An exploration of the psychological mechanisms associated with the resilience process of people who are homeless

Kieron Hegarty

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Supervisors:

Dr Jennifer Moses

Dr Rick Budd

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ABSTRACT

Homelessness is experienced by considerable numbers of people throughout the UK. Research convincingly demonstrates the multiple and frequent difficulties that people who are homeless face, including: limited support networks, mental and physical health difficulties, problems associated with substance use, and social exclusion. There is a lack of research however, that explores their strengths, resilience, and ability to cope with adversity. Many services arguably parallel this trend and focus on risk management and treatment strategies that target perceived pathology and vulnerability characteristics. The study contributed to strengths-based research and explored the psychological processes associated with a sense of manageability of people who were homeless. This unique line of research enquiry was guided by the study's systematic review. In-depth interviews were conducted with eight adult males who temporarily resided at a homeless hostel in Wales. Interpretative Phenomenological Analysis was used to identify themes. Processes that both enhanced and detracted from manageability were inferred. In particular, self-efficacy and self-esteem seemed important to sustain and promote the well-being of participants, and influenced actions towards future transition out of homelessness. There was evidence to suggest that these constructs were closely associated with participants' relationship experiences. The study supports the core components of Rutter's (1985; 2013) conceptualization of resilience. Intervention strategies were discussed in relation to the findings, but primarily, services were encouraged to promote supportive relationships for homeless people, as these can foster self-efficacy and self-esteem processes that are hypothesised to mediate resilience, and encourage people's social inclusion. Further culturally sensitive research of resilience processes is recommended.

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LIST OF ABBREVIATIONS

CASP	Critical Applied Skills Programme
CBT	Cognitive Behavioural Therapy
DCLG	Department for Communities and Local Government
DoH	Department of Health
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
PTG	Post-Traumatic Growth
UK	United Kingdom
WAG	Welsh Assembly Government

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CHAPTER ONE: INTRODUCTION

This chapter provides an overview of the research and literature relevant to homeless people. The overview includes: definitions of homelessness, demographic characteristics, the causes of homelessness, the disadvantage and hardship associated with homelessness, and representations and perspectives of homeless people. Research and literature relevant to homeless people's resilience, coping and strengths are then introduced. The second part of the chapter outlines the systematic review that was conducted in order to determine psychological processes associated with resilience. A critique of the review is included. Finally, the chapter closes by detailing the aims and objectives of the thesis.

1.1 DEFINITIONS OF HOMELESSNESS

The English Oxford Dictionary defines 'homeless' as 'a person without a home, and therefore typically living on the streets'. A common agreed-upon definition within the literature is provided by Rossi (1989, p10) who conceptualises homelessness as 'not having customary and regular access to a conventional dwelling.' The accepted definition of homelessness in Wales is, 'Where a person lacks accommodation or where their tenure is not secure' (Welsh Assembly Government (WAG), 2012). Such literal without-housing definitions fall short however, as even though rough sleeping is the most visible form of homelessness, in actuality, being homeless can entail living in sheltered accommodation, 'sofa-surfing', squatting, and indeed, the majority of homeless people never come into contact with 'street-life' (Kidd & Davidson, 2007).

Lee et al. (2010) stressed the significance of the temporal dimension of homelessness that defined three major types of homelessness: a) individuals who experience a brief spell of homelessness due to transition, b) those who cycle in and out of homelessness over short periods, and c) those who experience long-term, and sometimes permanent, homelessness.

When homeless in the UK, a person's status can fall into one of two defined groups as defined by English and Welsh Government: 'statutory homelessness' and 'non-statutory homelessness' (Shelter, 2008). Statutory homelessness is where local authorities have defined a household as homeless within the terms of the homelessness legislation. When a household is deemed to be in priority need and not intentionally homeless then local authorities have a duty to offer accommodation. Alternatively, when people do not fall within

the definition of ‘priority need’, or they are deemed to be ‘intentionally’ homeless, or they have not completed an application for housing, they are referred to as non-statutory homeless.

The former group are likely to include families with dependent children, pregnant women, and adults who are assessed as vulnerable, whereas the latter tend to include individuals and couples not classified as vulnerable and without younger children; thus they are sometimes referred to as the ‘single homeless’. These people may live on the street or in other forms of temporary accommodation, such as hostels, houses of friends or relatives, or squatting. Many are supported by the third sector (Shelter, 2007).

The ‘hidden homeless’ are a subgroup of non-statutory homeless people who do not appear in official figures as they do not seek or encounter aid from Government or voluntary agencies. They may find their own solution to their circumstance, like staying with friends or family prior to obtaining housing, or for a number of reasons they may fail to access voluntary organisations and either sleep rough or squat for long durations (Reeve, 2011).

1.2 DEMOGRAPHICS

It is estimated that over 100 million people worldwide are homeless (UN Press, 2005). Even though recent data suggested a reduction in homelessness nationally (The Poverty Site), numbers remain significant in England and Wales. In England, during the 2012/2013 financial year, 53,540 households were classified as statutory homeless (Department for Communities and Local Government, DCLG, 2013b), with a further 5,795 in Wales in the same period (WAG, 2013). According to the DCLG, in England, Black and Minority Ethnic groups were over-represented compared to the population as a whole; 64 per cent of applicants accepted were stated as being White and 30 per cent were from Black and Minority Ethnic groups. Younger people are also more likely to face homelessness; 84 per cent of all acceptances were applicants aged under 45 years old, and 54 per cent were aged between 25 and 44.

Conversely, there are no accurate figures or official lists of the number of single homeless people, although Crisis (Warnes et al. 2003) estimated the figure to be at 400,000 in England. Crisis’ estimation accumulates: ‘(i) around 596 rough sleepers on any given night, (ii) 76,680 single homeless people who placed themselves in bed and breakfast hotels, (iii) 26,500 single homeless people in hostels, (iv) 9,600 single homeless people in squats (estimated in 1995), (v) 24,000 asylum seeker absconders, (vi) 266,000 people who live in crowded

accommodation with too few bedrooms' (2003, p18). This last group likely contains many 'sofa surfers'.

All 326 local housing authorities in England provided a count of rough sleepers in the autumn of 2012 and from these figures the DCLG calculated that 2,309 people were currently sleeping rough (DCLG, 2013a). At present, such counts are not conducted in Wales but in 2008 the WAG estimated the figure to be around 124 people (WAG, 2008). Of course, large numbers of rough sleepers will likely be missed in official counts, and these figures only represent the visible at a single point in time. Interestingly, unlike the statutory homeless population, when compared to the population as a whole, Black and Minority Ethnic people are under-represented in rough sleeping counts, one reason being that they are more likely to stay with relatives and friends (Warnes et al., 2003).

Hostel accommodation provides an opportunity to gather more accurate demographic information. Although few surveys have been conducted, a comprehensive survey of residents in 71 hostels in London found there were 3,295 residents in the hostels, over three-quarters of whom were men (Crane & Warnes, 2001). This was consistent with Warnes et al's (2003) later review of a number of surveys, finding over 80% of rough sleepers and hostel residents to be male. According to the review, the ethnic diversity of homeless people residing in hostels was dependent on geographical area, with a large proportion of Black people in London hostels, and a very small number comparatively in Welsh hostels. As with the statutory homeless, there are a greater number of people under the age of 45 years old who are single homeless (Warnes et al., 2003).

1.3 CAUSES OF HOMELESSNESS

The causes of homelessness are multifaceted and complex. Both macro and micro antecedents are thought to play a part in most accounts (Anderson & Christian, 2003). Macro factors consist of broad trends such as political and economic climate that can render a population of poor people at risk of homelessness. The specific causes which lead people to become homeless, or the micro antecedents, include personal vulnerabilities, institutional experiences, situational crises, and general lack of protective factors to buffer against homelessness risk, such as access to a supportive network of family or friends (Lee et al. 2010). It is therefore accepted that for any one individual, there is likely to be an array of interacting and dynamic variables that may precipitate homelessness and indeed influence possible transition out of homelessness.

The most commonly reported cause of homeless occurrence across England and Wales is loss of accommodation due to family or friends withdrawing residence support (DCLG, 2013b; WAG, 2013). Loss of accommodation resulting from breakdown of relationship with a partner was the second most commonly reported cause (DCLG, 2013b; WAG, 2013). Interestingly, research suggests that people whose homelessness is triggered by family and relationship breakdowns tend to transition out of homelessness markedly quicker than people whose homelessness is more directly associated with personal vulnerabilities, such as prolonged substance abuse. Research suggests that the latter population is more likely to immerse themselves in homeless subculture and participate in activities that perpetuate their living circumstance (Chamberlain & Johnson, 2013).

1.4 HOMELESSNESS AND DISADVANTAGE

Some writers have tried to challenge the dominant discourse of homelessness and disadvantage, including Wasserman and Clair who described street homelessness as a time for adventure and "a life of self-reflection and personal freedom" (2010, p146), that result from the individual's disengagement from oppressive structures. Researchers have also depicted homelessness as a rational strategy to obtain a comfortable life (Rubenstein, 1992; Ward, 1979). However Parsell and Parsell (2012) strongly opposed this view, claiming a lack of empirical and theoretical work to convincingly demonstrate the beneficial aspects of homelessness. Unfortunately, compared to their non-homeless counterparts, a convincing body of international research-evidence suggests that people who are homeless are disadvantaged across many domains of life (Pritchard & Puzey, 2004).

1.4.1 Physical Health

A high proportion of homeless people have physical health problems (Credland & Lewis, 2004; Shaw et al., 1999) and often these health difficulties are classified as 'needing treatment' yet they remain untreated (Gould, 2005; Bevan, 1999). Accounting for this, homeless people report multiple barriers that hamper their access to medical services, including services being located out of transportable means, limited clinic opening times, and unaffordable health insurance for US populations (Martins, 2008; Rew et al., 2002). Furthermore, people feel discriminated against by healthcare professionals due to their homeless status (Hudson et al., 2010) and report being treated disrespectfully (Martins, 2008).

1.4.2 Mental Health

Whilst the prevalence in this population of serious mental health disorders is of debate, it is generally accepted that high rates of common mood disorders such as depression and anxiety exist (Fitzpatrick et al., 2007; Homeless Link, 2011). Despite this link there is uncertainty as to whether mental health difficulties predispose people to homelessness or if homelessness causes mental health difficulties (Loseke, 2003). Rather, it is likely that both statements hold some truth for such a large and heterogeneous population. Suicide, which has been linked to depression and hopelessness (Kovacs & Garrison, 1985), is a common cause of death among homeless people and those who sleep rough are 35 times more likely to commit suicide than the general population (Crisis, 2011; and see Gould, 2005). Furthermore, a strikingly disproportionate number of homeless people have histories or current problems with alcohol or drug abuse (Burt et al. 2001) that has been linked to trauma and attempts to cope with daily stress and mental health (Adlaf et al., 1996). Estimations of people who have a dual diagnosis of mental health problems and substance abuse vary from 10 to 50 per cent (Rees, 2009; St Mungo's, 2009) but these are clearly significant issues for the homeless population.

1.4.3 Crime

People who are homeless are frequent victims of crime, including theft primarily, but also physical and sexual assault (Burt et al., 2001) which likely contribute to the high prevalence of trauma (North & Smith, 1992) within the population. Homeless people, and the 'street homeless' in particular, can also be perpetrators of crime. Criminal acts of drug-dealing, prostitution, and theft, have been linked with people's efforts to support themselves in a context where access to other means of support are scarce and limited (Kidd, 2003; Martins, 2008).

1.4.4 Mortality Rates

Unsurprisingly, the interweaving web of poverty, social exclusion and adverse health circumstances (Burt et al., 2001; DoH, 1999; Pitchard & Puzey, 2004) culminates in high mortality rates for the homeless population (Hwang, 2001; Shaw et al., 1999). Mean age of death is between 40s to mid-50s (O'Connell, 2005), with chronic disease, traumatic injury and suicide amongst the most common causes of death, whilst substance misuse and homelessness duration appear to mediate mortality age.

1.4.5 Summary

In sum, the research suggests that life is hard for the homeless, and many, especially those living on the streets, link their poor health with their lack of resources and the challenges of accessing basic human needs such as healthy food, appropriate clothing, reliable shelter and sanitation, which also perpetuates their social exclusion (Lafuente & Lane, 1995; Martins, 2008; Shelter, 2008). Although people who live in hostels may have access to more resources, Holt et al. (2012) found that health status was still jeopardised by homeless status and many residents reported actual experiences or perceptions of danger and threat in various forms.

1.5 PERCEPTIONS OF HOMELESS PEOPLE

Perceptions of homelessness are of great significance as they influence policy, public and service responses. Therefore the messages portrayed by the media and reported in academic research need to be considered as tools that reflect, expand and create discourses about homelessness.

1.5.1 Media

Few people have prolonged contact with homeless people and therefore their ideas of homelessness depends largely on media constructions (Lee et al. 2010; and see research on the outgroup homogeneity effect, Park & Rothburt, 1982). News coverage during the 1980s portrayed the homeless as a diverse group of people prone to unmanageable hardships outside of their control and thus worthy of support and aid. This is in contrast to more recent stories concerned with the deviance and dangerousness of the homeless and the need to control for this, further perpetuating their alienation (Pascale, 2005).

1.5.2 People who are Homeless

People who are homeless sense social discomfort and stigma. Although unfortunate, this is not surprising as the homeless often experience multiple forms of marginality in addition to their homeless status (e.g. mental health difficulties, drug-culture). They often feel discriminated against and devalued by healthcare professionals, law enforcement, employers and society in general (Boydell et al., 2000; Finfgeld-Connett, 2010; Hudson et al., 2010; Lafuente & Lane, 1995; Martins, 2008). Interestingly, Boydell et al. (2000) found that homeless people are not passive recipients of projected negative identities, and elevate their

sense of self by comparing themselves to other homeless people perceived to be 'worse-off' (and see Holt et al., 2012).

1.5.3 Research

To date, much research on the homeless population has centred on causes of homelessness and their vulnerability and pathology characteristics (Bender et al., 2007; Kidd & Davidson, 2007). Common research topics within this field, such as substance use, mental illness and trauma, are essential as such phenomena are reported as prevalent and need to be acknowledged and understood in order to help address people's problems and improve their well-being (Klee & Reid, 1998; Parsell & Parsell, 2012).

Without a balance of focus though, and consideration of the strengths and skill-sets of homeless people, this line of investigation arguably perpetuates the social construction of the homeless as a homogenous group who are deficient, deviant, disempowered, vulnerable and hopeless (Parsell & Parsell, 2012; Rapp, 1998). Lee et al. (2010) suggest that negative attributes and characteristics of the homeless may be exaggerated in research as the chronically homeless are over-represented by cross-sectional research.

1.5.4 Impact of Perceptions

Public perceptions of the homeless, influenced by mediums of media and research, both of which tend not to depict the homeless in a favourable light or communicate their diversity, have an influence on policy and services (Lee et al. 2010). This could result in services that overlook people's strengths and resources and overly focus on risk-management strategies that *need* to be prioritised via problem-oriented approaches that undervalue service-user collaboration and inadvertently operate to further pathologise people (McCollum & Trepper, 2001; Rapp, 1998). There is a need then for an alternative line of research enquiry, one which considers strength and ability in order to present a more holistic portrait of homeless people.

1.6 RESILIENCE, COPING AND STRENGTHS: AN ALTERNATIVE PERSPECTIVE TO HOMELESSNESS

Despite living with such risk of disadvantage and adversity, many people who are homeless consider themselves to be healthy, or at least 'doing okay' under difficult circumstances (Holt et al., 2012; McCormack & Gooding, 1993). Against the discourse of disadvantage and difficulties discussed above, it is important to consider what is different about these people

and their sense of manageability. But beyond looking at those who appear to flourish or 'bounce-back', Rowe (1999) argues that many homeless people must utilise strengths and resilience in order to merely survive extreme and adverse living conditions.

An emerging body of research has begun to explore the strengths, coping strategies, and resilience of people who are homeless. Prior to presenting details of this research, the concept of resilience will be explored. This is necessary as there is great variation in how scholars conceptualise resilience (Harvey & Delfabbro, 2004). The problems with traditional notions of resilience will be presented and frameworks that value context, resilience processes, and subjective meaning will be put forward as they underpin the current project's resilience-research focus.

1.7 RESILIENCE: DEFINITIONS AND CONCEPTUALISATIONS

1.7.1 Origins – The Search for Protective Factors

Resilience research assumes that the majority of people are exposed to adversity, sometimes referred to as 'risk factors', during their lifetime, and one's well-being in the face of this will depend on an interplay of internal and external variables, commonly labelled, 'protective factors' (Rutter, 1985). Rutter defined protective factors as 'influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome' (1985, p600). Resilience research, historically and predominantly still concerned with young populations, initially concerned itself with identifying those who adapted to stressors, or 'bounced-back', due to 'protective factors' (Rutter, 1990). It was thought that, 'The study of children who overcome risk and adversity enhances the understanding of both normal development and maladjustment' (Masten et al., 1990, p425).

Garmezy (1993) identified an array of protective factors that were associated with positive outcomes for children living in impoverished conditions. These included social skills, intelligence, and psychological constructs of self-esteem and internal locus of control. Additional characteristics of so called 'resilient children' include optimism (Carver, 1998), determination and perseverance (Smokowski et al., 2000) and temperament (Tschann et al., 1996), among others. However, not all research has established a link between risk and protective factors on outcomes (D'Imperio et al., 2000), and resilience researchers have acknowledged their continuing struggle to identify the causal or "keystone" factors that predict health outcomes for 'at-risk' individuals (Fraser & Galinsky, 1997; Ungar, 2004).

1.7.2. Definitions of Resilience

Definitions of resilience, a selection of which are presented in Table 1, may differ slightly, yet have in common their emphasis on adversity and positive adaption. Indeed, Windle (2011) reviewed the resilience literature and proposed a 'most agreed upon definition' of resilience as 'the "successful" adaption to life tasks in the face of social disadvantage or highly adverse conditions' (p163).

Table 1. Definitions of Resilience *(cited in Fletcher and Sakar, 2013).*

- ''The process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances'' (Masten et al., 1990, p426).
- ''A dynamic process encompassing positive adaptation within the context of significant adversity'' (Luthar et al., 2000, p543).
- ''The personal qualities that enables one to thrive in the face of adversity'' (Connor & Davidson, 2003, p76).
- ''The ability of adults…exposed to an isolated and potentially highly disruptive event…to maintain relatively stable, healthy levels of psychological and physical functioning, as well as the capacity for generative experiences and positive emotions'' (Bonanno, 2004, p20).

There is no one accepted definition of resilience, and whether it is a trait, process, or outcome is of debate (Fletcher & Sarkar, 2013), however a growing area of research has shifted focus beyond protective factors to examine the process that enables individuals to overcome adversity (Luthar, et al., 2000; Rutter, 1985). This approach to resilience enables exploration of psychological mechanisms that underpin the process.

1.7.3 Psychological Mechanisms of Resilience

Psychological constructs are closely associated with the resilience process. For instance, 'self-efficacy' (Bandura, 1977) is often cited as an active ingredient of coping and resilience (Epal et al., 1999; Rutter, 1987). Bandura's (1977) self-efficacy theory can account for adaptive behavioural responses to stress based on beliefs of control and ability to determine change that will shape decision-making processes. Harvey and Delfabbro reflect their surprise that the construct of self-efficacy and resilience processes have not been extensively applied in resilience research:

> *'His* [Bandura's] *notion that people can develop cognitive schemas and expectations of success based upon prior experience…provides clear psychological mechanisms to explain the interaction of internal and external influences.'* (2004, p.10)

Other psychological processes linked with resilience and coping include, locus of control (Garmezy, 1993; Rotter, 1966), positive orientation future (Gonzalez & Zimbardo, 1985), hope and optimism (Seligman, 2002), and self-esteem (Kidd and Shahar, 2008). The terms 'ego-resilience' (Block and Block, 1980) and 'hardiness' (Bonanno, 2005) have sometimes been used to describe individuals who possess these traits. These terms are not utilised for the current paper however, as consistent with Bandura (1977) and described by resilience models outlined later in this chapter, psychological processes related to resilience are not hypothesised to be stable personality characteristics independent of social context. *Resilient people* as such do not exist as, 'Those people who cope successfully with difficulties at one point in their life may react adversely to stressors when their situation is different. If circumstances change, resilience alters.' (Rutter, 1987, p317).

1.7.4 Critique of Resilience: Its Operationalisation and Culturally Relevant Thresholds

Terms of 'successful adaption' and 'adverse conditions' have been central to resilience research. The ambiguity of these terms means they are not easily or consistently operationalised (Bodin & Winman, 2004; Ungar, 2004) and this undermines comparability of study findings. Does this mean for instance, that resilience occurs when an individual is faced with a significant stressor outside of everyday circumstances or even trauma, yet they overcome this and manage to maintain 'normal' levels of functioning, or, they overcome this and flourish? Or still, could individuals be resilient when they are faced with everyday stressors, that may be prolonged or fleeting, yet maintain adequate well-being (Davis et al., 2009), or again excel under these circumstances? The definitions provided above do not entertain such questions.

Resilience research has largely defined positive adaption from a Western psychological stance that does not consider what unique meaning resilience may hold for the individual within their cultural and historical context (Ungar, 2008; Ungar & Liebenberg, 2011). Kaplan argues the notion of resilience rests on social and cultural assumptions of 'successful outcomes',

> *'…it is possible that the socially defined desirable outcome may be subjectively defined as undesirable, while the socially defined undesirable outcome may be subjectively defined as desirable. From the subjective point of view, the individual may be manifesting resilience, while from the social point of view the individual may be manifesting vulnerability.'* (1999, p31-32)

Harvey and Delfabbro suggest that sensitive qualitative investigation, as planned for the current project, has potential to overcome the problem of definitional ambiguity and cultural bias,

> *'To address this problem, we believe that greater focus needs to be placed upon the reports and experiences of people who appear to have overcome adversity, and that the definition of resilience itself should be based less upon so-called objective cut-off scores, but also upon culturally and socially relevant ratings of success.'* (2004, p11)

Similarly, Dunleavy et al. comment that in order for resilience not to be overlooked or missed in certain populations and circumstances,

> *'…research involving people's subjective experience of health, and the resources involved in maintaining or promoting well-being needs to take place within, rather than divorced from, the different social contexts in which people live.'* (2012, p2)

Furthermore, traditional notions of resilience have tended to overlook the psychological processes and mechanisms that underpin resilience, as researchers have persisted with hypothesised resilience variables, whether these be outcome variables, e.g. psychological adjustment scale-score, or buffering variables, a common one being degree of social support (Rutter, 1987). Arguably, it is the process or mechanism that determines the protective function and not the variable.

1.7.5 Resilience Frameworks that Consider Context and Psychological Maintenance Processes

Conceptualisations of resilience are presented here that consider resilience to be: contextual, a process, and ongoing in order to maintain well-being and protect against frequent threats to well-being. This is consistent with the current project's conceptualisation of resilience, as it is hypothesised to hold relevance to resilience operations within a homeless population.

Rutter (1985; 2013) proposed a framework of resilience that emphasised the need to evolve from the quantitative exploration of protective vs. risk factors, to understand resilience as an active, fluid, psychological, and contextual process. According to Rutter, people who are resilient are exposed to adversity and engage with it, yet purposefully and proactively act to protect themselves from its negative consequences. This is different to coping, as people can cope by altogether avoiding negative situations (Lazarus & Folkman, 1987). Rutter theorised that previous experiences of mastery and success, and experiences of secure and affirming relationships, are central for the development of the required 'cognitive set', skills and

strategies for resilient functioning. Interestingly, he emphasised the importance of adolescence and adult life experiences as well as early life experiences for resilience development. One strength of the model is that it holds context as important, as certain factors are agued to function as both risk and protective factors, and 'Protection is not a matter of pleasant happenings or socially desirable qualities of the individual.' (Rutter, 1987, p318).

Of great importance to psychological understandings of resilience, Rutter usefully theorised on the psychological operations that underpin resilience,

> *'Resilience is characterised by some sort of action with a definite aim in mind and some sort of strategy of how to achieve the chosen objective which seems to involve several related elements. Firstly, a sense of self-esteem and self-confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem-solving approaches.'* (1985, p607).
>
> And,
>
> '*It should be noted, however, that this cognitive set is not a fixed personality trait; it may change with altered circumstances.'* (1985, p603).

Ungar (2004; 2008) developed a sociological perspective of resilience that did not hypothesise psychological mechanisms, but had in common with Rutter (1985) the idea that resilience is an ongoing process of sustaining well-being in the face of adversity, and the contextual and cultural frame that individuals operate within is of great importance. Ungar (2004) argued that the most disadvantaged and perceived vulnerable groups can demonstrate resilience. However, their resources to access experiences of health and well-being are often limited, and as a result, many engage in behaviours and activities that are deemed to be delinquent in order to sustain their health. With cultural lenses looking for 'positive adaption', researchers overlook marginalized people's resilience processes and outcomes (Gilgun, 1999). This perspective possibly holds relevance for homeless people whose specific cultural frame is often one of limited power and opportunity to access mainstream means of health. Ultimately, 'resilience success' would depend on the subjective sense of well-being and health the individual has enabled or sustained through their actions (Ungar, 2004).

Rutter's (1985) and Ungar's (2008) definitions of resilience have in common the active process work of well-being maintenance. Such conceptualizations of resilience appear to be

emerging within other fields, for example in the Nursing Forum, Brush et al. say, 'resilience implies a process of hurdling resistance and, in doing so, gaining strength against future stressors, challenges, crises, or trauma, much like a microbe develops resilience over time to an antibiotic and ultimately adapts to and survives its environmental conditions.' (2011, p161). Interestingly, in her meta-synthesis of qualitative research, Finfgeld-Connett found 'sustained action' to be key, '[homeless] women who successfully extricate themselves from a homeless existence overcome self-doubt and fear and are able to rally enough self-esteem to sustain them through multiple ordeals' (2010, p464).

The importance of maintenance processes for well-being is emphasised by Prochaska and DiClemente's (1982) Stages of Change Model, where at the final stage, an individual consciously operates to maintain behavioural changes that protect against relapse. Like Rutter (1985) and Harvey and Delfabbro, (2004), researchers in the field of health have taken an interest in psychological mechanisms that underpin health-related behaviours; Stretcher et al. (1986) reviewed studies that explored the Stages of Change Model in relation to individuals' health practices and found a strong relationships between self-efficacy and health behaviour change and maintenance.

In summary, resilience can be understood as a fluctuating and ongoing process, mediated by cognitive frameworks, such as self-efficacy. An incidence of resilience is not necessarily a successful outcome to a specific adversity, but one's effort to sustain a sense of manageability by protecting oneself from adversity and finding means of promoting well-being.

1.8 RESILIENCE RESEARCH IN HOMELESSNESS

An emerging yet limited number of studies have begun to examine strengths and resilience that enable homeless people to survive, find meaning, and improve their quality of life. Patterson and Tweed (2009) retrospectively explored the factors that helped people escape from homelessness. Participants expressed that their recognition of strengths, sense of worth and potential helped them to transition out of homelessness more so than substance-abuse treatment, mental health intervention, and social support. Strengths and resilience research is a common topic of interest for positive psychologists, and they have demonstrated the benefits of strength recognition and planned utilization in other populations (Linley et al. 2010; Quinlan et al. 2011; Seligman et al, 2005).

Other quantitative research has examined the relationships between hypothesised factors associated with risk and coping. For example, Epal et al. (1999) found that adults with high self-efficacy outcome scores had better coping strategies compared to those with lower self-efficacy scores. Kidd and Shahar (2008) found self-esteem to be the one and only variable to predict outcomes of mental and physical health over and above risk factors, such as abuse in childhood, and self-esteem served to buffer the impact of risks on outcomes. Kidd and Carroll (2007) revealed just one variable, 'belief and hope for a better future' to reduce risk of suicidal ideation and attempts, whereas the strongest predictors of suicidal ideation and attempts were avoidant coping behaviours, particularly drinking and substance misuse.

There are methodological limitations however, applicable to these cross-sectional studies. Protective, risk, and outcome variables of interest are of course pre-determined by the researcher and this ultimately limits findings to selected variables. For instance, Runquist and Reed (2007) found a positive, significant relationship between spiritual perspective and the well-being of homeless adults, whereas the other studies did not include this measure. Kidd & Shahar (2008) also acknowledge the common critique of correlational research in that causal direction of relationships between variables cannot be known. And, as discussed earlier, the definition and operationalization of the constructs examined will differ from researcher to researcher, and will often omit important contextual factors.

These methodological problems are not as apparent in qualitative investigations of the strengths, resilience and coping of homeless people. Martins (2008) interviewed people who were street homeless and discovered their 'underground resourcefulness'; a term employed to denote illegal strategies to find means to stay well. For example, people talked of prostitution or drug-dealing to continue reported self-medication (see also Evans & Forsyth, 2004). Other investigations identified means of coping with homeless life, including the importance of social relationships, or relationships with pets to cope with feelings of loneliness (Rew, 2000), hope and plans for the future and being active in seeking help and support (Finfgeld-Connett, 2010), and an acquired sense of wisdom (Boydell et al., 2000).

What is missing from such qualitative investigations however, is in-depth exploration of the psychological processes associated with these coping behaviours. For instance, hope for a better future is commonly reported as helpful and associated with coping, but how this belief manifests to influence action that buffer against adversity and sustain manageability is overlooked. Or, supportive relationships are frequently linked with those who sense that they

are coping, yet the central processes that enable people to initiate and sustain such relationships is not considered. As Rutter said, 'The search is not for factors that make us feel good but for processes that protect us against risk mechanisms.' (1987, p318).

The systematic review aims to fill this gap in the literature and determine processes of resilience amongst homeless people. More specifically, the review aims to address the question, *what is the psychological process by which a homeless person maintains a sense of manageability?* The research question addressed 'manageability' as opposed to 'resilience' due to the vast variability in how resilience is defined and operationalized. A sense of manageability is one of the three components that comprised Antonovsky's (1987) 'Sense of Coherence' framework that theorized on an individuals' capacity to deal with stressors in order to maintain health. Manageability is defined as the extent to which one perceives that they have access to the resources, whether they be internal or external in nature, required to deal with life challenges and ultimately cope. Generally speaking then, if someone has a sense of manageability, even though they may be experiencing difficulties, they would believe that such difficulties are solvable or manageable, and not entirely outside of their control.

1.9 SYSTEMATIC REVIEW

A systematic review was conducted to consider current research into psychological processes associated with the resilience of homeless adults. More specifically, the research question asked, *what is the psychological process by which a homeless person maintains a sense of manageability?* Although sympathetic to the argument that the application of quantitative review procedure to qualitative research undervalues such research, for instance, Sandelowski et al. argue that there is a loss of 'the vitality, viscerality and vicarism of the human experiences represented in the original studies' (1997, p366), the review was nevertheless deemed necessary to provide a systematic, exhaustive and unbiased search of the most up to date evidence-base in order to advance theory and knowledge. This chapter outlines the phases of the review, including: the search process, a detailed summary of findings of selected studies, a critical appraisal of each study via the application of a quality review-framework, a narrative synthesis of studies, and implications for further research.

1.9.1 Search Process

The search was conducted in two stages. Firstly the following databases were searched on the 30.11.2013: PsychINFO, PsychArticles, OvidMedline, ASSIA, Sociological Abstracts,

CINAHL, and PubMED. The search terms (their Boolean operators are included) used in the relevant fields were: 'Homeless*' in *title* field AND 'qualitative' in *'keyword'* field AND 'Resilien*' OR 'Self-efficacy' OR 'Well-being' OR 'Cope' OR 'Coping' OR 'Hardiness' in *all fields* field. The dates searched from were 1983 to 2013. In total, 618 articles were generated by this search. All titles and/or abstracts were evaluated by the inclusion/exclusion criteria, outlined as follows:

Inclusion Criteria

- *Peer-reviewed qualitative study*
  The review focused on ascertaining the subjective, lived experiences of coping strategies in order to identify the process/es of resilience rather than outcomes and therefore the participants' descriptions as situated within their particular cultural context was deemed important.
- *Samples with a minimum mean sample-age of 18*
  The review, as well as the current project, had its interest with adult experiences of homelessness.
- *Samples defined as homeless at time of interview*
  In order to capture 'live' and recent experiences associated with the resilience process.
- *Area of interest as primarily an investigation into how people who are homeless cope/manage/sustain health or wellbeing*.
- *Contain sufficient data that relates to an individuals' psychological process associated with perceived managing*.
  The two last points were designed to select studies that contained relevant data to the research question.

Exclusion Criteria

- *Duplicate papers.*
- *Investigations of non-Western cultures*
  These were deemed as non-generalizable to Western populations due to significant cultural differences.
- *Female only samples*
  The current research has its focus on people who are homeless and residing in a hostel. Such people are likely to belong to the non-statutory homeless group, and be male (Crisis,

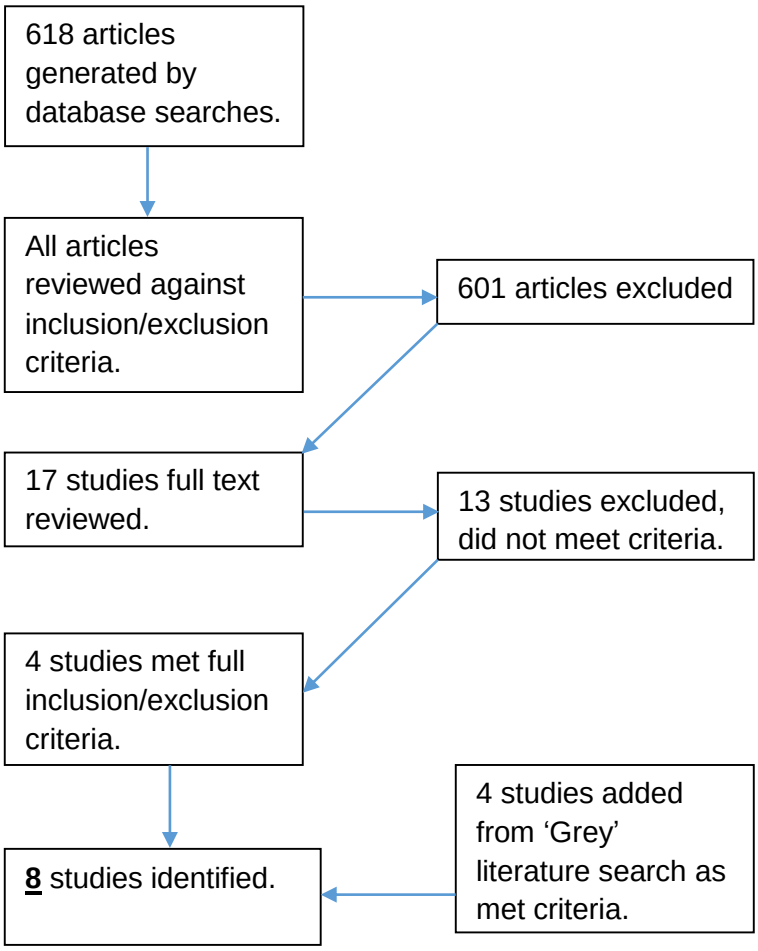
2003). Therefore it is deemed that a female only sample will not yield findings that are meaningfully generalizable to the population of interest.

- *Very specific sub-populations*
  Not deemed generalizable to wider homeless population, e.g. ‘homeless fathers with mental illness’, ‘older homeless people with chronic pain’.

The majority of articles that were excluded throughout were due to their primary research focus deemed as non-relevant, i.e. they did not focus on how people who are homeless cope or manage with adversities typical to the population. This was determined by reading the article titles and/or abstracts. Seventeen article abstracts indicated potential to meet inclusion criteria and thus were selected for in-depth evaluation via the reading of their full-text. Four of these articles met the inclusion/exclusion criteria for the final review.

At stage two, the references of the selected review articles were searched, and the “Grey” literature (via Google Web & Google Scholar) was consulted by using the same search terms as above. This yielded a further four articles that were added to the final review, making a total of eight (see Figure 1 for an illustration of the process).

Figure 1. Search Process



1.10 SUMMARY OF INCLUDED STUDIES

Only a very few studies were generated by the systematic review when the research question asked, *what is the psychological process by which a homeless person maintains a sense of manageability?* This possibly indicates a lack of research interest in this area, and more certainly a lack of peer-reviewed studies that have addressed psychological processes related to resilience and coping within the homeless population. Table 2 provides a detailed descriptive summary of the studies included for the review. An outline of the aim, methodology, and findings and discussion, are provided for each study, by author. A synthesized narrative summary of the participants in the studies is provided first.

1.11 NARRATIVE SUMMARY OF PARTICPANTS

1.11.1 Sample Size and Age

Sample sizes varied. Three studies (Bender et al., 2007; Kidd, 2003; Thompson et al., 2013) included relatively large samples of up to 80 participants, whereas two studies recruited relatively small numbers (Dunleavy et al., 2012; McCormack & MacIntosh, 2001), with the remaining samples containing between 15 and 29 participants. In terms of the ages of participants, half of the studies recruited younger samples, with mean ages of around 19 (Bender et al.; Kidd; Rew, 2003) and 21 years (Thompson et al.), and indeed often reported to be studies of 'homeless youth'. The other studies did not report mean ages but indicated the recruitment of younger and older participants, with ages ranging from 18 to 65. All studies recruited female and male participants, although the majority contained markedly more males (Kidd; McCormack & Gooding, 1993; Thomas et al., 2012; Thompson et al.). The male to female ratio was more equal in Bender et al. and Rew's samples, whereas McCormack and MacIntosh and Dunleavy did not state their sample-gender ratio.

1.11.2 Type and Duration of Homelessness

Often the homeless status of the sample was not precisely defined, but most authors did provide some description. Bender et al. (2007), Kidd (2003) and Rew (2003) labelled the majority of their participants as 'street homeless', and Dunleavy et al. (2012), McCormack & Gooding (1993) and McCormack & MacIntosh (2001) recruited participants living in hostels or shelters. Thomas et al. (2012) and Thompson et al. (2013) had a mix of street and sheltered participants.

Only half of the studies reported time spent homeless by participants. Participants in Rew (2003) and Thompson et al.'s (2013) studies spent an average of 4 and 3.5 years homeless, respectively. McCormack & MacIntosh (2001) reported that the majority of their participants were homeless for 1-5 years, and those in McCormack & Gooding's (1993) study were homeless from 1 week to 35 years. Unfortunately, these two studies did not report averages.

1.11.3 Country of Study and Participant Ethnicity

Most studies were either conducted in the USA (Bender et al., 2007; Rew, 2003; Thompson et al., 2013) or Canada (Kidd, 2003; McCormack & Gooding, 1993; McCormack & MacIntosh, 2001), with only one UK (Dunleavy et al., 2012) and one Australian (Thomas et al., 2012)

study. Of the studies that reported ethnic demographics, the vast majority of participants were ‘White’/‘Caucasian’, although the samples also contained participants from other ethnic groups. This is with the exception of Thomas et al. who reported that over half of their sample were identified as Indigenous.

Table 2. Summary of Included Studies

Study	Aim	Methodology	Participants	Quality Rating	Findings	Discussion
Bender et al., (2007). USA.	To explore the personal strengths and informal resources 'street youth' use to navigate and adapt to their environments.	Design: Qualitative. Focus groups, semi-structured interview. Analysis: Content analysis.	Convenience sample of 60 homeless people receiving Health and Social Service input from a homeless drop-in centre. Type of homelessness: Identified as homeless, and although not explicitly stated, the study purports to be an investigation of 'street youth'. Age: Mean=19.4 years. Gender: Females (N=28); Males N=31. Ethnicity: Caucasian (N=39); Hispanic &/or Latino (N=14); African-American (N=6).	18	-***'Street smarts'.*** Included: learning who you can trust and earning credibility. Helped negotiate the balance between self-reliance and accepting help in order to avoid danger and increase resources. ***-Personal strengths.*** -*Coping skills* of planning, problem-solving, intelligence and interpersonal skills enabled access to resources. -*Motivation* to improve life quality derived from role-models, pets and hope. -*Attitudes* of positivity, optimism and hopefulness, 'essential' to face everyday challenges. ***-External resources.*** *Peer networks* offered emotional support and protection.	The authors conclude that most street youth are forced to pursue non-traditional resources and internal strengths and develop a sense of self-reliance/'street smarts' to cope with challenges. They highlight the strengths, abilities and resources of homeless young people. Service providers have a tendency to view the homeless as powerless victims. Service providers should explicitly incorporate the homeless' strengths to provide strengths-based services that empower and better engage with them.
Dunleavy et al., (2012). UK.	To explore the subjective lived experiences of homeless people's wellbeing. Aiming to provide insight into the resources and mechanisms that enhance and maintain well-being in the face of challenges.	Design: Qualitative. Semi-structured interviews. Analysis: Framework Analysis (cited as a Constructivist approach). Second phase - categorizing transcripts according to the Salutogenic approach and theory.	Convenience sample of 9 homeless people (>25 years of age) living in a hostel in a socially deprived area of inner city. *Note*, gender, ethnicity, mean age not provided.	15	-Themes supporting wellbeing: ***Beliefs of recovery*** *a)beliefs of recovery b)effort c)positive thoughts.* ***Perceived resourcefulness*** *a)staff b)problem-solving c)initiative d)social skills* ***Personal participation and esteem*** *a)learning and helping others b)contributions c)recognition d)give something back e)feeling better about self.* -Second step of analysis revealed meanings of wellbeing as contingent within beliefs of a sense of control - related with Salutogenic concepts of generalized resistance resources (GRR) and sense of coherence (SOC) in terms of manageability and meaningfulness.	Participants faced threats to wellbeing whilst moving towards wellbeing. The authors suggest that beliefs of recovery, perceived resourcefulness and participation act as GRR's essential to well-being, and also relate to the maintenance of SOC, which can serve as a motivational component. Services should challenge homelessness assumptions and adopt practical approaches that enable people to recognise and utilize assets/resources for wellbeing. Salutogenic theory offers a framework to help achieve this end.

Study	Aim	Methodology	Participants	Quality Rating	Findings	Discussion
Kidd, S. (2003). Canada.	Sought to explore homeless youth's perceptions of, and experiences with, coping with 'survival on the streets'.	Design: Qualitative. Semi-structured interviews. Analysis: Content analysis informed by Grounded Theory.	80 homeless 'street youth' from Toronto (N=40) and Vancouver (N=40). Mean-age of 19.8 years. Female (N=31); Male (N=49). Mean level of education = 9.9 years. 85% Caucasian; 9% Native Canadian, remaining ethnicities 'varied'. 73% were street homeless, the rest lived in shelters and hotels.	15	***Social support experiences.*** Friends taught participants the 'rules of the street' and provided support (emotional and financial) until they developed self-reliance. ***Beliefs of self and world.*** -Sense of worth/value protected against the actions of others. -Beliefs of agency, ability and self-sufficiency were deemed as central to coping as was hope for the future. -Learning of strengths, including self-sufficiency, and developing important life-values were associated with the 'hard' times of homelessness. This increased confidence in dealing with stressors. ***Coping activities*** which positively impacted on thoughts and feelings were executed on 'bad' days.	-Coping strategies were often emotion-focussed; the author questioned practical benefit, e.g., how often did goal-directed plans manifest from hope? -The value of independence is acknowledged, yet this possibly hampers learning from positive role-models. -The author suggests that services should assess people's support networks and identify key positive relationships. -Participants spoke of negative experiences with services. It is recommended that services obtain service-user feedback. -Strengths-based services are recommended.
McCormack & Gooding. (1993). Canada.	To investigate the meaning of health as it is experienced by homeless persons. Of interest, how do homeless people achieve a sense of health?	Design: Qualitative, phenomenological approach. Semi-structured interviews. Analysis: described as inductive – transcripts coded and categorized to identify themes.	Convenience sample of 29 homeless people, aged 18-62 years, from 3 hostels and 1 drop-in centre within Ontario. Females (N=9) spent 1 week-to-3 years at the shelter, males (N=20) 3 weeks-to-35 years. 15 people graduated from high school, 11 did not complete high-school, and 2 had never attended.	15	Being healthy meant: ***-Doing the work of health*** actively taking responsibility to care for oneself in order to prevent ill-health. ***-Having a positive self-image and outlook.*** Feeling in control of stressful events protects from worry. Importance of self-esteem, confidence, and sense of agency and mastery. ***-Having a support network*** fostered a sense of worth and belonging. ***-Structuring the day*** gave people a sense of direction and control.	Homeless people employ a variety of means to derive a sense of health. The authors recommend that nurses assess how homeless people maintain their health, as well as health challenges, and capitalize on existing strategies and help to develop new ones. Adopting such a client centred approach may assist in the accessibility of healthcare services to the homeless.

Study	Aim	Methodology	Participants	Quality Rating	Findings	Discussion
McCormack & MacIntosh. (2001). Canada.	To explore the health experiences of homeless people and how they attain, maintain, or regain health.	Design: Qualitative, Grounded Theory. Semi-structured interviews. Analysis: Grounded Theory.	A convenience sample of female and male homeless adults (N=11, aged 17-56 years), recruited from 3 homeless shelters providing overnight accommodation. Education: 'some high-school experience (N=10); graduated high-school (N=3). All participants had work experience. Duration of being in 'shelter system': <1 year (N=5); 1-6 years (N=5) (N=1 'unknown').	15	*Pathways to health:* ***Person.*** -Self-confidence enabled people to accomplish tasks, such as employment. These, in-return, installed confidence. Self-reliance enabled navigation of systems of help. -Participants had a self-awareness and ability to purposively assess own health status by weighing options, analysing costs and benefits, and making decisions. This was motivated by benefits of feeling healthy, and supported by self-reliance. ***Behaviours*** conducted with intention to promote health and prevent illness, e.g. exercising, distraction for pain. However, some behaviours hindered health, e.g. addiction. Actions and their health effects monitored, evaluated and if needed, revised – for instance, access services if self-strategy not working.	-A model of health is presented: All participants accepted individual responsibility for health and considered self-care when needed, via internal strengths, prior to external health-related services. -Services should work with homeless people's self-reliance and determination. Providing options for greater decision-making is a basic idea put forward for user participation and more collaborative user-professional relationships.
Rew, L. (2003). USA.	To explore self-care attitudes and behaviours of homeless adolescents.	Design: Qualitative, Grounded Theory design. Semi-structured interviews. Analysis: Grounded Theory.	Purposive sampling of homeless youths (N=15; Females=6; Males=7; transgendered=2) who were receiving health and social services from a street outreach programme in central Texas. Mean age=18.8 years. Ethnicity: the majority were White=8; Latino=2; other=5. Average duration of homelessness=4 years. In the past year, the majority had lived in "squats".	17	A basic social process of taking care of oneself in a high-risk environment supported by: ***Becoming aware of self*** *-Developing self-respect* through actions (e.g. not being promiscuous) enabled participants to self-care better. *-Increasing self-reliance* meant trusting own judgement and actions which lead to confidence and agency, as opposed to receiving help and advice. ***Staying alive with limited resources*** Self-respect and reliance enabled motivation of daily practices to sustain health, for e.g. eating healthily, acting to ensure safety (e.g. carry weapons, have a dog). ***Handling own health*** by accessing resources and support via others.	-Despite frequent, serious threats to health and safety, homeless youth talked of a developed self-awareness that enabled self-care strategies to sustain health, to feel happy and safe. Strategies of attitudes and behaviours included planning and accessing available resources to protect against risk. Skills were learnt on the streets and by modelling peers. -The author acknowledges the courage of participants who, in harsh living conditions, moved with intention toward health and 'growth'. -Services should support such healthy strategies.

Study	Aim	Methodology	Participants	Quality Rating	Findings	Discussion
Thomas et al., (2012). Australia.	Aimed to explore homeless peoples' subjective experience of wellbeing, and the strategies performed to sustain positive experiences linked to wellbeing.	Design: Qualitative; 'Constructivist methodology'. Semi-structured interviews. Analysis: Involved both inductive and deductive phases; coding procedure to generate categories and themes.	For purposes of diversity, participants (N=20) purposively recruited from three locations: a drop-in centre, a night hostel for 'at-risk' individuals, and emergency family housing for people with children. 12 participants were living on the streets; 4 in hostels; 3 mothers were in emergency accommodation; and 1 in shared housing. Males=14; Females=6 Age range=22-65 years. 12 participants identified as Indigenous.	15	Wellbeing influenced by: ***Keeping safe.*** Uncertainty and insecurity linked with poor wellbeing. Keeping self safe from danger by being active, vigilant and self-sufficient (also via peer networks) linked with better wellbeing and perceptions of positive identity. Feeling safe enabled planning; the goal otherwise was current survival. ***Being positive and feeling good*** maintained via personal, environmental and social avenues. E.g. the conscious adoption of positive attitude and sense of independence linked with esteem and good wellbeing. ***Connecting with others*** Provided enjoyment, sense of belonging and esteem, and support via shared resources. Days were organized to ensure this. ***Staying human*** by socialising with non-homeless people and concealing homeless status. Reduced feeling judged.	-Participants acknowledged low wellbeing levels in face of persistent challenges, yet identified strategies to sustain and enhance wellbeing. These included personal attitudes, relationships, and resourcefulness. -Attitudes of contentment are acknowledged by the authors as coping strategies, yet this possibly impedes goal-oriented planning. -The authors suggest that social workers can employ strengths-based and context-specific perspective of homelessness and wellbeing; to counter deficit models, improve understanding, realise resilience, and better plan interventions.
Thompson et al., (2013). USA.	To expand upon the limited information available, the study aimed to investigate the perceptions of homeless adults concerning their strengths, life perspectives, and coping strategies.	Design: Qualitative, semi-structured interviews primarily examined resiliency, coping, and safety strategies. Analysis: Iterative content procedures.	Convenience sample of 45 (Female N=33%; Males N=67%) homeless adults (mean age=21 years). Living on street or temporary shelter (73.3%), staying with family/friends (24.4%). Average homelessness duration 3.5 years. White (80%), Latino (6.7%), Black (2.2%), other/mixed ethnicity (11.1%). Majority (35.6%) dropped out from school, 33% had graduated, 17.8% had a GED (US high school equivalency), 8.9% were currently in education.	17	***Individual strengths*** of resourcefulness, self-reliance, self-efficacy and sense of agency linked with managing adversity. Self-worth associated with ability to survive street-life, and desire for freedom as motivating. ***Positive life perspective*** of positivity and optimism as general source of resilience and of acceptance which linked with happiness. Participants talked of appraising difficult events positively in order to cope. ***External social supports.*** Seeking out specific people for emotional support, protection, guidance, recreational activity. Pets also provided comfort, stability and protection. ***Other coping strategies*** included avoidance, planned activity, and substance use to relieve stress, anger, trauma, and feel better.	-Most participants talked of their strengths, self-sufficiency, and positive outlook in order to manage adversity. But positive social supports also deemed as important. -Authors argue that services need to help people shift from poor coping skills to positive skill development, including capitalizing on existing strengths and healthy strategies. -Services tend to focus on problems and pathology only (e.g. interventions that only target drug-use). Strengths-based interventions, targeted early in homelessness trajectory, have potential long-term benefits.

Table 2: Summary of Included Studies

1.12 QUALITY REVIEW

The health field has traditionally valued findings derived from quantitative, experimental designs, as these are often deemed as more reliable, valid, and generally 'scientific' compared to qualitative research (Mays & Pope, 1995). The development of quality frameworks for qualitative studies have been devised to ensure the quality of research and trustworthiness of findings (Law et al., 1998; Tracy, 2010). The current review evaluated the credibility of the identified studies by adopting the Critical Applied Skills Programme (CASP, 2010) quality-review framework. CASP was selected from an array of quality-review procedures (e.g. Elliot et al., 1999; Spencer et al., 2003) as it provides a clear criteria checklist that is score-able, enabling a means of systematic comparison (Chenail, 2011), and it has been reviewed and recommended for research within NHS settings (Campbell et al., 2011).

CASP (2010) details ten quality markers, one of which, for example, is 'ethics': *have ethical issues been taken into account?* Each domain is scored between zero to two (please visit http://www.casp-uk.net/ for CASP scoring criteria-checklist). A score of zero means that the author(s) have not addressed the criteria at all, a score of 1 indicates partial fulfilment, and if the criteria has been fully met then a score of two is allocated. The sum of the scores provides the study with an overall indication of quality, with higher scores (the highest being 20) equating to greater quality. Table 3 presents the CASP evaluation of the studies (N=8) identified for the systematic review, providing brief explanation of scoring rationale to enable transparency.

Prior to presenting the review, it is noted that an interpretive element of judgement remains when applying structured criteria frameworks to qualitative research. A study by Dixon-Woods et al. (2007) found little inter-rater agreement over the quality of a series of studies when researchers applied the CASP. Furthermore, degree of agreement was comparable to those reviewers using personal judgement alone. However, CASP users were more explicit in their evaluation-reasoning-process compared to the unprompted reviewers. Additionally, a reviewer is likely to be more systematic in their decision-making process when applying a structured approach, hence the quality framework was deemed sufficient and was executed accordingly.

Table 3. CASP Quality Review

Study	**Aims** Was there a clear statement of the aims of the research?	**Methodology** Is a qualitative methodology appropriate?	**Design** Was the research design appropriate to address the aims of the research?	**Recruitment** Was the recruitment strategy appropriate for aims of the research?	**Data collection** Were data collected in a way that addressed the research issue?	**Reflexivity** Has the relationship between researcher and participants been adequately considered?	**Ethics** Have ethical issues been taken into consideration?	**Data Analysis** Was the data analysis sufficiently rigorous?	**Findings** Is there a clear statement of findings?	**Value of research** How valuable is the research?	**Total score** (0-20)
Thomas et al., (2012).	Clear aim and importance of study provided. =2	In order to address the research aim, the meanings and accounts of the lived experiences of participants were sought. =2	Research design appropriate and justified. =2	Explanation of how participants were recruited. And rationale why sample deemed appropriate. =2	Detailed procedure of how (and where) data were collected, and rationale for method. =2	Not considered. =0	Ethical approval gained. Ethical issues not further discussed. =1	Only brief detail of analysis process. Sufficient quotations to represent themes. Researchers' role in analysis not critically considered. =0	Findings are explicit and discussed in relation to research question. Credibility of findings discussed. =2	Practice recommendations made. Identified further areas of research. =2	**15**
McCormack & Gooding. (1993).	Clear aim and relevance of study provided. =2	The study aimed to illuminate the subjective experiences of participants. Qualitative methodology appropriate. =2	Design appropriate and justified. =2	Explanation of how participants were recruited. Rationale given why sample deemed appropriate. =2	Detailed procedure of how (and where) data were collected, and rationale for method. =2	Not considered. =0	Insufficient detail of ethical approach. =0	Clear description of analysis process. Insufficient data to convincingly represent themes. Addressed own role re. bias of analysis. =1	Findings are explicit and discussed in relation to research question. Credibility of findings discussed. =2	Practice recommendations made. Identified further areas of research. =2	**15**

Study	**Aims** Was there a clear statement of the aims of the research?	**Methodology** Is a qualitative methodology appropriate?	**Design** Was the research design appropriate to address the aims of the research?	**Recruitment** Was the recruitment strategy appropriate for aims of the research?	**Data collection** Were data collected in a way that addressed the research issue?	**Reflexivity** Has the relationship between researcher and participants been adequately considered?	**Ethics** Have ethical issues been taken into consideration?	**Data Analysis** Was the data analysis sufficiently rigorous?	**Findings** Is there a clear statement of findings?	**Value of research** How valuable is the research?	**Total score** (0-20)
Kidd, S. (2003).	Clear aim and relevance of study provided. =2	The study aimed to illuminate the subjective experiences of participants. Qualitative methodology appropriate. =2	Design appropriate but not justified. =1	Very brief detail how participants were recruited. Rationale given why sample deemed appropriate. =1	Detailed procedure of how (and where) data were collected, and rationale for method. =2	The researcher's position in relation to participants is considered, but no critical element to this. =0	Consent issues addressed in relation to minors. No further discussion of ethics. =1	In-depth description of analysis process. Sufficient quotations to represent themes. Address potential bias of analysis. =2	Findings are explicit and discussed in relation to research question. Credibility of findings discussed. =2	Practice recommendations made. Identified further areas of research. =2	**15**
Rew, L. (2003).	Clear aim and relevance of study provided. =2	Qualitative methodology appropriate and justified. =2	Design appropriate and justified. =2	Procedure explained how participants were recruited. Rationale given why sample deemed appropriate. =2	Detailed procedure of how (and where) data were collected. Saturation of data explained. =2	No. =0	Ethical approval gained. Confidentiality and consent emphasised. =2	Detailed description of analysis process. Sufficient data provided to represent themes. Address potential bias of analysis. =2	Clear statement of findings, and their credibility reported. =2	Findings discussed in relation to theory and literature-base. Practice recommendations only briefly mentioned. =1	**17**
Thompson et al., (2013).	Clear aim and relevance of study provided. =2	Qualitative methodology appropriate and justified. =2	Design appropriate and reported but not justified. =1	Procedure explained how participants were recruited. Rationale given why sample deemed appropriate. =2	Detailed procedure of how (but not where) data were collected. Justification of method. =1	Social-desirability bias mentioned and addressed. =1	Confidentiality and consent emphasised. Approval granted. =2	Detailed description of analysis process. Address potential bias of analysis. Sufficient data provided to represent themes. =2	Clear statement of findings in relation to research question, and their credibility reported. =2	Findings discussed in relation to literature-base. Practice recommendations made. =2	**17**

Study	**Aims** Was there a clear statement of the aims of the research?	**Methodology** Is a qualitative methodology appropriate?	**Design** Was the research design appropriate to address the aims of the research?	**Recruitment** Was the recruitment strategy appropriate for aims of the research?	**Data collection** Were data collected in a way that addressed the research issue?	**Reflexivity** Has the relationship between researcher and participants been adequately considered?	**Ethics** Have ethical issues been taken into consideration?	**Data Analysis** Was the data analysis sufficiently rigorous?	**Findings** Is there a clear statement of findings?	**Value of research** How valuable is the research?	**Total score** (0-20)
Dunleavy et al., (2012).	Clear aim and relevance of study provided. =2	Qualitative methodology appropriate and justified. =2	Design appropriate and justified. =2	Procedure explained how participants were recruited. Rationale not given why sample deemed appropriate. =1	Detailed procedure of how data were collected. Setting not mentioned. =1	Researcher examined their influence; acknowledgement of co-construction of data. =1	Confidentiality, anonymity, and consent stressed. Ethical approval granted. =2	Detailed description of analysis process. Address potential bias of data collection but not analysis. Insufficient data provided to represent all themes. =1.	Clear statement of findings in relation to research question, yet descriptions lack for many identified themes. Credibility reported. =1	Findings discussed in relation to theory and literature-base. Practice recommendations proposed. =2	**15**
McCormack & MacIntosh. (2001).	Research questions stated, relevance provided. But the goal of advancing a theory/model of healthcare, which is central to the study, is not clearly stated. =1	Qualitative methodology appropriate and justified. =2	Design appropriate and justified. =2	Procedure explained how participants were recruited. Rationale not given why sample deemed appropriate. =1	Detailed procedure of how and where data were collected. Methods modified – justification given. =2	No mention. =0	Ethical standards described, yet approval not mentioned. =1	Detailed description of analysis process. Potential bias of analysis addressed. =2	Clear statement of findings in relation to research question, and their credibility reported. =2	Findings discussed in relation to theory and literature-base. Practice recommendations proposed. Discussion how findings relevant to other populations. =2	**15**

Study	**Aims** Was there a clear statement of the aims of the research?	**Methodology** Is a qualitative methodology appropriate?	**Design** Was the research design appropriate to address the aims of the research?	**Recruitment** Was the recruitment strategy appropriate for aims of the research?	**Data collection** Were data collected in a way that addressed the research issue?	**Reflexivity** Has the relationship between researcher and participants been adequately considered?	**Ethics** Have ethical issues been taken into consideration?	**Data Analysis** Was the data analysis sufficiently rigorous?	**Findings** Is there a clear statement of findings?	**Value of research** How valuable is the research?	**Total score** (0-20)
Bender et al., (2007).	Clear aim and relevance of study provided. =2	Qualitative methodology appropriate and justified. =2	Design appropriate and justified. =2	Procedure explained how participants were recruited. Rationale not given why sample deemed appropriate. =1	Detailed procedure of how and where data were collected. Justification of method given. =2	Examined and addressed bias in development of interview questions. =1	Confidentiality, anonymity, and consent stressed. Ethical approval granted. =2	Detailed description of analysis process. Address potential bias of analysis. Sufficient data provided to represent themes. =2	Clear statement of findings in relation to research question, and their credibility reported. =2	Findings discussed in relation to theory and literature-base. Practice recommendations proposed. =2	**18**

Table 3: CASP Quality Review

1.13 SUMMARY OF QUALITY REVIEW

The quality framework of CASP was used to critically appraise the eight studies identified as relevant to the research question. As Table 2 depicts, the quality of research across studies varied, as it did within studies and many markers of quality (e.g. 'Recruitment', 'Data analysis') fell short, with 'Reflexivity' most frequently falling short. The score of 15 emerged most commonly. It was considered here as 'medium quality standard', and was achieved by most of the studies (Dunleavy et al., 2012; Kidd, 2003; McCormack & Gooding; 1993; McCormack & MacIntosh, 2001; Thomas et al., 2012). Only three studies (Bender et al., 2007; Rew, 2003; Thompson et al., 2013) can be said to be of 'good-to-high quality', with a score of 17 and over. No studies achieved 'quality excellence' as represented by the maximum grade of 20. Also, no studies reported applying a framework of criteria to monitor their quality standard.

An additional limitation, not revealed by the CASP review, was that many of the studies made reference to psychological constructs, for example, self-esteem, appraisal processes, and cognitive coping strategies, without being informed by psychological theory to guide interpretation and results discussion (with the exception of Duneavy et al. (2012) which employed the Salutogenisis framework). Likewise, despite being investigations of resiliency and coping processes, most authors do not draw on models of resilience in order to make sense of their findings (bar Dunleavy et al (2012) and McCormack & MacIntosh (2001) who developed a model of health). With these limitations in mind, the requirement for further, high-quality and psychologically-informed research in the area is indicated.

1.14 THEMATIC NARRATIVE REVIEW

Table 2 summarises the findings of the eight studies, as purported by the authors. In order to understand these findings and identify commonalities and differences, particularly in relation to the research question, a narrative review of the studies is presented. To develop this review the themes identified by the authors and their supporting data were examined and then coded to produce an overarching series of main and sub-themes relevant to the current research question (a process similar to Walsh & Downe, 2005; please see Appendix 1 to view the procedure). Table 4 depicts these themes and demonstrates their occurrence by study. The author acknowledges the interpretative meaning-making nature of this knowledge production. A narrative account of these themes is provided and it is recommended this is read in conjunction with Table 3 in order to consider the credibility and general quality of studies and their reported findings.

Table 4. Systematic Review Themes

		STUDIES								
		Bender et al., (2007)	Dunleavy et al., (2012)	Kidd, (2003)	McCormack & Gooding, (1993)	McCormack & MacIntosh, (2001)	Rew, (2003)	Thomas et al., (2012)	Thompson et al., (2013)	TOTAL
THEMES	Positive Beliefs	YES	YES	YES	YES	YES	YES	YES	YES	**8**
	Self-Awareness	YES	YES	YES	YES	YES	YES	YES	YES	**8**
	Coping Strategies	YES	YES	YES				YES	YES	**5**
	Relationships	YES	YES	YES	YES		YES	YES	YES	**7**
	Sense of agency		YES	YES	YES	YES	YES	YES	YES	**7**
	Attitude to change: responsibility & motivation	YES			YES	YES			YES	**4**
	Planning & organisation	YES	YES		YES			YES		**4**
	Hampering factors			YES	YES	YES	YES	YES	YES	**6**
	TOTAL	**6**	**6**	**6**	**7**	**5**	**5**	**7**	**7**	

1.14.1 Positive Beliefs

All of the studies reported that positive beliefs were beneficial for well-being. These included beliefs about the self, spiritual beliefs, and beliefs and optimistic attitudes relating to future events. Most commonly reported were beliefs about the self and indeed were evident in all of the studies. Some authors explicitly stated that they were referring to participants' self-esteem (e.g. Dunleavy et al., 2012), whereas others made reference to the benefits of having a sense of 'self-confidence' and feelings of 'self-worth'. Thompson et al. (2013) described participants' sense of self-respect linked to their perceptions as capable to face the hardships of street existence. Self-efficacy also seemed to exist within accounts of self-belief, as many participants believed in their ability to find resources, stand up for themselves, care for themselves and 'survive anything' (p.8). It is noted, however, that seldom did authors use the term 'self-efficacy', and here, the present author has interpreted its presence.

Participants of Rew's study also communicated their self-respect, their realisation of its importance, and directly linked self-worth to self-care actions, for example one participant stated "I respect myself more…I think it's [being promiscuous] so degrading." (2003, p4). Similar to Thompson et al. (2013), positive beliefs in one's ability were apparent and participants spoke at length of their belief in their ability to overcome any hardship. Interestingly, some of Rew's participants potentially hinted at the negative impact of possessing a very strong sense of self-competence as they appeared to be overly self-reliant and did not seek help from others in order to retain a maximum sense of agency.

Rew effectively reflected the self-reinforcing cycle of positive beliefs and actions, 'By gaining self-respect and self-reliance through new experiences (e.g., taking care of themselves and their pets on the streets, traveling with friends, improvising to maintain their health), they were changing old patterns of feeling devalued and victimized into new patterns of feeling worthy and capable' (2003, p4).

1.14.2 Self-Awareness: Awareness of Personal Vulnerabilities and Protective Factors

All of the studies referred to participants' self-insights that enabled them to better manage their homelessness. Some (Dunleavy et al., 2012; McCormack & Gooding, 1993; Rew, 2003; Thomas et al., 2012) referred to a recognition of factors that jeopardized well-being, meaning participants could adapt in order to maintain well-being. For instance, McCormack and Gooding's analysis revealed that many participants were aware of the harmful impact of substances and their need to completely avoid drugs and substances in order to maintain good health.

More common though, and evident in all of the studies, participants were aware of perceived protective factors, which amongst others included, services, optimistic attitudes, accommodation, health promoting behaviours and general occupation. Recognising the benefits of these factors, participants were able to capitalise on them. In particular, many of the studies (Bender et al., 2007; Kidd, 2003; Thomas et al., 2012; Thompson et al., 2013) described participants' awareness of the beneficial impact that supportive relationships had. Bender et al. reported that some participants deliberately chose to socialise and network with peers who did not use drugs in order to maintain their own sobriety. Many in Kidd's study also reported that friends helped them with substance use problems. In fact, participants named multiple benefits of supportive relationships, and in particular how they helped maintain their mental health and even acted as protection against suicide, as one participant

described, “I have come so close to killing myself but I think I couldn’t hurt him like that. So . . . we keep each other going . . . through thick or thin”. (p.247).

1.14.3 Coping Strategies

Five of the studies described coping strategies participants employed to deal with adversity. Here, such strategies are divided between behavioural and cognitive methods. Coping actions included socialising with friends and talking to others (Kidd, 2003; Thompson et al., 2013), taking substances to relax and deal with stress and mental health difficulties (Kidd; Thompson et al.), activities such as playing music (Thompson et al.), and accessing services when needed (Dunleavy et al., 2012). Coping processes of a more cognitive nature included, making time and finding private space to think issues through (Kidd), intentionally altering thoughts to ‘think about better things’ (Kidd, p250) and intentionally adopting positive beliefs (Thomas et al., 2012; & Thompson et al.), problem-solving (Kidd; Bender et al., 2007), and writing (Kidd; Thompson et al.) in order to process thoughts and feelings.

1.14.4 Relationships

Relationships that offered participants emotional and practical support was a theme across all studies, except McCormack and MacIntosh (2001). Some of the ways in which relationships provided support have been mentioned above. Most frequently participants talked about friendships with fellow homeless people, but they also discussed supportive professionals, family members, partners (although only mentioned in Kidd, 2003), and interestingly, pets, (Bender et al., 2007; Rew, 2003; Thompson et al., 2013) that offered participants protection, opportunities of responsibility and mastery, and reduced feelings of loneliness.

Some participants however, found friendships to be exploitive (Kidd, 2003). Participants in Bender’s et al.’s (2007) study illuminated on the process in which they determined and developed supportive relationships and protected themselves from exploiting others. Participants initiated relationships with caution and over time appraised the trustworthiness of the individual before categorizing them as a friend, ‘Implicit in this guardedness was the development of keen observation skills that helped them protect themselves’ (p5).

1.14.5 Sense of Agency

With the exception of Bender et al.'s (2007) study, all purported that participants valued and found meaning in actions that provided a sense of agency and independence. Such actions varied (e.g. self-care, employment, chosen leisure activities) but the essential ingredient of perceived agency was whether participants thought they had control and were 'free', to do what they wished to do. This theme appeared to be related then to efficacy beliefs. Many activities and general independence also provided feelings of mastery.

Some participants mentioned that their very desire for freedom motivated them to overcome adversities in order to 'survive street life' (Thompson et al., 2013). However, the strong desire also possibly operated to perpetuate street homelessness as the participants 'described their desire to experience new places and people without having responsibilities that would inhibit their mobility' (2013, p8).

1.14.6 Attitude to Change: Responsibility and Motivation

Another common theme related to attitudes (of readiness, motivation, and sense of responsibility) to change that could sustain or promote well-being. McCormack and MacIntosh (2001) (and similarly, McCormack & Gooding, 1993) found that participants held responsibility for their health-status, and therefore appraised and monitored their health. As a result they engaged in health maintaining and promoting behaviours and acted when health had become jeopardised, initially with self-coping strategies (e.g. imagery for dental pain); they evaluated the effectiveness of such actions, and if deemed necessary further actions were executed, such as the seeking of help from services. Motivation for change could be mediated through relationships, and Bender et al. (2007) found that individuals who had successfully transitioned off the streets served as role-models for participants and motivated them to do likewise, and increased their hope of transition success.

1.14.7 Planning and Organisation

Half of the studies found that participants actively planned their day, in order to provide them with structure in general (which could provide a sense of 'direction and control', McCormack & Gooding, 1993), to meet with friends and other sources of support (Thomas et al., 2012), and to partake in planned activities that provided them with opportunities of mastery and protected against boredom and rumination (Dunleavy et al., 2013). Bender et al. described the planning process and likely organisational skills, and possible memory functions required

to obtain resources, ‘They learned to coordinate times when various services were available, such as taking advantage of free meals or clinic services during times public services were also available. This coordination often necessitated youth “piecing together” a number of services in various locations’ (2007, p5).

Surprisingly, it was only Bender et al.’s study that mentioned future planning, for education and employment, as helpful to cope with living in ‘their current uncertain circumstances’ (2007, p8). Although Thomas et al. (2012) linked participants’ lack of security and lives of uncertainty with a present-time-focus as they dealt with immediate risks to well-being at the cost of making future plans or other helpful changes.

1.14.8 Hampering Factors

Although not the primary focus of the selected studies, most described factors that jeopardised the well-being of participants. The most frequent threat to well-being was when basic needs were threatened or violated. Examples included, when participants struggled to find food or a safe place to sleep (safe from physical attacks and theft) and lived in general uncertainty (Rew, 2003; Thomas et al., 2012); when physical health was perceived to be poor (McCormack & MacIntosh, 2001); and when substance-use and dependency hampered the ability to care for one’s self and sustain health (Rew; Thomas et al.).

Navigating to services (health-care, police force, etc.) in order to protect basic needs was problematic for many, due to a mistrust of services and professionals based upon prior negative experiences (Kidd, 2003; Rew, 2003; Thompson et al., 2013). McCormack and MacIntosh (2011) identified other service-access problems, ‘These homeless persons identified that providers imposed social distance through their use of language, lack of trust, and disrespect for age, which forced these participants into isolation from society’. (2001, p687).

1.15 SYSTEMATIC REVIEW SUMMARY AND CONCLUSION

The systematic review yielded only a total of eight qualitative studies that addressed the research question and met the inclusion and exclusion criteria. A quality review framework was applied in order to determine the credibility and trustworthiness of studies’ reported findings and revealed that only three scored as ‘good-to-high quality’ standard. Furthermore, most studies did not employ psychological (or other) theoretical frameworks or more general conceptualisations of resilience in order to guide interpretation of findings, extend theoretical

understandings, and elaborate on theory-practice possibilities for service-delivery. A narrative synthesis of findings across the studies identified multiple resilience and coping processes as well as factors that impacted negatively on participants' well-being. In light of the aforementioned limitations across the studies, and the lack of research conducted within this filed, further investigation is warranted.

1.16 CURRENT STUDY RATIONALE AND AIM

Many studies have shown the multiple difficulties and challenges that homeless people encounter, including for example, high rates of significant mental and physical health difficulties (Credland & Lewis, 2004; Fitzpatrick et al., 2007), and substance-use dependency and associated difficulties (Burt et al., 2001). Furthermore, effective coping responses and resilience are often jeopardised due to personal vulnerabilities, limited support networks, and difficulty in accessing resources and health-related services (Lee et al., 2010; Martins, 2008; Rew et al., 2002).

Resilience research could yield findings that guide intervention and support strategies, as demonstrated by positive psychology for other populations (Seligman et al., 2005). There is a lack of research that explores the resilience of homeless people however, as most research to date has focussed on the vulnerability and pathology characteristics and causes of homelessness (Bender et al., 2007; Kidd & Davidson, 2007). The review identified only a small number of studies that reported on psychological processes associated with resilience, yet most of these did not employ psychological literature, or resilience or coping models, in order to make sense of their findings and further understanding of processes that underpin resilience. Upon thorough evaluation of the studies, only a few reached the criteria of good quality research.

The current study aimed to begin to fill this gap in the literature, and explore psychological processes that may operate to enable homeless people to achieve a sense of manageability. The aim then, was not just to identify *what* homeless people did in order to cope, promote and protect well-being, but to identify *how* they achieved this within their contextual frame. Not only could findings have important implications for homeless services, but they could also further understanding of the resilience construct.

CHAPTER TWO: METHODOLOGY

A rationale is provided for the study's use of a qualitative methodology, and Interpretative Phenomenological Analysis (IPA) in particular. The study's design, procedure, and analysis are outlined. The attempts made to ensure the credibility and trustworthiness of data collection are also explained.

2.1 QUALITATIVE METHODOLOGY

Psychological research is usually characterised by two distinctly different epistemological positions, that of positivism and relativism - although approaches can reside at differing points of this spectrum, or indeed be 'purest'. Quantitative research, considered a positivist approach, is concerned with 'truth-finding' by the testing of hypotheses through the collection and analysis of quantifiable entities measured by carefully selected variables. Qualitative research is more explorative in its aim to provide rich accounts of phenomena. For this, data are often collected in the form of naturalistic verbal reports and the researcher's task is to interpret participants' responses in order to co-constructively make sense of their experiences and perceptions. Unlike most quantitative approaches, the collection of rich or 'thick' descriptive personal accounts enables the researcher to meaningfully consider the social and cultural frameworks that individuals are embedded within (Ashworth, 2008).

2.1.1 Rationale for Using a Qualitative Design

The current research project aims to explore resilience processes of homeless people. As discussed in the introduction, quantitative designs are limited in this line of investigation due to the inherent difficulties and ambiguity of the dominant definition and operationalisation of resilience phenomenon - which has particular ramifications when applied to the research of marginalised groups. To determine what resilience processes might be operating for the individual within their social and cultural context, and how these are experienced and made sense of by individuals, detailed verbal reports of their lived experiences and understandings of hardship, coping and overcoming are required.

As Harvey and Delfabbro advocate,

> *'Greater focus needs to be placed upon the reports and experiences of people who appear to have overcome adversity, and that the definition of resilience itself should*

> *be based less upon so-called objective cut-off scores, but also upon culturally and socially relevant ratings of success.'* (2004, p.11)

Furthermore, resilience has been conceptualised as a process and not a static and enduring personality trait (Bandura, 1977; Rutter, 1985). A qualitative line of enquiry can better capture a fluctuating and fluid phenomenon, and indeed strive to make sense of its transitional nature, in contrast to the measurement of pre-determined variables.

2.2 IPA: A DESCRIPTION OF THE APPROACH AND ITS THEORETICAL LINKS.

There are a number of qualitative approaches, each with its own theoretical and methodological emphases, although there is often considerable overlap. A recent yet increasingly applied approach, particularly in clinical and counselling psychology, is IPA. Its philosophical and theoretical underpinnings are informed by phenomenology, hermeneutics, and ideography. Each is discussed below to build a comprehensive description of the method.

2.2.1 Phenomenological Approach

IPA is chiefly a phenomenological approach (Smith et al., 2009) that aims to uncover and examine people's detailed descriptions and perceptions of their *lived experiences* that relate to the researcher's area of interest; objective statements or 'truths' are not sought. Influenced by key writers from phenomenological philosophy, such as Husserl, Heidegger, Merleau-Ponty and Sartre, Smith et al. conclude,

> *'We have come to see that the complex understanding of experience invokes a lived process, an unfurling of perspectives and meanings, which are unique to the person's embodied and situated relationship to the world.'* (2009, p21).

Such a philosophy encourages a rich approach to the examination and comprehension of lived experience.

2.2.2 Hermeneutics

Although the intention of the IPA researcher is to fully immerse themselves in the world of their subject, it is acknowledged that one can only ever get close to another's personal world. This is because the researcher possesses their own series of pre-conceptions and biases which will play an active part of the research process. Thus data and subsequent analysis is

a *co-constructed* effort between researcher and participant. Heidegger conveys the interpretative role of researcher,

> *'Whenever something is interpreted as something, the interpretation will be founded essentially upon the…fore-conception. An interpretation is never a pre-suppositionless of something presented to us.'* (cited in Smith et al., 2009, p25).

Thus IPA is informed by the theory of hermeneutics. A two-stage interpretation process is involved in which 'the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world.' (Smith & Osborn, 2008, p53).

2.2.3 Idiographic

IPA is bound to the detailed examination of the particular case, 'what the experience for *this* person is like, what sense this particular person is making of what is happening to *them*' (Smith et al., 2009, p3). As richness and detail are prioritised in both data collection and subsequent analysis, and not the generalizability of findings to the population as a whole, sample sizes tend to be relatively small and homogeneous so that within the sample there is something to be revealed of the experience of each participant in relation to the phenomenon of interest; additionally convergence and divergence can be examined in some detail. Furthermore, larger samples would be very resource demanding as thorough analysis of discourse-data is time consuming.

2.2.4 IPA Methodology

Typically, in order to explore the topic of interest, semi-structured interviews are employed and used flexibly in order to follow the participants lead. Interviews are usually recorded and transcribed, and then a systematic, qualitative analysis is applied, case-by-case. This is then transformed into a detailed narrative account of the researcher's analytic interpretation, evidenced by participants' own words in the form of quotations.

2.2.5 Rationale for IPA Use

The phenomenological approach suited the current project's aim to explore homeless people's uniquely lived experiences and perceptions of events and processes related to their sense of manageability. More specifically, the research question was, *what is the psychological process by which a homeless person maintains a sense of manageability?* IPA

is a useful approach to explore complex psychological phenomenon (Smith et al., 2009) and indeed is closely tied to contemporary psychology due to the sense-making processes conducted by both participant and researcher, which is essentially a cognitive task. Although the subject and their experiences and associated meanings are a complicated chain of connections of cognitive, linguistic, affective and physical being, (hence the need for interpretation), it is how one reflects on events or objects and gives meaning to them, or mental processes, that is of primary focus (Smith & Osborn, 2008). An understanding of the psychological processes associated with resilience was hoped to be identified through the co-construction of sense-making of participants' verbal accounts.

2.3 ENSURING QUALITY

As described in the introduction chapter, quality frameworks have been devised to encourage and evaluate the quality of qualitative research. The review itself evaluated the credibility of selected studies by adopting the Critical Applied Skills Programme (CASP, 2010) framework as it provided a clear and score-able checklist of standards, enabling a means of systematic comparison. Tracy's (2010) 'eight ''Big-Tent'' criteria for excellent qualitative research', although not a score-able framework, is more detailed and comprehensive in communicating its suggested standards of quality than the CASP. It is therefore applied to the current research project as an insurance of "good research".

There are in fact a large number of systems for ensuring the quality of qualitative research (see Chenail, 2011, for example). Tracy's is utilised due to its strong ethical stance and claimed broad applicability, in Tracy's own words:

> *'This is an eight-point conceptualization of qualitative quality that is unique, and perhaps provocative, because it delineates eight universal hallmarks for high quality qualitative methods across paradigms—and differentiates these from mean practices. I suggest that each criterion of quality can be approached via a variety of paths and crafts, the combination of which depends on the specific researcher, context, theoretical affiliation, and project'* (2010, p837).

The eight criteria for excellent research will now be considered in relation to this study.

2.3.1 Worthy Topic

Tracy (2010) identifies good qualitative research as relevant, timely, significant and interesting. This is in contrast to an opportunistic or convenient study that holds little significance or personal meaning and can consequently be pursued in a "shallow" and careless way. As outlined in the study's rationale and aims section prior to this chapter, the study is claimed to be a worthy topic that questions largely-unchallenged assumptions that homeless people are powerless and lack personal strengths and resources, and it is hoped that the findings could offer useful suggestions or have implications for services. Furthermore, there is potential to expand upon the psychological construct of resilience.

2.3.2 Rigour

Tracy (2010) poses several questions for the researcher to consider the rigor of their research. The questions are outlined and answered here:

- *Are there enough data to support significant claims?*
  A vast amount of data was obtained through the detailed analysis of the full-verbatim transcripts of eight participants (see Appendix 3 for an example, and below for procedure details). According to IPA guidance (Smith et al., 2009) this number of participants is suggested to generate sufficient data for analysis.
- *Did the researcher spend enough time to gather interesting and significant data?*
  To ensure a sufficient sample-size, participants were recruited and interviews conducted over four months due to the recruitment method (participants had to indicate their voluntary interest to partake in the study, as detailed later). Interviews lasted between 30-80 minutes and were usually terminated by collaborative agreement once a degree of saturation was judged by both parties.
- *Is the context or sample appropriate given the goals of the study?*
  Carefully constructed inclusion and exclusion criteria determined a sample appropriate to the goals of the study. Most importantly, people were homeless at time of interview.

2.3.3 Sincerity

Sincerity, an act of genuineness and authenticity, can be achieved through honest and transparent *self-reflexivity* - a hallmark of much qualitative research. Tracy (2010, p842) considers this as 'honesty and authenticity with one's self, one's research, and one's audience'. An awareness of one's values and biases enables the researcher to consider, and

at times lessen, their influence on the research process. Detailing these also invites the reader to make judgements about this process (Richardson, 2000) and can 'illuminate the reader's understanding of the cultural event, place or practice' (Krizek, 2003, p149). As discussed above, IPA acknowledges the co-construction of information and the need for self-awareness. With these considerations in mind, a *'position of self'* is made explicit by the researcher.

Reflexion throughout the research process is important to consider impact of self on data collection and analyses. Please see Appendix 2 for example of reflective diary entries about subjective feelings and sense-making, and Appendix 3 for an example of detailed and reflective transcriptions.

A Position of Self

First-person narrative is employed here to move towards a personal description of *self* and communicate more directly that the writer and object of reflection are one and the same person. I found my constructed reply, or 'story told', to answer the question, "why am I doing this study?" as posed in Tracy's (2010) paper, a suitable vehicle to convey my subjective experiences, hopes, fears, and vulnerabilities and provide a decent insight into my position as 'the researcher' of this project.

I am a 33-year old, white, third-year trainee clinical psychologist. I am male, and my identity as a male is perhaps accentuated by working in services dominated by female professionals. In terms of gender, this is a departure from being part of a majority - a family of five males, consisting of three siblings, my dad and my mum. Compared to the general population, I am highly educated, with a BSc and MSc, both in psychology, although I do not consider myself to be 'intelligent'.

At my core, I think I am a compassionate and caring person and therefore chose a profession that enabled me to express these values. I have a specific memory of an event that may have contributed to my chosen career path: aged 16, I recall working as a 'play-leader' with a group of children who were labelled as 'bad' and challenging by other play-leaders who refused to work with them. I noticed how the children 'played-up' to such labels, but were a joy to interact and play with when isolated from the other play-leaders. I'm sure this nourished my belief that much of reality is created through language and dominant ideas, and how such ideas can be changed in order to change one's reality. Now, I often think about issues of power

and have sought to work with and research groups who I perceive as disadvantaged and oppressed, at the risk of adopting the 'heroic rescuer' position.

When thinking of a research project, I decided to explore a field that would interest me. The exploration of resilience phenomenon within a homeless population excited me as it ran counter to assumptions that disadvantaged and largely excluded members of society are inherently flawed in some way, that they cannot possess personal strengths, intelligence, and hopes, just like most people do. This is not to deny that many homeless people experience social and psychological difficulties, and I hoped the project could illuminate on these and yield clinical and service implications.

Prior to this project, I have had little meaningful contact with the homeless. In fact, I have often avoided street-homeless people, with my noticing of a mild anxiety when passing them by, which I think is associated with my perceptions of their unpredictability. I remember often seeing an unkempt and unclean 'rough-sleeper' begging at a London Tube station when visiting grandparents as a child. Undoubtedly I felt my sense of personal safety threatened by him and had a stark insight into the harsher realities of the world. I wonder whether I unconsciously wish to explore and address implicit feelings of vulnerability by conducting this project.

Fortunately for me, I have always been housed and thus have no actual experience of homelessness myself. I have in common with participants my age, gender, and ethnic orientation as 'White'. Cultural differences are apparent due to my consistent housed status and relative financial security, level of educational attainment, lack of substance-misuse problems and diagnosed mental health difficulties, and lack of significant relationship difficulties linked with limited networks of social support.

Epistemological position

I believe that knowledge and truth are constructed in the context of the existing phenomenon. I am therefore less interested in testing experimental hypotheses and producing findings that pertain to be a truth. My stance has leanings towards phenomenology and social-constructionism, although I do not claim to be purist in these positions, or indeed by any means an 'expert'. However, I hold some tension in this position as I realise the value of, and indeed utilise, evidence-based clinical-practice, which consists mainly of quantitative findings.

2.3.4 Credibility

Credibility refers to the trustworthiness and plausibility of the research findings. This is important for many reasons, but perhaps primarily because decisions, actions, policy and practice are often informed by research, and thus research findings must strive to be what they claim to be. Credibility can be enhanced with an awareness of self and an acknowledgement of biases which may impact upon research, as outlined in detail above. Furthermore, specific practices, including thick description, triangulation, and member reflections, are suggested by Tracy (2010) to manage such biases and generally insure qualitative credibility.

Thick description is defined by Tracey as 'in-depth illustration that explicates culturally situated meanings (Geertz, 1973) and abundant concrete detail (Bochner, 2000)' (2010, p843). The in-depth analysis of participants' accounts enables the detailed descriptions of their lived experiences to 'come alive' in the analytic write-up. This is further improved when contextual factors relevant to the content and construction of accounts are also made explicit.

Triangulation posits that when two or more researchers reach agreement on the same source of data, then the findings are thought to be more credible. Despite this method arising from realist paradigms, for the project it functioned to better manage subjective bias; it is not claimed that a point of truth, or correct version of reality was acquired through its use (see Bloor, 2001). The researcher's academic supervisor checked two complete transcripts and indicated agreement of coding and themes.

Member reflections refers to participants' input during the processes of analysing data and composing the research report. One method of this is to take identified themes from analysis back to participants and discuss them, and essentially seek feedback to determine the participant's perceived accuracy of themes (Lindlof & Taylor, 2002). The researcher completed this procedure with two participants only, as arranging subsequent appointments with others proved difficult; One of the reasons being that some of the participants had transitioned out of the hostel at the follow-up time.

The researcher met individually with the two participants in the same room where interviews were conducted. Participants were reminded of the general subjects that were discussed during their interviews. Then, the researcher communicated the identified themes of interest in order to explore a sense of participant-agreement. The general procedure of this entailed

discussion of interview content relevant to the theme in question, and the reading of a key participant quotation interpreted to represent the theme. Both participants were generally in agreement that the identified themes were accurate. The process seemed to be an affirming one for both participants, as often, their positive attributes and strengths were reflected back to them.

2.3.5 Resonance

This is the researcher's ability to convey the report in a way that impacts the reader, engaging with their emotional and reflective processes. Bochner (2000) prizes qualitative narratives that are vivid, captivating, and structurally complex. Outcomes of communication style are difficult to claim without feedback from an audience, however, the researcher did at least strive to present information in a clear and comprehensive manner. Additionally, the academic supervisor read draft sections and suggested amendments.

2.3.6 Significant Contribution

To judge whether a study has a significant and meaningful impact, Tracy (2010) asks questions such as, "Does the study extend knowledge?" "Improve practice?" "Generate ongoing research?" "Liberate or empower?" In brief, the answer is potentially 'yes' to all of these questions, and they are discussed at length in the discussion chapter. By telling their stories, the study deepened insight into the lives of homeless people, making visible their strengths and resilience which are often overlooked. The deepening of theoretical understanding of resilience processes was achieved by extending knowledge of the construct and critiquing prior conceptualisations and assumptions.

2.3.7 Ethics

Ethical research entails study design informed by thorough consideration of how the research process impacts the lives of those studied. '[Ethics] are not just a means, but rather constitute a universal end goal of qualitative quality itself, despite paradigm.' (Tracy, 2010, p846). Later, this chapter outlines ethical procedures that include informed consent, no harm, confidentiality and anonymity, and voluntary participation (and see Appendix 4 for proof of ethical approval).

Relational ethics involve a conscious intention to enter into a respectful and reciprocal relationship with participants as opposed to solely aiming to get a "good story". The

researcher deemed this as essential, as he believed participants could perceive him to be an authoritative figure due to his professional role and their situational position of temporary residents amongst other professionals who worked at the hostel. The researcher spent time with some of the participants prior to and post interview, talking, playing pool, observing them in art-and-craft activity, and generally connecting with them in their community. The relationships formed with participants during (and pre-) data-gathering were valuable and served as a platform to think about their wellbeing throughout participation. For example, the researcher suggested a break in one interview for a participant who acknowledged being a heavy smoker, and for another who revealed that they had recently woken-up and were still tired.

2.3.8 Meaningful Coherence

Tracy's (2010) final quality marker encourages that studies 'hang' together well in a logical, orderly and consistent manner. A stream of coherence is claimed to run throughout the project: The research design, data collection and analysis (founded on IPA framework) were interconnected and consistent with the research aims and theoretical framework, that was in-turn situated by the literature review. The conclusions reached and their implications meaningfully interconnect with the literature and data presented.

2.4 RESEARCH DESIGN

A qualitative design was employed. Semi-structured interviews were conducted in order to gain verbal reports of participants' lived experiences and understandings of events and processes associated with resilience.

2.4.1 Research Context

Participants were recruited from a hostel located centrally within a town in south Wales. Interviews were conducted in a room that provided an opportunity for privacy at the hostel. The charity-organisation that ran the hostel provided a range of services in south Wales to support homeless people. The hostel itself had around 20 beds providing short to medium-term accommodation and support to adults (aged between 18-65 years) who were street homeless/non-statutory homeless. Individuals had to self-refer to access the service, but were often sign-posted by other services. The hostel was staffed 24-hours a day, mostly by support workers. Residents were allocated a 'key-worker' on entry who helped them to set personal goals and work towards independence. A range of individual and group activities,

as well as signposting to other services, were offered to help people's re-integration with their community and assist with establishing and sustaining re-housing. The hostel advertised that they provided mental health and substance-misuse support packages, personal skills development (e.g. budgeting), education, training and employment opportunities, and group leisure activities.

A clinical psychologist and an assistant psychologist worked at the hostel, and across several of the other charity-lead hostels within the local area. The psychology service mainly addressed the mental health and risk-related needs of residents via psychological assessment, formulation and intervention methods.

2.4.2 Ethical Approval

Ethical approval for the project was granted by the Cardiff University's School of Psychology Research Ethics Committee (Appendix 4).

2.4.3 Informed Consent and Confidentiality

Information about the study was provided to participants at various stages to facilitate their ability to make an informed decision in relation to their participation. Participants read the study's Information Sheet (see Appendix 5) prior to indicating their interest to partake in the study. In brief, this detailed: the aims of the study and what would be involved for the individual taking part, an explanation of procedures to ensure confidentiality and anonymity (including information about data storage and analysis), an emphasis on the right to withdraw at any stage, and a general consideration of the pros and cons of taking part.

Staff agreed to assist individuals who had limited literacy skills with the reading of the Information Sheet when requested by the individual. Individuals were also invited to telephone the researcher for additional information or to assist with their understanding of participation. On meeting the researcher, all participants were provided with an opportunity to ask the researcher any questions or concerns, and the Information Sheet was read-through together. The researcher assessed participants' understanding of participation and ability to provide informed consent, prior to the signing of the consent form and interview commencement.

The consent form (Appendix 6) served as a formal document to confirm that the participants had read and understood the information provided, were aware of what their participation would entail and how their data would be used, and of their agreement to take part.

Participants were informed that information collected about them during the course of the study would be kept strictly confidential. It was communicated to them that the recording and transcription would be stored in a safe and secure place and destroyed upon completion of the study (all interview recordings and transcripts were stored on the researchers pass-word protected laptop). Anonymity would be retained by editing information that could identify them in any writings, including their name and age, so they could not be recognised in quotations used for study write-up; pseudonyms will be used throughout this study. Circumstances which would require the breach of confidentiality were conveyed.

In addition, participants were informed that designated staff would know if they were interviewed, due to the booking of rooms at the hostel. Safeguards for negotiating consent and for maintaining confidentiality were established with hostel staff by the researcher and the clinical supervisor of the project. Consequently, staff agreed not to encourage, persuade or discourage people from participating and to respect their confidentiality if they disclosed that they had accepted or declined participation in the study.

2.5 PARTICIPANTS

2.5.1 Sample

As common for IPA methodology, participants were recruited purposively from the homeless hostel, described above. A relatively small and homogenous sample was sought to gather detailed information of the phenomenon of interest (Smith et al., 2009). Inclusion and exclusion criteria were used to select participants who could provide meaningful and credible data in relation to the research question.

Inclusion Criteria

The participants were deemed eligible for the study by meeting the following criteria:

- *At least 18 years old*

  The current project is focused on adult experiences of homelessness.

- *Male.*

  In order to achieve a homogeneous sample that is likely to be representative of the population the current research has its focus on people who are homeless and residing in a hostel, such people are likely to be male (Crisis, 2003).
- *First language English.*

  As people's use and understanding of the English language had to be sufficient to allow them to understand communication of the information sheet and to participate in an interview through the medium of English language. This also contributed to homogeneity of the sample.
- *Homeless at time of interview*.

  Participants must be either 'statutory' or 'non-statutory' homeless (definitions of each were provided in the introduction chapter). It is predicted that most, if not all participants, will fall into the latter category as they are drawn from a hostel.
- *Current episode of homelessness to have been for at least one month, or if under, to have experienced a prior episode of homelessness.*

  The latter two criteria points were specified to capture 'live' and recent experiences associated with homelessness and resilience processes.

Exclusion Criteria

The following exclusion criteria was used:

- Those who were unlikely to be able to participate in an interview for 30-90 minutes, including people who were known to be intoxicated at time of interview.

2.5.2 Demographics

To situate the sample, demographic information is presented in table 5.

Unfortunately, the hostel did not collect demographic information of its residents. However, Warnes et al. (2003) reviewed data from a number of hostels and found over 80% of residents to be male and the majority under the age of 45. The ethnic diversity of hostel residents was dependent on geographical area, with a large proportion of Black people in London hostels, and a very small number comparatively in Welsh hostels. According to these figures, the current sample is representative of homeless people present in the hostel.

Additional demographics: All participants were male and White Caucasian. All had lived in Wales for a significant number of years, with the exception of Andy.

Table 5. Participant Demographics

		PARTICIPANTS (pseudonyms)							
		Phil	Rich	Mike	Gary	Andy	Frances	Norman	Chris
DEMOGRAPHICS	Age	41-50	21-30	21-30	21-30	21-30	18-21	21-30	31-40
	Diagnosable Mental Health Condition		YES	YES		YES	YES		YES
	Mental health difficulties described as ongoing			YES		YES			YES
	Using prescribed medication for mental health difficulty		(in past)	YES		YES			YES
	Using cannabis as an identified coping method		(in past)			(in past)	YES	YES	YES
	Using alcohol as an identified coping method	YES	(in past)		YES	YES		(in past)	(in past)
	Length of time at hostel	3 months	4 months	1 week (2nd entry)	1 week	2 weeks	3 weeks	4 months	2 weeks
	Duration of current homeless episode	3.5 months	5 months	1 week	1 month	6 months	3 months	5 months	1 month
	Total number of homeless episodes	1	1	3	2	1	2	1	5
	Has slept rough		YES		YES		YES	YES	

2.6 PROCEDURE

The clinical supervisor identified the Welsh homeless hostel where participants were drawn from. Permission was sought and granted from the manager of the hostel to interview residents (see Appendix 7), and the researcher and clinical supervisor discussed the study and confidentiality issues with other key members of staff. As above, the Cardiff University's School of Psychology Research Ethics Committee approved the study. Information Sheets were distributed to the hostel and placed in communal zones, where residents could easily access them if they chose to. The Information Sheet invited people to either telephone the researcher directly or to inform a member of staff of their interest to partake in the study, and then that member of staff contacted the researcher. When communication was established with the researcher, if the subject met the inclusion criteria, a time convenient for researcher

and participant was arranged for both to meet at the hostel. On further discussion with the researcher about participation in the study, if the individual consented to participate, the interview took place at the hostel, in one of two small lounges.

2.6.1 Response Rate

In total, ten people volunteered to take part in the study, all of whom initiated contact with the researcher via two staff members at the hostel. One participant declined to be interviewed as they did not wish to be recorded, and one participant was excluded due to communication difficulties (their first language was not English). These individuals were excluded with sensitivity and thanked for expressing their interest in the study. Three people who had agreed to take part in the study were not available for interview on the scheduled day, but the researcher re-arranged an interview time and date and met with all three participants (note, the researcher initially checked whether they still wanted to partake). A total of eight people were interviewed.

2.6.2 Data Collection

A semi-structured questionnaire was designed to guide in-depth interviews (see Appendix 8). The resilience research literature initially informed questions. To increase the credibility and authenticity of the guide, it was then reviewed following consultation with staff at the hostel, and a pilot interview with a homeless male, Ken (pseudonym), who was a resident at the hostel (see Appendix 9 for an excerpt of this). The researcher's academic supervisor was also consulted. These key individuals reviewed the questions, language used, and the structure of the interview schedule, and each recommended insightful revisions. For instance, the staff thought that several questions were too long or complex. They also predicted that some participants would struggle to reflect on their thoughts and feelings. They concluded that the interview schedule would be improved by including some more direct questions. This idea was supported by Ken. He fed-back that the researcher could more directly ask about strengths and ability. He predicted that otherwise, some participants might not be able to reflect on their strengths and then express them. The relevant literature was then once more consulted to ensure that the questions seemed to tap-into constructs of interest, and additional prompts were added. In interviews varying from 30 to 80 minutes, participants were asked about the impact of homelessness, hardships they endured, coping strategies they developed, their sense of manageability and well-being, and what factors helped and hindered these.

At interview six, the researcher paused to run a preliminary analysis on the interview transcriptions in order to reflect on the themes so that prompting questions in the forthcoming two interviews could be targeted on deepening the exploration and focussing it on the specific areas of interest.

Interviews were conducted from November 2013 to February 2014. They were recorded on a Dictaphone and subsequently transcribed in full.

2.7 ANALYSIS

IPA literature does not offer a method to analyse data, and indeed the development of a flexible and even personalised style is accepted. Due to the researchers inexperience of IPA procedures however, the guidance provided in Smith et al. (2009) was utilised to work with the data, and move from the descriptive to the interpretative. The steps that were taken are outlined below:

2.7.1 Initial Noting

In order to identify how the participant talked and thought about the area of interest, the researcher thoroughly explored the entire transcript, making *descriptive, linguistic,* and *conceptual* comments in the transcript margin. Descriptive comments remained close to the participants' explicit meaning and had more phenomenological focus compared to more interpretative noting that involved examination of language use and identification of abstract concepts in order to try to make sense of patterns of meaning in their accounts.

2.7.2 Developing Emergent Themes

For each transcript then, a detailed and comprehensive series of exploratory comments resulted from 'initial noting'. These comments were analysed and re-organised into themes that captured the 'psychological essence of the piece and contain[ed] enough particularity to be grounded and enough abstraction to be conceptual.' (Smith et al., 2009, p.92). Consequently, the themes were tied to the participants' statements and thoughts but also the researcher's interpretation and sense-making of these (see Appendix 3 for an example of the process).

2.7.3 Connections across Emergent Themes

The themes were organised into a meaningful structure that represented the most interesting and important aspects of the participant's account. Related themes were clustered and 'super-ordinate' themes developed. The process was repeated for each separate case: the table of themes for the first case was put to one side but 'held in mind' to help orient subsequent transcript analysis, but in a flexible manner in order to acknowledge new data patterns.

2.7.4 Patterns across Cases and Identifying the Final List of Group Themes

The table of themes for each case was explored to establish connections across cases. This resulted in the reconfiguring and relabeling of some themes. A table was created to visually present the super-ordinate and main themes identified and then recurrence across cases was checked to produce the final list of themes. To appear in the final list, a super-ordinate and a main theme had to be present in at least half of the sample (so in 4 cases), although in actuality, most were present in at least 6-8 cases. This procedure of recurrence is thought to enhance the validity of IPA findings (Smith et al., 2009).

CHAPTER THREE: RESULTS

3.1 OVERVIEW OF CHAPTER

Interpretative Phenomenological Analysis (IPA) was employed to analyse the transcripts and identify themes. The analysis identified two super-ordinate themes that enhanced and detracted from achieving a sense of manageability. The first super-ordinate theme, discussed in Part One, is 'psychological processes that enable a sense of manageability' directly included the main themes: positive beliefs; self-awareness; planning; thought and mood management strategies; and sustaining supportive relationships. The other super-ordinate theme, discussed in Part Two, is 'ongoing factors that hamper a sense of manageability' included the themes: thoughts and worries, cognitive processes; and ongoing relationship difficulties.

Although the super-ordinate themes are presented as separate for coherence and readability, they were often inter-linked within participants' accounts, and processes that enhanced manageability often arose from the narratives of hardship and challenges. The themes that most apparently represent the dual-process of challenges to well-being and protective mechanisms of well-being best are, 'thought and mood management strategies' that emerged from accounts of 'thoughts and worries'.

As the reader can see, dominant psychological discourse has been used alongside participants' own words in order to co-construct and label emergent themes. Indeed psychological theory and the extant literature is used explicitly to interpret their meaning further, as in Chapter 4: Discussion. Seldom did participants use terms such as 'self-esteem' or 'self-efficacy', yet as described in the Methodology Section and in accord with IPA, the researcher utilised clinical psychological experience and academic knowledge in order to make sense of participants' accounts and identify themes.

The purpose of this section is to present a narrative overview of the identified themes. Each theme presented is described and interpreted, and selectively evidenced by participants' words. With every quotation, displayed in *italics*, the participant's pseudonym will be provided with the page number of the transcript from which the excerpt has been extracted. Words inserted into the symbol '[ ]' have been added by the researcher for purposes of clarification, and the three dots following one another, '…', represent instances where the quotation passage has been shortened.

Tables 6 and 7 (below) enable the reader to visually scan which themes are represented by which participant. This may be of interest to refer to throughout the section as not every theme is evidenced by quotations from every participant deemed to represent it.

PART ONE: PSYCHOLOGICAL PROCESSES THAT ENABLE A SENSE OF MANAGEABILITY

Table 6: Psychological processes that enable a sense of manageability

		PARTICIPANTS								
MAIN THEMES	**SUB-THEMES**	**Gary**	**Chris**	**Mike**	**Norman**	**Andy**	**Frances**	**Phil**	**Rich**	**TOTAL**
Positive Beliefs	Self-Efficacy		Y	Y	Y		Y	Y	Y	6
	Self-Esteem		Y	Y	Y		Y	Y	Y	6
	Hope & Optimism	Y	Y	Y	Y	Y	Y		Y	7
	Attitude to change	Y	Y	Y	Y		Y	Y	Y	7
Self-Awareness	Awareness of strengths & protective factors		Y	Y	Y		Y		Y	5
	Awareness of mental-health and substance-use vulnerabilities		Y		Y	Y	Y		Y	5
Planning	Daily planning		Y	Y	Y				Y	4
	Longer-term planning	Y	Y	Y	Y		Y	Y	Y	7
Thought & Mood Strategies	Cognitive strategies	Y			Y	Y	Y		Y	5
	Behavioural strategies		Y	Y	Y	Y	Y		Y	6
Sustaining Supportive Relationships	Sustaining Supportive Relationships		Y	Y	Y	Y	Y	Y	Y	7
	TOTAL	**4**	**10**	**9**	**11**	**5**	**10**	**5**	**11**	

3.2 POSITIVE BELIEFS

All of the participants related how their positive beliefs and attitudes in their ability, their worth and even in their predicted futures influenced their actions and helped them to manage homeless life. Beliefs were mediated by experience and knowledge, and through

relationships. Many realised the importance and benefits of such beliefs and therefore worked to sustain them.

3.2.1 Self-Efficacy

'I can do whatever it is I need to do'

All but two of the participants gave accounts of their belief and sense of confidence in their ability to overcome obstacles and achieve desired goals and how this led to actions. For some participants, like Rich, their sense of self-belief developed as a result of their homeless experience,

> *I think I just couldn't use myself enough before. You know? Just doing what I was told all the time. And just sort of getting on with it that way. But now, yeah, I can think for myself. I can do whatever it is I need to do.* (Rich, p21).

His confidence to do 'whatever it is' that is needed is linked to thought processes which leads to action - 'use of myself'. The former Rich who could not think or do for himself, and only did what others told him, lacked a sense of agency. Below Rich provided an example of how self-confidence manifested in social actions that increased his sense of manageability and agency in the hostel environment,

> *Interviewer (I). And how does that [Rich was talking about doing more things himself without assistance] help you? Because that's different.*
>
> *Respondent (R). It makes you feel confident in yourself. And I think that's – you know, being in a situation like this is probably the main thing to have, is a bit of confidence. To get on with it, like, you know?*
>
> *I. How does that confidence help?*
>
> *R. Oh, yeah, it's – you know, especially being in with a lot of people, you've got to communicate with them and it gives you confidence to mingle with the other people and all sorts of forms of it. You know? It just helps you in general.*
>
> *I. Yeah.*
>
> *R. Because instead of being, "Oh, I don't want to do that because I'm not so sure", it gives you the confidence to do it. You know?* (Rich, p4).

In the description, Rich's beliefs and actions seemed to develop a self-reinforcing cycle, where the more Rich would do, the more confident he felt, leading him to do more things for himself. Rich went on to provide an interesting insight into the analytical and intentional process behind his apparent self-efficacy process. Again, he hints at a more proactive self,

> *Well, I'm not afraid to ask for help…I knows that. Definitely not. But I tend not to do it as much. I try and – "Can I do it?" Or, you know, I'll analyse the situation first. And then if I do need help, then I'll ask for it.* (Rich, p23).

Perhaps most crucially, Rich's growing self-belief in his general ability to cope and manage, translated to his transition out of the hostel,

> *I. And sort of thinking that, you know, you've never done that before, and when you get there have you got any thoughts about what you're doing to do?*
>
> *R. I'm not thinking, "Oh, yeah, it's going to be happy days", because obviously I will be on my own…That's why I keep telling myself, keep driving myself, and I shall develop a way to deal with the way I think and the way I feel, so just use everything that I've built up now, smash it all in one when I'm there, and hopefully I should be okay.* (Rich, p29).

Despite his appraisal that the transition out would be difficult, partly due to his predicted isolation, his confidence is high in dealing with this due to his perceived resilience and owing to his repertoire of resources, denoted by the term 'smash it'. To 'smash it' suggests more than mere survival, but the ability to totally overcome and even obliterate obstacles with a 'driving' force.

Phil communicated an unquestionable sense of self-belief that, like Rich, provided him with the confidence to plan a manageable transition out of the hostel and out of homelessness via professional contacts he had maintained,

> *I know that without a question of doubt: if I put my mind to it I can do anything. Let's say, I've got a friend Kyle, he's in construction, and I can ring Kyle up or ring Derek, he's an architect, they are people I know or don't know through business…I've been in it 30 odd years.* (Phil, p5).

I can walk out there and go to a meeting with a managing director at many companies to get back there; only because I've got the experience and I've been around. I've grown up in a very business family. I enjoy it. I enjoy the challenge. (Phil, p4).

Phil said that he was a very successful 'business man' prior to becoming homeless. His ultimate goal was to regain the level of success he had before, including running his own business. His belief that he could work his way up to the very top once more, gave him determination and enabled him to plan for this, even if it meant starting at the bottom and being overly qualified in the position,

At this stage of the game I wouldn't mind going to work for somebody… There's an element where – this is not me being overly confident – I might know more than they know because I've been around the circuit. (Phil, p3).

Self-efficacy appeared to manifest in different ways across and within participants' accounts, but a common theme, as denoted above, was how it helped to plan for and manage future transitions. Mike and Chris both talked about their belief in their ability to navigate services with success in order to manage desired transitions; an example from Mike:

R. I know when I get my own place the rent should be all paid for, because of my age. The ones that speak to the housing get it deducted from their benefits.

I. I can see you're thinking ahead there to a time in the future about what will happen with rent and where you live.

R. I get the rent paid. So, if I speak to those people, the housing company I deal with that advises me, to ask me to take it out of benefits they should be able to. (Mike, p6).

Self-efficacy processes, for all of the participants who appeared to report them, were underpinned by accounts of experiences of prior successes, learnt skills and retained knowledge. Also, other people, or 'role-models', who overcame difficulties, appeared to enhance Rich and Phil's self-belief in similarly overcoming difficulties,

I use, you know, I don't know, like people's bad things as – sort of like it's not that bad for me… it's like just to help you a bit, it's like, "Woah, wait a minute. If they can get over that, I can get over this little thing". You know? (Rich, p17).

Yes. It's simple when things go easy. But when you come a bit of a cropper I suppose things aren't always plain sailing…In a way you get something like – who's the Conservative MP who wrote the books? Jeffrey Archer… You get someone like him and I admire him; he did his time, wrote a book and probably made a couple of million while he was in jail. (Phil, p10).

Interestingly, several participants talked about their active work to sustain their competence beliefs. For Chris and Rich, this meant managing their mental health and well-being,

I'd say. If you're not all in the head, then you're going to struggle...that's the worst thing. But, yeah, if you're strong mentally and you know you can do things, you know you can – everything. It just involves so much being headstrong. That you can't even explain it. It's to do with everything. (Rich, p25).

I keep trying to keep my head about me I am, I've got too many things going on, if I start drinking I'll just forget about them. I can sort things out if I'm straight in the head. (Chris, p14).

Although self-beliefs were generally considered a beneficial process that lead to positive actions, Norman's strong sense of ability and self-reliance possibly influenced a poor and risky planning strategy. He decided not to bid on bed-sits as he wanted a flat (these took significantly longer to obtain) so he could have his children stay over, whereas this would not be feasible in a bed-sit. He therefore risked being made street homeless as his contract of residency at the hostel was due to expire in the near future. His decision-making process was possibly related to his belief in his ability to manage street-homeless life,

R. I'm clever in a different way, different things like hands on things. When it comes to the brain, I'm like uurrgh!

I. Yeah because that's like I'm at university, but if you put me in the woods [where Norman slept rough]…

*R. Yeah you're f*ck*d, yeah? If you put me in university, I'm f*ck*d. Do you know what I mean? If I was in the woods I'm fine like. You're at university, you're fine with it.*

…I'm more hands on… I can look after myself. (Norman, p58).

3.2.2 Self-Esteem

'It gives me that bit of confidence.'

The majority of participants held perceptions of themselves as capable beings of worth. Accounts of self-esteem appeared to almost always be influenced by relationships; these impacted on self-appraisal and with participants' inferences of how others perceived them.

A few participants compared themselves with other homeless people, possibly in order to elevate their own sense of self. Below, excerpts from Norman's interview revealed his perceived identity as a 'good father' and a 'proper adult'. He constructed these by drawing comparisons to multiple others: other fathers, his own parents, and other homeless people. It is perhaps not surprising then that Norman's future goals revolved around sustaining and improving his relationship with his children, as the relationship seemed central to his self-esteem.

> *…Then I'll spend quality time with my kids, which most fathers out there like probably don't care. They don't care. There's people like me who wants to know, who wants to get to know my children. Well they already know me.* (Norman, p29).

Norman was talking about being able to provide food for his children, when he was living with them:

> *It makes me feel like I'm a proper adult like, it makes me feel like a lot of responsibilities…for my children that's why I make sure that I have food because I didn't want my children to have the life that I had…Me and my sister and brother had nothing.* (Norman, p35).

> *I'd have them live with me 24/7…because that's how much of a good father I am like, but without those I'm nothing. I'm nothing, I'm just a blimin' another hopeless bum like.* (Norman, p89).

Norman passionately stated that his sense of self-worth would be crucially damaged with the loss of the relationship with his children. Despite Norman's own homeless status, he voiced a derogatory term for homeless people, 'bum', which culturally denotes negative qualities of a lazy and jobless individual who begs for food (a 'bum' is often associated with the term 'vagrant'). But Norman clearly distinguished himself from being a bum, thanks to his

construction of ‘good father’. It seemed he therefore defined a possible hierarchical structure of homelessness, with the ‘bum’ being at the bottom.

Interestingly, below Norman briefly hints at a threat to his perception of being a good father who can provide for his children. It is likely his sense of worth fluctuates if he entertains thoughts associated with this, as he is at risk of slipping down to ‘bum’ status. Speaking of his parents he said:

> *Why bring kids into the world if you can’t support them? Do you know what I mean? I can’t speak to myself now because of my kids, I can’t support them because of the situation I’m in.* (Norman, p54).

Frances also spoke of a conflicting sense of self-worth associated with the breakdown of an intimate relationship, painting a picture of a non-static self-esteem state:

> *…it’s like, it’s like, me single [Frances was single at the time of the interview], is little shit-head me who is cheeky and who everybody loves and everything, me with Tara [ex-partner] is like grown-up, presentable person, do you know what I mean?...* (Frances, p3).

Other participants talked specifically about their skills and abilities and experiences of mastery, and how these empowered them in relationships. Mike often spoke of a former de-skilled and dependent self who was exploited for financial gain by his father, and residents used to harass him for money and cigarettes. However, his learnt skill of mechanics provided him with opportunities to demonstrate his expertise to others. In the example below, Mike’s knowledge of cars enabled him a greater degree of power in his relationship with his father,

> *R. …Basically I done stuff in college…But since I left college I just done it myself. Like my dad’s car…the mega fuse kept going…He said, “It’s the alternator”. I said, “It’s not. It’s your starting motor”. He said, “It’s not the starting motor; it’s definitely the alternator”. I said, “No. Get a starting motor, get a new mega fuse and it will work”. So, he did that; I fitted the starting motor for him…and it worked…*
>
> *I. …How did he respond when you fixed it?*
>
> *R. He asked me how did I know. I said, “That’s what you learn in college and that. You learn stuff in college and it’s always with you then; you always remember”…I*

thought back then in college and I remembered them saying if it's the starting motor you either hear a clicking or most cars go by mega fuses…(Mike, p16).

Mike realised how other people acknowledged and valued his ability,

Any problems any of the family gets they always come to me first and see what they can have done. (Mike, p19).

Mike spoke of intentionally maintaining other learnt skills in order to work towards independent living. Perhaps he realised that such skills were also important for his self-esteem. Other participants also worked to sustain self-worth, including Norman who maintained his relationship with his children as they made him feel 'loved', a feeling he did not derive from any other relationship. The extract below also importantly highlights how self-worth is linked to feelings of worth as well as cognitions,

Love that's the most important thing man. Making you feel special. Calling me "dad" like. They're looking up to me like. (Norman, p89).

Chris realised that his feelings of self-confidence were derived by his hygiene maintenance work. In a similar vein to Rich (see self-efficacy theme), Chris linked this pattern with a sense of efficacy and specifically with being able to socially interact with others.

I. What would be so bad about that [not being able to shower or shave]?

R. Just smelly and people avoid you. I look at others out there with beards out there and they stink and oooo and I don't want to speak to them. So that obviously how others would feel about me probably

I. Is it important to think what people think of you? Like, there's Chris, he's clean, he's a nice guy…

R. Yer, it gives me that bit of confidence. If I didn't have a shower or wet me hair I'd feel a bit dirty and all that, that's why I have a shower so I walk around more confident when I feel clean.

I. And when you're feeling confident and feeling better, does that mean you can do things that you wouldn't have otherwise being able to do?

R. Yer, it does actually, yer. If I got to go somewhere I suppose, if I didn't have a shower I'd be like, I'm not going out like this. (Chris, p10).

Chris had formed his beliefs about the importance of hygiene and how others would perceive and receive a dishevelled Chris, via his observations, judgements and reactions to others. Chris' drive to sustain his sense of self as clean and approachable motivated him to avoid street-homelessness, as in such a situation he would not be able to access washing facilities. Talking of the prospect of street-homelessness:

I just couldn't do it, like missing all those little things like shaving or having a wash or a shower. (Chris, p10).

3.2.3 Hope and Optimism

'*Eventually something will happen*'

Mike, Rich and Chris spoke of an optimistic belief that their situation would improve in the near future,

R. I'm not even meant to be here as long as I am. But it's just unfortunate. But there I am. But, yeah, that's the main part, that's step one.

I. What keeps you strong for that? Because you've had to wait a while.

R. Well, I don't know. You just – something's going to happen in the end. So it's just a case of just trying and trying and trying. And trying. Because eventually something will happen… (Rich, p11).

Rich linked his belief in things working out, more specifically he was talking about a successful transition out of homelessness, with his motivation to continue trying. The repetition of the word 'trying' suggests the tremendous effort that is required to work towards independence, which just highlights the importance of his positive beliefs. Optimistic attitudes are likely linked with self-efficacy, as Rich implied that he would not be so determined if he did not believe in a positive outcome (and see Norman, later). Similarly below, Chris connected his confidence that his future situation would be manageable with his belief that he could obtain employment,

R. I know in a few months I'll be alright. It's all about that person finding somewhere [a permanent place of residence], that's hopefully when things will start happening for me.

I. So you're actually feel quite confident, you said in a few months time…

R. Yer, I know I can get a job as well at the bakeries. It's only a shitty job and that, but its £300 a week… (Chris, p19).

Beyond professing in a belief that their situation would improve, both Rich and Chris claimed to *know* this.

For the remaining participants (with the exception of Phil) who did not seem to hold optimistic positions, they instead appeared to hold on to hope and claimed its beneficial properties. Frances and Andy both talked about personal belief-systems that provided them with hope. Below, Andy described how hope, tied with his belief-system and survival of encounters with adversity, enabled him to face further hardship and not 'give up',

R. …even if I should die now I'd go to the river and I'd carry on. I think I maybe believe that this isn't it; this isn't all there is. I've kind of had that belief, that hope that there are other things; there is something greater than this.

I. …I was wondering if that's a helpful thing actually to draw on that, that there is something more than this?

R. I think it is helpful. Things back into my life I could just give up, and at times I do want to give up, but I always seem to come out the other side – not necessarily smelling of roses; but I come out the other side…I try not to lose hope of things, when something goes bad at the time it will probably destroy me; but there might be a day when I wake up and I think right, I survived that, I can do this…

I. So, hope keeps you going?

R. I think so. I always hope for better things…I'm just hoping things will be better. (Andy, p12).

For Andy and Gary, a hopeful outlook meant they were motivated to engage with services and professionals,

I'm hoping my support worker can help me out a bit more with life and living and stuff like that. (Gary, p1).

If optimism and hope could manifest in actions that positively served participants, it would make sense if the reverse was true and indeed, for Norman, a pessimistic outlook led to inaction. Norman did not believe in his employment prospects and therefore had decided not to make further effort to attain employment despite his desire to work, thus affirming his negative outlook,

> *I. Do you look for jobs?*
>
> *R. No. I'll never get a job. The only time I'll get a job I'll go to an agency and that's only three months because I've got a criminal record and then obviously they check you up…and they won't take you on, but they wouldn't give me a job…I've tried it, I've tried testing it out like a couple of times and they've not given me a job and when I've lied about it, they give me the sack instantly…some people like me want to work…*(Norman, p 83).

However, to label Norman as a pessimistic person would be to miss-represent him as he had hopes in different areas of his life and hoped for a better future by starting a new family.

3.2.4 Attitude to Change

'I'm actually growing up and I want to do this.'

Some of the participants described their attitudes of readiness for change and their sense of responsibility associated with this. Such change almost always entailed the desire to achieve a greater degree of agency and independence. Extracts from Mike's account denote his thought processes underlying his readiness to acquire greater independence that lead to his intentional retention of learnt skills, such as budgeting, in preparation for this,

> *R. Basically I'm at the age now where I want my own space, my own place, where basically I'm not being told what to do…*
>
> *I. How do you plan to get that, your own space and your own freedom?*
>
> *R. Basically I've got to move on in life on my own. If I don't do it now I've got to do it eventually anyway because I can't live at my parents' permanently all my life. I thought to myself I can either carry on going where I'm going now, or move out now…*
>
> *…It was harder last time [previous homeless episode] because basically you had to try and budget your money because you've got to buy your own shopping and*

everything...But I carried on doing that at my dad's, so it hasn't changed from last time. (Mike, p8).

Rich almost mirrored Mike's narrative of change that entailed a readiness to move on and take responsibility for this, by reducing his reliance on others,

R. I want to move on. With myself. And get a place and all that. And kick on from here. You know?

I. Oh, so that's something in your mind? That you're thinking, you know?

R. Yeah, yeah. I just – you know, and especially for my independence, like, you can't get more independent than living on your own, really. You've got to sort it out for yourself. So I just want to get started and then build from there.

I. That kind of independence and-? Why is that so important to you?

R. Because you need it. You'll never have someone there to hold your hand all the time. You know? And you've got to be on your own at times. And, you know, it's a necessity, like. I suppose you've got to have – you know, obviously not so much, but you've got to have enough to keep you going. (Rich, p9).

For Chris, he had achieved many of the significant changes required to cope better with homelessness, perhaps what Rich described as 'enough' to keep him going. He reduced his use of substances and alcohol intake, and better managed his mental and physical well-being. Crucially, he was aware of the need to sustain such changes and perceived stable accommodation could support his chance of this,

I can think of something and actually concentrate on. Like when I was drinking and all that, I'd still turn up to services but they would…ask me questions but I couldn't respond because my head wasn't very clear. That's why I gotta keep a clear head on me now, I'm 39, I've been in and out of prison since I was 20, so it's hard to change, that's why I gotta get me somewhere, coz I don't want to go back there…I don't usually think like this. Perhaps coz I'm 39 now I'm actually growing up and I want to do this. Years ago I'd tell people I want to do it but in my head I'm really thinking, "yer right." (Chris, p14 and 15).

Chris' account implies that the motivation for achieving lasting change has to come from within and be genuine. Interestingly, all three participants above suggested that maturity was associated with independence. Chris and Mike both mentioned their age and reflected that due to their years, it was time to move on. Rich made parallels with a move away from childish behaviour of having one's hand held. It's almost like they are saying they are entering into adulthood, which is paired with responsibility and independence, and for Chris, this sense of 'growing up' can occur as late as 39 years of age.

Andy possibly illuminated what may hamper one's readiness to think about meaningful change. He had a more present-time focus than other participants in order to manage each day as it came. Even though he reflected on learning curves and insights related to his homeless journey, he did not think he could utilize these to move forward,

> *I. More insightful about yourself and other people. Is there anything you can take from that? Is there anything you can use about that insight?*
>
> *R. I'm not sure. Probably down the line, but not now. I think now just people to trust, people to walk past and people to talk to, people who are worth my time – that's what I'm learning whilst I'm here. But this is just this place. When I get a place of my own it's going to be again just people to trust, people to walk past; it's going to be new experiences again.* (Andy, p25)

3.3 SELF-AWARENESS

An awareness of one's thoughts, feelings, and behaviours in regards to personal limitations and vulnerabilities meant one could prepare and compensate for these. An awareness of personal strengths and protective factors meant they could be capitalised on.

3.3.1 Awareness of Strengths and Protective Factors

'*You need your friends'*

Three participants (Rich, Frances and Norman) could explicitly identify personal strengths. These increased their confidence to perform actions. Early on in the interview, Frances described perceived interpersonal strengths that he reported capitalising on in order to develop relationships that were central to his alternative (criminal) career plans,

…you could say I've got good imagination, erm, but I do make things happen, erm, you seen the film called Blow? Right, erm, erm, I was building towards that career [laughter] Erm, I got good relationship building with people…Because the way I've thought about it is, if I'm somewhere in the middle, because I've got a really stable personality. If I can gain everyone's trust, it means they can trust me like this little group now, and then after the job's done…. (Frances, p4).

Several participants were aware of important protective factors. Chris, Norman, and Rich described how supportive relationships were beneficial to their well-being. For Norman, he passionately described his children as providing him with multiple protective factors, and a preferred self-identity, and he expressed his wish to see them more, in part, because of this.

I. …What keeps you going?

R. My children isn't it? If it wasn't for my children I swear to God I would kill myself, I would've killed myself. I'm not joking. My dad done it so why can't I?...But my children keep me going…and I want to have them over on a weekend. Because they stopped me from drinking and smoking. Before I'd even had children I was a piss head… (Norman, p18).

Rich also recognised relationships he had, with family, friends, and hostel staff, as beneficial to his well-being. Throughout his interview he talked about using relationships 'just enough' to determine an appropriate balance of independence and support. With this protective factor in mind and his plans to transition out of the hostel in the near future, Rich worked to re-build family relationships.

I *What do you do now? Or do you have these kind of horrible feelings of loneliness? If you ever do that?*

R. Well I obviously don't so much now, but back in the day I never was close with my family, like. And now I'm starting to, you know, get, you know, closer to them, and talking to them…So I've got a bit of support family-wise. And I've got loads of friends…they give you a good kick up the arse. You need your friends…it's obviously being independent you've got to do things for yourself but…if you do need help, you do need to ask, you don't be afraid. So that's what people are there for, really. It's to give you a helping hand. (Rich, p14).

Rich's conception of a helping relationship as one where someone can lend a 'helping hand' nicely contrasted to his former self who was over-dependent on others and had someone to 'hold' his hand (p.9).

3.3.2 Awareness of Mental-Health and Substance-Use Vulnerabilities

'It's emotional thinking that you're on your own.'

Participants demonstrated a self-awareness of numerous vulnerabilities, and an awareness of mental health difficulties and complex relationships with substances was frequently reported. Below, examples of self-awareness of such vulnerabilities are provided, and how awareness leads to action in order to compensate for, and protect against, vulnerability is shown.

Chris, Rich and Andy (and to a lesser extent, Mike) spoke in detail about their mental health diagnoses and difficulties. They were aware of precipitating factors that could trigger their mental health difficulties and how to manage these in order to minimise them. They had also developed behavioural and cognitive coping strategies to be applied in worse-case scenarios (specific coping strategies are discussed later in 'Thought and Mood Management Strategies'-theme),

For both Chris and Rich, generally maintaining their mental health meant keeping occupied and avoiding too much time alone that could result in boredom, and crucially, negative rumination. Andy acknowledged his dependence on medication in order to sustain his mental health, and had learnt the necessity to be consistent with its consumption as well as a strategy to enable this,

> *I. You're on medication so you stay 70% well. How do you make sure you're not slipping under that 70%?*
>
> *R. I just keep taking the meds…I had ten years of mental illness [diagnosed with schizophrenia]. I've taken meds for a year, that's fine, stopped taking meds…I came from Manchester a real wreck and realised I needed meds. That has been the longest period of time, about six months, continuously taking the meds.*
>
> *…My memory is crap. I wake up in the morning and have to take one in the morning so I leave a couple of notes to remember to take the meds.* (Andy, p24)

Although Andy was aware that his mental health management strategy was possibly limited, he prized the value of the prescribed medication in order to avoid becoming a 'wreck'. Different meanings of the term 'wreck' will be formed, however, the researcher pictured a wrecked car of twisted metal, completely written-off. The 'real'-ness of the 'wreck' added severity to the dysfunctional state Andy likely referred to.

> *I. Other than keep taking those meds is there anything else you do to make sure you don't become unwell?*
>
> *R. No. I am really relying and dependent on the meds I think. There probably are better things I could be doing as well as the meds. But it's on my mind: take the meds, take the meds.* (Andy, p24).

Like Andy, Rich realised the vital importance of good mental health, and the realisation itself undoubtedly served as a protective factor that motivated him to sustain mental well-being,

> *I. In life. It could be like in a year, in general, what's important to you?*
>
> *R. Probably mental health…If you're not all in the head, then you're going to struggle…And that's the worst thing…if you're strong mentally and you know you can do things, you know you can – everything…It's to do with everything.* (Rich, p25).

Over half of the sample talked about their relationship with substance-use. All of these participants could detail the pros and the cons of using, and therefore, their decision to use or not seemed to be an informed one with intention. In the weeks prior to the interview, Chris could not access medication to manage his mental health difficulties and therefore used cannabis as a substitute,

> *I. And what about drink or drugs or anything like that, do they help you?*
>
> *R. I have a spliff now and again…it calms me down. I just had my tablets back yesterday off the doctor and they calm me down so I think I won't need cannabis anymore now.*
>
> *I. And let's say you didn't have the cannabis like last week when you needed a chill out, what would have happened?*

R. My head would just be all mad – all the thoughts going through my head – it like takes it all away. It don't last for long but it does do it for a bit…But when it wears off it makes it worse. So I kept smoking it to stay alright. (Chris, p6).

Chris described his developed dependency on cannabis to manage his mental health and realised this had major draw-backs on both his mental well-being and his physical health, describing, '*That's another reason I cut back on it, coz of my chest'* (p12). Thus he decided to 'cut-back'.

Norman was conflicted about his cannabis use; he wanted to give-up to save money, yet he said that cannabis helped him to curtail his anger and not '*do something stupid like'* (p.20) when interacting with his ex-partner. In fact, Norman thought that smoking helped him to sustain his relationship with his children, as this was essentially mediated by the relationship with his ex-partner. Additionally, Norman named cannabis as a method to avoid harder drugs,

I. How did you stay away from those drugs?

R. Just sit there and get stoned, that's it man. That's what keeps me away from heroin. (Norman, p19).

It seemed that the benefits of cannabis use for Norman outweighed the costs at the time of the interview. Like Norman, Frances decided to continue to smoke cannabis and linked its use with his worship of the Jamaican God, Jah. He was aware that his smoking caused relationships with his ex-partner and his mother to breakdown, yet he derived a sense of 'hope' and 'peace' in his smoking rituals and even described it as his 'therapy' (p.11).

Conversely, Rob, Chris and Andy decided to quit smoking cannabis, or in the case of Chris, to markedly reduce his use of it, due to their awareness of the negative impact of the drug on their mental health and general well-being. Moreover, Chris and Rich preferred their new-found sober-selves and recognised them as capable beings,

I can think of something and actually concentrate on… That's why I gotta keep a clear head on me now, I'm 39, I've been in and out of prison since I was 20. (Chris, p12).

I've been there [using drugs]. And obviously I've just pure distanced myself from being in that sort of situation again. Because at my worst, at my lowest, was during them periods. So…staying clean, like now, for instance, I feel much more better. And more focused on what I want to do, like. (Rich, p12).

With the exception of Andy, who gave-up substances with relative ease, this required effort for Chris and Rich and a continued effort to sustain the change. They were both aware of the precipitating factors that could yield them vulnerable to relapse and therefore controlled for these. Rich eloquently described a model of his former drug-use and how he overcame using,

> *Because it's emotional…thinking that you're on your own and all that. So that's when you're like, "Oh, you know, I'll drink. I'll take drugs", just to be blocking out. It's going to take away the sadness. You know? But it's a dangerous thing. Because you can carry on and carry on and carry on, and it becomes you. And then you've got to change yourself then to get off the drugs.* (Rich, p14).

The repetition of 'carry on' possibly denoted the slippery slope to addiction that the coping strategy of cognitive and emotional 'blocking' propelled, so much so, the self that is high on substances became the most familiar self.

> *I. How do you stay away from that? A lot of people might go back easily.*
>
> *R. …It's probably company…I know some of them could be your friends…but it's just to keep so much of a distance, like, you know? Because if they come around and drink or [take] drugs every day then you're always going to have that temptation…Where you see that guy once a week for like a couple of hours, then you're not going to get tempted as much, you know?* (Rich, p11).

3.4 PLANNING

'If I plan something I do do it and then I feel better once I done it'

3.4.1 Daily Planning

Half of the participants talked about planning skills that appeared to increase their sense of manageability. For some, this meant creating daily structure by planning activities in order to keep occupied and minimise boredom. Participants also spoke of planning for everyday necessities, such as appointments to attend, budgeting for food, and so forth.

Budgeting funds to maximise financial output was a common theme. Norman described the importance of this skill, as he was able to purchase adequate food (an important function for his self-esteem, see Self-esteem above), purchase treats (such as an occasional can of lager), pay his rent, and afford cannabis, which he perceived served beneficial purposes (see

mental-health and substance-use vulnerabilities themes). He actually collaborated with a fellow hostel resident, just as he once applied this learnt strategy with his brother, to join their funds '*Because £200 is better than £100 because we can budget that money'* (p34).

Participants' accounts possibly suggest the necessary cognitive abilities required to engage in planning and organising themselves. The extracts from Chris, below, reveal his memory skill, and possibly more specifically, his working memory operation to mentally organise thoughts,

> *I. I see you really want to maintain changes or make further ones. How do you remember your appointments and stuff, as these things help?*
>
> *R. I just remember, like 25th Feb at 15.00 appointment with psychiatrist, I've always been good with that, I never forget them, I'm never late, I'm always early if anything.*
>
> *…Yer, I do organise them in my head, yer. I'm constantly planning things, sometimes I don't follow through but most of the time I do it. It seems to be at night when I'm lying on my bed I plan things.* (Chris, p13-14).

Interestingly, Mike and Norman were both aware of their poor memory ability, and therefore compensated for this by developing strategies to assist with planning. Norman was talking about his tendency to plan his days and his dislike for staff who interrupt the process by announcing unexpected events,

> *I. So what is that? Is that you like to plan things?*
>
> *R. I like to plan, your life is planned.*
>
> *I. Well how does that help you, planning things?*
>
> *R. Because I've got a shit memory. So if I don't write it down and down there on my f*ck**g bill board like I'll forget… Everything, yeah. Anything I do, I'll write the thing down… I'll have to write it, I've got short term memory loss.* (Norman, p45).

Chris described a self-reinforcing cycle to his planning,

> *If I plan something I do do it and then I feel better once I done it. But if I didn't do it then it plays on my mind then, thinking, "you dick head, why didn't you just do it"…* (Chris, p13).

3.4.2 Longer-Term Planning

All but one of the participants had plans for their future. Plans usually revolved around transitioning out of the hostel into private accommodation and employment, and generally were aimed at means and ways of achieving a greater sense of agency, as well as sustaining the agency they had developed whilst in the hostel. Such plans gave participants a sense of direction, meaning, and led to actions in order to achieve them.

Phil aimed high and wanted to once more run his own business, yet he realised that he would have to start at the bottom of the ladder to achieve this. He planned to get back on his chosen path through his professional contacts that he had maintained. Below, Phil described the functional nature of his planning,

> *I. Is it important for you to have those plans and goals? It sounds like you have got goals.*
>
> *R. Oh definitely. I don't dilly-dally, wishy-wash. If I want to go for something I go for it. My aim is to get back out there.*
>
> *I. I'm really interested in that: my aim is to get back out there. How does that help you?*
>
> *R. Gives me strength and determination. I can walk out there and go to a meeting with a managing director at many companies…I enjoy it. I enjoy the challenge.* (Phil, p3-4).

Gary had not been at the hostel for long and therefore his plans were not as comprehensive as others, but like others, they entailed achieving a greater sense of freedom,

> *I. One of the things I was wondering, Gary, is how you feel you are coping at the moment?*
>
> *R. Well I'm coping alright at the moment. I see my daughter more and just get on with my life and get my life back to normal and look for work and stuff and have my own place so she can come and stay with me*
>
> *I. …And how do you plan to get a job…?*

> *R. Jobsearch, job-centre…Or I'll have to get some qualifications… I just want to be like that I don't want to be hovering all the time I just want to be doing something with my life.* (Gary, p5).

Frances' longer-term plans were comprehensive. He knew what he wanted to achieve, and the steps he needed to take, and the skills he needed to draw on. It appeared that cognitive processes helped Frances with decision-making procedures, reflecting, recognising and capitalising on his personal strengths, and as described below, with the visual mental mapping of his plan,

> *I didn't make a plan off the best planner. It was a spider-web. Say on the inside you got your main goal and you got your threads feeding off it and then you got your cross-stitches there. You got your goal in the middle then you got your people around it and then you got their personalities and you got things to make them tick, its its just basically working out what people want...It's in my head but it's also forgotten, until I see that person and then it all comes back to me and it just adds…I think where were they on the spiders-web and how did they fit in…* (Frances, p17).

3.5 THOUGHT AND MOOD MANAGEMENT STRATEGIES

'"Oh, come on, Rich, sort it out!"…to give yourself motivation is a big thing.'

Participants had developed methods to cope with difficult situations and internal states. This was true for those with mental health difficulties and those without. Coping techniques could be distinguished between psychological processes or direct actions.

3.5.1 Cognitive Strategies

These processes are distinguished from cognitive operations related to self-esteem and self-efficacy. The participants who met this theme intentionally addressed and/or manipulated their thoughts in a bid to feel better. Rich described an array of cognitive coping strategies for when bad things happened or he felt low. He would compare his situation and self to other homeless people and compare his current self to his former self (who struggled with addiction and mental health difficulties). Below, he explicitly referred to using positive self-talk when he recognised negative thinking patterns, to either distract and switch his attention from thoughts, or to directly address them,

*I. But are there any times when you have little blips? Where you go, "Oh, s**t", you know?*

R. Oh, yeah…But then that's when you – you know, you're sat there for ages thinking and then, you know, "Oh, you know, what if I do this?" and then it's just you change the subject with yourself. Do you know what I mean? Change the subject in your own mind.

…Just, "Let's change the bedding"…Just gets rid of it then…Especially for me to just stop and think. There's just so much bad stuff has happened. It's like, "Oh", you just end up feeling sorry for yourself or bad for what you've done...

…and it's mad, because it's crazy. You're sort of talking to yourself in your head. Do you know what I mean? But it helps.

… Say you're just thinking of something and you go, "Oh, come on, Rich, sort it out!"…to give yourself motivation is a big thing. Especially for me.

I. Can that actually change the way you feel?

R. Yeah. Yeah. It's changed the way I feel. You obviously don't just get it like that. But just try your hardest…You've just got to try.

…So, yeah. Just dig deep, man. And just keep telling yourself, keep, keep telling yourself that it's going to get better. It's going to get better. I think that's probably the most repetitive thing to think of. "It's going to get better". Whatever it is, it can only go up. (Rich, p25-28).

The repetition of "it's going to get better" is akin to a self-affirmation technique. Rich reported that he could change his mood via his thinking patterns. Rich and Gary appeared to employ cognitive coping strategies in the face of difficult moods and general hardship (Gary would think of his daughter to help him through hard times), whereas Frances and Andy appeared to more regularly address their thoughts, possibly in a bid to prevent the escalation of mental and emotional disturbance. Andy would write poems about 'past loves' or angry feelings and found putting 'words around that' helped to 'release' feelings (p22). Frances prayed when he smoked cannabis, his description below suggested a processing of thoughts and feelings with this ritual,

.

R. I think that's kind of like my therapy as well, do you know what I mean? Like I feel a lot more peaceful after that…I'm confessing my sins as well.

I. What does that mean, you're getting a lot of stuff off your conscience? Off you mind?

R. Yer, a lot a lot of stuff!

I. Is that getting rid of guilt maybe?

R. Yer you could say guilt, er, and the anger I got within myself for doing those things. It's all things like that, erm, I can't really explain it… (Frances, p11).

Frances had engaged in criminal activity in the past and planned to continue to do this. In order to walk this alternative line, perhaps he felt he had to regularly cleanse his consciousness.

3.5.2 Behavioural Strategies

Descriptions of behavioural strategies adopted to deal with hardship were more common than cognitive approaches. Often, participants distracted themselves from negative thoughts and feelings, and the best method of distraction appeared to be by interacting with known others. This was true for Mike, Frances, and as below, Chris,

I. So that stress and anxiety when you think about that; how do you cope with that? What do you do when you think about that?

R. I'll go to my mate's house and have a game of chess or something. Sometimes I go for a walk. Other times I just can't blank it.

I. When you see your mates and stuff does it take your mind off it?

R. Yer, yer. Like playing chess I'm focussed like…it makes me feel better. It's like when you're gone, it'll be on my mind again. (Chris, p2).

Chris stated the short-term effect of this strategy. In addition, some of his friends often drank alcohol and Chris found them difficult to be around when they were drunk. Andy also recognised limitations to his coping strategy, in that he further isolated himself by withdrawing to his bedroom to either write and/or drink alcohol and was aware that this may have led to missed opportunities of friendships.

3.6 SUSTAINING SUPPORTIVE RELATIONSHIPS

'It gives me the ability to open up to and talk to someone'

Participants talked about their actions and intentions to sustain relationships. Psychological processes appeared to influence relationship maintenance.

Norman, Chris, Rich and Frances were aware of the importance of supportive relationships to their well-being and plans. With this awareness, they actively worked to further develop and maintain relationships. Examples of this from Rich, Norman and Frances have already been provided in the 'Awareness of Protective Factors'-theme, outlined above (and see also Norman's anger-control strategy to manage his relationships with his ex-partner and children in 'Awareness of Substance-Use'-theme). Aside from these examples, all four participants revealed their knowledge of friendship rules and rituals that are necessary in order to keep a friendship. For instance, Chris and Frances talked about the necessity to give as well as take in friendships,

> *I. What does that kind of friendship give you?*
>
> *R. It gives me the ability to open up to and talk to someone, do you know what I mean? And if I say, I wouldn't mind a back-massage, then she does…And she makes me cups of teas and when I'm short of milk she brings the milk. I mean she does my fu**ing washing.*
>
> *I. Is there anything you have to give back to keep that friendship going?*
>
> *R. …Erm, I suppose showing her the respect she deserves erm just keep her smiling and that's it. Like last night she said she was craving Harribos, and when my mum picked me up I brought a massive bag back with me.* (Frances, p7).

Mike's empathy and social learning (via observations of other friendships) appeared to help him maintain supportive relationships. He was talking about leaving his friends' house where he was living,

> *R. I said, "Thanks for taking me in, but I can't stay here permanent till I get my own place because otherwise you two will end up splitting up [his friends were married] because you haven't got your own space. We could end up falling out as friends as well", because I've seen that happen to many people.*

I. Right, so you're actually thinking I've got to keep this friendship going?

R. Yeah. Because I've known my brother's friends stay with his friends and in the end they just fell out because they weren't getting space apart…I'm not doing the same mistake. (Mike, p3-4).

Empathy process also appeared to be in operation in Rich's description of bonding with others via supporting them,

… got people in here, some of them are in a bad way. And you get to realise of what other people's lives are like. And you know, you try and help them, even though you need help yourself, you know?...And it helps you bond with the people that's in the same situation as yourself. Yeah. (Rich, p6).

And,

I. And in what way do you kind of help other people?

R. …show them a bed, show them what it's all about. And, you know, make them feel comfortable and stuff. That's probably the main one to have…I remember when I come here I was like frozen. I didn't know what to do. And so I'd hate for other people to feel like that, you know? (Rich, p8).

And as already addressed, self-esteem enabled Rich and Chris to interact with others and likely helped them to initiate and sustain friendships, and Norman seemed to maintain his self-esteem by maintaining his relationship with his children (As exampled in the 'Self-efficacy'-theme for Rich, and in the 'Self-esteem'-theme for Chris and Norman).

PART TWO: ONGOING FACTORS THAT HAMPER PARTICIPANTS' SENSE OF MANAGEABILITY

Table 7. Ongoing Factors That Hamper Participants' Sense of Manageability

	PARTICIPANTS								
THEMES	**Gary**	**Chris**	**Mike**	**Norman**	**Andy**	**Frances**	**Phil**	**Rich**	**TOTAL**
Thoughts and Worries	Y	Y	Y	Y	Y	Y		Y	**7**
Cognitive Processes		Y		Y	Y		Y		**4**
Ongoing Relationship Difficulties	Y	Y	Y	Y	Y	Y		Y	**7**
TOTAL	**2**	**3**	**2**	**3**	**3**	**2**	**1**	**2**	

3.7 THOUGHTS AND WORRIES

'*It's not knowing what's going to happen'*

Significant negative thoughts and worries impacted negatively on all of the participants with the exception of Phil. Although quite a broad theme, the process of recurrence did not distinguish emergent themes. For instance, perhaps surprisingly, transition anxieties and employment concerns were only experienced by three participants and thus were collapsed into the broad theme here. Other problematic thinking patterns that appeared to hold significance for the participants included: what appeared to be delayed grief, as experienced by Gary; Chris' worries about his debt; Rich's worries of future isolation; and worries associated with mental health difficulties, for instance Andy reported being 'paranoid' of others and linked this with his diagnosis of schizophrenia. Chris, Norman, and to a lesser extent, Rich, had future transition anxieties. Chris and Norman feared the possibility of being made street-homeless.

A selection of quotations below briefly illustrate some of these cognitions:

> *Well, I'm alright coping, it's just switching hostels and not getting me house sorted…that's stressful…they're not re-housing me. So I gotta wait and they gotta keep me until they can find me somewhere to go. So that's playing on my mind.*
>
> *I. That's stressful and its playing on your mind, so do you think about it quite a lot?*

R. Yer, all the time, yer.

I. And what is it that's stressful? Is it the waiting or is it not knowing what's going to happen?

R. It's not knowing what's going to happen, coz I don't want to live out on the streets…It is worrying. I know if I go to the streets I couldn't manage, I couldn't do it, I'd rather go straight back to prison… (Chris, p2).

Chris, Norman and Rich also had in common their sense of stuckness regarding employment. To work meant an unaffordable increase in hostel rent, as expressed by Rich below,

…once I get into a place, then I can start, you know, get a job. Focus on like the future. In marriage or career-wise or whatever. Because at the moment being stuck in here and all that it's like you can't – you're sort of in limbo. Like I can't work. Because I'd have to pay more.… (Rich, p10).

Gary stated how thoughts of his late mother could motivate him to 'keep' his 'head up', but also how memories of her saddened him,

About two or three years ago [when Gary's mother died]. And that's in my head all the time since she's gone missing. She used to tell me things when I was a kid and make me happy and now she's gone so…Most people don't realise they got mums who haven't passed and its hard thinking about this mad stuff all the time, trying to get through it. (Gary, p6).

Chris, Andy and Mike reported negative thoughts that were associated with their mental health diagnoses (Rich reported having recovered from his mental health problems). For instance, Mike experienced 'stress' when he thought about family conflict and would feel 'dizzy' as a result,

I. Are there any other things that you sometimes think of that get you down that you don't like to think of so you keep yourself busy? Or not really?

R. It's basically with the family problems as well. It makes me dizzy it do, that stress. So, I've got to find something now to take my mind off that…It's due to the stress and depression building in together.

I. Do you mean literally dizzy then?

R. Yeah…I get them dizzy spells all the time. And if I don't try and make my mind off it I end up collapsing. (Mike, p12).

Chris and Andy both reported feelings and thoughts of 'paranoia' about other people,

I. …On a day to day basis, it might be that some days go by fine but there might be some things about being here, the everyday?

R. I think paranoia about other people is the worst thing. I'm not good with people. I'm quiet. If I'm not quiet I can have a giddy day when I'm not quiet and I'm then perceived I'm trying to show myself. But I just think paranoia about people is probably the worst thing.

I. Could that be about anyone or everyone?

R. Anyone. (Andy, p5).

3.8 COGNITIVE PROCESSES

'I tend to not really worry about the things that I should worry about'

A theme distinct from 'Thoughts and worries' is 'Cognitive processes'. This constituted a greater degree of interpretation as most of the participants included here did not reflect an awareness of their cognitive style as interpreted by the researcher or hypothesised on their impact on sense of manageability and ability to transition out of homelessness. To elaborate on the theme the identified problematic processes are described. These are distinct from already discussed and acknowledged mental health difficulties, such as paranoia or depressive thinking that can be linked with distinct cognitive processes, for example, 'biased thinking'.

During the interview, Phil appeared to lack reflective capacity and self-awareness. Only his strengths were portrayed, and they were frequently mentioned, yet the struggles and hardship of homelessness, as well as his personal vulnerabilities and limitations, were missing from his account. Of course, it could be that a good enough rapport was not created with Phil in order for him to feel comfortable enough to unveil this information. Or, Phil may have been protecting his self-esteem (as well as promoting it) by omitting vulnerability.

Norman appeared to possess a cognitive rigidity. For instance, his transition plans were clearly limited and not working for him, yet he seemed unable to generate an alternative

strategy, meaning his duration of homelessness was extended. Supporting a possible rigid thinking style, he seemed stuck on certain themes, such as his belief that he could not obtain a job due to a criminal conviction, and frequently referenced his negative perception of his mother.

Andy acknowledged a present-time focus. This was related to managing his paranoia of other people and his frequent strategies of distraction to escape himself. As a result, Andy was the only participant not to plan for the day ahead or the future. I asked Andy about his thoughts on rent or transition plans,

> *I tend to not really worry about the things that I should worry about. ((Laughter)) I worry about stupid things that probably aren't even there; rather than things I probably should worry about. I'll sit back and let something hit me rather than worry about I've got to do this, got to do that, got to do this.* (Andy, p10).

He went on to explain,

> *I. What would you hope for say in a year's time?*
>
> *R. To be honest I can't think of tomorrow, let alone in a year. So, I don't know…I think it is every day as it comes. I don't know what's going to happen; I couldn't tell you what's going to happen tomorrow. I read; that's all I can tell you.* (Andy, p16).

Frances mentioned two occasions when he was emotionally aroused and he reacted without thinking, possibly denoting limited inhibitory control ability. On one occasion this problem lead to Frances being attacked by several Pakistani men. He perceived them to be looking at him 'funny' and called them a racist name, thinking this was voiced quietly enough to be out of ear-shot. When one of them challenged him, Frances became racially confrontational *'coz when I get rattled I can't shut my mouth'* (p5).

Finally, Chris often presented strong contradictions in his account. Some examples of these (written in first person, although not Chris' exact words): I can't rely on anyone vs. I can rely on her; I am self-reliant vs. I am at the mercy of services; I will be out on the streets vs. I have a plan that will work; I can't get employment vs. I will get employment. Chris appeared to struggle to hold two viewpoints simultaneously ('both'/'and' thinking) or balance his perspectives, and instead he would hold one extreme opinion and be dominated by this

('either'/'or' thinking), possibly until the alternative perspective was triggered by a question. I reflected this observation back to Chris,

> *I. But going back to earlier, I wonder if sometimes you get confused, because sometimes you have that, "I don't know what's going to happen next" and that brings pressure and anxiety, but other times like now you're saying, "oh I can get a job I know the industry and its going to be alright." Do you know what I mean? Is it one or the other or do you get both sometimes?*
>
> *R. I get both sometimes. It's mad…*
>
> *I. Yer. Just depends what you're thinking and where your minds at?*
>
> *R. Yer. Sometimes I get really depressed though…* (Chris, p20).

3.9 ONGOING RELATIONSHIP DIFFICULTIES

'*I haven't got no one to get all my worries out*'

Most of the participants reported ongoing difficulties within relationships. This included with friends, family, and with fellow residents. This often resulted in a limited (in terms of quantity and quality) support network. Below, Norman described multiple relationship difficulties which he acknowledged as impacting on his well-being,

Norman's relationship with his mother,

> *I. So are you still in contact with her, your Mum?*
>
> *R. No not really, no…She wasn't there for us when we [Norman and his brother] was on the streets…I said to her, "I'd never see my kids on the street. Even if I had to sleep on the floor…She just didn't give a f**k did she?* (Norman, p12).

Norman's relationship with his ex-partner and children,

> *I haven't seen them for like four month now because I can't bring them in here and I don't get along with the missus. I've got nowhere else.* (Norman, p13).

Norman's lack of close relationships with other residents,

> *I come in here and the stress all got too much and I've got no one to speak to really. I haven't got no one to get all my worries out, do you know what I mean?* (Norman, p57).

Norman's relationship with hostel staff,

> *[On being asked to put Christmas lights up] That's not going to get me a flat is it? Putting the fu**ing lights up. That's not going to benefit me in any way…why can't they help me? I'm helping them why can't they help me?...All they're after is our money, that's all they're after, that's how I feel like they're after…* (Norman, p81).

Chris and Rich talked about the supportive nature of the hostel staff, although Chris mentioned their non-responsiveness to his transition worries, and Rich possibly implied that he experienced their expectations of him as 'pressure',

> *I think it's a lot to do with like, you know, especially living in a place like this, and being a homeless person, there's a lot of pressure for you to get out or to do things as well*. (Rich, p15).

Similar to Norman, Chris and Andy also said that they had not connected with fellow residents. Andy mistrusted residents whereas Chris felt a lack of common-ground due to age differences. Although Andy's mistrust seemed partly attributable to his mental health and 'paranoia', he reported that residents tried to break into his bedroom when he first arrived at the hostel and threatened him with physical violence, thus adding important context to his mistrust. Andy and Chris both said they could not relax in communal areas. Fortunately however, Chris and Norman mentioned having one friend at the hostel.

Frances, Rich and Mike also spoke of ongoing relationship difficulties with family members, and Mike linked these as a causal influence of his mental health difficulties. All three said their cause of homelessness was related to conflicts within their families and/or with ex-partners.

> *I became homeless just before Christmas. Me and my girlfriend split up, I was smoking pot, she thought I gave up, but I came back high…so she threw me out… I had a massive argument with my mum, coz she hated my girlfriend…Then I lived with my mate Gary for a bit…We went out for a drink and I lost him, I was looking for a bird. Next morning I ring him and got through to his Mrs, she said Gary never came*

*back and that I could f**k off, she said "I know about you and Gary sleeping with all those girls."* (Frances, p1).

Chris and Andy reported problems within their friendships outside of the hostel, and Chris recalled a recent incident when he thought that one of his friends stole his mobile phone. Gary could not think of a friend when asked. Along with Norman and Andy, Gary appeared relatively socially isolated,

I. Have you got a good friend here?

R. Not really no.

I. In the area?

R. My brother. (Gary, p10).

Strikingly, not one of the participants spoke of a current intimate relationship.

3.10 PARTICIPANTS' EXPERIENCES OF THE INTERVIEW PROCESS

Based on the lack of strengths-based research conducted with the homeless population, and the literature review's suggestion that a common feature of service provision for the homeless could be a problem-oriented focus, the researcher predicted that the majority of participants would not have been asked many of the interview questions that were especially designed to elicit processes associated with personal strengths, skills and abilities. How the participants experienced the interview process then, was of particular interest and is reported here.

Mike and Phil said they enjoyed the interview as it gave them a chance to meet and talk to someone new. Chris and Steve said they would return to their bedrooms to reflect on the interview. Gary said that he enjoyed the interview as it gave him a chance to talk to someone and 'relieve some stresses'. This seemed peculiar in the context that Gary did not seem to 'open-up' during the interview, possibly due to rapport issues, and the interview only lasted around 30 minutes. Considering this, Gary's response is possibly indicative of social desirability-bias influence (of course, a process that was possibly apparent, to different degrees, in all participant responses).

Of particular interest was Norman's and Rich's interview feedback. They both said that they had not been asked the sorts of questions in the interview before, and therefore had not talked about their interview content before. Rich said he had not even thought about some of

what came up in conversation, and novel reflections lead to his significant realisation of his strength and transformation,

> *It's just nice to reflect, isn't it? Just to see how far you've come in yourself. And like me explaining to you what I've gone through to what I am now is – while I'm telling you I'm sort of realising, "Woah", you know? How much much better I am, like…I've never really got the opportunity to explain this stuff that I've told you. But, yeah, it's quite like – quite a relief, you know? A release.* (Rich, p29).

Norman also described the opportunity to have this type of conversation as a 'release' and predicted an onset of new thinking,

> *I talked the whole of my life away like in that conversation and now I can start afresh now and start thinking about myself.* (Norman, p93).

The interview seemed to influence the possibility of new actions as well as new thoughts,

> *I. So you're going to go away and think about yourself and what you can do for yourself?*
>
> *R. Well what I can do for myself…and I'm going to go down there tomorrow and say, "I've got until January and I'm back on the streets"… I reckon, I'm too soft'.* (Norman, p.94)

Finally, Norman recognised the benefits of having this kind of conversation,

> *I need someone who will come in here and sit here like you have done and sit there talking to me… at the end of the day they've never done that and I've been here four months…you in a way are a good person to speak to like to get all my worries out like…we need someone to talk to like because most of them have never got friends in here.* (Norman, p95).

CHAPTER FOUR: DISCUSSION

This section presents a summary and interpretation of the study's findings, discussed in relation to the relevant research and theoretical literature. The main limitations of the study are communicated as are the clinical implications that result from the thesis.

4.1 Introduction to Discussion

The study aimed to explore and determine the psychological processes that enabled homeless adults to maintain a sense of manageability. Researchers of resilience (Harrop et al., 2006; Rutter, 1987) have emphasised the need to determine the underlying mechanisms that mediate protective factors that are shown to buffer against risk and vulnerability variables. It was hypothesised that qualitative research, seldom applied to the study of resilience, could identify resilience processes. Moreover, qualitative research could remain mindful of the social and cultural context of people's narratives whilst exploring their lived experience of adversity and coping.

Such focus of enquiry and methodology on resilience and benefit finding is rarely encountered in research on minority groups, possibly due to traditional and cultural assumptions about what constitutes 'successful outcomes' and their predicted absence amongst such groups. Conversely, qualitative methodology facilitates an exploration of process and demands clarity of purpose and assumptions from its outset, given the requirement for transparency and ownership of the researcher's position and the co-constructed nature of results (Tracy, 2010). In this study resilience processes were predicted to be present within homeless people's narratives and hypothesised to have developed as a response to the multiple and frequent hardships that they faced. To the author's knowledge, this was the first explorative study to explicitly examine psychological mechanisms related to resilience in a homeless population.

Analysis of transcripts identified two super-ordinate themes that related to processes that enhanced manageability (entitled, 'Psychological Processes That Enable a Sense of Manageability') and processes that detracted from it ('Ongoing Factors That Hamper Participants' Sense of Manageability'). The emergence of both themes makes sense in the light of general consensus that for resilience to be inferred there is a process of positive adaptation in the face of risk and stress (Harrop et al., 2006). As Rutter states,

> *'Coping successfully with stress situations can be strengthening: throughout life, it is normal to have to meet challenges and overcome difficulties. The promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility.'* (1985, p608).

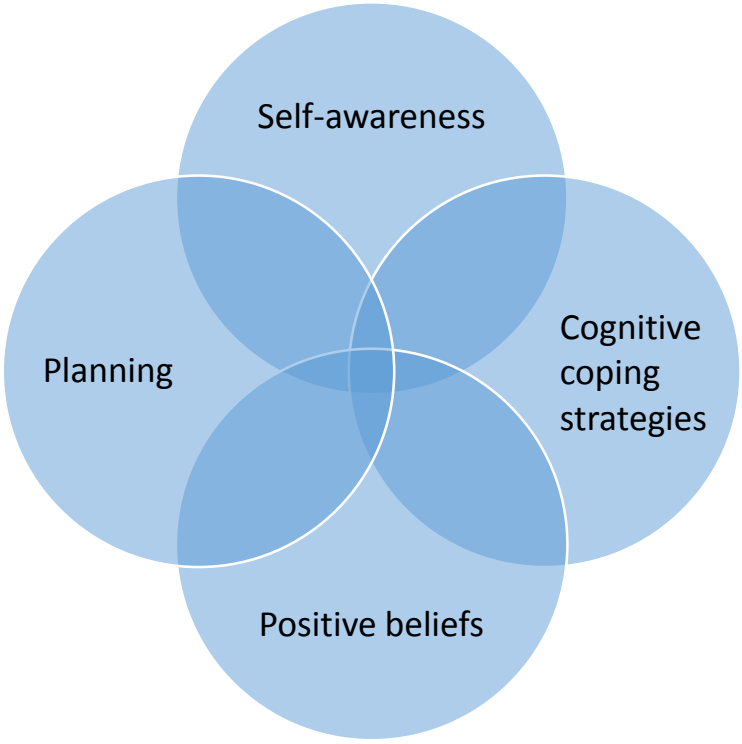
Thus, although presented as if they were separate themes, they are in reality linked, with many resilience processes emergent from descriptions of hardships, and hardships sometimes jeopardising participants' sense of coping. The former super-ordinate theme consisted of five main themes, with a total of ten sub-themes, and the latter super-ordinate theme consisted of three main themes. Themes are presented and described, and existing theory and literature is drawn on to make comparisons of these findings and to make sense of them.

4.2 SUPER-ORDINATE THEME 1: PSYCHOLOGICAL PROCESSES THAT ENABLE A SENSE OF MANAGEABILITY

A series of main themes (Positive Beliefs; Self-Awareness; Planning; Thought and Mood Management Strategies; Sustaining Supportive Relationships) detailed how participants maintained and protected their well-being. As discussed below, psychological processes were interpreted to underpin participants' resilience.

The multiple themes that make-up the overarching theme will be presented separately, but communication of their orthogonality and linearity is not intended. Although distinct psychological constructs are identified, they appear to be interlinked, as depicted by Figure 2, in that they constantly influence one another. For example, Self-awareness appeared to be linked to Planning, as some participants realised the need to plan their days in order to avoid ruminative processes. Planning daily structure enabled opportunities for mastery experiences and Positive-belief development, and so on. However, as will be demonstrated, Positive beliefs, and self-efficacy and self-esteem in particular, seemed to overlap significantly with other processes.

Figure 2. Processes contributing to a Sense of Manageability



The reader may be surprised to learn that all of the participants were interpreted to engage in multiple resilience processes. However, Masten (2001) emphasised the commonality of resilience based on the research with children who experienced adversity and disadvantage, and argued that resilience is made up of ordinary processes and normative functions of human adaptational systems. Also, Ungar (2004) argued that groups of people considered very vulnerable and disadvantaged can demonstrate resilience in a context of limited resources and opportunities to achieve experiences of health. Furthermore, he argued that many engage in behaviours and activities that are deemed to be delinquent in order to sustain well-being, but typically researchers interpret such actions as signs of inability to cope and vulnerability, thus overlooking resilience processes and outcomes.

The main themes that enhanced participants' sense of manageability are presented:

4.2.1 Positive Beliefs

All of the participants related how their beliefs about the self and the future influenced their actions and helped them to manage homeless life. The sub-theme, *'I can do whatever it is I need to do'* referred to participants' belief in their ability to perform certain actions with predicted success. Participants gave examples of how their belief in their capability enabled

them to perform positive actions, from socialising to applying for jobs, and many talked about a self-confidence that enabled them to plan and direct their transition out of the hostel.

This theme has much in common with and could represent self-efficacy processes (and hence was co-labelled 'self-efficacy'). Guarnaccia and Henderson (1993) also found self-efficacy to be prevalent amongst a sample of 180 homeless men and women in sheltered accommodation. Self-efficacy refers to an individual's belief in their ability to, 'organize and execute the courses of action required to attain designated types of performances' (Bandura, 1986, p39). The theory posits that one's motivation, emotions, and ultimately behaviour is heavily dependent on one's competency beliefs. Below, one participant, appeared to convey the process of personal assessment of competence to perform tasks,

> *Well, I'm not afraid to ask for help…I knows that. Definitely not. But I tend not to do it as much. I try and – "Can I do it?" Or, you know, I'll analyse the situation first. And then if I do need help, then I'll ask for it.* (Rich, p23).

Rutter also linked appraisal of stressor with behavioural response, as mediated by one's beliefs about self,

> *'To begin with, a person's response to any stressor will be influenced by his appraisal of the situation and by his capacity to process the experience, attach meaning to it, and incorporate it into his belief system.'* (1985, p608).

Interestingly, participants' accounts appeared to reveal how their positive beliefs developed and these were often in accord with the main ways in which self-efficacy is theorised to develop (Bandura, 1986): Many talked about the importance of being encouraged and supported by others, for instance, one participant learnt multiple skills from interactions with friends and hostel staff, from budgeting to interpersonal skills; in the literature this is often referred to as 'social persuasion' (Bandura, 1977). Observations of others successfully performing tasks and dealing with hardship were reported as helpful, hope-inducing, and motivating (this social learning process can be called, 'modelling'). And finally, participants enjoyed experiences of successful actions and gained confidence from them (referred to as, 'mastery'), increasing their likelihood of repeating pro-active behaviours.

As well as seeing themselves as capable beings, most participants reported their self-worth and value, as described by the theme '*It gives me that bit of confidence'.* Participants also linked such beliefs to positive actions as they did with efficacy beliefs, but they more explicitly

described positive feelings and thoughts about themselves deriving from these beliefs. In line with Social Comparison Theory (Festinger, 1954; Gruder, 1971), comparing oneself favourably to others was a common strategy that seemed to enhance one's self-evaluation. Research has also reported on homeless people's downward comparison tendencies (Boydell et al., 2000; Holt et al., 2012). Sense of worth and identity also arose from perceiving oneself to provide a functional role, which tended to be relational in nature (e.g. mentoring other residents, being a dad).

This sub-theme could have represented the construct of 'Self-esteem' that generally refers to 'what we think about the self…the positive or negative evaluations of the self, as in how we feel about it' (Smith & Mackie, 2007, p107). There was evidence within participants' narratives to suggest feelings of worth and competence could fluctuate (and hence the need to protect self-worth, described shortly), and could also be domain specific, for instance, one participant evaluated their physical appearance and intelligence negatively, but provided examples of their physical strength and practical intelligence and explained the feelings of worth they derived from these domains. This ran counter to notions of resilient personality types, or 'resilient people', as proposed by Block and Block (1980) and Bonanno (2005).

Research that examines the strengths and resilience of homeless people commonly finds beneficial influences of beliefs about self-worth and capability for homeless people (Bender et al., 2007; Dunleavy et al., 2012; Kidd, 2003; Kirst et al., 2014; McCormack & Gooding, 1993; McCormack & MacIntosh, 2001; Thomas et al., 2012). For instance, Rew (2003) reported that participants who described their sense of self-respect linked this to actions that enhanced or protected well-being, such as self-care behaviours. Likewise, Thompson et al. (2013) reported that many participants communicated their respect for themselves, and similar to Rew, many reported their sense of capability and confidence to deal with future hardships.

Although the aforementioned qualitative studies seldom made explicit reference to psychological constructs of self-esteem or self-efficacy, correlational investigations have explored these constructs in homeless populations and found self-efficacy to be predictive of better coping strategies (Epal et al., 1999) and self-esteem to be the strongest protective factor, amongst an array of variables, of mental and physical ill-health (Kidd and Shahar, 2008). Bandura (1986) argues that self-efficacy is central to resilience, as people with a high sense of competence in a given domain are more likely to perceive difficult situations as

challenges rather than threats to be avoided, set themselves goals, possess a high degree of perseverance, and are quicker to 'bounce-back' after failures. Whilst an emerging body of research (see also, Finfgeld-Connett, 2010; Stein et al., 2002) reports the significance of self-esteem for homeless people, the construct of self-efficacy has been markedly under-researched for this population, although its relation to behaviour and well-being is well documented in other fields, particularly in relation to health-promoting and protecting behaviours (Bandura et al., 1999; Harrop et al., 2006, Jones & Riazi, 2011; Stretcher et al., 1986).

As found by Rew (2003), the current study suggested participants' beliefs formed self-reinforcing cycles. Simply put, there was evidence that many actions stemmed from participants' positive beliefs, and the experience of independently and proactively executing actions reinforced beliefs of self-sufficiency. Although this was possibly an unconscious pattern for many, a few participants, whose sense of efficacy and agency were relatively new to them and resulted from homeless life experiences, seemed to recognise and value the importance of their agency and sustained it by maintaining their mental health and by reducing or ceasing the use of substances. Similarly, several participants seemed invested in maintaining their worth and could identify the factors that protected it. For one, this meant maintaining a standard of hygiene so as not to be judged negatively by others, whereas for another, this meant maintaining his relationship with his children who he perceived respected him and made him feel 'loved',

> *Love that's the most important thing man. Making you feel special. Calling me "Dad" like. They're looking up to me like.* (Norman, p89).

In addition to self-esteem and self-efficacy beliefs, beliefs about the future were also common amongst participants and most either had a sense of optimism about the future, expecting or predicting best possible outcomes, or at least were hopeful. As already mentioned, for several participants, role-models served to enhance their hope and optimism. Partis (2003) also commented on the relational nature of hope, and found meaningful relationships sustained hope for homeless adults. Predicted positive future outcomes were associated with motivation and proactive action, often related to planning and working towards transitioning out of homelessness. The reverse was true for one participant who had a pessimistic outlook regarding employment and saw applying for jobs as futile. These beliefs were possibly linked to self-efficacy, denoted by one participant who connected his belief that his future situation

would be manageable with his confidence that he could obtain employment. Research has suggested optimism and hope are distinct constructs but associated with self-efficacy (Duggleby et al., 2009; Magaletta & Oliver, 1999).

The literature on homeless people reports that hope and optimism (Bender, 2007; Finfgeld-Connett, 2010; Kidd, 2003; Kirst et al. 2014; Thompson et al., 2013) can protect against low mood generated by homelessness but, seldom elaborates further. This did not seem to emerge explicitly in many participant accounts in the current study, although other research also indicates the important protective factor of hope and optimism: Kidd and Caroll (2008) found hopeful attitudes reduced risk of suicidal ideation and attempts, and mental health research suggests that hopelessness is a risk factor for suicide (Beck et al., 1975; Saltz & Marsh, 1990). Interestingly, the importance of hope and optimism is frequently emphasised within the Recovery movement and mental health literature (Leamy, 2011; Resnick et al., 2005; Ridgway, 2001), and a recent study by Kirst et al. (2014) demonstrated the importance of hopeful goals for homeless adults with mental health difficulties. Positive psychology emphasises the benefits of optimism for well-being (Seligman, 1990; Seligman et al., 1995) and has found evidence to link optimism to multiple positive outcomes, including better well-being maintenance and more effective coping strategies, sometimes referred to as 'approach coping strategies' (Brissette et al., 2002; Scheier et al., 2001).

4.2.2 Self-Awareness

Self-awareness is conceptualised here as 'a psychological state in which people are aware of their traits, feelings and behaviour…[it] can either be temporary, as a consequence of a particular situation, or chronic, reflecting a personality trait that varies from person to person' (Crisp & Turner, 2010, p87). Over half of the sample demonstrated insight and awareness of their mental-health and substance-use vulnerabilities (theme labelled, *'it's emotional thinking that you're on your own'*). This enabled many to plan and perform actions in order to compensate for, and protect against, their vulnerability. Those with identified and diagnosed mental health difficulties recognised their quality of life and general sense of capability were improved when their mental health was managed, as illustrated by one participant,

> *If you're not all in the head, then you're going to struggle…And that's the worst thing…if you're strong mentally and you know you can do things, you know you can – everything…It's to do with everything.* (Rich, p25).

They were therefore motivated to maintain good mental health and had developed strategies, from medication adherence to keeping occupied, to minimise known triggers they linked with rumination and low mood. Coping strategies (constituting a main theme and discussed later) were also in place for when they experienced negative thoughts and emotions.

Similarly, due to their awareness of personal substance and alcohol relapse risks, some participants had developed strategies to avoid known triggers, and were motivated to do so by their awareness of the negative impact substance addiction and dependency had on their mental health and general well-being. Homeless people's intentional drug-avoidance for health maintenance has been reported elsewhere (Dunleavy et al., 2012; McCormack & Gooding, 1993). Other participants however, described their substance-use as an intentional method to deal with difficulties, these ranged from, relieving angry feelings, self-medication for mental health difficulties when prescribed medication was not available, and a method to process thoughts and feelings. Interestingly, these participants were aware of the cons of their drug-use and appeared to reach a decision that the perceived benefits outweighed these. Studies have reported on homeless people's insight into other potential threats to personal safety (e.g., risk of theft and physical assault) and how they subsequently acted to protect themselves (Rew, 2003; Thomas et al., 2012).

Protective factors, commonly identified in research at the individual and systemic level, are central to notions of resilience (Harrop et al., 2006). Participants highlighted an array of protective factors, but moreover, in demonstrating an awareness of personal strengths (for example, interpersonal skills) they reported having the confidence to capitalise on these in order to plan ahead, form relationships, make money, and partake in leisure activities that also enabled social opportunities. Contrary to popular social assumptions that overlook homeless people's strengths and focus on their deficits or deviance (Pascale, 2005; Parsell & Parsell, 2012), recognition of personal strengths is common amongst homeless populations (Banyard & Graham-Bermann, 1995; Patterson & Tweed, 2009).

A realisation that certain relationships served as a protective factor for psychological well-being and practical support, meant participants worked to initiate, maintain, and sometimes repair these. Studies have also revealed homeless peoples' awareness of multiple protective factors, but with particular regards to relationships (Bender et al., 2007; Dunleavy et al., 2012; Kidd, 2003; McCormack & Gooding, 1993; McCormack & MacIntosh, 2001; Rew, 2003; Thompson et al., 2013). Participants in Thomas et al.'s (2012) study described the emotional

and practical support they derived from relationships with friends, family, and acquaintances at a drop-in centre. With their recognition that support networks were good for them, they organised their days and time to meet up and form networks.

4.2.3 Thought and Mood Management Strategies

It is not surprising, considering the frequent number of daily challenges that homeless people face, that studies have identified a number of coping strategies that people have devised and adopted, ranging from leaning on support networks to a variety of methods that achieve avoidance of perceived stressors (Dunleavy et al., 2013; Kidd, 2003; Klitzing, 2004). Interestingly though, the current study inferred that some participants had developed cognitive coping strategies, sometimes linked to mental health management. Methods included, positive and motivational self-talk, intentional means to process thoughts and emotions such as writing poetry, using thoughts of loved ones, and comparison of self to worse-off others, or others who managed to overcome similar difficulties. Behavioural coping strategies are perhaps reported more often in the literature because they are more apparent (especially ones which are considered to be deviant), but two qualitative investigations have reported on participants' conscious adoption of positive and optimistic attitudes (Thomas et al., 2012; Thompson et al., 2013).

The empirical literature reveals that avoidant coping methods can be useful when stressors are uncontrollable and short-term (Suls & Fletcher, 1985), but longitudinal research suggests that attempts to avoid thoughts and feelings associated with persistent stressors predicts elevated distress (Rayburn et al., 2005; Stanton & Snider, 1993). The current study suggested that participants' cognitive coping strategies were more effective compared to more behavioural strategies, which for some, actually served to perpetuate difficulties.

4.2.4 Planning

Participants revealed planning skills that appeared to increase their sense of manageability. For instance, they planned activities to provide daily structure in order to keep occupied and minimise boredom. Cognitive functions were suggested to mediate daily planning. These included, problem-solving (when they recognised their cognitive limitations hampered planning), self-awareness (for example, the insight that boredom leads to rumination), and memory. Mastery experiences seemed to reinforce planning (see DeWalt, et al., 2009, for research on self-reinforcement of goal success). Bender et al. (2007) and Kirst et al. (2014)

both reported that homeless people found planning and goal-setting as helpful, and Thomas et al. (2012) linked participants' lack of security and lives of uncertainty with a present-time-focus. They suggested that this compromised planning for positive changes.

Almost all of the participants planned, to different degrees, for their future. This longer-term planning was hypothesised to be linked with problem-solving, self-efficacy and optimism processes. Plans usually revolved around transitioning out of the hostel into private accommodation and employment, and generally were aimed at means and ways of achieving a greater sense of agency, as well as sustaining the agency they had developed whilst in the hostel. Such plans gave participants a sense of direction, meaning, and lead to actions in order to achieve them. This proposed process of planning is consistent with Goal-Setting Theory (Locke, 1968; Locke & Latham, 2002) which argues that goals and intentions are cognitive and wilful (the theory references self-efficacy and optimism constructs), and that they influence actions. Rutter (1985) hypothesised on the psychological mechanisms that influenced women, who had grown up in the care-system, to make wise life-choices that enabled their experience of a good quality of life. He linked self-esteem and self-efficacy constructs, which he inferred were mediated by early mastery experiences, with planning processes (see also Heimpel et al., 2002, for evidence of the relationship between self-esteem and goal-setting).

4.2.5 Sustaining Supportive Relationships

Participants talked about their actions and intentions to sustain relationships and the psychological, emotional, and practical benefits of support networks. Psychological processes of self-awareness, social learning, empathy, positive self-beliefs, and planning, appeared to influence relationship formation and maintenance (some examples have been provided above). In-turn, relationships seemed to enhance these psychological mechanisms, for instance some participants described a self-confidence required to interact with others, and many reported that they derived feelings and thoughts of self-worth and confidence from appraisal of their interactions and relationships with others.

Research also suggests that psychological processes of self-awareness, hope, planning, self-esteem, and compassion and empathy, mediate relationships (Bender et al., 2007; Dunleavy et al., 2013; Kidd, 2003; Klitzing, 2004; Tedeschi & Calhoun, 2004). For instance, Thomas et al. reported how participants planned and organised social meet-ups as they described benefiting from a sense of 'shared identity and esteem' (2012, p.790). Some

participants realised the benefits of adopting a general trusting attitude of others as this enabled opportunities to talk to people when needed. Relationships seemed to be mediated by, 'An informal system of sharing and paying back created relationships of obligation, reciprocity, and interdependence.' (2012, p.789). The attachment literature theorises that an individual's 'internal working model', which is a cognitive framework of mental representations and beliefs of the self (e.g. 'I am of worth') and of others (e.g. 'others are trustworthy'), is crucial to one's ability to form and maintain relationships (Bretherton, & Munholland, 1999; Carnelley et al., 1994). The self-belief constructs of the internal working model appear to be associated with self-esteem and self-efficacy beliefs (Roberts et al., 1996).

4.3 SUPER-ORDINATE THEME 2: ONGOING FACTORS THAT HAMPER PARTICIPANTS' SENSE OF MANAGEABILITY

4.3.1 Ongoing Relationship Difficulties

All but one of the participants reported ongoing relationship difficulties with friends, family, and fellow residents. Participants described factors that caused and perpetuated limited networks, including: their substance-use, their self-acknowledged anger problems, their mistrust of others which were sometimes linked in their narratives with mental health difficulties, significant family ruptures, and unsupportive parents.

For many, this resulted in a limited (in terms of quantity and quality) support network, which impacted negatively on participants' self-esteem, existing coping strategies, mental health, and sense of safety and certainty at the hostel and exacerbated their sense of loneliness and fear of future isolation. Interestingly, two of the participants who appeared to have the most limited social networks were also those who failed to generate experiences illustrative of self-efficacy and self-esteem constructs. Additionally, unlike the other participants, their accounts did not reveal daily planning and organisation skills, or an awareness of personal strengths and protective factors.

The homelessness evidence base reports extensively on the relationship difficulties that homeless people experience that can lead to limited support networks and jeopardise their well-being (Lee et al. 2010; Thomas et al., 2012). For instance, Kidd (2003) found that many participants experienced 'friends' as manipulative and not to be trusted. A common research finding, that arose only in the accounts of two participants in the current study, is homeless people's mistrust and/or very negative perception of professionals and services (attributed to

prior negative experiences), meaning that they are consequently less likely to approach such services (police and healthcare) for support (Kidd, 2003; McCormack & MacIntosh, 2001; Rew, 2003; Thompson et al., 2013). Interestingly, many of the aforementioned studies report on homeless people's intimate relationships, whereas not one of the participants in the current study made reference to such a relationship, although two said that they had hopes of future marriage.

4.3.2 Thoughts and Worries

Most of the participants described significant negative thoughts and worries that negatively impacted on their psychological and social functioning. Common thoughts and worries included transition anxieties and employment concerns, and worries associated with mental health difficulties. The evidence base depicts homeless people as having high rates of common mental health difficulties such as depression and anxiety (Fitzpatrick et al., 2007; Homeless Link, 2011; Shelter, 2008), and these mood disorders have been linked to experience of negative cognitions (Beck, 1974; Clark & Watson, 1991). High rates of mental health difficulties are not surprising considering the many problems homeless people can face, from attending to their basic needs (Thomas et al., 2012) to repeated exposure to trauma (Adlaf et al., 1996; North & Smith, 1992).

4.3.3 Cognitive Processes

Some narratives were interpreted to reveal participants' cognitive processes that were hypothesised to impact on their sense of manageability and ability to transition out of homelessness. The theme does not represent cognitive content, as represented by the 'Thoughts and Worries' theme above, and the processes considered here are distinct from those which participants explicitly linked with diagnosed mental health difficulties (e.g. biased thinking, paranoia). Processes which were inferred included rigid and inflexible thinking, limited reflective capacity, limited inhibitory control ability, and a present-time focus. For example, one participant acknowledged that he did not worry about things that he thought he should have, such as transition or employment plans, as he said he was more preoccupied by present-time worries and strategies to manage his psychological functioning, which he linked to a lack of daily planning and future goal-setting (also found by Epal et al., 1999).

Backer and Howard (2007) reviewed a number of studies that reported on cognitive impairments within homeless populations. The authors found the number of homeless people

to reportedly have cognitive impairments was considerably greater than the prevalence in the general population (and see Burra et al.'s 2009 review). This makes sense considering that cognitive deficits are theorised to develop from factors that are associated with homelessness, including diagnoses of schizophrenia, substance misuse, trauma, and among others, acquired brain injury. Impairments can impact a person's memory, perception, attention, judgment, planning, and language functioning. As a result, homelessness could be perpetuated by poor problem-solving and decision-making ability (Medalia & Ravjeo, 2002).

4.4 LINKING TO MODELS OF RESILIENCE

Resilience models that assist in making sense of the current findings and guide their interpretation are presented. The findings can potentially contribute to and further understanding of resilience conceptualisations.

4.4.1 Rutter's (1985) Model

Based on the accounts of the participants, mechanisms of the resilience process were inferred. The two most well-known and researched psychological constructs to be identified were self-efficacy and self-esteem. These seemed to be prevalent within participants' narratives and to be linked with other emergent constructs, such as planning. As discussed in the introduction, Rutter theorised these two processes underpin resilience,

> *'Resilience is characterised by some sort of action with a definite aim in mind and some sort of strategy of how to achieve the chosen objective which seems to involve several related elements. Firstly, a sense of self-esteem and self-confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem-solving approaches.'* (1985, p607).

Rutter's (1985; 2013) resilience framework seems applicable to the study's finding that resilience was an active, fluid and contextual process. From their extensive review of resilience research and conceptualisations, Harrop et al. concluded the same, 'Resilience should be seen as multidimensional and variable across time, circumstance and context' (2006, p5). This seems to contradict notions that resilience is a stable and enduring trait linked to personality (Bonanno, 2004), and that commonly used measures of successful outcomes, based on social and cultural assumptions, can be globally applied to different populations at a singular time to effectively assess for resilience.

As hypothesised by Rutter (1985), participants who revealed resilience processes were exposed to adversity and purposefully acted to protect themselves from its negative consequences, and worked to sustain their sense of well-being and manageability. Consistent with the model, participants' prior experiences of mastery and success and their supportive relationships were central for the development of their positive beliefs that influenced the skills and strategies that enabled a sense of manageability. Interestingly, the two participants whose accounts were not illustrative of both self-efficacy and self-esteem processes were the participants deemed to be coping least well (described further below). Rutter also usefully considered contextual factors relevant to the participants who at times had to be creative in their methods of protecting resilience due to their limited access to resources or missed developmental and experiential opportunities, 'Protection is not a matter of pleasant happenings or socially desirable qualities of the individual' (1987, p318).

4.4.2 Relational resilience

The importance of participants' relationships and support networks to their resilience processes was apparent. Relationships themselves protected against stress, but also underpinned many of the interpreted psychological constructs related to participants' sense of manageability. Positive beliefs appeared to develop from and be perpetuated by relationships, but were also necessary in order for participants to initiate, form, and repair relationships. For example, some talked about a sense of self-confidence necessary to interact with others, and some revealed that their thoughts and feelings of worth were derived from appraisals of such interactions. Moreover, for those whose support networks were very limited, self-esteem and self-efficacy were deemed to be absent from their accounts, and these were generally the participants who seemed to be coping least well, had not built structure and activity into their days (thus missing mastery opportunities), and who struggled to identify personal strengths.

The Relational-Cultural Theory (RCT) of psychological development simply proposes that healthy development occurs within growth-fostering relationships throughout one's life (Hartling, 2008). In-line with the current study's findings, RCT would argue that relationships do not merely serve as a protective factor, but they fundamentally strengthen psychological processes associated with resilience. Miller suggests that sense of worth (she argues the term 'self-esteem' reinforces a sense of psychological separation from others) develops in mutually valued relationships in which the relational partner 'conveys attention to, and

recognition of, our experience' (1986, p6). Of course, many schools of psychology, from Attachment Theory (Bowlby, 1978) and Humanistic Psychology (Maslow, 1943), to Social-Cognitive Theory (Andersen & Chen, 2002; Bandura, 1986), propose that the quality of important relationships is crucial for psychological development and healthy self-beliefs. Thus, arising from them are therapies intended for clients with wide-ranging difficulties which target client-therapist relationship nurturance (Hughes, 2007; Rogers, 1957). As Andersen and Chen theorise,

> *'When one feels fondness toward someone and begins to invest emotionally and motivationally in the person…one sets the stage for forming a significant-other representation designating this person. New aspects of self are likely to then be developed or enhanced on the basis of the new relationship…the self can be extended in positive directions on the basis of newly formed relationships and thus offers some hope for changing counterproductive patterns and building desired identities.'* (2002, p638).

4.4.3 Post-Traumatic Growth Model

Post-Traumatic Growth (PTG) has been reported to follow traumatic events. Growth refers to the development of positive changes following trauma when the survivor comes to engage in a process of meaning-making of the negative event. Growth has been reported to include improved relationships, development of personal strengths, spiritual change, general positive outlook and appreciation for life (Tedeschi & Calhoun, 1996; 2004). Paradoxically, trauma survivors often simultaneously report growth and an increased sense of vulnerability, which makes sense as most trauma experiences are perceived to be outside of the person's ability to control or prevent them (Janoff-Bulman, 1992).

Goodman (1991) proposed that psychological trauma is a very common occurrence for homeless people (and see Coates & McKenzie-Mohr, 2010) and described three core causes of trauma symptoms, namely: the gradual or sudden loss of home; conditions of shelter and hostel life; and incidents of sexual and/or physical assault. Based on the accounts of participants, the current thesis extends this argument and proposes several other facets of homelessness that can potentially cause psychological trauma, and therefore growth, due to the severe disruption and subsequent re-ordering of the 'assumptive world' (Linley & Joseph, 2004). These include: the unexpected death of a loved one, the complete removal of a pertinent relationship (e.g. children), the constant perceived threat of being made street

homeless, and being street homeless and exposed to conditions that continuously compromise multiple basic needs.

Many of the participants in the current study linked their strengths and resilience to hardships that they encountered whilst homeless. Two participants appeared to describe growth following their overcoming of specific trauma by claiming newly found personal strengths and positive belief development, including a sense of their capacities to survive and prevail – this is a common theme amongst those who have encountered major life challenges (Calhoun & Tedeschi, 1999). One participant in-particular talked about the development of his deep sense of empathy for homeless individuals newly entering into the hostel, as he recounted how incredibly difficult he found the same experience; he said it left him 'frozen'. Operating from this empathic stance, he decided to befriend and comfort new residents and this undoubtedly helped him to extend his support and social network. Survivors of trauma often develop relationships with others who have suffered through similar traumatic circumstances, mediated by a greater sense of compassion and empathy for others (Tedeschi & Calhoun, 2004).

4.5 CLINICAL AND SERVICE IMPLICATIONS

The dissertation's themes and the literature review indicate a series of approaches and interventions that services could incorporate in order to generally increase the resilience of people who are homeless.

Intervention should always follow careful assessment of need, and if the homeless person is in crisis, experiencing acute stress, or their basic human needs are compromised, such issues will likely need to be addressed in order for the person to feel safe and stable enough prior to considering the below ideas. Importantly, the delivery of any intervention method for resilience-building requires an approach that encourages the service-user 'to feel that they can "act" to improve their situation, rather than feel that all benefits derive from what the clinician does' (Rutter, 2013, p484).

4.5.1 Relationship Promotion for Psychological Growth

Even though psychological constructs of self-esteem and self-efficacy can be seen as individual traits or internal processes, their relational nature was apparent throughout the described themes, in that psychological mechanisms seemed to be influenced and reinforced by relationships. It is therefore possible, and research indeed suggests, that these resilience

processes can be developed and strengthened in people through the medium of relationships, specifically through 'growth-fostering relationships' (Bandura, 1986; Hartling, 2008; Mancini, 2007; Rutter, 2013). Of course, as discussed, relationships can be beneficial in other ways too, such as the sharing of resources, and thus Thompson et al. concluded that, 'leveraging peer support networks in the treatment of homeless young adults must be understood to most effectively intervene in their lives' (2013, p14). Services can examine homeless people's support networks and quality of relationships (for good assessment questions, see Tedeschi & Kilmer, 2005), and work with them, to improve and extend these if necessary, as the current study suggests will often be. Based on the study's findings and the literature discussed under 'Relational Resilience', the following ideas are proposed:

In order to improve the quality of existing social networks, professionals could promote the homeless person's awareness of the impact of any unsupportive and problematic relationships, and, if wanted, provide support in the management or ending process of such relationships. Participants in the current study distanced themselves from unsupportive others when aware of their negative impact. Motivational Interviewing techniques (Rollnick & Miller, 1995) are an avenue for those who are ambivalent about their problematic relationships.

Specific interventions aimed at improving relationships could entail, for example, assertiveness skills training for those being exploited, or anger-management for those who acknowledge relational difficulties associated with anger. Such learning does not have to be formally taught though, and new relationships founded on trust, respect and acceptance could provide opportunities for social learning that lead to better psychological and social functioning. Also, structured and formal interventions aimed at either improving interpersonal skills or developing processes associated with resilience, are unlikely to be provided on a community-wide and long-term basis by services. Rather, promoting opportunities for new and supportive relationships, that have potential to foster self-efficacy and self-esteem development, could be targeted at all who are assessed to benefit, and at comparatively little cost to direct and individual therapeutic work. Guiding relationship development, and not instructing or teaching it, could also promote agency and mastery experiences for the person, as well as encourage their social inclusion. This is important as research suggests that homeless people feel isolated by services that are not perceived to be collaborative (Hudson et al., 2010; Martins, 2008; Thompson et al., 2006). Means of this intervention include, providing opportunities of functional community roles, such as voluntary work; providing

access to community clubs, courses, groups and social activities; and forming buddy and mentor relationships with people who were formerly homeless but successfully transitioned into housing (Bender et al., 2007, found that such relationships can be hope-inducing and motivational).

One problem with simply providing relationship-building opportunities, however, is that many homeless people may lack the necessary social skills or self-belief to manage relationships. Specific mental health difficulties such as paranoia, depression, anxiety, and so on, might also hamper interpersonal ability and motivation. Practitioner one-to-one work could help in such instances to gradually and tentatively develop a relationship that mediates healthy psychological processes of self-esteem and self-efficacy. The skill level of the practitioner undertaking such work should depend on the nature of the individual's interpersonal difficulty, however in general, through the medium of the service-user-practitioner relationship the practitioner could promote growth and relational skills. This relationship could include: praise of the clients' successes and focus on their strengths, a collaborative approach to set daily and future goals for mastery experiences, teaching problem-solving skills, social skills training, sharing their emotional experience of the client, repair work of client-practitioner ruptures; the list of possibilities is vast. Such a relationship could prepare the person to engage in other relationships. There is evidence to suggest that homeless people can partake and benefit from such structured and individual therapeutic work (Maguire, 2006).

4.5.2 Ideas from Positive Psychology and PTG: The Value of Assessing Strengths

Asking homeless people about their unique strengths, coping strategies and experiences of overcoming adversity could prove a useful intervention in itself. Most of the participants could identify personal strengths and protective factors, but two of the participants in particular gave feedback that the interview helped them to reflect on difficulties, recognise their strengths, problem-solve and plan new actions, and described the interview as affirming, empowering, and an emotional 'release'. Both participants said that they had not encountered such questions before, perhaps unsurprisingly as clinical assessment has traditionally focussed on problems and risk (Tedeschi & Kilmer, 2005). Qualitative researchers have noted the apparent beneficial and even healing effect interviews with participants can have (Hutz & Koller, 1999; Morse, 2000; Moyle, 2002) when the researcher provides a forum for participants to be listened to non-judgementally. In a retrospective study, Patterson and Tweed (2009) found it was homeless people's recognition of their strengths and sense of

worth and potential that helped them to transition out of homelessness more so than substance-abuse treatment, mental health intervention, and social support.

Positive psychologists have demonstrated the benefits of strength recognition and planned utilization in other populations (Linley et al. 2010; Quinlan et al. 2011; Seligman et al, 2005). Solution-Focussed Therapy (De Shazer, 1985) suggests methods to elicit strengths and exceptions and how to facilitate the client to engage in a process whereby they capitalize on these to work towards personal constructed goals (and see Saleebey, 1996). Assessment of strengths, protective factors, and coping strategies may elicit processes associated with PTG, although good knowledge of the domains and elements of PTG is likely to be required to assess and work with it (Tedeschi & Kilmer, 2005). Calhoun and Tedeschi (1999) suggest that practitioners can facilitate the PTG process by listening carefully to the language of the client and joining communication within the existential framework that they have developed or are trying to re-organise, without attempting to re-structure distorted cognitions for them (e.g. 'I can now survive anything'), that may serve a useful function and become adapted in time (Taylor & Brown, 1988). As Tedeschi and Kilmer explain, '…the labelling and discussion of the apparent growth can encourage further development of the cognitive processing of trauma into growth…A life narrative that includes the aftermath of trauma as having value…has a more emotionally powerful positive quality and may motivate survivors to do something positive and possible with the memories of trauma, rather than tackle the virtually impossible task of trying to forget' (2005, p234).

Furthermore, services that adopt a strength-based approach that respect autonomy, are likely to enhance engagement with their service-users as hope and optimism is encouraged and more collaborative, affirming and empowering working relationships can be developed (Cowger, 1994; Saleebey, 1996; Thompson et al., 2006). This is important as many homeless people feel discriminated against by healthcare professionals and report being treated disrespectfully (Hudson et al., 2010; Martins, 2008), meaning they are less likely to engage with services (Jarrot, 2010; Thompson et al., 2006).

4.5.3 Planning and Organization

Most of the participants reported that they benefited from being able to plan and structure their days in order to pursue leisure and meaningful activities, engage in supportive relationships, attend important appointments, organise effective medication management, and conduct actions directed at transition out of homelessness. As evidenced by some of the

participants, these skills can be learnt when homeless. Services and professionals may presume that all homeless people possess these skills, as the average Western person likely does to differing degrees, and could mistake those who are not goal-oriented and are more disorganised and inactive than others as unwilling or unmotivated. The teaching and modelling of planning and activity scheduling could be relatively straight-forward, for instance, one participant in the current study learnt budgeting and time-management skills when he was homeless, via friends.

4.5.4 The Role of Clinical Psychology

Clinical psychologists would ideally reside at the heart of such intervention strategies when working with the complex difficulties that homeless people can present. With their breadth and depth of theoretical knowledge relevant to the psychological constructs discussed, their ability to translate the evidence-base into practice, and clinical experience of a diverse range of populations and difficulties, clinical psychologists are ideal candidates for such work given their skills in offering supervision, teaching, training, and consultation to staff working with the homeless, who often receive very little in the way of psychologically-informed training (Jackman, 2013; Jarrot, 2010).

Unfortunately, psychological services for the homeless are few (Maguire, 2006), but clinical psychologists have anecdotally reported on the effectiveness of psychological assessment and interventions, such as cognitive functioning assessment, cognitive-behavioural therapy (CBT), Motivational Interviewing, and relationship-promoting approaches (Jarrot, 2010). Maguire (2006) provided evidence from a pilot study that demonstrated the effectiveness of a clinical psychologist training and supervising staff at a homeless service in psychological formulation and intervention. Staff delivered CBT to rough sleepers with complex difficulties, including excessive alcohol use. The intervention was associated with reduced incidents of theft and violence, and reduced alcohol consumption. Interestingly, measures of self-efficacy increased for all clients. There is preliminary evidence then, that clinical psychologists working within homeless services can disseminate psychological knowledge and skills to members of staff for greater understanding of homeless people's difficulties and for psychologically informed intervention strategies (Maguire et al., 2012). CBT in particular could be a relevant intervention for certain homeless people, in light of the identified Theme 'Thoughts and Worries'.

4.6 LIMITATIONS OF THE STUDY

Tracy's (2010) 'eight ''Big-Tent'' criteria for excellent qualitative research' was applied to the current research project as an insurance of good research. The careful consideration and application of this framework can be considered an important strength of the study, increasing its trust-worthiness, sensitivity, and credibility (this is comprehensively demonstrated in Chapter Two: Methodology, particularly under section 2:3 Ensuring Quality). Nevertheless, the study contains several key limitations that should be considered when interpreting findings.

Generalizability of findings to the homeless population is limited due to the small sample size, the all-male sample, and that all participants were drawn from one hostel. Their experiences, beliefs and responses are unlikely to be representative of the general homeless population then, or even those who live in hostel accommodation. Although, this does not render the results as non-comparable to other homeless cohorts, as many commonalities of themes are hypothesised to exist. In addition, all those who participated in the study volunteered to do so (the sample pool was not big enough to randomly select from volunteers) and therefore it is possible that these participants shared personal and/or cultural characteristics that other hostel residents might have lacked. For example, a motivation to volunteer and share one's story with an unknown professional might be linked with a greater social confidence compared to those who declined the invitation. The sample was also relatively culturally and ethnically homogeneous. Those with language or cultural difference might have been less likely to come forward. This could have biased the representativeness of the sample.

The definition of homelessness used to recruit participants could render problems when comparing the results to those of other studies. It was stated that participants had to either be statutory or non-statutory homeless (please see the introduction for definition of these). This covers a broad spectrum of types of homelessness although in actuality, most participants were likely non-statutory homeless, as is common for those who live in temporary hostel accommodation. However, across research studies of the homeless, there is an absence of agreed definitions, across time and place, of what constitutes homelessness. For instance, some studies included in the systematic review defined homeless participants as those who were sleeping rough or who were 'street homeless', which only make a small proportion of the homeless population. Other studies included both the street homeless and

families who lived in temporary shelter. This definitional ambiguity needs to be considered when comparing the current studies' findings to other studies of homeless populations.

Second, the method of data collection would likely bias some participants' narratives. Trauma and chronic stress are prevalent within the homeless population. One participant hinted at a traumatic event and this participant kept his responses minimal throughout the interview, which only lasted 30 minutes. Two other participants stated that their mental health and 'paranoia' meant they found it difficult to trust others. These are just some of the factors that could have impacted on rapport development and trust-building between interviewer and interviewee, with the potential of important information being omitted by participants.

Social desirability bias also needs to be considered; for instance, analysis revealed evidence of coping strategies that are often socially frowned upon, such as substance-use. There may have been further 'underground' actions participants engaged in to manage their homeless situation that they felt too embarrassed or shameful to reveal. Confounding this could be their possible contrast of themselves to the interviewer, who could have been perceived as well-educated, 'a professional', middle class, and represented a figure of authority even. Participants could have attempted to preserve and promote their sense of self-esteem by highlighting positive qualities and down-playing attributes and actions that they perceived the interviewer might have judged. The interviewer's engagement with *relational ethics* (Tracy, 2010) could have partially countered some of these processes.

Related to the above point of how the interviewer may have been perceived by the participants is the location of interviews, they were conducted at the hostel. An obvious advantage of this was the organisation of interview arrangements and the predicted greater comfort participants would derive from familiar surroundings. However, the participants could have perceived that the interviewer was professionally connected with hostel staff as he was 'another professional' at the hostel, and he would have often been seen interacting with staff, and many interviews were arranged through staff. One participant joked that he would 'worship' the interviewer if he would be influential in securing him a flat. Whether this was an outright joke, or a communication of hope that the interviewer could help achieve this was unclear. Despite declarations of confidentiality and anonymity and description of interviewer role and background then, participants could have edited their accounts if they perceived the interviewer to be aligned with hostel staff, and depicted hostel life, and staff, in a more favourable light than they experienced.

Other factors that could have influenced responses included variations in participants' reflective ability and emotional literacy, possibly due to developmental pathways, missed schooling opportunities, or prolonged use of substances (of note, Willig, 2008, argues IPA favours educated participants for reflective capacity). If this was the case, psychological processes may have been under-represented in some accounts due to its communication difficulty. Also, the interviewer thought that one participant could have been intoxicated with alcohol during the interview, although it was difficult to be certain. If this was the case, again, information processing, memory and other cognitive functions could have been hampered, limiting the participant's narrative.

It is to the researcher's credit that steps were taken to improve the trust-worthiness and credibility of the results, including co-constructing and piloting the interview schedule, consulting for purposes of triangulation (although the consultant was not independent of the study), and conducting member reflections and checks (although only with two participants). However, the researcher acted as the sole interviewer and main coder, and therefore subjectivity-researcher bias may be present. For example, the researcher was aware, prior to conducting the interviews, of a few studies that suggested positive beliefs were beneficial to a sense of coping within homeless populations. Although reflexivity processes could have helped bracket this knowledge as best as possible, participants may have been influenced by subtle cues from the researcher and have altered their responses to either comply with or contradict perceived cues.

Finally, the systematic review evaluated the credibility of studies by adopting the Critical Applied Skills Programme (CASP, 2010) quality-review framework. The CASP was selected as it provided a clear checklist that produced an overall study score, enabling a means of systematic comparison which proved useful in the reviewing of a number of studies. However, Smith et al. (2009) advised caution with easy-to-use checklists such as the CASP as 'assessment procedures become simplistic and prescriptive and that the more subtle features of qualitative work get missed out' (p179). The authors promoted Elliott et al.'s (1999) and Yardley's (2000; 2008) approaches for assessing quality of qualitative research as they present more general guidelines that are more 'sophisticated' and 'pluralistic'. Tracy's (2010) quality framework, also considered here to be comprehensive and sophisticated and an improvement on the CASP, was outlined and used to inform the current projects design and ensure its credibility. The critical review of the studies included in the systematic review then, could potentially have been improved if Tracy, Elliot, or

Yardley's frameworks were employed as opposed to the CASP. Furthermore, the critical review could have been improved if a second rater reviewed a sample of the studies according to CASP criteria to check for inter-rater reliability.

4.7 IMPLICATIONS FOR FUTURE RESEARCH

The study demonstrated the benefit of research that carefully considered the social and cultural contexts in which coping and adaptation occurred for a marginalised population. There is scope, and indeed a need (Harrop et al., 2006), for further resilience research with other marginalised groups, so long as a cultural sensitivity is maintained in order to respect and meaningfully interpret processes associated with resilience.

The study's findings have relevance for clinical practice and service provision, however results need to be interpreted with caution due to the small sample size of homeless men recruited from one hostel. In addition, psychological constructs have been markedly under-researched within the homeless population. Further investigation is warranted then, to determine whether results are unique to the sample or in accord with other samples of homeless people. The study can be replicated with homeless people from different hostels, with those who sleep rough, and with women who are homeless, to see whether there is evidence for similar processes that enhance and detract from a sense of manageability.

Self-efficacy seemed to have a central role in accounts of manageability, yet this process is markedly under-researched within the homeless population. Further exploration of self-efficacy in general then is recommended.

The study theorised that participants' relationships influenced self-efficacy and self-esteem processes. Correlational research, undertaken with a larger and more diverse sample of people who are homeless, could examine the relationships between the processes identified here with an array of outcome measures, including quality/quantity of support network. This could yield a predictive and contextualised model of psychological mechanisms relevant to resilience. However, longitudinal research has potential to more clearly identify the processes associated with resilience as people transition out of homelessness or relapse into street homelessness.

4.8 CONCLUSION

An emerging body of research has examined the resilience of people who are homeless. However, very few studies have explicitly explored psychological processes that underpin resilience within homeless populations, or other populations for that matter (Harrop et al., 2006). The study aimed to begin to fill this gap in the literature and asked, *what is the psychological process by which a homeless person maintains a sense of manageability?* An array of processes were identified within all participant accounts, which both detracted from and enhanced people's sense of coping and well-being. Interestingly, many participants revealed that they had developed skills and beliefs that enabled a sense of manageability whilst homeless. Positive beliefs, and self-efficacy and self-esteem processes in particular, seemed to have most influence. These were often linked to examples of actions that protected participants' well-being in the present, and actions that supported a future transition out of homelessness. There was evidence to suggest that these processes were closely associated with participants' relationship experiences. Relationships seemed to foster positive psychological processes, and certain processes enabled people to initiate and sustain relationships. Although a number of resilience frameworks were used to make sense of the findings, the core components of Rutter's (1985; 2013) conceptualization of resilience in particular is supported. Intervention strategies were discussed in relation to the findings, but primarily, services are encouraged to promote supportive relationships for homeless people, as these can foster self-efficacy and self-esteem processes, hypothesised here to be central to resilience, and encourage social inclusion.

REFERENCES

Adlaf, E.M., Zdanowicz, Y.M., & Smart, R.G. (1996). Alcohol and other drug use among street-involved youth in Toronto. *Addiction Research & Theory*, *4*(1), 11-24.

Andersen, S.M., & Chen, S. (2002). The relational self: an interpersonal social–cognitive theory. *Psychological Review*, *109*(4), 619-645.

Anderson, I., & Christian, J. (2003). Causes of homelessness in the UK: a dynamic analysis. *Journal of Community and Applied Social Psychology*, *13*(2), 105-118.

Antonovsky, A. (1987). *Unravelling the Mystery of Health - How People Manage Stress and Stay Well*. San Francisco: Jossey-Bass Publishers.

Ashworth, P. (2008). Conceptual foundations of qualitative psychology. In Smith (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*, London: Sage, 4-25.

Backer, T.E., & Howard, E.A. (2007). Cognitive impairments and the prevention of homelessness: research and practice review. *The Journal of Primary Prevention*, *28*(3-4), 375-388.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215.

Bandura, A. (1986). *Social foundations of thought and action*: a *social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A., Pastorelli, C., Barbaranelli, C., & Caprara, G.V. (1999). Self-efficacy pathways to childhood depression. *Journal of Personality and Social Psychology*, *76*(2), 258-269.

Banyard, V.L., & Graham-Bermann, S.A. (1995). Building an empowerment policy paradigm: self-reported strengths of homeless mothers. *American Journal of Orthopsychiatry*, *65*(4), 479-491.

Beck, A.T. (1974). The development of depression: a cognitive model. In Friedman, Raymond J. & Katz, Martin M. (Eds), *the Psychology of Depression: Contemporary Theory and Research*. Oxford: John Wiley & Sons.

Beck, A.T., Kovacs, M., & Weissman, A. (1975). Hopelessness and suicidal behavior: An overview. *Jama*, *234*(11), 1146-1149.

Bender, K., Thompson, S.J., McManus, H., Lantry, J., & Flynn, P.M. (2007). Capacity for survival: exploring strengths of homeless street youth. *Child and Youth Care Forum, 36*(1) 25-42.

Bevan, P. (1999). *Rough Sleeping in Wales*. Welsh Assembly Government.

Block, J.H., & Block, J. (1980). The role of ego-control and ego resiliency in the organization of behavior. In W.A. Collins (Ed.), *Minnesota Symposium on Child Psychology*, Hillsdale, NJ: Erlbaum, 39-101.

Bloor, M. (2001). Techniques of validation in qualitative research: a critical commentary. In R.M. Emerson (Ed.), *Contemporary Field Research,* Prospect Heights, IL: Waveland Press, 383-396.

Bochner, A. (2000). Criteria against ourselves. *Qualitative Inquiry, 6*, 266-272.

Bodin, P., & Wiman, B. (2004). Resilience and other stability concepts in ecology: Notes on their origin, validity, and usefulness. *ESS Bulletin, 2*, 33–43.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events?. *American Psychologist*, *59*(1), 20-28.

Bonanno, G.A. (2005). Clarifying and extending the construct of adult resilience. *American Psychologist, 60*(3), 265-267.

Borrego, M., Douglas, E.P., & Amelink, C.T. (2009). Quantitative, qualitative, and mixed research methods in engineering education. *Journal of Engineering Education, 98(1)*, 53-66.

Bowlby, J. (1978). Attachment theory and its therapeutic implications. *Adolescent Psychiatry, 6*, 5-33.

Boydell, K.M., Goering, P., & Morrell-Bellai, T.L. (2000). Narratives of identity: re-presentation of self in people who are homeless. *Qualitative Health Research*, *10*(1), 26-38.

Bretherton, I., & Munholland, K.A. (1999). Internal working models in attachment relationships: a construct revisited. In Cassidy, J. and Shaver, P.R. (Ed), *Handbook of Attachment: Theory, Research, and Clinical Applications,* New York: Guilford Press. 89-111.

Brissette, I., Scheier, M.F., & Carver, C.S. (2002). The role of optimism in social network development, coping, and psychological adjustment during a life transition. *Journal of Personality and Social Psychology*, *82*(1), 102-111.

Brush, B.L., Kirk, K., Gultekin, L., & Baiardi, J.M. (2011). Overcoming: a concept analysis. In *Nursing Forum, 46*(3), 160-168.

Burra, T.A., Stergiopoulos, V., & Rourke, S.B. (2009). A systematic review of cognitive deficits in homeless adults: implications for service delivery. *Canadian Journal of Psychiatry*, *54*(2), 123-133.

Burt M.R., Aron L.Y., Lee E., & Valente J. (2001). *Helping America's homeless: emergency shelter or affordable housing?* Washington, DC: Urban Inst. Press.

Calhoun, L.G., & Tedeschi, R.G. (1999). *Facilitating posttraumatic growth: A clinician's guide.* Mahwah, NJ: Erlbaum.

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R. *et al.* (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15,* 43-180

Carnelley, K.B., Pietromonaco, P.R., & Jaffe, K. (1994). Depression, working models of others, and relationship functioning. *Journal of Personality and Social Psychology*, *66*(1), 127-140.

Carver, C.S. (1998). Resilience and thriving: issues, models, and linkages. *Journal of Social Issues*, *54*(2), 245-266.

Chamberlain, C., & Johnson, G. (2013). Pathways into adult homelessness. *Journal of Sociology*, *49*(1), 60-77.

Charmaz, K. (2005). Grounded theory in the 21st century: applications for advancing social justice studies. In N.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed), Thousand Oaks, CA: Sage, 507-535.

Chenail, R.J. (2011). Learning to appraise the quality of qualitative research articles: a contextualised learning object for constructing knowledge. The *Qualitative Report, 16*(1), 236-248.

Clark, L.A., & Watson, D. (1991). Tripartite model of anxiety and depression: psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, *100*(3), 316-336.

Coates, J., & McKenzie-Mohr, S. (2010). Out of the frying pan, into the fire: trauma in the lives of homeless youth prior to and during homelessness. *Journal of Sociology & Social Welfare*, *37*, 65-96.

Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: The Connor-Davidson resilience scale (CD-RISC). *Depression and Anxiety*, *18*(2), 76-82.

Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work, 39*, 262–268.

Crane M., & Warnes, A.M. (2001). Single Homeless People in London: Profiles of Service Users and Perceptions of Needs. Report for Bondway, St Mungo's and Thames Reach. Sheffield Institute for Studies on Ageing, Sheffield.
http://www.shef.ac.uk/polopoly_fs/1.90720!/file/bsmtrpg2.pdf.
Retrieved: 01/12/13.

Credland S. & Lewis H. (2004). *Sick and Tired: The Impact of Temporary Accommodation on the Health of Homeless Families.* London: Shelter the Housing and Homeless Charity.

Crisis. (2003). *How many? How much? Single homelessness and the question of number and cost*.
www.crisis.org.uk/downloads.php/121/HowManyHowMuch_full.pdf
Retrieved: 13/9/2013.

Crisis. (2011). *Homelessness: A silent killer. A research briefing of suicide amongst homeless people.*
www.crisis.org.uk/data/.../Homelessness%20-%20a%20silent%20killer.pdf.
Retrieved: 13/9/2013.

Crisp, R.J. & Turner, R.N. (2010). *Essential Social Psychology*. London: Sage Publications.

De Shazer, S. (1985). *Keys to Solution in Brief Therapy.* New York: WW Norton, 3-17.

Department for Communities and Local Government. (2013a). *Rough sleeping statistics England: autumn 2012.*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/73200/Rough_Sleeping_Statistics_England_-_Autumn_2012.pdf.
Retrieved: 04/11/2013.

Department for Communities and Local Government. (2013b). *Statutory homelessness: January to March 2013 and 2012 to 2013 England.*
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/205221/Statutory_Homelessness_Q1_2013_and_2012-13.pdf.
Retrieved: 04/11/2013.

Department of Health. (1999). *Saving Lives: Our Healthier Nation.* London: HMSO.

DeWalt, D.A., Davis, T.C., Wallace, A.S., Seligman, H.K., Bryant-Shilliday, B., Arnold, C.L., *et al* (2009). Goal setting in diabetes self-management: taking the baby steps to success. *Patient Education and Counselling*, 77, 218-223.

D'Imperio, R.L., Dubow, E.F., & Ippolito, M.F. (2000). Resilient and stress-affected adolescents in an urban setting. *Journal of Clinical Child Psychology*, *29*(1), 129-142.

Dixon-Woods, M., Sutton, A., Shaw, R., Miller, T., Smith, J., Young, B., *et al.* (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Service Research and Policy, 12,* 42-47.

Duggleby, W., Cooper, D., & Penz, K. (2009). Hope, self-efficacy, spiritual well-being and job satisfaction. *Journal of Advanced Nursing*, *65*(11), 2376-2385.

Dunleavy, A., Kennedy, L.A., & Vaandrager, L. (2012). Wellbeing for homeless people: a Salutogenic approach. *Health Promotion International*, 1-11.

Elliot, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-219.

Epel, E.S., Bandura, A., & Zimbardo, P.G. (1999). Escaping homelessness: The influences of self-efficacy and time perspective on coping with homelessness. *Journal of Applied Social Psychology*, *29*(3), 575-596.

Evans, R.D., & Forsyth, C.J. (2004). Risk factors, endurance of victimization, and survival strategies: the impact of the structural location of men and women on their experiences within homeless milieus. *Sociological Spectrum*, *24*(4), 479-505.

Festinger, L. (1954). A theory of social comparison processes. *Human Relations, 7*(2), 117-140.

Finfgeld-Connett, D. (2010). Becoming homeless, being homeless, and resolving homelessness among women. *Issues in Mental Health Nursing*, *31*(7), 461-469.

Fitzpatrick K.M., Irwin J., La Gory, M., & Ritchey F. (2007). Just thinking about it: social capital and suicide ideation among homeless persons. *Journal of Health Psychology*, *12*, 750–60.

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European Psychologist*, *18*(1), 12-23.

Fraser, M.W., & Galinsky, M.J. (1997). Toward a resilience-based model of practice. In M.W. Fraser (Ed.), *Risk and Resilience in Childhood: An Ecological Perspective,* Washington, DC: NASW Press, 265-276.

Garmezy, N. (1993). Children in poverty: resilience despite risk. *Psychiatry*, *56*(1), 127-130.

Geertz, C. (1973). *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.

Gilgun, J.F. (1999). Mapping resilience as process among adults with childhood adversities. In Mccubbin, H.I., Thompson, E.A., Thompson, A.I. & Futrell, J.A. (Eds.), *the Dynamics of Resilient Families*. Thousand Oaks, CA: Sage, 41-70.

Gonzalez, A., & Zimbardo, P. G. (1985). Time in perspective. *Psychology Today*, *19*(3), 21-26.

Goodman, L.A., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: broadening perspectives. *American psychologist*, *46*(11), 1219-1225.

Gould, M. (2005). Charity for homeless launches GP service for hostel residents. *British Medical Journal*, *331*(7527), 1226.

Grenier, P. (1996). *Still Dying For a Home*. Crisis, London.

Gruder, C.L. (1971). Determinants of social comparison choices. *Journal of Experimental Social Psychology, 7*(5), 473-489.

Guarnaccia, V., & Henderson, J.J. (1993). Self-efficacy, interpersonal competence, and social desirability in homeless people. *Journal of Community Psychology, 21*(4), 335-338.

Harrop, E., Addis, S., Elliott, E., & Williams, G. (2006). *Resilience, coping and salutogenic approaches to maintaining and generating health: a review*. Cardiff: Cardiff University.

Hartling, L.M. (2008). Strengthening resilience in a risky world: It's all about relationships. *Women & Therapy*, *31*(2-4), 51-70.

Harvey, J., & Delfabbro, P.H. (2004). Psychological resilience in disadvantaged youth: a critical overview. *Australian Psychologist*, *39*(1), 3-13.

Heidegger, M. (1927/1962). Being and Time. Oxford: Blackwell.

Heimpel, S.A., Wood, J.V., Marshall, M.A., & Brown, J.D. (2002). Do people with low self-esteem really want to feel better? Self-esteem differences in motivation to repair negative moods. *Journal of Personality and Social Psychology*, *82*(1), 128-147.

Holt, N., Christian, J., & Larkin, M. (2012). Maintaining connectedness: exploring the experiences of older homeless men living in hostel accommodation. *Journal of Community & Applied Social Psychology*, *22*(6), 485-501.

Homeless Link. (2011). The health and wellbeing of people who are homeless: evidence from a national audit. London.
http://homeless.org.uk/sites/default/files/SECTION_2_Understanding_mental_health_wellbeing_and_homelessness%20pdf.pdf Accessed
Retrieved: 01/02/2014.

Hudson, A.L., Nyamathi, A., Greengold, B., Slagle, A., Koniak-Griffin, D., Khalilifard, F., *et al*. (2010). Health-seeking challenges among homeless youth. *Nursing Research*, *59*(3), 212-218.

Hughes, D.A. (2007). *Attachment-Focused Family Therapy*. WW Norton & Company.

Hutz C. & Koller S. (1999) Methodological and ethical issues in research with street children. New Directions for Child and Adolescent Development 85, 59–70.

Hwang, S.W. (2001). Homelessness and Health. *Canadian Medical Association Journal*, *164*(2), 229-233.

Israel, N., & Jozefowicz-Simbeni, D.M.H. (2009). Perceived strengths of urban girls and boys experiencing homelessness. *Journal of Community & Applied Social Psychology*, *19*(2), 156-164.

Jackman, L. (2013). When, how and why does indirect formulation work? Proposing a 'shared formulation' framework. *Clinical Psychology Forum, 245*, 25-31

Janoff-Bulman, R. (1992). *Shattered assumptions*. New York: Free Press.

Jarrot, C. (2010). Helping the homeless. The Psychologist, 23(4), 284-287.

Jones, F., & Riazi, A. (2011). Self-efficacy and self-management after stroke: a systematic review. *Disability and Rehabilitation*, *33*(10), 797-810.

Kaplan, H.B.(1999). Toward an understanding of resilience: Ac ritical review of definitions and models. In. Glantz, J. & Johnson, J.L (Eds.). Resilience and development: Positive life adaptations. New York: Kluwer Academic/Plenum, 17-84.

Kidd, S.A. (2003). Street youth: coping and interventions. *Child and Adolescent Social Work Journal*, *20*(4), 235-261.

Kidd, S.A., & Carroll, M.R. (2007). Coping and suicidality among homeless youth. *Journal of Adolescence, 30*(2), 283-296.

Kidd, S. A., & Davidson, L. (2007). "You have to adapt because you have no other choice": The stories of strength and resilience of 208 homeless youth in New York City and Toronto. *Journal of Community Psychology*, *35*(2), 219-238.

Kidd, S., & Shahar, G. (2008). Resilience in Homeless Youth: The Key Role of Self-Esteem. *American Journal of Orthopsychiatry*, *78*(2), 163-172.

Kirst M, Zerger S, Wise Harris D, et al. (2014). The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada. *BMJ Open, (4)*: e004379. doi:10.1136/ bmjopen-2013-004379, 1-9

Klee, H. & Reid, P. (1998). Drug use among the young homeless: coping through self-medication. *Health, 2*(2), 115-134.

Klitzing, S.W. (2004). Women living in a homeless shelter: stress, coping and leisure. *Journal of Leisure Research*, *36*(4), 483-512.

Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: a 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry*, *1*(42), 559-563.

Krizek, R.L. (2003). Ethnography as the excavation of personal narrative. In R.P. Clair (Ed.), *Expressions Of Ethnography: Novel Approaches To Qualitative Methods,* New York: State University of New York, 141-151.

Lafuente, C.R., & Lane, P.L. (1995). The lived experiences of homeless men. *Journal of Community Health Nursing*, *12*(4), 211-219.

Law, M., Stewart, D., Letts, L., Pollock, N., Bosch, J. & Westmorland, M. (1998). Guidelines for Critical Review of Qualitative Studies.
http://fhs.mcmaster.ca/rehab/ebp/pdf/qualguidelines.pdf
Retrieved: 20/01/2012.

Lazarus, R.S., & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality*, *1*(3), 141-169.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.

Lee, B.A., Tyler, K.A., & Wright, J.D. (2010). The New Homelessness Revisited. *Annual Review of Sociology*, *36*, 501-521.

Lindlof, T.R., & Taylor, BC. (2002). Qualitative communication research methods (2nd ed.). Thousand Oaks, CA: Sage.

Linley, P.A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17,* 11–21.

Linley, P.A., Nielsen, K.M., Gillett, R., & Biswas-Diener, R. (2010). Using signature strengths in pursuit of goals: Effects on goal progress, need satisfaction, and well-being, and implications for coaching psychologists. *International Coaching Psychology Review*, *5*(1), 6-15.

Locke, E.A. (1968). Toward a theory of task motivation and incentives. *Organizational Behavior & Human Performance, 3,* 157-189.

Locke, E.A., & Latham, G.P. (2002). Building a practically useful theory of goal setting and task motivation: a 35-year odyssey. *American Psychologist, 57*(9), 705-717.

Loseke, D.R. (2003). The homeless mentally-ill and involuntary hospitalization. In Loseke, D.R., & Best, J. (Eds.) *Social Problems: Constructionist Readings*. Transaction Books, 146.

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child development*, *71*(3), 543-562.

MacKnee, C.M., & Mervyn, J. (2002). Critical incidents that facilitate homeless people's transition off the streets. *Journal of Social Distress and the Homeless*, *11*(4), 293-306.

Magaletta, P.R., & Oliver, J.M. (1999). The hope construct, will, and ways: their relations with self-efficacy, optimism, and general well-being. *Journal of Clinical Psychology*, *55*(5), 539-551.

Maguire, N. (2006). Cognitive behavioural therapy and homelessness: a case series pilot study. *Behavioural and Cognitive Psychotherapy*, *34*(1), 107-111.

Maguire, N. (2011). Tackling homelessness requires a more psychological focus. http://www.theguardian.com/society/joepublic/2011/dec/20/homelessness-psychological-focus#start-of-comments
Retrieved: 20.05.2014.

Maguire, N., Grellier, B., & Clayton, K. (2012). The impact of CBT training and supervision on burnout, confidence and negative beliefs in a staff group working with homeless people. *Housing, Care and Support.*

Major, C. & Savin-Baden, M. (2010). *An Introduction to Qualitative Research Synthesis: Managing the information Explosion in Social Science Research.* Routledge.

Mancini, M.A. (2007). The role of self–efficacy in recovery from serious psychiatric disabilities: a qualitative study with fifteen psychiatric survivors. *Qualitative Social Work*, *6*(1), 49-74.

Martins, D.C. (2008). Experiences of homeless people in the health care delivery system: a descriptive phenomenological study. *Public Health Nursing*, *25*(5), 420-430.

Maslow, A.H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370.

Masten, A.S. (2001). Ordinary magic: resilience processes in development. *American Psychologist*, *56*(3), 227-238.

Masten, A.S., Best, K.M., & Garmezy, N. (1990). Resilience and development: contributions from the study of children who overcome adversity. *Development and Psychopathology*, *2*(4), 425-444.

Mays, N. & Pope, C. (1995). Qualitative research: rigour and qualitative research. *British Medical Journal, 311,* 109-112.

McCollum, E.E., & Trepper, T.S. (2001). *Family Solutions for Substance Abuse: Clinical and Counselling Approaches*. New York: Haworth Clinical Practice Press.

McCormack, D., & Gooding, B.A. (1993). Homeless persons communicate their meaning of health. *The Canadian Journal of Nursing Research*, *25*(1), 33-50.

McCormack, D., & MacIntosh, J. (2001). Research with homeless people uncovers a model of health. *Western Journal of Nursing Research*, *23*(7), 679-697.

Medalia, A., & Revheim, N. (2002). *Dealing with Cognitive Dysfunction Associated with Psychiatric Disabilities: A Handbook for Families and Friends of Individuals with Psychiatric Disorders*. Albany, NY: New York State Office of Mental Health.

Miller, J.B. (1986). *Toward a New Psychology of Women (2nd Ed.).* Boston: Beacon Press.

Morse J.M. (2000). Researching illness and injury: methodological considerations. Qualitative Health Research 10, 538–546.

Moyle W. (2002). Unstructured interviews: challenges when participants have a major depressive illness. Journal of Advanced Nursing 39, 266–273.

North, C., & Smith, E. (1992). Post-Traumatic Stress Disorder among homeless men and women. *Hospital and Community Psychiatry, 43,* 1010-1016.

O'Connell, J.J. (2005). *Premature Mortality in Homeless Populations: A Review of the Literature.* Nashville, TN: Natl. Health Care Homeless Council. http://santabarbarastreetmedicine.org/wordpress/wp-content/uploads/2011/04/PrematureMortalityFinal.pdf. Retrieved: 04.11.2013.

Park, B., & Rothberg, M. (1982). Perception of out-group homogeneity and levels of social categorization: memory for the subordinate attributes of in-group and out-group members. *Journal of Personality and Social Psychology*, *42*(6), 1051-1068.

Parsell, C. & Parsell, M. (2012). Homelessness as a choice. *Housing, Theory and Society*, *29*(4), 420-434.

Parsell, C. (2011). Responding to people sleeping rough: dilemmas and opportunities for social work. *Australian Social Work*, *64*(3), 330-345.

Partis, M. (2003). Hope in homeless people: a phenomenological study. *Primary Health Care Research and Development*, *4*(01), 9-19.

Pascale, C.M. (2005). There's no place like home: the discursive creation of homelessness. *Cultural Studies – Critical Methodologies, 5*, 250-68.

Patterson, A., & Tweed, R. (2009). Escaping homelessness: anticipated and perceived facilitators. *Journal of Community Psychology*, *37*(7), 846-858.

Pritchard, J.W., & Puzey, J.W. (2003). Homelessness--on the health agenda in Wales?. *Reviews on environmental health*, *19*(3-4), 363-379.

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy: toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, *19*(3), 276-288.

Quinlan, D., Swain, N., & Vella-Brodrick, D.A. (2012). Character strengths interventions: Building on what we know for improved outcomes. *Journal of Happiness Studies, 13(*6), 1145-1163.

Rapp, C.A. (1998). *The strengths model: case management with people suffering from severe and persistent mental illness*. Oxford: Oxford University Press.

Rayburn, N.R., Wenzel, Elliott, M.N., Hambaarssomians, J.R., Marshall, G.N. & Tucker, J.S. (2005). Trauma, depression, coping and mental health service seeking among impoverished women*. Journal of Consulting and Clinical Psychology, 73*, 667–677.

Rees, S. (2009). Mental ill-health in the adult single homeless population: a review of the literature. Crisis.
http://www.crisis.org.uk/data/files/publications/Mental%20health%20literature%20review.pdf
.
Retrieved: 10/02/2014.

Reeve, K. (2011). The hidden truth about homelessness. *Crisis, CRESR, 4*, *34*.

Resnick, S.G., Fontana, A., Lehman, A.F., & Rosenheck, R.A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia Research*, *75*(1), 119-128.

Rew, L. (2000). Friends and pets as companions: strategies for coping with loneliness among homeless youth. *Journal of Child and Adolescent Psychiatric Nursing*, *13*(3), 125-132.

Rew, L. (2003). A theory of taking care of oneself grounded in experiences of homeless youth. *Nursing Research, 52*(4), 234-241.

Rew, L., Chambers, K.B., & Kulkarni, S. (2002). Planning a sexual health promotion intervention with homeless adolescents*. Nursing Research, 51*, 168-174.

Richardson, L. (2000). Evaluating ethnography. *Qualitative Inquiry, 6*, 253-256.

Ridgway, P. (2001) Restorying psychiatric disability: learning from first person narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335-343.

Roberts, J.E., Gotlib, I.H., & Kassel, J.D. (1996). Adult attachment security and symptoms of depression: The mediating roles of dysfunctional attitudes and low self-esteem. *Journal of personality and social psychology*, *70*(2), 310.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95-103.

Rollnick, S., & Miller, W.R. (1995). What is motivational interviewing?. *Behavioural and Cognitive Psychotherapy*, *23*(04), 325-334.

Rossi, P.H. (1989). *Down and Out in America: The Origins of Homelessness*. Chicago: University of Chicago Press.

Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs: General and Applied*, *80*, 1-28.

Rowe M. (1999). Crossing the border: Encounters between homeless people and outreach workers. Berkeley: University of California Press.

Rubenstein, E. (1992). Homelessness and values: A stopping point or way of life? *Vital Speeches of the Day, 58*(13), pp. 401–404.

Runquist, J.J., & Reed, P.G. (2007). Self-transcendence and well-being in homeless adults. *Journal of Holistic Nursing*, *25*(1), 5-13.

Rutter, M. (1985). Resilience in the face of adversity. *British journal of psychiatry*, *147*(1), 598-611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American journal of orthopsychiatry*, *57*(3), 316.

Rutter, M. (2013). Annual research review: resilience–clinical implications. *Journal of Child Psychology and Psychiatry*, *54*(4), 474-487.

Saleebey, D. (1996). The strengths perspective in social work practice: extensions and cautions. *Social Work*, *41*(3), 296-305.

Saltz, A., & Marsh, S. (1990). Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *American Journal of Psychiatry*, *147*(2), 190-195.

Sandelowski, M., Docherty, S., & Emden, C. (1997). Focus on qualitative methods Qualitative metasynthesis: issues and techniques. *Research in nursing and health*, *20*, 365-372.

Scheier, M.F., Carver, C.S., & Bridges, M.W. (2001). Optimism, pessimism, and psychological well-being. In E.C. Chang (ed.), *Optimism and Pessimism: Implications for Theory, Research, and Practice.* Washington, DC: American Psychological Association, 189-216.

Schrank, B., Bird, V., Rudnick, A., *et al*. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review. *Social Sciences and Medicine, 74*, 554–64.

Segerstrom, S.C. (2006). *Breaking Murphy's Law.* New York: The Guildford Press.

Seligman, M.E.P. (1990). *Learned Optimism.* New York: Simon & Schuster.

Seligman, M. E. (2002). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfilment*. Simon and Schuster.

Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: empirical validation of interventions. American psychologist, 60(5), 410.

Seligman, M.E.P., Reivich, K., Jaycox, L., and Gillham, J. (1995). *The Optimistic Child*. New York: Houghton Mifflin.

Shaw, M., Dorling, D., & Brimblecombe, N. (1999). Life chances in Britain by housing wealth and for the homeless and vulnerably housed. *Environment and Planning A*, *31*(12), 2239-2248.

Shelter. (2008). *Good Practice: Briefing. A Long Way from Home.* London: Shelter.

Smith, E.R., Mackie, D.M. (2007). *Social Psychology* (3rd Ed.). Hove: Psychology Press.

Smith, J.A. & Osborn, M. (2008). Interpretative Phenomenological Analysis. In Smith, J.A. (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage, 53-80.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, Research.* London: Sage.

Smokowski, P.R., Reynolds, A.J., & Bezruczko, N. (2000). Resilience and protective factors in adolescence: an autobiographical perspective from disadvantaged youth. *Journal of School Psychology*, *37*(4), 425-448.

Spence, S., (2004). Cognitive dysfunction in homeless adults: a systematic review. *Journal of the Royal Society of Medicine*, *97*, 375-379.

Spencer, L., Ritchie, J., Lewis, J. & Dillon, L. (2003). *Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence*. London: Cabinet Office

St Mungo's. (2009). Happiness matters: homeless people's views about breaking the link between homelessness and mental ill health.
www.mungos.org/documents/2013.
Retrieved: 20/02/2014.

Stanton, A. L., & Snider, P. R. (1993). Coping with a breast cancer diagnosis: A prospective study. Health Psychology, 12(1), 16.

Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: Mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect*, *26*(10), 1011-1027.

Strecher, V.J., DeVellis, B.M., Becker, M.H., & Rosenstock, I.M. (1986). The role of self-efficacy in achieving health behavior change. *Health Education & Behavior*, *13*(1), 73-92.

Suls, J., & Fletcher, B. (1985). The relative efficacy of avoidant and nonavoidant coping strategies: a meta-analysis. Health psychology, 4(3), 249.

Taylor, S.E., & Brown, J.D. (1988). Illusion and well-being: a social psychological perspective on mental health. *Psychological Bulletin, 103,* 193–210.

Tedeschi, R.G., & Calhoun, L.G. (1996). The posttraumatic growth inventory: measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455– 471.

Tedeschi, R.G., & Calhoun, L.G. (2004). Posttraumatic growth: conceptual foundations and empirical evidence. *Psychological Inquiry, 15,* 1–18.

Tedeschi, R.G., & Kilmer, R.P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice*, *36*(3), 230-237.

The Poverty Site. Homelessness statistics.
http://www.poverty.org.uk/81/index.shtml?2
Accessed on: 15/01/2013.

Thomas, Y., Gray, M.A. & McGinty, S. (2012). An exploration of subjective wellbeing among people experiencing homelessness: a strengths-based approach. *Social Work in Health Care, 51*, 780-797.

Thompson, S.J., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: Perceptions of services and providers by homeless young adults. *Evaluation and program planning*, *29*(1), 34-43.

Thompson, S.J., Ryan, T.N., Montgomery, A., Bender. K. & Ferguson, K. (2013). Perceptions of resiliency and coping: homeless young adults speak out. *Youth & Society, 20,* 1-18.

Tracy, S.J. (2010). Qualitative quality: eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851.

Tschann, J.M., Kaiser, P., Chesney, M.A., Alkon, A., & Boyce, W.T. (1996). Resilience and vulnerability among preschool children: family functioning, temperament, and behavior problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, *35*(2), 184-192.

Tweed, R.G., Biswas-Diener, R., & Lehman, D.R. (2012). Self-perceived strengths among people who are homeless. *The Journal of Positive Psychology*, *7*(6), 481-492.

UN Press (2005). *Briefing by special rapporteur on the right to adequate housing*. http://www.un.org/News/briefings/docs/2005/kotharibrf050511.doc.htm.

Retrieved: 04/11/2013.

Ungar, M. (2004). A constructionist discourse on resilience multiple contexts, multiple realities among at-risk children and youth. *Youth & Society, 35*(3), 341-365.

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38*(2), 218-235.

Ungar, M., & Liebenberg, L. (2011). Assessing resilience across cultures using mixed methods: Construction of the child and youth resilience measure*. Journal of Mixed Methods Research, 5*(2), 126-149.

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing, 50*(2), 204-211.

Ward, J. (1979). *The Street is their Home: The Hobos' Manifesto* (Melbourne: Quartet Books).

Warnes, A., Crane, M., Whitehead, N., & Fu, R. (2003) *Homelessness Factfile*. http://www.crisis.org.uk/data/files/publications/factfile_Full.pdf.
Retrieved: 04/11/2013

Wasserman, J.A., & Clair, J.M. (2010). *At home on the street: People, poverty, and a hidden culture of homelessness*. Lynne Rienner Publishers.

Welsh Assembly Government (2008). Statistical article: National Rough Sleeping Count, Wales, 2007 and 2008.
http://wales.gov.uk/statistics-and-research/national-rough-sleeping-count/?lang=en.
Retrieved: 01/11/2013.

Welsh Assembly Government (2012). *Code of Guidance for Local Authorities on the Allocation of Accommodation and Homelessness.*
http://wales.gov.uk/docs/desh/publications/120813allocateaccommodationen.pdf.
Retrieved: 01/11/2013.

Welsh Assembly Government (2013). First Release: Homelessness: January to March 2013.
http://wales.gov.uk/docs/statistics/2013/130626-homelessness-january-march-2013-en.pdf.
Retrieved: 01/11/2013.

Willig, C. (2008). Introducing Qualitative Research Methods in Psychology (2nd Ed.). Sage.

Windle, G. (2011). What is resilience? A review and concept analysis. *Reviews in Clinical Gerontology, 21*(2), 152-169.

Wood, J.V., Heimpel, S.A., & Michela, J.L. (2003). Savoring versus dampening: self-esteem differences in regulating positive affect. *Journal of Personality and Social Psychology*, *85*(3), 566.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215–228.

Yardley, L. (2008). *Demonstrating validity in qualitative psychology*. In J.A. Smith (Ed.) Qualitative psychology: A practical guide to methods (2nd edn, pp.235–251). London: Sage

Zufferey, C. (2008). Responses to homelessness in Australian cities: social worker perspectives. *Australian Social Work*, *61*(4), 357-371.

APPENDIX 1: CODING AND THEMATIC PROCEDURE FOR NARRATIVE REVIEW

		Bender et al., 2007	Dunleavy et al., 2012	Kidd, 2003	McCormack & Gooding, 1993	McCormack & MacIntosh, 2001	Rew, 2003	Thomas et al., 2012	Thompson et al., 2013
THEMES	Sustaining Supportive Relationships	YES (via learning (exp & observation;) awareness rel is protective)	YES (via empathy & esteem work)	YES (awareness; self-esteem)				YES (planning; awareness; self-esteem; sharing)	
	Planning & Organisation	YES	YES		YES (P.41)			YES	
	Self-Efficacy (Recognition Of Belief In Ability)	YES		YES	YES (P.40)	YES	YES		YES
	Awareness- Recognition Of Personal Strengths	YES		YES					YES
	Suggest That This Means They Capitalise On	YES							
	Attitude To Change/Motivation	YES (via role-models; linked with hope)			YES (Pg.39) Responsibility for health	YES (Resp2 maintain self-care)			YES (leads to engage w services)
	Relationship = Emotional Support & Practical - Resources	YES (pets & peers) YES	YES(peers& professionals & family)	YES (partners mentioned!)	YES		YES	YES	YES (all of it plus pets!)
	Mastery	YES (via pets)	YES (activities)					YES	
	Hope & Optimism	YES		YES				?YES? 'Positive attitudes'	YES
	Future Plans (Or Hopes)	YES							
	Spiritual Beliefs	YES		YES					YES
	Awareness Of Protective Factor (Thus Capitalise On)	YES (relationships)	YES (accommodation)	YES (friends, linked 2 drugs)	YES (services) P.41	YES (health promoting)	YES	YES (relationships)	YES (optimism, relationships)
	Self-Esteem		YES (explicitly mentioned)	YES	YES (Pg.40 top & bot)	YES	YES (action)	YES	YES

	Bender et al., 2007	Dunleavy et al., 2012	Kidd, 2003	McCormack & Gooding, 1993	McCormack & MacIntosh, 2001	Rew, 2003	Thomas et al., 2012	Thompson et al., 2013
Sense Of Agency/Independence		YES	YES	YES (P.40)	YES	YES	YES	YES
Awareness Of Vulnerability		YES (occupied; avoid users)		YES (P.41) avoid drugs		YES (& poor coping)	YES	
Hampers – Boredom, Isolation		YES						
Behavioural Strategies		YES	YES (including drugs)				YES	YES (including drugs)
Sense Of Meaning/Purpose		YES (comm participation)		YES (functional role)			YES (via relationships)	
Hamper – Basic Needs –Lack Of Safety, Health, Food, Etc.					YES (health)	YES (basic needs SR)	YES (dangers and threats of SR)	YES (physical violence)
Hamper – Cognitive Style							YES (present time focus for SR)	
Hamper – Stigma (and Social Exclusion)							YES (impact soc incl and Self-esteem)	
Cog Coping Strategies	YES (prob-solving)		YES				YES ('conscious adoption of positive attitudes)	YES (via awareness of optimism & others)
Hamper – Ongoing Difficult Relationships			YES					
Hamper - Services			YES		YES			
Basic Needs				YES				
Hamper - Over Self-Reliance						YES		

KEY

Positive Beliefs	Self-Awareness	Coping Strategies	Relationships	Sense Of Agency	Responsibility & Motivation	Planning & Organisation	Hampering Factors

APPENDIX 2: REFLECTIVE DIARY EXTRACTS

The following notes were hand-written in a journal. Here, extracts have been typed almost verbatim (some short-hand was originally used) for evidence of reflection processes. Unfortunately, dates of entries were not recorded.

---

1 Context: second visit to the homeless hostel:

Feel quite relaxed now unlike when very first came – good to chat to staff. Feeling comfortable in myself when interviewing will hopefully help rapport. The place is quieter than I thought it would be, are most people out or in their rooms? I wonder what a typical day entails [for a resident]. I wonder what it is like to work here? Note – mostly female staff. Interesting in an almost all-male home.

---

2 Context: reflection of first interview:

So glad first interview is out of the way. Seemed to go well but much shorter than thought it would be. This mean I didn't do it well enough?! He felt uncomfortable?

Really hard to strike balance between directing interview on my focus, and how much to listen when he appears to veer off into unrelated material.

Funny how I felt put-on-the-spot when he asked me a question and I totally mumbled. Is this how he felt? Attempt to share power and assert his authority? Self-esteem and achievement seemed real important for him. Interesting I can't remember reading about interviewer self-disclosure guidance, must have missed this?

[Listened back to audio recording to reflect more]

A lot of apparent steering away from subject actually sounded relevant! Incorporate this into my interest, 'okay, so how do you cope with this loss?

Kicking myself listening back – missing questions.

Was really interesting talking to X

---

3 Context: reflection on 4th interview:

Hard to hear 'I'm worthless' and in a therapeutic context, over-time, may explore that more, provide demonstration of understanding, validate yet possibly challenge with sensitivity, depending on psychological model employed. Whereas I thought to just listen and sit-with. The tension between accepting this and trying to draw out strengths that may be there – could be invalidating, like [X may think] 'so, you're not really listening are you'

… Power – interview – interviewing people seems even more one-sided than therapeutic encounters when initial session may be a bit like this – I ask the Q's, you provide the answers, whereas over time you know you will develop a more balanced and collaborative working relationship where the client can lead at times, put ideas forward, shape course of therapy…

---

4 Context: a reflection about half-way through analysis:

Just can't believe how long analysis is taking and worried it will delay everything. IPA guidance very very useful though…Accounts are so interesting, X had such a poor start, used by his dad and dependant on him, has since been a 'master-learner', soaking up knowledge and skills from friends and professionals to reach his agency-related goals. I get a sense others don't see X this way? Unique questions really unveil people's strengths? Sometimes strengths can be subtle compared to difficulties that seem to be striking and obvious to most?

…Interesting that the interpretative bit was difficult at first and I was real unsure about it, so much more confident now...

APPENDIX 3: TRANSCRIPT ANALYSIS

	I	Of course. Of course.	"*Oh, you know, this, that and the other" spoken w.enthusiasm…to relay confidence?*
Transitions as hard Empathy for others	R	Because I remember when I come here I was like frozen. I didn't know what to do. And so I'd hate for other people to feel like that, you know?	Entry was difficult. *Frozen – cold?emotionally?State of helplessness?* <u>Emphasises change and confidence/self-reliance.</u>
	I	Yeah.	
	R	Yeah. So it's good to help them in that way. Yeah.	Empathy for others based on own experience
	I	Do you feel like things are manageable?	
Sense of manageability Strive independence Motivation 4 change	R	Yeah. Yeah. I feel quite comfortable in here. It's just, you know, obviously I want to move on. With myself. And get a place and all that. And kick on from here. You know?	Sense of manageability and comfort *'Kick'- a short,sharp burst of action required to leave?Hard to leave? 'Quite'…*Planning ahead: acquire a home
	I	Oh, so that's something in your mind? That you're thinking, you know?	
Strive independence Motivation 4 change Responsibility 4 change	R	Yeah, yeah. I just – you know, and especially for my independence, like, you can't get more independent than living on your own, really. <u>You've got to sort it out for yourself</u>. So I just want to get started and then build from there.	Strive for independence/agency. Ultimate is living on own. Responsibility on self to move on…<u>to plan and act?</u> Desire for change
	I	Yeah. Sure.	
	R	You know?	<u>Has had hand held in past?</u>
Independence import to manage Preparing for future Balance of I v. D	I	That kind of independence and-? Why is that so important to you?	*Need it* Independence essential to look after self as others can't help all the time
	R	Because you need it. You'll never have someone there to hold your hand all the time. You know? And you've got to be on your own at times. And, you know, it's a necessity, like. I suppose you've got to have – you know, obviously not so much, but you've got to have enough to keep you going.	*'Hold hand' as a mother would to a child…to be an adult is to be free of this need?* Balance. Too much, too little a bad thing. <u>Thus receiving some support a necessity?</u>
	I	Sure.	Must be able to cope on own in case socially isolated.

Preparing for future	R Just in case, you know, there's no one there to help you.	Prepare for worse? Worried that no-one might be there?

APPENDIX 4: ETHICAL APPROVAL

-----Original Message-----
> From: psychethics [mailto:psychethics@Cardiff.ac.uk]
> Sent: 04 October 2013 13:14
> To: Kieron Hegarty (Cardiff and Vale UHB - Psychology Training)
> Cc: Jenny Moses (Cardiff and Vale UHB - Psychology)
> Subject: Ethics Feedback - EC.13.09.10.3506R
>
> Dear Kieron,
>
> The Chair of the Ethics Committee has considered your revised postgraduate project proposal:
> Homeless people's narratives of strengths, coping and resilience (EC.13.09.10.3506R).
>
> The project has now been approved.
>
> Please note that if any further changes are made to the above project then you must notify the Ethics Committee.
>
> Best wishes,
>
> Natalie
>
> School of Psychology Research Ethics Committee Tower Building Park Place CARDIFF
> CF10 3AT
>
> Ffôn /Telephone: +44 (0) 29 2087 0360
> Ffacs/Fax: +44 (0) 29 2087 4858
>
> http://psych.cf.ac.uk/aboutus/ethics.html
>
> Follow us on Twitter -
> https://twitter.com/PsychCardiff
>
> Confidentiality
>
> This message is strictly confidential and intended for the person or organisation
> to whom it is addressed. If you are not the intended recipient of the message then please notify the sender
> immediately. Any of the statements or comments made above should be regarded as personal and not necessarily those of Cardiff & Vale University Health Board, any constituent part or connected body.
>
> Email communication is subject to monitoring; for further information
http://www.wales.nhs.uk/sitesplus/864/page/50329

APPENDIX 5: PARTICIPANT INFORMATION SHEET

NHS WALES GIG CYMRU

School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Cardiff University
Tower Building
Park Place
Cardiff CF10 3AT
Wales UK
www.cardiff.ac.uk/psych
Prifysgol Caerdydd
Adeilad y Tŵr
Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig

Information Sheet: Homelessness Study
Hi, my name is Kieron and I am a trainee clinical psychologist based at Cardiff University.

Please read this to help you decide whether you would like to take part in a study by being interviewed. If you like, a member of staff can read this sheet through with you. I**f you would like to be interviewed you can let [redacted] member of staff know who can contact me, or you can contact me directly.**

What is this study about?

I am interested in men's experiences of homelessness, and how people get by from day to day and cope.

Do I have to take part?

No, you do not have to take part. It is completely up to you. If you decide to take part, you can still change your mind at any time and withdraw from the interview and study without having to give a reason.

What happens if I do not take part?

Nothing will happen if you decide not to take part, or if you withdraw from the study. You will not lose the support of any services, including services that you may be accessing [redacted]

What is involved if I do take part?

You and I will arrange a time to discuss your experiences of homelessness. This will take place in a room at the [redacted]. We might talk for around an hour, but we can talk for less time.

With your permission, I will record our conversation so I can type it up.

Confidentiality and anonymity

All information which is collected about you during the course of the study will be kept strictly confidential. This means that in the write-up of the study, your name and any information that could be used to identify you will be removed or changed.

Information about you, including the recording and transcription, will be kept in a safe and secure place and destroyed upon completion of the study.

It is possible that members of staff will know that you are being interviewed. Staff have agreed not to inform anyone outside of the staff team of your choice to be interviewed. They have also agreed not to approach you to discuss the interview conversation.

The only circumstance in which we may pass on your details to another professional would be if you either tell us that you are planning on harming yourself or somebody else, or if you give us serious reason to believe that you intend to commit a crime. If this happens, we will talk to you first before talking to anyone else and hopefully together we can decide on a course of action.

Are there any disadvantages to taking part?

We do not think that there are any disadvantages to taking part in this study. However, some of your experiences of sleeping rough might have caused you distress and be upsetting to talk about. It is up to you whether you talk about upsetting experiences. If you do find the interview unpleasant, you can let me know and I will be in touch with someone who will be able to help you.

Are there any benefits to taking part?

We hope that you will find the conversation interesting and even useful, as you will be encouraged to think about your unique strengths and how you have coped with being homeless.

What will happen to the results of the research study?

The study will be written up as a dissertation project and submitted to Cardiff University as part of a doctorate in clinical psychology.

A summary of the project and its findings will be provided [redacted]. You will be able to read this even if you decide not to take part.

It is possible that the study and its results may be published in an academic journal or presented at an academic conference. It would be impossible to identify you personally as all recorded and presented data will be completely edited to ensure this.

What if there is a problem?

If you experience a problem or have concerns related to the study please do not hesitate to contact me, or [redacted]

If you want to make a formal complaint, you can contact the School of Psychology Ethics Committee, Natalie Moran +44 (0) 029 208 70360; psychethics@cardiff.ac.uk.

I appreciate you taking the time to read this letter.

Contacts If you have any questions about this letter please contact me:

Kieron Hegarty, Trainee Clinical Psychologist

Telephone: 029 208 70582 (please leave a message for me how to contact you)

E-mail: Kieron.Hegarty@Wales.nhs.uk.

Or, you can speak to my clinical supervisor, [redacted] who is a clinical psychologist who works at [redacted] on: [redacted] or e-mail [redacted]

Thanks,

Kieron Hegarty

Trainee clinical psychologist

APPENDIX 6: CONSENT FORM

Consent Form

Please read the following statements and **if you are in agreement** with them tick the box at the end of the page:

- I confirm that I have read and understood the information sheet, and I have had the opportunity to ask questions.

- I understand that my participation in the interview and study is voluntary.

- I understand that I can refuse to answer any question I am asked. I know that I can withdraw from the interview and study at any time without having to give a reason.

- I agree for the interview to be recorded and then typed-up. I understand that the recording will be kept in a safe place and destroyed when the study is finished.

- I understand that when the interview is typed-up, any information I provide that can be used to identify me, for example, my name, will be changed so that I cannot be identified.

- I understand that the recording of the interview and the typed-up transcript will remain secure and confidential. A relevant professional will only be told about me if in the interview I say that I am thinking or planning to harm myself or someone else.

- I give permission for parts of the interview to be included in the dissertation and in academic articles and conferences.

☐

I have read the statements above. I understand and agree with them

_____

APPENDIX 7: PERMISSION TO RECRUIT FROM THE RELEVANT ORGANISATION

From: [redacted]
Sent: 15 May 2013 14:37
To: Kieron Hegarty (Cardiff and Vale UHB - Psychology Training)
Subject:

Hi Kieron

[redacted] has asked me to e-mail you, to indicate to your assessors if we are okay about you interviewing clients at [redacted]. I am fine with this but just to insure confidentially is observed.

Regards [redacted]

Head of Adult Services [redacted]

[redacted]

APPENDIX 8: SEMI-STRUCTURED INTERVIEW SCHEDULE

Demographic: **Name:**

Age: Age when first became homeless:

Do you regard yourself as homeless now?

Current episode of homelessness duration:

Length of time [redacted]

Previous episodes of homelessness:

No. of days slept rough:

Known mental health difficulties/diagnoses:

Interview:

How are you coping at the moment (day-to-day)?

What helps you cope (*prompt: during times of stress*)?

How has this helped?

How did you discover this? (*prompt: organizations, individuals, services, other people in a similar situation)*

What have you learnt about your coping ability (*prompt: given stressful experiences*)?

What are some of the everyday difficulties you face?

How do you manage these difficulties?

Do you think that your situation is manageable? (if too abstract – are these difficulties avoidable? Are you getting on top of them? Can you deal with them? How?Etc)

What helps with this?

When you think about how you are managing your difficulties how do you feel?

Has anything bad happened to you when homeless? (If participant answers 'no', ask, *what has been the greatest struggle when homeless? And/or, how do you stop bad things from happening?*)

How did this affect you?

How do/did you cope/manage/respond?

What helped with this?

Can you think of a recent example when something went wrong or you faced a challenging experience? Were there things you said to yourself that helped?

Were there thoughts that kept you going?

Are there beliefs that you have that are helpful?

What do you hope will be different in a year's time?

How do you plan to achieve this? Make this happen? ? If yes, What are your hopes and plans for the future? If not? What would have to happen for you to be able to make a plan?

Why is it important to have these plans?

Has the experience of being homeless made you a stronger person?

What strengths would you say that you have needed to draw on?

How has this kept you going?

What would you say your strengths are? (If struggle to identify, can ask, *what wold other people say are your strengths*, or, *what have you done that has gone well when homeless*, or, *what have you done that you are proud of?*

End: What was it like to be interviewed?

APPENDIX 9: PILOT INTERVIEW EXCERPT

Pilot interview with 'Ken', aged 31-40 on 08/4/13

I –. I was wondering what you might say some of your strengths are?

K – Jeez, that's hard. [long pause] I think I am strong willed or minded, I dunno if that is a strength though.

I – Has that helped?

K – I think so. I had to believe I would get off the streets, whereas other people didn't seem to care.

I – So that hope kept you going?

K – yer, definitely, that I was gonna get out, that things would get better. That I would get my own place one day, and get work.

I – Have you always been like that?

K - I think so, although I'm sure sleeping rough made me more determined and hardened me up.

I – Yer, I can see how that would help.

K – Yer, you need goals. If you have no goals then you have nothing to strive for.

I – And what's keeping you off the streets? That's of course assuming that you don't want to return to the streets?

K – Oh, definitely not. I'm hoping for a place for myself, ya know, so I have my own key, even if it's a bedsit. I'm also hoping to start off my own painting and decorating company.

I – So your hopes and plans are keeping you off?

K – Yer, It'll take a few months to get my own place.

I – I guess the real big achievement too is coming off the drugs, that must help?

K – Yer, my head is a lot clearer.

Interview feedback from Ken:

I – what did you think of the questions? You can be honest.

K – They were alright. Yer, good.

I – do you think there is anything else I could ask?

K – like how people got homeless. You could ask ‘how did you become homeless?’ and they can tell their story.

I – that’s a really good point – let me write that down

K – And single out the strengths and then go for them!

K – You could also see the other end of the spectrum. Like people here have slept rough a bit sometimes, but at [redacted] [day centre] there will be people who are really struggling, ya know.