* 1992) and locality and health (*cf.* Platt *et al.* 1993) it is appropriate to consider the areas in which the interviewees spent all, or the greatest part of their formative years. Here housing tenure is necessarily considered as an accepted measure of socio-economic status in health research (*cf.* Blaxter 1990; Arber 1991; Rahkonen et al. 1995). For reasons of confidentiality these areas are not identified.

Most interviewees reported coming from Glasgow: nineteen from peripheral social housing estates; twelve from other social housing areas within the city; five from social housing in 'satellite towns', that is towns linked to Glasgow yet traditionally distinct; and, two from owner-occupied areas within the city. A further three came from outwith Glasgow and said they had been reared in

'council' housing in their 'home' towns. Two of those latter interviewees reported coming to Glasgow because their own towns had lacked facilities for homeless people and recounted their ability to secure their present accommodation by virtue of employment. Although very few explicitly described the areas in which they grew up as 'poor', almost two-thirds emphasised negative aspects of these estates in terms of lack of job opportunities and high unemployment, and 'bad reputation' arising from crime, drugs or violence. Moreover, problems with their family and dislike of this area were presented as inextricably linked:

> Well compared to the area I come from, (named housing estate), that's really bad, really, really bad. I want away from aw that and to escape from my mum and aw as well. I want away from aw that. I'm not wanting that, I've had enough of that. (Interview 14)

> I'm frae (named peripheral estate). It's worser than here (laughs). Aye. You don't even want to know (said area). Full o' junkies and everything man! That's how I don't get on wi' my ma and that, been arguing wi' her. I'm glad I've moved away and that, still go up and see her a couple o' times, but it's terrible up there so it is. (Interview 20)

The high number of accounts which employed this concept of 'escape' is fundamental to understanding issues of well-being, considered in subsequent chapters. Although, as shown in the earlier extract, there were reports of short moves out of the family home when parents had 'fallen out'. A notable exemplar of family disruption was found in the accounts of four who had already experienced statutory homelessness when their mothers' own relationships with husbands or cohabiting partners had broken down. This previous homeless experience tended to provide a 'normative' context for accounts of interviewees own presentation as homeless. This was most apparent, in the reply to what one interviewee appeared to consider a rather absurd question regarding how she knew to go to the Hamish Allen Centre, where it was only in the response that the previous history of homelessness emerged:

> *Everyone* knows where to go! Well, I knew cause I was there with my mother when she got put out by (partner). I just knew that's where homeless people go cause I was there with my mother when she was made homeless and now I was homeless so I went. (Interview 33).

The apparent desire to neutralise accounts of their experiences of the family background, and to present themselves in a light of 'reflective maturity' was particularly noticeable among the teenage interviewees who were found to speak of their mothers' youthfulness. This was posited as a key factor in placing strains upon mother-daughter relationships, although most emphasised how their mothers had 'done her best' in the circumstances. In this manner interviewees were providing justificatory contexts for their mothers' actions and this was to have important implications for their own sense of well-being and future aspirations, as examined in Chapter 7. Moreover, interviewees were also helping to explain the extent to which they felt, because they were 'girls', mothers had tried to exert control (*cf.* Brannen *et al.* 1994) over their behaviour so as to prevent history from repeating itself. This facilitates understanding many of the 'reasons' for their homelessness, and how interviewees felt about 'being homeless'. In offering such explanations the interviewees were underlining their own determination to have a different life from their mothers and this is expanded in Chapter 7. This mix of 'reasoning' highlights the complexity of emotions involved in recounting such relationships:

> Like he's left, she's tried to cope, hard enough to cope wi' six weans, cause that's how many she's got. So like all o' them are younger, so it's like dead hard trying to cope wi' them and aw that. And like she just sits and argues wi' everyone, like she says, it's like she doesnae want us to go through what she's went through. On top o' it she doesnae want us to fall pregnant when we're young and aw that. Like, but I keep telling her 'I'm stupid, but I'm not that stupid! I know what I'm daeing and aw that!" But she's scared in case I fall pregnant, know like at this stage, and she's like that "Oh you've got your whole life ahead of you" and I'm like that "Oh shut up! I'm no' gonnae fall pregnant", but she's like that "How do you know?". So we just sit and argue. (Interview 20)

> I don't want to be like my ma, she always says like "It's your fault I never got a life" and aw that, that's what she says. Like she was only seventeen when she had me and so I suppose it's all right for her to be like that with me cause she didnae want a wean, she was too young. I think that's why maybe she went mad cause she couldnae get out of the house cause she had a wean. I think she wanted to get rid o' me, like an abortion. (Interview 9)

Such accounts of their mothers provided a useful insight into the types of expressed conflicts in the majority of mother-daughter relationships, although, as demonstrated later, whilst mothers' actions were implicated in their homelessness there was a expressed desire not to attribute blame. These actions were contextualised, almost passively as products of circumstances over which their mothers were regarded as having had little control. Moreover, as expressed in the latter extract, a further five interviewees recounted how their mothers had stressed they had desired termination or adoption as a solution to their 'unwanted' pregnancies (*cf.* Downing-Orr 1996), of which the interviewees were the product, but had been prevented from doing so because of 'family pressures'; the notion of 'having to get married' was mentioned. Whilst this too was presented as a justificatory context for both mothers' actions, and to emphasise their own determination not to have a similar 'fate', such detachment was found to be difficult to sustain in the interviewees' accounts of how this knowledge had affected them. As with other points in the interviews, when questioned on their feelings regarding specific events or circumstances, interviewees tended to become more pensive:

> That's always stuck in my heid know? "Does she love me? Does she no' love me?" I think that's my main problem and it's always at the back of my mind "Does she love me? Does she love me? Did she ever love me?" I don't know. (Interview 14)

The recounted consequences of such expressed feelings of 'rejection' were illustrated in aspects of psychosocial malaise reported in Chapter 5. Further insight into family backgrounds will be gleaned later when exploring the factors behind leaving home, but 'the family' was not the only site for

childhood and adolescent experiences. Nine interviewees recounted their experiences of social services care. In percentage terms this compares with other findings (Randall 1989; Anderson *et al.* 1993), although this is said with caution given the small sample size.

The length of reported time those interviewees reported having been in care ranged from a brief six week 'detention order' for problems associated with drug use to twelve years. Amongst the reasons interviewees offered for their admittance to care were physical abuse, 'neglect', and sexual abuse. These reasons were contextualised by reference to parental alcohol or drug use, mental illness or a host of examples of malfeasance. Correspondingly, in light of similar histories, two interviewees related how, when teenagers, *they* had requested to be placed in care and both accentuated the 'shock' at the ease at which their parents had complied.

The extent to which those interviewees employed such 'official' terms as 'neglect'- which encompassed a general lack of care and support to being locked in a room for several days at a time without food or access to a toilet - when yielding their histories suggested that they were accustomed to presenting themselves as 'cases'. Moreover, such formal detachment also appeared to serve to neutralise the effects of recalling such events. As earlier, this tone altered significantly when they were asked how they had felt about their time in care. Such recollections were clearly divided, either it was portrayed as having been a highly positive experience, in terms of 'people caring', or the experience was depicted in a negative light by outlining specific situations, especially the uncertainty produced by frequent moves, 'having to fit in with' other 'problem' youngsters and 'trying to cope' with the experiences which had brought them into care. Such opposing experiential narratives are typically expressed here:

> Oh aye, see being in care, the best years of my life. I'm no kidding you on, it was. I felt so happy, I felt so safe, I felt secure, eh, I felt I

> was getting loved for the first time. I got hugs, do you know what I mean? My ma would never gie you a hug or a kiss good-bye or anything like that, but the staff there would gie you a hug. When I got my first hug I felt so good, I thought "It's brilliant!" (Interview 35)

> Loads o' problems, like lassies fighting and aw that, and like punch-ups, like pure, see when I went in there I was dead quiet and, like, I never smoked or anything, but I started smoking and drinking and aw that, staying out all night and running away and aw that. I kept trying to kill myself aw the time. Felt I'd lost my childhood, didn't have a childhood cause anything I wanted I had to get for myself, had to look after me. Like a staff tried to touch me up and aw that in the children's home and I got moved into another home. I was just fourteen, he was trying to get off with me and trying to touch me up and that. I ran away then they put me in another home (Interview 13)

On leaving care three reported unsuccessful returns to the parental home, four had been placed in supported accommodation, and only one said that she had remained in care until the age of eighteen. All spoke of having been provided social work support on discharge, but either before or at the age of eighteen such support, after reported tapering down, had been withdrawn, or as stated 'case closed'. Regardless of whether they recalled these experiences of care in a positive or negative light, as expressed in this latter extract, those interviewees who had experienced care all mentioned or alluded to the prerequisite of 'self-reliance'. As a necessary corollary of this, all of the interviewees were asked if they had felt equipped for life on discharge (*cf.* Watson 1988; Garnett 1992), and in various ways all expressed a belief that they had been unprepared for life on their own, yet emphasised that they would not have accepted this at the time:

> I was left by myself at eighteen, left tae dae it for myself. I hadnae had a hoose of my ane. I was getting rent letters saying I was getting evicted, I just didnae know what tae dae. I was just shoved into this house "Here's you're hoose. Bye bye have a nice life". And then I was stuck in this hoose, I was like getting letters for rent, for the light, all demanding hundreds of pounds back money, but I didnae know how to go aboot paying it, I think that's what gie me the push into hospital. If they'd (social services) hung aboot I wouldnae be here, if they'd hung aboot I'da been able to get my stuff sorted oot, but it wasnae explained. Like if they'd said "This is how you budget your

> money", but they just put me away sorta "Beat it". I was scared, I was fucking terrified, but at the same time my pride got in the way, I wouldnae want anyone to know I couldnae cope, I always made oot "I'm all right". I was big headed enough to think I could dae it, but I couldnae. I tried and failed. (Interview 35)

This section has provided strong evidence to suggest that the idiosyncratic family background was one of flux, insecurity and risk, in psychosocial, physical and material terms. The recounted health problems which interviewees associated with these features were presented in Chapter 5. As indicated in the extract above, having been denied the crucial founding elements of a secure home life (*cf.* Rutter 1990), these backgrounds were found to exert a strong negative influence upon the founding elements of the other main transitions. The first of these to consider is that of educational attainment.

Education

The constituents of the second transition, that of home to employment are explored in this section, and as outlined in Chapter 1 the foundations for a successful transition generally lie in educational attainment, but, as indicated elsewhere (*cf.* Zimiles and Lee 1991; Banks *et al.* 1992; Roberts 1992; Jones 1993; Coles 1995; Furlong and Cartmel 1997) circumstances were said to have constrained or limited potential. Two of the interviewees reported having left school prior to the statutory school-leaving age as result of having run away from care or through expulsion. Whilst eight said they had remained on at school to the age of seventeen years, either to sit SCE Higher grades or to retake Standard grades, thirty-one reported having left at the age of sixteen. One of the interviewees reported being sufficiently qualified for university entrance and a further two reported having obtained between one and three Higher grades. Seventeen stated they had obtained between one and seven SCE Standard grades, and the remaining twenty-one reported they had left school without any qualifications.

Given the small nature of the sample it would be erroneous to draw any conclusions about the effect of care on schooling, although the stated qualifications obtained would appear to suggest that those who had been in care had marginally fewer qualifications (*cf.* Garnett 1992; AAC 1996) than the sample as a whole. Only three had obtained Standard grades and six had none. What is important is to acknowledge that those interviewees believed that being in care had affected their performance:

> When Ah went inti the children's home Ah wisnae really bothering much wi' schoolwork. It wisnae an outside school, so sometimes Ah wisnae bothering wi' it. I never really done much, but Ah sat my Standard grades and I passed them, but Ah would have liked to have achieved more (sighs). But you always say that once you're through wi' it don't you? (Interview 10)

This interviewee, as with most others who had experienced care spoke of a combination of factors which they believed had contributed to their performance at school and these fall into three inter-related groupings: the effects of, and problems associated with why they had been brought into care; the effects of care itself in terms of being placed in a home with other youngsters with 'emotional problems' or 'behavioural difficulties'; and moves to other homes or periodic returns to parent(s). However, those who had a background in care were not alone in offering reasons for their performance at school and a sense of lost opportunity pervaded most recollections which mostly encompassed why interviewees felt they had been unable to apply themselves, or felt they had been denied the opportunity to stay on at school. The lack of family support was the most common difficulty cited (*cf.* Dornbusch *et al.* 1985; Stockley and Bishop 1993) and those interviewees who mentioned this expressed frustration that they had not been given the encouragement they had hoped for, though some justified this by explaining their parent(s)' own lack of aptitude:

> I was at high school and I'd got the top mark in maths out of my whole year, right, and I thought "This is amazing!" So I ran all the way out of school and I came in and I says, I told my mum and she

> says "That's good" and went on talking to my sister. I went "Right, okay, fine", went away into my room and sat on my own and just gret. (Interview 37).
>
> See like my mother, there's something wrang wi' her. She cannae read, she cannae write, she's, like a bit stupid. But she's no' stupid when she knocks the hell out o' you! (Interview 20)

Other factors which reportedly prevented educational aspirations to be met related to family commitments or distractions, low parental ambitions for their children, becoming homeless and health problems:

> I left school at seventeen. I did want to stay at school till I was eighteen, but what happened, my mum took no' well and I had to take my sister up to school and everything, I done the messages, done the house cleaning. I wanted to go to college, but my mum was like that "You don't need to bother going to college, you can go and get a full-time job". She wanted me to do aw the work, like factory work or something, but I didnae want to do that. I wanted to go to college and make something of myself, do you know what I mean? But "No" she says "No, you're no' going to college, that's a loada crap. Just go oot there and get a full-time job!" I don't know, I felt like going like that to her "Come on Mum give me some encouragement here. Push me Mum!" (Interview 15)
>
> I stayed wi' some o' my pals til I was seventeen. Taken my Highers, but I failed them cause I was trying to do my schoolwork when I was staying in different houses here, there and everywhere. Just couldn't study right, so it was hard. I was sitting my exams and my mind was somewhere else, know what I mean? "How am I going to get my clothes out of this house?" and "Where am I gonnae stay this week?" It was killing me really. (Interview 17)
>
> I actually collapsed at school, walking into an exam. There wasn't enough time to get an emergency tutor during the week of my exams, so I didn't get to sit. But I suppose I'll go back to school, take night classes and get my exams sometime at a later date. (Interview 1)

The sentiments expressed in this latter extract summarise the aspirations of those who felt they had 'lost out' when at school and who expressed a desire to return to complete their education when settled. For a few, however, who tended to be characterised by having no formal qualifications, recollections of

school were unfavourable inasmuch as it was said to have been difficult to apply themselves because of conflict within the parental home (*cf.* Kurdeck and Sinclair 1988), or they had truanted (*cf.* Jones 1993; Stockley and Bishop 1993), either because they could not cope with the work, or because of lifestyles associated with alcohol or drug use.

> Every time he (mother's partner) was in the hoose I was in the hoose in a bad mood because he was there. It was cause o' him I left school, I didnae enjoy the school. Went to my head teacher and she got me a social worker to see what was up wi' me. Aye, cause he was drunk one night, and then he got up, he just grabbed me and hit me and I ran oot the hoose screaming. And I says to my ma I wasnae coming back cause he was there, but I ended going back and he was still there. I went to my bed and next day I went to school and told the head teacher at school and she went and got me a social worker. But he was still, he was still staying there. He used to hit my ma and aw, a lot o' the time, cause he used to drink a lot o' the time and he used to hit my ma, but then it stopped. Then it aw just started up again and we just had to put up wi' him. The work, just felt I couldnae dae it and I tellt my guidance teacher and I don't know, she sent a letter away to somebody and they sent me a letter. I was to go see somebody, but it said at the bottom "Psychiatrist" and I didnae want to go and see a psychiatrist, so I never went. So the next day I went into school, cause I told my teacher I couldnae do the work, I didnae know how to do it. It was just after that I stopped going to school. (Interview 19)

> I was aff school aw the time cause o' the drugs. I stayed in this house with this other guy who wanted sex and everything. That was until I was sixteen and a half. I was aff school aw the time then wi' taking the heroin. (Interview 18)

With the exception of those who cited drug use, considered in Chapter 5, most interviewees implicated their 'home' life in the educational outcomes reported, yet these were recounted as but another element within larger chronological narratives. Whilst domestic background and educational attainment were inextricably linked as factors which exerted influences upon employment opportunities, lack of employment opportunities were reported to place further strains upon domestic relationships.

Initial post-school employment

All of the interviewees had left school and Table 6.2, over, shows their immediate post-school employment status.

Table 6.2. Immediate post-school employment status

STATUS	NUMBER
Unemployed	18
Employed - 'genuine' work	9
Employed - Youth Training/ Skillseekers	10
College	2
Full-time caring for relatives	2
N = 41	

The most compelling evidence presented for the financial difficulties experienced by some interviewees' families can be surmised from half of those reporting unemployment recounting they had been awarded Severe Hardship Payments (*cf.* Evans 1996), as explained in Chapter 1. Attending regular interviews and completing forms was described as 'a hassle' by the majority and some stated they had been 'made' to feel 'like scroungers'. Parents were said to have provided the main incentive to continue claiming:

> I was getting Hardship, but I was only getting fifty-five a fortnight, but that only lasts for about eight weeks then you have to keep going back and reclaiming and going to aw these appointments and aw that. So like I missed a few appointments, so that means my money was stopped for ages and I didn't have any money. And that was me and mum arguing, really it was just, really brain damage to be quite honest with you! (Interview 25)

For those who reported having entered employment or having been allocated a place on a Youth Training scheme complaints about low income levels were commonplace, and three interviewees reported having had more than one job for this reason. Although most stated that work had been 'all right', as experiences were recounted strong expressions of having felt undervalued (*cf.* Spafford 1991; Courtnay and McAleese 1993) emerged:

> I left that one at (named area) because it was slave labour. I was working from ten in the morning to seven at night for twelve pound a

> day. We were allowed a fifteen minute break during the day and that was the only break you got to sit down and have something to eat and have a smoke, we weren't allowed to sit down at all. Even if they were quiet, even if there were no customers we weren't allowed to sit down and have a cigarette. And I used to walk out at night in absolute agony. (Interview 12).

Among those who had entered Youth Training or Skillseekers inconsistency of experience and lack of support were two additional grievances:

> As soon as I left school I went into a training scheme, computing and aw that. When I left training they put me into a shoe shop, then into a lawyers, then I was moved out of the lawyers into another shop. (Interview 20)

> I started in the beginning of January and left in the middle of February. Just felt I was getting used aw the way through it. I didnae feel I was getting the right treatment, but I didnae know I could, cause it was a Skillseekers. I didnae know they could help me and maybe get me another job, put me in another project. But I didnae know that. (Interview 19)

This latter extract offers an insight into the matter of 'expectations' for, by suggesting that because she was on a Skillseeker scheme, this interviewee had believed that her status did not accord her the same rights as other workers. This is a significant point and, in a variety of contexts is one which permeates many of the narratives and is considered in Chapter 8. When considering the types of training placement or employment undertaken a strong consistency of gender-specific experiences (*cf.* Ashton *et al.* 1990; Courtnay and McAleese 1993; Coles 1995) emerged in that these had been characterised by low status, low pay and often unsociable hours associated with the 'female-type' occupations of care work, catering, cleaning, factory work, hairdressing, junior office and shop work.

Despite stated grievances, over half of those who had held 'genuine' jobs on leaving school recalled their work fondly. Significantly, these were jobs in which careers could have been made had they been able to accumulate experience, additional training or job-related qualifications. However, family

commitments, or the effects of becoming homeless (Randall 1988; Thornton 1990; Hutson and Liddiard 1994; Evans 1996) were said to have marred career plans:

> I used to work in (named) hotel as an underchef. I worked there for a year, then I moved to (named) hotel because I wanted to be something in the catering business, but it fell through wi' looking after my grandda. (Interview 14)

> I got landed in here, it was too much travelling for me and that. I was always late. I was never late where I worked, I was always willing to work overtime and everything. So I ended up having to give it up, but if I wasnae in the hostel I would be out working. (Interview 15)

The interaction between unemployment and homelessness was a major stated concern for most of the interviewees and is returned to in Chapter 7. For those who reported having lost their jobs as a result of becoming homeless, interviewees emphasised how 'easily' this had happened:

> I had a good job and everything. But my da broke my arm and I phoned my boss and I told him "Listen I've been made homeless" and I explained my situation. I says I wouldn't be able to come into my job, cause I'm right-handed, and he broke my right arm. "Sorry!" and I got the sack. My benefit was cut for six month in here, I had to live on forty pound a fortnight. But it wasn't right cause I didn't leave my job, I just couldn't go in and work. (Interview 16)

This interviewee further explained how on being unemployed with good Highers she sought to pursue her ambition:

> I always wanted to be a nurse, always, and when I came here I applied for a course. Word came back "You've got the qualifications, but your address is unsuitable". They didn't want me because I'd mentioned that I lived in a hostel. It's hard cause when I leave here I want to get a job, and they'll say to me "What have you been doing for the past year and a half?", whatever, and I'll tell them I was in a hostel. I don't think they'll want to know cause I've phoned for jobs from I've been in here, as soon as you mention the place they're like that "No!" (Interview 16)

As underlined in these latter extracts, the data presented thus far are eroding any assumptions of homelessness arising from single, readily identifiable 'reasons' which are open to the researcher. The cumulative and contingent nature of the process of alienation from the family is superimposed by the stratified and exclusionary operation of the socio-economic system for which, by virtue of their limited educational qualifications, most interviewees were ill-prepared, and, by virtue of their gender, interviewees were ill-placed materially. This, in turn, placed additional strains on already precarious domestic relationships and circumstances. Within this process, gender is emerging as a significant issue in terms of socialised expectations and experiences within the home and, thereafter, in the employment opportunities available to those able to secure work. Given the complexity of these inter-connections, therefore, it is erroneous to look for 'causes' of homelessness. Instead attention should focus upon the process of leaving home.

The process of leaving home

In order to understand preparedness for the process of leaving home it was initially necessary to discover the age at which the interviewees left the parental home, or 'surrogate home' for independent living. Although these ages ranged from eleven to twenty-three years, the significant age, for over half of the sample, was sixteen. Four reported having left home prior to this age and thirteen from the age of seventeen onwards. Twenty-four recounted having left at the age of sixteen which is at least four years earlier than the average age at which young women tend to leave home (Jones 1987, 1993; Jones and Wallace 1992; Ermisch *et al.* 1995). Supporting findings from a recent study (*cf.* Smith *et al.* 1998) those latter interviewees emphasised the importance of this age and typical explanations focused upon having attained the age of majority. This was an ever-present factor in almost all of the accounts of those who had left the parental home at this age and the over-riding focus was upon the sense of empowerment this new legal status had produced. However, as implied in the

second extract below this age was also said to have been important to several of the interviewees' parents, a point returned to shortly:

> I waited til my birthday on the Sunday and moved out on the Wednesday, Thursday actually. I just thought "I have to make the break and get it over and done with" And I did do it! (Laughs) It was actually, it was the fact I was sixteen, I could go out and do it. And I didn't have any feelings, really low, nothing. I could go out and do it, it had to be done. (Interview 1)

> Well Ah was planning it frae (thinks), no planning it, but like since Ah wis a wee lassie about nine, but I could only go into homes and that. Once Ah turned sixteen they always threatened to throw me out and Ah'd be like that "Right, fair enough, gie her a fright". But it took me a lot of courage ti dae it and it's the best step Ah've ever taken, so it is. Best step! (Interview 7)

Although four reported having become homeless prior to the age of sixteen, eleven others, including those who had reported negative experiences arising from social services care, recounted episodes of 'running away' for periods ranging from single days to weeks and this is consistent with other research findings (O'Connor 1988; Hutson and Liddiard 1991). In most cases odd nights had been spent with 'pals'. Two-thirds recalled 'sleeping up closes' in their local area, and three had slept rough in the city centre. In many of these accounts, however, there was an explicit or implicit acknowledgement of the futility of such endeavours and, as outlined in the latter extract above, almost half claimed to have learned from these experiences in terms of the need for planning (*cf.* Jones 1994) for a final move:

> I was about fourteen, I used to run away all the time. I'd sleep rough, then it was the city centre, things like that. But I started wisening up to myself "What am I daeing this for, its cold?" and all the time I'd got a bed at home, know? So I stopped that, then at sixteen that was it, just had to get out of the place. (Interview 14)

Accordingly those who became 'homeless' prior to the age of sixteen may be regarded as the most 'successful' of the 'runaways' in that they would or could not return home. Although three felt that they had 'chosen' to leave home at the

time, the interviewee who had been in care retold the outcome of her 'decision':

> I left the care of the children's home, but I didnae leave the care of the social work, I was still under their care until I was eighteen. I was under the care of a Section 16 , so I was in care voluntarily. On the day I got out of care, that was the day I just said to the social worker "I'm only here on a Section 16" and it wasnae the right environment for me, so I just says "Get me oota here!" and they took me down there. It was quite shocking, they put me into (named voluntary housing association). It was, whooh, like the Amityville, it was full of people with problems basically, it was full of junkies. You couldn't trust any of them. You had no space to yourself cause you'd to share a room. It really, really wasn't the place, at fifteen, being put in there. It was shocking, it really, really was a bad environment to be put in. (Interview 40)

The theme of inappropriate placement for need was one which peppered interviewees' accounts and they associated this with a lack of familial (Jones 1994) or other support (Garnett 1992) at specific crisis points in their histories, although, as stated earlier most believed it was only now with the benefit of hindsight that they were able to recognise this. This interviewee who had been in and out of homelessness for almost ten years succinctly reinforced this point:

> If somebody had just stopped me and says "What d'you really need?", cause I wouldnae have asked, but no. So I've been in and out of housing since I was eleven, staying with ma pals, in and out of many hostels from eleven upwards to about twenty (names every hostel, supported project, and bed and breakfast) in just about every hostel there is and noo I'm back in the hostels again after getting ma hoose and I didnae want to get back into the hostels. (Interview 9)

As suggested here, the inability to maintain tenancies when secured emerged as a strong factor in some interviewees' accounts of their re-entry into homelessness and this is discussed shortly. Before considering the various pathways through which the interviewees' negotiated their housing 'careers' it is necessary to identify why they had left home in the first instance. The first notable feature to present is that the more 'usual' reasons for leaving home for the purpose of further education or employment (Jones 1993), had no bearing

in any of the histories. Only one had left home at point of marriage. Secondly, the question 'why did you leave home?' produced an almost unanimous initial response; 'arguments' (*cf.* Stockley and Bishop 1993). Subsequent questioning, generally introduced in the form of: 'Was there any one thing that made up your mind to go?', however, revealed a complex picture of interacting factors, persons and events which created difficulties in understanding whether the interviewee had 'opted' to leave or had been 'pushed'. Accordingly, the following outline is presented in a manner which affords an insight into key features in the process of 'youth-parental alienation' (Downing-Orr 1996: 37). As will be shown, this process superimposes upon the contextual foundations already established.

The process of youth-parental alienation

This section provides an insight into the thematic commonalities which were said by the interviewees to render them unable or unwilling to return to live in the parental home (*cf.* Randall 1989; Nassor and Simms 1996). Ten interviewees stated that they had been 'put out', although as the extracts below demonstrate a combination of supplied factors were found to have spurred this. Nevertheless there is a need for clarity so, ordered from highest number of mentions, accounts included: parents having been unable to afford to retain the unemployed teenager or overcrowding in the family home; the interviewee had drug or alcohol problems; or, simply, the mother was said to have refused to support her daughter after her sixteenth birthday. These factors correspond with findings from other studies with young people (Liddiard and Hutson 1991; Jones 1993; Evans 1996).

> Well at first when I got kicked out of my house my mum was saying, like it was gonnae happen for ages, she was saying "I'm gonnae kick you out if you don't get a job" and aw that. "You're too lazy, get off your bum and get a job!" and everything, and I was pure arguing with her. So in the end (after Hardship payments were stopped again) I did get kicked out. (Interview 25)

> Because ma house wis overcrowded Ah wisnae getting on wi' anybody, so I couldnae stay there anymore. (Interview 6)

> Because I was always drinking, I was drinking a lot, and I was staying oot at week-ends, overnight, and my ma would always worry, call the police and that, and she just had enough. So as soon as I was sixteen she threw me oot, no for badness. (Interview 36)

These accounts later proved important for, unlike the majority of interviewees who emphasised the notion of 'escape', a few of the interviewees who claimed to have been 'pushed' continued to maintain favourable relationships with family members. As will be explained in subsequent chapters this had a direct bearing on both their health perceptions and self-conceptions. However, because of tensions associated with the build up to this final 'push' a minority of those who reported having been 'pushed' also underlined the benefits of 'escape' from members of their family or their neighbourhood.

A novel and gendered finding contributing to the process of 'youth-parental alienation' was located in accounts of interviewees' domestic responsibilities. In seven cases this was presented as the main factor why they felt they could no longer stay within the family home. Characteristically, all had been the eldest female child in the family and related how they had been required to look after their siblings, parent(s), or grand-parent whilst still at school, and thereafter on a full-time basis or when working. Although this domestic responsibility factor has not been identified in any homelessness literature reviewed the subject of 'domestic work' has been explored elsewhere (Banks *et al.* 1992). This study demonstrates the intersection of class and gender differences in the amount, and expectations by parents, of work done with working class young women doing more, and having less choice in what households tasks were performed than any other grouping. Levels of household tasks are also shown to have strong health associations for young women (*cf.* Sweeting and West 1995). This was found to be particularly germane in the reported health outcomes of those who emphasised the psychosocial and physical strains of looking after

'alcoholic' parents, especially stresses surrounding fear of alcohol-induced violence (*cf.* Downing-Orr 1996).

All interviewees recounted the pressures involved in looking after their relatives, focusing upon the consequential 'exhaustion' and lack of personal time which they believed had impacted on schoolwork, impinged upon job opportunities, and limited social life. The majority, who reported having complete responsibility for their siblings provided explanations for this which incorporated feelings of pity for the mother, especially the state of her mental health arising from her social and material circumstances. Such considerations provided the context for narratives which revealed a complex mix of sentiments concerning their experiences, as typified here:

> I'm quite angry about it. I always wanted to go to college, finish my education and that. There are loads of things I know I could be doing. I wanted to study law, but I never got the chance to do it, never even got the chance to do something that was close to it. I'm happy in my job, but it's only a job, it's not a career for life, not what I want to do. My mum was okay, she may not have been the best, but she did the best she could, if you know what I mean. She was just not meant to be a mother, she didn't bother too much. She could have done better for herself, like done more with her life. And then, in another way, aye, too much pressure and that, but it's good in a way, helped me to grow up, opened my eyes, you know looking after my wee sister, what's involved, all the wee things. (Interview 23)

Among those who insisted they had left because of arguments (*cf.* Jones 1993(3)) it emerged that these had tended to revolve around the more 'usual' disagreements which characterise teenage years (*cf.* Smetana *et al.* 1991) and those most frequently cited were associated with boyfriends, staying out later than agreed, the friends associated with and drinking or drug use. In all but one of the six cases these were set against a background of difficult economic circumstances and reported long-standing tensions which made such arguments difficult to resolve. These tensions included: mothers' problems in handling her daughter's good relationship with a father or former partner; parents' mental or

physical illness which was said to have produced fluctuating moods; and, in the exceptional case, this interviewee claimed she could no longer accept the 'pressures' placed upon her by divorced professional parents and who felt she had 'too much to live up to'. The account offered by one interviewee, whose parents had both been unemployed for several years, illustrates the multiplicity of factors behind such descriptions of 'arguments' as 'the reason' for leaving home:

> Well me and my mum were always arguing and my dad was always shouting at me because her blood pressure was going up, like she's asthmatic, so because of that I had to leave. When she's angry she can be very vicious to me, that's the only thing I've really got against her, that and slagging my boyfriend. She's got worse, I suppose I maybe deserve it, aw the hassle I gave her, but my da, well he's never really hit me hard, most of my brothers got hit harder. It made me dead depressed. I had arguments with my mum; I was the biggest trouble, I was the biggest mistake she's ever made. See I was an accident and my mum and dad had to get married, and I wasn't meant to be and she keeps bringing that up, so (pause), I'm okay now, I forgive her for what she says. (Interview 26)

The matter-of-fact way in which this interviewee alluded to, and later reinforced, the level of violence (*cf.* Killeen 1988; Thornton 1990; Jones 1993 (1); Stockley and Bishop 1993) within the home helps to introduce why, although mentioned in a total of ten cases *excluding* the accounts of those who had been in care, only five provided this as a principal 'reason' for leaving home. From all the accounts it emerged that, unless a specific incident of violence had provided the context for leaving, it was not regarded as a factor in their departure:

> I heard them fighting in the room, I was used tae it. But it all went quiet and I went into the room and she was just lying there and he had his hands round her neck trying to strangle her and I went into the kitchen and got a knife and said "Let her go" and he let her go. I didn't stab him, just pushed it in a bit, but he hammered me (Interview 33)

As found elsewhere (Downing-Orr 1996) alcohol was the given precursor to the violence. Such violence was said to have been perpetrated by fathers or the mother's partner. Characteristically, all spoke of the mother being the initial subject of such attacks, but eventually the interviewees had been targeted, as they said, very often when they had tried to intervene to protect the mother. Once more, excluding those who had been in 'care', in a further two cases sexual abuse was also referred to (*cf.* Hendessi 1992; Stockley and Bishop 1993).

The final group of factors relate to problems associated with a parent's new cohabiting partner and appears to be consistent with works indicating that youngsters living in families with a 'step-parent' tend to leave home at an earlier age (*cf.* Kiernan 1992; Jones 1993 (1), 1994). These new partners were said to have been at the root of the difficulties with family relations. This was reported to have started, for example, when the partner had tried to adopt the dominant, and often disciplinary, role within the household, or their remarks and behaviour had been becoming increasingly problematic. The ensuing tensions and arguments were said to have created increasing parent-child friction which resulted in the interviewees reporting that they felt they had no option but to leave:

> It was getting to the stage that I thought I was going to snap, it was as if I was going to explode. She'd bring me right up to the stage where I couldnae turn back, it was pure mental abuse. I *had* to leave. (Interview 17)

This section has provided an insight into factors which were reported to have contributed to the interviewees' departure from the parental home. Whilst continuing to underline the argument that single 'reasons' alone do not explain why individuals left home, it has been shown that distinct commonalities existed in the accounts. In many cases these commonalities continued to be founded in gendered expectations or experiences arising from the exercise of male power within the household. These commonalities, however, do not

explain why the interviewees became and remained homeless, but they do provide the means of understanding why interviewees focused upon aspects of psychosocial malaise prior to their 'homelessness'. However, without an acknowledgement of the interviewees' lack of preparedness for independent life, rooted in their earlier experiences of the family and their precarious economic status, any attempt to explain 'causes' of homelessness are meaningless. This is not to fall into the victimising trap of determinism for these apparent constraints provided the context for action.

Housing careers

This section explores the constituents of the interviewees' housing 'careers' (Jones 1987, 1993 (1)&(2), 1994; Hutson and Liddiard 1994). Hutson and Liddiard record that most of the literature on homelessness among young people 'implies that the experience' is 'wholly negative and progressively problematic' (*Ibid.*: 124), yet very few of the interviewees presented their histories in such a manner. Instead these were related as a progression of strategies employed, either because the preceding one had 'failed' or because a new opportunity had presented itself. The use of the term 'career', therefore, implies that the interviewees did not experience this process passively, but were cognisant and goal-directed agents whose choices and decisions effected subsequent outcomes.

Residential instability is shown to constitute 'a feature of the homeless experience' (Tomas and Dittmar 1995: 500). In an attempt to identify the potential effects of such moves upon the interviewees' well-being, it was imperative to see if such 'instability' had been the case. As demonstrated above, this was a feature of some of the interviewees' experiences when younger. It was also necessary to identify to what extent this was characteristic of their subsequent experiences. In terms of well-being this would provide the context for ascertaining how these moves had been apperceived.

Table 6.3, over, reveals the various housing situations reported by the interviewees and the extent to which such measures were utilised. These figures relate only to the situations themselves and not the number of occasions these might have been utilised as this would have produced a distorted image of the numbers.

Table 6.3. Housing situations after leaving main parental home or 'surrogate home'.

HOUSING SITUATION	NUMBER
Friends	24
Returns to main parental home	13
Own or joint tenancy	11
Supported accommodation	11
Sleeping rough	11
Hostels	9
Own tenancy	9
Wider kinship network	8
Hospital	6
Separated parent	5
Bed and breakfast accommodation	4
Siblings	3
Bedsit	2
Rehabilitation/Detoxification centre	2
Prison	2
Owner-occupied marital home	1
N = 33 (explanation below)	

Seven interviewees stated that they had moved directly out of the parental home to the Hamish Allen Centre and thence to the hostel within which they were now living, and only one of the young mothers said that she had moved straight into the present facility from the parental home. What tended to distinguish those interviewees from the others was that they had had a knowledge of these facilities and had planned their move with or without social services assistance.

Most interviewees cited more than one situation and very often interviewees could not recollect exactly how many times they had moved between friends, relatives, sleeping rough and returns home before approaching the Hamish Allen Centre. This inability to recall can be taken as a measure of the extent of moves undertaken and may help to explain why the term 'chaotic' is so

frequently employed in the literature and by professionals. Attempts to present a groupings of these situations according to a scale is impossible for homeless careers were very often not straight-forward because interviewees had reported returns to the family home, had been in cohabiting relationships, or had held their own tenancies in between episodes of homelessness. However, as might be expected, age-related differences were apparent, but this is said with extreme caution since one strategy, for example, 'staying with friends' does not account for how many friends any individual may have stayed with. The general duration and number of situations tended to be less for the sixteen and seventeen year olds than their older counterparts, with the majority of situations being no more than three with a maximum duration of around eighteen months. Amongst those aged eighteen and over, five had only employed one strategy prior to living in the present hostel, the majority had employed between two and four, and six reported multiple housing strategies. Only one of the mothers could not recall exactly how many housing situations she had been in over an eight year period.

Because of the importance of time to accounts, presented in subsequent chapters, it necessary to report that none of the 'single' sixteen and seventeen year olds had spent more than ten weeks in their present facility and this was an effect of time limitations here during which assessment for next-stage accommodation was conducted. Amongst those aged eighteen and over who were living in the 'adult' hostels there were no time limits and interviewees had been resident for longer periods of up to eighteen months. In the 'mothers' facilities there were no time limits either and the longest reported stay was around three and a half years.

The largest numbers of reported housing situations are representative of aspects of 'hidden' homelessness (Webb 1994), that is, where the interviewees stayed with friends or relatives for short periods (*cf.* Randall 1988; Jones 1993(3)). Among those who reported that they had lived with friends this was found to

have ranged from one or two to, frequently, the exhaustion of an entire network before moving on. There was one overwhelmingly expressed difficulty with this arrangement: although friends were said to have been welcoming initially, relations became strained as time progressed:

> I was staying with different pals, but it gets to the stage where you don't feel comfortable, you feel as if you don't want to make a cup of tea in case you're in the road, do you know what I mean? I felt I was getting under their feet, so it was making me dead edgy. It ended up I was staying with different pals one week, then going to other pals the next week and I ended up I had no-where, so I knew I had to get out of that. (Interview 17)

As found elsewhere (Jones 1993 (3)) thirteen recounted attempts to return to the main parental home, and this includes those who moved here from social services care. These unsuccessful returns were generally spurred by two main reasons, either a final attempt to try to re-establish a relationship with the parent(s), or because interviewees had felt there was no alternative at the time:

> It's only been two friends I've stayed with anyway. Went back to stay with my mum and we still didn't get on, so I just left home again. (Interview 6)

> I've been in and out o' the hoose since I was sixteen, naw fifteen year old, stayin' wi' ma pals, stayin' wi' ma da, other folk, aw different places, but they never worked oot. Usually I'd leave one place when something happened, then I'd move back to my ma's for a wee while and then I'd end up somewhere else. (Interview 11)

Finch and Mason (1993) identify the importance of the support offered by kinship networks to young people and this is supported here. Staying with relatives was the second most popular housing strategy reported. For those who had spent time with siblings, aunts or uncles this was said to have offered a stopgap (*cf.* Randall 1989) between leaving home and the next homeless stage and the duration of this measure tended to have been between days to a couple of weeks. Such support, however, was reportedly limited and two specific groups of problems were mentioned as key factors why they had been unable to stay for longer: relatives were said to have been reluctant to be seen to be

'taking sides', or they were reportedly receiving 'hassle' from the interviewees' parent(s) for permitting the youngster to stay. In almost every case lack of space and inability to afford to maintain the interviewees were cited:

> Moved in with my sister, she didnae really have the room, so I was sleeping on the sofa. Lost my job and she couldnae afford to keep me on the bru money, so that's when I moved. (Interview 39)

Among those who recounted experiences of having attempted to live with the parent who had not reared them only one of these moves had proved successful. In this case the interviewee remaining with her father until her marriage, the remainder of attempts having lasted for no more than a few weeks. The main difficulty stressed by those interviewees was being unable to 'fit in' with the new area, the other parent's new lifestyle or family and as a result of this they had moved on to stay with friends or other relatives.

Amongst those interviewees who reported at least one experience of supported accommodation (*cf.* Hutson and Liddiard 1991) the reasons offered for this included discharge from care, death of the supporting parent, or, by virtue of their age having been sixteen or seventeen years old at the time. Among those in this latter category all recounted how they had exhausted other housing strategies, such as staying with friends or relatives, or returning home. Feelings about this stage were mixed, though many recalled having been happy to have had 'someone to turn to' and they all stressed the extent to which they felt they had to 'prove' themselves here, through demonstrating domestic and budgeting abilities. This was also explained in terms of a stage of 'transition' and subsequent moves from here were to their own tenancies, to bed-sits, to live with partners, to the present hostel, or to the parental home.

Eleven interviewees recounted having held tenancies at some point in their housing career, either in their own right or jointly with a partner, seven of whom reported having come to this from supported accommodation, or from

bed-sits. The reasons for having to give up these tenancies revealed distinct commonalities: victimisation by local residents (*cf.* Speak *et al.* 1995), relationship breakdown (*cf.* Watson with Austerberry 1986), moving in with a partner, or inability to continue to afford to maintain the tenancy (*cf.* Jones 1993(3); Muir and Ross 1993) on separation or after becoming unemployed.

Three of those who reported having left their tenancies because of victimisation by local residents provided an insight into manifestations of territoriality within the city. Because this facilitates an understanding into the expressed fears offered by many interviewees in their later explanations of why they would not accept tenancies in certain localities it is worthwhile to consider these in closer detail. Having been housed in 'difficult-to-let' areas with which they had no local connection, those interviewees explained the isolation arising from geographical detachment from their previous social networks, which was said to have been compounded by the isolation and fear arising from their experiences of harassment, intimidation and burglary:

> It fell through, kept getting broken into. They gave me a bottom flat in (named east end estate) and I'd never been in that area before and I didnae know what it was like. It was life-threatening because they were gonnae murder me basically because they didnae like me. The people started breaking into the house, kicking in the door and aw that, breaking inti kill me if I didnae move out. It was crazy, really. I thought it was just drunks, but it was the people upstairs from me, they just didnae like my face. They said tae me, did I come frae here and I says "No" and they says "Well you shouldnae be here. Apply to the council to get you out" sorta thing. (Interview 9)

This interviewee reported abandoning her tenancy when her dog 'went missing' after threats that this would happen. In a second case, a young mother recounted burglary and harassment by a group of 'girls', reportedly armed with knives, in the local area which was said to have culminated in threats directed towards her infant. Like her counterpart above, this interviewee left the property and was reportedly informed that because she had 'given up her house voluntarily' she could only be offered bed and breakfast accommodation,

which she accepted. The final interviewee explained how she had been unable to cope with threats to 'burn her out' of her house because of her ex-boyfriend's drug debts and related how this had resulted in her admission to hospital and being advised to give up the tenancy for the sake of her mental health.

Amongst the interviewees who had lived with partners, two had been married. Seven of the relationships had produced twelve children. The general length of time with partners had been two to four years. The factors behind the failure of over half of these relationships were found to be complex, but there were strong commonalities in the accounts. The first of these was physical abuse (*cf.* Warlow and Spellacy 1985; Watson with Austerberry 1986; Charles, 1994; Tomas and Dittmar, 1995) which related to accounts of 'battering' or 'stabbing', or violent coercion into prostitution to support a husband's heroin addiction. This was closely associated with lengthy accounts of mental abuse and refers to reported incidences of being locked in the house, timing of outings, monitoring of all the interviewee's activities, and detailed accounts of progressive undermining of the interviewees' self-confidence. Such problems were attributed to partners' drug, alcohol or mental health problems which in three cases were said to have developed as a consequence of unemployment. Other reasons offered included the lifestyle associated with drug use or partners 'cheating'.

In all cases the interviewees reported losing out on the tenancies or owner-occupied house, either immediately to partners, or subsequently through recounted difficulties arising from a combination of their own psychosocial problems and financial circumstances. Those who did not have children, or whose children had been placed in social services care, reported moving in with friends or into a hostel, and one spent a few months in hospital with mental health problems. Those with children related being accommodated within the facility in which they were now living, or having come to this

project via various homeless situations, a detoxification centre, the parental home, or a bed and breakfast hotel.

One factor which emerged in the accounts of six interviewees was the extent of stated debt (*cf.* Oppenheim and Harker 1996) accrued in their housing careers. These debts amounted to hundreds of pounds for previous loans to buy furniture which had been burgled, left in properties they had since abandoned, or had been left with a partner because interviewees had no-where to store it. Four also reported owing for unpaid electricity bills and outstanding rent. These debts were being repaid at a few pounds per week and the interviewees reported having been told they would not be offered another tenancy until these debts were cleared:

> The housing just contacted me and said that I'd be here until I paid them five hundred pounds. That's for, I was given a house a couple of years ago, in this area and like I says it's a bad area and I just would not have moved into it, not with the two kids because of the area we had been in before. I just couldn't move into it, so I didn't. I didn't realise, because I took a few weeks to hand back the keys, the rent built up, but I just didn't know. (Interview 31)

Rent arrears were cited as one reason why eleven interviewees had experienced episodes of sleeping rough (*cf.* Saunders 1986; O'Mahony 1988; Hutson and Liddiard 1991; Tomas and Dittmar 1995) which ranged from days to several months at a time. Five reported having been unaware of provision, four explained that they had been 'barred' from the hostels for factors associated with their drug use or breaking hostel rules, and two said they could not cope with the hostel they had been sent to - a common sentiment expressed by those who had stayed in that particular hostel. The one commonality lay in their belief, at the time, that they had no other place to go (Jones 1993(3)). The shorter-term rough sleeping tended to be among teenagers who had slept rough in their local areas before, and in between stays with friends. To varying degrees the interviewees punctuated anecdotes of their experiences with reference to the practical strains of daily life:

> It was winter at the time, it was snowing, really, really cold and all that I had was the clothes on my back, and I didnae have a lot on either. I didnae really manage at all, it was (pauses) really, really hellish. A lot of people I knew helped me out but. A lot o' lassies that were there we used to go out during the day and shoplift things like that ti be able ti feed aw o' us. Couldnae cook anything, so it was just crisps and things you could get, fruit or whatever, things like that. Nae money jist gathered in tigether and tried ti get on wi' it. At that point in time I didnae think there was anywhere ti go, thought you were just on your own and that was it, had to fend for yourself. There was toilets down at St Vincent Street or down in Central, you can get a shower for fifty pence or something, most of us done that every day. Just managed, you had ti manage, know what I mean? You had ti look after yourself, try to tell yourself that things would be awright. (Interview 9)

Such mixed reflections of life on the street were typical, especially the expressions of camaraderie (*cf.* Downing-Orr 1996). Similar support was emphasised by those two interviewees who had spent time in prison and reported having no place to stay on discharge (*cf.* Watson 1988; Gosling 1990; Jones 1993(3)). Both reported having been heroin users who had lived in various homeless contexts and had been imprisoned on a few occasions for shoplifting, or drug offences. Episodes of prison life were recalled with some fondness and pragmatism, especially by this interviewee who had been in care continuously from the age of seven:

> I've been in and outa the jail from when I was sixteen. Feel secure in jail as well, it's really stupid that, but I dae, uhu... (When asked why)...Donno, it's a lot more caring, all the lassies are caring to each other, know? Aw stick together and aw that. At least you get your three meals a day, and your fags every day! (Interview 32)

As illustrated here, but indicated throughout, recollections of the effects of the presence or absence of support in various circumstances was believed to have ameliorated or contributed to the effects of any given situation upon interviewees' well-being. As shown in Chapter 5, the relationship between objective material and environmental circumstances, more usually the focus of

homelessness research, and (ill)health cannot be understood without recognising the mediation of the affective body in reported health outcomes.

Concluding remarks

The data represented in this chapter problematises any simplistic conceptions of homelessness as the result of one-dimensional factors, such as 'arguments' or 'unemployment'. Homelessness amongst this sample of young women requires to be conceived of as a result of a cumulative process of personal relationship breakdown with parents and/ or partners, key features of which are located in the thematic commonalities identified. A predominant theme in the accounts was that the interviewees' gender exerted an influence upon these relationships in terms of socialisation, expectations and experiences. Furthermore, as consistently maintained and supported throughout, this process must be contextualised within the wider exclusionary structures and processes which placed strains upon and circumscribed the lives, socially and materially, not only of the interviewees, but their parents and partners, and which prevented the actualisation of 'normal' youth transitions.

This problematisation of the notion of 'causation' is important. Having identified the cumulative and mutually-reinforcing aspects of the processes which contributed to the outcome of 'homelessness', it is possible to transcend simple representations of the interviewees as 'victims' or 'guilty' of the situation within which they now found themselves to an exploration of the meanings interviewees ascribed to their lived experiences and their consequences for action, both of which are associated with the reported health outcomes recorded in Chapter 5, in their abilities to perform health work as considered in Chapter 8, and in their self-conceptions examined in Chapter 7. As 'speech acts' (Coffey and Atkinson 1996) such contextual narratives proved indispensable to a qualitative understanding of the experience of 'homelessness' and the sample's accounts and conceptions of 'health'.

The importance of acknowledging the purpose of these 'speech acts' is no more apparent than in the focus upon aspects of psychosocial malaise reported prior to homelessness, regardless of whether the interviewee had undertaken a housing transition of her own before becoming 'homeless'. Rather than accepting these recounted health problems in their own right, they are illustrative of how interviewees apperceived the social and material circumstances from which they presented as having 'escaped', and especially, as will now be examined, how they apperceived their present situation.

Chapter 7

Lifeworld and identity

The cumulative evidence presented in the preceding chapters serves to problematise basic pronouncements concerning homelessness and health. These are, that there exists some kind of verifiable, nomothetic relationship between homelessness and ill-health, and that there are 'causes' of homelessness which can be reported in a straight-forward manner. These theses, however, cannot be challenged completely without problematising the popular imagery surrounding the experience of homelessness itself which, as introduced in Chapter 6, Hutson and Liddiard record that the literature on young people 'implies that the experience is 'wholly negative and progressively problematic' (1994: 124). This draws upon the assumption, however well-intended, that homelessness only represents a progressive downward spiral, as characterised here by Prime Minister Tony Blair in his foreword to the *Report on Rough Sleeping*:

> There are good reasons for aiming to end rough sleeping. It is bad for those who do it, as they are intensely vulnerable to crime, drugs and alcohol, and at high risk of serious illness, and premature death ... The longer people spend on the streets, the harder it is to return to anything like a normal life. Many have severe problems with drugs and drink, or untreated mental illness. Others despair of finding a way back to family and friends - or no longer want to. (Social Exclusion Unit 1998: 1)

As indicated here, the decline associated with homelessness tends to be supported by such emotive terminology as 'vulnerable' (*for example*, Boulton 1993) and is closely related to the popular imagery that homelessness produces only 'hopelessness' (SCOPH 1994: 36) arising from such factors as 'low self-esteem' (*Ibid.*; Fisher and Collins 1993) or 'self-contempt' (Boulton 1993). Within this vista, homeless young people are especially portrayed as

emotionally 'damaged' (*for example*, Boulton, 1993; RSIC 1997) and, therefore, in need of protection from this slippery slope, particularly young women who are said to be 'frequently dragged into a downward spiral of loss of identity, depression and attempted suicide' (Dibblin 1991: 66). Notable authors have laid the foundations for a questioning of this type of representation (Hutson and Liddiard 1994; Tomas and Dittmar 1995; Downing-Orr 1996). Moreover, furnished with an appreciation of the recounted histories it was immediately apparent that such imagery could not be sustained. The numbers reporting psychosocial improvements, either through camaraderie when sleeping rough or as attested to in the decline in suicide behaviour and level of reported psychosocial well-being provided the key for exploring the social, cultural and material circumstances within which such pronouncements were produced.

The foundations for a problematisation of this assumption lie in the accounts of the interviewees' experiences of 'home'. For most, the 'home' had not represented a place of safety, comfort or security, it was the site for conflict, insecurity and risk. However, the outcomes arising from these negative experiences of 'home' cannot be fully understood without their contextualisation within the processes of social and material exclusion reinforced and reproduced by the wider society. Nevertheless, within these processes interviewees did not present themselves as passive 'victims' of circumstance; these circumstances were to provide the context for the production of meanings and self-identity arrived at through negotiation with others and themselves. This chapter will reveal that, without exploring the meanings interviewees ascribed to their situation, socially, materially and culturally, meaningful associations between homelessness and health cannot be made.

Identity

> This place has brought me back to who I was, and I forgot who I was myself. I was, I felt as if the world was going round in circles and I used to stop myself and say "Who am I?". And it was like going about having great big blackouts saying "Who am I?". And from coming in here I'm myself again, I can realise who I am and that I'm a person. (Interview 31)

The data presented thus far has indicated support for a conception of homelessness as the product of 'fractured transitions', the origins of these fractures having been associated with social factors and the cumulative outcomes experienced, especially, in terms of psychosocial well-being. As a reward for a successful outcome, the three main transitions considered confer identity and status upon the individual, socially and materially, which bears on the ability to participate fully in society. If then, homelessness is the product of fractured transitions how can status and identity be achieved when these more usual 'frames of reference' (Furlong and Cartmel 1997) are absent? Moreover, the interviewee quoted above, among others, expressed a belief that her self-identity, and thus her sense of self-worth, had been recovered by the support received on becoming 'homeless' after relationship breakdown. The pressing analytic task, therefore, was to find an efficacious means of interpreting how interviewees constructed their own identities.

As argued in Chapter 1, most homelessness studies have tended to overlook the fundamental question of identity formation. Instead, they focus upon 'health risk' aspects of homelessness. For example, 'drug misuse is part of the culture of the young homeless (*sic*), helping to form bonds between peers' (Evans 1996: 71), but instead of investigating such cultural aspects, unfortunately, this report advances popularist sentiments of drugs or alcohol as a means of alleviating 'helplessness and hopelessness' (*Ibid.*). Such imagery implies similar value-judgements as found in the psychological literature on the more

limited period of adolescence and the 'health risk behaviours' associated with identity formation.

This literature highlight the 'emotional turmoil' associated with identity formation with many proposing adolescence as a period of 'risk', notably 'health risk', and they focus upon a range of 'problem behaviours', such as substance 'abuse', crime or pregnancy (*for example*, Jessor *et al.* 1991; Kagan 1991; Mechanic 1991; Jessor 1993; Heaven 1994, 1996). However, these tend to individualise, and treat as 'deviant' behaviours which sociologists reveal are a part of youth experience, as will be exemplified in Chapter 8 in the context of 'risks' associated with sexual experimentation. Consistently, as explained in Chapter 2, the sociological literature on youth and health has undermined such judgmental notions since such 'behavioural' differences are shown to have social and material bases and outcomes.

Accordingly, in an attempt to provide a less value-laden approach, identity is employed in this chapter as 'embracing the individual's own perceptions of herself generally and in specific domains' (Banks *et al.* 1992: 12). Such a definition appears appropriate since it has been maintained that identity formation in youth is a twofold process arising in the mid-teenage years. Up to the late-teens young people are said to be involved in the quest for personal identity and, simultaneously, to their mid-twenties they seek to establish social identity and relationships (Rapoport and Rapoport 1975). By accepting this notion of 'quest', individuals can be conceived as active agents in this process.

In the ESRC's 16-19 Initiative, a longitudinal study of 5000 young people growing up in four labour markets (Banks *et al.* 1992), the process of identity formation is accorded prominence. Two broad and inter-related components of identity were explored: 'self-concept', where responses to key statements were analysed to uncover what the young people perceived the characteristics of this to be and these related to 'enterprise', 'self-efficacy', 'estrangement',

'satisfaction with self-evaluation', and the 'sources of self-evaluation'; and 'social identity', in terms of attitudes, values, beliefs and commitments in relation to society. Identity, in turn, also played an important role in the goals pursued, that is the young people were found to 'make choices and pursue goals consistent with notions of who they are and what they are capable of' (*Ibid.*: 181). Equipped with these considerations, the fundamental questions underpinning this chapter were:

1. How did interviewees characterise themselves and give meaning to their situation?
2. What factors shaped the construction of interviewees' self-identity?
3. Did a relationship between self-identity and expressions of well-being exist?
4. How can the relationship between self-concept, social identity and well-being be understood?

Three main considerations influenced the decision to explore how and why interviewees constructed their identities. Firstly, in the recounting of their histories, both events and the self were presented in a 'normative'(*cf.* Brannen *et al.* 1994) light. Although pathology was imputed in the behaviour of parents or partners where no other explanation could be offered, at no time did interviewees allude to the events or 'careers' which brought them to their present situation in any deviant sense. It has been suggested that most young people attribute their own position or that of other people to personal failings (Heinz 1987) and this could be supported in the explanations of, for example, some interviewees' past drug use, or parental alcoholism, drug use, or mental health problems. Even here, however as shown in Chapter 6, these 'failings' were set in a social context, such as an effect of boredom or the desire for 'escape' from the social circumstances within which they had been living, or their mother having been 'too young', 'forced' into marriage or having had 'too much to cope with', or fathers or partners 'changing' with unemployment. Three explanations can be surmised from such chronological accounts. Firstly, interviewees, especially those with experience of social work intervention, appeared to have become accustomed to presenting themselves as 'cases'

which, essentially, 'normalised' the recounting of personal histories, and, as such, the histories themselves. Secondly, as explained shortly, interviewees' interactions with members of society appeared to have taught them the need to explain themselves in such a manner. Thirdly, as indicated by the high levels of emotionality when recalling especially traumatic experiences, the presentation of self in such a 'detached' manner could have been a form of coping.

The second matter related to the association between accounts of hostel life, in terms of time and perceptions of the social environment, and reported changes to psychosocial well-being. With the exception of the mothers, where only one mentioned this as a problem, specific age-related differentials emerged. As explained in Chapter 6, none of the sixteen and seventeen year old 'single' interviewees had spent more than several weeks in their present accommodation, yet among those aged between eighteen to twenty-five years living in the 'adult' hostels, most had been residents for longer periods of up to eighteen months. When asked how they felt about their present accommodation only three of the younger age group expressed dislike:

> Ah hate it. Ah think it's crap. Ah don't get on wi' anybody. Ah mean Ah talk to them, but Ah don't really get on wi' them. Ah don't like them. You know, if Ah was to see them on the street Ah'd just walk right by them. Ah wouldnae choose them for pals because you cannae trust them. You just have to put up wi' it. It's annoying though. It's pure boring and depressing in your room, you're sitting there yoursel' and there's naebody to talk to. It's boring (laughs nervously), it gets tae ye after a while. (Interview 5)

All three associated this with problems of 'fitting in' with fellow residents, either as a result of their perceived 'maturity' as opposed to others, two because they were working, and the other believed it was difficult to establish friendships because of her 'higher-class' background. The young mother attributed her inability to 'fit in' with other residents in the project to a combination of being seen as 'square' because she did not smoke, drink or take drugs and spent most week-ends with her parents. Nevertheless, the majority

of younger interviewees reported being happy with their present accommodation and the reasons for this tended to be associated with their new found independence and the supportive relationships made in 'comfortable' surroundings, as characterised here:

> See when Ah left, Ah even said this to my pals, Ah could have flung a party Ah wis that happy, Ah've never been that happy, noo that Ah've left the house. Cause when Ah wis in there it was always sad, moans, groans, but in here Ah'm just full o' happiness and aw that, so it is. Just glad Ah'm oot. Ah know it's terrible ti say that about how you feel about your mum and dad and that, but no, it's the best thing Ah could ever have done. The best thing ever. Nae regrets, none at all, just dead happy. Got what Ah wanted an' got new pals and aw that, it's brilliant, even the staff in here are really, really good. They comfort you an' aw when you're feeling sad and if you've got any problems you can go ti them. Ah'm doing awright. Everybody's like dead friendly. So it was like movin' in, meetin' new people, an' like after a few days it was like a family. That's what it's like, bein' sisters and brothers in here. It's good. This is a palace in here. Ah never expected a hostel ti look like this honestly, Ah wis like "This isnae a hostel, it's a hotel!" It's lovely, so it is. (Interview 7)

There was only one reported drawback to this 'palace' to which all of the interviewees here referred and this related to fears arising from the surrounding neighbourhood which were said to infringe upon their freedom of movement, especially at night (*cf.* Green *et al.* 1990; Mowl and Towner 1994):

> Dead scared when you're walking up the street. Too many murders, too many junkies hanging around. I cannae walk up that road without someone saying "Hey pal, any beans?" You're like that "Gonnae gie us peace!" It happens to me every day. (Interview 2)

Many younger interviewees alluded to 'hostel rules' which were said to forbid associations with local people, and those interviewees believed this to create problems for themselves because they did not have the opportunity to be seen as part of the local community rather than an 'outsider' who was 'different'. Unlike the studies cited above, fear of potential male violence was not always the main concern. This matter also arose in the accounts of those living in one facility where 'negotiations' were said to take place between 'new' residents

and members of a local female gang for 'hassle-free' passage to local shops and this was believed to reduce potential tensions and increase personal safety.

Among those living in the 'adult' hostels there emerged an almost equal balance between those who reported they were happy where they were living and those who expressed pessimism with their situation. As with their younger counterparts these feelings were linked to a combination of factors, but the most common complaint related to perceived inappropriate placement for need which was believed to be detrimental to psychosocial well-being. This eighteen year old who was placed in an 'adult' hostel immediately upon leaving social services care explains the difficulties she had faced:

> When I first came in I was really frightened because I'd never been in an adult home before the now, and then, and the first few days I was complaining, trying to get oot because I didn't want to be in here, cause I was put in with junkies at first, two junkies and one of them was sitting and hitting up in front of me and aw that and I was scared. (Interview 13)

Many of those who had been placed in 'adult' hostels related the 'shock' of their initial experiences of the material, environmental or social fabric of these, but continued to stress how they had settled in once friendships were established. However, for those who expressed pessimism, the combination of time and the perceived lack of formal support was implicated in their changed perceptions, and evaluations of poorer psychosocial well-being:

> At first it was awright, you know didn't really care, never got into trouble or anything, but now it's really, really starting to get on top of me. Just wanting to get out, just wanting to get out of here. They say they're trying to get me a place out there, but if they don't find me a place to stay soon I'm just going to head back (to previous town). Canna handle it anymore, it's getting bad. I need my own place, canna wait for them to do it... I was told I'd be here for six weeks, same as all people in here, I was told "You'll be here six weeks and then you'll have a flat". Nearly eight months later I'm still waiting. (Interview 12)

As evident in the extracts presented key factors were found to influence evaluations of well-being. Initially, after acclimatisation to surroundings, the concept of 'escape' and the notions implicit in independence, these being freedom and autonomy, appear to have provided a favourable context for perceived improvements to psychosocial well-being and such improvements appear to have been sustained where supportive relationships with peers and with staff were established. However, where hostel-living was not perceived as a form of 'escape', but rather the only accommodation strategy available, where supportive relationships were not established, or passage of time had eroded initial 'hopes', one or a combination of these factors were believed to have exerted a negative influence on psychosocial well-being. Accordingly, perceptions of well-being were rooted in two over-riding factors: the extent of control interviewees believed they had exerted, or could exert over their situation, and the support available.

The third matter, already illustrated in the example of 'skin problems', related to the effects of other people's perceptions upon interviewees' sense of well-being, a factor about which they all appear to have been aware from their own previous perceptions:

> Like when I first came in I was very, very scared, so I was. Didnae know what to expect. Like I'd heard about these places, full of junkies, lesbians. I'd never been in, around these situations and when I came in I was really worried. (Interview 14)

As expressed here, overcoming fears arising from perceptions of hostels and the 'types of people' therein was said to have been the main obstacle for those with no previous experience of 'homelessness' to overcome. Accordingly, apparently equipped with an awareness of their own past judgements, interviewees offered numerous anecdotes of perceived prejudicial treatment, by others, in respect of their present circumstances:

> See they must class us all together or something "You must be on drugs", "You must have an alcohol problem". They think you're all

> young offenders and that annoys me cause we're no like that. You get a bad name. You get people phoning up and asking for sex and things like that. People phoning and no answering. Guys pulling up in motors outside and shouting up for lassies and aw that. That's the things you've got to put up with. (Interview 15)

As indicated here interviewees reported difficulties arising from living in a hostel. Being seen as homeless, they believed from their recounted experiences of others' attitudes, was associated with a host of 'deviant behaviours': drugs and alcohol problems, a willingness to provide sexual services, and criminality. Whilst most of the interviewees claimed to have 'learned' to accept these types of impressions, it was not a willing acceptance since they reported fearing for their safety when returning to the hostel, if alone, at night when males or known drug dealers were loitering nearby. Moreover, conversation itself with non-hostel dwellers was said to increase tensions since explanations were reportedly necessary to 'justify' that they were 'only houseless', and there were frequent reports of concealment of address when speaking to strangers for this reason. Various degrees of resentment were expressed at this ongoing requirement to explain themselves to others.

Reactions to, and consequences of being unemployed were reported to be equally troublesome. The most common complaints among interviewees related to members of the public, potential employers, but especially staff in social security offices who were believed to 'look down' or 'treat us like scroungers', particularly among those who had experience of applying for Crisis Loans. Once more, resentment was expressed at having to explain their status to people whom, many interviewees believed, could not appreciate the difficulties in maintaining or securing employment when living in a hostel:

> That puts a lot of pressure on you because you think "That's the impression people have of you". People look down on you because you don't have a job, which is not right. It doesn't make you a bad person or anything. We're just going through life and people have ups and downs and this is just one of the down parts. (Interview 1)

Among the mothers, however, the greatest levels of resentment towards stereotypes were expressed, primarily at perceived 'double standards' within society, and living with the consequences of not conforming to socialised expectations:

> Where's the bloody dad away to? Off making someone else a single mum! Men have got a lot to do with it as well, but they never get mentioned. It goes back through generations as well, we're supposed to behave "You're not a woman, you're a lady and to be a lady you've got to have a husband". I think a lot of single mums are out there because the guy hasnae been responsible enough for kids, so we've got to do it and you're classed as a "single mum". It's not fair, cause when I moved in here I felt he got off scot-free, you know. It's not as if I wasnae happy to bring up my kids, I was happy to bring them up, but here was this guy who was in the same boat as me and for the next sixteen years of my life I've got to look after my two wee kids and he can do whatever the hell he pleases. It's unfair, but it's the way it is. (Interview 31)

Frustration with 'double standards' was also marked among many who attributed the perceived prejudicial treatment to their material position:

> If we had money behind us we wouldnae get treated like we dae. It's like two different worlds, so it is, like the high and the powerful are the rich living in one world, and the poverty, the poor like us, like we live in another world, it makes me angry so it does. Now if we had money behind us we wouldnae be brought down. If people would just give us a chance. (Interview 41)

In contrast to the 'normative' histories presented these latter extracts demonstrate the types of judgements which were reported to be experienced in daily lives, the perceived social and material origins of these, and has alluded to the main psychosocial outcomes of these experiences, mainly anger and frustration at being perceived, not as they perceived themselves, but as a part of an aberrant homogenised mass, as objects of society's gaze, and having to substantiate themselves in a host of social settings. When considering both sets of imagery, however, an immediate question is raised: how did the interviewees resolve the inherent conflicts between normative self-

presentations and the stigma which they claimed to experience? The initial direction for analysis was found in other work among homeless young people (*cf.* Downing-Orr 1996), and in the accounts already presented above where the psychosocial components of hostel life, most notably the perceived presence or absence of support, and the extent of empowerment or estrangement were found to exert positive or negative influences upon psychosocial well-being. Based upon the conjecture that identities are subject to reflexive negotiation and are rooted in social relations and social circumstances (Breakwell 1987; Banks *et al.* 1992), it was necessary to elicit the processes of inclusion and exclusion within the 'hostel' culture. This would provide a means of representing the context within which the apparent interregnum between self-concept and social identity was resolved.

Social relations

As asserted in Chapter 1 homelessness represents a process of exclusion and, having identified wider aspects of this exclusion in Chapter 6, the more personal aspects are considered here.

> Actually I've no seen my mother for five months, none of my brothers or anything since then. My mum's told the kids they've no to speak with me "Don't speak to her or you're getting it!" It's hurting me cause I'm missing them. (Interview 14).

As indicated in Chapter 2 the period of youth is associated with progressive detachment from parents and this is associated with well-being through the development of peer relationships (*for example*, Glendinning *et al.* 1995; West and Sweeting 1996a). The data presented in Chapter 6, however, suggests that such detachment began at an early age and, for many, culminated in complete termination of relations at or around the age of sixteen years. As illustrated in the above extract this detachment had implications for associated relations with siblings and wider kinship networks. Younger siblings were found to be an especial source of concern where interviewees had left the parental home

because of abuse and there were several accounts of secret meetings to maintain contact and offer support:

> If I want to see the weans I just go down to their school at lunch-time and see them. I cannae go up to see my big brother cause he stays with my ma, and I don't want to go back up there in case my da starts laying his hands on me again.' (Interview 34)

Complete detachment from parents was not always the case, particularly among those who had reported 'being pushed' as a result of overcrowding or parents not being able to support them financially. Several of those parents were said to 'help out as much as they can' by providing meals or small amounts of cash for food, bus-fares or one off items, such as clothing or shoes for birthday or Christmas presents. For a few interviewees, older kinsfolk: siblings, grand-parents, aunts, uncles and cousins were also said to play an important role in terms of support, advice and small amounts of cash. In those cases interviewees expressed a desire to be housed as near as possible to members of their family since they believed the present detachment from family support was negatively associated with psychosocial well-being:

> I think that's what I miss mair than anything. I think once I get a house and once I'm settled in hopefully things will look different, but just now it looks lonely, incomplete and empty. (Interview 37)

Maintaining friendships established at school, in the 'home' neighbourhood or when in 'care' was said to be difficult and only a minority, who tended to have been recent admissions to the hostel, reported having been able to do so and in three cases this was because friends had become 'homeless' themselves. The process of losing touch was said to have been related to the strains placed on friendships whilst interviewees had been living in the friends' homes, an effect of moving or being moved around, interviewees being unable or unwilling to return to the 'home' area, a deliberate move to sever relations made when using drugs, or, simply, interviewees had found they had 'nothing in common' with earlier friends:

> I've lost contact with most of them cause I've got moved around. Like you have to make new pals everywhere you go and you usually lose contact wi' most of them. Horrible, it's horrible cause you make really close pals and you get attached ti them and you want ti keep in contact wi' them and you dae for a good while or they don't bother phoning you again. Could have been a good pal, could talk ti, go oot wi', dae anything wi' and be happy, know what I mean? You just get on wi' it. It's weird moving aboot aw the time, it's horrible. (Interview 9).

Sixteen interviewees reported having boyfriends, half of whom were living in hostels themselves. The difficulties of maintaining such relationships were recounted at length and tended to revolve around the twin themes of lack of privacy and money. Dates were said to comprise going for walks, meeting friends whose circumstances were similar, or, if money allowed, having a drink in a pub. These relationships tended to have been formed recently. In contrast, those who reported having 'housed' boyfriends were in longer term relationships of up to a few years standing. Even with these, however, lack of privacy and money were mentioned because, being unemployed themselves, most boyfriends were living with their parents. For the few whose boyfriends were in employment dates were found to be more varied, going to the cinema or dancing, and they were said to provide some financial support to the interviewees. Above all, however, for the interviewees the emotional support received was said to be the most important aspect, but among those latter few there was evidence to suggest that perceptions of a new social distance arising from the interviewees' unemployment and 'homelessness' was placing a strain on these relationships through the mediation of altered self-efficacy:

> My boyfriend helps if I need it, but I feel sorry for him cause I'm putting a lot on him and that. Many a time I've said to him "You can dae better. You could get somebody with a job" and this, that, the next thing. He says "It's you I love. I'm no wanting anybody else with a job". He says "You're going to have a job again one day (name). you're going to have a lot going for you", he says "It's just the way you're feeling in here". Sometimes I get him down, get him depressed. then I just fall out with him, walk away and say "Go find yourself someone, go find somebody else" cause it has, it puts a lot of strain on your relationship when you come in here. (Interview 16)

Perceptions of the professional support received was directly related to well-being. All of those younger interviewees in the supported projects and the mothers could name their case- or keyworker, and, in most cases, their social worker. These professionals were believed to be trying to help, by ameliorating benefit problems or trying to secure accommodation, and the practical and emotional advice and support they offered were said to be appreciated. Aside from the odd report of disagreements, usually surrounding a conflict between the interviewee and the professional over what was deemed the most suitable next-stage accommodation, interviewees in these projects expressed a belief that they were receiving sufficient support. These sentiments contrast with those expressed by interviewees living in the 'adult' hostels.

The main problem identified by the 'older' interviewees related to there being only one caseworker per hostel and, because of this workload, they felt caseworkers did not have the time to devote attention to anything but the most basic housing matters. Frustrations with the perceived shortfall in this support fell into four main categories: lack of awareness of from whom to seek advice; lack of information; fear of being pressured into flats into 'undesirable' areas; and, uncertainty about rights:

> You're feart to put in for a house in case you're offered one that's a pure mess, no like the area. See I've seen a lot of people getting offered areas where there's a lot of drug addicts and they're no wanting that area, and I can understand why. They knock that back and get another offer and it's the same again, know knock that back and turn around and get told they're not getting anything else. So what happens after that? I know nothing about things like that. What happens if you say after your third offer that you're no wanting it? See I don't know nothing about things like that and I should know, I don't know nothing about housing, hostels, I think I should know. I don't know if it's my fault for no' asking. (Interview 18)

Additionally, interviewees reported their impressions of staff in the 'adult' hostels. Whilst the support offered by individual, often named staff, or teams of

staff was said to be good, there were elements of mistrust in most accounts. Concerns were expressed about a male member of staff in one hostel who was said to 'go with the vulnerable lassies', which reinforced a matter raised in one of the focus groups with a separate group of previous residents. Those who mentioned this claimed to feel safer now that CCTV cameras had been installed. On a more general level, several interviewees expressed disquiet about the high numbers of male staff, especially among those where there had been problems with males in the past:

> There's a lot of men staff and like only one woman, maybe she's no there and sometimes people just want ti talk ti somebody and they don't want ti talk ti a guy. I think they should have a bit more female staff given the population than what they've got. And I think they should open their eyes a bit more and they would see what's going on and it would stop a lot of people getting into trouble and harming theirself. (Interview 10)

As alluded to here, interviewees believed many staff were reluctant to see what was going on within the 'adult' hostels, and here drug use, bullying and self-harming were the main concerns. Furthermore, many interviewees reported they had learned not to trust some members of staff whom they had heard 'gossiping' about fellow workers or residents and this uncertainty regarding confidentiality was said to have made interviewees reluctant to disclose information to, or seek support from those staff. The attitude of 'them and us' peppered many accounts, but this was not restricted to staff-resident relations alone. One of the 'informal rules' within these hostels related to 'not informing' on fellow residents; if problems existed it was said to be common practice for the individual or their friends to 'sort matters' themselves, verbally or physically. However, within the 'informal' hierarchy, discussed shortly, there were behaviours which interviewees reported 'would not be' tolerated, especially violence against those deemed unable to defend themselves. Emphasising that the decision to report on a fellow resident was not easy, those interviewees who recounted having done so underlined the lack of appropriate response with frustration. In this example an initial attack had reportedly been

upon an older resident and two interviewees had expressed their concern to a member of staff:

> (Name) says to me and my mate "See if you want to give her a doing", this is what one of the staff says "Throw your jacket over the camera and set aboot her", right? And then, this is what they're like, one o' them says this to us. And she was fighting, this lassie was fighting with another lassie the other day and the other lassie got moved to another hostel, but she's still here! And this member of staff was telling us that if we batter her they'll toss her out cause they want any excuse to get rid of her and yet she was caught fighting the other day and she's still here! (Interview 15)

In contrast, three interviewees praised their drug counsellors whose support was perceived as having helped them through very difficult periods. Those interviewees reported having the counsellors' telephone number and having this ability to contact them whenever necessary was said to provide security in terms of support or advice being available when required. Two interviewees reported having been referred to psychiatrists after suicide attempts, and one following discharge after hospital admissions for depression. One reported attending a psychologist as a result of her self-harming practices. Those latter interviewees claimed that it had helped to have someone to talk to, but only one reported any real benefit from appointments since consultations were deemed inappropriate for their needs, in that if problems developed there was no immediate support available, and, once more, social distance was referred to. One interviewee who had a probation officer spoke of this support in rather prosaic terms as all part of being in and out of prison for several years.

To conclude this outline of social relations each interviewee was asked to whom they turned most of all when they needed advice or support. On distinguishing between 'formal' and 'informal' support, seventeen were found to turn to a 'professional' and twenty-three claimed to turn to someone in their own informal network, especially friends made within the hostel or boyfriends. One said she would not speak to anyone. Distinct accommodation-specific

differences were expressed here. Most of those who stated they would normally utilise one form of 'formal' support, such as project staff, caseworkers and social workers, were living in the supported facilities.

The culture of inclusion

The previous section has indicated how the process of homelessness can contribute to the breakdown of previous social relations which superimposes upon exclusion from wider processes and, yet, how potential psychosocial effects of this exclusion can be ameliorated or magnified by experientially-rooted perceptions of the support available. Consistently, references to relationships with fellow residents were accorded prominence, either through being 'like brothers and sisters' or 'not fitting in', and these were important to interviewees' accounts of both institutional life and psychosocial well-being. The main factor predisposing interviewees to a sense of inclusiveness was an empathy among others whose histories appeared to provide a normative context for their own experiences:

> See when I came in here I was pretty confused, still am I suppose, but I met this lassie, she lost her baby too, she's went through a lot of things I've went through. We talk, we talk a lot and it's helped, it's really helped. The rest o' them's good as well, we've all been through a lot, so we try to keep ourselves up, just act daft at times, keeps you going. You should hear us all in that telly room, it gets wild (laughs). But we're all there for each other cause we understand, other folk say they understand, but unless they've went through what we've, they're not going to understand really. (Interview 33)

The sharing of common experiences was said to foster solidarity among residents, but this cannot be accepted without question since some interviewees reported feelings of estrangement. Moreover, solidarity was not something automatically given for, as indicated above, and as consistently reinforced through participant-observation and focus group work, aspects relating to the unofficial culture of the institutions appeared to govern conduct. The unofficial

hierarchy, by denoting 'otherness', further appeared to provide a context for self-concepts of 'normality' or 'differentness' from the hegemonic group.

On compiling reported findings thus far, some commonalities were found. Firstly, as will be explained in Chapter 8, in the accounts of budgeting strategies, borrowing from and lending to each other was reported frequently and this was found to be based on an assumption of trust that repayments would be forthcoming. Where trust had been broken, no further lending or borrowing took place. Food, generally, was not reported to be part of such exchanges, primarily because interviewees reported they could only buy enough for themselves, but also because eating was generally presented as individual and functional. However, as found among young people in general (*cf.* Banks *et al.* 1992) cigarettes, more than any other commodity, appeared to intensify and extensify friendship networks; they were an important source of social interaction in terms of reciprocity and exchange:

> If I've no got fags there's always people in here that's got fags, so you just say "First, second", so you always get a draw of a fag. (Interview 21)

During focus groups and participant-observation the sharing of one cigarette between two or three young women was noted to be widespread practice, and appeared to be a taken-for-granted norm, for frequently no words were exchanged as the cigarette was passed around. Offering cigarettes was found to break down initial barriers and afforded a means of fostering primary bonds between individuals, lending support to West and Sweeting's (1997) argument of the existence of a relationship between health 'risk' behaviour and peer group orientation. Cigarettes also appeared to confer status, a factor which interviewees claimed had been reinforced by earlier peer groups, and even parents, although few depicted the process of status negotiation quite so graphically as this:

> I started smoking, I was about thirteen, but my mum had caught me. She was watching me from the window and I came up the stair that night and I walked in and she was like that "Let's smell your breath". I'm like that huhh, huhh, huhh, dead fast and she was like that "You've been smoking" and she grabbed me by the hair "If I catch you smoking again! That's no good for you and, fair enough I dae it, but that doesnae say you've got tae dae it." On my sixteenth birthday she sent one of my friends to the van and she says "Get me thirty Club king size" and I was standing out on the veranda and aw my pals were standing there and she came out and done that "There you go" and I was feart to take them "Do I take them or do I no take these?" And she's like that "Here take them, I'm gieing you them, but I tell you, you do not smoke in front of me, if you want a cigarette you smoke in your room. I better no see you wi' a cigarette in the street. Don't ever smoke in front of me." As soon as I turned eighteen I walked into the living room with a cigarette and she never says anything to me. (Interview 14)

Thirty-one interviewees reported smoking, five said they had stopped, and five, although reporting 'having tried' had never smoked. These figures suggest a rate almost three times that of recent work among seventeen and eighteen year olds claiming to be 'regular smokers' in the general population (*cf.* Glendinning *et al.* 1997) though the level is comparable with figures for homeless women (*cf.* Balazs 1993). The age at which the interviewees reported having commenced smoking regularly, defined here as daily use, ranged from nine to nineteen years, with a mean age of thirteen years, although experimentation was said to have occurred up to a couple of years prior to this. The sample appears to represent an 'aggregate type' for the many studies reporting family class background, early age at leaving school, unemployment, parental smoking and poor perceptions of family life, as factors shown to be associated with teenage smoking (*for example*, Green *et al.* 1991; Conrad *et al.* 1992; Plant and Plant 1992; Hammerstrom 1994; Foxcroft and Lowe 1995; Glendinning *et al.* 1997). When asked why they had started smoking two reasons were offered: experimentation, and the example of family and friends where smoking cigarettes was explained as 'part of growing up'.

Those who reported having 'never smoked' or had 'given up' provided reasons for this. They reported not having liked the experience or the smell, expressed a belief it was a waste of money, or they had never started or had stopped for 'health' reasons, referring to asthma, other breathing problems, or pregnancy. Three reported having reduced consumption, an effect of chest infections and financial cost, but most said their intake had increased markedly with present circumstances. As shown in Chapter 5, smoking was directly implicated in incidences of chest infections, and was associated with high numbers of reports of breathlessness and 'being unfit'. Having been underlined in the earlier focus groups, in the accounts of their smoking habits, interviewees seemed to reproduce wider 'health-education' discourses. Whilst most said they 'knew' they should not be smoking for financial and health reasons, they then tended to justify their action by emphasising the 'benefits' rather than 'costs' (*cf.* Heaven 1996) and, at present, the benefits were perceived as outweighing any potential costs. Cigarettes were used to calm or relax, supporting 'coping strategies' found amongst working class women elsewhere (Graham 1987), yet they were also used as a stimulant when required, they suppressed appetite when hungry, or helped to maintain body weight and they provided something to do with the hands when sitting for long periods.

As indicated earlier a few of those who did not smoke either because they expressed dislike for the smell or reported having asthma, spoke of the problems associated with smoke-filled common rooms and how they tended to avoid these as much as possible. This had made them subject to charges of regarding themselves 'better than' the cigarette-smoking majority. Whilst those interviewees claimed not to be too concerned about others' impressions, they did refer to the ongoing feelings of exclusion as a source of stress. In contrast to the dominant accounts of smoking, accounts of the social aspects of drinking were more variable.

In the large literature on youth and alcohol consumption, social drinking is regarded as another marker of growing up, yet this is also shown to be mediated by class background, gender and familial factors (*for example*, Green *et al.* 1991; Plant and Plant 1992; Foxcroft and Lowe 1995). Three interviewees believed they had an alcohol problem at point of interviewee. They highlighted benefits associated with 'blocking out' past experiences, anxieties or feelings of depression and to promote a sense of well-being and self-confidence. Those interviewees, however, believed that alcohol had now become another 'problem' to cope with:

> I take a good drink, but I feel bad the next day. When I get my Giro I buy a bottle of vodka, it probably lasts me about one or two nights and that's it. I dae it ti enjoy it, ti make me feel better I think. I think that's gonnae be the answer to my problems, I think I take it just ti cope wi' things, but I don't know. I think if I keep going the way I'm going I could end up a alcoholic, but I don't want that because my dad's an alcoholic. I don't know, I keep saying ti myself "Ye better watch what you're doing" cause I'm drinking for nae reason, basically I'm drinking ti put up wi' life. (Interview 10)

Among most interviewees the reported levels of alcohol consumption were low and thirteen claimed not to drink at all. Cost and perceptions of alcohol were the reasons given for accounts of not drinking more than one or two drinks on an infrequent night out, or if sharing the price of a bottle of spirits, or some cans with others. For a few, alcohol tended to be used to mark a 'special occasion', such as birthdays or if a friend had obtained a tenancy, otherwise it was not depicted as a routine part of most of their lives. Many interviewees claimed not 'to relate to' or 'understand' the type of culture which associates alcohol with 'having a good time', since a 'night-out' on its own was said to promote well-being and pleasure. Among those who expressed strong opposition to alcohol consumption one strong common factor, relating to experiences associated with parental or partners' drinking, was said to have influenced this impression:

> See I've seen too much of it with my ma and da. That's how I've always stayed straight. My boyfriend says to me "I thought you would have turned to something when you moved in there, turned to drugs, drink or something". I was like that "No that's something I'll never give in to, I've seen too much of drink". (Interview 16)

In contrast, unlike alcohol consumption, cannabis use was reported to be a 'normal' part of the lives of fifteen interviewees and the benefits of this as opposed to alcohol were stressed. Most claimed not to be able to afford to buy cannabis and said they relied upon friends', or boyfriends' benevolence and this 'sharing' was described in terms of the bonding aspects of friendship (*cf.* Pearson *et al.* 1987). Moreover, it was said to promote relaxation and a sense of well-being instead of the violence which many interviewees associated with alcohol. It was also reported to be used to facilitate sleep and ease tensions they associated with hostel life:

> I think that's great, that relaxes me totally, great. A lot o' people say it's addictive, but I think it's only addictive if you want it to be addictive. Know, it's not physically addictive, it's mentally addictive if you want it to be addictive. It relaxes me, takes a lot of my mind and whatever. I don't take it in here, but I dae take a wee smoke, I take it because I find it relaxes me. See when I'm out of here and I take it, like a joint, I take a joint and that's me, I just calm right down. But see when I'm in here, I'm just too high, trying to watch out for things, but as soon as I leave here, that's it, a wee joint and I'm happy. (Interview 14)

Similarly, four who mentioned using 'ecstasy' on rare nights out to 'the dancing' also believed this to be a 'normal thing to do' to engender 'good feelings' and feel relaxed among strangers. As stated in Chapter 6 and found in other research with young people (Brannen *et al.* 1994) interviewees reported a variety of drugs having been 'widely available' in their home areas, but use tended to be restricted to cannabis, and to a much lesser extent ecstasy because these were not perceived as 'proper drugs'. However, reports of just under two-thirds of the sample reporting having 'tried' or used these substances are again three times higher than rates found among young people in general (*for example*, Plant and Plant 1992; Brannen *et al.* 1994; Graham and Bowling

1995) and could be an effect of reported low levels of alcohol consumption, ease of availability in neighbourhoods in which they grew up and peer orientation (*cf.* Leitner *et al.* 1993; West and Sweeting 1997).

'Real drugs' were perceived to be those associated with 'junkies', that is: amphetamines, such as 'speed' or 'sulph', benzodiazepines, especially 'jellies' or 'beans' (temazepam), heroin ('smack'), LSD ('acid'), and narcotic analgesics, such as DF118, diconol or temgesic. As indicated at several earlier points, the term 'junkie' was ubiquitous, in descriptions of the area in which they grew up, the area within which they were now living, perceptions of people who lived in hostels, other peoples' prejudices, and experience of fellow residents in the adult hostels. The underlying objective of such accounts seemed to be to reinforce the benefits of 'escape' and underline their own 'normality', in this case, when compared to her sisters:

> I was thinking about they two the other day, they're both junkies and they're a pure mess. I thought "My God! I could have been in that state". They're black, they're pure filthy and they've started foaming at the mouth and things like that and I thought "Thank God I'm away from all that! (Interview 35)

Like this example, several interviewees mentioned personal experience of siblings, other relatives, friends or others known to them who had become seriously ill or had died as a result of their drug use as the main reason why they would not use drugs regardless of whether they reported having tried, were presently using cannabis, or had never tried. The basis of the main hierarchical distinction between the interviewees in the 'adult' hostels is exposed here where 'normal', 'houseless lassies' distinguished themselves, and were distinguished from those who were 'drug' users. Considerable resentment was expressed at 'having to live with junkies' and the 'better' formal support they were perceived to be receiving, yet those who reported having a drug habit expressed frustration since they believed they were receiving less support than non-using residents. But those few interviewees who reported themselves to be

'users' indicated that the feeling of differentness extended beyond this, a matter illustrated in the course of two interviews where the responses to several questions included the caveat 'but my experience'll be different from normal lassies' and the most overt expression of differentness, 'it's not fair on the normal lassies being put in with us'. Former users in the adult hostels tended to be found on the fringes of both groups, and spoke of the ever-present 'temptation' whilst living with others who were using:

> It makes me feel uncomfortable, depending on how I feel. Like I get my downie days like everybody else and I get my up days. And I sit and see one of the lassies in here that has got a habit just sitting full o' it, know what I mean? And then I just get that, just for a split second, I get that feeling again to see what it's like. (Interview 17)

Only one interviewee, who reported not having a drug counsellor, recounted a 'relapse' whilst living in the hostel, at a particularly 'low point', and she employed the example of feeling 'like turning to the needle again' as a means of illustrating her increasing inability to cope with not having secured a tenancy after several months of hostel-life.

As introduced in Chapter 6 the process of homelessness is not experienced passively, it is one of conflict and negotiation with foundations laid before physical 'houselessness' occurs. It is a process of exclusion from social and material resources, yet as suggested in regard to the psychosocial components of rough sleeping and prison life, it is also a process of inclusion derived through negotiation of shared meanings with others and with oneself. The hegemonic influence of the ascribed 'normal' group within the institutions set limits upon the extent to which individuals could feel included or estranged from the social and cultural resources of this 'normal' group. This served to ameliorate or magnify feelings of exclusion from other forms of social support and, accordingly as illustrated in the next section, whether or not interviewees conceived themselves to be homeless. As also shown, this process was subject to the situational variables of time and space, dependent on the nature of the

facility and the length of time spent there. The relationship between the ideas and values with which they identified and psychosocial well-being were highly dependent upon the perceived temporality of their situation.

Homeless?

All interviewees had been required to present themselves as 'homeless' prior to statutory acceptance, but impressions gathered from relatively comparative research (*cf.* Tomas and Dittmar 1995) and reinforced through participant-observation and the focus groups had engendered a confident expectation that several might not regard themselves as such. All were asked if they regarded themselves as 'homeless' and only fifteen said that they did. Twenty-four did not see themselves as homeless, and two claimed they did not know (or care). Interviewees were asked subsequent questions to elicit reasons for their responses. Among those who claimed to regard themselves as homeless this was related to the fact they were now living in a hostel because they had nowhere else to go. In a matter-of-fact way, responses tended to be succinct:

> Aye, aye, I'm homeless. I see homeless in hostels as well as skippering.' (Interview 32)
>
> I do see myself as homeless and people who say "No I'm no homeless" and they're staying here are just totally, they just don't want to face the fact. Obviously I knew when I went into the Hamish Allen Centre that was me, I was declaring myself as homeless and I had to get on with it. (Interview 1)

As demonstrated earlier many of those interviewees continued to explain how their impressions of homelessness had changed as a result of their own experiences. In these accounts the terms 'dirty', 'smelly' and 'junkies' were common adjectives, but 'homelessness' was no longer a completely pejorative term. Although as supported by what has been stated already, whilst reporting that opinions had changed, long-standing perceptions of differentness did not appear easy to eradicate:

> That's what I thought homeless people used to be like, pure smelly and on drugs, but I suppose you get people like that, but not everybody's like that. (Interview 25)

Among the larger numbers who did not regard themselves as 'homeless', reasoning was rather more complex and lengthy anecdotes were provided with examples of when they had believed themselves to be homeless prior to the present:

> Aye, it hit me straight away as soon as I left the hoose. The first night I left the hoose I always remember I had a holdall and a rucksack and two carrier bags and I stayed in (named area) and I was going to the flats in (named area) to stay with my pal, know? I always thought I was going to be crapped wi' it as soon as I left, as soon as I walked out the door panic rushed into me, know? "Where am I gonnae go? Where am I gonnae stay now? How long am I gonnae be able to stay there? What am I gonnae do if they throw me out?" Cause I wasnae aware, I didnae know anything about hostels, it was my pals that told me...When I was staying with other people they were saying "This is your hame. This is your hame", do you know what I mean? But you cannae cause it's their cups you're using, it's their plates you're eating offae, it's their telly your watching, their couch you're sitting on, know? But I here, it's my ain room, like I pay my rent, it's no much, but it's what they're wanting off you, so your gieing it. Paying my rent now so I'm paying my way. I've got my room, it's my cups that I'm drinking out of, that way. So I feel really settled here. So I'm just gonnae say this is my hame noo, til I get my ain hoose. (Interview 17)

Independence and personal autonomy were key features in the explanations offered by those who did not regard themselves as homeless. Many interviewees described their status as 'houseless', in that they did not have a tenancy of their own. In distinguishing 'houseless' from 'homeless' interviewees appeared to be underlining how they could 'feel at home' in their present abode whilst still looking forward to having their own tenancy at some future point. Moreover, by exemplifying where they had 'felt homeless', at point of leaving home or when staying with friends, and in all cases where there was a history of sleeping rough, interviewees appeared to be reinforcing their own 'normality' at having been able to surmount an 'otherness', for

although they expressed a belief that they had been 'homeless', they had not been 'really homeless' since this was defined inexorably as:

> People that lie about on the street, have nowhere at aw to stay, so they're sleeping on the street, up closes and that. (Interview 19)

As consistently reinforced throughout this chapter, the essential component of perceived support was said to influence why most of the interviewees who did not regard themselves as homeless reported feeling this way:

> No I don't because o' everybody that's giving me all the support. I feel as though I'm wi' people that care. I don't feel as though I'm homeless, no. (Interview 36)

Initial attempts to uncover immediate differences which might lead interviewees to regard themselves as homeless or not were inconclusive since neither age nor type of facility within which they were living produced any clear trends. However, by sorting accounts according to the reasons why they did or did not view themselves to be homeless intelligible patterns emerged and these were found to be related closely to the groupings of reported present health problems outlined in Chapter 5. Descriptive labels are employed, *only*, to facilitate recognition of these groupings.

Those who regarded themselves as homeless could be divided readily into two groupings with the first being found predominantly among those living in supported projects and the second being overwhelmingly in the 'adult' hostels, who reported having been homeless for longer periods. The first being termed here as *Optimistic Pragmatists*, namely those who had described this as a necessary stage in their housing career whilst they awaited their own home and who stressed how they could cope with the present because they looked forward to a brighter future freed from the past. Generally, those interviewees tended to be employed or among the older mothers, or among those who had presented themselves as 'more mature' than other residents, had reported emotional or physical detachment from the dominant social group within the

institution, maintained contact with some members of their family and had longer term 'housed' boyfriends.

> I am happy now because I could have been in the house unhappy. Here I've got something to look forward to, but in the house I didn't have any plans, but now I have things to do with my life. It does, it feels I've done the right thing. I'm not happy with my living arrangements just now, by living in a homeless unit, a hostel basically, but you've got to think and look at the end. It's like a goal at the end and you've got to set your targets for it. (Interview 1)

In contrast, the second smaller grouping are termed *Pessimistic Pragmatists*, those who reported satisfaction with the 'adult' hostel environment previously, but who now expressed the highest levels of physical health problems and psychosocial malaise which they rooted in increasing feelings of hopelessness and social isolation. With nowhere else to go, those interviewees reported finding it increasingly difficult to cope with their circumstances, with mentions of suicide behaviour or ideation, or an episode of 'returning' or strengthening desires to return to drugs. They tended to state difficulties associated with making new friendships, either through experientially-rooted lack of trust, or because previous friends made within the hostel had moved on to their own tenancies. They expressed feelings of having been 'left behind', and they had no contact, or 'strained' relations with family or previous friends, and expressed acute frustration with the lack of 'formal' support, emotionally and practically within the hostel. High levels of emotionality were expressed throughout these interviews.

> Most of them have gone, some o' them have had house offers and turned them down, that makes me angry. I'm homeless cause I've naewhere else to stay. It's embarrassing, it bugs me aw the time when people ask where you are living, can't understand what kind of person would live in here. It changes you an awful lot. My attitude, taken an overdose of sleeping tablets, I used to be a cheery bubbly person, dying to get up and get ready, put my make up on, go oot. Noo I just don't care. (Interview 38)

Those who did not regard themselves as homeless could also be divided into two groupings, although the first of these represented around half of the entire sample. This grouping is termed *Homemakers* because of the positive reasons provided as to why interviewees felt this present address to be their 'home'. These were freedom from past circumstances, having independence and autonomy, feeling settled and secure, friendships and the formal and informal support available. Those, generally mothers and/or younger interviewees, were living predominantly within the supported facilities, or in what they called 'the best' 'adult' hostel and emphasised the improvements to their psychosocial well-being, largely as an effect of 'escape'. Those interviewees expressed a belief that theoretically they could be 'homeless', but they did not *feel* that they were. Although stating that they would like a 'home' of their own at some future point those interviewees expressed satisfaction with their present circumstances and, whilst underwritten by a perception of temporality, hoped to stay here until they were ready for life on their own, this including a resolution of reported emotional problems rooted in past experiences. Uniting these factors was the security associated with having a stable base with which interviewees could identify.

> It actually feels dead good. I've my ain freedom, cause you're no sleeping on the streets or nothing, it's like your ain wee hoose, do you know what I mean? Except you're no allowed your pals in or carry on and they tell you what time to come in for, if you've got your ain hoose you can come in at whatever time you want, but it feels like your ain wee hoose. You've got your ain wee bed, your ain wee sink and that, and it's just, it just feels brilliant cause it feels like your ain hoose. Like when I go oot people go to me "Where are you going?" and I'll go like that "Oh I'm going to ma hoose" and they're going "Your hoose?" and I go "Eh, a hostel", you just feel you're going to your ain hoose. (Interview 20)

The final grouping, representing the smallest number, is termed *Eremites* who were living in 'adult' hostels. Those interviewees tended to have reported especially traumatic past experiences, had recounted a variety of homeless situations, and can be characterised by their reported isolation from any support

networks, arising from the length of time they had been living in hostels or their past or present drug use, and few aspirations as far as life goals were concerned. Throughout the interviews their demeanour was generally apathetic, except where specific experiences were recalled, and this suggested that this general mien was a form of coping.

> I can't look to the future, it's a burden to look to the future because you're too busy striving for things, that's one of my biggest regrets looking to the future. It's cost me so much so it has instead of grabbing what could have been possible at the time. It's cost me too much and I've lost so much through it. (Asked how she copes) Try to keep myself to myself, couldnae cope with a friendship until I resolve how I'm feeling. (Interview 40)

Meaning of home

A necessary extension to the interviewees' perceptions of homelessness was that their definitions of 'home' should be explored. Before considering this, however, a conflict of terminology must be explained. Most of the interviewees tended to speak in terms of 'house' rather than 'home'. The ideology of 'home' was a bourgeois construct, so perhaps the interviewees were demonstrating a form of class distinction by employing the term 'house', which connotes a far more functional and tangible reality than the concept of 'home'. This differential also appears to be an effect of local terminology. Nevertheless, neither explain the specificity of its usage where 'home' appears to have been employed to emphasise how interviewees were feeling about where they were living presently, or would feel about their own tenancy:

> Like when you're out people say like "Right I'm going home" meaning back here, but it's not really your home, just somewhere to stay til you get a home. Never be home this place, no matter what you make your room like, your own room is not your home in a place with fifty other women. (Interview 12)
>
> I *feel* this is my home. (Interview 28)

To reduce potential semantic misinterpretation all interviewees were asked: What would it mean to you to have a home of your own? Regardless of their perceptions of present circumstances, key terms emerged which refer to conceptions identified elsewhere as being imbued in notions of both 'house' and 'home'(*cf.* Tomas and Dittmar 1995): a base, cleanliness, control, freedom, independence, normality, own space, peace of mind, privacy, responsibility, safety and security. Aside from 'cleanliness', none of these conceptions of 'home' relate to more tangible features such as shelter or warmth.

Having a base was said to be essential to being able to proceed with the rest of their lives, and for most a place from which, they believed, their lives could begin. As will be explained in Chapter 8, many interviewees alluded to their lives being 'on hold' at present and having such a base would allow them to find employment and to have fixed social and emotional roots. The term 'freedom' was more usually expressed as 'I'd have my own freedom', but it had two specific meanings. Freedom from past and/or present circumstances, and being able to choose how to live without 'having to fit in' with other peoples' rules or dicta since many interviewees felt they had never had the opportunity to set their own parameters of action and this was seen as a necessary part of 'growing up'. 'Independence' was closely associated with 'freedom' and this related to being an autonomous individual capable of making their own decisions which, once more was a marker of 'normal' maturation.

To be able to feel a sense of 'normality' in their lives was said to be especially important. With direct reference to reported experiences, interviewees stressed the hopes being placed in having a home of their own as a means of enabling them to live almost invisible 'normal' lives, as stated by one 'I'd just be like normal, or what society sees as normal anyway' where interviewees believed they could develop as individuals freed from judgement. The desire to have their 'own space' was almost indistinct from the 'privacy' interviewees

anticipated a 'home' would allow. These terms encompassed the ability to have peace of mind within, and control over their own personal space, to choose with whom they associated, to have time on their own if so desired and, once more, to develop as individuals within their own world without having to worry about other people. Simply 'to do just all the things people take for granted'.

Responsibility, taken as another marker of 'growing up' encapsulated the practicalities of running a home, but this was only one aspect. The social status of maintaining a tenancy and so being seen as a 'responsible' member of society was important. The 'respect' which they associated with this status was linked to gaining respect from others because they would be seen to be 'responsible'. Finally, 'safety' and 'security' were paramount. Whether referring to physical or emotional security most explained that, because this was not something they had felt in their pasts, they hoped having a home of their own would provide the safety and security they desired.

As outlined here, in their conceptions of 'home', interviewees appear to be presenting these psychosocial constituents as a means through which the developmental process of self-identity and social identity could be consummated. This certainly is supported in the data presented where perceptions of temporality and, the hopes invested in this temporality exerted a positive influence on psychosocial well-being. Where hopes had been eroded, psychosocial well-being was reported to be poor. This emphasis on 'hopes' was omnipresent, but the realisation of these was not something interviewees believed would be automatically given,

> You've got to have a sense of hope or else you would end it there and then. There's always something good going to come out of life, always. Depends on what you make it, if you make your life good then it will come good because for anything good to come out of it you've got to work for it. (Interview 24)

The future

Whether perceiving themselves to be homeless or not, interviewees referred to the temporality of this status. The present was not regarded as fixed and immutable. To varying degrees, according to the world-views outlined above, it was something most hoped would change. These prognostications were key to identifying how most interviewees managed to resolve present social identity with self-conceptions:

> I hope that next year I'll have a hoose, I'll be working. Hope by next year I'll feel that this year's been my bad year. I hope for next year. (Interview 38)

Research with working class 'girls' (McRobbie 1977, 1991) identifies the implicit temporality of the friendship patterns and culture to which the young women felt part and records how the long-term ideas and values with which those young women identified were associated with other female members of the family, values which connected femininity with motherhood and the home. As shown here, the general blueprint most interviewees presented was also 'conventional', or as stated consistently 'normal': a house, a good job or completing education and a career, money, a car, for the 'single' interviewees marriage and children, and for the mothers a secure future for their children. Here too, and regardless of their present familial relationships, the influence of other female family members was important, but largely in a motivational sense. In placing emphasis upon the material advantages of completing education, having a 'good job' or a career most interviewees were illustrating their aspirations to have a 'better life' materially, socially and emotionally than their mothers and other females with whom they had been reared. Whilst marriage and motherhood were longer-term aspirations, aspects of femininity and home-centredness were much less so than found in McRobbie's earlier study and this reveals the extent to which interviewees conceived themselves as part of the wider culture which produced the ideals and values of the 'wannabe'

and 'girl power' generation. The status and identity to which most aspired was to be independent of background and the mediation of male partners.

The past was presented, largely, as a confining oppositional-type to the interviewees' future aspirations whilst the present was depicted as a stage of transition between both. The data presented in this chapter have demonstrated the main factors determining the alacrity at which interviewees desired this 'future' to arrive. These were related to the succour or estrangement produced by their present social relations, the feelings of empowerment or alienation these relations had engendered and the extent of enterprise interviewees believed they had shown by extricating themselves from the perceived limitations and destructiveness upon the self of past circumstances. Whilst their 'homelessness' itself can be conceived as the product of the fracture of wider transitions, the meanings and values interviewees imbued in their present circumstances were essentially normalised by conceiving of this as a transitory stage in their life careers which, although reported as different from other young people by virtue of these circumstances, were not perceived as fundamentally different because they believed they had 'normal' aspirations.

The vista offered by the interviewees indicates that 'accepted' notions of homelessness as a 'hopeless' state require to be modified to accommodate a conception of the process of homelessness among young women as one of an alternative stage of transition for those whose previous circumstances, they believed, offered few prospects, security and hopes for the future. The lack of longitudinal follow up, however, means that the extent to which these aspirations could be maintained or even realised cannot be known, but the data indicate that the psychosocial well-being produced by these notions can only be sustained by timely and appropriate formal support mechanisms to help exorcise past ghosts and lay stable future foundations. Longitudinal research must, therefore, be a priority for future homelessness researchers.

However, there is a basic contradiction to be resolved. On the one hand, the interviewees expressed conventional lifegoals and plans, and conformity was an essential part of the lifeworld of the hostels. Yet, on the other, the prototypical portrayals from professionals, some of whom worked with those same young women emphasised the 'chaotic' nature of homeless young women's lives, as reported in Chapter 3. Such imagery is also reproduced in much of the homelessness and health literature which proclaims that homeless people have 'chaotic lifestyles' which create health problems (*for example*, Fisher and Collins 1993: 47), and which render health a 'low priority' concern given the exigencies of daily life (*for example*, SCOPH 1994: 28). Accordingly, discovering how interviewees lived their daily lives in a health context is the pressing theme of Chapter 8.

Chapter 8

Health agency

This chapter examines the context within which the interviewees lived their daily lives and within which their health agency was framed. The basis for such an examination was laid at the end of the last chapter and, as will be shown throughout this chapter, the interviewees' accounts contrast with those found in much of the literature and amongst homelessness practitioners. As recorded in Chapter 3, the most frequent sentiment expressed during interviews with homelessness professionals, and in daily fieldwork interactions with hostel staff, was 'You have chosen the most chaotic group to study'. This was offered as a main reason for health being a 'low priority' concern or homeless young women's 'poor motivation to attend to health needs'. Such types of imagery about homeless people as a whole appear common currency amongst homelessness workers in Glasgow (*cf.* Collins 1997) and are even reproduced, for example, in the researcher's conclusions relating to diet: 'some homeless people' 'may lack the motivation to buy food and cook for themselves', 'may prioritise the purchase of alcohol or drugs, for example, before food', 'have chaotic lifestyles...'(Ibid. 37-8). Given the contrast between such imagery and the highly conventional and ordered lifeplans presented in Chapter 7, such sentiments had to be examined. It will be demonstrated that, without asking the subjects of research how they themselves conceive health, and without exploring the context within which health meanings and actions are framed, such types of pronouncement about motivation are misleading.

Nevertheless, much of the findings presented in Chapter 5 would appear to lend support to the 'poor motivation' thesis, particularly when the fairly low levels of utilisation of formal health services are compared with the high numbers of health problems reported. Moreover, as also outlined in Chapter 5, aspects of 'lethargy' were the most common types of health problem reported, although

this is consistent with other women's studies indicating tiredness, fatigue or exhaustion as commonly reported symptoms (*cf.* McIlwaine 1989; Popay 1992). Still, it might be assumed that 'poor motivation towards health' is merely an extension of 'poor motivation' towards daily life in general. On initial inspection the interviewees appeared to provide convincing support of this in their accounts.

Daily lives

Collating data on the interviewees' day to day life was necessary, not only to be able to appreciate the context within which they lived their lives, but so as to be able to explore the effects they perceived such factors as having on their well-being. When asked to 'describe a typical day' most of the unemployed interviewees expressed surprise at interest in what they perceived as mundane and boring. Accounts were almost facsimiles of each other: get up, shower and dress, have breakfast, tidy and clean bedroom, go to the job centre and look for work or make career appointments, go for a walk with friends, return to the hostel, have an afternoon nap, chat with other residents, eat evening meal, watch television and go to bed. By contrasting accounts of this routine with earlier times or behaviours, this was directly implicated in the levels of lethargy expressed:

> I just get dead, dead lazy and I could just sit back like that (reclining motion), just cannae be annoyed moving, just cannae be annoyed daeing anything. I just want to sit here all day and you're always saying to yourself "God, there's nothing tae dae in here!" You know? It wasnae like this when I'd a job, no way. (Interview 15)

Those with children, who had boyfriends, or who were able to visit family or friends provided the main alternatives to this routine since these relationships allowed for greater variability in the accounts. Distinct accommodation-specific differences also emerged: in the two facilities which catered for younger age groups, activities such as group outings or learning to cook were said to provide welcome diversions from everyday routines, whilst those in the

projects for mothers and children mentioned the beneficial support from regular groupwork sessions. In contrast those who had reported being on methadone programmes explained the daily routine of collecting prescriptions, whilst those who had reported working as prostitutes described lives structured around sleeping, working, obtaining drugs and eating.

Only six interviewees reported paid employment, either shop work or hairdressing and one sold *The Big Issue*. One was attending college. Twenty-seven interviewees reported being unemployed and seven 'on the sick', one of whom attended a drug recovery project daily. The reasons offered for their unemployment included: never been employed, cessation or quitting of Youth Training schemes, redundancy, having had to give up work because of present circumstances, and child-care responsibilities. Those on Incapacity Benefit had reported multiple physical and psychological health problems, or a history of drug use and were receiving some form of professional support, outlined in Chapter 7. Two interviewees reported having job interviews pending, and three were waiting to hear if recent job applications had been successful.

Amongst the remainder, employment was said to be desirable, and most reported attending Jobclubs, but most expressed a belief that they would be unable to secure employment whilst living in a hostel. A second factor found to influence these pronouncements related to the cost of living in a hostel when working and interviewees believed these charges to militate against participation in paid employment. This commonly expressed perception was actually misplaced for hostel charges were commensurate with income levels. Both factors appeared to be important in creating a 'normative' context for the interviewees' unemployment and, accordingly potential effects upon their well-being; the 'stigma', discussed in Chapter 7, lack of earnings and inactivity associated with unemployment were said to be sources of stress. However, by expressing 'acceptance' of the difficulties associated with securing employment, reported previously experienced tensions arising from

unemployment appear to have been reduced. In their accounts interviewees appear to lend convincing support to the thesis that the potential impact of unemployment is modified by 'situational variables' (Banks *et al.* 1992: 116) as demonstrated in the previous chapter.

Most interviewees were dependent on welfare benefits. Those in receipt of weekly Incapacity Benefit, the mothers and the twenty-five year old, reported being 'better off' than other residents on lower Income Support or 'Hardship' benefits paid fortnightly, or even their parent(s) on benefits. This difference was illuminating, in that those former interviewees reported it being easier to manage their limited budgets on a weekly basis whilst those paid fortnightly all mentioned money difficulties in the last few days before the Giro was due. Four interviewees, however, reported they were not receiving any benefits either because they had not yet 'signed on', having entered the hostel recently, or because they had left their previous employment 'voluntarily' as a result of stated travelling problems associated with the move to the hostel. Only two of those latter interviewees reported having secured Crisis Loans.

Such fixed incomes did not impact only upon the interviewees materially, they delimited their social and cultural participation. The spending priorities of sixteen to twenty-four year olds in the general population have been identified elsewhere as clothes, music, going out/ drinking, saving towards a special purchase, something for car, cosmetic and haircare products, books, sports, and hobbies (Stewart 1992). To elicit the priorities of this sample all were asked if they could 'manage' on present income levels. Most reported that budgeting was an ongoing source of 'worry' and cited examples of items they would like to be able to buy or replace, such as shoes or clothing for themselves or their children, or highlighted the difficulties in affording bus fares to visit friends or family. For those who reported large outstanding debts for unpaid rent or utility bills, and those with smaller debts arising from Crisis Loans received on admission to the hostel, or 'catalogue money' for past purchases, budgeting

was said to be a major source of concern. Accordingly, to be able to determine their budgeting strategies, all were asked how they managed to balance their money. Many itemised expenditure to the last pound. Accounts were unanimous: each paid their contribution towards rent and, where applicable debt repayments, then purchased food and toiletries as soon as Giros were cashed. For those in employment or attending college *Transcards* were also described an 'essential' purchase. These priorities were said to be virtually unchanging and, compared to Stewart's (1992) study cited above, contrast markedly with those for young people in the general population.

> You've just got to budget yourself, make sure you don't go and live it up, then have nothing left. You have to budget yourself to buy things like food and toiletries. I can manage. If I need to buy sanitary towels, then I don't buy cigarettes and I'm trying to give up smoking as well. (Interview 2)

The most detailed accounts of expenditure came from the sixteen and seventeen year olds who were living in a supported project and who stressed the 'need to prove to staff' their budgeting abilities as this was one means of demonstrating their ability to maintain a future tenancy. However, this was the 'formal' presentation of self, for even in some of those accounts, akin to their older 'single' counterparts, examples of 'informal' budgeting strategies emerged. Because payments were received on different days, borrowing money from fellow residents was found to be commonplace in the local authority hostels and the ability to 'pull together' was emphasised, yet correspondingly, those who borrowed referred to 'the circle of debt' as a 'strain':

> Need to start borrowing money, then by the time your Giro comes in you owe half of it out an' you just keep going like that aw the time. Ah worry cause when Ah borrow money off people Ah don't know if Ah'm going to see my Giro cause sometimes they don't send it oot and they make you gae up, so Ah know Ah'm no gonnae be able to pay people back. (Interview 4)

As considered in Chapter 7, such collectivity was said to foster bonds between residents. However, among those who stressed they 'would never borrow', two

factors dominated accounts: they did not wish to be in perpetual debt, or tales of 'fairweather friendships' were imparted. Receiving small amounts of cash, tins of food or meals were reported by those who had 'housed' boyfriends' or who still maintained contact with families. Pawning jewellery was also cited, but was said to create problems with finding cash to redeem items. A few of those living in the 'adult' hostels mentioned utilising voluntary organisations for food or clothing and one reported 'shoplifting' whenever toiletries were required. Only rarely were staff approached for tins of food, since this was said to be tantamount to admitting inability to 'cope'.

Poor motivation - some tentative remarks

Three factors lead to an immediate questioning of the 'poor motivation' thesis: firstly, all interviewees were sufficiently motivated to present themselves for interview for a research project from which they would derive no reward and, secondly, as indicated above, although reporting upon the mundane nature of their daily lives, the decisions implicit in their accounts of budgeting strategies suggest that the apparent minutiae of daily life merits investigation. The prioritisation of expenditure is not only a practical exercise in terms of the fundamental human needs of ensuring shelter and food, it points to purposive reasoning, and references to forgoing some purchases, generally cigarettes, or 'treats' such as chocolate, in order to buy sanitary protection demonstrates a reordering of priorities as required. Such apparently unavailing matters are essential guides for understanding the context within which the interviewees lived their daily lives as cognisant, goal-directed agents within a given material framework. The third influence was derived from participant-observation which, as exemplified in Chapter 3, revealed a variety of health strategies undertaken in young women's daily lives, ranging from eating specific foodstuffs or asking for warm clothing to chiropody and dental consultations. Moreover, such background work identified how, overwhelmingly, most expressed a belief that they were doing as much as they were able, health-wise, in their circumstances.

Health work explained

As established in Chapter 2, 'health', and its patterning cannot be understood by reference to one-dimensional paradigms alone, nor can it be defined without acknowledging the meanings individuals ascribe to it. Interviewees' definitions are considered at the end of this chapter, but as outlined in the accounts of 'health problems' in Chapter 5, interviewees provided examples of mind-body connections and associated the production of these problems with biological, psychosocial, environmental and material processes. Given the complexity of these associations, it is incongruous to assume interviewees' passivity, implicit in the 'poor motivation' thesis, as far as health production, maintenance, restoration and amelioration activities are concerned. Accordingly, based upon the conjecture that individuals undertake 'health work' (*cf.* Abbott and Payne 1990; Stacey 1993) as an integral part of their everyday lives, the data was interrogated using the following questions:

1. What aspects of 'health work' can be deduced from the narratives?
2. Do these support the 'health work' thesis?
3. What factors were perceived, by interviewees, to exert influences, positive or negative, upon their ability to perform 'health work'?
4. Why were 'professional health workers' consulted for some health problems and not others?

The production and maintenance of health

Diet

In the accounts there was strong evidence to suggest that interviewees acknowledged the importance of their own actions in the production and maintenance of health, but, as they consistently emphasised, such actions were subject to material and environmental constraints. The most fundamental issue raised by most of those living in the 'adult' hostels which was believed to set limits upon their potential for health improvements related to lack of basic facilities and money to buy necessary items:

> I came in here with nothing, apart from my clothes. And I came in with a can of soup, but how can you have a can of soup if you don't have a can opener and a bowl to put it in? I went to the Social for a Crisis Loan, that "wasnae a crisis", but I had nothing. I'd nae clothes, nothing to cook wi', nothing to eat wi', or nothing, do you know what I mean? I didnae have any money for washings, so I'd nae clean clothes and they're saying "If it's no' a problem wi' your health we cannae help you". And I'm trying to say to them "Well if you don't gie me something to eat wi', or cook wi', I'm no gonnae be eating, so if I'm no eating I'm gonnae fall on my arse again! I'm starving!" "Oh" it's no' their fault "Go and ask the hostel for something". But it's no' the hostel's fault, if they're gonne gie it out to me, they're gonnae have to gie it to everybody and they're no' gonnae get it back off everybody. (Interview 17)

As indicated in Chapter 2 an association between diet and health is long established and the interviewees acknowledged this in their accounts. However, apparently contradictory findings from the data suggested that the lengthy narratives relating to diet should be examined closely since buying food was said to be a priority after rent and debt payments, yet diet was implicated in many of the health problems reported in Chapter 5. Moreover, as the most important element of 'health work' identified during participant-observation, as illustrated in Chapter 3, dietary issues were emphasised by all interviewees with the most common response to the question 'do you do anything to keep yourself healthy or to improve your health?' being 'I eat'.

All were asked loose opening questions on their perceptions of their diet, generally posed as 'are you happy with the kinds of food you eat?' Excluding those twelve who had reported 'eating problems', thirteen believed their diet to be 'good' and sixteen believed it to be 'bad'. Further questioning revealed the basis of most diets: tinned soup, macaroni cheese or hot dogs, dried pasta in sauces, chips, hamburgers, pizza, spaghetti or beans on toast, *Pot* and *Super Noodles*. Only four, who considered their diet to be 'good' reported consuming fresh meat, fish, fruit and vegetables and combinations of bread, cereals, rice and pasta daily; three were mothers, and one, for whom food was described a

'new joy' and who attributed her 'great diet' to information provided by the drug recovery group she attended, reported spending most of her Incapacity Benefit on food, and most of her free time in food buying and preparation since lack of storage, and one saucepan, was said to limit buying more than was required daily.

Distinct accommodation-based differences were found. Those in the 'adult' hostels reported being provided with cooked breakfast and this was said to be the only food consumed until evening, unless breakfast was 'missed' and bags of chips or pre-made filled rolls were bought for lunch. Those who lived in the supported facilities tended to report having cereal or toast in the morning and making a filled roll, or soup at lunchtime. All of those latter interviewees reported having their own fridge and buying additional foodstuffs, such as dairy products, fruit, salad ingredients and frozen foods as 'usual' purchases. Interviewees who believed their diet to be good could be placed in one of two categories: those who were eating a more varied diet, and those who typically explained their diet as based on 'normal things' referring to the basic foodstuffs listed above, upon which previous diets had reportedly been based. Those who believed their diet to be 'good' did not report any health problems associated with diet.

In contrast, those who believed their diet to be 'bad', or who had reported 'eating problems', implicated their diet in various health problems reported and, once more, two distinct groupings were identified: those, generally younger, interviewees who attributed their 'bad' diet to how they were feeling in terms of 'no appetite' or 'cannae be bothered cooking', and older interviewees who expressed frustration with their diet and reported 'going hungry' frequently. In this latter grouping were two, with diagnosed bowel disorders, who expressed concern that they were unable to comply with the diets recommended by their doctors. As indicated in the extract cited above the root of the reported 'stresses' arising from these frustrations lay in their

material and environmental circumstances: shortage of money to buy necessary utensils; 'dirty kitchens' and lack of secure or appropriate storage facilities (*cf.* Conway 1988), since stealing from communal fridges was said to be commonplace, and this alongside heat in the bedrooms was said to militate against buying fresh foodstuffs. The costly nature of pre-made or packaged food was implicated in money running out before 'Giro day'.

Some insights have been derived here. Firstly, as initially suggested in the accounts of those with prior experience of 'homelessness', previous experience appears to provide a normative context for present perceptions. For a few, what was eaten in the hostel was said to be no different from the types of food eaten prior to entry, in the parental home, or subsequently when moving around. Secondly, interviewees connected their material and environmental circumstances with perceived health outcomes, that is, where these were perceived to be inadequate they were directly implicated in poor health outcomes. In contrast, where diet was not associated with health problems, material and environmental circumstances were deemed to be sufficient, and although health problems, which others had attributed to diet, were reported these were related to physical, such as menstruation, or psychosocial factors 'just the way I'm feeling'. These data lend strong support to these accounts being meaningful expressions of interviewees' material circumstances (*cf.* Popay 1992).

Thirdly, with the exception of those who believed their diet to be based on 'normal' or 'usual things', most explained what they believed constituted a 'good' diet, for example fruit, vegetables, 'low fat foods', 'a lot of fibre' and meat, although three reported no longer eating any beef products because of 'BSE worries' and one reported having become a vegetarian. As alluded to in the extract above, where such foodstuffs could not be eaten because of storage or affordability problems, this was cited as one of the main sources of 'stress' because interviewees perceived their diet to be inadequate. Such expressions of

'stress' arising from frustrations were directly associated with perceptions of 'powerlessness' to improve material and environmental circumstances. Fourthly, most stressed the benefits of the foodstuffs consumed in that they were 'cheap, hot and filling'.

Furthermore, the lacuna between awareness of what should be eaten and what could be eaten created additional concerns, as exemplified in the cases of the diet-related health problems mentioned in Chapter 5. 'Poor compliance with treatment' (*for example,* Balazs 1993; Boulton 1993) is commonly reported in the homelessness literature, but the over-riding factor to emerge in this regard was that inability to 'comply' was said to create tensions. This was especially evident in the accounts of those who reported diagnosed anaemia as a health problem. Immediate inspection of the numbers not 'complying' with their iron treatment would appear to support the 'non-compliance' thesis, but to accept this without question is to disavow the rationales provided:

> They found out I was anaemic. Your blood count is supposed to be 12.9, or something like that, and mine's 5.7. So they put me on a course of iron tablets, *ferrous sulphate*, and I was on six hundred milligrams a day, but they were killing me. I was doubled up with the pain in my stomach, so I just knocked it on the head and stopped taking them. But it's awful cause I'm still always light-headed and dizzy and starved. And the pain in my stomach, I can't tell you how painful it was, I was doubled up with it, just couldn't handle it and I stopped taking them. They're still in my drawer, but I just can't take them, you know, not six hundred milligrams a day, that's a lot of iron! (Interview 12)

This interviewee, like others who had stopped taking their iron tablets, was referring to pain associated with constipation arising from this medication which they also connected with the lack of fruit and vegetables in their diet, their lethargy and associated lack of exercise. Unlike this interviewee, however, four reported taking an occasional iron tablet when symptoms, such as dizziness, became marked, and stopping once more when abdominal pains or constipation could not be tolerated. None were found to have returned to

explain these problems to the GPs who had prescribed treatment. When asked why, three main explanations were offered: reluctance to consult their GP either because they had not adhered to the treatment and did not wish to be 'told off', or they believed they would have to inform their GP of their changed circumstances and did not wish to re-register until they had a permanent address. Most importantly, however, anaemia was perceived as diet-related, which in turn related to low incomes and poor facilities. Anaemia, therefore, although a physical problem was perceived as material in origin.

Personal hygiene

> Naebody's got an excuse in here for no being clean, they havenae cause there's always hot water, there's never been no hot water. You can even get up through the night to have a bath or shower! It's great, so it is! (Interview 9)

In direct contrast to the accounts of circumstances as related to diet, interviewees consistently illuminated the benefits to their well-being, as indicated in this extract, of being able to bathe or shower whenever they desired, usually reported to be 'at least once a day'. Although, those living in the 'adult' hostels recounted negative aspects of sharing these communal facilities, including problems associated with other residents not cleaning the bath after use, or with older residents' incontinence, the lengthy narratives on the subject of personal hygiene indicated the priority interviewees accorded this, a factor supported on inspection of their budgeting strategies. As recorded earlier, buying soap, shampoo, anti-perspirant and sanitary protection was said to be a priority on receipt of benefits. Moreover, money was said to be 'set aside' for 'washing tokens', although 'doing odd jobs for staff', such as cleaning, was reported a popular way of obtaining such tokens.

Three interviewees believed themselves to be 'a bit obsessed' with cleanliness or potential body odours. They connected this with other reported long-standing 'health problems', such as anorexia or 'heavy periods' and previous

abuse. These accounts were united by the twin themes of financial and time costs since all three believed their expenditure on toiletries and washing powder to encroach upon their food budget, and mentioned the time involved in showering or bathing, on average, twice a day and hand-washing clothes daily. They were the exceptions, however, among a sample for whom cleanliness was accorded prominence in their accounts.

Three key elements were found to indicate the importance of hygiene matters. Firstly, in their accounts of 'home life' or when staying with friends there had been a stated reluctance to 'use up hot water' which they had not been paying for, or when sleeping rough showering, generally in train station facilities, was described as a 'luxury' when money was available. Secondly, in their definitions of 'home', 'cleanliness' was found to be a key defining feature, and this was related to these past experiences and, for some, the present sharing of communal facilities. Thirdly, and related to a main defining feature of 'home' explained in Chapter 7, in the many definitions of 'real homeless people' the words 'smelly' and 'dirty' were employed. Accordingly, it could be implied that, in their focus upon issues of personal hygiene many were reinforcing their 'differentness' (Goffman 1963) from 'real homeless people'.

This latter point also appears to provide a clue into GP consultations regarding 'skin problems'. National and international studies demonstrate that skin problems are one of young people's, especially young females, main health concerns (*cf.* Hodgson *et al.* 1986; MacFarlane *et al.* 1987; Sobal 1987; Brannen *et al.* 1994; Currie *et al.* 1994). Yet, as the second highest reason for GP consultations among the sample, amid a host of other health problems for which consultations were not sought it was necessary to consider possible psychosocial factors which may have spurred these actions. Despite being attributed to such factors as diet, being 'run down', or period-related, spots were generally believed to be a sign of being 'dirty' or 'not looking after yourself properly'. As also explained in Chapter 7, other peoples' opinions

were found to exert an influence upon interviewees' well-being. Thus topical ointments, cream and tablets were sought to try to cure these visible 'markers'. To exemplify these matters, having reported multiple health problems this interviewee was asked what worried her most about her health. She replied 'ma spots' because,

> Feel I look dirty. If I'm in a crowd or anything I'm dead shy and I don't like anyone staring at me and that sort of thing because of them. Just puts me off. I'd do anything to get rid of them. Tried everything to get rid of them. (Interview 19)

As this section has shown, diet and personal hygiene were fundamentally important to the interviewees sense of well-being. What is important to bear in mind at this point is that interviewees expressed strong beliefs they were doing as much as possible to maintain their health through these activities within their given circumstances.

Health promotion

This section addresses a related assumption to the 'poor motivation' thesis. Homeless people are said to have more untreated disease than the housed population (*cf.* Featherstone and Ashmore 1988) and this is said to be compounded by indications of health promotion being 'a very low priority' (Balazs 1993: 85). Accordingly, at interview it was necessary to elicit what, if any, health promotion activities interviewees undertook. All had been asked a question, loosely posed as 'Do you do anything to try to keep yourself healthy or to improve your health?' (*cf.* Blaxter 1990: 165). Over and above eating, as exemplars, the three most readily mentioned areas will be highlighted here. These were dental consultations, walking and cervical screening. The first two correlated with data derived from participant-observation, where chiropody came third, a reflection of foot concerns associated with sleeping rough and working on the streets.

Dental health

Homeless people are said to have a 'low level of perceived need', despite high levels of dental disease (Hopes 1985). Accordingly it was necessary to elicit any evidence in the data to support this impression. Sixteen interviewees reported presently experiencing toothache, gum infections, or problems with wisdom teeth. Those with problems relating to wisdom teeth 'coming through' explained they had not consulted a dentist because this was 'just part of growing up'. Paracetamol or aspirin were reportedly used for the associated pain. Among those who reported toothache six had not consulted a dentist, although four said they would if the pain increased, three of whom stating they 'would probably' go to the dental hospital rather than registering with a local dentist because fellow residents had told them the treatment there was 'good'. Toothache and gum infections were attributed to 'not going to the dentist for check-ups', no facilities for routine dental hygiene when sleeping rough, teeth being 'weak' after pregnancy, being 'run down', or too many fizzy drinks in childhood.

Reports of dental consultations were mixed. Fourteen reported having consulted a dentist within the past six months, twelve within the past year, and fifteen had not been for over a year. The first group was divided into two sub-groups: eight whose approach can be termed 'proactive', that is, who reported they had been in the habit of attending regularly for dental examinations and reported few, if any, dental problems; and the others whose approach can be regarded as 'reactive' were presently consulting a dentist, or the dental hospital with toothache, gum infections or for cosmetic purposes.

The second group comprised seven who reported having been in the habit of consulting their dentist regularly, but who had been unable to do so latterly for factors associated with their homelessness or employment. Examples of these included, inability to travel to the areas or towns in which their dentists were

located, an unwillingness to return to this area for fear of meeting parents, or being unable to ask for time off work. All expressed an intention to register with a new dentist, but stated reluctance to do so presently since they were uncertain as to how long they would be living in the hostel or where they would be living thereafter. Others reported having presented with dental problems, or as part of 'check ups you have when pregnant'.

In the third group, with a reported range of between one and nine years, the general length of time since consultation was found to have been between two and four years. Four related this to their homelessness and reported having been in the habit of attending previously. They expressed a belief they would register with a dentist when 'settled'. Among the remainder previous check-ups were found to have been infrequent and when they had attended extensive treatment had been required. This was said to militate against future consultations:

> Last time I went to the dentist I didn't think there was anything the matter with my teeth. I thought I had perfect teeth. I went to the dentist. How many fillings would you say I've got? I've got four there and two there (points) and I've got six silver ones (points). What's that? About twelve fillings and I still need more done. The last time I was back he gave me two jags up there (points) and two at the back and it was painful, it was bleeding and all that. And he pulled two of my teeth out as well and he left a bit inside it. I had to pull it out myself after I'd went to the dentist, so I never went back to him. I'm a bit scared now. (Interview 3)

The first conclusion to be drawn from the data is that the connection between homelessness and preventative dental health measures is rather more tenuous than suggested in references to 'poor motivation' or 'low priority' since only nineteen reported a history of routine six monthly check-ups. Secondly, where homelessness is implicated in either non-registration, or non-attendance each interviewee could provide a 'reason' why they would or could not do so. Thirdly, where interviewees had no history of 'proactive' dental health work, perceptions arising from their experience of the care received was said to have

reinforced negative impressions held previously which had disinclined them from future check-ups. Finally, although accepting the potential for 'interviewer effect' here, in the accounts of those who stated an intention to register with a dentist when 'settled' two main factors were found which are of relevance to earlier considerations on GP registration. Here 'embarrassment' of 'saying you live in a hostel', or the belief that there was 'no point' in registering because 'you never know when you'll get a house' supported other findings presented in Chapter 7, as evident in their definitions of 'home', in that lives were presented as being 'on hold' until the future was more certain.

Exercise

All informants reported one common health promotion activity: walking, although this tended to be through necessity rather than choice, since it 'saves on bus fares'. Distances of several miles were found to be covered over a single day, either to 'go for a wander round town', when visiting friends or family, or because of access problems to public transport when alone with a child, a pushchair and shopping. Although the savings on fares were reported, the extent of walking was said to 'wear shoes down' and this was particularly problematic where interviewees stated they only had one pair.

For most, walking was the only exercise undertaken, though one interviewee reported attending a sports-based recovery group daily, and four others mentioned going swimming as often as they could afford to a local pool which was said to offer discounts to unemployed people. In total, seventeen interviewees recounted regular participation in sports or other exercise activities, predominantly swimming and aerobics, whilst at school or when living with parents and expressed regret that they were unable to do so now, one of whom had stated her long-standing desire to be a physical education teacher particularly emphasised the frustrations arising from her present circumstances. Although acknowledging the potential for 'interviewer effect',

those interviewees expressed an intention to resume past activities when settled.

The numbers here are too small for any concrete comparisons to be drawn, but the lower number of those reporting previous participation in exercise activities when juveniles compares with findings elsewhere (*cf.* Brannen *et al.* 1994: 119) where just under two-thirds of young women reported no 'vigorous physical activity', such as swimming or 'keep-fit' in the previous week. Present exercise levels were found to be highly different to those found among Blaxter's youngest female sample: walking found to be much higher and 'active sports' much less (28% and 43% respectively, Blaxter 1990: 167). These differentials, as indicated above, were reported to be ultimately rooted in the interviewees material circumstances.

Common explanations were offered for the present state of non-participation: lack of money to join a sports club or to pay for individual activities; lack of energy, although most acknowledged this would probably provide them with energy, but could not make the initial 'effort'; not wishing to be alone in public spaces (*cf.* Green *et al.* 1990); and, not having the 'right kit', nor money to buy appropriate sportswear. It is posited that patterns of consumption are key to the social construction of youth identity (*cf.* Miles 1996) and this latter consideration, identified elsewhere among unemployed young people (*cf.* Jones and Wallace 1992), was particularly evident among the youngest interviewees who tended to specify brand-names they would like to have, but could not afford. As indicated in Chapter 7, this appears to exemplify the desire by the interviewees, as young women, to adhere to appropriate cultural identities.

Cervical screening

The literature on cervical screening and homelessness is very limited and what exists under-emphasises that it is poverty which provides the biggest 'risk' factor for death from cervical cancer (*cf.* Whitehead 1988). Balazs (1993)

proposes that homeless women are more at risk of having abnormal cervical cytology, an effect of identified 'risk factors', especially 'behaviours', but they are less likely to have had smears and, even where conducted are less likely to know the results. In his study of an opportunistic sample of fifty homeless women between the ages of twenty to sixty-five years, thirty-six had had smear tests previously, but only twenty-four knew the results (Balazs 1993, 1997).

Eighteen interviewees reported having had cervical smear tests and they could be placed in one of three groupings: those with an experience of pregnancy, whatever the outcome; those who were using the contraceptive pill or *Depo-Provera*; and, those who had contracted a sexually transmitted disease. All reported having been informed of the result, and one was attending a colposcopy clinic. Among those twelve who expressed an intention to have a smear test at a future date were interviewees who reported they were still virgins and did not see this as necessary until sexual relations were established. With the exception of those who had mentioned 'vaginismus', the remainder expressed reluctance for three main reasons: they did not 'like the idea' of the procedure, describing it as invasive, particularly if performed by a male, a point stressed though not restricted to those with a history of abuse; a few did not 'see the point' since they 'wouldnae want to know' if there was something wrong; and some expressed a belief that it would be 'too sore'.

To varying degrees all expressed an awareness of what this procedure was for from, the majority of explanations which encompassed 'something to do with cancer' to one who explained she was in 'a high risk group', as a result of substance use and prostitution. In general terms, however, smear tests had been performed as an aside to other health matters since only this latter interviewee reported having presented for screening voluntarily. This could be a reflection of the age of the sample, since both youthfulness and virginity were the most common reasons for over half of interviewees perceiving this to be unnecessary at this stage in their life.

This section has problematised motivational assumptions associated with homeless people in general and homeless young women in particular. It has also served to reveal contradictions in these assumptions. For, if the 'poor health' of homeless individuals is attributed to 'health risk' behaviour, an 'active' category, how then can implicit assumptions of 'passivity' as far as their health promotion is concerned, be sustained? Such contradictory value-laden assumptions are no-where better expressed than in the popular mythology surrounding young women and pregnancy.

Control of reproduction

Three key issues underlined the need to explore contraception issues. Firstly, and despite no evidence being found (*cf.* Greve with Currie 1991; Jones 1993(4); Ermisch *et al.* 1995; Speak *et al.* 1995), the popular mythology of 'young women deliberately becoming pregnant to obtain a house' persists. Secondly, there has been ongoing debate about teenage pregnancy being a response to unemployment (*cf.* McRobbie 1991). Thirdly, young women who have experienced family disruption are shown to be more predisposed to pregnancy before the age of eighteen years (Sweeting and West 1995b). Given the extent of histories of family disruption and family conflict among the sample it was necessary to elicit the nature of the relationship here. Accordingly analysis was guided by the following questions:

1. To what extent was contraception reportedly employed?
2. What reasons did interviewees provide for the use, or non-use of contraception?
3. Were there any common trends in interviewees' expressed attitudes towards contraception?
4. How can the relationship between homelessness and these attitudes be interpreted?

Studies of young peoples' attitudes and behaviour towards sexual relationships indicate a majority (75%) who approve of pre-marital sex (Furnham and Gunter 1989) and high levels of sexual activity (*cf.* Darling and Davidson

1986; Humphries 1991). Around half of sixteen year olds report having experienced sexual intercourse by this age (Breakwell 1992). In Brannen *et al.*'s study five per cent of females in the questionnaire survey reported taking the contraceptive pill. In their interviews with fifty-six young people, nearly two-fifths reported early sexual intercourse, over half of whom reported not having used contraception for first sexual intercourse; and, among the respondents, those sixteen who reported present use of contraception, nine used condoms, five the contraceptive pill and two coitus interruptus (Brannen *et al.* 1994: 104). From these studies alone it can be deduced that many young people have liberal attitudes towards sexual intercourse and, to various degrees, are sexually active. They also take 'risks'. These 'risks' are shown to have a material base since young people in deprived neighbourhoods tend to have earlier, and 'unprotected' sexual intercourse than other comparable groups (O'Reilly and Aral 1985; Bagnall and Plant 1991; Breakwell 1992).

Most interviewees who reported being in a long-term relationship stated they were using either the contraceptive pill or *Depo-Provera* to avoid unplanned pregnancy. Seven, who recounted recently established sexual relationships, reported using condoms. In the former cases the choice of contraception was said to have been made after discussions with partners, GPs or family planning clinic staff. Discussions with partners were reported to have taken place for those using condoms. A further three who claimed not to be in a sexual relationship said they were 'taking precautions': mothers who had requested *Depo-Provera* or an intra-uterine device after their last births, and a 'single' interviewee was taking the contraceptive pill, primarily for dysmenorrhoea. Both interviewees who worked as prostitutes emphasised their 'safe sex' practices with condoms.

Twenty-two reported no use of contraception. Among this number were two who said they were in sexual relationships and reported having used condoms initially, but were not using any form of contraception because their boyfriends

'didn't like them' and 'said he'd stand by me if I fell pregnant'. The majority, however, were those who reported being virgins, not presently involved in a sexual relationship, were pregnant, had reported vaginismus or previous sexual abuse, or a lesbian. To discover the extent to which most of those interviewees in the former two categories, had considered contraception they were asked what they thought they might use. Almost equal numbers cited a preferred form, or had either not considered, or did not intend to use any form.

The two interviewees who were not using any form of contraception suggest support for other work (*for example*, Gordon 1990) indicating females very often 'succumbing to pressure' from partners against the use of condoms, or in several of the interviews with homelessness professionals where 'powerlessness to insist on the use of condoms' was reported. This issue of 'lack of personal power' in sexual relationships is also found in the homelessness and health literature (*for example*, Boulton 1993). However, those two interviewees were in the minority compared to those who asserted they would use condoms in a new relationship:

> If I get a boyfriend again he'll *have* to wear a condom, or no sex! (Interview 23)

> When I was first wi' somebody, the first time, I think I'd want them to use a Durex, no' just for no' getting pregnant, but for everything else and aw. But when I get into, if it got to the point that we were serious I don't think I'd want to keep using them aw the time. (Laughs) Get them to get an AIDS test first! But eh, I wouldnae want to carry on using them if it was gonnae be serious. Think then I'd probably have to go on the coil or something like that. But at first, at first, I'd definitely be using them cause you never know where people have been do you? Or what they've got! (Interview 37)

As with the interviewees who reported present use of condoms, as indicated in this latter extract, all those who believed they would use condoms initially expressed an intention to change to another form when the relationship progressed. This indicates a change of focus from initial concerns about

sexually transmitted diseases, especially HIV, to subsequent worries about pregnancy. These focal changes concur with findings elsewhere (*cf.* Richard and Van der Plight 1991). Some confusion, however, was found to exist concerning possible alternative forms, since most expressed varying degrees of concern over, at the time, media reports of 'side effects', or 'dangers' associated with the contraceptive pill. Two also expressed concern about *Depo-Provera*, questioning 'what happens to the blood?' because menstruation does not occur, surmising that this might create future health problems.

The strongest factor to emerge in many accounts was an expressed awareness of the aforementioned popular mythology and much anger was directed at the media and politicians:

> Ah wouldnae fall pregnant for tae get a hoose. Ah mean, crikey, what about the wean? Christ Ah'd gie my right arm to get a hoose, but Ah wouldnae want a life sentence! A wean's a big responsibility and Ah don't want tae bring up ma wean the same way as ma mum wis wi' me, so Ah'm no having one til Ah've thought it through and everything. (Interview 5)

The effect on their sense of self, and well-being, exerted by such awareness was illustrated in Chapter 7. This is important for it introduces here reasoning behind the differential attitudes expressed towards actual or future contraceptive practices and these tended to be underlined by surmised actions that would be taken if 'accidents' were to happen. Whilst one disclosed her belief that she might be pregnant again and 'didn't know what to do', the remainder expressed strong opinions and could be divided into two clear categories. Interviewees were divided amongst those who stated they would terminate the pregnancy, and were generally those who were using contraception or expressed an intention to do so when in a sexual relationship, and those who stated they would continue with the pregnancy. Amongst this latter group were those two who reported having stopped using condoms or tended to have reported they did not think they would use contraception. All

here referred to religion or morality, expressing their belief that 'abortion is wrong'. Uniting all responses, however, was a consensus that adoption would not be considered because: firstly, interviewees reported that they could not 'cope' with a future knowing they had a child 'somewhere' and would not have any part in the child's rearing, and secondly, those with an experience of 'care' did not wish to 'put a wean through that'. This latter point provides a clue into both sets of responses, since world views arising from their lived experiences exerted a strong influence on expressed attitudes, exemplified here:

> I'd keep the wean. See if I ever have a wean I would gie it all, want to pure love it. I would really make sure it was pure loved and aw that, love it aw it wants. I said that to ma social worker, I said "I'd pure love ma weans. I'd make sure they knew I wanted to have them, not like my ma. I'd love it." But hopefully that won't happen, I want to wait till I'm a bit older and that, but if it happens, it happens and I'd love ma wean all the same. (Interview 13)

> I would probably get an abortion cause I couldnae have it. It wouldn't really be a self, like wi' emotions and that, it would just be a body, better to get it out of a body before it got into a human. I do want weans, but far, far in the future, far, far away when I've got a good life to bring the child into. This is not a good life to bring a child into just now. I'd want to give it what I never had, so I'll wait til I've grown up to have my wean, nice stable home so I can bring it up in a good environment and I'll have an awful lot of love and knowledge to give it when I'm ready, but not now. (Interview 24)

As alluded to in the second extract, those who expressed a resoluteness not to become pregnant until they were ready tended to express various degrees of optimism about their present lives and spoke of their determination to work towards a secure future based upon three, generally ordered, priorities: 'nice home', 'good job' and 'stable relationship'. A potential unplanned pregnancy was described in such terms as 'ma life would be ruined'. Those interviewees indicated that, by providing materially for themselves around these priorities, they would offer any child a 'better chance in life' than themselves. This inability to prepare materially for her coming child was reportedly the main

source of 'stress' for one of the pregnant interviewees who reported having been unaware of the pregnancy until the third trimester:

> Shocked. If I could have had an abortion, it was one of the things I would have considered if it had been earlier and I'd just found out. Because of the situation that I'm in, homeless, no job, my boyfriend's unemployed just now, he's still staying with his mum and dad, and I'm out o' the house. It's not the environment you'd want to bring up a kid. If I had a good house and a job I would have been pleased, I suppose I'm pleased now, but it's taken a long time to sink in. (Interview 39)

Correspondingly, among those who expressed they would continue with any pregnancy, similar priorities were found, but the difference lay in their expressed belief that they 'would just have to live with the consequences' of their actions, 'the wean shouldnae suffer cause o' what I done', maintaining that the 'love' they had to offer should surmount potential material difficulties. This focus upon 'love' was associated with tales of 'rejection' as children. The accounts offered by two of the mothers who had continued with their unplanned pregnancies, which as with others were said to have arisen from failed contraception, or 'didnae think it would happen to me' provides a way of understanding the meanings underlining these sentiments:

> At first I felt like crying and everything, felt really sad. But about a month later I felt it was part of me. For the first time in my life I had something to care for, just me. (Interview 28)

> When I found out I was pregnant I was happy, so happy, aye. I think it was because, well a lot had been missing from my life. I know I shouldnae have thought about having a wean, but it wasnae til later on in years, like you're like that, it wasnae a wean that was missing from my life, it was a life that was missing from my life. Know, like sitting in the house twenty-four hours of the day and aw that. It wasnae that I yearned a wean, it was that I yearned a life. (Interview 41)

Among those interviewees who were pregnant and 'mothers' the mean age of first pregnancy was seventeen years, with a range of fifteen to twenty years. Associations between reproduction and homelessness were mixed, but two

groupings can be identified. The first group comprised those who had reported becoming homeless after relationship breakdown with partners and those whose parents could not afford to maintain them. All reported having good relationships with their parents. In the second group comprising the remaining cases, and whether or not they had been in cohabiting relationships, common themes of high levels of family conflict and disruption and, especially experience of 'care' characterised histories. Such themes were also typical of the histories of those, generally younger, interviewees who accorded primacy to the psychosocial constituents of motherhood regardless of circumstance.

This section has demonstrated that popular conceptions of homeless young women and pregnancy are over-simplified and misplaced. Without an understanding of their lived experiences, socially and materially, and associated aspirations no connections can be made. Underlining the popular assumptions of homelessness and pregnancy is the general demonology surrounding welfare dependent lone mothers and the reported psychosocial effects of this stigmatisation was introduced in Chapter 7. Existing studies of homeless mothers and their children do little to challenge this mythology. Instead these reinforce an imagery of passivity in their tendency to focus upon the ill-health experiences and the limitations of the circumstances within which their 'respondents' live. The concept of 'health work', therefore, provides a means to access the everyday lived experiences, and the motivations and decisions which exert influences upon the care of dependants.

Care of dependants

Having illustrated, with examples, the extent to which combinations of material circumstances, knowledge and attitudes interact to produce health work outcomes this section considers care of dependants as a useful exemplar of health work. Key questions influencing the analysis here were:

1. What evidence of health work pertaining to dependants exists in the data?

2. What factors did interviewees perceive to exert an influence, positive or negative, upon their ability to perform such health work?
3. Are there any differences between the health work undertaken for themselves and for their dependants?
4. If differences exist, how can they be interpreted?

Three examples of health work are considered here which relate to dependants' diet, restorative and preventative measures, and laying future foundations. These had emerged as the three strongest areas to pursue from data derived from participant-observation and the focus group with the mothers where the positive, rather than the negative aspects of motherhood, despite material circumstances, had been particularly stressed.

Dependants' diet

Breast-feeding is regarded as 'good practice' today and women are actively encouraged to do so by health professionals, particularly because of its beneficial effects upon health for both mother and child (*cf.* Oakley 1993). Only one interviewee reported having breast-fed her infant for the duration of her time in hospital after delivery and had changed to bottle-feeding on discharge. Another, whose infant had spent several days in a Special Care Unit said that she would like to have tried, but the separation had made it 'impossible'. One pregnant interviewee reported having considered this, but had now decided to bottle-feed. On immediate inspection the data would appear to indicate that, as an example of health work, breast-feeding is a rather weak one. However, by exploring the knowledge and attitudes of the interviewees as related to their social and material circumstances, the decision to bottle-feed can be understood.

Firstly, returning to the outline of the interviewees' labour and immediate post-natal histories outlined in Chapter 5, reports of either their own debilitation, or their infants admission to Special Care was said to have militated against breast-feeding. Although these reasons were proffered as acting as a final disincentive, they do not explain why most reported having made the decision

to bottle-feed prior to delivery. Research has long shown that the preferred method of feeding is chosen before pregnancy (*cf.* James 1981) and that over one-third of women decide not to breast-feed, this being closely linked to lower social class, young age, lower education attainment and region (White *et al.* 1992) with low Scottish levels (7.6%) found among women in a Glasgow housing estate (Campbell and Jones 1996). Previous experience of breast-feeding is also shown to exert an influence (White *et al.* 1992). Accepting the similarities in the sample's class, age, educational levels and areas of origin it was necessary to elicit the psychosocial processes behind the decision to bottle feed.

All reported having decided upon the milk formulae used prior to the birth following the example, or recommendation from others known to them. The reasons offered were complex, yet underlined by main themes: convenience and, for some embarrassment, as implied in 'just didnae like the idea' or 'couldnae see me doing that' (*cf.* McIntosh 1985), practical difficulties with breast-feeding in public and lack of support (*cf.* White *et al.* 1992) whether or not they had been in a relationship, and anecdotes of others' experiences. However, practical concerns arising from their situation were paramount:

> Well I'm not breast-feeding! I'm picturing what do you do if you're out getting messages and in the middle of it the baby's hungry. You cannae exactly drop everything and say "Wait till you get home and I'll feed you". I mean you could be in the middle of anywhere. It's no' just that you could be caught in an awkward situation, like on a bus, cause everybody, you get these clothes now that you no longer see it. I wouldnae be embarrassed that way, everybody seeing my breast and actually doing the breast-feeding, but I think I'd rather bottle feed. I donno, it's easier to bottle feed I think, I know that your chest'll be sore after, but that'll go away soon. I was gonnae try, but I though "No I don't want to be in awkward situations", big queues wi' the messages and the baby gets hungry, you can't put the messages doon and start feeding the baby in the middle of a big queue (laughs). I can't imagine that! (Interview 39)

A final group of explanations, relating to earlier accounts of their own and their infants' 'poor' post-natal health, surrounded the interviewees' perceptions of their own health status. This, generally, was not deemed conducive to providing sufficient nutrients (*cf.* Jones 1987; McIntosh 1985; White *et al.* 1992) and, whilst this may have been regarded as 'more acceptable' than other explanations provided (*cf.* McIntosh 1985), the accounts of dependants' diets indicate that 'health' was one important factor in decision-making:

> I bottle fed. Wi' me smoking and I'm no' really into health foods or anything either, so I really didnae see much point in breast-feeding. (interview 37)

Although there were exceptions who reported a more varied diet, in contrast to the rather processed basic foodstuffs consumed by most interviewees, mothers emphasised the importance of 'quality' in their children's diet and most recounted 'shopping around' for 'best buys' in branded products rather than buying cheaper shop's-own alternatives, despite reports of purchasing these for themselves. This, alongside emphasising the importance of buying branded nappies, rather than cheaper versions, reinforced the imagery provided by the mothers that brand-names equated with quality. This suggests that, despite not being able to 'buy into' consumer culture themselves, interviewees were trying to ensure that their offspring did not lose out. Although a couple of children were said to be 'fussy eaters' the data on their diets revealed a greater degree of variety, such as more dairy products, fresh vegetables and fruit, and 'treats' such as crisps or sweets, than found in interviewees' diets. There was also concrete evidence indicating that interviewees occasionally limited their own diets in order to provide for their children (*cf.* Lang *et al.* 1984; Milburn *et al.* 1987; NCH 1991).

Finally, in the context of infants' nutritional concerns, both of the pregnant interviewees reported taking iron and folic acid supplements daily. One reported receiving these through her GP. This interviewee also reported

attending an ante-natal clinic for check-ups and 'parentcraft classes'. For the other, however, buying these was said to pose an additional financial strain because she was not receiving any ante-natal support as a result of difficulties relating to the location of her GP. Both expressed high levels of frustration at being unable to prepare 'decent' meals for themselves because of the lack of facilities in the hostel and reported going to friends or family for meals to ensure ' the baby gets fed properly'.

Restorative and preventative measures

The types of health problem affecting the children or infants compare favourably with, but were not as extensive as those recorded elsewhere (For example, Boyer 1986; Drennan and Stearn 1986; Stearn 1986; Conway 1988; Parsons 1991). This may be a reflection of the nature and quality of the accommodation within which the sample was living, about which most tended to speak in positive terms. All of the mothers spoke of common problems with their children's health, largely colds and other respiratory infections, which they related to shared living and children 'mixing together' in the crèche. Three children were also reported to have excema or dermatitis. All, however, stressed how 'happy' they were with their children's development. Those with babies referred to anecdotal reports from Health Visitors whilst those with older children particularly highlighted conversational capacities, alphabet or counting skills, attributing this to constant mother-child verbal interaction throughout the day. Unlike accounts of their own variable use of formal health services, GPs and Health Visitors were said to be consulted for any actual or perceived health problems their infants or children might have.

Despite such positive accounts, interviewees with older children expressed concern over the possible effects to their children of present limited playing space and sharing a bedroom (*cf.* Lissauer *et al.* 1993) or bed with themselves. These were superimposed upon by concerns about the possible effects of

previous factors associated with the breakdown of the relationship with their partners and the disruption associated with moves. Three of the oldest children, who also had additional skin, or congenital problems, were said to be showing signs of having been affected by these events and this was said to have manifested in behavioural patterns which included being 'clingy' that is demanding cuddles and constant attention, crying spontaneously, hyperactivity and self-injury. GPs had been consulted and whilst food additives were said to have exacerbated one child's problems and all products containing these were now avoided, the mother of the other two reported the GP's diagnosis as 'just breaking their temper' and described strategies she had developed to limit these behaviours, including physical activities to 'tire them out' and mental activities counting, drawing, reading and talking to keep the children occupied.

One final factor was highlighted in many of the accounts. This will be termed 'the possibility of history repeating itself' and motherhood was said to have provided specific concerns:

> What I'm thinking is like, some people that are abused physically or whatever in the past will take it out on their own children, some people dae that. That sticks in my mind all the time. There's part of me that's really scared in case that comes out, you know, cause it's in there, in me. That's why I really want to see this counsellor. (Interview 28)

As with another interviewee who reported not having contested custody of her children for this reason, deliberate measures were being taken to delimit any potential problems that may arise from interviewees' own unresolved experiences. Paramount among these measures was a maximisation of the professional support available.

Laying future foundations

In every mother's account, there was an emphasis on the hopes being invested in their dependants. As with their 'single' counterparts, obtaining a tenancy of

their own was merely the first step in much longer term plans. All expressed a belief that it would be impossible to work, practically and financially until their children were at school (*cf.* McRobbie 1991) and accordingly focused upon the positive aspects of being able to 'have this time' with their children. One was presently attending college as part of an initiative organised by an association for lone parents, and most expressed an intention to return to education, or undertake or resume vocational training which pregnancy had interrupted (*cf.* Sharpe 1987). These intermediate plans for themselves were explained in terms of their children, as typified here:

> That's who I'll be doing it for, the weans. I want to be able to talk to them, laugh with them, give them a secure future. I want the two of them to have a good education, that's something I never had. I refused to go to school point blank. Two o' them to get a good job, pass their O'Levels, go to college, university, do something for theirselfs. Aye, I can see that happening. That's something I never done and I want them to have that kind of life. It's no for me anymore. I just think positive these days and get on wi' it for them. (Interview 30)

As found amongst working class young women elsewhere (*cf.* McRobbie 1991) interviewees displayed rather conventional outlooks as far as their children were concerned. A 'secure future', emotionally, physically and materially, was the paramount goal for their children in these prognostications. This indicates why, unlike GP consultations for themselves, medical advice was reportedly sought whenever a child was perceived to be ill; because of the hopes invested in their children all possible means of ensuring their well-being were pursued.

By focusing upon these daily life activities and the ideas, values and motivations that influence the interviewees' agency in regard to the well-being of their offspring, they are no longer portrayed as inert or reactive in the face of circumstance. With explicit acknowledgement of the material limitations of their present situations, all mothers emphasised 'how much' rather than 'how little' could be done for their children within these temporary circumstances.

Using their own lived experiences as a gauge, all interviewees reported a common motivating force in their desire that their children would have a more secure life than themselves.

Restoration of health and amelioration of long-standing health problems

Having progressively problematised assumptions and images throughout this chapter it is now time for a final challenge to the 'poor motivation' thesis. This section will demonstrate that even using the tenuous standard of GP consultations as a measure the 'poor motivation' thesis is difficult to sustain. As indicated, GPs were consulted for specific health problems, but not others. The pressing question, therefore, to address here is why was this so? Chapter 5 indicated the interviewees' propensity to refer to psychosocial, environmental and material factors in the production of their health problems, and, moreover, to underline the inter-relatedness of mind and body. This provides not only the direction for an understanding of the utilisation of formal health resources, but how 'health' is conceived:

> What's the point in going to ma doctor? He's no gonnae be able to gie me more money or a hoose, is he? He cannae change the way I'm feeling cause I've no got a job, no got a hoose, all the things that's happened, no doctor can dae that. (Interview 33)

The gulf in perceptions is exposed. Aside from those receiving Incapacity Benefit who stressed the contribution of their GPs in securing this, doctors were perceived generally as being able to ameliorate conditions perceived as 'medical', such as infections or asthma, but were regarded as unable to resolve health problems perceived to be rooted in material or psychosocial factors. Where doctors had been consulted the advice received tended to be deemed inappropriate and this militated against further consultations. Moreover, doctors, generally male, were perceived as socially distant 'higher class' and lacking in empathy 'he couldnae understand', and because of this perceived distance tended to be consulted only when it was believed they could make a contribution to interviewees' physical health. Accordingly, in addition to the

health work recorded above and when symptoms warranted, interviewees reported self-medicating with over-the-counter analgesia, expectorants, laxatives and night sedation as required. However, as outlined in Chapter 7 interviewees also included cigarettes, alcohol and drugs in their accounts of ameliorative measures.

Having identified that interviewees located the production of their present health and ill-health within their past and present social and material circumstances and indicated the extent to which health work was an integral part of their everyday lives, it was requisite to consider the extent to which they believed they could exercise 'control' over their health. Thirteen expressed a belief that they had little, or no control over their health in their present circumstances; 'health' was something to aspire to at some later point in time when the exigencies of housing and employment were remedied. Three could not answer because they had 'never thought about it' and, whether good or bad, health was something to be accepted, 'you just have it, or you don't'. A majority believed that they could exercise various degrees of control over their health through reported interventions, such as eating well, walking, reducing substance use, trying to reduce stressors, practising 'safe sex' and, wearing correct clothing in inclement weather. Herein lies a contradiction, however, in that among those who expressed they could exercise 'control' were many who had reported increased cigarette consumption, this suggesting that such an evaluation does not necessarily correlate with action (*cf.* Blaxter 1990; Brannen *et al.* 1994). This underlines the importance of considering the additional psychosocial components discussed in Chapter 7. Most believed they were exercising as much control as possible in the given circumstances, but what was said to be important was not the control which could be exercised, it was the 'control' many felt they *had already* exercised.

In this latter group were those who reported psychosocial and/ or physical health improvements since entering the present accommodation and who cited

measures currently undertaken to try to 'improve' their health, or prevent it from 'worsening' by trying to eat food perceived as 'healthy', trying to reduce cigarette consumption or overcoming drug addictions, or going swimming. However, whilst most interviewees here reported that *full* control over their health could not be realised until their material situation was resolved, they described the extrication of themselves from the circumstances implicated in past poor psychosocial well-being in terms of 'empowerment' (Wallerstein 1992) by explaining how they had already taken control of their own lives, and consequentially, their health. This insight facilitates an understanding of concepts employed in the definitions of 'health' below, and 'home' and 'homelessness' in Chapter 7.

Health defined

Given the problems of definition outlined in Chapter 2, it had been surmised that asking interviewees for a definition of 'health' would prove difficult, but most did so with gusto. All were asked in a manner akin to: 'We've been using this word 'health' a lot, but it's a word that doesn't really have a meaning. What does 'health' mean to you?' The responses provided notable consistencies with those identified by Blaxter (1990), but tended to be too composite to locate in a single category. A small group, those who reported having 'never thought' about 'health' and control of health, explained 'health' in physical terms of the absence of illness. It was conceived of as a state of 'normality', something to consider only when ill:

> Just as long as you don't feel ill, get tired, sore stomachs and things. You just feel awright. You cannae really tell if you're healthy or no...But I think, I suppose if you've no got anything wrong wi' you, then you've got your health. (Interview 9).

In contrast, among the majority of accounts 'health' was defined in highly positive terms and similar themes were found:

> Being able to do things and make plans
> Being alive again

Feeling confident
Feeling good about yourself
Feeling happy
Having energy
Not having a care in the world
Sense of achievement

Chapter 2 identified the problem in arriving at a definition of 'well-being', and although the term itself was not employed in the interviews, in their definitions of 'health' interviewees appear to have provided a tangible means of how 'well-being' can be conceived. Health was a multifarious, holistic and affective concept:

> Health is being dead confident, great, happy, feeling good, eating right, looking after yourself, being able to go out, do things, like get a job, set yourself up, just be dead happy, no worries. (Interview 3)

For the majority, using as a basis their lived experiences, 'health' was considered as something to which interviewees aspired, an integral part of the common life goals with which they associated 'leading a normal life' as considered in Chapter 7. Interviewees appeared to be underlining the importance of the affective body in their conceptions and recognition of these key elements facilitates an appreciation of the improvements to psychosocial well-being reported at the end of Chapter 5; present social circumstances were conceived as a watershed in the process towards 'health' attainment. For others, however, the 'hope' of attaining such psychosocial attributes at some future point was a means of coping with the compound effects of the past and present. Here too interviewees subscribing to both sets of outlook were referring to the concept of 'normality' as a benchmark; health was conceived of as that which would enable a state of 'normality' to be actualised, but was also believed to be an accomplished outcome of that actualisation:

> Oh I think I'd feel I'd have everything! It would give me a real sense of achievement if I had my health. (Interview 24)

Concluding remarks

In problematising the thesis of 'poor motivation towards health' this chapter has chipped away at the pellicle of common portrayals of homeless young women. By listening actively to the accounts of their lived experiences and understanding these as the contexts within which their health actions are framed, homeless young women's motivations towards health are removed from professionally-assessed value judgements and contextualised within the conditions of their social being. Interviewees believed their present material circumstances to circumscribe potential for major health improvements to be made, but within the conditions of their daily lives examples of health maintenance, promotion and amelioration activities, control of reproduction and care of dependants were found to be intentional activities. Moreover, as accentuated throughout preceding chapters, these perceptions and actions were influenced by their past experiences and experientially-based future aspirations. Any meaningful pronouncements, therefore, about homeless young women's health, health agency and health conceptions must acknowledge the reflexivity and intentionality produced by the mediating effects of individuals' lived experiences. Chapter 9 will now formalise this proposition.

Chapter 9

The paucity of theory: some directions

"Nothing is miserable unless you think it so"
Anicius Manlius Severinus Boethius (524)*Consolations of Philosophy*

The simple intelligibility of Boethius' words resonate throughout preceding chapters. This thesis has argued consistently that many existing assumptions about, and associations between homelessness and health are rather more tenuous than much of the literature suggests; such associations appear to be based on an erroneous axiom that the objective material circumstances within which homeless people live only produce negative health outcomes. With noteworthy exceptions (Hutson and Liddiard 1994; Tomas and Dittmar 1995; Downing-Orr 1996) the experience of homelessness tends to be explained and presented in a manner which overlooks how homeless people account for, and give meaning to their situation, and more so how these meanings come to exert influences upon health evaluations.

This thesis has asserted that the difficulties with existing homelessness and health studies are theoretical, and consequently methodological. The dearth of theoretical engagement relegates homelessness studies to the fringes of academic discourse. Such detachment can no longer be sustained for, as this thesis has shown, simply by tapping into well established research traditions such as women's health, youth transitions, family life or poverty, homelessness can be understood as part of a greater social equation and not a research specialism merely for the attention of housing research centres, medical professionals or campaigning groups. Greater inter-disciplinary dialogue and collaboration is essential to the progress of homelessness studies and, more importantly, the informing of more appropriate policy responses than has existed.

Allied with this detachment is the orientation of most of the homelessness and health studies that exist. The positivistic tendency of most studies which, however laudable their intentions to demonstrate or even 'prove' connections as a basis for action, are founded in two fundamentally flawed premises, that 'health' is an objective category and that 'homelessness' is essentially a 'housing problem'. These weaknesses have important consequences in that, by failing to conceptualise homelessness and health as social products, as outcomes of the same iniquitous structures and processes which affects a much wider population, homeless people continue to be objectified as 'different' and neither popular stereotypes nor fragmentary policy responses are challenged. No research is value free, but it must be acknowledged that simplistic explanations and overly sympathetic pronouncements can contribute to reinforcing the pejorative imagery of homeless people as much as the uninformed stereotypes perpetrated in the wider society.

These arguments have peppered this thesis, but as yet neither the implications of the data presented, nor the theoretical, methodological and policy issues have been explicated in any comprehensive manner. Accordingly, by means of systematically working through these issues it is necessary to return to the initial research questions brought to this project since these have not been answered explicitly. As recorded in Chapter 3, these questions were

1. Why do young women become homeless?
2. How do young women experience homelessness?
3. Is there a relationship between these experiences and health?
4. If so, what is the nature of that relationship?

Paying due regard to the small-scale nature of this enquiry and not making any false claims of representativeness or generalisability, this chapter will draw together the main conclusions derived from this study and its potential implications for further research and policy.

Why do young women become homeless?

This thesis has conceptualised homelessness among young women as a product of 'fractured' transitions, these having been presented as the education to employment transition, the domestic transition and the housing transition. Unlike a recent study with homeless young people which focuses upon familial factors and regards this 'transitional' type of approach as inappropriate for the 1990s, proposing instead a 'processes of separation' approach (Smith *et al.* 1998), the data presented has supported this more processual and structural conceptualisation. Structure must be acknowledged in any conception for, as contended in Chapter 1, these youth transitions are framed within the structures and processes of the 'Risk Society' (Beck 1992) which renders specific groups susceptible to exclusion and, as asserted in Chapter 2, to higher levels of morbidity and mortality.

A recent article on single homelessness and social exclusion argues that single homelessness is a form of social exclusion, characterised by 'the inability of a section of the socially excluded population to get access to welfare services and social housing' (Pleace 1998: 46). Access to welfare services and social housing, although necessary ameliorative measures, are not the relevant issues. As with simplistic explanations of 'homelessness', for example, as a consequence of 'unemployment', 'shortfall in social housing provision', or 'familial factors' this explanation is weak. For, without acknowledging why individuals require welfare services and social housing in the first instance, genuine debate on the means through which homelessness could be prevented cannot commence. However, the one important question which Pleace (*Ibid.*) does raise relates to the fact that, if accepting homelessness as the outcome of social exclusion, why are most socially excluded people not homeless? This question can also be posed to those who offer one-dimensional 'causes' of homelessness, as outlined above. Fundamentally, the failure of most existing studies to conceptualise sufficiently the complete process of 'becoming'

homeless is where the weakness lies. Whilst Smith *et al.*'s (1998) study does, however, attempt this through interviews with 'homeless' and 'housed' young people and their families, by concentrating upon familial factors and policy responses, wider social and material structures and processes are missed. In effect, whilst this thesis has criticised the 'structural' causes of homelessness offered, this inadequacy is rooted in their being *not sufficiently* structuralist.

The term 'social exclusion' has been employed in this thesis to encompass a lack of material resources alongside the inability to participate effectively in the economic, social, cultural and political life of mainstream society (*cf.* Duffy 1995). The key notion in the literature on social exclusion is its compound nature (*for example*, Lee *et al.* 1995) whereupon one disadvantage builds upon another and, as argued in Chapter 1, this composite process of exclusion is framed within and reproduced by the 'Risk Society'(Beck 1992). The emergence of the 'Thirty-Thirty-Forty Society' (Hutton 1995) has shifted risk to the lowest common denominator; to the level of the individual. As contended in Chapter 1, the individuals most exposed to risk tend to be in the lower strata where opportunities continue to be circumscribed by their class and gender, whether in terms of education or employment and, especially, health-wise. Supporting Beck's thesis that in late modernity, whilst there has been an individualisation of identities, lifestyles and social ties, individual life chances continue to be highly structured and 'remain relatively unchanged' (Beck *op cit.*: 92). This individualisation of risk is especially germane to homelessness studies for, by ignoring this wider context, responses can only ever continue to be piecemeal. The dualism inherent in this conceptualisation between objective social and material position and subjective identity (*cf.* Beck 1992; Banks *et al.* 1992) is essential to understanding the data presented in this thesis.

Responding to the first question posed, the data presented in Chapter 6 reveal the compound nature of the process of 'becoming homeless'. The young

women in this study reported high levels of material and social insecurity in the families and the neighbourhoods within which they were reared. These insecurities were cited as having impacted upon educational attainment which, in turn, infringed upon employment opportunities and consequentially their ability to 'buy' themselves out of homelessness. Nevertheless, these structural features alone cannot explain why this sample of young women became homeless because these factors affect greater numbers than those who become homeless. It is here that the reductionism of existing 'structural' accounts of homelessness is demonstrated, yet simultaneously the weaknesses in studies which cite 'family conflict' or 'arguments' as *the* cause of homelessness are also unveiled. By acknowledging the material basis for the strains placed upon family structure and functioning (*cf.* Hutton 1995), by incorporating the extension of the period of dependency in youth (*cf.* Coles 1995; Jones 1995; Furlong and Cartmel 1997) the context for the development of the process of 'youth-parental alienation' (Rutter 1990) is recognised, and as Rutter maintains this process commences in early to mid-childhood. The data reveal that the process of 'youth-parental' alienation was already established quite early in most interviewees' lives, as most clearly exemplified in the cases where interviewees were placed in social services care, and in some cases was reported to have developed even before interviewees were born through their mothers' 'unwanted pregnancies'. There is, therefore, also compounding inter-generational dimension to consider and, as expressed by interviewees, whether 'single' or mothers, a major driving force behind their actions was that the material and social history of their parent(s), especially their mothers, should not repeat itself in their own or their children's lives.

Perceptions of the lived experience of women known to them were important in the sample's accounts. As highlighted in Chapters 6 and 7, interviewees did not attribute direct blame for their situation to their mothers. Instead they focused upon the social and material strains placed upon their mothers, the social and material limitations of the circumstances within which they had been reared,

and the perceived negative consequences of these environs upon siblings or friends who had remained there. As introduced above, there is, therefore, sufficient evidence to suggest that the process of 'becoming homeless' is a useful example of the objective/ subjective dualism in Beck's (1992) thesis. Yet, it is at this point that the 'epistemological fallacy' (Furlong and Cartmel 1997) of the 'Risk Society' comes to the fore whereby individuals seek personal solutions to problems that are of a structural nature. Within contemporary 'Risk Society' individuals are encouraged to perceive themselves as able to 'choose' their own lifestyles and identities (*cf.* Beck 1992). This is certainly supported in the data submitted in Chapter 7 where interviewees presented themselves as pursuing goals, like young people in the wider population, consistent with notions of who they perceived themselves to be (*cf.* Banks *et al.* 1992). Whilst the material and gendered bases for their present situation were chronicled, most interviewees placed emphasis upon their ambitions, whether their own or for their children, by means of surmounting the effects of the past and the limitations of the present. It was not who they had been that was important, it was who they *aspired to be*. Neither class of origin, nor gender were perceived as obstructions to this vista. Lawyer, veterinary surgeon, teacher, nurse, children going to university were among ambitions specified; ambitions which did not fit with the confining circumstances within which they reported having been reared. However, the mutually reinforcing effects of time and perceptions of lack of appropriate support when 'homeless', as exemplified in the cases of those illustratively defined as *Pessimistic Pragmatists*, reveal impediments to sustaining such dreams. Moreover, the lack of longitudinal follow up means that there is no means of knowing if such ambitions could ever be realised and what effect upon the person any inability to realise these might be. Longitudinal research is undoubtedly required in this area.

How do young women experience homelessness?

With these latter caveats in mind, for the majority of this sample, however, the experience of 'homelessness' is not presented as a 'progressive downward spiral'. Regardless of whether interviewees had been single or in cohabiting relationships, or had reported their situation having arisen from social or material factors, their lived experiences were found to have influenced perceptions of their present circumstances; freed from the social and material limitations and risks which they associated with their past, the present was generally presented positively or neutrally, as the vehicle to a hoped for future. Relativity, as a social concept (*cf.* Wilkinson 1996) is central to understanding the interviewees' accounts, for this relativity was formulated through their lived experience. Again, without longitudinal follow up, however, the accounts presented in this thesis can only ever serve to problematise the 'progressive downward spiral' thesis and it is hoped that future research will actively test this issue. Nevertheless, it is in this regard that the gulf is laid open between this, alongside other qualitative studies (Tomas and Dittmar 1995; Downing-Orr 1996), and the majority of existing studies of homelessness; relative to the lived experience of researchers, homelessness *is* an apparently negative experience.

Without qualitatively establishing the context for this sample's homelessness through focused interviews, facilitated through having engendered an empathic understanding of homeless young women's lived experiences and the meanings and values these experiences produce through participant-observation and focus group work, this study could quite easily have been subject to similar assumptions. For undoubtedly, the presuppositions of those studies which immediately transform 'health' into 'ill-health', influence the types of questions asked and, therefore, the data gathered. As this thesis and the two qualitative studies cited above demonstrate, qualitative research, enables the researcher to go beyond the apparent 'limitations' ubiquitously perceived as

inherent in 'the homeless experience' to an exploration and analysis of the *lifeworld* (Husserl 1970), the meanings and the strategies employed within a material framework. In short, it allows for a means of connecting human agents, the conditions and consequences of their autonomous action with the structured causes and consequences of the conditions of their existence. From the data, this translates into important interpretations.

Firstly, whether interviewees perceived themselves to be homeless or not, the search for an academic or professionally-ascribed definition of homelessness is irrelevant to this sample's lived experiences. By simply contrasting their definitions of 'home' with these experiences, it is possible to see that the material and psychosocial aspects which they associated with 'home' were either a present state of pathos or future aspirations, they were not something which most interviewees associated with their past. As such, 'homelessness' can neither be conceived as an objective and measurable category nor a new aberrant state of being. As a gender- and class-blind, yet gender- and class-imbued construct the label 'homeless' serves only to objectify. Whether regarding themselves as 'homeless' or not, the label was not relevant to their self-conceptions, except among those who had become 'pessimistic' as a result of space and time where the negative connotations of the label had been internalised and had contributed to a sense of hopelessness. Despite the reported irrelevance of the label to most interviewees' self-conceptions, their interactions with the wider society had taught them its power, through stigmatisation, and it is this stigmatisation which served to compound and magnify the cumulative processes of exclusion already experienced, such as when seeking employment or in general social intercourse.

From this research, therefore, it is proposed that the term 'homelessness', with all its value-laden gendered and class-orientated origins and assumptions is a flawed category for the reality of young women's experiences. Indeed the sample aspired to a 'home' of their own, for reasons firmly rooted in their lived

experiences and, especially, to allow society to perceive them as they saw themselves, as 'normal' young women with 'normal' needs, if afforded opportunities to overcome the social and material processes which had contributed to their present state of being. The caveat, therefore, for future researchers, for practitioners, campaigning organisations and policy-makers is that, without listening to 'the defined' any conclusions derived, actions, or responses will not address the needs of individuals thus labelled, and may in fact serve to contribute to their further stigmatisation and social exclusion, objectively thence subjectively once internalised. Listening also enables a more open understanding of 'the homeless experience'.

The second related conclusion lies in the finding that the sample did not explain their situation as something they had either been 'pushed into' or had 'chosen'. Their 'homelessness' was recounted as a product of cumulative social and material processes where no single cause and effect mechanism could be established clearly. Once 'homeless', however, these processes were reported to have intensified as particularly exemplified in the reported scant opportunities for employment whilst living in a hostel. Yet, despite the weight of such incontrovertible processes, interviewees did not conceive themselves as having been passive. Rather than concentrating only upon the limitations, interviewees narrated the strategies employed throughout, for example, their housing career or managing low incomes. Furthermore, those interviewees in the supported facilities especially illuminated the benefits to be derived from this transitionary condition, in terms of physical security, peer group relationships and emotional stability. This agency, and the advantages of 'homelessness' has largely been overlooked, but it is an important emergent factor in non-housing-based, social psychology research with homeless young people (Downing-Orr 1996) and, especially women (Tomas and Dittmar 1995). Greater inter-disciplinary collaboration is undoubtedly prerequisite in future research projects.

The initial means of connecting this sociological study with such social psychological approaches was indicated in Chapter 3 where the key assumption derived from the symbolic interactionist tradition provides a straight-forward point of union. This shared tradition enables individuals to be conceived as purposive agents who confront a world that must be interpreted and who employ the meanings derived as a guide for action (*cf.* Denzin 1989). Therewith, by drawing upon the phenomenological orientation towards the ways in which the lifeworld (Husserl 1970) is produced and experienced it became possible to understand how and why the young women constructed their own definitions of their situations. In combining such complementary tenets, it was then possible to discern the essential reflexivity of meaning built into social action (*cf.* Garfinkel 1967), that is, the contextual nature of meaning. Accordingly, it is this active category of reflexivity that needs to be incorporated within future homelessness and homelessness and health studies.

Thirdly, and related to their 'normal' self-conceptions, in stark contrast to the 'chaotic' prototypical portrayals, the sample proffered highly conventional, though not entirely gendered, lifegoals. Whilst interviewees cited having a home of their own as a foremost intention, this was but the first step to much longer-term plans. Such apparently contradictory opposites: individualisation of risk and solution-seeking, and conventionality is further characteristic of the 'Risk Society' since,

> Coupled with this interest in the 'individual solution' there is however considerable pressure to conform and behave in a standardised way; the means which encourage individualism also induce sameness (Beck and Beck-Gernsheim 1995: 40)

Such 'pressure to conform' is exemplified in accounts of inclusion in, or exclusion from the hegemonic hostel culture. Yet, in other small ways it was evident, for example, in their adherence to the consumer culture: in expressions of desire for designer clothing for themselves, for various specified hard goods for their planned home, or in acts of purchasing branded foodstuffs for their

children despite the practical and financial difficulties this was said to pose. Thus the structural constraints placed on individualisation mean that, whilst the existence of this sample of 'homeless' young women directly challenges societal mores and sensibilities, as tacitly classic-case products of the 'Risk Society', they posed no threat to the existing social order. Yet, inasmuch as their ambitions or actions might indicate complete acquiescence to this social order, and indeed may serve to reproduce this, they were not dupes to structure, for intentionality had been a key driving force.

Although recognising that society perceived them as deviant and recounting various aspects of their stigmatisation, most interviewees did not perceive themselves as such. Instead, by contrasting their own aspirations with the social and material circumstances, mental health or drug use of women known to them: mothers, sisters or past friends, interviewees emphasised the 'normality' of their own lifeplans and anticipated identity relative to those women, and to societal mores. Amongst a majority, 'homelessness' was presented as having provided a sense of empowerment, in that, by having extricated themselves from lives potentially circumscribed by gender and strained social and material conditions, interviewees expressed a belief that they now had an opportunity to create a better life for themselves and for their children. Accordingly, relative to the women whom they knew, those interviewees who emphasised the notion of 'escape' can be conceived as having been enterprising and self-efficacious (*cf.* Banks *et al.* 1992) in their actions to overcome the estrangement produced by the circumstances within which their formative years had been framed.

This is not a comparative study and so it is impossible to state, with any certitude, what has been a circumspect inference derived from all aspects of fieldwork which is introduced here to promote wider debate and future research. Having weighed up the personal, social and material 'risks' of remaining where they were with those associated with 'homelessness', is it possible that those who reported having left the parental home at the age of

sixteen, when they were legally able, were not the most 'vulnerable' or even that perplexing term 'damaged', but the most enterprising and self-efficacious 'risk-takers' among other young women subject to similar disadvantages? This would greatly advance an understanding of why, from a population subject to similar social and material processes of exclusion, only a small number actually become homeless.

This is not to present homelessness as a panacea for socially excluded young women, but, by incorporating the fundamental conception of individuals as cognisant and purposive agents, this introduces a more plausible, and less value-laden dimension to the study of homelessness than those generally on offer. The data presented in Chapters 7 and 8 on 'health risk behaviour' and 'health work', by revealing the omnipresence of decisions based upon weighing up the advantages and disadvantages of actions in terms of health, intimates endorsement for such an inference. Nor is this an attempt to minimise the consequences of the various lived experiences to which this sample had been exposed, such as the high levels of domestic violence and various forms of abuse prior to their 'homelessness', and the host of material, physical and psychosocial risks which they associated with their 'homeless careers'. What this does make all the more pressing is an understanding of interviewees' health and ill-health reports as expressions of these experiences, not simply as unproblematic categories to be quantified.

Is there a relationship between these experiences and health?

Chapter 2 laid the foundations for a problematisation of the assumption that there is a relationship between homelessness and health which can be explained in any objective and absolute manner. It also insisted that the ill-health experiences of homeless people should be understood as different only by degree of intensification, not of kind, to those found among a wider population subject to similar social and material disadvantages and processes of exclusion. Having demonstrated the need for a differentiation between health status and

health state, the data presented in Chapter 5 reinforced the futility of any such endeavour. Indeed, initial inspection of the list of ill-health reports in Table 5.2 avers that the sample's health was poor, thus confirming findings from existing homelessness and (ill)health studies, and the cases of those who moved directly from hospital to homeless facilities indicates a straight-forward relationship. Yet, without acknowledging the social and material circumstances within which their overall stock of health had been framed, circumstances which also rendered those latter interviewees 'homeless' on discharge from hospital, any pronouncements on the associations between health and homelessness are tenuous.

Given the particularly poor morbidity levels among women, generally, in Glasgow, as reported in Chapter 1, it comes as no great discovery that young women, predominantly reared in the most deprived areas of this city, who have been subjected to compound social and material disadvantage arising from their family background and thence 'homelessness' should report high levels of ill-health experiences. What should be the focus of concern, and any future research, derives from consideration of the 'period of latency' thesis (*cf.* West 1988) which was outlined in Chapter 2. Given that class-based inequalities in morbidity rates are said to diminish in youth, only to re-emerge in early adulthood, the prognosis for this sample's future health does not augur well. For this sample were not receiving respite from previous class-based inequalities, their 'homeless career' represented a microcosm wherein the excesses of materially-based 'health risks' could be augmented. Moreover, as reported in Chapters 5 and 8, compounding inter-generational effects were already being attested to by the mothers among their children and they expressed concerns about the effects of the past and present upon their children's present and future well-being.

Accepting that retrospective accounts are fraught with errors of reliability, Chapter 5 provides further essential considerations. Whilst the types of juvenile

health problems recounted can be accepted as testifying to the perceived effects of the social conditions within which the sample was reared, unlike later accounts, interviewees rarely associated negative physical health outcomes with the material environment. Given the material fabric of the estates in which most reported having spent their formative years, the lack of attention to such matters, in terms of physical health outcomes, is insightful. Interviewees tended to accentuate various aspects of psychosocial malaise prior to their 'homelessness', thereafter, regardless of their 'homeless' situation, accounts then included a focus upon physical outcomes of the material environment. As asserted, these focal changes cannot be taken as absolute, but relative; they are mediated by space, time and perceptions of social support. Accordingly, as argued throughout, self-reports of ill-health should not be the end product of research, but the starting point for analysis of these as meaningful expressions of interviewees' lived experiences (*cf.* Popay 1992).

As indicated in Chapter 2, it has been argued that, of all the determinants of health, the psychosocial influences, notably social cohesion, may be pre-eminent (Wilkinson 1996). As shown throughout, psychosocial influences were paramount in the sample's accounts of their health and ill-health experiences. Wilkinson's proposition is certainly supported in the accounts of the majority group who tended to be younger, those illustratively depicted as *Homemakers* who reported distinct improvements in their psychosocial health as an effect of 'escape', social support and cohesion and feelings of safety and security. Although physical health problems associated with their material environment were reported, these were presented as almost inconsequential to their psychosocial well-being, for example, respiratory infections were an accepted part of shared living, and problems associated with diet were attributed to shortage of money or amenities. Although these matters were reported to irk interviewees, they were obscured by accounts of the benefits to be derived from their present situation. In contrast, the second largest grouping, those generally older interviewees characterised as *Pessimistic Pragmatists*, expressed both the

highest levels of psychosocial malaise and physical health problems and associated these with a lack of social support and cohesion which magnified the effects of material circumstances.

These categories of response have profound implications for policy responses and, especially the assumptions associated with the 'vulnerability' or 'in priority need' criteria. Firstly, the belief that homelessness is essentially a 'housing problem' motivates the provision of accommodation to individuals who meet the criteria and, in the case of those represented as *Optimistic Pragmatists*, this indeed may be all that is required. This grouping, who had largely become homeless as an effect of reportedly poor material circumstances, such as parental inability to support interviewees as a result of unemployment or motherhood, or overcrowding in the family home. had retained family ties and wider social support networks in the 'home' area. As advocated by homeless campaign groups, affordable accommodation, therefore, was simply a basic requirement to help those interviewees, half of whom were already in employment, proceed to independent 'adulthood'. Yet, for those who were unemployed, their employment needs still had to be addressed.

In stark contrast, those interviewees portrayed as *Eremites* reveal the acute misconception in the 'housing problem' thesis. This smallest grouping of interviewees reported the lowest, but potentially the most serious physical health problems, such as recent cardiac surgery or suspected HIV infection, and also reported the *least* present mental health problems of all the groupings. Having recounted histories that included habitual abuse in childhood, experience of care, violence from partners, death of an infant or children in care and drug use, those interviewees reported detachment from any formal or informal support networks and expressed few lifegoals or hopes for the future. In what appeared to be a means of coping with such cumulative lived

experiences, those interviewees exuded apathy. Isolated within 'adult' hostels, housing was the least apropos of their needs.

This leads to the second, and related policy concern exemplified in the two groupings lying between such extremes. As shown in Chapter 1, age alone does not qualify a young person for accommodation under the homeless legislation, but the various discretionary decisions allowed for under the Code of Guidance (Scottish Office 1997), outlined in Chapter 1, do provide a form of safety net. The operation of Glasgow City Housing Department's *Youth Housing Strategy*, outlined in Chapter 4, has accorded priority to sixteen and seventeen year olds. The beneficial effects of this policy in action is fully attested to in the accounts of those depicted as *Homemakers*. Whilst this represents a more progressive outlook than found in other areas of the country (*cf.* HAHP 1997) the data presented in this thesis suggest that the provision of local authority support to such a limited group is too restrictive and has conspicuous consequences for those excluded from such support, as exemplified in the accounts of those represented as *Pessimistic Pragmatists*.

Nevertheless, this does not redress the fundamental problem of definition. In providing such support it is evident that the codification of 'homelessness' as a 'housing problem' is erroneous. For, quite simply, if 'homelessness' was truly a 'housing problem' there would be no need for such additional practical and psychosocial support mechanisms. Yet, as has been consistently demonstrated in this thesis, it is the presence or absence of these in the sample's accounts which were said to have exerted the greatest influences upon their well-being. Having presented the case for the need to conceptualise this sample's 'homelessness' as a direct product of the 'Risk Society' it is surely time to redefine this as a general social and welfare issue. The development of the Foyer system which combines training, work and housing for young people represents a good starting point for such a shift. For young mothers, an example of another advance was found during fieldwork. Through inter-agency

co-operation, young mothers were beginning to be afforded the opportunity to attend college courses supported by a voluntary organisation for lone parents which also arranged remuneration for travelling costs and provided crèche facilities for children. This co-operation linked the practical and psychosocial assistance offered by the supported facility with concrete opportunities for educational development and future employment. However, until the real social and welfare needs of 'homeless' young women are fully recognised and codified, such measures shall remain ad hoc and fragmented. The neglect of these social and welfare needs is closely related to the objectification of 'homeless' people and the denial of their own evaluations. Nowhere is this more evident than in the context of their health.

This sample of young women have demonstrated the complexity of their conceptions of 'health'. Not only was 'health' something to which they aspired as an essential part of their lifegoals, but in their accounts which connected the mental and physical with the social, interviewees provided an efficacious demonstration of the holism inherent in their conceptions. Recognising that interviewees operated within a social model of health therewith provides a means of accessing the motivations underlining their actions in terms of health, as exemplified in the criteria upon which they would base their decisions for consulting a GP; where health problems were perceived as relevant to the biomedical model, GPs were consulted, where they were deemed as social or material in origin interviewees saw little point in doing so. Instead of 'poor motivation' or being a 'low priority concern' this is reflective of cognisant rationalisation within their own frames of reference; their lived experiences.

This introduces a fundamental dimension to the health-care provision debate (*cf.* Fisher and Collins 1993; Rosengard 1997). Whether mainstream or specialised provision is advocated or exercised, both types adhere to a biomedical model of health and health-care, but this is not the paradigm within which this sample operates. Two examples demonstrate this well. Firstly, as

shown in Chapter 8, interviewees perceived many of their health problems, such as dizziness, fainting or anaemia, to be diet-related, stemming from the lack of cooking utensils and appropriate storage facilities within the 'adult' hostels which they could not solve to any satisfactory degree because shortage of money either limited the utensils or the types of food they could buy. Secondly, as characterised in the accounts of those depicted as *Pessimistic Pragmatists*, their reports of psychosocial malaise were attributed to a lack of formal and informal support, the fabric of the facilities in which they were living, lack of progress with housing applications and unemployment which superimposed upon difficulties continuing from the effects of unresolved problems which had rendered them 'homeless' in the first instance. Neither type of health problems can be resolved within a biomedical framework.

Without asking potential service-users what they perceive their health-needs to be and without integrating health and welfare services with housing services, provision will not begin to address the real needs of 'homeless' young women. This is supported in their accounts for, in order of priority, when asked what would help to improve their present health, interviewees responded thus: 'someone like you to talk to', more money, a job and a house. For most, the question of mainstream or specialist provision was irrelevant, the main criteria upon which any service would be judged was that they would be treated 'like normal lassies' by approachable and empathic health workers, akin to the qualities highlighted by those with drug counsellors. Importantly, this stress on having 'someone to talk to' did not only apply to the present, but many interviewees surmised benefits that might have been derived from having an independent adult to turn to for support and encouragement when younger. Mentoring systems are developing throughout the United Kingdom and this sample certainly lends support to their further spread as a means of helping to resolve problems which the young women believed contributed to the outcome of homelessness.

Assumptions about homeless people's 'poor motivation' towards health were further shown to be tenuous in Chapter 8. The examples of 'health work' presented reveal that, like women in the general population, 'health work' was an integral part of their daily lives. For interviewees, diet and personal hygiene were the most important aspects of this work and walking was the main extrinsic activity undertaken. These apparently unavailing matters further denote differentials between findings from this study and existing assumptions. Motivations towards health are, seemingly, assumed to refer to formal health services or health education-type discourses, within which, for example, the diet of, and extent of smoking amongst most of this sample would be subject to disapprobation. Yet, as shown, the decisions and actions taken in terms of health were framed by the same restrictive structures and processes which not only circumscribed the actions that could be taken, but which were believed to contribute to the poor health outcomes reported. They were also strongly influenced by interviewees' perceptions of their lived experience. Using dental consultations as an example, without acknowledging the extent to which these were usual practice prior to their 'homelessness', or educing the rationales why interviewees 'chose' not to do so whilst in their present abode, poor motivation could have been surmised, but this did not appear to be supported. Present actions cannot be understood without reference to past experience or future considerations. This line of argument is fully established in the context of the sample's agency towards issues of reproduction. But before recapitulating upon this, a further and related matter should be underlined.

What emerged strongly in this research were the similarities in the social and material backgrounds of interviewees, whether 'single' or 'mothers'. Whilst differences, in terms of GP consultation rates for and projected aspirations to their children, the additional stigma of and responsibilities associated with their status, the compounding effects of partnership epiphanies, and specific health problems arising from their reproductive experiences were all noted, in most other respects those interviewees denoted as 'mothers' were indistinguishable

from their 'single' counterparts, and especially those 'single' interviewees whose children were in social services care. This immediately serves to question the distinction in homelessness discourse between 'single' and 'families', a matter beginning to be addressed by some campaigning groups, such as Homeless Alliance and Scottish Council for Single Homeless (Rosengard 1998). In terms of provision this false boundary was fully exposed in the cases of the two pregnant interviewees who, according to Glasgow City Housing's policy should be counted in the 'family' statistics, but were living in a 'single' hostel. Yet, because they were living in an 'adult' hostel, they were not receiving any social and welfare support and it was this lack of formal support which was directly implicated in the high levels of psychosocial malaise reported. Given that one occasion of sexual intercourse is all that is required to alter a young woman's status, a not uncommon event affirmed through long-term contact with individuals throughout participant-observation, existing criteria and provision is not equipped for the potential changing status and needs of young women. This is not to reduce the debate to a type of biological determinism for, as consistently demonstrated throughout this thesis, experiences arising from their gender exerted the predominant influence upon the sample's lives.

Returning to the context of reproductive 'health work', it is here that the data from the 'mothers' provided a means of understanding the expressed motivations and actions of the sample as a whole. Motherhood had arisen generally in one of two contexts: established partnerships, or where there had been high levels of various forms of family conflict and disruption, and histories of 'care'. Though both groupings had been reared in similar material circumstances, the more intensive aspects of 'youth-parental' alienation recounted in the backgrounds of this second, younger, grouping contrasted with reports of continuing relationships with families among those in the former group who tended to be older. Among those generally younger interviewees it was their perceptions of the psychosocial deficits in these environments which

provided the context for continuing with pregnancies, as was transparent in Chapter 8.

When this conclusion was transposed to the accounts from their 'single' counterparts, the reasons for clear divisions could be identified. Based upon world-views arising from their lived experiences, none of the interviewees wished their children to be reared in a similar vein to themselves, but two key factors influenced whether or not contraception was being, or would be used in sexual relationships and termination considered if this failed. These two factors were: expressions of 'rejection' in juvenility, this being related to experience of care or their mothers reportedly having been 'forced' into marriage when pregnant, and employment aspirations. Those who stressed the former factor were among those who had more gendered aspirations such as shop assistant, care assistant or hairdresser and had boyfriends who were either unemployed or 'homeless' too. Those in the latter group aspired to complete their education and establish a career prior to any committing themselves to a 'steady' relationship, though a couple had long-term employed boyfriends. Based on their own social and material backgrounds, all interviewees focused upon house and job as essential prerequisites before marriage, but it is only among those who emphasised feelings of 'rejection' as juveniles that placed the 'love' they had to offer above those other considerations, should 'accidents happen'. Conceivably, more realistic in their life goals, they were emotionally idealistic, whilst their counterparts were perhaps more idealistic about their lifegoals, and realistic about the kind of future they could offer any children, materially, socially and emotionally, unless they achieved these ambitions. As stressed throughout, present world-views and actions cannot be understood without reference to past experience or future aspirations. Nor can they be considered without contemplating the potential inter-generational repercussions of these world-views and actions. Resolving 'homelessness' among young women, therefore, is not just a matter for their own present and future health, but is an imperative for the future well-being of their actual and potential children.

Having presented a case for a problematisation of assumptions that snapshots of self-reports of ill-health can, alone, explain the effects of homelessness upon health, there is one final area to consider before formalising an exegesis of this relationship; 'health risk behaviour'. As outlined in the *Introduction*, accessing information on the health of homeless young women necessitates an exploration of what has been written about either the 'risks' to which they may be exposed, or their 'health risk behaviour'. Both types of perspective appear to be underlined by, and reinforce the 'victim/ guilty' dichotomy in popular conceptions and media portrayals.

As shown in Chapter 8, interviewees expressed awareness of the relevant health 'scares' at the time of interviews, such as concerns over BSE and the contraceptive pill. A small number reported having either thought about changing, or had changed their 'behaviour' by saying they were having 'second thoughts' or were now worried about taking the Pill in the future, or they were no longer eating beef products, notably beefburgers. Moreover, all expressed fears about the possibility of contracting HIV and emphasised the necessity for 'safe sex' practices in any new relationship. However, with the exception of this latter concern, most expressed resignation by referring to the frequency of such types of 'scares' and the dubiety of health education pronouncements which, in their eyes, rendered most foodstuffs and activities 'risky'. Their youthfulness, set against the many 'health risks' to which this sample had already been exposed, had rendered any slight chance of contracting potentially fatal blood clots or CJD to be dismissed as inconsequential.

It is this context which is important to understanding the high numbers of smokers in this study. Every interviewee and focus group participant who smoked acknowledged health education messages about this and the cost disadvantages. However, as shown in Chapter 7, perceptions of smoking were subject to rather more symbolic inferences; past status negotiation, present

identity and bonding. Middle class teenagers would appear to have clearer staged markers of status acquisition, for example, they might anticipate their seventeenth birthday for commencing driving lessons, and the age of eighteen as representing the break from the parental home for educational purposes. With only one concrete marker of status, the important age of majority at sixteen as illustrated in Chapter 6, smoking had denoted 'maturity' for themselves, their peer group and even their parent(s) in neighbourhoods where 'normal' transitionary markers were not readily available, materially and socially. Now 'homeless' smoking denoted membership of the 'in' and 'out' groups within the hostels where there was also a rational economy in action. Costs were dispersed throughout the group through the sharing of single cigarettes, the bounds of reciprocity and exchange were set and sanctions of exclusion were said to be employed where individuals did not conform.

For the interviewees, these psychosocial factors, superimposed upon and strengthened other benefits to be derived from smoking such as, appetite suppression, when hungry, and weight maintenance, especially where anorexia or bulimia were reported. The potential for smoking-related diseases in the future was simply far too remote and irrelevant when compared to these positive aspects. Within their frames of reference, rather than being 'health risks', smoking was presented as an aspect of 'health work' since it influenced physical, mental and social well-being. Smoking, as with alcohol and drug use or involvement in prostitution, therefore, is behaviour neither to be 'pitied' nor 'condemned', it was presented as an integral part of their cognitive processes which had been, and continued to be informed by meanings derived from their lived experiences.

So, returning to the question posed at the beginning of this section, there is indeed a relationship between homelessness and health in so far as homelessness and health outcomes are products of the same iniquitous structures and compound processes of exclusion fostered by the 'Risk Society'.

By demonstrating, with many examples, the hollowness in the long-standing pursuit of 'proof' that homelessness is detrimental to health, for confirmation that homelessness exacerbates existing health problems, for evidence to support the argument that poor health contributes to homelessness, it is asserted here that the time has now come to move on to a more mature debate on the actual structures and processes that effect poor housing and health outcomes. This requires a more integrated, inter-disciplinary approach than has been the case thus far. It has also exposed the need for a different approach to researching and understanding the experiences associated with homelessness. For, without listening to the accounts of 'the defined', the material and psychosocial factors which exert influences upon reported changes in health, including health improvements, or actions in terms of health are denied and, as such, representations will continue to confirm, rather than challenge, popular objectifying and exclusionary labels and stereotypes.

How, then, can the nature of the relationship between homelessness and health be interpreted?

Before considering the theoretical implications of the data offered it is necessary to step back, once more, from the minutiae and consider why the health of homeless people has become such a popular subject for research. This thesis illuminated the basic weakness in the belief that this is an attempt to 'medicalise' an essentially housing problem (Shanks and Smith 1992). Nevertheless, the 'medicalisation' thesis (*cf.* Zola 1975) itself is not without merit through the way in which it encourages an exploration, not only of that which is labelled as 'illness', but to the social and cultural relativity of these constructs as manifestations of the hegemonic structures within society:

> The medical mode of response to deviance is thus being applied to more and more behaviour in our society, much of which has been responded to in quite different ways in the past. In our day, what has been called crime, lunacy, degeneracy, sin and even poverty in the past is now being called illness, and social policy has been moving toward adopting a perspective appropriate to the imputation of illness. (Friedson 1975: 249).

The dominance of medicine in explanatory models of deviance has long been recognised as having replaced more punitive forms of social control (Parsons 1958), but it is in today's fragmented and illusory society that the cynicism behind this shift is fully exposed. Masked behind a status of scientifically-grounded neutrality, illness labels serve to locate both the source of the problem, and the treatment in individuals (*cf.* Zola 1975). As contended above, the individualisation of 'risk' is a direct product of late modernity and, through medicalised discourses, it is the individual who is objectified and 'treated', not the circumstances within which ill-health outcomes are produced (*cf.* Conrad and Schneider 1980). The medicalisation of homelessness, therefore, has served to deny society's central role in homeless people's exclusion and to conceal the bitter actuality that, through acquiescence to the status quo, each and every adult member of contemporary society is implicated in reproducing the structured inequalities that produce homelessness. Politically, a window of opportunity now exists for more genuine debate on the issues of exclusion, and more importantly, inclusion. But will the nettle be grasped? Nowhere is this more pressing than in the present situation of homelessness, and especially homelessness and health research.

The dearth of sociological exegeses thus far means that the 'medicalisation' of homeless people's experiences and, consequentially, their otherness has been reinforced and consolidated. By codifying homelessness as a 'housing problem', by offering one-dimensional explanations for homelessness, and by representing the (ill)health of homeless people in a manner that portrays them as 'passive victims' of their circumstances or 'guilty' of their ill-health experiences through 'risky behaviour', those researchers have been able to disregard the wider structures and processes which contribute to both homelessness and poor health outcomes. The fictitious character of a young women, Cathy, spurred public response in the 1970s. It is hoped that the real young women who participated in this study will advance a more appropriate

academic debate and policy response to these issues. A direction for more theoretical engagement will now be considered.

The need for a more normative context for understanding homelessness has been argued throughout and, as proposed, the interviewees in this study are propounded as classic-case products of the 'Risk Society'. By recognising the objective/ subjective dualism in this conceptualisation, both structure and agency can begin to be united, evaluated and translated into a more meaningful appraisement than has existed heretofore. As referred to in Chapter 3, the need for such a union in homelessness research is long overdue (*cf.* Neale 1997a, b), but, unlike Neale's suggestions, the structural factors underlining the choices and actions taken by interviewees leads to an immediate and emphatic rejection of post-modernist and post-structuralist theories as overarching explanatory devices. As contended above, the illusory objective/ subjective aspects of the 'Risk Society' are symptomatic of late modernity and not post-modernity.

Nevertheless, as indicated by Neale, Giddens' 'structuration' thesis is useful in so far as it underlines the fundamental issue; that the general dualism between objectivism and subjectivism in sociological theory actually masks their complementarity (Giddens 1993). Giddens proposes that this complementarity is representative of a 'duality of structure' and he expresses this inter-dependent relationship in his 'structuration theory' (*cf.* Giddens 1979, 1984). In his conceptualisation structure is simultaneously the medium for, and the outcome of human agency. Whilst his thesis benefits from illustrating how individuals intervene in the world through their actions and, although structure places limits upon these actions, they can still effect change through resistance, the extent to which individual reflective beings can effect structural change is rather overplayed. As this study has demonstrated, the sample were active reflective participants in their own histories and in the recounting of these histories through their narratives and most indicated how and why they were able to resist extraneous labels. Through their agency they had indeed been

able to alter the course of their own histories, but this individual agency had made no impact whatsoever upon the structures and processes which produced and sustained the outcome of 'homelessness'. This is not to deny 'homeless' people the potential to resist and effect wider change, for a collective political will does exist (*cf.* Speakout 1995). It is requisite that this organisation be given the opportunity to be heard by a society which, as yet, has not shown any great willingness to listen.

Giddens' considerations on modernity and self-identity provide a more persuasive and applicable starting point for formalising the arguments presented thus far through his proposition that the distinctive features of modernity are the polar extremes of 'extensionality', through globalising influences, and 'intentionality' (Giddens 1991: 2). According to Giddens, 'difference, exclusion and marginalisation' (*Ibid.*: 6) are the consequences of late modernity and within this schemata individuals must necessarily operate with a 'calculative attitude to the open possibilities of action' (*Ibid.*: 28), and, through interpretation of their experiences, construct their self-identity reflexively. Giddens' prioritisation of the human capacity for reflexivity, has indeed been supported in the data educed from 'subject-subject', rather than 'subject-object', research relationships (Giddens 1976: 146) engendered by the approach employed in this study. It was not merely that the young women recounted their experiences, but it was their evaluations of these experiences upon which actions had been, and continued to be based, self-conceptions formulated and feelings of well-being or malaise conveyed. As indicated throughout, the basis for such reflections and agency was the lived experience arising from their social being.

The connection between Giddens' helpful considerations and that which is to be offered below lies in the need to consider how human beings make their own history (*cf.* Giddens 1984). As argued in earlier chapters it is imperative to incorporate an understanding of the affective body in homelessness and health

studies, for the affective body cannot be extricated from the physiological body since the 'felt world combines feelings, thoughts and bodily processes into a single vital structure' - the lived body (Hughes and Patterson 1997: 336). This lived body is simultaneously physiological, psychological and social and by incorporating individuals' capacity for reflexivity the foundations for a heuristic theoretical framework are laid. Consistently, preceding chapters have demonstrated the inter-connectedness of the mind, the body and the social in interviewees' accounts of their ill-health experiences, in their conceptions of health, in their health-work, and in their expressed 'feelings' about the past, present and future. The common factor influencing all such judgements was their structured, by class and by gender, lived experience and this further reinforces the appeal for greater inter-disciplinary collaboration in homelessness, and homelessness and health studies.

Writing almost at the end of the twentieth century it may seem rather peculiar and outmoded to suggest a closer inspection of humanistic versions of Historical Materialism as the most suitable vehicle for theorising about the data presented. Nevertheless, the basis for such reasoning shall be made, for the reclamation of Historical Materialism from the structuralist wastelands has already been achieved. In his contention that the real lesson of Historical Materialism is 'the crucial ambivalence of our human presence in our own history, part-subjects, part-objects, the voluntary agents of our own involuntary determinations' Thompson (1980: 280) highlights his proposition that human beings make their own history as much as they are made by it. For Thompson all historical subjects are conceived as agents concerned with their own conscious, goal-directed activity and although these are inscribed within existing social relations and may even serve to reproduce these, they are intentional activities. Human intentionality, therefore, should be conceived as more than expressions of a structural framework for, as exemplified in Chapter 7, it was intentionality as expressed in the sample's future plans and aspirations

which provided the main measure of their present self-conceptions and social well-being.

The concept of 'experience', as advocated by Thompson, provides a means of connecting human agents and the conditions and consequences of their autonomous action with the structured causes and consequences of the conditions of their existence. Experience is characterised as the way through which human beings convert objective determinations - structure, into subjective initiatives - agency, it is the means by which 'structure is transmuted into process' (Thompson 1980: 362), or as one of his main antagonists delightfully proclaims 'the privileged medium in which consciousness of reality awakens and creative response to it stirs' (Anderson 1980: 57). The appeal for an incorporation of lived experience in homelessness, and homelessness and health studies has been sustained throughout. Accepting there are fundamental problems in Thompson's variable usage of this term, the means by which it should be understood here will be explained. The conceptualisation of 'lived experience' is that of a 'junction concept' between social being and social consciousness which operates thus:

> Changes take place within social being, which give rise to changed experience: and this experience is determining, in the sense that it exerts pressure upon existent social consciousness, proposes new questions, and affords much of the raw material which the more elaborate intellectual exercises are about. (Thompson 1981: 406).

The 'social consciousness', therefore, which spurs agency is rooted in, but not completely circumscribed by the objective conditions that produce lived experience, materially and socially, as exemplified in Thompson's renowned statement that the working class was 'present in its own making' owing 'as much to agency as conditioning' (Thompson 1968: 9). Accordingly, whilst lived experience is determined by the productive relations into which human beings are born, the way through which this experience is 'handled' and made manifest in social consciousness is not immutable. The essence of Thompson's

historiography is lucid and realistic, for in imploring 'it is the active process ... that I am insisting on' (Thompson 1981: 398) individuals are conceived as they are, not as passive and subjugated before structure, but as makers of their own history. Yet it is only by following the purpose of what he regards as 'real' history: 'to recover, to explain and to understand' (Thompson 1980: 238) the subjects of investigation that this agency can be uncovered and interpreted, for

> The historical evidence is there in its primary form, not to disclose its own meaning, but to be interrogated by minds trained in a discipline of attentive disbelief. (Thompson 1981: 220)

Any accurate approach to the study of homelessness, and homelessness and health, therefore, requires that researchers suspend their own presuppositions about the experience of homelessness, be prepared to question the very basis of their own and others' pronouncements and to listen to the accounts of 'the defined', and also be prepared to go beyond these accounts to the material and social bases of the meanings and values imbued in these formulations. For, as has been demonstrated consistently throughout this thesis, the young women's lived experiences were grounded in the material and social outcomes of the class-based and gendered conditions into which they had reportedly been born and for which they reported having been socialised. Yet, having also internalised the culture of subjective individualisation, characteristic of late modernity, their reflective agency in light of the social and material circumstances within which their lived experience was said to have been framed was to try to break the chain of their parents' histories being repeated in their own or their children's lives. Accordingly, by exploring the epiphanies in the sample's histories, context and agency can be examined, united and understood in a processual manner. Simply stated, this ongoing dialectical interaction between social being and social consciousness was the processual motor of their respective histories. It was also the context within which their health outcomes, health actions and health conceptions were produced, informed and judged.

Neither pity nor guilt can, or should be imputed for this is not how the young women in this study portrayed themselves. Wider public discourses must be challenged, but this can only be achieved by acknowledging that present statutory, professional and academic hegemony over definitions and explanations cannot be sustained. As effected in the methodological framework of this exploratory study, researchers 'have to learn to see the minds' of the subjects of research 'with more humility than patronage' (Thompson 1993: xv). By drawing upon much wider and well-established research traditions, by seeking answers beyond the apparent and by listening to the subjects of research, this qualitative bricolage has simply provided one means of 'learning to see'.

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Appendix A

Overview of Research Schemata

October 1994 to January 1995	Main review of literature
From December 1994	Establishing research contacts
April to September 1995	Thirty-one interviews with homeless, health and welfare professionals and practitioners from statutory and voluntary organisations who work with homeless young women in Glasgow. Other interviews followed when necessary, e.g. to negotiate access to homeless facilities.
August 1995 to September 1996	Participant-observation: working as volunteer with voluntary sector organisation
October to November 1995	Two focus groups: one with young women living in voluntary sector 'medium' supported accommodation; one with young women living in a local authority 'adult' hostel. One focused interview with a young women living in 'heavily' supported voluntary sector project.
January 1996	Four pilot interviews: two with young women from a voluntary sector 'medium' supported project; two with local authority hostel residents
July 1996	Focus group with six young women living in a voluntary sector supported project for young mothers and their children
March to August 1996	Main interviews conducted with forty-one young women living in three local authority 'adult' hostels and one supported project for young people, in one voluntary sector supported project for young people and two voluntary sector projects for young mothers and their children
September 1996 to January 1997	Transcription of main interview tapes
February 1997 to August 1998	Main analysis and writing up
August 1998	Thesis completed

Appendix B

Focus Group Topic Guide

Aims

To elicit

- understandings of, and attitudes towards the experience of 'homelessness'
- understandings of, and attitudes towards health and ill-health experiences
- the experiences and factors perceived as having exerted an influence upon these health and ill-health experiences
- attitudes and experiences in regard to formal health services and education

Topics explored

Perceptions of homelessness
e.g. How would you describe the situation your are in just now?

Perceptions of health changes as related to 'homelessness'
e.g. Do you think your health has changed since you left your last permanent home?

Significance of health in daily lives
e.g. How much do you think about your health from day to day?

Understandings of health and ill-health
e.g. What would you call 'being healthy' or 'being ill'

Understandings of factors that affect health
e.g. What kinds of things would you say have affected your health for the better or for the worse?

Health maintenance and promotion activities
e.g. Do you do anything to keep yourself healthy?

When and why formal health services would be used
e.g. What kinds of things would you see your doctor about?

Attitudes towards formal health services
e.g. How do you feel about the advice or treatment you have received?

Attitudes towards health education
e.g. How do you feel about the advice given by health education people?

Consideration of factors that would improve personal health
e.g. What kinds of things would help to give you better health?

Appendix C

Interview Guide

Present circumstances

- length of time in present facility
- feelings about present circumstances
- social support relationships
- daily life activities
- managing daily life
- feelings about day to day life

Past experiences

Housing history

- prior to present facility
- frequency and duration of housing moves
- reasons for moves
- feelings about housing strategies

Employment/ education history

- length of time employed/ unemployed
- feelings about employment/ unemployment
- educational experiences and feelings about school
- employment aspirations

Family background

- age left family 'home' permanently
- whether contact maintained with family
- family structure
- family functioning
- experience of social services care
- cohabitation/ marriage experiences

Perceptions of homelessness

- in general
- in relation to self identity
- definition of 'home'

Physical health

- self-evaluation of present physical health
- self-reported present physical health problems
- perceived sources of these problems
- actions in regard to these physical problems
- present physical health compared to past physical health
  in childhood
  throughout housing career
- perceived sources of these changes over time
- consumption of cigarettes, alcohol and drugs

Health actions

- informal health maintenance and promotion activities
- formal health maintenance and promotion activities
- definition of health

Reproductive health

- menstrual history
- contraceptive attitudes and practices
- motherhood experiences
- children's health

Mental health

- self-evaluation of present emotional health
- self-reported mental health problems
- perceived sources of these feelings
- coping strategies
- present mental health compared to past mental health
- perceived sources of these changes

The future

- present feelings in light of past aspirations
- present aspirations
- how health improvements can be made

Appendix D

Profiles of Interviewees

This appendix is included to provide some context for extracts provided in the text. However, because many of the young women have been processed by a number of organisations throughout their lives, providing any individualised details might compromise the assurances of anonymity given at interview. Thus, only key information deemed conducive to an insight into their individual lives is offered. Moreover, those who participated in illegal practices of prostitution or drug use are not identified. As throughout the thesis, no pseudonyms are used as they do not contribute to a qualitative understanding of the young women's lives.

Interviewee 1

16 years old. Though she said she had left home after long-standing difficulties with her father, she still retains contact with her family and visits as often as possible. Left home immediately after sixteenth birthday. Over and above the support staff in the project, she received support from a caseworker and a social worker. Though recounting her happiness at having removed herself from the family home, she reported feeling rather depressed about present situation because she felt 'more mature' than other residents and, therefore, felt unable to fit in.

Interviewee 2

17 years old. Parents had separated and she had eventually moved to be with her mother, but this did not work out and she returned to city to stay with a sibling who was reluctant to be seen to take sides in family dispute. She now had no contact with any members of her family. Reported having been required to undertake all household duties and look after younger siblings. Over and above the support staff in the project, she received support from a caseworker and a social worker. Although reporting to feel happy about present situation, especially the camaraderie in the project, she also reported feeling depressed when on her own and thinking about unresolved problems.

Interviewee 3

16 years old. Prior to her present residence she had spent five months moving between several friends, who could not accommodate her for long periods, and relatives who experienced problems from her parents for having taken her in. Reported long-standing difficulties with mother, domestic responsibilities and previous alcohol problem. Had been in job-related training until homelessness made travelling difficult. Was awaiting interview for related training place which would develop earlier experience. Over and above the support staff in the project, she received support from a caseworker and a social worker.

Interviewee 4

16 years old. Reported unsuccessful moves from the parental home before the age of sixteen and before presenting as homeless on this occasion had spent several weeks moving between friends and sleeping rough. Recounted parental alcohol problems. Her mother had told her to leave on unemployment. She believed she presently had an alcohol problem and reported drinking to block out long-standing depression arising from her family history. Over and above the support staff in the project, she received support from a caseworker and a social worker. She hoped to move on to a project where she could receive help with her problems.

Interviewee 5

16 years old. Left home soon after her sixteenth birthday as a result of problems relating to her mother's new partner and her mother, and had moved to stay between a sibling, who could not afford to support her, and her father, but there were long-standing problems with him and, now, his new partner. She had attempted to leave home before this to stay with her mother's previous partner who continued to provide some support. Over and above the support staff in the project, she received support from a caseworker and a social worker. Reported depression arising from long-standing problems with parents and, to a lesser extent, present circumstances and deepening suicide ideation. Related problems with some of the other residents.

Interviewee 6

17 years old. Recounted that her mother had told her to leave the family home because of overcrowding and she had been moving between friends and the family home for under two years. Reported having had to give up work because of the constant moves. Over and above the support staff in the project, she received support from a caseworker and a social worker. Related long-standing depression, primarily in regard to the previous problems with her mother and, now, not having a job. She was hoping to move to another project because she felt she could not cope on her own yet.

Interviewee 7

17 years old. She reported having been responsible for the family household for around three years. After unsuccessful short episodes of going to stay with friends, she reported having planned for her departure from the family home for a few years and presented as homeless immediately upon leaving at the age of sixteen. Her recounted background was imbued with parental violence. Reported depression arising from this background which had lessened since moving out, differentiating between 'heavy downers' at home and 'happy downers' now and previous suicide attempts, but not now. Over and above the support staff in the project, she received support from a caseworker and a social worker.

Interviewee 8

20 years old. History of care, returning to the parental home and a two year history of homelessness, primarily moving between friends. She recounted a history of physical

abuse by her father and had experienced the death of her infant one year previously. She had no contact with the infant's father, any members of her own family or previous friends. Reported previous addiction to analgesia. She was receiving no support and had not established friendships in the hostel. She had no future plans and appeared resigned to stay in this hostel.

Interviewee 9

20 years old. Recounted a history of homelessness for eleven years. She related problems associated with her parents' marital break up and then with her mother's partner. From the age of eleven she had been staying with friends and squatting between unsuccessful returns to the family home, had stayed in several statutory and voluntary sector facilities in the city, bed and breakfast accommodation, episodes of sleeping rough and had had her own tenancy which had failed. She owed several hundreds of pounds in rent and utility arrears and loans for decorating and furniture for her flat and reported having been informed she would have to pay this off before she received another property. She reported deep bouts of depression, a history of suicide attempts and had been on anti-depressants for a couple of years. Excepting her GP, she received no formal support. She was rather pessimistic about her future in light of the outstanding debts and the time they would take to repay.

Interviewee 10

19 years old. Recently unemployed as a result of losing her tenancy and being now unable to travel to work. Parents were divorced and she had recently re-established contact with her mother. Her father was an alcoholic. She recounted a history of several years of care and frequently running away. With an additional history of sleeping rough, from care she had moved in with her father for a couple of weeks before moving in with a boyfriend for a couple of years, becoming homeless when this relationship failed. She reported a history of suicide attempts when in care. She was receiving no formal support and was spending most of her time looking for housing association and affordable private accommodation.

Interviewee 11

20 years old. She related a history of homelessness, in between unsuccessful returns to the family home, since the age of 16 where she had moved between friends, her father and a variety of relatives. Difficulties with her mother were superimposed by problems with depression, anxiety and drug use. She no longer used these and was receiving support from a drugs counsellor. She was taking diazepam for her panic attacks. Having had her name on the waiting list for over a year she reported being happy to make this her home until receiving the offer of a property.

Interviewee 12

25 years old. Had originally become homeless following the death of her mother and had moved into a voluntary sector homelessness project in her home town. She then became involved in drugs and lost her accommodation. After episodes of homelessness, she then moved in with a partner, becoming homeless when this relationship failed. She later moved to Glasgow to be with a new partner, becoming homeless again when this failed. She reported previous suicide attempts experiencing

increasing suicide ideation now. She reported feeling very 'homesick'. but did not have the money to return to her home town and expressed pessimism about the her future in light of the length of time she had been living here. She was receiving no formal support and expressed increasing isolation from the other residents.

Interviewee 13

18 years old. History of supported lodgings after having been in care from the age of four, in between returns to her violent mother and abusive sexual relationships with males. Although having received counselling following an earlier rape, because of her age she no longer received social work support and was receiving no other formal support other than the hostel's housing caseworker. She reported being on anti-depressants and had a long history of self-harming and suicide attempts. She expressed happiness with the friendships made with other residents and reported being prepared to stay here for the next year or so. Referred to the hostel continuously as an 'adults' home' vis a vis 'children's' home'.

Interviewee 14

22 years old. Had experienced episodes of homelessness, primarily living with friends, since the age of sixteen between unsuccessful returns to the family home. She had lived with a partner briefly at the age of seventeen, but after his violence had returned home. She reported having been the sole carer for a relative and had left home permanently upon his death. She reported having run away from home from the age of fourteen. She had had no contact with her father from a young age and severed all ties with her mother, who will not let her have any contact with her siblings. Recounted history of amphetamine use, now stopped, which she had been using to help cope with full-time employment and caring responsibilities. Reported going to the hostel caseworker for housing advice, but had no other formal support.

Interviewee 15

20 years old. History of stays with friends and another hostel. Reported a very strict and gendered upbringing, especially high levels of household tasks and responsibility for looking after siblings. Recounted having been pressurised by her mother to leave school earlier than she wished and had taken on three part-time jobs. Had become unemployed on homelessness because she had now been unable to get to work. Received support from a relative, but had limited contact with family and no formal support aside from the hostel manager. Reported aspects of depression mainly about her lost ambitions and lack of formal support in regard to housing applications.

Interviewee 16

20 years old. Had become homeless following years of domestic violence from her father which was eventually directed to her when she tried to protect her mother. Recounted previous experience of homelessness with her mother. Had completed college course and was employed when living at home, but was sacked when she could not go to work because of injuries sustained after attack by father. Recounted worries about sibling who remained in family home. Also concerned about being pressurised into taking difficult-to-let flats. Reported increasing depression as a result

of being in the hostel for so long when friends had moved on, numbers of drug users accommodated now, levels of violence within the hostel, stigma of circumstances and lack of formal support.

Interviewee 17

19 years old. Had been homeless for the previous 3 years where she had moved between friends, sleeping rough and been accommodated briefly in another hostel. Reported having left home immediately upon the age of 16 because of long-standing problems with her step-mother. Had no contact with mother. History of drug use - diazepam, temazepam and then heroin. Her increasing drug use meant that she had had to give up employment where she had been on a college-based apprenticeship. Without any formal support, she had gone to a city centre drop-in service for advice about her circumstances and now attends recovery group daily. Although she had no other formal support, she found some members of hostel staff helpful.

Interviewee 18

19 years old. Recounted history of living in other hostels, staying with friends, a partner and relatives, rough sleeping, in a drug rehabilitation project, imprisonment and unsuccessful returns to the family home where she had experienced long-standing problems with her mother's partner. Had been a regular drug user from the age of fifteen, primarily heroin and temazepam, and was now on methadone. Frequently mentioned that her experience would be different from 'normal lassies' and frustration at differential treatment by authorities. She had no contact with family of earlier friends and no strong friendships in the hostel. Aside from GP for methadone prescription, she also had a social worker and a probation officer. She expressed resignation with her present circumstances.

Interviewee 19

16 years old. Reported becoming homeless when a relative could not afford to keep her because she was not receiving benefits, an economic factor which had been at the root of arguments with her mother. She recounted inconsistent youth training positions, then unemployment and having held main responsibility for the rearing of her younger siblings. Previous history of homelessness with her mother following the break down of her mother's relationship with a violent partner. Wished to maintain contact with siblings, but could not afford to do so as her benefit situation had not been resolved. Had a social worker and a housing caseworker, but was unsure how to contact them. Though reported to feel low when thinking about past experiences, she felt that feelings of depression had lessened since entering project because of the friendships made and the staff.

Interviewee 20

17 years old. After holding main carer responsibility for her younger siblings and a neighbour for a number of years, she had left the family home at the age of 16 to live with a relative before an unsuccessful return to her mentally-ill mother. Recounted inconsistent youth training experiences and episodes of unemployment. Reported a history of suicide attempts. Recounted an attempted rape when living in the family

home and sexual abuse by a relative for which she had not received any support. Over and above the staff in the project, she had a social worker and a caseworker. Despite initial reservations about the hostel, she reported feeling that everything was beginning to work out for her and being very much at home because of new peer group relationships and the support being received.

Interviewee 21

16 years old. After long-standing problems with her alcoholic father she had a history of running away before leaving home to sleep rough in her local neighbourhood before presenting as homeless on this occasion. She had a long history of self-harming and suicide attempts. She also reported having been raped by a person known to the family and having become pregnant and recounted that, when trying to escape from her parents after she had informed them of the pregnancy, a miscarriage had resulted. Over and above staff in the project, she had a social worker and a housing caseworker. She was also waiting for counselling to help her overcome the problems associated with the rape. She reported feeling that this project will mark the turning point in her life towards a better future.

Interviewee 22

24 years old. Admitted to this hostel from hospital because of problems arising from the heroin addiction. She was now on methadone and a range of medication including analgesia, iron tablets and diazepam. She recounted a seven year history of homelessness: staying with friends, various hostels and sleeping rough in between living with a partner. Had a child in care. She was unaware if she was to receive any professional support other than from her GP. She had not made any friends within the hostel because she did not wish to associate with drug users, but felt she was regarded as a user by non-users. Expressed apathy towards her future and appeared resigned to accept whatever happened to her.

Interviewee 23

17 years old. Admitted to this project following discharge from hospital after suicide attempt in the family home where she had been responsible for the care of her younger siblings. She expressed deep frustration at not having been able to complete her education because of these responsibilities. She had a history of homelessness since the age of sixteen. In between stays with several friends and her father, where there had been problems with his violence towards her mother in the past and, now, with his new family, there had been several unsuccessful returns to her mother's home. She was employed and felt her colleagues were supportive. She now had a psychiatrist, but had not been contacted by a social worker or caseworker yet. Expressed difficulties with not fitting in with the other residents.

Interviewee 24

16 years old. History of homelessness for about a year between returns to the family home. She reported long-standing problems trying, and failing, to live up to her divorced professional parents' expectations. She expressed problems at fitting in with other residents because of her middle class background. Over and above the staff in

the project, she had a caseworker. She was employed. Felt pretty depressed with her present situation, but claims this is much less so than when living with her mother. Though feeling unhappy, she expressed optimism about her future when she obtains a house of her own.

Interviewee 25

17 years old. Prior to this hostel she had stayed with a couple of friends, and had attempted to live with her father, in between returns to her mother where, being unemployed, there had been ongoing arguments about her lack of income and her mother could not afford to support her. She also reported a strict upbringing because of her gender. She is trying to maintain contact with her family and a close friend from her local neighbourhood was already living in this project. Over and above staff in the project she had a social worker and a caseworker. Expressed deep anger and depression at being unemployed.

Interviewee 26

16 years old. Recounted a history of frequent moves with her family and had lived in various areas throughout the city. She stated that her employer was very supportive. Recounted a long history of household violence by both parents and arguments, and an explicit awareness that her parents had been forced into marriage because her mother had been pregnant with her. She reported previous problems with alcohol. Over and above staff in the project, she had had a social worker for a number of years after several attempts at running away and sleeping rough, and now also had a housing caseworker. Claimed to be feeling pretty confused about her circumstances, though reported feeling more at home here than she had felt anywhere else.

Interviewee 27

16 years old. Mother. Had moved to this project, via another one run by this organisation, from home because her parents could not afford to support both her and the new baby. She had become pregnant at fifteen. Her boyfriend had departed when the baby was born. She was maintaining a good relationship with parents and visited as often as she was able because they could not afford to visit her. Over and above the staff in the project she had a social worker. Reported being unhappy as she had problems fitting in with other residents. She was hoping to be housed near her family.

Interviewee 28

16 years old. Mother. She recounted a history of several months of homelessness, including living with friends and in a supported project before returning to the family home from which she had been running away for several years. Her baby was presently in care to give her a break and to give her the opportunity for psychotherapy to resolve a combination of post-natal depression and psychosocial difficulties rooted in her past. She reported a long-standing history of suicide attempts, self-harming and previous alcohol problems, and had recently been prescribed anti-depressants. She had a friendship with the baby's father. Very concerned about her own history repeating itself in her relationship with her baby. Emphasised the benefits of the peer group relationships made in this project.

Interviewee 29

18 years old. Mother. Had moved to this project after staying with a number of friends, where threats and violence had been experienced, for around a year before the birth after leaving the family home following the death of her mother and her father's changed behaviour following an accident. The baby's father had departed soon after the baby was born. Over and above the hostel staff, she had a social worker. Emphasised the benefits of the peer group relationships made in this project.

Interviewee 30

24 years old. Mother. Reported a history of care as a result of drug use from the age of 12, thence homelessness since the age of 15, which included living in a number of hostels, bed and breakfast properties, a detoxification centre and rough sleeping. Maintain a good relationship with her supportive parents and, over and above the staff in the project, had a social worker. Hopes to be rehoused as near as possible to her family without re-entering the home area where the drug problems had begun. Children are the product of two cohabiting relationships which failed, one because of violent episodes. Placed strong emphasis on the hopes being invested in her children.

Interviewee 31

24 years old. Mother. Had come to this project via a bed and breakfast hotel on leaving her abusive partner. She owed several hundred pounds to the Housing Department and reported being barred from council property. She had a history of care having requested admittance to be free from her mother. She had since re-established a relationship with her mother and had maintained good contact with siblings. From care she had a history of supported accommodation, hostel living and a failed tenancy during which time she had met her partner. She was attending college and laid emphasis on working to ensure that her children would have a more secure life than she. Expressed great frustration at portrayals of single mothers.

Interviewee 32

24 years old. History of homelessness since leaving care at 16. She had been in care from the age of 7 and recounted frequent running away from children's homes. Having experienced a two year episode of a cohabiting relationship which had broken down, the remaining six years had been spent in a host of voluntary and statutory sector hostels, sleeping rough, when barred from the hostels for a year, and in prison. She reported a previous alcohol problem and a five year history of heroin use and was now on methadone. Nine year history of suicide attempts and self-harming which had stopped when she ceased drinking three years previously. She had a drugs counsellor and used a couple of drop-in advice centres for their support and advice services. Expressed optimism that a combination of her now being employed, having come off heroin and the support she was receiving might mean an end to her homelessness.

Interviewee 33

17 years old. History of frequent moves around the country with her mother, including their homelessness, a brief episode of living independently which failed after amphetamine use and a miscarriage, and moving between friends and relatives. For a number of years she reported having witnessed, then experienced domestic violence from her mother's partner. Recounted episodes of marked depression as a result of this and her mother's consequential alcohol problems. Retains contact with her mother, but received support from a relative and wishes to be housed near this person. Over and above staff in this project, she had a social worker and a case worker. Though still feeling very confused about her past, she expressed highly positive feelings about this project, especially mentioning peer and staff relationships.

Interviewee 34

16 years old. Had stayed with relatives and a friend for a few weeks after leaving the family home where there had been a history of parental violence and alcoholism. Reported that her social worker was trying to have her placed in a voluntary sector project, but she was reluctant to move from this project where she had established peer relationships. Recounted history of self-harming necessitating hospitalisation. She recounted that her older brother had become homeless before her and expressed strong worries about younger siblings who remained in the family home from whom she is denied access by parents. Over and above hostel staff, she had a social worker and a caseworker. Although not happy about her present situation, she regarded it as a means to an end.

Interviewee 35

20 years old. Reported having requested to be taken into care at the age of 15 because of her mother's violence. From care she had moved into supported accommodation and then her own tenancy which failed because of mental health problems associated with threats to her partner who had been living with her at that time. She had completed a further education course. She recounted a history of hospital admissions for self-harming and depression and was presently taking a combination of anti-depressants and sedation. Reported that her mother had introduced her to drugs and, like her sisters, she had gone on to use heroin, having come off this during one hospital stay. Over and above the support staff in the project, she had a drugs counsellor and was awaiting a visit from a social worker. Expressed strong feelings that she now had the opportunity to be freed from her past.

Interviewee 36

16 years old. She had a long history of problems associated with alcohol use which had been the root of family arguments. Reported missing her family, especially her younger sibling whom she visits, and hopes to re-establish better relationships with her parents when her life is sorted out. She had not consumed alcohol for a month and was attending a support group for this. Over and above support staff in the project she had a social worker. She had just been accepted for a college course in the following year and was waiting to hear if she had been successful with a recent job interview.

Emphasised that this was just a temporary state of houselessness whilst she waited for a tenancy of her own.

Interviewee 37

22 years old. Mother. Married at 17, but there were problems with her husband following the birth of the first baby and these had come to a head when he moved his girlfriend into their home. This was followed by a difficult, and failed, reconciliation, including violence associated with his alcohol problems after unemployment. She owed several hundred pounds for her husband's damage to the marital home she had vacated on leaving him and reported being told that she could not be rehoused until this was paid. Reported long-standing difficulties with her mother and had left her in her early teens, after problems with her mother's partner, to live with her father with whom she continued to have a supportive relationship and expressed hopes to be housed as close to him as possible.

Interviewee 38

24 years old. Had left home because of alcohol-related problems associated which she associated with the responsibility of caring for her ill mother. She was pregnant and was no longer with her boyfriend. She reported not receiving any formal support because, living in a single person's hostel, such support was apparently not available, but had reportedly been informed by housing staff that they would be in a position to help her when the baby was born. She was applying to housing associations on her own in an attempt to resolve her situation before the baby is born. She reported not having any medical support because her doctor would not see her because she was out of the practice's catchment area. As the interviewee wishes to be housed in her previous area, to be near her friends, and the practice's lists are full, she would not be able to re-register if she changed doctor. She reported increasing feelings of isolation, despondency and aggressiveness.

Interviewee 39

20 years old. Prior to her homelessness this interviewee had experienced problems with her mother's partner and then, when they left him, her mother could only afford a bed-sit which was too small to accommodate two adult women. She stayed with a sibling who could not afford to keep her when she became unemployed. She maintains contact with both. She recounted that she had discovered she was pregnant only two months previously and expressed great fears that her housing situation had not been resolved. She reported that her unemployed boyfriend could not accommodate her because he lived with his parents who have also been supportive. She reported that the hostel caseworker could no longer offer support because she is pregnant and, after some effort, she had recently secured another housing caseworker. She also had a hospital-based social worker and was happy with the support from midwifery staff there.

Interviewee 40

22 years old. She recounted a history of suicide attempts and self-harming having been in care from the age of ten after years of neglect and physical and sexual abuse by her parents and her mother's partner. From care she was placed in a few supported projects and then moved on to a bed-sit where she was evicted because of problems associated with her housing benefit. She then shared a tenancy with her husband with whom she had children. She had recently been living in hostels for several months after leaving him because of his violence. She reported having given up heroin when she left her partner, having become involved in this through him coercing her into prostitution to support his heroin addiction. She did not have custody of her children. Though reporting to feel happier with the staff in this hostel than a previous one, she was receiving no formal support, felt she was unable to establish friendships within the hostel.

Interviewee 41

22 years old. Mother. Prior to this she had held her own tenancy, but had left this because of burglary and threats and still owed around three hundred pounds in outstanding bills for this property. She reported having first left home at the age of fourteen to stay with relatives because of problems with her mother's alcoholism and earlier episodes of sexual abuse. Attempts to return home were unsuccessful and she requested social work involvement after which she was in care until the age of sixteen, but episodes of violence experienced there had caused her to run away frequently. After an unsuccessful stay in a bedsit, there followed stays in a supported project. From here she was given a furnished flat which she left, when pregnant, because it was infested. The cohabiting relationships with the fathers of both her children had failed. Expressed the greatest frustration at portrayals of welfare-dependent single mothers.