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Trauma and the art of healing: examining pathways of coping and healing for women experiencing poverty and homelessness

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BOSTON UNIVERSITY
SCHOOL OF MEDICINE

Thesis

**TRAUMA AND THE ART OF HEALING: EXAMINING PATHWAYS OF
COPING AND HEALING FOR WOMEN EXPERIENCING POVERTY AND
HOMELESSNESS**

by

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Submitted in partial fulfillment of the
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DEDICATION

This work is dedicated to my mother, Shari Saunders, whom I wish I had known better,
and my grandmother, Ellen Daniels, who knew me the best.

Two very different women who, combined, made me the person I am today.

ACKNOWLEDGMENTS

First and foremost, this work could not have been done without the generosity and vulnerability of my participants. There was absolutely no reason for any of them to trust me – a young(ish) masters student, whom they had only know for a very short period of time – with the weight of their stories, which matter so much. There is a huge risk in telling *anyone* your story for *any* reason, let alone being willing to tell it to someone who you know will publicly write about it later on. I will never stop being grateful that they gave me that chance, and it is the main goal and hope of this project that I earned that trust and did their stories at least some amount of justice.

In that spirit, I would like to especially give thanks to my first participant, “Laura,” who not only asked me about participating before the study was even approved (and then continued to remind me of her interest during the several weeks until it finally *was* approved), but also (unbeknownst to me at the time) advocated on my behalf following her participation. While I do not know this for certain, she could have been a main reason why my accrual picked up so quickly, as at least a couple of the women I later interviewed mentioned that they had decided to talk to me specifically after hearing good reviews from “Laura.” As such, she deserves a particularly high level of gratitude from me, for believing in me and this project and acting as my cheerleader throughout the unexpected journey. I hope the product matches her expectations and hopes – thank you again, my friend.

Conversely, I would also like to acknowledge all of the women who actively chose not to participate. These unspoken stories are as crucial as the spoken ones. At the

same time, we're all just trying to survive in the best way(s) we know how to. Thank you for your conversations with me, even if they were purposefully not included in this thesis. I hope, if you do read this, you can still find something useful here.

I would also like to thank the staff at my research site. While I wish I could reference them by name, there were two shelter staff in particular to whom I owe a big debt of gratitude. These two women, for no reason at all, took me under their wing and made me feel accepted and a part of the community. Nor was this unique to me. Over the time that I have been there, I have seen these two incredible women constantly and consistently take care of others: absorbing others' anger and frustration, supporting both staff and guests with firm but consistent love, and ultimately acting as (truly) unspoken heroes in what can often feel like an environment of constant chaos. Moreover, these women are not just caretakers at the shelter – they are caretakers in every aspect of their lives. They are mothers, sisters, partners, and friends. They are the heart that keeps the shelter going, and they further gave me hope that good people *do* still exist, even when they are still fighting within the trenches of trauma. They are my role models.

In addition, this work could not have been carried out without the support from both the shelter manager – who, while unnamed, should know that she is *also* incredible in her patience and support for all of the various elements she has to manage – and my thesis readers. Specifically, I would like to thank Linda Barnes, Lance Laird, and Justeen Hyde for their time and effort in helping me to form this thesis during a very difficult period in global history – the COVID-19 pandemic. I will always be grateful for their continued patience and guidance along the way.

Furthermore, it is my belief that researchers in the field of trauma – such as myself – cannot succeed without tethers to the real world. My academic readers gave me feedback; my non-academic supporters gave me re-grounding in reality. Because of this, I will always be grateful to Meg and her family, who accepted me as one of their own even though they barely knew me. Through them I saw models of depthless kindness and love, and it is through those experiences that I began to re-learn what it means to belong and be cared about. Even when things were murky, they never stopped acting as a lighthouse – allowing me to, even if briefly, come out of the darkness.

Lastly, I would not be here today without my sisters. While we have frequently bucked heads and come to the point of wanting to end ties to one another, for better or worse, they are the thread of my life. More than anyone else that has been listed here, this thesis is for them.

To my sister, Krystal – you have always tried to pave the way for us, keeping everything in and doing your best to carve an example for us. You were put in a position of taking everything on from a very young age, without being able to have a relational place of safety. Thank you for continuing to try to stay strong for us, even during the times when I don't understand it.

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I share the capacity for both intense rage and intense love. It is my hope that, similar to the goals of this thesis, we can one day join forces to create more good.

And finally, to my sister, Lara – you are truly the other half of my soul. You are the person who keeps me grounded, and you are the only person in my whole life who has never left my side. You love me even when we're fighting in the most extreme ways, and are the anchor that keeps me tied to this world. There would be no me without you.

I love you all to the moon and back.

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ABSTRACT

This study sought to examine pathways of coping and healing for women experiencing homelessness and poverty in the Boston area. Data was collected through participant observations of shelter dynamics, semi-structured interviews with shelter clients (referred to as “guests”), card-sorting activities in which participants were asked to rank self-generated cards for support groups, coping mechanisms, and internal selves across a range of situations, and a free association task, which involved having participants submit whatever self-generated cards of the above groups they associated with the terms “health,” “safety,” “shame,” and “pride,” respectively. Results were subsequently organized into three analytical chapters representative of the three levels of physiological response to threat. The first level of analysis looks at social engagement in the form of receiving and giving care. The second level examines expressions of rage and how these contribute into cycles of isolation, violence, and suffering. The third level further explores these dynamics within the realm of grief and erasure. The final chapter of this thesis then discusses the implications of these areas, as well as some suggestions for how to improve or potentially intervene in the perpetuation of these cycles, with a focus on how to emphasize healing while decreasing the need for coping.

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CHAPTER ONE: INTRODUCTION

My Mother's Homelessness

I was 8 years old when my mother became homeless. It wasn't because of alcohol or mental health issues - although she struggled with those as well, especially as time went on. It was because she trusted in the promise of someone she had loved deeply for many years. She believed in him and his word as bond, and she shouldn't have. She was the one who ultimately paid the price, and was later isolated from her children and demonized for it to boot.

To understand the events that transpired, you'd have to first understand who my mother was as a person. My mother grew up within a dirt-poor, conservative Southern household, where she was repeatedly told she had no worth outside of eventually being a good wife and mother. Over and over throughout her entire life, she was told she was ugly, stupid, and inept at everything she did. She was no one and had no purpose – at least, outside of what she could produce from her body and take care of. When she met my father – a Navy SEAL about to go to war in Vietnam – it was in many ways a dream come true. Even during the subsequent years of domestic abuse, infidelity, and the weight of trying to support his PTSD from the war, my mother never stopped loving my father. Along with the abuse, he gave her a sense of purpose and place in the world, one she had never known before but was always looking for.

As the years went on, the abuse and extramarital affairs increased. Eight months after I was born, my parents decided to drop my two older sisters and me off with my paternal grandparents. The goal (I'm assuming) was to have time and space to resolve the

issues in their lives. When my parents picked us back up again three years later, however, things had not changed.

We all lived together for another two years until my mother finally committed the ultimate sin: she converted to a religion outside of Catholicism. Even more egregious, however, was that my mother had found a friend and mentor in her faith who wasn't my father, and this was all the cause he needed to leave her for one of the women he was already seeing, with blessing from the Catholic church because of my mother's religious infidelity. As a result, despite the physical and emotional abuse she had endured from my father for over two decades, my mother was, for all intents and purposes, kicked to the curb.

Shortly after this, my father announced that he would be moving from our current home in Michigan to a new job in California. However, because my mother had been brought up to be a homemaker – a role she wholeheartedly embraced once she was married – she had no real work experience or current salary to support herself, let alone (now) four children. By contrast, my father had left the Navy and become a neurosurgeon, and in the court's eyes that meant he was the better parent. He was not.

Upon his announcement to the family, my father (along with his soon-to-be new wife) gave my mother two options. One option was that she could remain in Michigan (where she had no family or friends, as she had only moved there because of my father's residency program), try to rebuild her life (whatever that meant), and potentially never see her children again. The other option was that she follow the two of them, "play nice,"

and graciously be allowed to see her children some of the time. For a person whose sole purpose in life was to be a mother, it was a no-brainer.

When we finally arrived in San Diego, my mother was still operating under a false pretense. Unbeknownst to us, my stepmother and father had promised her that, not only would she still have contact with her kids, but they had also set her up with an apartment. It wasn't until she had helped them unload the last box that they finally revealed there was no plan for her. There was no apartment: there never had been. She had no friends in the area, no family, nothing. It was a dark night, the kids were inside, and the locks were turned against her.

My mother's story is by no means unique in its contradiction of the U.S.' cultural messages regarding pathways to homelessness. I myself was homeless off and on during my later high school years due to the fact that my grandmother – whom I was living with at the time – started developing dementia. Often she would become paranoid of the people around her, and kicked me out a number of times because of the belief that I was stealing from her and/or trying to kill her. I never told anyone at the time because I was extremely protective of my grandmother, and was afraid of her being committed and me getting taken away again. At the same time, I never went to a shelter because I had heard the stereotypes that shelters were dangerous places, and felt my situation didn't really count anyway.

The women in this study also come from a wide range of backgrounds leading up to their current state of homelessness and poverty. For Laura, it was being unable to retire despite decades of being in the working world, but also currently being unable to find

work because of her age. For Faith, it was using up her finances to take care of her sick and dying mother, leaving her with no savings when her mother finally passed. For Brooke, who received her masters from a prestigious university and who was in fact a published author, it was her struggles with alcoholism as a result of unprocessed trauma and social isolation. For Miriam, it was pursuing a nursing degree and then, during it, being unable to withstand the high level of racial discrimination, leading her to quit her dream. For Sexy, it was getting a disabling injury while working, resulting in her having to pay enormous amounts in medical expenses, both for the injury and her existing chronic illnesses. For Ariel and Mejor, it was fleeing overbearing, isolating, and abusive households, whatever the cost. Despite these differences in backgrounds, all of these stories have one thing in common: a history of experienced interpersonal trauma.

Understanding Trauma in My Own Life

Despite the fact that trauma has always been deeply interwoven into my life, and the fact that I have been in and out of therapy since I was 5 years old, not one person along the way ever specifically discussed trauma with me until I started attending a women's trauma support group in May 2019. At the time, I had never done group therapy before and was hesitant about discussing my history openly with a group of strangers. But, after my mother's murder in August 2018 (WKRK, 2021), I found myself at a loss for options.

My sisters were the only family I really had left, but while they could understand some of the problems I was trying to work through, all three were on the other side of the

country, and I felt I had to maintain a stoic persona so as to not further burden them as they worked through their own issues. Having graduated from college in 2011, I also didn't have a lot of friends that I still kept in contact with, and the few people I did open up to didn't know how to react to my disclosures. Often, I found that people treated me as if I were a problem to be fixed, instead of a person to be listened to and seen. This left me feeling angry and alone, and my anger furthered my isolation as I became less and less tolerant of what I viewed as the "blissful ignorance of privilege." It is extremely painful trying to exist in a world which would rather ignore unpleasant realities, and my isolation kept me in a perpetual state of only being able to focus on day-to-day coping, leaving little room for healing.

Every day became that mantra: "Just one more day." But the pain never stopped, and I questioned why I was even fighting so hard for "just one more day" when every day that came was miserable. I felt as though I were alone in the middle of the ocean, sitting in a boat full of holes and surrounded by sharks. With every act of coping, I was desperately bailing out water, knowing it was only minimally slowing down the sinking ship at best. I knew that the more I bailed water, the more tired I would be when I eventually *did* have to swim. But I also couldn't see another option to avoid the sharks, particularly with no land in sight. I knew the coping strategies I was using weren't helping in the long-run, but they were also the only things keeping me afloat in a world which I felt had abandoned me.

It wasn't until doing research for this project that I learned there was a label for what I was doing: engaging in the *pain paradox*. Specifically, the *pain paradox* is when

“traumatized or otherwise suffering people sometimes inadvertently engage in pain-enhancing or sustaining behaviors while trying to reduce painful or upsetting states... The paradox lies in how we are socialized to address emotional pain and discomfort” (Briere & Scott, 2015, p. 102). These words allowed me to both validate my pain and give me an awareness necessary to begin shifting my strategies. At the time, though, I did not have a name for the desperation I felt within my body, and felt my actions of coping were solely my fault: a sign of my internal weakness and proclivity towards self-indulgence.

Eventually, thoughts of suicide became what felt like my only dependable companion: the only stable thing in my life. In a world where I was consistently being made to feel powerless and invisible, suicide remained the one realm where I felt like I actually still had control – an unspoken vestige of all the other power that had been systematically stripped away from me over three long decades of abuse and erasure. Living life felt akin to being tied by one leg to an angry horse and being dragged across rough terrains full of obstacles - having no control over the path you’re being pulled through, but bearing all the consequences of that journey. I didn’t want to die. I just wanted to cut the cord so that I could rest - and heal.

I attended the trauma support group as a last-ditch effort, with no real expectations of anything good coming from it. However, as I sat listening to each person’s story, the spark that had been sputtering inside of me started to grow, fueled by the validation of shared experiences and truly feeling seen. It was the first time in my entire life where I felt that I and my anger were not the problem, but rather a natural

reaction to so much unresolved injustice in my life. And not just in my life – much of my anger also came from carrying along the memories of loved ones who had been wronged but were no longer around to fight. I had been dragging along these ghosts because I felt as though, if I let their stories fade, I would be helping to legitimize the violence done to them. Hearing so much similarity between stories – not so much the events, but feelings that “it doesn’t count” as trauma, and apologizing immediately after for even talking about what happened – renewed my sense of righteous anger and resolve to be heard. It reminded me of the power in silencing people and, as a form of resistance, the power in speaking back.

After one of the meetings, the main facilitator approached me with a book called *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, written by one of the leading experts on trauma, psychiatrist Dr. Bessel van der Kolk. I had never been a fan of non-fiction in general - and have always been particularly wary of “self-help” type books, because of their propensity to focus on individual control over larger influencing factors - so didn’t invest much in it initially. However, as I started reading it on my commute to work one day, I remember feeling overwhelmed by emotion. I am not someone who cries in front of others. And yet, even within the first few pages, it took all of my willpower not to start weeping profusely on the packed bus.

It is painful to be abused. While reading those pages, however, I fully realized how painful it is to *also* finally have your experiences and feelings validated, particularly when you’ve spent so much time trying to convince yourself that they aren’t valid or are specific to you. It’s like emerging from a cave - sunlight is important for our health and

wellbeing, but it can also be excruciating when you've lived in darkness long enough. You feel the comforting warmth of the sun, but you can't stop your eyes from watering. And sometimes, while you're trying to get used to the light, you have to close them again when the pain becomes unbearable. For those who have always lived in sunlight, this closing can sometimes be viewed as that person wanting to remain in darkness, even when it really means they're trying to stick it out and adapt. This judgement from others can further feelings of separation, leading some to decide the benefits of living in painful warmth don't outweigh the benefits of remaining alone in cooling darkness, with the ability to control your own emotional/physical pace.

Once I finished with that book, I became insatiable. Pain was already such a huge part of my emotional and physical life, so the discomfort of being seen felt like a small price to pay for the excruciating agony of having your life and experiences systematically erased. Prior to that book, I had felt like I was facing a sheer rock wall with no holds to climb up it, adamantly but hopelessly trying to scratch my way up through sheer will (and very short nails). In reading it, I finally had some answers to questions I had been grappling with alone, my whole life. Finally, I felt as though the "irrational" parts of me – my memory holes, my nightmares, my propensity to "self-sabotage" and "self-isolate" – were contextualized and validated.

My whole life I had been treated like a broken machine, one who is inherently misconfigured and therefore doomed to a life of suffering, no matter what I did. Dr. van der Kolk's words illuminated a path for me, and I quickly jumped to the next ledge, in the form of *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-*

Alienation by Dr. Janina Fisher. Through these two texts, I came to an understanding that there were parts of me which had developed out of necessity, and while they might no longer be advantageous in my current life, they had still been beneficial parts of me at one point, which should be embraced and “thanked for their service” (Fisher, 2017). In addition, I began to recognize the importance of the body’s sense of safety and its subsequent impact on the mind’s sense of safety. In other words, I began to understand that we have to first convince our bodies that it’s safe, before we can convince the mind.

As I grappled with these new understandings, I frequently thought about why it was still so difficult for me to accept these parts of myself which I, at this point, logically knew had been so influential in my survival. Shame emerged as the common thread linking my hatred of some selves, versus pride in others. I began to recognize, for instance, that I had two main selves which I hated above all others - and with comparable intensity - but which paradoxically represented opposite poles of what I saw as the emotional/action-driven spectrum: my submissive, people-pleasing self and my angry, violent self.

My submissive self had been essential in surviving my childhood because resistance came with the cost of severe mental, emotional, and physical punishment. For instance, when I was 12 and started living with my mother again after much custodial shuffling, I decided that I needed to take a stand against having to attend her religious meetings, which I was vehemently against. My mother was a Jehovah’s Witness at that point, which meant at minimum that we had to attend blatantly sexist, religious meetings 2 hours a day, 3-4 times a week, in addition to going door-to-door for 8-10 hours every

Saturday. One day I told her that I would not put on a dress for the meeting – my feeble attempt at resistance. Without discussion, she immediately began punching and kicking me, throwing me across the room and eventually bringing out her belt. After I still refused, she threatened to call the “brothers” – the male leaders of her faith – to “change me.” Having already experienced sexual abuse in general at this point, I gave up and gave in, deciding it was better to suppress my pride than to be violated again. Even at that age, I was learning to choose the pain of silence over the consequences of being seen.

My anger, on the other hand, had a different but equally difficult trajectory. Although I had 3 sisters, I was the only one who was treated with kindness by my paternal grandmother, who took all of us in on an on-and-off-again basis while our parents continued to live their lives. The reason for this was because I was so similar to my father, whom my grandmother had loved above all of her (otherwise female) children, but whom she had later become estranged from. Conversely, my sisters, in her eyes, were painful reminders of the stain my mother had left on the family, specifically because she was from a “white trash” family.

My propensity towards “maleness” was thus a strength in my grandmother’s house. My anger, while not embraced, was tolerated and silently upheld. For my grandmother, it was an indication that I was a fighter – that, despite being born in a female body, I could survive in a “man’s” world. While my sisters were kept in the basement, I was allowed to sleep upstairs. When I lost control and punched holes through their wooden fence, my grandmother would perhaps reprimand me, but would ultimately avoid discussing my actions and where they were coming from. As long as I continued to

do well in school, anything else that I felt or did were dismissible. When I didn't meet her expectations, however, my grandmother would use comparison with my (submissive) mother as an insult: "You know, you're just like your mother." This dynamic ultimately had two profound effects: 1) that I had a lot of unaddressed anger, which was superficially supported in this microbubble, but meaningfully supported nowhere else, and 2) the repeated, and subsequently internalized, association between being like my mother and being a failure or social pariah.

All of these events led me to wonder how our social memberships (Bourdieu, 1977), physical embodiment of trauma (van der Kolk, 2014), and internal selves which are produced by trauma (Fisher, 2017) affect our ability to cope and heal. This is particularly relevant for populations such as homeless women, whose situations demand that they must constantly navigate between various types of threats while having little to no resources and/or space to themselves. Being in a position of having to ask for help also means being especially vulnerable to both 1) abuse and 2) isolation, even from our own sense of self. This is because, in exchange for support, homeless women have to adopt the kind of social mask which aligns with narratives of deservingness. As a result, homeless women in essence have to live dual lives: being polite and meek "victims" in order to receive support on the one hand, and on the other, being incredibly tough, shrewd, and sometimes even violent in order to survive once they are back on the street. This leaves little room for healing, thereby reinforcing cycles of coping which may themselves result in keeping people homeless and poor.

Argument and Chapter Overviews

In this thesis, I ask the question of how homeless women in Boston attempt to cope and heal with their experiences of interpersonal trauma, even while continuing to remain in states of emergency and/or threat. Here I use the term “homeless” as opposed to “houseless” or “housing displaced” for two reasons. The first is that, from a logistical standpoint, many of the women at the shelter go in and out of different housing situations, and so the term “houseless” may not necessarily apply in the strictest sense. More importantly, however, what I hope to highlight with the term “homeless” is how this group’s situation interacts with trauma. Specifically, trauma healing emphasizes the need for having a “relational home” (Briere & Scott, 2015; Stolorow, 2007). This then begs the question – what does it mean to try to heal from trauma while also being homeless not just in the literal, structural sense, but also in this larger, symbolic and relational sense? When women are homeless, how do they navigate different pathways of coping and healing in an attempt to maintain or restore their sense of self, purpose, and connection to the world around them?

In exploring these pathways, I argue that the way in which mainstream U.S. culture frames and interacts with both 1) marginalized identities specifically (e.g., race/ethnicity, citizenship status, gender, age, behavior-based identities such as being an “addict”), and 2) homelessness/poverty in general, combine to create cycles of isolation and ongoing trauma. Furthermore, these cycles of isolation cause individuals to engage in practices of coping (surviving) rather than healing (thriving), leading to progressive states of *erosion*, *exhaustion*, and *erasure*. Finally, I will argue that these acts of coping –

particularly when the effects of trauma are misrecognized – subsequently reinforce existing stereotypes, thereby “justifying” keeping homeless individuals emotionally and physically isolated. In other words, the way that U.S. culture and its systems frame and interact with homeless women causes certain coping behaviors to emerge - behaviors which then cyclically reinforce the same toxic stereotypes initially driving these cycles. Simply put, we implicitly expect homeless women to be healed before they can reintegrate, without recognizing that reintegration is a key component of trauma healing.

Because this thesis is about exploring the feedback loops between the body and the social, I begin in Chapter 2 by discussing what it means to live as our bodies in general, and how this relates to experienced homelessness and trauma specifically. I will frame the discussion of “the social” using themes of necropolitics, medicalization, and cultural reactions to ambiguity, within the context of the U.S.’ historical foundations. In addition, I discuss how threat is processed within the body in terms of three activation levels: social engagement, fight/flight, and freeze/collapse. Each of these activation levels will then be explored in depth across the three analytical chapters, outlined below.

In Chapter 3, I will discuss the methods of how this research was conducted. In Chapter 4, I begin my analysis by focusing in on aspects of both giving and receiving care (engaging in social support). During this chapter, I explore how stereotypes of homeless women as “Welfare Queens” or con artists – *combined with experiences of betrayal and interpersonal trauma* - cause them to shrink their needs. They do this by diversifying their vulnerability across multiple resources, thereby making it so they don’t have to exclusively rely on any given social resource. However, as clinician and

medical/psychological anthropologist Rebecca Lester (2019) noted in her research on eating disorders, this act of limiting dependency – which is called for by systems of care - may in fact reinforce these same stereotypes of homeless women trying to manipulate or otherwise “con” the system, as they are perceived to be “double dipping” across resources. Furthermore, because homeless women are spreading their needs across many different resources, this can result in a slow *erosion* of both physical and financial resources, as well as a sense of personhood.

In Chapter 5, I move onto how engaging in fight/flight practices further results in homeless women becoming exhausted. Here I argue that the lack of comprehensive social support described in Chapter 4 – *combined with cultural practices of shaming homeless women while silencing their anger* – result in behaviors which reinforce stereotypes of homeless women as dangerous and unpredictable. As I discuss in this chapter, this is because being in a constant state of threat means that our bodies are chronically activated, leading to simultaneous states of hyperreactivity and *exhaustion* (Luke, 2020). When the body is not given the space to feel safe and quiet down again, this can lead to big explosions even over seemingly minor incidents. Yet, rather than these explosions being regarded as reactions to ongoing feelings of trauma, injustice, and isolation, they are instead used to justify keeping homeless women at arm’s length, further entrenching cycles of isolation.

Chapter 6 builds on the previous two chapters by examining the final activation level: freeze/collapse. In this chapter, I argue that lack of comprehensive social support (chapter 4) and an inability to have voiced injustices be taken seriously (chapter 5) –

combined with profound loss and silenced grief – result in behaviors which reinforce stereotypes of homeless women as being indifferent to their own wellbeing. Here I emphasize that, because U.S. culture is largely grief-averse (Cacciatore, 2017), many of us grow up internalizing the message that we need to box up and bury our grief as soon as possible. From a practical standpoint, this may be particularly true for homeless women, as they must often focus on day-to-day survival, leaving little space for processing grief and loss. However, this may lead to feelings of meaninglessness – of being rootless in an uncaring world.

Because of this, sustained, unprocessed grief may lead to feelings of *erasure*, which can also further enhance an internalized sense of danger and despair. In other words, if you feel as though you are alone in the world and have lost loved ones who seem to have then been forgotten by everyone else, you may feel as though it is just as easy for you, too, to be erased from society’s consciousness. When individuals feel as though nothing they do or feel matters, they may adopt numbing practices or fall into dissociative states as a way of continuing to adapt to (and survive in) this grief-averse environment. However, these practices may then reinforce the idea that homeless women are, for instance, merely addicts who don’t care about what happens to them. These views can then paradoxically lead to justifying investing *less* in women who are doing what they can to survive, because of the belief that their behaviors “prove” they don’t care.

Finally, in Chapter 7, I offer some potential changes which could occur within institutions dedicated to supporting homeless populations, particularly with regard to trauma healing. Here I once again emphasize the need for connection as a counterforce to

these cycles of isolation, with the goal of supporting both homeless women and those who aim to care for them.

CHAPTER TWO: BACKGROUND

“Everyone thinks you're worthless
When you're down and out.
No one scratches the surface
When you're down.” – *“Down and Out,” EMA, 2017*

The goal of this project is to not only explore how homeless women cope and heal with their trauma, but to specifically ground that analysis within the social conditions which influence these behaviors. To do this, I will first introduce the concepts of phenomenology/embodiment, social fields, and habitus, as well as providing an overview of the body’s responses to both threat and shame. I will then describe some of the social factors which form the basis of how we respond to individuals within this population. These include medicalization efforts, a shift in sovereignty, and necropolitics. The relationship between these two areas – the social and the body - will continue to come into play across my three analytical chapters.

Finally, I will wrap up with a brief discussion of some of the politics of displacement in the U.S., which often pits oppressed groups against one another, thereby ensuring power remains in the hands of the powerful while reinforcing cycles of isolation and depletion. This will provide a framework for understanding how trauma can become reinforced in both the individual and intergenerational body over time, making it that much more difficult for individuals and communities to heal.

Traumatized Bodies

Bodies Telling Stories

“Every boy dreams of being Batman, because it actually *is* possible to be him.” – *Val Kilmer, “Val,” 2021*

“Show a man what he expects to see, and he won’t look beneath the surface.” – *Catwoman, “Batman Returns,” 1992*

The phenomenological concept of embodiment focuses on how the bodies we inhabit affect our experiences and perceptions of the world around us. Phenomenology focuses on how we first unconsciously *experience* sensations in our bodies, as opposed to what we *think* about them. Because we all physically inhabit our world, regardless of age, ability status, disease status, race, sex, and so on, perception is a universally shared phenomenon among our species (Merleau-Ponty, 1948/2002). At the same time, we are born with a certain combination of characteristics, which are further personalized and differentiated by our actions and experiences. Consequently, because of the uniqueness of our physical bodies, no two persons' histories and understandings of the world can be identical (Merleau-Ponty, 1948/2002).

Our bodies shape how we interact with – and adapt to - the world around us. They also tell our stories: sometimes through figurative scars, sometimes through literal ones. Bodies tell the story not just of how we’ve interacted with the world, but how the world has acted upon us (Schuetz, 1945). Our bodies influence what we’re allowed to do or not do within our local and global worlds, based on how our bodies are regarded by others. For instance, in the U.S., individuals who are regarded by others as female are expected to wear bathing suits which cover their upper bodies (specifically their breasts),

regardless of whether they personally identify as female or not (or even have breasts, e.g., young children or individuals post-mastectomy). Conversely, those identified as male are socially allowed to expose their chests – even if their chests physically resemble female breasts.

Furthermore, these societal body-related expectations extend to how we're allowed to *feel* about various restrictions, particularly if/when we push back on imposed bodily-based limitations and insecurities (Goffman, 1963/2006). For instance, while identified males in the example above may choose to cover their chests if they so desire with little pushback from those around them, identified females are likely to meet fierce resistance and external shaming if they push back on having to cover up their upper bodies. As will be discussed in the section, “Regulating Bodies,” this reflects a culturally ingrained framework of how to interact with a “normal” versus “deviant” body, where those who defy cultural expectations are subject to punishment or isolation via social rejection.

Bodies also contain *inherited* stories as well as directly experienced ones and, because of that, can be said to carry intergenerational as well as cultural meaning, in addition to individual meaning. Sometimes, these constant, projected messages regarding the “truth” about our bodies – and who we as people are, as products of our bodies - create feedback loops which reinforce false assumptions, violence, and isolation (Bourdieu, 1977; Bourgois, 2009; Chemaly, 2018). As described by theories of embodiment:

“Bodies tell stories about – and cannot be divorced from – the conditions of our experience... bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell... our living bodies tell stories about our lives, whether or not these are ever consciously expressed” (Krieger, 2005, p. 350).

These ongoing cultural messages about how we should act based on our bodies become internalized and incorporated into unconscious habits and cognitive frameworks, which may be further nuanced by the different social memberships we hold. The bridge between the realm of the body and that of the social is thus perhaps best explained through French sociologist Pierre Bourdieu’s (1977) work regarding *social fields* and *habitus*.

Social fields can be understood as the various “social and professional contexts in which agents operate and in which they are hierarchically positioned” (Soro, 2017, min 6). While Soro offers examples of society, education, and birdwatching as types of social fields, this can also arguably extend to social group memberships and shelter spaces, as these are still social arenas in which individuals vie for status and resources. Within each social field, individuals compete according to a set of criteria related to status. For instance, in the field of birdwatching, you may gain high status by being able to identify or collect a unique bird. In the field of the stock market, however, this skill will gain you little to no prestige or capital.

In addition to this, we may have memberships in multiple fields, all with their own customs and expectations. Many homeless women, for instance, must straddle the

social fields of both shelters – which prize docility and politeness – and the street, in which aggressiveness and/or rebelliousness is much more crucial, both for survival and status. In crossing between fields, individuals may subsequently have to engage in code-switching in order to adapt to specific sets of mandates. As will be discussed further in chapter 4, having to constantly adjust how we present ourselves may also lead to a sense of erosion and isolation.

In addition to social fields, Bourdieu also introduced the idea of *habitus*, or the way in which our structural environment(s) produce a system of dispositions which become unconsciously incorporated and reproduced in how we think, act, and perceive the world around us (Bourdieu, 1977). In other words, we develop a set of dispositions based on our past experiences, which then form the template for how we interact with the world around us in our current life. These concepts matter in the context of trauma because, while we may *feel* the effects of trauma in our bodies, we may also misrecognize or mislabel these feelings based on how they fit into our existing cultural schemas, especially with regard to what “counts” as trauma and expected pathways for how to deal with it. Misrecognition furthermore means that the individual’s efforts to resolve the issue may result in practices of coping (e.g., suppressing/silencing, in order to survive) rather than healing (e.g., addressing/expressing, in order to thrive).

Understanding the Relationship Between Trauma, The Body, and The Social

“Fear is the mind killer. Fear is the little-death that brings total obliteration.” – *Frank Herbert, Dune, 1965*

For those attempting to heal from trauma, being in touch with your body is crucial (Briere & Scott, 2015; Luke, 2020; van der Kolk, 2014). This is particularly true when individuals are triggered, as identifying how your body is physically reacting to the situation puts you in a better position to emotionally regulate (Briere & Scott, 2015). Yet, as author Soroya Chemaly (2018) notes in her book *Rage Becomes Her: The Power of Women’s Anger*, in mainstream U.S. culture women’s bodies continue to be objectified, thereby creating a distance between women’s subjective selves and their physical bodies and sensations (Chemaly, 2018). This effect was most salient during my interviews, when all 8 participants had difficulty answering the questions, “What is it like to physically experience your health issues?” and “Which social groups or coping methods make you feel (overall) ‘good’ in your body?” The majority of participants either did not answer the question, or gave non-sensation-related answers (e.g., “I can feel that this is ok, to let whatever happens happen”). The only participant to report something close to experienced physical feelings was Laura, who said her medical issue “doesn’t feel like anything. It’s like a, it’s like a plane crashing. You don’t know it crashes ‘til it lands somewhere.”

When we feel in danger, our autonomic nervous system (ANS) reacts by activating three hierarchical levels of physiological states: social engagement, fight/flight, and freeze/collapse (van der Kolk, 2014). At the first sign of threat, whether it be physical, emotional, or otherwise, we respond by looking for support through social

engagement. This can result in both conscious actions - such as calling out for help or seeking comfort – as well as unconscious signaling, such as changes in our facial expressions, body posture, or tone of voice (van der Kolk, 2014). In fact, this instinct for seeking shelter in others is hardwired into us as humans because it is *necessary* for our survival as vulnerable infants (Gibson, 2015). This is what makes interpersonal trauma so excruciating: it creates a relational contradiction whereby people are both needed for, and are threatening to, our overall survival and well-being. In other words, while our species' innate programming demands we seek others for safety, interpersonal trauma experiences scream out that, by and large, people are sources of danger and pain.

While I will discuss the role of shame in trauma more in-depth in subsequent chapters, it is worth briefly noting that shame and trauma often go hand-in-hand for a number of reasons (van der Kolk, 2014). In addition, shame – or the feeling that there is something wrong with who we *are* as opposed to what we have *done* – *also* taps into our threat-defense mechanisms (Elison, Garofalo, and Velotti, 2014; Velotti, Elison, and Garofalo, 2014). This means that our brain reacts to social threats (e.g., perceived rejection/exclusion) in the same way that it reacts to physical threats. Importantly, these threat-defense mechanisms are by necessity rapidly activated, and therefore often operate before conscious thought can begin to intervene (Velotti, Elison, and Garofalo, 2014). Thus, when individuals are unable to engage help through social means (e.g., because of being chronically shamed and therefore socially isolated), our ANS switches gears by activating our *fight or flight* instincts (van der Kolk, 2014). Because of this, “shame – as with physical pain – may result in maladaptive defense aggression, even against innocent

others... [and therefore] many instances of aggression would be better understood as reactions to shame” (Velotti, Elison, and Garofalo, 2014, p. 455).

As will be discussed more at-length in Chapter 4, women’s socialized expectation to be caretakers, combined with structurally enforced gender- and race-based financial inequalities, further complicates this idea of *fight* or *flight*. For example, when a woman stays with an abusive partner – particularly when she has children - she is demonized for “choosing” to put herself and her children at risk. Yet, if she leaves the situation and her children behind, she is likely to be considered selfish and morally reprehensible for “abandoning” her role as a mother. Her third, most “acceptable” option – of fleeing, along with her children – may not even be financially possible or sustainable, let alone logistically feasible. In essence, she is caught up in an impossible situation, with no way out which does not provoke (at minimum) a potentially negative social reaction.

As someone who later grew up with three sisters and a single mother, I can personally attest to the difficulty my mother had in trying to find a place that would take us, particularly given my mother’s low income and sparse work history. Even when we *were* accepted into housing, we often faced near-constant surveillance and scorn, in addition to receiving much unwanted attention from our male neighbors. In removing my father from our lives, we didn’t suddenly become safe – we simply transitioned from one dangerous male-dominated environment to another.

When humans cannot find others to help us, and we cannot fight our way out of the situation or run away from it, we may enter into our last level of defense: *freeze or collapse* (van der Kolk, 2014). At this stage, our body attempts a last-ditch preservation

effort by shutting itself down and trying to expend as little energy as possible, with the result that “other people, and we ourselves, cease to matter. Awareness is shut down, and we may no longer even register physical pain” (van der Kolk, 2014, p. 85). While in this stage, individuals may feel dissociated or socially numb, and may even become catatonic. They may also engage in potentially lethal activities, such as substance abuse or suicide attempts.

Tragically, these responses – which signal an overwhelming need for help and loving engagement – often result in societal judgements which further isolate individuals coping with trauma. In other words, by responding with harsh, shaming criticisms and social/legal punishments, U.S. culture and its associated institutions such as hospitals, law enforcement, and shelters more often than not serve to *reinforce* the idea that the world and its people are dangerous, making it that much harder for traumatized individuals to willingly or successfully give up their existing methods of protection.

Inheriting Trauma in the Body

“Walk in silence
 Don't walk away, in silence
 See the danger, always danger
 Endless talking, life rebuilding.” – *“Atmosphere”* by Joy Division, 1988

As discussed above, trauma - regardless of type - becomes encoded into our bodies first, making explicit/ordered narratives difficult while profoundly affecting our ability to assess danger versus safety in our environment (van der Kolk, 2014). Added to this are the complex ways in which unresolved trauma manifests and, in some cases, leads to inflicting further trauma and violence onto others (MacNair, 2015), in addition to

causing a fragmentation within our personal sense of identity (Fisher, 2017). How individuals interpret events – as well as their own role in them - can also affect how they react to future threats.

Because of this, individuals' reactions to trauma are as unique as their bodies. But, when their ability to regulate is compared to expectations for “normal” social conduct, their behaviors have the potential to be likewise misrecognized and subsequently mishandled by those unfamiliar with potential signs and symptoms of trauma (Briere & Scott, 2015; van der Kolk, 2014). This mishandling can moreover cause further traumatization of the individual, thereby reinforcing cycles of distrust, violence, and self-isolation as a means of self-protection.

In the same way that cultural messages are inherited through our bodies, unresolved intergenerational trauma can also play a large role in how individuals process trauma, as well as how they seek pathways of coping and healing. For instance, in their study looking at the impact of pre-natal maternal stress on fetal development and infant behavioral outcomes, Davis et al (2011) found that higher levels of cortisol and psychosocial stress experienced by mothers while pregnant led to poorer emotional regulation and higher levels of anxiety in their infants once they were born. Another study by Boeckel, Wagner, and Grassi-Oliveira (2017) found that mothers who were in abusive relationships were less available for their children, and that the more severe the intimate partner violence (IPV), the weaker the quality of emotional bond between mother and child. Weaker bonds between mother and child were also associated with higher PTSD symptoms among children (Boeckel, Wagner, & Grassi-Oliveira, 2017).

Taken together, these studies indicate that individuals who experience trauma in utero may already be set up to be less adept at regulating emotions, particularly in response to stress. Moreover, if they remain in traumatic environments, these individuals may experience their trauma more intensely as they continue to emotionally develop in general, with less feeling of support from the same person that brought them into this world in the first place.

Externally, inherited trauma can also take the form of methods which may have previously been seen as necessary for survival, but which may subsequently become barriers to thriving in the present. For instance, a daughter may learn from her mother that her best course of action is to embody submissiveness, in order to avoid violence (particularly from men). While this may have been crucial to her survival as a child while living with an abusive father, as an adult submissiveness may mean that she is less likely to seek out or ask for help, thereby appearing to “not care” about her life. This once again echoes the idea that there is a standard way in which individuals demonstrate investment in their lives, which subsequently structures ideas of deservingness and aid for their situation. Furthermore, continuing to embody submissiveness – particularly if working in a male-dominated field – may mean she’s passed over for promotions, thereby impacting her financially as well as her sense of self-worth.

Thus, inherited messages from our forebears and close communities may become complicated by contradicting mainstream cultural messages regarding what trauma is, who is allowed to claim it, and what needs to be done to resolve it. These messages may themselves be re-traumatizing, in addition to being ineffective. This further highlights the

need for a more nuanced look at how trauma impacts coping and healing as a function of both experienced and inherited trauma, as well as how this internalized embodiment interacts with existing cultural schemas.

Regulating Bodies

Isolating Deviancy

“It’s not really a measure of mental health to be well-adjusted in a society that’s very sick.” – *“The OA,” “Homecoming,” SIE1, 2016*

During the 17th and 18th centuries, colonial governing bodies had to grapple with an “economic and political body of a society that was undergoing both a demographic explosion and industrialization” (Foucault & Ewald, 2003, p. 249). As a result, sovereign powers realized their previous methods of control (e.g., a king’s decision to execute certain individuals) would no longer prove effective. This led to what Mbembe (2003) refers to as “neocropolitics,” or the relationship between sovereignty, biopower, and the threat of death.

According to this theory, as power (theoretically) shifted from the king to the people, the focus likewise shifted from one of “letting live and making die” to “making live and letting die” (Foucault & Ewald, 2003; Mbembe, 2003). One way to justify acts of “making live” or “letting die,” while maintaining control over the public, was to employ methods of biopower and surveillance under the rhetoric of risk assessment and prevention. Biopower, or “that domain of life over which power has taken control” (Mbembe, 2003, p. 12) is utilized by sovereign powers through the establishment of a

“normal” body, which can be used to measure and identify deviancy in need of intervention. In addition, necropower, or the power/terror of death, can be used to both threaten actual death as well as the “destruction of a culture in order to ‘save the people’ from themselves” (Mbembe, 2003, p. 22).

As discussed by Lock (2004), modernizing efforts beginning in the 17th century likewise evolved into an “engineering mentality,” whereby science was used to increase a sense of control over nature and its perceived unpredictability. Unsurprisingly, much of this industrialized mindset coincided with these larger colonization efforts to conquer and control “uncivilized” populations and territory. This led to a medicalization agenda which was overall “designed more to protect the colonizers and to ‘civilize’ the colonized than to ameliorate their health” (Lock, 2004, p. 117).

The result of these parallel and interconnected programs was thus the establishment of a universal “normal” body, which could be used to evaluate individuals in order to identify deviation and, by association, disease (Foucault & Ewald, 2003; Lock, 2004). As the medical profession became more involved in life cycle events, it continued to reinforce various “disciplines of surveillance” (Foucault & Ewald, 2003) whereby:

“Public health and preventive medicine, always closely allied with the state, made the overseeing of the health of populations its domain... [and] with this type of reasoning certain persons and populations are made into objects of medical attention and distinguished from others who are subjected to different authorities including the law, religion, or education” (Lock, 2004, p. 117 - 118).

In other words, this process of standardization and surveillance, coupled with existing ideas of quarantining *physical* disease, further justified isolating and incarcerating individuals who were perhaps considered propagators of *social* disease (e.g., those considered mentally or morally unsound, as well as those living in poverty).

By establishing processes for pathologizing certain bodies and states of being, sovereign powers could also claim more jurisdiction over “the capacity to define who matters and who does not, who is *disposable* and who is not” (Mbembe, 2003, p. 27). Thus, expressions of “wellness” became social markers for measuring virtue and perceived desire for independence, as well as implicitly signaling who is worth investing in. Inherent in this ability to determine who matters is the ability to judge and assign markers of potential – not just potential for greatness or evil, but also potential for conformity, predictability, and control. In other words, “by taking personal responsibility for health, individuals... actively cooperate in the creation of ‘normal,’ healthy citizens, thus validating the dominant moral order” (Lock, 2004, p. 122). Furthermore, by placing responsibility for one’s health in the individual’s hands, systems affecting health can avoid blame by leading individuals to misrecognize and internalize their issues as being exclusively their fault. This consequently reinforces dominant, toxic systems while isolating and demoralizing individuals who do not conform to systemic expectations for order.

Simply put, what these concepts amount to is a system which justifies isolation in response to perceived deviancy. Those who hope to be deemed “well” or at least seeking wellness must therefore showcase certain beliefs and behaviors in order to demonstrate

that they deserve investment from dominant care systems. Those who fail to meet these criteria – especially those with limited social support or resources – face the risk of remaining isolated until they eventually disappear, die, or seek refuge elsewhere.

In a culture built around capitalism, this can have a profoundly negative effect on women struggling with both homelessness and trauma. First, in the U.S., homelessness and poverty are largely treated as a type of social deviancy. This is because homelessness and poverty are fundamentally antagonistic to the inscribed mantra of being able to “pull ourselves up by our bootstraps” as well as being an affront to the “American Dream.” In response, hostile architecture (which will be discussed in more detail later on) constructs a physical environment which pushes homeless individuals out of the public gaze, seeking to minimize or otherwise quarantine their presence. This allows institutions to continue projecting whatever messaging they would like *about* homeless individuals, while shrouding the actual realities of their lives from the larger public.

In this way, homelessness becomes the shadowy threat which keeps people invested in the system of capitalism and its associated institutions: you better go to school, find a well-paying job, and work hard, or else you’ll end up like *those* people. Creating an unambiguous, homogenous stereotype of what homelessness is and how one becomes homeless allows dominant cultural systems to maintain this individual-centered narrative of wellness: the individual is homeless because they did/didn’t do x, y, and z steps promoted by our culture, so their situation is their fault. This subsequently supports an environment where those with resources may end up engaging in toxic humanitarianism (Fassin, 2010) and/or shaming criticism in order to “save the people

from themselves.” Furthermore, when social messaging frames homeless individuals as, amongst other things, addicts or con artists, it also justifies “letting [them] die” – or, at the very least, limiting support.

Crossing Boundaries

When homeless individuals attempt to cross these various physical and social boundaries, they potentially face serious (not to mention expensive) consequences. For example, two years ago one of my participants, Ariel, was sleeping in the Logan airport in order to get out of Boston’s harsh winter weather. She was first arrested and then subsequently transferred to a mental institution. While at the institution, the staff attempted to get her to fill out a housing application, to which she refused. This was because she had grown up in an extremely overbearing and abusive household which she had eventually fled from, thereby starting her decades long career of nomadism. In fact, of all 8 participants, Ariel was the only one who actually felt positive about her state of homelessness, as it afforded her a sense of freedom and control which she had never before experienced.

But, despite the fact that Ariel clearly did not want to remain in the institution, the staff there told her that there was a law where “you cannot release someone, especially an indigent woman, elderly indigent woman, into the street in the dead of winter. So they had to hold me [until I could find another place].” In an attempt to regain freedom without compromising her sense of safety and autonomy, Ariel reached out to both friends and overnight shelters, with no luck. When I last spoke to her in January 2022,

she was still stuck in the institution, with both staff and residents constantly remarking that she was taking up a bed which could have been better used for someone else.

Individuals like Ariel - who do not wish to engage in the available homeless-specific resources, regardless of their reasoning – are often framed as being the ones to blame for their situation by “choosing” to remain in it. When they are punished by institutions such as law enforcement, often the response is, “Well, what did you expect?” At the same time, as will be discussed further in Chapter 4, when individuals *do* reach out or tap into resources dedicated to them, they are often stigmatized for being a drain on the system – essentially, of trying to con “hardworking Americans” out of resources. This type of double-bind (Lester, 2019) can subsequently strengthen in group/out group relational responses, thereby decreasing empathy and potential for connection on both sides. As a result, homeless individuals are forced into a position of being beholden to the same institutions which homogenize, delegitimize, and ultimately attempt to curate or otherwise erase their lives and histories.

That pattern of relational contradiction – of both needing a social resource for survival and, at the same time, having it threaten your (emotional if not physical) survival – echoes the internalized dynamics of childhood abuse and trauma (Blizard, 1997; Gibson, 2015). As anyone who has ever experienced gaslighting can tell you, abusers often oscillate between states of providing (at least perceived) comfort and safety, and states of extreme abuse and terror (Sarkis, 2018). Chronic relational trauma can have such a potent effect *because* we simultaneously feel a sense of love for, or at least

obligation to, our abuser(s). Often however, these abuser(s) are aware of the cultural expectations they must operate under, and use these to their advantage.

In fact, several of the women I interviewed experienced and remained silent about the sexual and/or physical abuse they endured at the hands of their fathers and male partners *because* they felt it was their obligation as daughters and girlfriends/wives (in other words, socialized women) to do so. Thus, within this trauma-centered context, it makes sense for individuals to be suspicious of caregivers and care institutions because of being hesitant to repeat the same kinds of relational dynamics, particularly for those with longer standing histories of abuse and self-silencing. It also makes sense why there would be a lot of anger directed at even well-meaning support sources, such as shelter staff, as the overall situation sets those with trauma histories up to be retriggered on an unconscious level within their bodies. However, because trauma training is often not given to shelter staff and others providing care to these individuals – including at my site – much of the time these behaviors only further entrench misrecognition, while justifying practices of isolation/wariness towards those “acting out.”

In summarizing the various pieces presented thus far, we can start to see how cycles of isolation are both created and maintained by our existing cultural practices in the U.S. First, efforts to colonize and control an expanding population led to the establishment of a universal “normal” body. Existing practices of quarantining or otherwise isolating *physical* disease/deviancy were subsequently extended to justify practices of isolating *social* deviancy. Those identified as deviant can attempt to reintegrate through expressions of wellness based on the condition (e.g., if you are sick

with x, you must take y medicine), which both reflect and reinforce dominant system expectations and schemas. Conversely, those who do not or cannot display these wellness markers are subsequently regarded as either being indifferent to their own wellbeing, or beyond repair. In addition, cultural schemas become internalized into unconscious dispositions for how to think and act. These schemas are further nuanced by the interplay between our social memberships and expectations related to our bodies.

In the U.S., poverty and homelessness are implicitly regarded as social deviancy because they contradict the cultural message of “the American Dream” and “living in the land of plenty.” Because of this, we isolate homeless populations in various ways, ranging from more physical methods – in the form of hostile architecture, such as designing public benches in a way which discourages sleeping, or restricting where shelters get set up (Carey, 2018; Chan, 2018) – to socialized shaming and punishment, such as in Ariel’s situation of being arrested for being homeless and attempting to reside in a “public” space (a term which implicitly reinforces who is regarded as being part of the “normal” public body). From a support standpoint, we may even isolate interrelated issues for homeless women, to their detriment. For instance, at the time of their research, Goodman et al. (2009) noted that the connection between IPV and persistent poverty had largely been ignored by spheres of research, policymaking, and direct care providers, despite high rates of co-occurrence. As a result, the authors argued that women contending with both IPV and poverty end up engaging in what they coined as “survival-focused coping,” leaving women little room to meaningfully address and integrate the impact of ongoing grief and trauma.

Because we expect individuals to “pull themselves up by their bootstraps,” ideas of wellness related to poverty/homelessness translate into advocating for oneself and utilizing resources to address one’s (material) needs. At the same time, cultural stereotypes regarding homeless women as “Welfare Queens” discourages individuals from trying to engage in these very same demonstrations of wellness, and further shames them when they do. Moreover, obtaining safety and resources *from* institutions of care may be linked to a very different internalized schema than obtaining safety and resources *outside of* institutions of care. While asking for institutional support, individuals may be expected to act in a way which is both deferential and appreciative, thereby emphasizing their status as victims in need. However, once back on the street this type of display may make one a target. In essence, by engaging with institutions of care, homeless women are forced to straddle two cultural worlds - that of the shelter and that of the street. Because of this, homeless women must contend with two opposing expectations of wellness and safety: being obedient, polite, and minimal while at the shelter (displaying vulnerability), and being defiant, aggressive, and expansive when outside of it (displaying strength). This leaves people feeling internally fragmented, distrustful of others, and isolated no matter what they do, resulting in practices of coping (surviving) while being denied the space to heal.

Politics of Displacement in the U.S.

Dirty Bodies, Unsanitary Citizens

“I don't belong here
 I don't belong there
 Just try to do your very best
 Stand up, be counted with all the rest
 For everybody knows about Mississippi Goddam.” - “*Mississippi Goddam*” by Nina Simone, 1964

As noted by van der Kolk and countless others, social support is not the same as being in the presence of others. Support requires being truly heard and seen by others and feeling as though we can be safely held by them. In order for us to trust that people can help us, we need to know that they understand where we're coming from, and that they understand who we are as people. This means listening to injustices we have faced and are currently facing. And, in the context of this study's population especially, it means listening to women's anger and taking it seriously, rather than automatically dismissing or silencing it. Sadly, particularly for marginalized groups such as homeless women, this need continues to be unmet within U.S. culture at large.

In her book, *Purity and Danger*, British anthropologist Mary Douglas discusses how pollution-based behaviors reflect ideas of social order. Specifically, Douglas proposes that culture provides a certain set of standardized categories and principles, which are meant to both reflect shared values of the community and help mediate the experience of individuals. Thus,

“Ideas about separating, purifying, demarcating and punishing transgressions have as their main function to impose system on an inherently untidy experience. It is

only by exaggerating the difference between within and without, about [sic] and below, male and female, with and against, that a semblance of order is created” (Douglas, 1966, p. 5).

In many ways, this parallel’s Lock’s concept of medicalization, in that it creates cultural schemas for identifying unambiguous, universal “normal” bodies and ways of being. However, because of their public facing, generalized nature, these cultural categories are often more rigid than perhaps privately held ideals and experiences. This disconnect may subsequently challenge the authority of the system, through instances of ambiguity.

This echoes back to my earlier note on cultural messages regarding homelessness. In the U.S., stereotypes regarding homelessness promote the unambiguous idea that homelessness is the result of a singular trajectory – one in which the individual fails to adhere to cultural expectations for obtaining success (e.g., finishing school, getting a job, persevering through difficult social environments no matter the personal cost). This causes individuals to then want to invest in cultural systems and social expectations, so as to maintain perceived normalcy and social integration while avoiding a negative outcome. When real experiences challenge this rhetoric, however – such as one of the guests at my site, who was homeless despite being a medical doctor – this weakens the idea that investing in toxic capitalist systems and expectations ultimately pays off, thereby challenging the authority of the overarching message.

As culture responds to ambiguity, it does so in several ways: re-interpreting the anomaly, physically controlling the anomaly, avoiding the anomaly, and/or labeling the

anomaly as dangerous, which helps reinforce conformity from others (Douglas, 1966).

Further, as Douglas puts it:

“In the course of any imposing of order... the attitude to rejected bits and pieces goes through two stages. First they are recognisably out of place, a threat to good order, and so are regarded as objectionable and vigorously brushed away... This is the stage at which they are dangerous; their half-identity still clings to them... But a long process of pulverizing, dissolving and rotting awaits any physical things that have been recognised as dirt. In the end, all identity is gone... So long as identity is absent, rubbish is not dangerous. It does not even create ambiguous perceptions since it clearly belongs in a defined place, a rubbish heap of one kind or another” (Douglas, 1966, p. 197).

In the following section, I will briefly touch on some of the ways in which methods of addressing and erasing ambiguity are interwoven into U.S. culture, and how these further entrench cycles of isolation and trauma, particularly for homeless populations.

Divide and Conquer

“Injins must either work or starve. They never have worked; they won’t work now, and they will never work... Why should the government support 260,000 able-bodied campers?” – *General Sherman, 1890* (cited in Dunbar-Ortiz, 2014)

In his work on racialized trauma in the U.S., Menakem (2017) notes that trauma responses can become activated by anything that is perceived as a threat to “not only our physical safety, but to what we do, say, think, care about, believe in, or yearn for” (Menakem, 2017, p. 7). In thinking about research on shame and its ties to our neural

threat-defense mechanisms, this makes sense: we react to threats to our social/symbolic self in the same way we do to physical threats, because our bodies are physically unable to discern between social and physical pain (Elison, Garofalo, and Velotti, 2014; Velotti, Elison, and Garofalo, 2014).

When people experience a negative event, the perceiver processes information in a systematic order that first considers causality, then intentionality, then reasons (if the event is considered intentional) or preventability (if the event is considered unintentional) (Guglielmo & Malle, 2017). Because we engage with social support as our first line of threat-defense (van der Kolk, 2014), *how* we are socialized and socially supported (which is largely determined by our bodies-as-social-markers) is therefore crucial in determining how we identify and mitigate those perceived threats, as well as how we seek justice and reunification.

Unfortunately, the foundations of U.S. culture are rooted in a long history of violence, dispossession, and the pitting of oppressed groups against one another as a strategy for discouraging uprising (Dunbar-Ortiz, 2014; Menakem, 2017). These traditions, which can be traced back to medieval Europe and which were brought over during the initial and ongoing colonization of the Americas, are deeply interwoven into the politics of expansion and governance within what we now refer to as the United States. For instance, in the late 1600s and early 1700s, (white) indentured servants and some “pardoned” bondsmen were being sent over from places such as Scotland, Ireland, and England. These Europeans had years of internalized, physicalized trauma which they had witnessed, experienced, and used against others (Menakem, 2017), passing onto their

children methods of survival which were deeply interwoven with ideas of economics and land ownership.

Once in the U.S., these white indentured servants worked and lived alongside Black slaves and immigrants on plantations that were almost exclusively owned by powerful white male bodies (Menakem, 2017). As a result, in early worker revolts, Black and white individuals rose up together against plantation owners, which posed serious threats to the power and supremacy of wealthy white landowners (Menakem, 2017). Thus, “it was only in the late seventeenth century that Americans began in earnest to formalize a culture of white-body supremacy in order to soothe the dissonance that existed between more powerful and less powerful white bodies; to blow centuries of white-on-white trauma through millions of Black and red bodies; and to attempt to colonize the minds of people of all colors” (Menakem, 2017, p. 63). In tandem with this, the U.S. was engaging in the eradication of resistant Indigenous tribes, destroying land and resources and causing tribes to become economically dependent on the U.S., while simultaneously reinterpreting their resistance for the public as “lazy” peoples resistant to “progress” (Dunbar-Ortiz, 2014).

By reinforcing a cultural system which simultaneously promotes white fragility (DiAngelo, 2018) and race-based shaming (Berry and Duke, 2011; Riggs, 1994; Smith, Herbes-Sommers, & Thomson, 2015), the U.S. continues to make it difficult for both white individuals to confront race-based privilege (and therefore less likely to use their privilege to change systems) while suppressing and/or reinterpreting dissent from people of color. Further, this avoidance/dismissal solidifies economic disparities at large, which

subsequently reinforces poor white individuals' inherited beliefs that white privilege does not exist, as they are not seeing these professed benefits in their own economic realities (Oluo, 2020).

Conversely, even "choosing" to assimilate rarely leads to positive outcomes for marginalized individuals. One example of this can be seen in the testimony of Plenty Horses who, in response to the cultural pressures of his time, attended a Christian-based school from 1883 to 1888:

"There was no chance to get employment, nothing for me to do whereby I could earn my board and clothes, no opportunity to learn more and remain with the whites. It disheartened me and I went back to live as I had before going to school." (Utley, 1974)

Unfortunately, over one hundred years later not much has changed for many individuals, as demonstrated in the following study participant's case:

Miriam: When I went in the class, and did the work, I can say, because of the time we were living in, they were shocked. I was a all A student. They couldn't understand that. 'Where she come from?' It's not the students, it's the teachers. All like, 'Oh, she got a A?' Because you're Black! Some people thought you were beneath them. But I showed them I could do the work! The math, the science, whatever. Algebra, pre-calculus – I had a ball! Chemistry, I loved that, because I could talk all that shit. Like the formulas and stuff. They. Were. Shocked! So I didn't - then I began to feel rejected. Like, what's, what's wrong with y'all? 'Cause I didn't understand the prejudice and bias some people had in their head. And, I was glad I graduated and got out of there... Then I got a scholarship for, I was gonna be a nurse. But, as quiet as it's kept, [a major Boston hospital], at that time, the professors were very prejudiced. When I went in to be a nurse, as a nursing student there were some patients who didn't want me. I may look like a white lady 'cause I got the Irish in me, but the hair was too nappy. In other words, they'd be up in the bed, lookin' at you like this [squinting eyes]. They'd ring the bell, 'Uh, we'd like to get another uh nurse, we' – they talk all quiet – blah blah blah. Next thing you know my instructor's coming to me saying, 'Uh I'm going to assign you to so and so and so. They have somebody for her.' That happened a

LOT. A HELL of a lot! So I dropped out, 'cause I couldn't stand the rejection. I was wondering, I'm afraid to give him a needle, her a needle, I'm learning how to give a needle and and, you know. That's my concern, I wasn't trying to hurt them or do nothing... So I, so I dropped out... I had like a 3.9, sometime a 4.0 average. But the professors were like this [eyes narrowed]. I'm telling you, they were like that. And, I couldn't take it. I can't, I couldn't adjust to them rejecting me.

By keeping individuals down and displaced from both themselves and each other, those in power can continue benefiting from systems of structural violence. This is because structural violence works by obscuring truth, maintaining social ignorance, and normalizing the status quo (Bourgois & Schonberg, 2009; Farmer, 2009; Hixon et al., 2013; Scheper-Hughes, 2004; Thandeka, 1999; Winter & Leighton, 2001). When we fail to see ourselves in others, we fail to empathize with their plight, making it less likely that we will intervene when injustice occurs (Winter & Leighton, 2001). Furthermore, as a way to counteract moral discrepancies when witnessing these injustices, we may moreover engage in exclusionary thinking - the belief that victims of violence deserve their fate (Winter & Leighton, 2001). Thus, by concluding that the victim is 1) not like us and 2) did something to prompt the violence, we maintain our ignorance, realign our moral expectations, and normalize the experience by holding onto a false cause-and-effect logic.

All of these factors result in the following for homeless women coping with/healing from trauma. First, U.S. meritocratic culture is one which claims that there is equal opportunity for all, as long as people work hard and adhere to the social contract. The reality that many individuals experience poverty and homelessness, despite investing (and even succeeding) in institutions such as school and work, contradicts this message and creates cultural ambiguity. This ambiguity challenges the authority of these power

structures, and so homelessness and poverty are both 1) physically contained, through hostile architecture and 2) socially re-interpreted/re-labeled using narratives of impurity (e.g., lack of willpower, drug abuse).

These toxic practices of disambiguation subsequently justify “letting die” individuals who, according to the framework of medicalization/standardized ideas of wellness, are viewed as not caring about their own lives. Misrecognition/mislabeling of trauma reactions specifically further entrenches stereotypes of the violent, dangerous, and unpredictable homeless person. Finally, systems of scarcity - which underlay institutions such as shelters - enhance narratives of deservingness, even between homeless individuals. Having to compete for limited resources, coupled with social shaming of the identity of homelessness, keeps individuals isolated from one another while perpetuating internalized states of emergency. Thus, instead of feeling as though they are on the “same team” and being able to consolidate power in order to create change, homeless individuals are instead pitted against one another, while simultaneously having their personhood erased.

Summary

In this chapter, I have discussed concepts of phenomenology, embodiment, and socialization at large, as well as how these relate to trauma specifically. In addition, I have utilized Mary Douglas’ work on *Purity and Danger* as a framework for looking at how the U.S. addresses areas of ambiguity in the context of homelessness, as well as the negative consequences of these systems of disambiguation. Specifically, because SES is *theoretically* more fluid than other identity-based categories such as race, there is an even

greater potential for individuals to actively avoid association with other similarly-identified individuals, as a way of coping with existing systems which label homeless individuals as dangerous, mentally incompetent, lazy, and morally barren. However, lack of community cohesiveness may in fact make it harder to engage in collective healing and change in the long run, thereby reinforcing cycles of isolation and re-traumatization. These complicated, nuanced tensions therefore beg the question: how do homeless women in the U.S. cope with, and heal from, interpersonal trauma?

CHAPTER THREE: METHODS

Designing the Study

This purpose of this study was to explore pathways of coping and healing for homeless women who have experienced interpersonal trauma. As discussed in Chapter 2, our bodies drive our understanding of the world, including how we interact with it and how it interacts with us (Merleau-Ponty, 1948/2002). This includes trauma, which becomes encoded into the body at an unconscious level (van der Kolk, 2014). If you don't understand what's going on in your body, it can leave you feeling hopeless, helpless, terrified, and out of control. At the same time, the types of groups we exist in impact how trauma is conceptualized and supported (or not) in our individual lives. Furthermore, these narratives both inform how we identify and react to what we are experiencing in our bodies, as well as how we choose to cope.

In thinking of these dynamics, it felt natural to approach the topic of trauma and healing by bridging the world of the physical, through the lens of phenomenology and embodiment, and the world of the social, through theorists such as Bourdieu and his work on social fields and *habitus* (Bourdieu, 1977). I therefore planned to collect data in two ways. The first was through participant observations of shelter dynamics, with a focus on how guests interacted with each other, with me, and with other staff members. I did this to capture not only shelter dynamics, but also potential impacts on interview data as a result of my perceived positionality. I also conducted participant observations while attending virtual volunteer meetings, in order to further compare interview data and observed interactions *directly within* the shelter, with how the shelter was discussed

among the organization's more transient (e.g., volunteers) or less directly interactive (e.g., board members, fundraising/social media staff, managers) roles.

Secondly, I collected data through interviews with shelter guests. The structure of the interviews consisted of two components (see Appendix for full list of questions). First, I had a semi-structured interview portion which asked questions about self-reported identity, reasons for coming to the shelter site, health history and experiences in the healthcare system, and how the person explicitly felt about their medical diagnoses physically, socially, and emotionally. In doing this, I predominantly wanted to get a sense of how this person had come to know their body over time, as well as how others had acted upon it, what had led them to seek help specifically at the shelter site, and how that need was met.

In the second part, I added a component that involved tactics for eliciting implicit knowledge, in the form of a series of card-sorting tasks (Barton, 2015). I did this because, regardless of the type, trauma gets physicalized in the body, which can make discussing trauma and its effects in a narrative way difficult (van der Kolk, 2014). Thus, I wanted to have these two components in order to compare the explicit interview responses with the implicit card-sorting arrangements, in an effort to capture a more complete picture of how individuals approached and thought about pathways of coping and healing overall.

During the card sorting tasks, participants were asked to write out three sets of cards: one set for social groups/resources that they belonged to or interacted with, one set for coping mechanisms that they might employ when dealing with various issues, and one set for internal selves which might emerge while addressing any given situation. These

responses were open-ended and specific to their own lives, and participants could always add to the card stacks if they thought of other resources/mechanisms/selves along the way. These cards were then used for two separate card-sorting activities: ranking and free association.

For the card-ranking task, I would ask participants a question and request that they rank their coping mechanisms and social groups on one side going from most likely to least likely to engage with, and then on the other side, which internal selves would be most likely to emerge or be utilized in that particular setting. If they were equally likely to engage with two or more resources, they could put the cards side-by-side in the overall hierarchy. These questions spanned a variety of situations, including financial, physical, and emotional emergencies, accomplishments/pride, creativity/curiosity, shame, and feeling good in one's body, however the participant interpreted that question.

The reason for this is because trauma is not just about heightened awareness of threat – it also affects how we allow ourselves to experience joy and creativity. I therefore not only wanted to compare the interview responses with the card-sorting tasks, but also to compare the card-sorting tasks with each other, in order to create a more well-rounded picture of how that person made various types of safety calculations. In other words, what does it mean if someone has a very robust network to tap into for emergencies, but no one that they would go to to celebrate something they had accomplished or were proud of? Essentially, I wanted to evaluate not just survivability, but *thrivability*.

As opposed to only being able to focus on day-to-day survival, being able to thrive means that, for instance, we feel safe and secure enough to *want to explore and expand* within our lives, rather than having our efforts limited to self-protection and acquiring basic needs. It means being able to *grow*, rather than having to hole up and wait out the storm. It also means that we can engage with the same resources for a variety of issues, and that we have relational home(s) for *all* of the pieces of ourselves. At its foundation, being able to thrive starts with being cared for as a whole human being and feeling safe and secure in our connections with others. Trying to survive means having to *cope* with the current situation; *thrivability* means having the space to *heal*.

Figure 1 is an example of what this exercise produced, specifically for the question, “Which groups and/or coping methods would you be most likely to go to for support/comfort during an emotional/mental emergency (for instance, if you started to have thoughts of suicide or felt as though you were having a “nervous breakdown”)? Here the participant, Faith, is indicating that she would first try to resolve the issue by herself and, if she could not, would then go to her grief counselor. Simultaneously, the parts of herself which would come out during an emotional emergency would first be her “avoidant” self, followed by her “totally inane” self, and then lastly the part of her which “laugh[s] and make[s] fun of [herself]”.

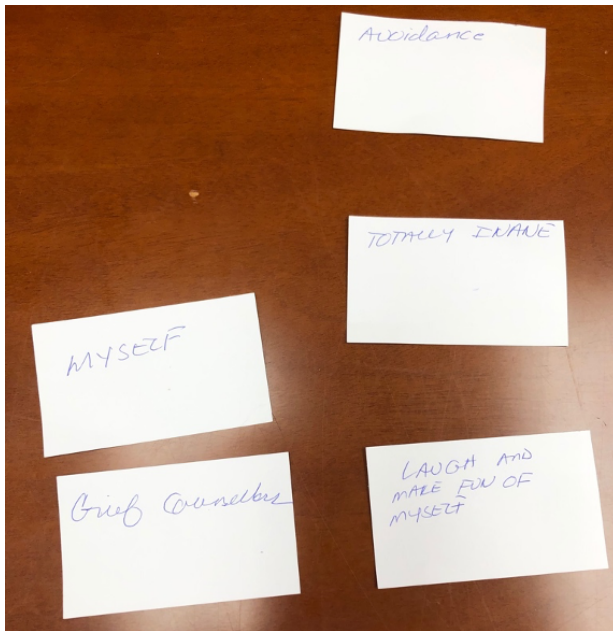


Figure 1. Participant card-ranking response to the question, “Which groups and/or coping methods would you be most likely to go to for support/comfort during an emotional/mental emergency (for instance, if you started to have thoughts of suicide or felt as though you were having a “nervous breakdown”)?”

In the second part of the card-sorting activities, I had participants do a free association task. During this task, I would give them a certain term and ask that they put in any and all cards that they felt related, regardless of why. Similar to the other tasks, I wanted to see how these answers corresponded to both the interview and card-ranking responses, in order to provide another nuance for looking at implicitly held beliefs and how that might impact coping and healing. For instance, what would it mean if an individual lists a certain self at the top of all the card-ranking activities – in other words, a self they must become to deal with these situations and those involved – but then associates that self with the term “shame”? Or, conversely, what if they never listed a certain self for the card-ranking questions (because they have learned that self isn’t

“useful”), but still associates that self with the term “pride”? Again, the goal was to create as nuanced a view as possible, in order to understand how individuals implicitly and explicitly felt about their bodies, social groups, and selves, and how this in turn relates to health and healing overall.

Figure 2 is an example of how one participant, Brooke, responded to the question, “Which groups, coping methods, and/or internal selves do you associate with the term ‘shame’?” In no particular order, Brooke indicates here that she associates the parts of herself which she labels “slut,” “survivor,” “[a] drunk,” and “one who withdraws” with the idea of shame. She also associates this concept with her “drinking buddies” social group and her coping mechanism of “drinking/relapsing.”

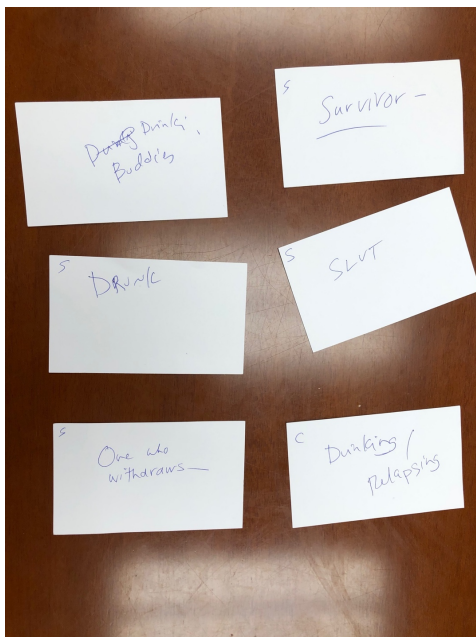


Figure 2. Participant free association response to the question, “Which groups, coping methods, and/or individual names do you associate with the term ‘shame’?”

The intent was to conduct the semi-structured interview and card-sorting activities over three, one-hour sessions, after which the participant would be given a \$20 gift card. In addition, all sessions would be recorded for audio, and photos would be taken of the card-sorting tasks, with the participant being offered a copy of those photos at the end of the session, if interested. Furthermore, while it was emphasized that the session was for the participant to have their voice heard, I also tried to set the expectation that any question I asked the participant, the participant could ask back to me as well. This setup was meant to provide another opportunity for empowering the participant, by allowing both researcher and participant to have equal stakes in the transactional field of research and knowledge/experience sharing. Thus, this framework was intended to build rapport by creating an equal-risk environment for both researcher and participant, with the hope that it would allow for more transparency and therefore richer, more reflective data, both in amount of content and level of depth/breadth. All interviews and observations were anonymized.

Finding a Site, Sampling, and Recruitment

Finding Shelter

When I was first accepted into this masters program, I had a number of sites that I was interested in working with. However, shortly after I received my acceptance letter, COVID-19 struck the U.S., and within a few months all my potential sites had either shut down or were no longer accepting volunteers/interns, as they already had to reduce their staffing numbers due to concerns such as budget cuts and attempting to reduce the spread

of the virus. Originally, my searches largely revolved around various support groups and organizations for individuals experiencing or recovering from trauma specifically. However, as it became necessary to expand my search, I began looking at other organizations such as addiction recovery programs and homeless shelters, as the literature suggests programs such as these are also likely to have a large proportion of individuals with a history of trauma (Centers for Disease Control, 2020).

Eventually, I was able to secure an internship with a women's day shelter, which I will refer to as City Women's Shelter (CWS). CWS is a privately funded 501(c)(3), non-profit community day women's shelter located within the wealthier financial district of a major U.S. city in the Northeast. Officially, the organization states that it serves anyone who 1) identifies as a woman and 2) is currently experiencing poverty and/or homelessness. While in theory this implies that the shelter is restricted to cis and trans women, in my observations I also met individuals who, like myself, identify as genderqueer/nonbinary but were assigned female at birth (AFAB).

As part of its mission, CWS operates on a no-questions-asked basis which purposely avoids formal intake processes, priding itself on empowering women through dignity and the promotion of agency. As an extension of this, all clients coming into the shelter are referred to as "guests," which is done to emphasize a sense of welcome and hospitality. In my own mind, however, I often wondered how this labeling might also impact guests' sense of community and rootedness. Guests may be *welcome* in the home, but by nature they are also separate from the family/household community – they are outsiders being temporarily contained, but never truly belonging.

On the surface, being a guest at a shelter might seem like a good thing: no one wants to be in a permanent state of need. At the same time, being a guest means you do not have a real place or say in the overall household dynamic. In life, guests can be (theoretically) kicked out at any time by those living in the house. They must therefore abide by the rules and expectations of the house if they want to remain there. Thus, in being cared for (e.g., given shelter and food), guests must also, to some extent, sacrifice their freedom (e.g., by adhering to household laws rather than doing what one wants). In the shelter context, this creates a cycle of coming in to receive care *in order to increase agency* but having to also give up a sense of agency *in order to receive care*. Particularly for guests who have been coming into the shelter for years or even decades, this sense of powerless separateness may also result in reinforced states of coping, rather than healing.

Getting to Know the Lay of the Land

According to staff and guest lore alike, when CWS was first founded decades ago it was run by two women out of their basement. For the last several years, however, CWS shifted to renting space within a nondescript, multi-storied church. Surrounding the church are streets littered with people wrapped in expensive-looking clothing, laden with multiple shopping bags from high-class stores, and carrying constant stares which, through the narrowing of eyes, both ask and answer the question, “*Do you belong here?*” While the organization does have an online presence, in the local, physical environment it exists unadvertised outside of a small, tented sign in the front, which is brought in and out each day the shelter is open. Tellingly, during my first visit to the shelter I completely missed this sign, and spent a number of minutes panicking over whether I had gone to the

right place or not. In fact, it was only because of a guest who happened to be waiting outside that I was eventually able to find the shelter entrance.

The main center of activity is contained within the basement, which comprises both the kitchen space and cafeteria area. This can be accessed through a set of stairs going into a side entrance or, for those who need it, via an elevator from the first (street-level) floor. Guests who need elevator access to any floor other than the basement must be escorted by a staff member, as all other floors can only be accessed using a key to “unlock” that particular floor (otherwise the elevator won’t move). Upon returning back to the basement level, staff re-lock the elevator floors and keep the keys on themselves at all times.

The two other levels used by the shelter are for food pick-up and private, shelter-related advocate offices, respectively. This latter floor also previously contained a library for guests to enjoy, but during COVID the library was closed to guests in order to minimize potential spread of germs. The advocate rooms, however – where guests can meet one-on-one with advocates - remained open. On Sundays, the only day when CWS is closed, the basement is repurposed as a space to hold AA meetings and other related support groups.

Most guests come into the shelter through the side entrance, where they must walk down a set of twenty or so slightly curving stone steps ending at a solid steel door containing a small, barred window. Upon walking through the door, guests are required to first wash their hands at a washing station immediately adjacent to the entrance, followed by receiving a fresh surgical mask and having their first names written down by

the staff member watching the door. While I have joked with staff and guests that manning the door feels somewhat akin to being the bouncer at a club, most of the time this role of door-watcher is more of a formality than need, as most guests are both familiar and compliant with this process. As a result, it's fairly easy to identify new guests, as they tend to either 1) quickly and nervously report their full name and ask what other information is needed (we only need their first name) or 2) to eye us suspiciously and ask what we need it for (which is to keep track of how many people come into the center).

Prior to COVID-19, the cafeteria space was filled with a dozen or so large round tables which, in total, could accommodate close to 200 people. While this was before my time, guests have told me that the shelter was usually full, with members being able to freely drift between tables. Since the onset of the pandemic, however, the layout shifted to using small plastic tables seating two at a time, with a plastic divider in between. In addition, to minimize the spread of germs guests are asked to remain seated in the spot they initially choose, and to refrain from wandering. As of this writing, shelter capacity also remains at about half of its previous volume, with many guests opting to take their meals to go.

Finding People

Due to the short amount of time to recruit, combined with the potentially high volume of data to interpret per individual, my goal for this study was to interview 8-10 shelter guests. Because I wanted to reflect a range of experiences, I planned to recruit women who were diverse along factors such as race, age, sexuality, and disability status,

wherever possible. However, because I had been warned by the shelter manager that most of the women might not want to speak with me (given that I was a new person/researcher), I chose not to utilize a quota strategy because I did not want to unnecessarily limit potentially useful data. I did, however, include in the eligibility that they must be age 18 or older and comfortable completing activities in English, due to my own monolingual limitations.

The plan was to recruit participants through posted flyers within CWS. I chose this approach because I felt it was the least confrontational, and would allow participants to approach me on their own time/based on their own interest, rather than being referred by someone else or approached by me directly. As I have mentioned above, much of the difficulty in trauma is having to operate on someone else's timeline or according to someone else's expectations. As such, I did not want to inadvertently cause someone anxiety over wanting to decline but feeling unable to, for any reason. In addition to obtaining verbal consent immediately prior to all interviews, I also offered copies of the list of questions I would ask, as well as the verbal consent form, if guests wanted more information prior to agreeing to participation. In total, I had 3 participants take me up on this offer.

Lastly, as part of the screening process, I chose not to use any formal criteria for confirming trauma "eligibility," but rather relied on self-reports. The reasons for this were twofold. First, this study is founded on the critique that there is no "proper" level or state-of-being related to trauma. Because of this, the act of "confirming" trauma felt both arbitrary and potentially re-traumatizing/shaming in and of itself. In addition, I felt that

screening in this way could negatively impact subsequent attempts to build rapport between the participant and myself, thereby affecting the quality of the data. Second, as previously mentioned, the likelihood of individuals in this population having experienced interpersonal trauma was already expected to be high, thus outweighing the con of potentially enrolling someone who might be “formally” ineligible, but who might have nonetheless had traumatic/relevant experiences.

What Changed

The impact of COVID on this research project cannot be understated. Even after finally securing an internship, I was unable to have any direct interactions with guests for the first four months due to staffing limits in the actual shelter. Instead, January through April was spent working in CWS’ development office, mostly doing work involving data entry for gifts and other donations. During this time, I was able to attend volunteer town halls which were being held virtually, but otherwise did the majority of the work from home. Starting April 30th, 2021, I was finally able to join the direct care staff on the floor, and was onsite twice a week from 7:45 am to 2 pm (when the center closes). I remained in this role until July 26th, 2021, when I finished my masters program’s 200 hour (unpaid) service learning internship requirement and switched to being part of CWS’ hired relief staff force. As of this writing, I continue to work in the shelter on an as-needed basis.

Ironically, the restrictions of COVID actually ended up being to my benefit when I initially began on the floor, as CWS had been restricting the inflow of guests from their normal 200-250 to around 40 a day. My first day onsite, there were 18 people total

throughout the course of the day. Prior to COVID, meals and beverages were all self-serve, buffet style. However, because of the need to restrict contamination/potential spread of COVID-19, the policy had shifted to having direct care staff act as essentially waiters, thereby ensuring that guests remained seated. Both this change in role and reduced volume/slower pace in the center allowed me the opportunity to really get to know people as I got their orders, as well as giving me an excuse to talk about my role at the site and, by extension, my research. In fact, one of the first guests I met at the center ended up being my first participant, as well as later on becoming my unintended, but deeply appreciated, “hype-(wo)man” due to her large enthusiasm for the topic of trauma and her approval of me overall.

While I did not plan on using snowball sampling, this did inadvertently happen in some cases because many of the guests who frequent our day shelter also end up staying at the same small sets of night shelters. It was a lucky occurrence for me that this happened, though, because the flyers themselves could have ended up being a lot less effective, given that the shelter was still trying to discourage guests from getting up and walking around. Regardless, although I had been preparing for the worst (e.g., only being able to enroll one participant), I ended up having to make significant adjustments to my transcription/coding timelines due to the unexpectedly *high* volume of interest in the study. Eventually, I closed recruitment one week earlier than planned, in order to have enough time to get through transcriptions and coding.

As a final note, although this was not officially a change to the study itself, I would be remiss if I didn't address my experience regarding gift cards. As an excerpt from one of my field journals explains:

“Gift cards are appealing for researchers in that they’re 1) “flexible” use, in terms of being a blanket sum of money, 2) impersonal/“neutral”, so as to avoid seeming to privilege some participants over others, and 3) convenient and easy for the researcher to obtain, as they don’t require significant amounts of mental energy to select (in theory). Symbolically, though, they act as another facet of maintaining distance between researchers and communities while reinforcing a model of capitalism as worth. Participants oftentimes share intimate pieces of themselves, sacrificing time out of their lives and spending emotional energy all in exchange for money which can be quickly spent and forgotten. There is no concrete, long-lasting token of meaningfulness which is given back: in exchange for sharing something personal, they are given something which again makes them faceless and forgotten.

This is why, outside of the IRB-approved gift card compensation, I decided to (independent of the research/out of my own pocket) buy personal tokens for participants, based on what I have learned about them during our time together, both within the session and in general. Gift cards are problematic for this population for a number of reasons, including the fact that many come with additional fees upon activation and the available, non-fee options may not be easily accessible for a population who already tends to be more restricted in their mobility. In addition, because my site already offers free food and basic needs (including clothes), these gift cards did not feel as though they had the level of elevated worth that truly matched the exchange we were making. This was apparent to me after my first participant interview, when my participant told me that she hadn’t talked about herself like that in years, and that I now “knew her better than anyone else here [at CWS]”. Thus, I plan to give these tokens out when I finish with recruitment (so as to avoid any potential appearance of coercion) in the hopes that my participants can see a tangible reminder of what they exchanged with me about who they are... Tokens which reflect value not in their cost, but in their symbolic relational meaning to the participant – tokens which will hopefully reflect my personal feeling that information/understanding should not be “neutrally” purchased by those with power, but instead meaningfully shared/exchanged between individuals.”

Thus, while I did also give out the \$20 gift cards as stipulated in my IRB protocol, after recruitment was completely finished I made it a point to pass out the personalized thank you gifts/cards, independent of research compensation. This proved to be

particularly meaningful as all participants, with the exception of one, declined receiving copies of their photo activities, for fear of having them stolen later on and used against them. On the other hand, the tokens I bought them tended to be small/easily concealable and fairly inexpensive, with symbolic meaning that they would be able to reference for themselves, but that others would not necessarily be able to de-code and use to undermine them.

What I Ended Up With

As discussed above, while my internship began in January, my time working with guests did not begin until the end of April. Thus, participant observations in the first segment of my internship largely consisted of notes on the various processes behind the tasks I was doing. This included observations of the kinds of donations that were being made and by whom (e.g., a large volume of “small donors” vs. small volume of “big donors”, one-time donors vs. frequent or long term) as well as the virtual volunteer town halls. Starting at the end of April, however, these shifted to being more in line with my original research plan, namely regarding the dynamics of the center and specifically between staff and guests. While onsite, I made it a point to carry my journal with me at all times so it was visible to both staff and guests, and always took notes in a visible place to maintain transparency. In addition to this, I made it a point to introduce myself as a student intern, and to let guests and staff know I would be doing research on trauma during the summer. Because of this, there were a number of times where I would have new guests approach me and ask if I was the “trauma lady,” as I came to be known for

giving out suggestions for books to read, helpful therapeutic tactics, and so on, in addition to being “the person who likes to listen to people.”

In total, I was able to conduct interviews with 8 guests from CWS, with interviews starting June 15th, 2021 and continuing until July 20th, 2021. I did receive interest from a ninth person prior to closing recruitment, but after an initial no show at the beginning of July, we were unable to reschedule a new time where both of us were available. All participants chose to complete all three study components in one session, which ranged in recorded duration from an hour to two and a half hours. The median recorded interview length was 122.5 minutes, with an average recorded interview length of 115.5 minutes. This does not include time spent prior to recording the interview, however, with pre-interview informal conversations sometimes going on for upwards of an hour before I was able to turn the topic back to the formal interview. All interviews and activities took place in a separate, private area within the overall CWS building, at a time and day of the participant’s choosing.

While not intentional, my study population ended up being reflective of the general age demographic at CWS, with participants ranging in age from 55 to 75 years old. Although there are younger guests who consistently come into CWS, this could perhaps be because the older guests, whose stories are now largely ignored by society, might have been more likely to reach out to me as a last resort way of being heard and taken seriously, whereas younger guests might have been more wary of a perceived peer of theirs handling the gravity of their experiences. Of the participants, three were white, two were Black/African-American, two were mixed race, and one was of Asian descent.

Finally, while the study criteria only stipulated that participants self-identify as women - which is the same criteria for being a guest at CWS - all interviewees ended up being cis gender females.

Data Analysis Process

At the start of the interviews, transcription of the audio recording had to be done manually, as our masters program had not yet approved use of transcription software. Because of the sheer volume of interview content to transcribe, combined with the fact that I am hard of hearing in both ears and have to transcribe at a much slower pace, I chose to take the advice of faculty and switched to creating outlines of the interview content, as opposed to transcribing everything word for word. At the same time, these outlines ended up being extremely detailed. I would mark the timestamp and content for not only every response to a question, but also any changes in conversational topic in general, including any tangents, even if unrelated to anything I had been asking. This was done to ensure that no content was overlooked or omitted because of my own potential biases, as a compromise for not transcribing all content verbatim.

That being said, I would also, in real time, *fully* transcribe any and all responses that seemed 1) particularly relevant to the question, 2) helped contextualize responses or self-reported selves, coping mechanisms, and social groups, and/or 3) anything that related to emerging or overlapping themes (within and across participants), as well as any instances of sighing or laughter. This last effort was done in order to also be able to identify any patterns of when implicit, “body” responses occurred in tandem with explicit, narrative responses (e.g., patterns of the participant laughing off situations where

they had felt angry, or been regarded by others as “unnecessarily” angry, even if the anger was justified).

When we were later given access to use Otter.AI for transcriptions in late July 2021, I went back and more fully fleshed out the interview portions. I also compared all manual transcriptions to the software ones, listening again to the recordings in cases there were discrepancies. This process of transcription was undertaken for both the semi-structured interview and card-sorting portions of the overall session, and photos of the card-sorting activities were included in the outline along with their associated text responses and timestamps.

In addition, I compiled all of the ranking and free association responses for all participants in an Excel file, as well as the time it took for each question to be answered. I then utilized Excel’s pivot table functionality to get a sense of 1) whether there were also any patterns related to which questions participants spent the most versus least amount of time answering, as well as 2) any patterns regarding the volume of resources and selves present across situations. As mentioned above, I also wanted to examine how the various combinations of selves would manifest and for what contexts, and how this related to both free association responses for the terms “health,” “safety,” “shame,” and “pride,” as well as responses from the semi-structured interviews.

Once outlines were complete, I uploaded the content into NVivo for further coding and analysis. This consisted of grouping responses according to emerging themes (e.g., grief) and recording the codes in an Excel codebook. Using a somewhat grounded theory approach (Kelle, 2011), codes were not determined ahead of time, but rather were

spontaneously created while reviewing the outlines. Specifically, in order to avoid missed themes, I created codes which were more precise than broad, with the intention of then grouping similar descriptions under parent codes as part of my second round of analysis. As such, many responses to a single question resulted in several separate codes, and codes for responses were not mutually exclusive. For example, one response could yield codes for “grief,” “loss,” “homelessness,” and “emotional emergency,” all regarding the same content. I then repeated this process with my uploaded memos and participant observations.

After all transcripts and notes were initially coded, I reviewed the list of codes to consolidate themes and hone in on what was most salient. First, I began by organizing codes according to a hierarchical system, adding a “description” column for each code and then another column for whether it was a child or parent code (Ando, Cousins, & Young, 2014). As recommended by other qualitative researchers (Chickasaw Nation, 2017; Ryan & Bernard, 2003), when refining the list of codes, I specifically looked for patterns both within and across participants’ responses, as well as repetitions in both my memos and participant observations. I further made notes of when participants gave a completely unrelated response to a given question, as well as questions which were either partially answered or passed on altogether.

Tying Things Together

This study attempted to address the question of how women dealing with homelessness and poverty navigate various pathways of coping and healing. In order to explore this question, data were gathered through both participant observations and

interviews with guests. Interviews consisted of two parts. The first part was a semi-structured interview asking questions about self-reported identity, reasons for coming to the shelter site, health history and experiences in the healthcare system, and how the person explicitly felt about their medical diagnoses physically, socially, and emotionally. The second part consisted of both card-sorting and free association tasks, in order to gather implicit knowledge (Barton, 2015). All data was transcribed and coded, with a focus on themes which both related to the question and appeared as salient patterns across/within participant responses.

Because this project revolves around trauma, the following three analytical chapters are organized to explore each of the three levels of threat response (*social engagement, fight/flight, and freeze/collapse*, respectively). In the following chapter I begin at the level of social engagement, focusing specifically on the dynamics of giving and receiving care.

CHAPTER FOUR: GIVING AND RECEIVING CARE (EROSION)

Chapter Overview

“She has 80 names, 30 addresses, 12 Social Security cards and is collecting veterans’ benefits on four non-existing deceased husbands. And she’s collecting Social Security on her cards. She’s got Medicaid, getting food stamps, and she is collecting welfare under each of her names. Her tax-free cash income alone is over \$150,000.” - *Ronald Reagan, Jan 1976, Asheville N.C Campaign Trail Speech on “Welfare Queens”*

The overarching argument of this thesis is that the ways in which mainstream U.S. culture frames and interacts with homeless women creates cycles of isolation and ongoing trauma. Furthermore, I argue that these cycles of isolation cause individuals to adapt by engaging in practices of coping (surviving) rather than healing (thriving), and that these same behaviors then cyclically reinforce the same stereotypes initially driving these cycles. In this chapter, I focus specifically on how stereotypes of homeless women as “Welfare Queens” or con artists, combined with their experiences of betrayal and interpersonal trauma, result in behaviors of phenomenological shrinking.

Before moving onto the data, I will begin by unpacking what “phenomenological shrinking” means and how it relates to homeless women and trauma. First, phenomenological shrinking can result in response to shame, whereby we physically shrink our bodies through behaviors such as lowering our heads or drawing our shoulders in. As noted by Elison and colleagues:

“Just as cowering in response to a physical threat communicates a great deal of information and may avert the attack, the submissive posture of shame in response to a relational threat communicates understanding of the relational dynamics.” (Elison et al., 2014, p. 449)

Just as we shrink our bodies in response to shame, we may also shrink our overall presence around others. This may be particularly true in situations where care institutions are structured to regard their clients as overly needed.

For instance, in her work on eating disorder patients, Lester (2019) noted a system of “double binds” where:

“[C]lients are perceived as perpetually ravenous and needy, [so] clinicians feel the need to be constantly on guard, to vigilantly focus on boundaries and limits, and to be cautious with what they give lest they be “consumed” by the clients’ needs. Like the focus on control, this leads to an oppositional relationship between client and caregiver, and it is exacerbated by an insurance system that prioritizes conserving resources and is suspicious of greed and waste. At the same time, clients are deemed “resistant” if they do not recognize their illness and willingly accept care.” (Lester, 2019, p. 58)

This framework likewise applies to stereotypes of homeless women as drains on the system. In my own observations of CWS, I saw a number of instances where guests would be informally discussed amongst staff regarding whether or not they truly needed a particular resource (e.g., shoes, coats) based on how long ago they were given that item and/or how often they asked for goods in general. While staff did concede to me that guests *could* need another item sooner because of the potential for theft while sleeping on the street, they almost always followed up with justification that you can’t completely trust guests, and that many of them likely sell what they get from the shelter.

Even in times of surplus, there was always a fear that giving too much to one person might result in everyone taking all they could get, leaving the shelter with nothing for those in “actual need.” In other words, one must gatekeep against those trying to “cheat” the system by maintaining a tight grip on resources, in order to be able to support those most “deserving” in the future. Being beholden to donors for what goods a shelter can offer at any given time further exacerbates this type of scarcity environment, reinforcing a system which constantly reasserts the idea that women should limit their asking and only take the bare minimum of what they need.

As will be discussed in this chapter, homeless women adapt to these experiences and stereotypes by shrinking themselves in terms of both forced vulnerability (needs) and voluntary vulnerability (expression of self). They do this by limiting how much they present themselves to others, which both (theoretically) decreases the chances of them being perceived as social drains and maintains a sense of self-protection. Especially for women with experiences of childhood trauma, being in a position of dependency can itself be threatening and re-traumatizing. As such, from a relative risk standpoint, sleeping on the street instead of in a controlled shelter may *feel* safer, even if probabilistically riskier. In other words, “how we *move* [behave] is tied to how we *feel*” (Pliszka, 2016, p. 107). This is particularly true regarding trauma and its integration with the body.

In addition to this, women in the U.S. are largely socialized to put the needs of others over their own, and to be ashamed of asking for too much (Chemaly, 2018). Thus, in addition to avoiding shame and reducing potential threat, limiting expressed needs may

also feed into a sense that one is “doing the right thing,” by both embodying the expectations of womanhood and the independence of the “American Spirit.” However, in diversifying their needs across resources, homeless women may paradoxically reinforce stereotypes of the insatiable “Welfare Queen” as they are noted to be, for instance, going to multiple shelters/resources even within the same day. Given the above dynamics, this may be enough to justify withholding resources from them, further entrenching their embodied understanding that they cannot depend on others and especially not institutions of care. Furthermore, this constant division of need and *presencing* – or “coming into being or becoming real in ways that are locally recognized as mattering” (Lester, 2019, p. 65) - can also result in a slow *erosion* of both physical and financial resources, as well as a sense of personhood.

Shrinking Needs

This study was not originally intended to be mixed methods. However, the card sorting task inadvertently produced a type of quantitative dataset, which bears discussion. First, a total of 159 cards were generated by the 8 participants of this study for use in the card sorting/free association tasks. Of these, 104 were related to coping mechanisms and social support resources (hereafter referred to collectively as “support” cards) and 55 were related to internal identities (hereafter referred to as “selves” cards). However, only 109 (69%) of the total cards submitted were actually used at least once during the card sorting task, and only 70 (44%) were used during the free association task. Furthermore, the number of cards used varied per question, with the most notable decreases occurring

during both the shame card sorting task and in the free association task, in relation to the term “shame” (Table 1).

Table 1. Number of cards used per card sorting task situation and free association task term.

Question Category	# Coping/Social Cards Used	# Internal Self Cards Used	Grand Total
Card Sorting Task			
Financial Emergency	22	17	39
Physical Threat	17	16	33
Emotional Distress	27	16	43
Accomplishment/Excitement	28	19	47
Curiosity/Creativity	22	14	36
Shame	8	3	11
Feeling Physically Good	22	14	36
Free Association Task			
Health	24	7	31
Protection	18	7	25
Shame	7	11	18
Pride	12	8	20

In addition, when focusing on the emergency-related questions - where one would expect to see the highest use of resources – I instead discovered that 82 (52%) of the 159 cards were *not used at all* when addressing any of the three measured areas (financial emergency, physical threat, and emotional distress). Moreover, of the remaining 77 which *were* used at least once during the set of emergency questions, 20 (26%) were used exclusively for the emotional distress (ED) category, 18 (23%) were used exclusively for the financial emergency (FE) category, and 12 (16%) were used exclusively for the physical threat (PT) category (Table 2). In other words, 65% of the time (50/77), women struggling with poverty and homelessness are only utilizing a resource or type of internal self *once* across three types of emergency situations. This is despite the fact that many of

these women have experienced – and continue to experience – all three threats simultaneously.

Table 2. Areas of overlap for cards submitted during the card sorting tasks for emotional distress (ED), financial emergencies (FE), and physical threats (PT).

Area of Overlap	# Cards Used
All	11 (14%)
ED	20 (26%)
FE	18 (23%)
FE, ED	6 (8%)
FE, PT	4 (5%)
PT	12 (16%)
PT, ED	6 (8%)
Grand Total	77

This means that, for example, when experiencing a financial emergency, a participant might go to resource A and, while engaging with that resource, become her submissive self, as she is in the shameful position of requesting a “handout.” However, if experiencing a physical threat, she would not engage with resource A but rather go to resource B and, while engaging with *that* resource, become her aggressive self as a means of reducing perceived weakness. This might be particularly true in cases of disclosing intimate partner violence, as continuing to adopt her submissive self in *that* context may reinforce the belief from others that she made herself a target through her meekness. Finally, if also experiencing an emotional emergency – perhaps because of her combined financial and physical distress – she would divide herself even further and only go to resource C, while also adopting yet another internal self in order to “deserve” that resource: her “I can do this” persona.

Moreover, women may choose to omit going to *any* resource for a particular type of issue, even as they continue to adopt different internal selves while in that situation as compared to others. For instance, Sonny reported that she would go to CWS for a financial emergency and would become her overwhelmed/unfocused self because “I can’t focus when it comes to money, greed works evil to me.” However, if dealing with a physical threat she would go to an external resource such as the emergency room or the police (essentially a social resource which is meant for ad hoc, singular/emergent issues as opposed to resources which guests might use and develop connections to long-term). As opposed to the part of herself which may take a backseat with financial emergencies, while experiencing a physical threat she also reported that her “extremely watchful even when asleep,” “quiet when angered,” and “methodically creative” selves would be most likely to come out. Finally, Sonny reported that she would not go to *any* social resource if experiencing emotional distress, and instead would engage in coping through “[singing] songs that represent the way I feel,” “Crying/Praying; Regarding,” and engaging in her “likes” which she specifies as being “Creativity: music, art, masonry, old eclectic Decco Art/Engineering/Hydrolics/Plain [sic] Engines.” Furthermore, as opposed to her previous two sets of selves which are more reactive in nature, it is notable that these more expressive sides resulting from emotional distress manifest in the absence social gaze.

When all three emergency situations occur simultaneously – such as in one situation where another participant had her apartment broken into, money stolen, and life threatened, leaving her feeling hopeless and terrified – this results in individuals having to spend vast amounts of time and energy in order to be holistically cared for. Because

they also need to adjust how they present themselves to these different social groups/within these different social fields, it may also contribute to/reinforce internalized feelings of imposter syndrome and fragmentation, as well as reinforcing external stereotypes of them being “con artists” as they continue to adopt an array of social personas.

Not only is this process exhausting, this pattern also indicates that women are attempting to divvy up the “burden of need” (so to speak) so as to not overuse those they may need to rely on again in the future. This further supports the argument that - as opposed to stereotypes based on “Welfare Queen” propaganda, which suggest that poor women aim to cheat the system and take advantage of those around them – women struggling with poverty and homelessness often attempt to *take up less space* in their individual relationships, phenomenologically shrinking themselves as a response to both stigma and chronic interpersonal trauma. This makes sense because not relying on any one person or institution also decreases the chances of becoming beholden to (and subsequently trapped and/or abused by) that entity through accepting their aid. In this sense, trying to keep outreach both superficial and diverse in some ways allows vulnerable women to continue to protect themselves. However, these acts often get reinterpreted as engaging in “double dipping” with resources, thereby reinforcing stereotypes of homeless women as self-focused, amoral cons.

Moreover, as shown in Table 3, even for cards that *were* used for multiple emergency situations, there is a marked shift in the type of card submitted. For example, for cards that overlapped in the areas of financial emergency and emotional distress, 50%

of the time these cards were related to internal selves which might emerge during those times. In addition, *all* cards that overlapped for both financial emergencies and physical threats were exclusively related to “selves” cards. What this means is that, for example, while the same internal self might emerge during both financial emergencies and physical threats, the actual resources utilized remain unique to each area. This further emphasizes how homeless women engage in acts of phenomenological shrinking, even in the face of great need, as well as highlighting the potential ongoing disconnect between their internal (identity) and external (social) environments.

Table 3. Areas of overlap for cards submitted during the card sorting tasks for emotional distress (ED), financial emergencies (FE), and physical threats (PT), categorized by type of card submitted.

Areas of Overlap	#Coping/Social Cards	# Internal Self Cards	Grand Total
All	7 (64%)	4 (36%)	11
ED	13 (65%)	7 (35%)	20
FE	12 (67%)	6 (33%)	18
FE, ED	3 (50%)	3 (50%)	6
FE, PT	0 (0%)	4 (100%)	4
PT	6 (50%)	6 (50%)	12
PT, ED	4 (67%)	2 (33%)	6
Grand Total	45 (58%)	32 (42%)	77

When we dig further into these areas of overlap, focusing specifically on the cards for coping methods and social resources, this shrinking becomes even more pronounced. For instance, of the 7 “support/coping” cards referenced in Table 3 which were used for all three emergency areas:

- Two were for pastors. Notably, both cards were submitted by the same participant, and for all three questions, both pastors were ranked second place in the hierarchy of resort. Incidentally, this participant also had a third pastor card, but that resource was only utilized for financial emergencies (and was ranked second place there as well).
- Two were for coping mechanisms which did not require reliance on others (specifically, “listening to music” and “trying to feel quiet and centered”, respectively).
- One was for “drinking buddies,” which was also used by the same participant during the free association task in relation to the word “shame.”

The remaining two cards were for our shelter (referred to here as “CWS”) and “Social service + Housing Advocates; ER/psych.” With the latter, even though the same card was used, it is noticeably packed with a range of (separate) services. This once again shows participants’ reliance on a diverse array of resources, even when they think of them as one lumped-together entity. Moreover, and perhaps more interestingly, this card was also *not* used in the free association task in relation to the words “health” or “protection.” This suggests that, while participants may use these resources when absolutely pushed to, they do not necessarily feel cared for by them, nor happy (or healthy) about doing so.

Conversely, the “[CWS]” card was used for every single question by a second participant (self-named “Sexy”), suggesting, amongst other things, two options. The first is that, per her interview, she is a woman suffering from extreme social isolation due to

her process of immigrating to the United States, leaving behind her family, and getting diagnosed with a serious medical illness, all while attempting to navigate the unintelligible mess of bureaucratic hoops and ladders structuring the U.S.' healthcare system. Our shelter, CWS, offers both connection with other women and help with a wide array of services, helping to consolidate many of her specific needs in one place.

However, even if this first theory were true, Sexy remains fiercely focused on being self-sufficient as much as possible. For instance, following her kidney transplant, Sexy explained:

They give me a pain medicine - I didn't even have to use it. The doctor was so shocked. He even come and talk to me and say "Miss [redacted], I notice your pain medicine not going down, you're not using it?" And I tell him, "No, I don't need it."... 'Cause I'm a fighter. And when they sent me home, they sent a nurse with me - she didn't even stay a week 'cause I'm trying to get better to do things myself. So I watch her, what she do, 'cause they send me home with a bag in my side. She showed me how to clean it. The next day when she called me, she said, "I'm not coming back." I said, "Why?" "You're doing it so perfect, you don't need me!" So I'm always trying to do for me. Obviously I don't want depend - I'm not a person where we used to sit down and depend on nobody. If it wasn't my sickness, or when I was sick, I was working. I was, [for instance,] when I was on dialysis, I was doing two job [sic].

Given the evidence, this leaves option number two: that, knowing I am "part" of CWS, she was playfully buttering me up as part of our friendship, via the card's continued presence (importance) across situations. In an ambiguous, dialetheic world, both are likely (at least partially) true.

Vulnerable Engagement

As a final note, it is worth briefly touching on how these areas of overlap for emergency situations interact with areas of overlap for situations involving emotional joy

or comfort - specifically, feeling excited about a new opportunity/feeling pride in accomplishing something and feeling curious/creative, respectively. As shown in Table 4, of the 159 total submitted cards, only 40 (25%) were used for at least one type of emergency situation *and* at least once in situations of emotional joy/comfort. By contrast, 37 (48%) of the 77 cards used during emergency situations were *never* used in areas of positive emotional health and well-being, further highlighting the fragmentation that can occur in response to interpersonal trauma.

Table 4. Intersection of cards that overlap emergency situations compared with cards that overlap situations of emotional comfort/joy (accomplishment/excitement/pride and curiosity/creativity, respectively).

Areas of Overlap	Pride + Creativity	Pride Only	Creativity Only	Not Used	Grand Total
All	4	4	2	1	11
ED	4	4	4	8	20
FE	1	3	1	13	18
FE, ED	3	2	1	0	6
FE, PT	2	0	0	2	4
PT	0	2	1	9	12
PT, ED	0	2	0	4	6
Grand Total	14	17	9	37	77

Only four cards were used in all three emergency situations and both areas of assessed emotional joy/comfort. Of these four, three were from the same participant and were specifically related to: one of her three pastors (mentioned above), her “author (intellectual) (Natural)” self, and her “wicked Bostonian” self. Notably, all three of these cards were also associated with the word “Pride” in the free association task, suggesting that the ability for a resource/self to provide support during both good *and* bad times can

have a positive effect on one's sense of self and worth. The fourth card, also discussed above, was submitted by Sexy (for "[CWS]").

Taken together, these data challenge stereotypes such as that of the "Welfare Queen," while also demonstrating various ways in which homeless women continue to engage in acts of self-protection, even while seeking out care. Specifically, data from the card sorting and free association activities suggest that struggling women are not only diversifying the resources they use, but also diversifying their areas of vulnerability. In other words, as opposed to *forced vulnerability* - in which we find ourselves responding to emergent, outside threats - expressions of pride and curiosity act as a kind of *voluntary vulnerability*, whereby we willingly expose our most intimate parts to the criticisms of the larger world. As such, keeping these worlds separate decreases our likelihood of being further holistically shamed because of *both* the situation we're in *and* the people we are at heart.

This habitus of limiting vulnerability may also help explain why there was a lower number of cards used for both the shame-related card sorting task and when associating cards with the term "shame," as compared to the other questions (Table 1). Tangibly showing someone (e.g., a masters student interviewing you) the parts of yourself which you feel ashamed of, as well as what/who you might rely on when feeling ashamed, is yet another form of vulnerability. When shame is weaponized – as it often is with interpersonal trauma in general, and especially in relation to homeless women's experiences specifically – it understandably decreases one's desire and ability for expressing vulnerability overall. Without vulnerability, however, deep, meaningful

connections are less likely to occur, thereby further entrenching feelings of loneliness, fear, and suspicion. As the next section will highlight, these tensions affect not only how women approach *receiving* care, but also how they are able to *provide* it.

The Politics of Caregiving

“When routine bites hard
 And ambitions are low
 And resentment rides high
 But emotions won't grow
 And we're changing our ways, taking different roads
 Then love, love will tear us apart again
 Love, love will tear us apart, again.” – *“Love Will Tear Us Apart”* by Joy Division, 1980

One participant I interviewed, Miriam, provides an excellent example of how the inability to be vulnerable specifically affects the area of caregiving, particularly as it relates to perpetuating cycles of violence. Being a mom was (and still is) a core part of her identity, as well as being the motivation for almost all areas of her life. By her own admission, this obligation for providing care is even more pronounced because of the fact that Miriam was adopted, and feels as though she owes any positive outcomes in her life to the teachings and support from her foster mother. However, the need to carry on the legacy of caregiving by embodying maternal stoicism often paradoxically resulted in furthering the emotional divide between Miriam and her care recipients.

For instance, when asked whom she would go to and what internal selves would come out if she were to experience an emotional emergency (e.g., feeling suicidal), Miriam replied:

Well, I've already been through stuff like that... If I was all stressed out suicidal like that, I would come out like a kitten. But, I would develop into a lion, because I have to fight. Because I got children. I'm, because I'm a mom... Because I'm a

mother. I have to be around and show my children. Even though they may not know what's going on in my head and what's affecting me, I would still have to be a mom, to set [an] example.

But this internalized need for Miriam to protect her children often resulted in her engaging in acts of self-silencing, thereby inhibiting her ability to collaboratively process through perceived threats and difficult emotions directly with her charges. While this was meant to protect them from life's harsh realities (including hers), Miriam's acts of self-limiting actually seemed to at times exacerbate fears regarding both her children's well-being and her potential failure of protecting them, creating a feedback loop of isolation, dread, and sometimes violence:

Like I couldn't tell my sons anything. 'Cause, they would kill 'em. They'd get a street gang involved, I'm telling you the truth. And go kill that, the person who's hurting me. Oh yes they would. Oh yes they would. So no, I ain't gonna have my sons – if I'm dead in the ground, and they up in jail, and they have children also? So who's gonna raise my grandkids? Are they gonna have a stranger as their father, when I didn't know who my father is till I'm 26? Nah, we, we ain't having that. So yeah, I'd have to turn into a lion, and fight back. 'Cause I know what, I can just imagine what my sons – I raised ten kids, I have 3 sons and a daughter and let's just say I took in other children I guess 'cause I was taken into a different home. I was taken in and raised, I took in other children my sons brought here off the street who were in street gangs and stuff, ok? They come in my house and somehow, they look at me and know I'm just as crazy as they are. Bring your black ass in here and act up, we gonna fuck you up! That's, that's how we talk! Because, when they come in your house, they checking out to see your environment, and how you'll handle stuff.

In this context, Miriam's "lion" self serves two functions. The first is self-protection:

You cannot do that [show weakness] with kids off the street – what the hell are you doing? No!... Salute me, 'cause I'm in charge. That's how you handle it.

The second is protection of loved ones. For instance, Miriam related that one of her grandchildren had a particularly tumultuous upbringing, resulting in his being transferred

from home to home for the first 10-11 years of his life. Right before coming to live with Miriam, he had essentially been given up on, leaving her to act as a sort of last resort:

He attacked his mother, mashed up her stuff in the house, she gotta take her baby, a couple of months old baby, go in the room and lock the door away from him. And then when the cops came, the cops [sic] told her - I had heard - if he was his father, he would whip his behind. But he said he can't write that down on the thing... So when I had [my grandchild] in my house, I acted just like [my grandchild] did.

“Acting like he did” meant that when “he tried me a couple of times... I whipped his behind.” After one particular incident of this, a social worker was sent over to the house to assess the situation. However, this person just happened to be the same individual who transferred the grandson into Miriam’s care in the first place. Because of this, after checking out Miriam’s house:

He said, ‘This is where he should be. ‘Cause you got him on a schedule, you got rules that he can read, you go to his school, you make sure you go to the meetings at the school, he learned how to focus and get his homework and school done.’ He said, ‘I’m not going to write you up,’ he said, ‘but I have to let you know, had you put scars on him, where a doctor have [sic] to stitch him or something, then we couldn’t do nothing else.’

There is a lot to unpack with this situation, including how we privilege physical scars over emotional ones. However, in the spirit of embracing ambiguity, we should first start by 1) acknowledging and appreciating the level of care evidenced through Miriam’s consistency of caregiving and 2) ask what the rationale was behind these physical interactions – in other words, what is/was at stake. For Miriam, she felt compelled to embody her “lion” self because anything less:

Would give them the upper hand. I’m not about that... Because if I give in, and whoever’s hurting me or depressing me kills me, I’m telling you now. All my grandchildren wouldn’t have a father looking after them, because my sons, they would kill somebody. Especially the ones I raised off the street... Because I was a

mom to them. No, I can't. I can't allow what I do to trigger them... It would be like them going backwards from how they grew.

In our interview, this was both Miriam's rationale for *not* telling her children if she were feeling physically or emotionally threatened, and also her reason for embodying a harsher parenting style towards them. What is at stake here in the relative context of both survival and care is the need for her to continue to be emotionally/physically strong in order to protect not just herself, but *all* of her charges, who are themselves in many ways vulnerable extensions of herself. Failure to do so would result not just in her potentially getting hurt, but rather - as was more her focused fear - the potential that it might result in a child being taken from her home, or having some sort of other retaliation happen which could have fatal outcomes for some, in addition to jail time for others.

Self-Limitation

"I feel the pain of everyone.
Then I feel nothing." – *"Feel the Pain"* – *Dinosaur Jr., 1994*

Throughout the interview, Miriam repeated the statement "I can't do that" specifically in relation to seeking out comfort from those closest to her, so as to not hurt them. At the same time, Miriam paradoxically used this to also justify being more physically abusive towards her charges, as a way to maintain her maternal authority and ability to continue to provide care long-term:

I can't do that, I can't set them up emotionally, to think they gotta kill somebody or get back in the street with guns and stuff. I I can't do that... this little kitten would be sleeping somewhere, but this lion would come out. Because I know I have children, grown children, who would turn it all around and be on the, they don't care about being on the news. They don't give a damn. They would say, 'Well, we're gonna be locked up a while.' That's how they think, that's how they were thinking... But when they came to my house, I tried to inspire them to leave

the negative alone... Because if you give in, like the kitten, and just back up in a corner and let the person overpower you or something overpower you, where's your strength? So you gonna have to be a a lion. Because you're a mother, and you want to teach. You want to teach your children. And your grandkids. You can't just, 'Well this happened, Imma, Imma commit suicide and be out of here y'all. I'm, I'm taking a journey.' No, nuh-uh, I can't do that.

Thus, as demonstrated in this particular example, what is “readily identifiable” as abusive on the surface may also be fundamentally driven by moral gray zones of caretaking within a much larger system of threat (this latter topic will be further explored in the next chapter). For Miriam, physical abuse and stern discipline means keeping her children alive and protected in a culture all too quick to incarcerate or shoot down Black individuals, and particularly Black men. She fears telling her (specifically male) loved ones of existing threats because the potential of them engaging in retaliative acts may result in jail time or death, for which she will feel directly responsible. Further, she has to continually protect herself from potential abuse from *both* her charges *and* those outside the family because she knows if she isn't around, no one else will care for her loved ones. By examining “abuse” in this way, we are thus able to identify larger systems at play (e.g., systemic racism resulting in the disproportionate incarceration of people of color) and start to put the blame where it belongs.

Shelter Needs

“I'm just an animal looking for a home and [to] Share the same space for a minute or two.” – “*Naïve Melody*” by the Talking Heads

Although they are different environments, there are many parallels between dynamics in the shelter and caretaking dynamics in the home, especially for those living

within the context of trauma and poverty. On the one hand, there is a real need to protect oneself from others, particularly in situations where the care recipients are themselves dealing with trauma. This is because unprocessed trauma may lead individuals to unconsciously respond in violent or otherwise seemingly “irrational” ways when their triggers are activated (Briere & Scott, 2015; van der Kolk, 2014). However, when the need to protect oneself becomes the all-encompassing focus – as it often does while living in prolonged states of survival, with limited social support – this can also paradoxically lead one to becoming an abuser/oppressor, even while simultaneously remaining a victim (Levi, 1988).

While the next chapter will look at these dynamics further within the interactions between staff and guests, we can also see this in Miriam’s story. There, Miriam sought to protect her charges by protecting herself. This perceived need was especially enhanced because Miriam felt as though she both lacked support for her own needs and that, if she weren’t around, her charges would be significantly harmed or even killed. However, this focused self-protection ironically came at the cost of self-silencing and violence towards her charges, thereby negatively impacting both parties and reinforcing cycles of isolation and embodied danger.

On the other hand, when the focus remains exclusively on protecting others, this can *also* lead to continued cycles of victimization, in addition to eroding individuals both symbolically (in terms of their emotions/sense of self) and literally (in terms of their resources). For homeless women especially, prioritizing others may contribute to accepting and even justifying acts of violence against oneself, or otherwise downplaying

one's needs. In this chapter, we saw this dynamic in particular within the generalized card sorting data, where there was a demonstrated pattern of embodied and experienced fragmentation.

There, in an attempt to avoid overburdening a single entity, women instead tapped into a wide array of situation-specific resources which, in turn, required different “selves” to be adopted in order to meet various criteria of deservingness. However, doing this is not only unsustainable and exhausting, but it may in fact reinforce stereotypes of homeless women as “con artists” who are simply double-dipping across resources. This perception by institutional gatekeepers such as shelter staff may subsequently lead to justifying withholding resources from these individuals, which in turn reinforces their perceived need to diversify.

In addition, continued experiences of having resources withheld may result in the embodied understanding that support overall is fragile and fleeting. Not only does this reinforce the feeling that the world is dangerous and uncaring, but from a physiological standpoint (as discussed in Chapter 2), when we cannot engage in social support, we are more likely to then have our *fight/flight* or *freeze/collapse* responses activated. However, these responses – which may manifest in the form of behaviors like screaming, drug addiction, or missed appointments – only serve to strengthen stereotypes that homeless women don't care about themselves, are dangerous, and are unpredictable. The cycle continues, with those most in need paying the price.

Given these two ends of the spectrum, the question becomes: within the domain of caretaking and trauma, how do we balance the need to protect ourselves *and* the

need/desire to protect others, especially while continuing to live in a seemingly cruel and unjust world? While there are many potential answers to this, one good starting point is to think about it in the context of healing and coping. In order to heal, we need to feel safe. Otherwise, we are really just engaging in acts of coping. If you just got stabbed and are running away from your attacker, you aren't going to stop and ponder how your relative concept of safety within interpersonal relationships has been altered. Instead, if you want to survive, you're going to hold your hand over the wound and run until you find a safe place to stop and assess the immediate damage.

For people who have experienced interpersonal trauma, the underlying commonality is a profoundly deep, relational wound – an inability to trust in our connections with others, even as we continue to seek them out. Because of this, knowing that others “see” us – that they know who we are and want to protect us - may help ease this perceived state of emergency, thereby allowing people to shift into a more neutral space between intrapersonal and interpersonal concern. However, when shelters not only prioritize material needs over connection, but make them the sole purpose of the institution itself, this often reinforces perceived states of emergency and coping at the cost of connection and healing.

CHAPTER FIVE: RAGE (EXHAUSTION)

Chapter Argument

In the previous chapter, I examined how the first level of threat activation (social engagement) plays out within the dynamics of giving and receiving care for homeless women in Boston. In this chapter, I explore how the second level – *fight or flight* – manifests in shelter spaces and within homeless women’s lives in general. Because many of the women I spoke with expressed feeling as though they could not escape their situations – in other words, that the option of *flight* was limited due to lack of funds, perceived universal prejudice, or other factors – this chapter more so focuses on how instances of rage (*fight*) emerge, and how these further entrench cycles of isolation and coping rather than healing. Furthermore, chronic states of threat activation (through shame, loneliness, and the need to self-protect) can also cause the body to become simultaneously hyperreactive and *exhausted* (Luke, 2020), and can impair our ability to make decisions, emotionally regulate, and control coping-based cravings (Amen, 2021).

In addition to being a reaction to threat, anger is an emotion which bridges what is and “what ought to be,” and is thus an emotion tied to our sense of in/justice (Chemaly, 2018). Yet, many homeless women’s claims of injustice are dismissed as a further effect of 1) how women’s anger is socially silenced in general in the U.S. (Chemaly, 2018) and 2) how homeless individuals specifically are culturally stereotyped and held responsible for their own circumstance. This constant silencing and undermining of an emotional response to injustice means that “women report feeling anger more frequently, more intensely, and for longer periods of time than men do... men more frequently associate

feeling powerful with experiencing anger, but women, notably, associate powerlessness with their anger” (Chemaly, 2018, p. xv). Because “anger warns us viscerally of violation, threat, and insult” (Chemaly, 2018, p. xx), this can mean women who have to consistently silence or disregard their anger have to also disregard their bodies while spending exorbitant amounts of energy keeping their anger “in check” (and thus agreeable to U.S. patriarchal culture and its systems of care). This effort can further enhance feelings of isolation in addition to feelings of hopelessness, manifesting in sentiments such as *feeling* exhausted in addition to *being* exhausted.

In this chapter, I expand on the previous chapter’s findings to argue that lack of comprehensive social support – *combined with cultural practices of shaming homeless women while silencing their anger* – result in behaviors which reinforce stereotypes of homeless women as dangerous and unpredictable. Rather than explosions being seen as predictable reactions to ongoing trauma, isolation, and injustice, these behaviors are instead used to justify keeping homeless women at a distance. This furthers feelings that one must have one’s own back because no one else does, thereby maintaining chronic states of vigilance and exhaustion. It also perpetuates a tense guardedness in the relationships between staff and guests, as both parties feel the need to protect themselves even as they engage in practices of giving and receiving care.

Exhausted Bodies

As discussed in Chapter 2, when we perceive or experience threat it is our autonomic nervous system (ANS) which becomes activated (Briere & Scott, 2015; Luke,

2020; van der Kolk, 2014). The ANS is in turn made up of two systems: our sympathetic nervous system (SNS) and our parasympathetic nervous system (PNS). Simply put, the SNS is responsible for preparing the body to take action in response to danger, while the PNS is responsible for returning the body to a balanced state once the individual is safe again (Luke, 2020). When the SNS is activated - *regardless of whether the danger is real or perceived* - it responds by increasing our heart rate, slowing or stopping our digestion, constricting blood vessels, and stimulating our adrenal glands (Luke, 2020). The PNS essentially acts in the opposite way, thereby returning us to baseline.

Importantly, the SNS acts much more quickly in activating these different processes than the PNS does in quieting them down again (Luke, 2020). From an evolutionary standpoint, this makes sense. If we are wandering around and suddenly see a tiger, we want to be able to get away quickly and therefore increase our chances of survival. As such, our bodies are designed to be hypersensitive to danger, and likewise overly cautious about putting our guard down again. In addition, erring on the side of being more generalized in our labeling of threats – of not spending time debating whether the striped body we see in the bushes is a real animal or perhaps just a cardboard cutout – further ensures our overall survival.

Ironically, however, when individuals cannot escape perceived and/or experienced threat, these survival systems eventually become damaging. In addition to trauma making the body more susceptible to chronic disease (Goodwin & Stein, 2004; Scott et al., 2013), prolonged activation of the SNS can lead people to become chronically exhausted, anxious, and reactive (Luke, 2020). In fact, research has shown

that chemicals released during stress can impair activity in the prefrontal cortex (our “thinking brain”) while strengthening the emotional responses of our amygdalae (Arnsten et al., 2015). This simultaneously makes it difficult for people to engage in decision making and emotional regulation, while prompting them to rely on non-conscious, habituated responses.

This is particularly relevant in the context of this thesis because, as we can recall from Chapter 2, threat can also manifest in the form of experienced shaming, which affects our threat-defense mechanisms in the same way as physical threats do (Elison, Garofalo, and Velotti, 2014; Velotti, Elison, and Garofalo, 2014). For the women in this study specifically, shaming can (and has) occurred for a variety of reasons, many of them compounded and continuing: joblessness/homelessness, stereotypes behind them seeking aid, their race, age, histories of interpersonal trauma, existing coping strategies, and even (natural/expected) trauma responses such as avoidance.

As discussed in Chapter 4, women in this population are then faced with deciding between two evils. On the one hand, they can try to reach out to services and risk being shamed or denied. Even if these don’t occur, going back to a state of fragile and fearful dependency has the potential to retrigger previous childhood traumas of being abused because of one’s vulnerability. Because trauma is embodied at an unconscious level (van der Kolk, 2014), reengaging with this type of dynamic can subsequently cause a deep feeling of unsettlement and hyperarousal in their bodies, even if abuse does not occur in the current situation.

On the other hand, homeless women can try to go into a hyper-independent state and attempt to distribute and therefore reduce their dependency on any particular service. However, this may result in them not only spending an exorbitant amount of time and energy during their time of need, but also may (paradoxically) result in them being labeled a con artist or otherwise justifying the withholding of support. In essence, both these processes result in homeless women embodying the belief that they are alone in a dangerous world.

Being left to your own devices in this context is scary enough. However, to add insult to injury, women in the U.S. are furthermore generally socialized to ignore or otherwise suppress expressions of anger, even in response to blatant injustice (Chemaly, 2018). These social conditions become even more exacerbated for homeless women specifically, as their demands for justice are even likelier to be dismissed based on existing stereotypes of them being mentally ill, dangerous con artists, and/or drug addicts/alcoholics. Because anger is an emotional tool for advocating for justice, this means that homeless women are forced to remain that much more vulnerable, fearful, and defensive, and therefore that much more activated within their bodies. Without a way to feel safe, rest, and regroup, this inevitably results in homeless women being simultaneously hyperreactive and exhausted, leaving little room for healing and growth.

Illness Politics Within Shelter Spaces

“Doctor, Doctor
We have nothing in our pockets
We continue
But we have nothing left to offer.” – *“Making Flippy Floppy” by the Talking Heads*

One may wonder why we have such negative views regarding homelessness in the U.S. One reason for this may be because it is an extension of our views on illness, which have their roots in both necropolitics and medicalization. While medicalization in the strictest sense sought to create a universal normal body – which allowed for deviancy to be identified and quarantined - necropolitics helped justify efforts to “make live” or “let die” its citizens. Furthermore, judgements in this realm were based on criteria such as the person’s perceived investment in their own wellness and autonomy, which was determined according to their adherence to existing dominant systems of health.

We can extend these practices from the physical body to the social body. American sociologist Talcott Parsons described illness as a special form of “deviant” behavior, where the individual is “failing in some way to fulfill the institutionally defined expectations of one or more of the roles in which the individual is implicated in the society” (Parsons, 1951, p. 452). Using this definition, homeless women have (at minimum) two strikes against them. First, as women in need, they are no longer seen as fulfilling their role as caretakers or, when they are, often have this status re-interpreted as subpar or even suspect (Luna & Luker, 2013). This is further exacerbated when taking into account unprocessed interpersonal trauma, which may affect one’s ability to take care of others.

Second, as “Americans” (regardless of actual citizenship status), they are not fulfilling their role as being productive members in the capitalistic sense, as they are both economic non-contributors while also receiving aid. This is an affront to the “American Dream,” which unrealistically expects individuals to “pull themselves up by their

bootstraps” with no help from others. However, rather than challenging the image of the “American Dream,” we once again culturally re-interpret the disconnect between cultural expectations and lived realities under a neoliberal lens. Thus, instead of acknowledging that there are limits to achievement outside of one’s willingness to work for it, we more often than not ascribe someone’s non-working status to them just being “lazy” or avoiding responsibility for their lives. Because of this, indigent, traumatized women are often shamed for being drains on the same systems which are supposedly designed to support them, making it that much harder for them to engage with resources while reinforcing cycles of isolation, distrust, and deprivation. In this way, systems of support contribute to individuals remaining in cycles of poverty and need, even while blaming them for their current state (Bourgois & Schonberg, 2009).

Once labeled as deviant, Kleinman, Eisenberg, and Good (1978) further note that, “Illness behavior is a normative experience governed by cultural rules: we learn ‘approved’ ways of being ill” (pg. 252). Thus, in order for women to receive care within a moral economy of suffering and humanitarianism (Fassin, 2010), they are expected to both know and appropriately embody the “illness” that is poverty and homelessness. More than anything else, this translates once again to engaging in phenomenological shrinking by not asking for too much, not taking up too much space, and not making your presence overly known. It means coping in a way that shrinks even the awareness of your bodily needs and sensations in order to continue surviving (such as the person who drinks to avoid the cold while having to sleep outside). It means accepting and embodying a

passive state of disposability, even while simultaneously actively working to survive on a daily basis (Lester, 2019).

Because of their lived experiences, the women in my study subsequently spend a *lot* of time and energy taking care of themselves—so much so that they even sometimes do others’ caretaking work for them, so as to minimize need while also protecting themselves:

Brooke: I’m a little careful with social service advocates, only because they have a job to do, and I don’t want to turn them into my therapists. So, that’s why I think I work well with social workers, ‘cause I come in with a folder... I call it an emergency, um, my “survivor file”... You know how social services will rubber stamp, rubber stamp, rubber stamp, rubber stamp? That – I know what they need to do.

In many ways, this also allows for a sense of independence while (theoretically) increasing the likelihood that their needs are met. But it also means that they internalize a sense of being just another number - another issue to deal with - rather than a whole human being. While Brooke’s strategy may be advantageous in getting her immediate needs met, it is also telling that she 1) designates emotional issues for therapists only, while social service advocates are for basic needs, housing, and jobs and 2) that she has internalized the message that she only works well with these advocates because she does the work for them. In other words, in order to receive care, you must first prove that you can care for yourself. Because trauma healing is about establishing relational homes, these messages and adaptive strategies actually prove disadvantageous in the long-run, even if they allow for more efficient short-term coping and survival.

Furthermore, all of this phenomenological shrinking has its limits. When you keep trying to compress yourself and your emotions down over and over again, but

continue to be treated with shame, scorn, and suspicion no matter what you do, it can make you want to explode. This is further intensified by the hyperactivity of one's SNS, resulting in a disconnect between what is being experienced within the body and what is allowed to be expressed externally to the world. Rather than being pathologic, expressions of rage can instead be viewed as a natural reaction geared towards re-establishing one's emotional homeostasis. For example, picture someone who is forced to exhale until every molecule of air is pushed out of their lungs – until their lungs have shrunk down to the smallest size. When they can no longer exhale – when there is nothing left – they will likely take in a huge breath of oxygen when finally allowed to. As a result, they (their lungs) expand much more intensely than if they were allowed to inhale/exhale normally.

In a way, anger and care act as the emotional inhalations and exhalations of our life. When we care for someone, we blow ourselves into them. We give them our time, resources, and energy; we take life from ourselves and put it into them. Women at the shelter not only care about themselves, but also care deeply for others, particularly those who share in their vulnerability. For instance, when asked what brought them to CWS, all 8 participants reported other shelter-based/homeless women as being the ones to refer them. In turn, many of my interviewees also reported having engaged in significant caretaking (in both family and job settings) prior to their becoming homeless, as well as continuing to concern themselves in others' wellbeing in their present lives.

Yet, if care is the exhalation which pushes ourselves into others, then anger is the inhalation which redirects focus and resources back onto ourselves. Specifically, as noted

by Chemaly (2018), anger is an emotional tool which bridges “what is” with “what should be.” In other words, anger is a tool for demanding justice. Thus, when women are constantly expected to deplete themselves in the name of caregiving, but then feel continually snubbed while receiving care, it only makes sense for anger to be the resulting emotion. As such, rather than being seen as “selfish” or “entitled,” this anger could be better interpreted as a general desire to achieve justice in an unjust world.

Living Within the U.S.’ Social Boiling Pot

“Sometimes being a bitch is all a woman has to hang onto.” – *Vera Donovan, Dolores Claiborne, 1995*

As one of too many individuals born and bred within the world of interpersonal trauma, I’ve struggled with anger all of my life. When you’ve been hurt enough, for long enough, it can feel like your skin has been stripped off your body. Every comment, every interaction hits the exposed raw nerve endings of your selfhood directly and fully. Every offhand statement made in ignorance sticks like tar on fire. It burns you, and it stays. It hurts you, it scars you, and after a while you start to resent everyone around you who is, by whatever perceived circumstance, seemingly afforded the armor of ignorance and (relatively “better”) privilege, of which you were deprived. You begin to hate the people around you who don’t understand what it means to feel the pain you have to live with daily.

Unfortunately, because shelters such as CWS are designed specifically “for” homeless women, shelter staff often take the brunt of these frustrations, even when unwarranted. Part of this may be because shelters remain businesses at the end of the day and, as such, are subject to the same socialized rules and expectations as other consumer-

based institutions. Specifically, the customer service model – which was an invention of the Industrial Revolution aimed at increasing public trust in big business (Mull, 2021) – actually exacerbates tensions between shelter “guests” and staff because, in the shelter context, it blurs socio-economic roles and expectations not otherwise seen in other consumer settings.

As noted in her detailing of the history behind our current “the customer is always right” socialized mentality:

“[The motto of] ‘The customer is always right’ emerged as the essential precept of American consumerism—service workers weren’t there just to ring up orders, as store clerks had done in the past. Instead, they were there to fuss and fawn, to bolster egos, to reassure wavering buyers, to make dreams come true. If a complaint arose, it was to be resolved quickly and with sincere apologies... [Through this,] retailers won over [the] growing middle class by convincing its members that they were separate from—and opposed to—industrial workers... For the price of customers’ purchases, the stores’ legions of service workers gave the newly flush a sense of superiority, as well as a readily accessible group of inferiors on which to impose it. Customers might not have been able to afford a household staff to do their bidding like the era’s truly wealthy, but corporate stores offered them a little taste of what that would be like” (Mull, 2021).

The shelter space thus combines two contradictory – but equally strong – culturally enforced “American” messages on status and expected power dynamics. On the one hand, guests coming into the shelter are socially regarded as being at the bottom of the entitlement ladder. Under this framework, they should be grateful for anything that they receive because they haven’t economically “earned” it the way paying customers do within other consumer-based environments. On the other hand, because they are the intended “customers” of the institution, and have been socialized within the general customer-is-always-right mindset, guests have *also* been taught that, as customers, their needs should supersede the feelings, viewpoints, and needs of staff members.

As noted by Luscombe (2021) regarding the increase of violence against customer service employees due to ongoing pandemic restrictions:

“It’s not a coincidence, psychologists say, that much of the incivility occurs towards people who are in customer service industries. “People feel almost entitled to be rude to people who are not in a position of power,” says Hans Steiner, emeritus professor of psychiatry at Stanford University. “Especially when they come at them, and remind them of the fact that they have to do their piece to get rid of this pandemic.”... The workers who are now in charge of enforcing rules are traditionally regarded as caregivers and servers. The power dynamic has been completely upended. And of course, it’s always easier to punch down. “It’s displaced anger,” says Bernard. “They’re angry about other things but they take it out in those encounters.”... In the minds of some of the individuals, snapping at the flight attendant is not rude, it’s civil disobedience.”

While Luscombe was writing about this in the context of looking at customer service-based assaults in response to the COVID-19 pandemic, homelessness and poverty themselves are a type of pandemic, which has for too long been strategically made invisible outside of humanitarian-based fundraising campaigns. As a result, homeless women often get subjected to different rules and authorities than the general population, solely by virtue of their status as homeless women. They witness true selfishness by those existing in their same cultural environment (such as politicians, who demand restrictions for citizens but blatantly disregard them in their personal lives), and yet are subject to harsher rules, criticisms, and punishments than the general population.

For example, during the summer I spent one day telling a particular guest – who was currently being treated for lung cancer, and had significant difficulty breathing as a result of both that and her asthma – that she *must* wear her mask while in CWS. This, I told her (and truly believe[d]), was a sacrifice that she needed to make for everyone’s

safety. Every time she took her mask down, she was approached by a staff member requesting her to put it back up, unless she was actively eating or drinking.

Later that day, while I was commuting home on the T – which was packed with people to the point of being unable to move – I had to stand next to three white males who looked to be in their early 20s. However, despite being both loud and gesturing to the point where they accidentally hit multiple people multiple times with their hands and arms, they remained maskless during the entire 30 minutes that I personally rode with them. And no one – including myself – said anything to them.

Power is always relative. When we speak up, when we claim space, we also (at least theoretically) reclaim power. The women in CWS are angry. They are exhausted in their bodies and minds, and they are made to constantly feel afraid, ashamed, powerless, and undeserving. Eventually, like a rubber band stretched too far, some individuals may snap. They may use their bodies in any way they can to reclaim any semblance of power – whether it's white bodies claiming power through racist slurs, cis female bodies claiming power through transphobic remarks, older guests mocking younger staff members, or claiming power through the status of being a shelter “consumer.” Our perceived power (and, by extension, the ways in which we feel we can claim it) will always be relative to the social fields we exist in (Bourdieu, 1977), with our bodies further influencing our different social statuses and memberships. But, when vulnerable groups are pitted against one another in a vie for power - as discussed both here with staff and guests, and in Chapter 2 with racial groups – both parties end up losing.

Hurt Cycles

“The Lord said, ‘If as one people speaking the same language they have begun to do this, then nothing they plan to do will be impossible for them. Come, let us go down and confuse their language so they will not understand each other.’” – *Genesis 11:6-7, The Holy Bible*

Speaking as someone externally labeled as a woman, I already knew from years of experience that my trying to say something would change nothing regarding the subway situation above, other than potentially putting myself at risk for the socially sanctioned, entitled (and often violent) responses of more privileged (white male) bodies. So, I swallowed my anger up and took it home with me, as many socialized females do. However, silencing anger doesn’t make it disappear, and it often then ends up manifesting within safer spaces but aimed at the wrong parties. Thus, it is important to emphasize that socialized cycles of silencing anger often result in hurting people on *both* sides – particularly within shelter contexts – even while both parties are in fact trying to achieve a form of justice.

This tension can perhaps be best illustrated in the following field notes excerpt, which will be discussed further in the next section:

I am in the back room sorting mail when I hear the screaming start. As I come out into the main space, I catch the staff member who was involved and ask her what happened. Rose tells me that there was a miscommunication between another staff member (Bee) and a guest (Tyler), where Tyler misunderstood a request about moving her stuff off of a bench to mean that she had to leave the shelter altogether.

At the time, Tyler had showered and was waiting for her laundry to finish, so was wearing one of our bath robes. When she went outside, Rose saw her and told her she had to stay inside when wearing the robe. The potential for guests stealing always hangs in the interspaces of communication and, because of this, the staff engage in active monitoring of loaned computers, robes, extension cords, and the like, while encouraging other staff and volunteers to keep their phones and personal items close at all times, as these have previously gone missing for

guests and staff alike. Because of this, it was natural for Rose to tell Tyler that she had to return inside, particularly as Rose was unaware of the previous staff-guest interaction. However, Tyler had been struggling with a lot of frustrating setbacks and abuse from others outside of the shelter, and this felt like one more instance of getting conflicting information, trying to adhere to it, and then being punished for it. So she lost it on Rose.

Meanwhile, moments after speaking with me, Rose (who is still in the process of trying to de-escalate herself) tries to tell another guest that she has to keep her mask on while in the shelter. This is a standard rule that has not changed since we reopened the doors earlier this year, and the guest is well aware of that. For whatever reason, though, the guest also becomes enraged, and begins screaming at Rose. Finally, Rose loses her patience and leaves the shelter, saying that she is quitting.

Since starting my internship at the shelter, I have come to see Rose as the backbone of this organization. Many of the full-time employees that are still at the shelter came in because of her and continue to stay because of her. I have seen her act with both extreme gentle kindness with guests and, oftentimes, also be forced to take on the role of enforcer, as she is both tough and has developed relationships with many of the guests. I made the comment to her once that she seems to be the one who absorbs the most abuse from guests at the shelter, and asked her who she is able to go to to vent in return. She replied no one.

Because of this, I understood and felt for Rose when she left. No one should be treated like that - ever. At the same time, I knew from my own past experiences of extreme desperation that living in a world of constant threat, while also being punished and silenced no matter what you do, can lead people to react to seemingly small things in extreme ways. It can feel as though you are a boiling pot of water with the lid on, and the world is cranking up the flames while continuing to clamp the lid down. The longer the pot boils, the more intense the heat, the higher the pressure, the more likely an explosion will occur.

While it's hard to explain this to others, it physically hurts me when people are breaking and alone. So when another staff member, Courteney, tells me that an ambulance has been called because Tyler is now threatening violence against herself, it is painful for me to see people giving her distance, as if she were a contagion. People often do this out of protection for their selves or because they assume the person needs to cool off on their own. There's nothing wrong with either of these stances - many occasions call for them. But because Tyler is crying silently to herself, and because I know shame can crawl in in the aftermath of an explosion, I go to see if she needs anything.

While talking, Tyler expresses deep regret and sadness for hurting the staff member, whom she considers a friend and respects for her work at the shelter. She feels lost, confused, angry, and hopeless. She feels she doesn't deserve to be at the shelter anymore, or in the world at large. She tries so hard to follow the rules and keep quiet, but in her silence she absorbs more and more

micro- and macro-level violences until she can no longer contain them all behind closed doors.

Eventually we talk about her apologizing to Rose and she expresses extreme fear at doing so, knowing there will be a big chance that her vulnerable act will be shot down out of Rose's own need to protect herself. As I continue talking to her about my own experiences, and validating the fear, anger, and sadness which were perpetually swirling in her, she begins to open up. Eventually, she is able to calm down and we no longer need the ambulance – which is good, as our manager says the usual wait time is 4 hours or more, if they even show up.

As I walk back with the manager, she expresses surprise at how well I was able to talk down the guest, particularly that I “even made her laugh.” However, while I am happy it ended better for the guest, I am also self-consciously aware of being watched by the other staff. In helping Tyler, I feel like a traitor to the staff member(s) who were on the receiving end of her explosion. I can feel myself regressing back into the panic I felt when my parents divorced and my sisters, parents, grandparents, and I were scattered and placed at odds with one another. When you try to be a friend to everyone, you end up a friend to no one.

Picking Sides

“After a deal of worry Zeus had a happy thought. ‘Look here,’ he said, ‘I think I have found a scheme; we can let men still exist but we can stop them from their violence by making them weaker... I will slice each of them down through the middle! Two improvements at once! They will be weaker, and they will be more useful to us because there will be more of them.’” – *“Symposium” as translated by Rouse, 1984*

I have never enjoyed picking sides. Perhaps this is because, as a multiracial, non-binary, pansexual, spiritual-but-not-religious individual, I have always found myself straddling false dichotomies. My father was an accomplished military-man-turned-surgeon who came from a long line of Japanese aristocrats with deeply held sexist beliefs, which were always at odds with his demands regarding his daughters' individual successes. Being raised by my paternal grandmother for many years, education became a central component to my identity, and she continued to raise me with the idea that you could either be elite or be nothing.

At the same time, being intermittently passed off to my mother for several years – who was a deeply poor, devoutly religious, alcoholic Southern woman – gave me the experiences of being overly scrutinized and condemned by social stigma, solely because of where I lived and what I looked like. With my grandmother, we read the classics and spoke French; with my mother, I had kids at school wiping “dirt” from my seat every time I got up, and telling others that if they befriended me, I would make them stupid and give them lice. With my grandmother, we shopped at the Gap and Saks Fifth Avenue; with my mother, I frequently stole food from Thrifty’s so that I wouldn’t go hungry at night.

We live in a world of constant schisms where many of our thoughts, feelings, and behaviors find themselves grounded in acts of moralized labeling. You can be *either* rich *or* poor. You can be *either* an “upstanding citizen” *or* a “criminal.” You can be *either* a “good person” (and therefore not racist/sexist/abusive) *or* a “bad person” (and therefore racist/sexist/abusive). You can be *either* a liberal/Democrat (and therefore pro-vaccine) *or* a conservative/Republican (and therefore anti-vaccine).

But these dichotomies are dangerous and inherently false. The “good person” can do good deeds and still have deeply internalized racism, which they may unconsciously perpetuate within their daily interactions. The liberal Democrat may still be against getting the COVID-19 vaccine, not out of spite for their own party or others’ wellbeing, but because of deeply held fears concerning their own bodily safety due to medicine’s long history of abuse, particularly against women and other marginalized groups. Thus, when approaching the topic of coping and healing within trauma, it is important to

ground ourselves in a fundamental starting point: we are all *both good and bad*, with these labels being more subject to situational context rather than static self-truths. In other words, these states are not stagnant categories, but rather exist in constantly changing, ambiguous relativity according to how actions and intentions are perceived by others. People are all born with the potential for “goodness” in them *and* are simultaneously capable of doing horrible things under the right circumstances – neither makes them one or the other.

This is why, especially regarding trauma, I strongly advocate that there are no truly “bad” people – just survivors. This is important because, as discussed above, our bodies are designed to encode experienced threat in a way which is both unconscious and generalized. Furthermore, our body reacts to threat regardless of whether the threat is real or imagined. In other words, “perception creates real bodily responses” (Luke, 2020). When we stereotype homeless women as dangerous or unpredictable, we are already priming our bodies to be on alert. This may even be further enhanced when engaging with women who more closely “match” these culturally promoted, stereotyped images (e.g., women who appear less hygienic, speak less eloquently, who are non-White, and/or who are more “aggressive” in their interactions). Conversely, homeless women – especially those with experiences of being abused while in positions of dependency – are likewise primed in their bodies to be wary of those offering care. Guests may even unconsciously “test” staff members *through* fights, as a way of determining earlier rather than later whether or not they can truly rely on or trust them.

When these two forces come together, it results in similar situations as the one with Tyler, Rose, and Bee. For Tyler, her experiences of being abused by individuals in similar positions of power have led to a “bad guy” threat archetype related to institutions of care and their agents. Her body – which is already chronically stressed and hyperreactive as a result of experienced racism, sexism, homelessness, and isolation – is thus already activated upon coming into the shelter space and being in a position of vulnerable dependency. Because women in the U.S. are largely socialized to disregard their bodies and bodily sensations (Chemaly, 2018), this leads to a disconnect between the bodily experience of anxious activation and the subjective experience of being in a place of safety. Thus, when she felt she was being admonished because of responding to mixed messages, that shame-based activation confirmed her existing wariness of being taken advantage of again, thereby tipping her over the edge and justifying an explosive response against a universal, uncaring “bad guy.” Similarly, Rose and Bee also experience abuse and threat at the hands of guests, and are likewise primed to proactively defend themselves by either dismissing the person (so as to limit abuse received) or responding aggressively (including kicking the person out). The stereotyped idea that guests’ behaviors are due to *who they are* (e.g., utilizing good guy/bad guy frameworks) rather than *what they are going through* further justifies these practices, which ultimately keep both sides isolated from – and protective against – one another.

As shown above, the reason why it is so important to disregard good guy/bad guy moralizations – *especially* for those who have experienced/continue to experience trauma – is because these frameworks cause us to choose sides and provide support for one party

but not the other, even though both parties are interconnected and hurting. To illustrate this another way, imagine a puppy which has just been adopted into a family. This family has a young child, who has a strong fear of dogs. The parents believe that exposure to a nice, friendly puppy will help the child overcome their fears. When the puppy comes home, it is excited and immediately rolls onto its back to get its tummy scratched. However, the child, out of fear, kicks it hard in the stomach. The puppy instinctively curls up and runs away.

As time passes, every time the puppy goes to roll on its back, it continues to get kicked by the child. At the same time, the child becomes more and more distraught at the intruder in the house, particularly since its attempts at self-protection do not seem to be scaring the puppy off. It increases the frequency and power of its attacks. The parents, heartbroken over the abuse towards the puppy and equally protective of their child, admit defeat and give the puppy back to the shelter.

After a few days, the puppy is adopted by a new family. This family's child *loves* dogs, and when the puppy arrives, the child immediately reaches out its hand to try to rub the puppy's stomach. However, the puppy, having only known kicks, instinctively responds by biting the child's fingers. The child is terrified and significantly injured and, after a few of these repeated incidents, the family decides to give the puppy back to the shelter. The puppy has now learned that its attempts to protect itself cause it to be discarded by people - who also forced it to be overprotective in the first place. As a result, it retreats into itself, hoping it will not be adopted again but also knowing that, if it remains in the shelter for too long, they will have to put it down.

In these cycles, as with the event at my site, all of the actors involved are hurting - both *hurting* others and hurting *from* others. That is how trauma works: it becomes encoded into our bodies and expressed in our reactive feelings and actions, often resulting in shame, fear, anger, violence, and isolation (sometimes all at once). Because of this, if we hope to heal trauma, we cannot continue to think of people as fundamentally “good” or “bad.” Doing so only reinforces cycles of isolation, which in turn prolong threat activation and exhaustion in bodies. It also allows for dismissal of anger expression for those labeled as “bad,” and justifies practices of allocating resources to some but not others, regardless of need.

The child kicking the puppy is *both* a protective mechanism *and* a violent act – just like the puppy’s biting of the second child. If we use the good guy/bad guy mentality to determine care, with no regard to overall context and trajectory of events, we might thus say the puppy deserves care in the first situation but then not in the second – even though it is still the same puppy dealing with the same trauma issues and need for safe connection. Instead, we should trace back to the *why* of thoughts and actions and resist the impulse to automatically assign blame. In doing so, we can find connection through empathy – healing through shared suffering. We can begin to speak a common language again.

The Moral Gray Zone of Caretaking

“Well I guess, I should stick up for myself
 But I really think it's better this way.
 The more you suffer,
 The more it shows you really care -
 Right? Yeah.” – “*Self-Esteem*” by the *Offspring*, 1994

In writing about his experiences within Nazi concentration camps, Holocaust survivor Primo Levi introduces the concept of moral “gray zones,” whereby “the two camps of masters and servants both diverge and converge” (Levi, 1988, p. 31).

Specifically, Levi uses this to examine how the need to survive takes over our socialized moral decency, resulting in the oppressed engaging in acts of self-survival which lead to the further oppression of others who are in the same overall situation. Thus, even if two inmates are being oppressed by the same entity (e.g., Nazis), one inmate may subject the other to harsher treatment in line with the camp dynamics, if it means they gain even a shred of advantage that allows them to survive a little bit longer. Further, by pitting inmates against one another, the few in power are both removed from the violence while also benefitting from the resulting intra-oppression, thereby maintaining their power/control as well as professed moral absolution.

This idea of dual embodiment – of being both victim and oppressor, as a product of living in a state of emergency designed by those in power – has been applied to a number of different social-moral areas. Bourgois and Schonberg (2009), for instance, utilize this framework to examine the lives of homeless heroin addicts, whose “addiction under conditions of extreme poverty and concerted police repression creates a morally ambiguous space” (Bourgois & Schonberg, 2009, p. 36). In this context, the physical addiction to heroin in and of itself becomes an embodied state of emergency, creating a hierarchy of needs in which survival (in the form of getting a fix) remains top priority. In other words:

“All of the Edgewater homeless know exactly which foot to put in front of the other as soon as they wake up every day. Their needs and priorities are unambiguous: they must solve their most urgent physiological problem before worrying about anything else. Finding employment, acquiring food, obtaining shelter, appearing in court, applying for public assistance, or treating an abscess become inconsequential.” (Bourgeois & Schonberg, 2009, p. 103)

However, while most works regarding gray zones focus on individual survival, we can also examine this concept of moral relativity in the context of both giving and receiving care. For instance, with the rise of child abuse awareness over the last few decades, there has been much moralizing concerning parenting practices which appear harsh or cruel. As one participant put it:

Faith: Now they take the babies away from the mother. For the longest time they did everything possible in my life to keep the babies, the children with the mothers. They just stripped those children away from their mothers now! They're doing it completely differently and I'm like, yeah, this abuse is bad... [Now it's changed to where] they supported those kids. OK. Which I think is just absolutely wonderful. Which they don't just leave it in the hands of the parents to do whatever horrible destruction they're going to do to the, those kids, no. They are supporting those kids.

Like Faith, I endured a significant amount of emotional and physical abuse growing up. On the surface, this push to remove kids from abusive environments seems morally unambiguous – abuse is bad, protecting children is good. At the same time, if we are to embrace ambiguity and apply the framework of moral gray zones to this area, we need to ask ourselves what exactly is at stake when abuse occurs. In other words, how we actually define abuse should be relative to the context. The same should be true when identifying the source of abuse as well. Importantly, this should not be used to simply justify abuse when it occurs, but rather to help us avoid engaging in acts of misrecognition. In doing so, this will further allow us to meaningfully address the issue.

Creating a warm, loving environment where those receiving care are both empowered and protected should always be the goal of caregivers. At the same time, when the stakes are high and threats are pervasive, with little room for error or external help, harshness can itself act as a form of loving protection, both for ourselves and others. If I am walking with my child on the street and there's a sudden zombie outbreak, I'm not going to stop and explain the situation to my child and get their permission to get into the car and drive away. Instead, I'm probably going to grab their hand and yank them with me as quickly as possible, risking a potential fractured wrist if that means they can escape the mouths of the hungry masses. Similarly, as shown in the case of Miriam, one might have to become a "lion" and respond aggressively or even violently towards one's charges in order to stay alive, keep *them* alive, and be able to care for them long-term. Importantly, these feelings emerge *in response to* living within a world which is viewed as threatening and uncaring, rather than being innate behaviors. Moreover, these feelings and response strategies are further enhanced when one feels as though they lack social support or validation, causing us to be more self-protective through activated *fight or flight* instincts.

Breaking Cycles

At the beginning of this chapter, I argued that lack of comprehensive social support, combined with practices of shaming homeless women and silencing their anger, result in behaviors which reinforce the idea that homeless women are dangerous and unpredictable. In introducing the concept of moral grey zones and denouncing good guy/bad guy frameworks, I further argue that attempts to disrupt these cycles should not

be focused on moralizing or otherwise validating one party over the other, but rather on dismantling the cultural structures which create and maintain tensions between those giving and receiving care.

Providing support to caregivers does not need to be mutually exclusive from providing support to care recipients, and vice versa. In the example of Rose, Bee, and Tyler, all involved parties had valid grievances resulting from feeling both threatened and unsupported. Tyler felt as though she was the only one looking out for herself, while Rose and Bee felt as though they were always being treated as the “bad guy,” despite providing daily care to abusive individuals. In supporting meaningful connection between guests and staff, we can increase the likelihood of empathy and a sense of community, thereby reducing the potential for fight-based reactions. Not only does this impact how guests potentially feel while in shelter spaces, it may also decrease provider burnout, which is yet another form of exhaustion. We can do this by challenging stereotypes regarding homeless women, changing how we socially shame/silence women’s anger in general, and specifically providing trauma education to both guests and shelter staff, to allow them to better contextualize both their own bodily responses and the behaviors of others. Doing so allows the body to de-activate, thereby allowing it to rest and recover. It allows us to heal through connection, rather than coping through protection.

CHAPTER SIX: GRIEF (ERASURE)

“Do not pity the dead, Harry. Pity the living. And above all, all those who live without love.” – *Albus Dumbledore, Harry Potter, 2011*

“Grief, I’ve learned, is really just love. It’s all the love you want to give, but cannot. All that unspent love gathers up in the corners of your eyes, the lump in your throat, and in that hollow part of your chest. Grief is just love with no place to go.” – *Jamie Anderson, n.d.*

Interpersonal relationships are crucial – not just for our psychological wellbeing, but also as a form of survival capital. Generally, social ties allow access to certain resources in exchange for adherence to specific standards and codes, which in turn may vary across social fields (Bourdieu, 1977). Specifically, in the area of health, whether behaviors are determined “healthy/advantageous” versus “unhealthy/disadvantageous” is also contextual, and is likely to be driven by ongoing negotiations between implicit (embodied/internalized) and explicit (socially-reinforced) understandings of safety versus danger. In other words, how we deal with threat is contingent upon factors like experiences and expectations related to threat, perceived personal ability to deal with it, and likelihood of social support.

In the previous two chapters, I have discussed two main areas of struggle within the lives of women experiencing poverty and homelessness: erosion and exhaustion. Through practices of caretaking, women in this population have experienced a sense of erosion regarding both resources (e.g., finances) and emotions. Specifically, they must both phenomenologically shrink themselves and their needs in order to avoid the stereotype threat of being labeled another “Welfare Queen,” while simultaneously being expected to constantly self-advocate, particularly for those who feel they do not have

anyone else to rely on. Moreover, homeless women have to be tough on the street in order to avoid being harmed or taken advantage of, yet must present as polite, self-contained, and vulnerable when engaging in resources such as shelters, so as to fit models of deservingness. Thus, these simultaneous but contradictory embodied states of survival – which are a factor of culturally sanctioned norms - further erode women’s sense of identity, personhood, and general subjectivity.

In addition, anger, which is an emotional tool for demanding justice, is often silenced as part of women’s overall socialization within U.S. culture (Chemaly, 2018). Moreover, those who are poor are more likely to have their suffering silenced (Farmer, 2009). This ongoing, compounded silencing – which is both self-imposed and enforced by others – consumes an enormous amount of emotional energy, as well as maintaining a toxic status quo. Thus, while caretaking *erodes* one's resources, energy, and ability to self-care, suppressed/silenced anger further leads to *exhaustion*, as well as illness, isolation, hopelessness, suspicion of others, and, sometimes, perpetuated violence.

In this chapter, we come to our final field of analysis: *erasure* and grief. Here I argue that the cycles noted in chapters 4 and 5 – *combined with profound loss and silenced grief* – result in coping behaviors which reinforce stereotypes of homeless women as being indifferent to their own wellbeing. As noted by grief expert, counselor, and research professor Joanne Cacciatore (2017), grief comes from having deep love for something. When we force people to “get over” their grief, we are also forcing them to get over their love. The more grief and loss we have, combined with living in a grief averse culture, means the more likely we are to start to inhabit a world of loneliness. Not

only do we have to bear the weight of indefinite loss, but we become social outcasts – essentially having to make a Sophie’s choice decision between 1) keeping our dead and losing the living or 2) existing as socially palatable but hollowed out shells. In feeling erased by the world, homeless women may subsequently respond by unconsciously adopting/utilizing coping mechanisms which erase both their connection to themselves and to the world around them (e.g., chronic avoidance/self-isolation, substance abuse, and suicide attempts/self-manipulation). However, while these responses would be better understood as survival-based adaptations to living in a grief-averse culture, these acts may instead justify practices of de-investing in homeless women or otherwise “letting [them] die,” as they are framed as not caring about their own lives.

I will begin by discussing different types of losses, followed by practices of silencing grief. Using participant interviews, I will explore these dynamics in the context of internalized narratives, particularly in relation to self-silencing. Finally, I will discuss how these elements impact other emotional areas such as pride and joy. Thus, while caretaking/care receiving may cause internal erosion and suppressed anger may lead to exhaustion, continued experiences of loss – both in relationships and within one’s relationship with themselves – may inevitably result in a sense of erasure. Combined with embodied erosion and exhaustion, erasure reinforces a state of existential emergency, in addition to the real threat of being hidden from society and therefore more likely to be susceptible to abuse and violence. As a result, these three embodied states force individuals into cycles of isolation and coping, leaving little room for healing.

Losing Parts

“Yes, I’d give you anything
I gave you everything.
Now I’ve got to
Watch myself and
Love myself and
Take care.” – *Tegan and Sara, “This is Everything,” 1999*

“If lovelessness is godlessness
Will you cast me to the wayside?...
Am I vital
If my heart is idle?
Am I doomed?” - *“Doomed” - Moses Sumney, 2017*

When people think about interpersonal trauma, they often picture it in terms of extremes such as intentional physical, sexual, and/or emotional violence. But relational trauma can also come from forced loss of loved ones. Loss can happen for a number of reasons, but in the context of abusive relationships it can happen as a result of those closest to us severing our ties to the outside world, in order to maintain the status quo. As one guest recounted:

Faith: You know, I just really learned... I had to go a step further and admit that when it comes right down to it, my parents didn't love us. I am [sic] a family that's called a family, but there is not an ounce of love in that family. The siblings don't even love each other. I think I love people more than anyone else does in the family, which I think is really sad... [but] I had a friend. We were really, she was like my best friend. And uh, [their family] loved me. I used to go and stay in the house all the time... It was clean and dry, no dust. And they had racks on the wall, where they had stuff very neatly stored, and it was very clean. And I came home, and I told my mom all about [their] house, and that it wasn't supposed to be like this, and all this stuff, and oh my God, was the house a wreck. And my mom looked at my, looked at me and she said, “Don't you ever tell our business, or anything about me, or this house, anywhere.” And she looked at my father, and my father took me downstairs and beat the shit out of me. So it's like my mother told my father to take me downstairs, 'cause I remember she looked at my father. I mean, he really beat me. And, you want to know what I did? Can you guess what I did?

Sam: Took it?

Faith: Of course I took the beating, but after that was all over and done with, can you guess what I did?

Sam: You left?

Faith: I never had another friend. I never went back.

For Faith, the loss of her friend was the result of actions taken to silence and keep hidden abuse, neglect, and poverty. As a result, even while experiencing loss at an unconscious level – one might say in her body - Faith was unable to actively process through very difficult emotions, as she was simultaneously not allowed to express or even acknowledge her grief to those around her. These silencing actions were performed by one of her abusers – her father – and therefore she was able to eventually act upon this betrayal by distancing herself from him in her adult life. However, the practice of silencing grief persisted in her life, as an embodied understanding of how grief must be dealt with. This internalized lesson further led to proactively avoiding future pain, by avoiding future connections.

For others, loss and betrayal came not at the hands of abusers, but of the grieved themselves. However, like with Faith, we continue to see similar outcomes of silenced grief:

Laura: My father died when I was a kid. He was absolutely my mainstay, he was absolutely my go-to... And when he died, not only did my lifeline die, I no longer have a house, I no longer have anywhere to live. I no - I had to have some kind of a career in the middle of my last year of high school, something to make sure that I survive while I finished high school. I have a plan for college at the time, which there was no way for me to pay for it. So I had to figure out how to get a scholarship, which is nothing that I ever even figured about or knew how to do. And nor did I plan for this thing at all. I didn't do anything right, like as far as - the only reason I got it was generic [sic – “genetic”] ‘cause I could figure it out. I

was so desperate to be having to have a place to live where I could go forward... But you can't go backwards. You can only go forward.

This is regardless of whether the death was “natural” (as in the case of Laura’s father passing after a long battle with cancer) or “unexpected,” such as with Sonny’s friend, who relapsed and subsequently overdosed on heroin:

Sonny: And she, she told me, ‘I’m not leaving you. You’re going to be my best friend till I’m, for life. No matter what happens.’ And uh, she hated God, ‘cause she thought God had a hand in wrecking her life with her kids and her mom and her grandma. The religious affairs again and uh, she was, she was like me. Try to make everybody happy, do everything she was told, and found out that [redacted] didn’t give a fuck about her and she went to heroin. She had been off heroin five years from shooting it... And she left before me. And it made me angry as hell... It was made known to me the week of [redacted] that she was found dead in an OD. In her new home in [redacted]. I couldn’t respond... And that was it. So, I’m fine, you know? But I’ve resolved it in my heart to never let no one else in. Because that was too much.

What was particularly painful for Sonny was the fact that, despite her closeness to her friend, she was casually given the news in passing by individuals who she felt cared for neither her nor her friend. This disregard for not only the life that was lost, but also the meaning *behind* that loss in terms of Sonny’s own sense of self, reinforced her sense of replaceability and invisibility. In a way, it erased their shared history of struggle, of achievement and progress, and of loving connection. It erased a huge part of her purpose for continuing on.

Regardless of the reason for loss, the end-messaging is the same: in order to heal, one must move forward and forget the past. This may feel particularly true for those who have multiple losses, as the more loss you have, the more vulnerable you feel (particularly as resources remain static). But this “moving forward” comes with the cost of continued isolation and unresolved grief, causing women to shoulder the unfair

burdens of loss and betrayal alone while simultaneously dismissing, misidentifying, and/or reducing their pain:

Sexy [on being told by her doctor that she had severe kidney disease and would need dialysis/a transplant, and the grief she had over it not being identified sooner]: So, I appreciate [that they identified the issue], but I was feeling real down. I was upset with my own self - not with what they said, just with myself. I don't know why I feel that way, but that's how I did feel. 'Cause, from the day they tell me, I don't cry my people say. But when I'm by myself, I cry a LOT. I'm a, a - I was even sleeping, I'm crying in my sleep. I'm telling you... That's how hurt I was. And then, I didn't have no family or friends but you know, sometime you can't tell your friend your business. So, I just keep it to myself.

Laura [on her father's death while she was in high school]: Yeah, somebody died that you absolutely adore and they can't possibly come back to life and there's nobody to replace them. You're sad, you feel like you miss them, oh yes. Are you in big trouble because of that? Oh yeah, you could be, absolutely. Because no other people are going to react to him not being there. And you just gotta, you just - you can acknowledge a feeling. And then you can put a time limit on it, and you dismiss it.

Brooke [on deciding to move out of a previously toxic environment into a new city]: My friend [redacted] moved there, and she said, '[Brooke], we have an apartment on [redacted]. It's good and there's buses.' And I'm like, OK... So within a month, broke up with my girlfriend, put my stuff in storage, and went out to [a completely new city] to be with [my friend]. And [my friend] said, 'Oh [Brooke], you know, hey, I moved in with my lover but,' she said, 'you can have the apartment, you just gotta find a tenant.' And I'm like, ah, how could you?! So that began the tradition of itineracy. 'Cause I could not, I couldn't hold on to that. God, man, don't do that to me!... I could have killed [my friend]. But she was an opportunist and she, you know, whatever fine.

Mejor [on relationships overall]: That's why I'm afraid of love. 'Cause one minute somebody say they love you, and then the next one they want to hurt you... I like being an animal. When I lost my kids, I had a hard time accepting it... [accepting redacted's] authority... So, I became - I liked it, being an animal. When you're an animal, you don't have to love nobody. And nobody can love you. You don't have to get mixed up in all those feelings. And so, I really enjoyed being an animal.

Taken together, these stories demonstrate a pattern of first experiencing disregard of loss by others, and then internalizing that disregard to further erase one's connection to

both our own bodies and the relationships that give us meaning and keep us grounded in the world. For Sexy, she can acknowledge that she is profoundly hurt, but she also knows she has to keep this to herself in order to maintain the image others have of her as one who is strong and “doesn’t cry.” This silencing thus allows her to maintain a sense of pride and connection in her relationships, while also simultaneously leaving her feeling disconnected and alone.

For Brooke and Laura, the internalized message was that, in a fast-paced world, if you want to survive (particularly financially), you have to box up your emotions and put a time limit on grief. That practice of restricting grief is not unique to either of those individuals, but rather reflects our cultural attitudes on grief within mainstream U.S. culture (Cacciatore, 2017). In addition, for Mejour, her grief was so profound and, simultaneously, so dismissed and erased in her interactions with others, that she felt she had to undergo a complete transformation in order to cope with the disconnect.

Similar to the “righteous outlaw” mentality that Bourgois and Schonberg (2009) describe in their research on homeless heroin users in San Francisco, Mejour “became an animal” because it allowed her to, in some way, reject her continued subordination and the helplessness she felt as a result of her unacknowledged grief. In other words, her grief was so profound that she was willing to give up who she felt she was as a person – *to erase who she was, even to herself* - in order to stop the pain. But, as with Bourgois and Schonberg’s research, “the outlaw habitus that offered them a sense of self-respect through asserting control of public space [also] convinced those who interacted with them that they deserved their fate” (Bourgois & Schonberg, 2009). As an animal, Mejour was

further abused and isolated under the justification that she was dangerous and didn't care about her life based on how she was behaving, which only contributed further to her buried grief.

Silencing Grief and Trauma

“One of the cruelest affronts though, was the expectation that pain should be hidden away, buried, privatized — a lie manufactured, so as to mask and uphold the social order that produces so many of our unnecessary losses.” – *Cindy Milstein, 2017*

“The only method
Proven in time
To stop
The heart from hurting
Is to stop the heart.” – *Roland Hudson, "The World Doesn't Require You, 2019*

As with the areas of caregiving and anger, one of the key ingredients here is that of self-silencing. Within toxic systems, denying trauma is advantageous for perpetrators because, “If the trauma never happened, not only is the alleged perpetrator innocent of any wrongdoing, there is a complete reversal in the perpetrator-victim relationship such that the supposed victim is in fact the aggressor who is casting false allegations against others, tarnishing their reputation, and receiving undeserved reparations for harm that was never committed” (Hirschberger, 2018, p. 9). Indeed, this type of gaslighting is often used by domestic violence perpetrators, who convince their victims that they are making things up, and that no one will believe them if they report being abused (Sarkis, 2018). Perhaps unsurprisingly – given how we treat their anger overall - women are the usual targets of this type of gaslighting (Sarkis, 2018).

Based on this, it might be easy for one to assume that the solution is for women experiencing trauma to come forward and voice complaints, in order to both end trauma

and abuse and gain social support. But, as discussed earlier, threat perception is context-dependent: and, for women, sometimes it is safer to remain invisible. This could be because of learned fear for one's own safety:

Miriam [on having her house broken into]: If you call the police to report stuff, you become a target. Because [the neighborhood is] checking you. They think, 'Oh, she's a bitch, man. She got them po-po up there.'... So I only reported it twice, no, one time. And then I reported the shooting, because I had to... I ain't told anybody in that building I'm moving. I want to wait to the day or two before, when the truck pulls up. [Then] I'm gone. Because, you got to be very careful, you know? You got to be careful. Don't trust anybody because you don't know what they're trying to find out. So, I just keep a low profile. I'm gone. I'm gone. Yeah, it's very depressing.

Laura: My 'I will live' motto... you become invisible, which basically a dumb blonde is invisible. You don't know much about them – ah cute little, whatever. Like a baby chick or something, I don't know... Maybe there's a better approach, but there's a lot of people that lose that don't follow that approach.

Or even fear of negatively impacting others' emotional wellbeing:

Miriam: [My step-father] was one of the people that molested me. And, but I never told [my mother] simply because I don't want to hurt her. Because he abused her the way he treated her.

Furthermore, there is no guarantee that disclosing or even visibly showing signs of trauma will lead to safety or support:

Faith: Could you imagine showing up one day to a doctor with a child in such a condition that she has bruises on the bottom of her feet? And the doctor never questioned, 'Why did you wait so long to bring her in?', for example. 'What's going to, how long, you know, how long has she been like this? How, you know, did this just happen overnight?' Right? And, and nobody did anything about it... So we get the message. We're not supposed to tell. We don't tell. Where's this, where's this incredible loyalty come from? You're not supposed to tell, and we don't tell.

Particularly for women in abusive environments, this may have less to do with loyalty and more to do with repercussions for exposing one's situation to the public. In

fact, one study by Sullivan et al. (2010) found that the more severe a woman's intimate partner violence (IPV) trauma, the more likely disclosure recipients were to attribute some of the cause to her. One reason for this could be because of attribution bias, which the authors discuss specifically as relating to the fundamental attribution error and just world hypotheses:

“The fundamental attribution error posits that disclosure recipients tend to overattribute causes of victimization to the woman and underestimate both the responsibility of the aggressor and the dynamics of the abusive relationship. The just world hypothesis posits that “individuals have a need to believe that they live in a world where people generally get what they deserve” (Lerner & Miller, 1978, p. 1030), which protects their own belief system and/or allows them to feel less personally threatened” (Sullivan et al., 2010, p. 639-640).

As a result, women in the study who experienced more severe trauma - and thus experienced more negative reactions to their victimization - were more likely to adopt avoidance coping strategies. However, these adopted strategies further increased negative social reactions towards their situations, as this was viewed as them not “actively dealing with” the situation. At the same time, women in that study who disclosed their IPV victimization to a larger number of people *also* experienced more negative social reactions than women who disclosed to fewer people. This again reflects patterns of expected self-silencing in the face of threat, and the social repercussions for individuals who fail to meet this expectation. Because reaching out to others *is* a form of “actively dealing with” threat, taken together these results indicate that it's less about being active in addressing the situation, and more about addressing it *in the “right” way* – one which keeps grief and trauma restricted to the individual and erased from the public mind.

This study and the excerpts above should not be surprising, as these are merely reflections of the same types of dynamics seen in medicalization and necropolitics, with uncontrolled/unsilenced grief representing a form of illness/social deviancy. This is because we in the U.S. live in a culture which is both grief-averse and which qualifies different types of grief as deserving or not (Cacciatore, 2017). As a result, many of those who grieve are expected to “move on” quicker than they are perhaps able to, causing a disconnect between them and their existing social supports when they are unable to do so (Cacciatore, 2017).

In fact, in an article entitled, “How Long Should It Take to Grieve? Psychiatry Has Come Up With an Answer,” the New York Times announced that the DSM-5 – “sometimes known as ‘psychiatry’s bible’” (Barry, 2022, p. 1) – had recently added “prolonged grief” to its list of disorders. “The new diagnosis, prolonged grief disorder, was designed to apply to a narrow slice of the population who are incapacitated, pining and ruminating **a year after a loss**, and unable to return to previous activities” (Barry, 2022, p. 1, emphasis added). Supporters of the diagnostic addition cite the fact that this will allow clinicians to bill insurance companies for additional treatment needs while also increasing funding for treatment research. But it also negatively impacts individuals experiencing grief and trauma in two fundamental ways.

First, this framework pathologizes people for not adhering to an arbitrary, universal timeline for what is a subjective, personal experience. In fact, the article goes on to say that medical researchers originally pushed for the cutoff to be six months of grieving, and only relented to increasing it to a year over fear of public backlash. The

short duration of this limit also disregards unique types of grief such as that resulting from racial trauma, which may be both intergenerational and ongoing. However, because of our cultural reliance on biomedicine providing “objective truth,” individuals who are unable to move forward may further internalize the idea that they are weak or deficient in some way, in addition to potentially being stigmatized by others.

Second, this diagnostic addition justifies funneling support and money into capitalistic systems of profit and control/surveillance (e.g., drug manufacturing, “at-risk” surveillance programs, increased support for biomedical systems) and distracts from surrounding factors which may make it hard for people to process through grief in general (e.g., having to focus on daily survival and/or living in chronically re/traumatizing environments). It also further entrenches the cycles of isolation and coping described throughout this thesis. Thus, shifting funds into biomedical and profit-based systems rather than into programs geared toward things like affordable housing, affordable healthcare, increased minimum wage and equal pay, and child support means that this pathologizing will continue to be disproportionately shouldered by marginalized populations such as homeless women. Furthermore, this may be especially compounded for homeless women of color, who may uniquely experience racial trauma and its associated grief in addition to other types of grief, loss, and erasure.

As a way of suppressing grief and regaining autonomy, individuals may subsequently (and detrimentally) engage in messages of toxic positivity and the idea that one is responsible for one’s own (negative) mental state:

Laura: I don’t go into sad this, depressed that, you know?... You allow two hours for sadness, two days at the most, and then you move on... You’re not going to go

anywhere being in a depressed mood, or being sad, or whining... So you do away with the things that aren't going to go anywhere... You are in charge of your reactions... You're responsible for ongoing depression.

Faith: That's so sad I don't have anything. So I'm going to have to start building this. Or just make myself as best as I can be.

Sexy: It was a LOT. It was a LOT I'm going through. Plus, I was on dialys (sic), I was working, I have a lot on my plate, but you know what? God put me through... And then one day, I said, well, what's this I'm doing? And I shake myself outta it and just start thinking positive.

Miriam: I'd have to listen to music to get, you know, help me stay in in the mood of happiness and expression, you know. Positive, positive expression.

Mejor: I wasn't a good person, I was a rebellious child. I substituted. I (long pause) I became a bad person, because I couldn't be a good person for my mom.

Expectations for general self-sufficiency have been a long-standing part of U.S. reform movements, whereby “[t]he values of the body social were being implanted in the body personal in multiple ways through a range of disciplines: Prisoners under surveillance were expected to learn penitence; the sick, that they had the potential to heal (or reform) themselves – and, implicitly, the fault if they did not” (Barnes, 1995, p. 13). Moreover, within a political-economic paradigm, “Emphasis is placed on processes of social differentiation, as opposed to social cohesion, and on different capabilities of people to overcome constraints” (Thomas, 1998, p. 67). This creates a social environment where homeless women, in an attempt to differentiate themselves from their peers and to signal that they are capable of being independent and worthy of respect/social reintegration, swallow or hide their grief even while unconsciously still dealing with the effects of it. They do this by self-silencing and erasing their grief from both others and

themselves, making it that much harder for them to actively process through, and heal from, their experiences of loss.

Lonely Joy

“The tougher the armor, the bigger the heart you want to show. But you’re afraid to.” - *Metallica lead singer James Hetfield on the song “Nothing Else Matters,” 2021*

“I’m gonna die in a place that don’t know my name.
I’m gonna die in a space that don’t hold my fame.” – *“Lonely Soul,” Unkle, 1998*

The flip side to constantly silencing grief is that it often results in a dual silencing – or at least, strategic suppression - of shared joy and excitement. In grief, trying to “move on” may come at the cost of suppressing both the pain of loss *and* the loving, happy times you shared with those now gone (Cacciatore, 2017). As evidenced throughout my interviews, this is particularly true for those living in states of emergency, where there is little room for reflection and/or validation. In addition to this, emotional investment in the form of joy and excitement represents a different type of vulnerability - one which is also subject to ridicule and internalized shame. As such, it is this loss of shared joy that constitutes yet another important – if often overlooked – outcome of interpersonal trauma.

When I originally designed my interview questions, I was (admittedly) largely influenced by my own experiences of relational trauma, achievement, and shame – themes which I felt were largely absent from the trauma literature I was reviewing. For instance, excelling in areas such as academics was, for me, always a double-edged sword. On the one hand, being a straight A student meant I continued to receive my grandmother’s love and protection, while (theoretically) ensuring my ability to prosper

financially later on. On the other hand, demonstrating pride in my achievements made me a target of ongoing criticism by both of my parents.

For my mother, the fault was that my demonstrating pride signified that I thought I was better than she was, no matter what I did. This started with my winning a reading award in the fourth grade and ended with my *cum laude* undergraduate graduation from a top institution, to which she only stated, “You know that this doesn’t matter at all. The only thing that matters is what you do for Jehovah.” For my father, it was that my pride was undeserved, particularly in relation to financial achievement. When I started making six figures by the time I was 25 and he still found me inadequate, I began to accept that this was a goal which could never be met.

Along the way, however, these familial rejections made it easier to accept shaming practices in other types of relationships, specifically in relation to things I felt good about. This extended outside of academics to other areas of pride, such as being self-taught in woodworking, cooking, guitar, and general mechanics. When I cleaned – even when I was the only one to do so — it was never clean enough. When I wrote poetry or songs on the guitar, they were at best disregarded, and at worst ripped apart. When I did puzzles to help me think (and garner some sense of joy, control, and tangible accomplishment), I was being childish. When I kept silent, I was being emotionally closed off, immature, and unfair. When I spoke up, I was abusive and out of line. I couldn’t provide, I couldn’t improve; I couldn’t create, and I couldn’t maintain. In the words of one participant, Mejer, “I was like a ghost.”

I highlight these aspects not as a means of emotional catharsis and finger-wagging, but rather as a way of perhaps anchoring why my participants also report aversions to exposing their own sources of pride. Physiologically speaking, these dynamics are also, in fact, almost expected within trauma populations specifically, as noted by Dr. van der Kolk:

“If an organism is stuck in survival mode, its energies are focused on fighting off unseen enemies, which leaves no room for nurture, care, and love. For us humans, it means that as long as the mind is defending itself against invisible assaults, our closest bonds are threatened, along with our ability to imagine, plan, play, learn, and pay attention to other people’s needs” (van der Kolk, 2014, p. 76)

Thus, we see the same kinds of shrinking/avoidance practices in not just areas of receiving care and processing grief, but also in areas of pride and celebration. For instance, when asked about what selves/support groups she would be most likely to go to if she had accomplished something she worked hard for or been excited about, one participant replied:

Faith: That’s a great question, ‘cause I have never had a soul I could do that with. Myself is the only answer. And that is something very purposeful and in fact I don’t celebrate. I don’t even celebrate my own birthday. I’ve never had that. So, myself... I was taught not to celebrate. I was taught to be a loner... So this is why I stay to myself so much, because I don’t have, I don’t have anything. This is also why I’m homeless, you know. I don’t have that person I can call up and say, ‘Help!’

It should be telling that this response was given in the context of asking about sharing experiences of accomplishment and pride. For many of my participants, loneliness and accomplishment go hand-in-hand, and are particularly apparent when pride from others is absent:

Faith: I can’t tell you how many times I’ve been alone. And like graduation, I didn’t even go to my graduation for [redacted] because I just quit a job and went

to [redacted] to change my career and I was number one in my class... and I told my mother about it, and I told my mother about the graduation... Anyway, she said, ‘What do you want me to do about your graduation?’ That’s what she said to me. She had no joy, no happiness, no pride. Could give a shit. And I didn’t go. I did not go.

Laura: Um, also people are open to friendly, dumb blondes. They are not at all intimidated by them. So I can get all kinds of information from anyone, because nobody is threatened by the dumb blonde. And they might not even think of it that way, but subliminally, in this culture, it's an image that really it does, it, I mean, it was so, it's such an ingrained cultural image, that when I went to graduate from college, and my mother went to the thing, you never know what that lady is going to say. She said, she said, “You really graduated,” she said. “It must be because you're cute.” [Slams hand on table.] You know how many papers and tests I took to be told that I'm cute?!... I don’t feel creative with anyone.

Ariel: That’s a tough one, I don’t know how to answer that. Pride.

Without a way to express and integrate two very different ends of the emotional spectrum – loss/grief on the one side and accomplishment/joy on the other – homeless women and their sense of place in the world can become erased, including their relationship to themselves. They can become ghosts still trying to live in a world which has largely – and intentionally - forgotten them.

A Final Note

“Call out to the lonely with regrets
 Loveless is your answer time will pass
 Couldn't take a chance on us.” – *“Loveless” – Lo Moon*

In some respects, it is the loss of shared joy and pride - not the taking on of suffering - that is the most painful part of interpersonal trauma. Without shared celebration, life becomes grey and repetitive: a Sisyphean rut of continuing to push the boulder up the hill, only to have it roll back down as soon as you get to the top, with no

one to view your simultaneous pain/accomplishment either way. The loneliness of continuing to embody states of combined silenced grief and joy is overwhelming. It is isolating. It is devastating. And, in many ways, it actively erases who you are. You become one of the forgotten loveless.

In U.S. society, we don't like to focus on the negative – our culture is one that emphasizes a desire to “move forward,” in spite of our grief (Cacciatore, 2017). But when we continue silencing states of grief and anger, we don't move forward. Instead, we perpetuate cycles of suffering, violence, misrecognition, displacement, and disenfranchisement. We *can* do better. And, more importantly, we *need* to do better. Otherwise, we are doomed to continue living within a haunted world structured by cycles of trauma, isolation, and despair.

CHAPTER SEVEN: CONCLUSION

Living as Ghosts

“When it’s just you talking to yourself, the only responses you get are your own.” –
Laura, study participant

“I was walking with a ghost,
I said please, please don’t insist.” – “*Walking with a Ghost,*” Tegan and Sara, 2004

In this study, I sought to examine various pathways of coping and healing for women with histories of interpersonal trauma who are currently experiencing poverty and homelessness. Specifically, this analysis focused on cycles which keep women in states of coping, while simultaneously preventing them space to heal both physically and emotionally. In doing so, cultural systems and structures in the U.S., such as hospitals, shelters, and hostile architecture, reinforce states of ongoing, embodied threat through isolation and invisibility. This occurs in many ways, including the fact that homelessness and poverty are products of capitalism, and yet are not considered representative of it within larger cultural messaging.

Keeping individuals in a state of coping also means keeping them in a state of dependency, and vice versa. This, combined with specific acts of coping – such as those representing the *pain paradox* (Briere & Scott, 2015), where individuals engage in behaviors like substance abuse in order to reduce pain but which, paradoxically, only increase it – often reinforce negative stereotypes about homeless women while justifying keeping them isolated and/or “letting [them] die.” Importantly, death here is not just threatened in the form of *physical* death (through, for example, violence and/or medical neglect), but also in the individual’s *spiritual or cultural* death (Mbembe, 2003). For the

women in this study, this happens in the form of cultural structures and relationships eroding, exhausting, and ultimately erasing their bodies and personhood. In this way, U.S. cultural systems - which help to both create and keep homeless women in their situations - are the very same systems which condemn them for their current state of being. This subsequently sets individuals up to misrecognize their situation and internalize blame for it, while keeping dominant structures powerful and free from scrutiny.

Because of this, there can be a sense of dignity in isolation for those with trauma histories – a sense of safety in suffering alone when you’re at your weakest and most vulnerable. In the short-term, this might actually help to quiet down the SNS, particularly for those whose social interactions are largely coupled with experiences of being shamed. Moreover, in some situations, being alone may be the *only* way for traumatized individuals to be able to get back in touch with themselves as people, outside of the painfully judgmental gaze of others. At the same time, humans are social creatures, and long-term isolation can be devastating to both our mental/emotional and physical health. In fact, researchers have found that “as a predictor of early death, loneliness eclipses obesity” (Hafner, 2016, p.1).

Nor is loneliness a rare issue. According to the Hafner article, roughly 1 in 3 people older than 65 live alone in the U.S., with the prevalence of loneliness ranging from 10% to almost half of those 60 or older. Moreover, in an article by *The Atlantic* entitled, “Why Making Friends in Midlife is So Hard,” Katharine Smyth (2022) laments:

“If our 30s are ‘the decade where friendship goes to die,’ as the science journalist Lydia Denworth notes in her book *Friendship: The Evolution, Biology, and*

Extraordinary Power of Life's Fundamental Bond, then it's no wonder that making friends at 40 is more akin to dating than I had anticipated: It's dependent not only on chemistry and common interests, but also on a shared vision of what your new relationship could provide. Half the struggle is finding someone who wants the same thing you do, and at the exact same time."

Thus, inability to share the range of our emotional experiences with others – whether that be grief, pride, excitement, or anger – deprives us of our ability to engage in larger meaning-making processes and develop close relationships, thereby impacting our sense of purpose. Without a sense of purpose and place in the world – without relational homes and a direction forward – we remain lost in cycles of surviving (coping), not thriving (healing).

This is even more profound for individuals who, like the women in this study, have experienced and continue to experience an enormous amount of suffering and sacrifice. Sacrifice creates the need for purpose – a reason that justifies or otherwise makes meaning of what has been lost. When a diabetic suffering from neuropathy learns that they must amputate their leg in order for the rest of their body to survive, they may accept this because sacrifice of the part means survival of the whole. For individuals with histories of trauma, fragmentation often occurs in the form of their internal sense of self (Fisher, 2017), with the connection between our "core" self and "other parts" gradually being numbed according to experience and expectation. Thus, similar to the diabetic, when individuals continue to hear that they must amputate certain parts of their fragmented being – such as a grieving self – they may accept this because of the linked message that this will ultimately lead to their overall survival and wellbeing.

For the women in this study, this translates into cutting off or otherwise suppressing *both* their direct physical and emotional needs overall, *and* the parts of their internal selves corresponding to crucial, meaning-making emotions, such as anger, grief, and even joy. In the case of the diabetic, cutting off one limb may result in prolonged life; cutting off *every* limb, however, is likely to result in the opposite. For the women in this study, the outcome is no different, leaving them feeling as though they are living ghosts. Rather than their sacrifice being associated with meaning-making, it in fact deprives them of the tools needed to both make meaning and heal/live as whole human beings.

Seeing these patterns be repeated again and again – within my participant observations, interviews, and even in my own life experiences – can feel overwhelming. Living in the U.S. – which, *especially* prior to the COVID pandemic, almost exclusively emphasizes the individual over the collective – can further leave one feeling completely helpless and hopeless against the longstanding systems of oppression, discrimination, and isolation. It can feel as though you are a drop of blue dye lost in a colorless ocean, your vibrant color quickly but unmeaningfully dissolving into nothingness. As a result, there were countless times where this thesis almost didn't happen, as - in the words of one participant, who perhaps expressed the sentiment best - "Nothing that you do with this project will matter anyway. What's the point?"

This is the refrain that I keep returning to: "What is the point?"

Realistically, this thesis is unlikely to be read by anyone outside of my readers and perhaps a handful of individuals in my life who have a personal interest in the

subject. This thesis will likely not change the lives of any of my participants; it won't even change much in my own life.

In a way, throughout this writing I have engaged in the same kinds of dynamics as my participants. As a result of both researching trauma in general, and reliving my own trauma specifically, I have gone through countless periods of truly debilitating anxiety, depression, anger, and hopelessness. I have attempted to shrink, package, and translate the screams of my body and internalized experience into pretty words and easy to read sentences, which will hopefully be acceptable to people who may or may not even truly understand what it is to live in this type of embodied world. I have given up on these efforts one night, only to return again the next day. I have grieved and sacrificed over the course of two very difficult years, all in an attempt to have it make a difference, only to have it potentially mean little to nothing in the end. And - despite all of these things - similar to my participants, I still somehow have hope. Hope is the ultimate double-edged sword: sometimes keeping us alive, sometimes stabbing us where we are most vulnerable, sometimes all at once.

So, the question is, what now?

Framing Issues, Finding Happiness

“If it makes you happy,
Then why the hell are you so sad?” – *“If It Makes You Happy,” Sheryl Crow, 1996*

In her guest appearance on the podcast, *We Can Do Hard Things*, Yale professor of psychology Laurie Santos spoke at length about what it means to be happy (Doyle, 2022). Specifically, she referenced two areas which are particularly relevant to this thesis.

First, she brought up the idea that happiness is derived from both being happy *in* your life and happy *with* your life. Moreover, if having to choose between the two in terms of impact on overall wellbeing, being happy *with* your life (even when you are unhappy *in* your life) means being able to tap into a sense of purpose, even when surrounded by darkness. Conversely, being happy *in* your life but unhappy *with* your life might mean that, while you might be satiated in the short-term, you may be less resilient when tragedy strikes.

In addition, Dr. Santos introduced the idea of hedonic adaptation, whereby we get habituated to both the best and worst parts of our lives. For positive habituation, she gives the example of a new mother, who initially feels extreme happiness when her newborn first utters the word, “Mama.” However, over time, as the baby continues incessantly chanting, “Mama, Mama, MAMA, MAMA!!,” her feelings of extreme joy become significantly tampered. At the same time, Dr. Santos pointed out that our ability to become habituated to negative experiences is even faster than it is for positive ones. While this may be part of why people are able to become so resilient in the face of ongoing tragedy, it also, in the context of this thesis, suggests that individuals with histories of interpersonal trauma may become habituated towards expectations of being disregarded and erased.

Though there is much discussion about the idea of “resiliency” and trauma, another way to frame resiliency is to say that it’s a form of adaptation. In other words, we say that people are resilient because they are finding ways to adapt to their environment/situation. However, when we in the U.S. apply the term “resiliency,” it is

typically used to applaud a culturally sanctioned, pull-yourself-up-by-your-bootstraps, “positive” *way of adapting*, rather than the act of adaptation itself. When someone suffers a devastating loss and then uses that experience to, say, write a book or start a charity, we use them as an example of resiliency and the idea of “never giving up.” But when someone has suffered profound losses and turns to substances so that they may numb the pain in order to continue living in a grief-averse society, we regard them as a failure – the opposite of a resilient person. This is despite the fact that they may be adopting this coping strategy in order to continue surviving – in other words, *resisting* defeat and death – and doing so in a way which is *also* conditioned through U.S. culture. As Laura van Dernoot Lipsky, founder and director of the Trauma Stewardship Institute, points out, “We don’t talk about loss. By and large [in the US], it’s all about consumption to help numb you out” (Yong, 2021).

Thus, utilizing the framework of adaptation as opposed to resiliency allows us to have a bigger picture in order to dismantle some of these toxic cultural structures. Resiliency is a personal and somewhat moralized label, which keeps the attention focused on an individual’s perceived characteristics (and, more importantly, their culturally determined “successes”). In order to be labeled resilient, individuals in the U.S. have to be stoic, controlled in their behavioral and emotional expressions, independent, and signaling that they are “invested” in their own wellbeing. In other words, they need to embody the cultural practices and beliefs of medialization, necropolitics, and neoliberalism. Thus, those seen as “resilient” are paradoxically labeled as such because they are adhering to the same systems and cultural frameworks which *create the*

environment(s) they are being resilient against. In striving to be seen as resilient and “well,” individuals in fact reinforce dominant systems, while simultaneously being used as an example by those systems to further entrench cultural messages for pathways to success and wellness.

Adaptation, on the other hand, is conceptually more bidirectional/cyclical in nature – the environment acts upon the individual, who then acts upon the environment, who then responds to the individual. In the U.S., resiliency is seen almost as an innate trait, one which can’t necessarily be taught or supported through programs or institutions. When someone succeeds against all odds, we attribute it to individual-level traits such as their strength of character or overall level of determination: the reverse is also true when they fail. When we shift this framework to one of adaptation, however, we can likewise shift areas of intervention and support to be at *both* the individual/micro-levels *and* systemic/macro-levels, as well as decreasing social messages of stigma and shame. Viewing interactions through the lens of adaptation also allows us to develop a trajectory of events, which is crucial for contextualizing the very personal experience of trauma and its subsequent effects. Thus, rather than comparing two individuals with “similar” trauma events or situations (e.g., IPV) and using that as a benchmark for determining where someone “should” be in their healing process, we can instead view people as their own unique combination of embodied experiences and dispositions, thereby allowing for a more personal, meaningful connection and path forward.

Finally, how we frame issues - and label people as a result - relates back to Dr. Santos and the idea of being happy *with* your life even if you are not happy *in* your life.

Because I did not ask my participants directly about resiliency, I will use myself as an example. For most of my life, and especially during my 20s and now into my 30s, I have been labeled as “resilient” by many people. While this should have made me happy *with* my life – because I am “survivor,” and positively viewed as being able to overcome hardships – it instead made me feel incredibly lonely, angry, and stressed out. This was because my being “resilient” came at the cost of me never letting myself cry in front of anyone, of not asking for help even when I needed it, of not discussing topics I knew would make people uncomfortable, even if they were important to me, and of embodying success in the form of working long hours at an extremely competitive, well-respected but toxic company because it was a signal of “how far I’ve come.” Being “resilient” meant that I had to keep on a happy face, even when I was screaming inside. It put me in a box of expectations, one which I was terrified to break out of because I knew people I cared about were looking to me as an example. Likewise, because others would sometimes get compared to me, I also felt guilty for the potential *negative* effects of my sham image on others who were more outwardly struggling and less able to mask it. No matter where I turned, there was no escape from the trap of my “resiliency.”

Under the static benchmark of what it means to be “resilient” in the U.S., I was a success. I had experienced significant and long-enduring trauma and, despite that, had achieved much in both my academic and occupational careers. But under the framework of adaptation, I was a mess. Rather than engaging with others, I was adapting to my near-constant loneliness, terror, and grief by socially retracting in order to maintain my stoic façade and avoid future relational damage and shame. I wasn’t sleeping or eating because

I was constantly either working or thinking about work. I was adapting to the numerous, everyday microaggressions I experienced by engaging in destructive coping mechanisms which allowed me to cognitively disengage or otherwise numb my thoughts and emotions, so that I could continue to put a smile on when I had to interact with others and maintain my status within my working environment. I contemplated suicide on a near daily basis because I didn't feel like I could keep up the act much longer, and also didn't feel like there was any alternative. In other words, I was both resilient *and* still profoundly suffering *because* I was still adapting to a world which, to this day, feels overwhelmingly hopeless and dangerous. Thus, if we hope to truly support healing for those with trauma histories, we must first shift our focus away from qualifying *how* individuals are adapting, to changing *what they are adapting to*.

Suggestions for Change

Micro-level changes

“How did you survive so long down there?”

“I survived because I wasn't alone.” – “*The OA*,” “*Empire of Light*,” *S1E7*, 2016

“Loneliness is about the scariest thing there is.” – “*Angel*,” *Buffy the Vampire Slayer*, *S2E11*, 1997

“Frodo wouldn't have got far without Sam.” – “*Frodo*,” *Lord of the Rings: The Two Towers*, 2002

Interpersonal trauma is ultimately a profound disruption in our ability to connect. It causes individuals to become both worriers and warriors. It isolates people from others and themselves, making it that much harder to continue forward, let alone heal. But there is hope in this: if trauma is the act of severing, then connection can act as a form of

healing. This doesn't mean becoming best friends with every traumatized person we interact with, but it *does* mean making the effort to understand and validate their experiences: in other words, to make them visible again, without coupling that visibility with shame and/or harm. Ultimately, it means giving them the space to be able to return their focus to what the meaning of their lives is, and being there for them as they go through that process.

There is a wealth of information regarding the negative physical and emotional toll of microaggressions (for example: Hunn et al., 2015; Mar, 2021; Yearwood, 2013). However, like with microaggressions, even acts of micro-compassion can have a profound effect. Paying attention to the small things – remembering someone's name, remembering a piece of their story, *asking* about their story, looking at them when they speak, showing an interest, demonstrating vulnerability, engaging with them in small moments of pride – *makes an impact*, even if it doesn't directly impact their overall lives:

Ariel: Although it is like prison in a way but (pause) just the way of, at least in my experience, at this particular shelter, they just, it's like the women, it's women workers who just like (pause) feel that they, that you have to be, that they, it's like some kind of dominating thing, like slaves. (Long pause) I don't know, I, you know, I haven't really talked about this to anyone except, you're the first one that I've mentioned this whole feeling.

Laura: How do I know who you are when you walk into the room and I'm not paying attention? You got eyes that smile... and I'm not saying that the other people aren't kind or whatever, but your whole face lights up. Your whole face lights up.

Faith: You helped me a lot with some of your stories and telling me that you're the same... Thank you for sharing what you shared with me, [because] this has been the hardest part of my homelessness, is really learning.

These small acts of basic human decency represent tiny pebbles being thrown into a large body of water. They are small and they disappear if you only focus on the specifics of their initial impact. But, when we consider the ripples, we can start to see that nothing – even small gestures – remain contained. In the words of one participant, Sonny, “When I’m happy, it allows me to be free to be these individuals that respond to people.” This includes not just supporting shelter guests, but also supporting the people who support them.

By integrating trauma-informed care into overall onboarding training, institutions such as shelters, hospitals, law enforcement, and even schools can give employees the tools to be able to better identify and respond to trauma-related behaviors from those they serve, while also being able to identify trauma within themselves. While there are numerous things that can be included under the umbrella of what it means to have “trauma-informed care,” one of the foundational frameworks is shifting the focus from “What is wrong with you?” to “What happened to you?” (Briere & Scott, 2015; Trauma-Informed Care Implementation Resource Center, n.d.). As part of asking this question, understanding how the body responds to threat, and how threat is perceived by the body, is crucial for translating what *has* happened into what is *currently* happening. This is true for *both* recipients and providers, as both parties may be experiencing trauma within their bodies even solely through their interactions with each other, regardless of whether they are aware of it or not.

When we view interactions through this question’s framework, we can start to shift from acts of self-protection and isolation to ones of empathy and integration. Even

the simple act of asking, “What happened to you?” may foster or otherwise strengthen compassion and empathy towards both others and ourselves, particularly for those continuing to reside within the realm of trauma. It asks how we and others have *adapted* to the world around us (and, by proxy, prompts us to think about what we can change around us), rather than judging any given individual’s capacity to be *resilient* (and, by extension, how much damage they’re able to endure while remaining socially “productive” in toxic, self-serving environments).

In fact, I would argue that the situation between Tyler, Bee, and Rose (discussed in chapter 5) could have ended differently if *anyone* involved had asked the question, “What happened to you (that might be causing this reaction)?” For Tyler, the response might have included 1) being harassed by police for sleeping in her car earlier that day (which was especially trauma-activating because of both her race and her more masculine gender presentation), 2) attempting to go to a library afterward to sleep and subsequently being identified as homeless and rejected from there (which added to her bodily activation through shame-based pathways and further sleep deprivation), and then finally 3) feeling shamed by staff for following what she thought were orders for her to go outside, resulting in an explosive response. Likewise, if anyone had asked Rose why she suddenly stormed out after a not-uncommon interaction with a guest, Rose might have replied that she is the type of person who takes on everyone else’s problems even as she has no one to voice hers to, and has to endure racial slurs and other assaults from guests on a near daily basis while being in a position where she is not allowed to fight back. She might have also included that she originally joined up with CWS in order to restore

dignity to her community, and yet has to witness continued suffering and indignity while bearing the brunt of guests' displaced anger. Because this question was never asked, however, both parties ended up hurt, angry, and feeling on their own.

When we make shelter staff feel safer, we allow them (and, more importantly, their bodies) the space to also feel safer, which subsequently puts them in a better place to support others. This may also help to decrease high turnover rates in institutions such as shelters, which is crucial when considering how much relational connection makes a difference in both establishing safety and de-escalating situations as they arise. Likewise, creating mentorship programs *within* homeless populations may allow for the opportunity of connecting them with others who understand them in an unspoken way, while simultaneously re-establishing a sense of purpose, worth, and community. In fact, in their study on poor women, stressors, and coping strategies, Broussard et al. (2012) found that low-income women were able to relieve some of their stress and increase feelings of empowerment solely through volunteer work with other low-income individuals. By creating peer mentorship programs, we can potentially channel homeless women's experiences of grief and anger into more positive, meaning-making connections both within their lives and the lives they come into contact with, without dismissing those experiences altogether.

Furthermore, including homeless women's voices in organizational matters such as fundraising and the development of various shelter programs is not only important for dismantling toxic assumptions and frameworks: it is also conceptually more efficient for addressing issues overall. While critics may contend that this could be logistically

difficult due to the transient, “unpredictable nature” of homelessness, I would also argue that 1) this contention reflects a homogenized view of homelessness, which is inaccurate and 2) in general, it is a lot harder to address an issue that you have no direct understanding of, as opposed to asking for knowledgeable opinions, even if those voices eventually leave the (more immediate, local) conversation. Including homeless women in decision-making efforts which directly impact them also helps to 1) share decisional burden with shelter staff, thereby potentially decreasing the anger directed at them while 2) increasing representation, which can subsequently help to dismantle cycles of stereotype-based isolation discussed throughout this thesis.

Macro-level changes

“Why can’t you just be nice?”

“Because the world isn’t nice.” – *Blade Trinity, 2004*

When I informally asked shelter staff what they would change about the U.S.’ current systems/structures in order to improve circumstances for homeless women, their thoughts were almost identical to my own: there is so much to change, and so much interconnectedness between issues, that it is hard to know where to start. It is like walking along a hiking trail, coming across a fly caught in an intricate spiderweb, and then being asked which thread is holding it in place. Often in the U.S., we approach issues in a linear, singular fashion – x causes y which causes z . We identify one individual thread attached to the fly, triumphantly decree that it is the source of the issue, and cut it, expecting the fly to now be able to escape.

With trauma, however, the threads wrapped around the fly are multi-layered, non-linear, and cyclically re-forming in a way which makes it hard to solve in the typical U.S. fashion. How trauma is encoded into our bodies, processed through our minds, represented in our actions, and supported by those around us (or not) is also unique to each person, and so the same types of solutions may not work as well for all individuals. Despite these limitations, and acknowledging that these suggestions fall outside of the specific scope of this project, I would like to propose a few societal changes which may help to alter these cycles of isolation and coping.

First, we need to improve our educational system – both in making higher education free or significantly cheaper, and supporting more inclusive content at the lower levels (e.g., preschool through high school). At the undergraduate and graduate levels, crushing debt contributes to impairments in both mental health and academic performance (Body, 2018; Novotney, 2013). Investing such a significant amount into educational credentials also pigeonholes people into certain career paths once they graduate. This may result in people remaining in toxic work environments or careers because they have no viable financial alternative. Furthermore, ongoing debt has a strong relationship with suicide completion, drug and alcohol abuse, and even obesity (Richardson, Elliott, & Roberts, 2013), which can subsequently reinforce cycles of poverty, illness, isolation, and trauma for not just individuals in debt, but their dependents and loved ones as well.

In addition, because education is the gatekeeper of jobs in the U.S., those who are *not* able to afford increasingly expensive education are restricted to typically lower

paying, customer-service based jobs. This means that women – who overall continue to be underpaid as compared with men – are especially disadvantaged when they are unable to attend higher levels of education. Given that the minimum wage has not been raised since 2009 while inflation continues to rise, this means that women, and especially women of color, are particularly vulnerable to remaining in cycles of poverty and homelessness (Cummings, 2022). Being underpaid also means that women who are in abusive relationships may be hesitant or unable to leave their partner - or, if they do leave, may have to relinquish custody of their children due to not being able to financially support them.

Furthermore, because topics such as critical race theory, queer theory, and feminist theory are almost exclusively taught within higher levels of education (or within expensive private schools), individuals who are not able to afford college are barred from being able to learn more about themselves and those around them. Even as schools are attempting to introduce these areas at the lower levels, they continue to be attacked by agents of the status quo, such as politicians and school administrators. This is demonstrated in, for instance, Florida’s “Don’t Say Gay” bill, which bars schools from discussing sexual orientation or gender identity (Sopelsa, Bellamy-Walker, & Reuters, 2022). It is also shown through acts of removing books from school libraries, disproportionately targeting both authors and topics related to race, gender, and LGBTQ identities (Natanson, 2022).

This silencing of identities, perspectives, and even historical facts further entrenches cycles of isolation and distrust, while maintaining a racist, sexist culture

which pits vulnerable parties against one another. For example, for some cis gender women, the effects of living in a sexist society which predominantly views them as products of their bodies (e.g., “babymakers”), as well as *objects because of their bodies*, may actually lead them to internalize transphobic opinions (Chemaly, 2018). In other words, living in a society which claims that you should be exhibiting certain (innate) behaviors or thought patterns *because of your body* means that cis gender women may adopt transphobic beliefs because they have been socialized to believe that bodies equal dispositions. For cis gender women who have experienced trauma at the hands of “male” bodies, this may lead them to internalizing the idea that trans women are really just “men in disguise,” and therefore potentially dangerous. As a result, shelters like CWS, which attempt to create a safe haven for *all* traumatized women, often become the stage where socially reproduced instances of sexism manifest between guests *because* this is where these false categories break down.

Finally, if we truly want to help individuals heal, connect, and become independent, we need to not only pay people better and give them better access to education and opportunity: we also have to keep them healthy and safe. This means supporting free healthcare, so that people don’t have to decide between paying the rent or eating – or staying in a job that makes you sick because it also provides you with insurance to cover your medical bills. Lack of affordable healthcare also disproportionately affects individuals whose jobs don’t provide insurance, which includes many low-wage jobs as well as part-time work. In addition, lack of affordable *housing*, or affordable housing that is located in a more remote area, contributes to increased stress

levels, health problems, and relationship tensions (Stewart, 2021). Lack of affordable housing also contributes to rising rates of homelessness which, in Massachusetts alone, have more than doubled since 1990 (Massachusetts Coalition for the Homeless, 2021).

For people to feel safe, they have to also feel like they are living in a just environment. This means holding those with power, such as law enforcement officers, accountable for their actions, especially with regard to marginalized communities. When powerful individuals are not held accountable – such as the officer who shot Breonna Taylor to death, who was not even tried for her killing and was also recently found not guilty of wanton endangerment (Mack, 2022) – it reinforces structural violence and cycles of isolation and trauma. It forces people to be their own self-protectors which, as shown throughout this thesis, can further lead to violence against others, lost or severed connections, an erosion of resources, self-isolation, and self-destruction. It forces people to carry all of the responsibility, while having none of the power.

At the end of the day, the art of trauma healing starts with connection. This means being able to develop strong, meaningful relationships not just with other individuals, but also with ourselves and the world around us. This includes understanding where we came from and how that has led us to where we are, both as individuals and as a society. It means allowing for a range of voices to be heard and challenging how we socially categorize people. It also means redirecting our efforts towards identifying factors in the social and physical environment which force people to adapt in certain (sometimes destructive) ways, instead of restricting our gaze to moralizing individual behaviors. Finally, it means promoting a culture of vulnerability, one which allows us to find unity

through shared suffering and grief. In this way, we can shift away from cycles of isolation, coping, and surviving, and instead foster pathways towards connection, healing, and thriving.

APPENDIX

Semi-structured Interview Questions

1. What name would you like me to use for you as part of this study?
2. What year were you born?
3. How do you identify (what are the first aspects that come to mind if you were to describe yourself to someone who hasn't met you yet)?
4. When did you first come to [CWS] and what initially brought you?
 - a. What has the experience been like since?
5. Do you have any health issues that you have dealt with or are currently dealing with (however you define "health issue")?
 - a. How long have you dealt with this for?
 - b. What does it feel like to experience that **physically** in your body?
 - c. What is it like to experience that **mentally/socially** (specifically, in terms of your sense of self/how it relates to who you feel you "are" and how you interact with others)?
 - d. What is it like to experience that **emotionally** (e.g., creating a sense of mortality/fear of death, anxiety/frustration with needing to rely on others, helplessness, community)?
 - e. What experiences in your life have influenced your health and how you approach coping with issues regarding your health?
6. What have your experiences within the healthcare system been like? What types of care/interactions have you had regarding your physical and/or mental well-being?

Card-Sorting Questions

Card-Ranking (Note each question was asked a second time regarding which internal selves would be most likely to emerge in each situation.)

1. Which groups and/or coping methods would you be most likely to go to for support/comfort during a **financial emergency**?
2. Which groups and/or coping methods would you be most likely to go to for support/comfort if you were experiencing a **physical threat** (if you felt your life was in danger, or if you were having a medical emergency e.g., DKA if you were diabetic)?
3. Which groups and/or coping methods would you be most likely to go to for support/comfort during a **an emotional/mental emergency** (for instance, if you started to have thoughts of suicide or felt as though you were having a "nervous breakdown")?

4. Which groups and/or coping methods would you be most likely to go to if you **accomplished something you had worked hard for or been excited about/felt proud of** (e.g., earning a degree, getting a new job)?
5. Which groups and/or coping methods make you feel the most **creative/curious**?
6. Which groups and/or coping methods would you be most likely to go to if you needed to talk about/process through something that you felt **ashamed of, related to something you had done or experienced**?
7. Which groups and/or coping methods make you feel (overall) **“good” IN YOUR BODY** (however you define “good”)?

Free Association

1. Which groups, coping methods, and/or internal selves do you associate with the term **“health”** or the idea of being healthy?
2. Which groups, coping methods, and/or internal selves do you associate with the term **“protection”** or the idea of being safe and/or secure?
3. Which groups, coping methods, and/or internal selves do you associate with the term **“shame”**?
4. Which groups, coping methods, and/or internal selves do you associate with the term **“pride”**?

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